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Making Every Contact Count: Evaluation of the use of MECC within the outpatient MSK Physiotherapy service and Bury Integrated MSK Service at Fairfield General Hospital, part of the Bury and Rochdale Care Organisation which is part of the Northern Care Alliance Group

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School of Health & Society

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1 Overall project aims

This report presents the findings of a commissioned study to evaluate the use of Making Every Contact Count (MECC) within the outpatient MSK Physiotherapy service and Bury Integrated MSK Service at Fairfield General Hospital, part of the Bury and Rochdale Care Organisation which is part of the Northern Care Alliance Group (hereafter referred to as Fairfield MSK Physiotherapy Services). The study was a three-stage evaluation to include:

1. an initial service description analysis for musculoskeletal (MSK) treatment
2. a secondary data analysis of data related to MECC referrals made by Fairfield MSK Physiotherapy Services
3. and a patient questionnaire relating to experiences of MECC within Fairfield MSK Physiotherapy Services

2 Background:

2.1 Definitions of MECC

MECC is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change¹ by building on the contacts those working in health and public health have with individuals every day which allow these conversations to occur. MECC is defined as:

“...an approach to behaviour change that utilises the millions of day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.” (Making Every Contact Count (MECC): Consensus statement, 2016)

The focus of a MECC conversation is around lifestyle topics, for instance stopping smoking, improving levels of physical activity, or health eating. All of which can also influence the health outcomes of those visiting the AHP departments that are part of this study. Although it can be difficult to capture the influence of MECC conversations, there is evidence around the positive impact MECC can have for staff and patients. For example, Public Health England and the NHS in April 2016 published a Making Every Contact Count: Consensus Statement, which provides a number of examples of local impact², such as:

“... MECC has also been shown to generate lifestyle and behaviour change among workforces where MECC activity, training and support have been provided. For example, with South Tyneside’s Every Contact a Health

¹ Further information around MECC can be found on the NHS England fact sheet - <http://www.makeeverycontactcount.co.uk/media/1129/mecc-factsheet.pdf>

² More information on the Gov.UK document around MECC can be found at - <https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources>

Improvement Contact (ECHIC) programme, the local street cleansing team lost a combined weight of 15 stone, after putting advice received as part of the MECC training into practice for their own health and wellbeing”.

MECC is widely utilised within the NHS mostly through the allied health care practitioners (AHP’s) and within the wider public health workforce. It is important to note that in secondary healthcare, MECC is not about having an additional conversation with patients, it is about changing the conversations already being had so that they are more effective and focused on helping the person to look after their health. It is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change.

2.2 Why has this project been chosen?

To achieve changes in long-term lifestyle behaviour, organisations need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals (Varley & Murfin, 2017). In the NHS, MECC is now integrated into standard NHS employment contracts³ and there is an expectation that services should be able to demonstrate their MECC activity. The integration of MECC into services is a key aspect of NHS England and Public Health England’s aims to improve health and wellbeing across the UK population (Making Every Contact Count (MECC): Consensus statement, 2016).

The Physiotherapy Department at Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group, have been pro-active in the integration of MECC into their services and is one of the leading examples in the Bury & Rochdale Care Organisation. The Physiotherapy Department to date have some anecdotal information that this does improve patient outcomes.

Bury Council along with the Physiotherapy Department of Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group commissioned this study to establish: how MECC works in the service; how it can be improved; what impact it has on patient outcomes, and finally what patients report in respect of whether they are aware that a MECC interaction has occurred.

2.3 Evaluation outline

Public Health England and Health Education England published documents in 2016 in relation to integrating MECC into services and how services are managing this. Further to this they also published a ‘*Making Every Contact Count (MECC): Evaluation framework*’ (2016) and aspects of the design of this project have been guided by this.

This proposal is for a three-stage evaluation of the use of MECC within the Physiotherapy Department of Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group. The three stages include:

³ NHS Standard Contract Section SC8: 8.6

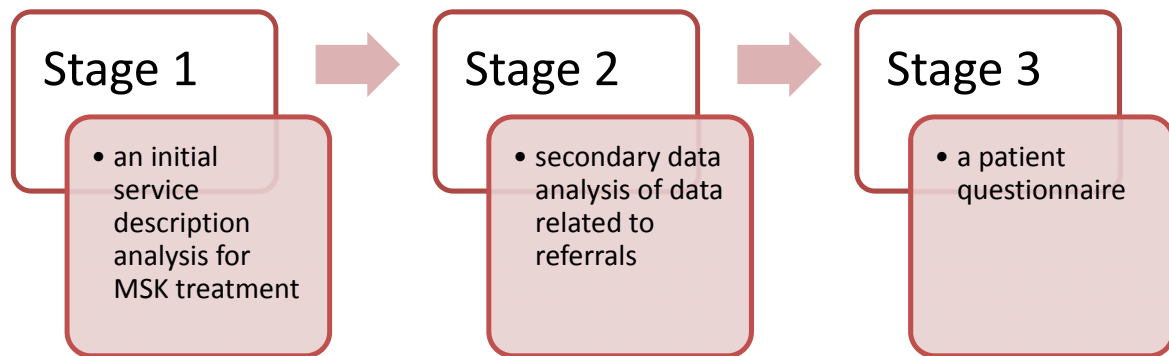


Figure 1 Evaluation process for MECC in Fairfield MSK physiotherapy services

Ethical Approval has been granted by the University of Salford for this project (HST1718-035). This project was classed as Audit by the Health Research Authority (HRA) and an audit number granted by Pennine Acute Hospital NHS Trust (2018 061).

3 Stage one – Service description analysis for MSK treatment:

3.1 Within Stage 1, the aims of this evaluