Enhancing Existing Communication Channels for Large-Scale Health Interventions: Making Every Contact Count in the United Kingdom

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Chapter Overview
This case investigates a large-scale health intervention developed by Social Marketing Gateway in the City of Salford, UK. The Making Every Contact Count (MECC) program indirectly encourages Salford residents to make healthier lifestyle choices by training frontline staff, particularly those in the health industry, to have conversations with clients about their health and wellbeing. The training program covered interpersonal and communication skills, basic behavior change theories, issues related to wellbeing, and local services. By using communication channels that already exist, MECC was able to increase the efficiency of health guidance without exhausting limited resources.

Campaign Environment and Background

The 220,000 residents of Salford, UK, face significant health inequalities. A woman born in Salford can expect to live almost 3 years less than the national average and a man from Salford can expect to live 4 years less than the national average. The health issues underlying these inequalities place a huge financial burden on local service providers at a time when they are under increasing pressure to cut staff and deliver services. Local health and other public sector agencies therefore set out to

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tackle the arduous task of increasing the efficiency of health guidance without additional resources.

Following a visit from the Department of Health (UK) Health Inequalities National Support Team, local agencies decided to create an early interventions program, where public sector staff would be trained to provide public health guidance to their clients. The Department of Health speculated that such a program, if delivered systematically and on a large enough scale, could significantly impact the health and well-being of Salford residents. Building the assets of local people would reduce the burden on local services and, in turn, allow service providers to target resources to where they are needed. Also, raising awareness among the frontline staff of other services and supports, and improving the levels of quality referral and signposting that they can deliver, will both improve coordination between services and more effectively connect people with the services they need.

A core arguement for the Making Every Contact Count (MECC) program is that millions of health practioners and other staff from a diverse range of professions talk to members of the public every day. These frontline service staff, if properly trained, have the potential to influence the behaviors of the wider public and help people stay well. MECC, therefore, seeks to achieve behavior change at two levels: first the behavior of frontline service delivery staff working within service delivery organizations, and second the lifestyle behaviors of citizens who are the customers of public services.

MECC aims to teach the local workforce how to carry out conversations with residents about their health and well-being in order to encourage healthier lifestyle choices. This aim is based on the idea of *whole systems* working, a broad, holistic, and multi-agency approach where health is everybody's business. If frontline staff across the full range of public services can have helpful and consistent conversations with their customers and clients, then a major impact can be made on population health and well-being.

MECC adopted an asset-based approach to achieve organizational change and improved population health and well-being. An asset-based approach assumes a community development philosophy that seeks to build on the skills of local people and the supportive functions of local institutions. MECC does this by seeking to change the culture and practice of service delivery organizations, encouraging and supporting their frontline staff to work in new ways to build stronger, healthier, and more sustainable local communities for the future.

Governance of the MECC programme was through a MECC Program Board that fed into the local Health and Wellbeing Board for the area. The Health and Wellbeing Boards are a new governance level established across the local government sector in England in 2013 in response to the new public health responsibilities given to local government. A MECC delivery team was formed in Salford to focus on the nuts and bolts of implementation, and a stakeholder group also came together to provide regular input from the perspective of the key organizations participating.

In Salford, the rollout of the MECC training began early in 2012, with a number of courses scheduled on a monthly basis. The courses were delivered in community venues or in the premises of some of the participating organizations (e.g., local

hospital or community centre). The number of staff participating in individual training courses varied but averaged around 15 people per session.

SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats)

Strengths

Health Services is already a well-recognized health resource for the public.

The Local Government's Health and Wellbeing Board is firmly behind MECC, as are senior leaders from the other main service delivery organizations.

MECC was introduced as a central part of the local health service's strategic commissioning plan in 2010. Since then, heavy investment has been made in developing a program that will meet the recommendations of the National Support Team for Health Inequalities to "industrialize" the health gain conversations of the local workforce.

The delivery team organized a group of stakeholders to offer additional input.

Weaknesses

At the time, MECC was a new effort with a new delivery team. Although the delivery team members had experience of implementing other projects, none had worked on a project quite like MECC.

Opportunities

The UK has a huge healthcare workforce which, along with the many thousands of other public- and third-sector workers, represents a very significant asset that can be mobilized to support behavior change at the population level.

Frontline staff members are in a position to ask, advise, assist and prompt the people they interact with on a daily basis to think about and act to take care of their own well-being.

Threats

The causes of ill health and health inequalities are complex and usually cannot be dealt with by one service or organization acting alone.

Staff may not be interested in the program or changing how they do their job.

Work, housing, and income variables act as competition to behavior change among Salford residents.

Target Audience

The MECC program targeted frontline staff, particularly those in the health industry and other industries who have a direct or indirect role in helping their clients or customers change their health-related knowledge, attitudes, and behavior. This target audience was ideal because they regularly interacted with numerous clientele, therefore providing an extensive communication channel to a large proportion of Salford residents. In Salford, there are over 15,000 frontline staff members and volunteers that represent the target audience.

Barriers to Adopting MECC

Staff may not be experts in all factors influencing health and well-being, particularly those factors that are outside of their specific service area.

Some staff members would have more time to chat with clients than other members.

Staff may be reluctant to move beyond the comfort zone of *doing their job in the way they have always done it.*

Campaign Objectives and Goals

The MECC program aims to change the behaviors of both frontline service staff who interact with the local population and of the local population itself. The focus is on workers within public services and on encouraging them to have short, opportunistic conversations ("healthy chats") with members of the public that they interact with on a daily basis. The intention is that all frontline staff have a role to play, not only health and social care workers, but also other staff members who meet the public on a daily basis; they can all help improve local health and well-being by "making every contact count." In turn, it is expected that, as a result of these conversations, the public would start to take better care of their health and access a range of local services that support well-being. Thus, the main objective was to initiate another route to encourage healthy behaviors by using a communications system that was already in place: frontline staff. The overall goal is to raise the level of population health and well-being and reduce the rising cost of health services at a time when the public-sector expenditure in the UK is under severe strain.

Behavioral Goals

The behavioral goal was to increase the number of healthy chats, in the form of brief advice or interventions that frontline staff and volunteers held with Salford

residents. This goal was established through the creation of MECC competencies. These competencies are segmented to reflect the fact that some staff involved in MECC would deliver only *brief advice*, while others would deliver both *brief advice* and *brief interventions.* While brief advice was seen as being a very short chat, possibly leading on to the client being steered in the direction of an appropriate service, a brief intervention would involve a slightly longer, and possibly more complex, structured conversation that looked to build the client's motivation to change an unhealthy behavior and could conclude with a planned course of action that would support the behavior change identified.

To reach this goal, staff members need to be able to quickly assess a person's need and motivation to change and to be confident enough to encourage people to act and take small steps along the change journey. Staff would either be strengthening a person's ability to self-care, delivering brief advice or a brief intervention, signposting to other sources of help, or making a quality referral. The principle of engaging with people and opening up a conversation is a simple one, but is also potentially a difficult one to implement in the context where many staff are reluctant to move beyond the comfort zone of *doing their job in the way they have always done it*. But to do MECC and to do it well, staff would need to understand that they were being asked to do things differently.

Campaign Strategies

Product Strategy

The MECC training program was developed around the distinction of brief advice versus brief interventions and involved two levels of training (Level 1 and Level 2). The competencies developed for MECC covered interpersonal and communication skills, basic behavior change theories, issues related to well-being, and local services. Level-1 training prepared staff to engage with the public, encourage self-care, and signpost people to appropriate sources of support. Level-2 training went further, ensuring that the staff knew the range of factors that could influence well-being and were prepared to deliver brief interventions.

Three courses were developed with a range of interactive elements. Two half-day courses were prepared for Level 1, and one full-day course was organized for Level 2. To lay the foundations for long-term sustainability, a separate *Train the Trainers* course was also developed to establish a pool of internal trainers that would ensure that staff could continue to gain the necessary competencies when they needed them. The program designer (Social Marketing Gateway), incorporated extant behavioral theory to show how staff members might be able to help others in a short space of time. For example, staff members were taught about incentivizing and removing barriers in order to encourage behavior change (McKenzie-Mohr, 2000). Other theories that were particularly useful for the program were the Stages of Change Theory and Exchange Theory.

Stages of Change Theory (i.e., Transtheoretical Model; Prochaska & Velicer, 1997) demonstrates that needs vary in terms of information, motivation, and support, depending on the client's stage. So, frontline staff had to learn how to identify the client's stage in order to provide appropriate guidance. For example, action-oriented guidance is only useful for clients in the action stage, and such guidance would be counterproductive for clients in earlier stages (Prochaska & Velicer, 1997). A basic appreciation of the theory allowed staff members to assess how ready a person was to change and to decide how (if at all) to help.

Exchange Theory (Houston & Gassenheimer, 1987) suggests that successful health interventions require a voluntary exchange of resources (e.g., money, time, effort) for perceived benefits. To encourage a client to participate in an exchange, the client must believe that the benefits of adopting a healthy behavior outweigh the costs of purchase/adoption. It is important to note that clients may not be willing to exchange certain resources at all, but incentives can be offered to ensure benefits outweigh the costs (Alcalay & Bell, 2000). Frontline staff were therefore taught to acknowledge the costs and benefits of healthy behavior in order to minimize costs and maximize benefits.

In general, staff working directly with the public needed to appreciate that a range of factors (lifestyle and other) can influence a person's health and well-being. As such, staff members working in one area of service delivery (e.g., giving financial advice, delivering a smoking cessation service, working as a receptionist in a library, and so on) needed to be sensitive to factors outside of their specific service area that contributed to a client's situation. They did not need to be experts in these other service areas. Rather, a basic understanding of the main factors affecting well-being and the key services available would help staff members be in a better position to spot a person's needs, engage them in conversation, and encourage them to take even a small step in the right direction. Ten key factors that influence the well-being of the local population were identified: housing, employment, welfare benefits and tax credits, money and debts, smoking, weight management, substance misuse (including alcohol), physical activity, emotional health and well-being, and sexual health.

Initially, staff members aspiring to deliver brief interventions (Level 2) needed to first demonstrate that they met the competencies for delivering brief advice (Level 1). This led to some staff needing to complete multiple self-assessments and courses. The system was therefore revised, such that both brief advice and brief interventions were covered by one self-assessment and, if required, one training course. Staff members also used a technique called "MECC Touch Point Mapping" to identify intervention opportunities that existed in their day-to-day work environment. By rooting the training firmly in the "working realities" of staff members, it was easier to highlight the range of factors that influenced well-being and the importance of a more holistic approach between different services.

Rollout of the MECC training courses began early in 2012, with a number of courses scheduled on a monthly basis. The courses were delivered in community

venues or in the premises of some of the participating organizations (e.g., the local hospital or community center). The number of staff participating in individual training courses varied but averaged around 15 people per session.

Augmented Products

An online self-assessment tool (SAT) in multiple-choice format was developed to assess whether or not staff members met the required MECC competencies. For example, SAT asked staff about (1) their confidence in starting a conversation with clients, (2) the factors influencing health and well-being, (3) their understanding of the Stages of Change model, (4) confidentiality and safeguarding issues, (5) their knowledge of key local services, and (5) how and when to refer people to other services. The implementation of SAT brought significant negative feedback from the target audience. Many were critical of the questions and viewed the self-assessment as an onerous *test* rather than a supportive tool. Revisions were made to improve the clarity of the questions, but criticism and resistance from staff did not completely disappear. Consequently, SAT was abandoned in favor of a new MECC Induction Session wherein staff members decide for themselves what, if any, further help they need from MECC. Additional augmented products included the following:

- A Web site offering training and supplementary resources
- Drop-in classes and workshops for staff members who continued to struggle with delivering brief interventions after attending the training courses
- Action Learning Sets and forums in which staff members could share experiences and problem solve real-life interventions.

Pricing Strategies

MECC's price strategy is to decrease the monetary costs for frontline staff to participate in the program. In order to offer the training courses at no cost to staff members, the local public sector organisations covered the cost of the training program for all users. However, employers were responsible for paying any additional tangible or intangible costs (such as inconvenience, reallocating staff duties).

Place Strategies

The place strategy is to make attending the courses as convenient and accessible as possible for frontline staff members. As such, the courses took place in a variety of local venues in the City of Salford. Venues were selected by the employers of the

staff members in order to ensure that the venues were locally accessible. In many cases, the courses were taught right in the staff's place of work (e.g., a hospital environment).

Promotion Strategies

MECC focused on promoting the program to public and third-sector employers in Salford. Employers have the authority to not only schedule a time during work hours for their staff members to complete the course, but also ensure that staff members held brief chats with their clients (e.g., by adding this duty to their job description). MECC primarily recruited employers through direct, face-to-face marketing. In their sales pitch, organisations promoting MECC focused on how easy it is for frontline staff to make real changes to the health and well-being of Salford residents. A comment from the local Director of Public Health carries a key advertising message: "*The great thing about MECC is its simplicity. A frontline worker having a quick chat with people about their well-being is all that is required. That's going to feel a normal part of the job for people that work in public service. And when you add that chat to the conversations that thousands of other workers will have, we'll really see some benefits for the people of Salford.*" Once employers committed to the training program, the MECC delivery team worked directly with managers to launch the event. To help managers sell the program to staff members, the MECC delivery team also offered an interactive website, posters, handouts, and introductory videos.

Evaluation Techniques

At the end of each MECC training course, evaluation sheets were filled out by participants and returned to the instructors. Post-training evaluation sheets requested specific feedback on the perceived value and applicability of the course content. The evaluations, coupled with the registration data, provided the basis of a monthly report to the commissioning organisation. Additionally, an independent review was commissioned after the first year to assess whether or not the original objectives of Salford MECC had been achieved and to identify areas for improvement. The review employed a mixed methods design, using information from the self-assessment tool, post-training evaluation, semi-structured interviews, focus groups, online questionnaires, and consultation with key stakeholders and the commissioning group.

Lessons Learned and Future Direction

The MECC approach has grown across the UK's public sector. In 2012, there were 17 examples of MECC in practice and that number has grown steadily since. Currently, the Salford program still represents the largest and most ambitious MECC health gain program yet implemented in the UK. After its first year of delivery (March 2013), 1509 staff members from 36 organizations had successfully completed the program. Furthermore, results from the one-year review indicated that frontline staff and volunteers felt better equipped to carry out brief conversations and brief interventions with their clients. MECC's strength lies in their ability to acquire feedback and willingness to revise the plan. While many challenges were addressed within the first year, MECC identified new challenges for the program to overcome in the future.

First, the one-year review highlighted differences in motivation among frontline staff and management. Compared to managers, frontline staff members were more willing to participate, less skeptical about MECC's impact on the general population, and more optimistic about the sustainability of MECC in the future. The above findings highlighted a major challenge for the MECC program: the strength of buy-in and the engagement of senior and management staff. Consequently, some organizations have been slow to include MECC into their appraisal, monitoring, and core training processes. The sustainability of MECC therefore depends on program acceptance by these key stakeholders. One solution is to offer tailored communications to different stakeholders. To assist stakeholder buy-in, a communications toolkit with specific sections for each staff group was added to the MECC website.

Second, the review indicated a difference in satisfaction among staff members participating in the Level-1 course and Level-2 course. Specifically, staff members who completed the Level-1 course, compared to those who completed the Level-2 course, had more knowledge of and confidence to carry out health chats. Furthermore, staff members who completed the Level-1 course were more likely to incorporate MECC in their day-to-day work. These findings suggested a need to improve the Level-2 course offer. To increase the value of the Level-2 course, instructors were therefore advised to go in-depth on key topics, such as *asking the difficult question*, *dealing with resistance,* and *withdrawing from a difficult situation*.

Finally, it remains to be seen how the MECC program affects the health and well-being of Salford residents. This unknown is a key limitation to the evaluative evidence to date. Better monitoring and evaluation mechanisms are needed to show stakeholders the impact of MECC on the health and well-being of local residents. This intelligence will make it easier for advocates of MECC to sell the program to new organizations and markets.

Discussion Questions

1. What can MECC do to further increase the number of healthy chats?
2. The MECC program assumes that frontline service staff, if properly trained, have the potential to influence the health behaviors of the wider public. How might they monitor and evaluate this causal relationship?
3. How might MECC promote the program to senior management?
4. What can MECC advocates do to expand the program into other cities?

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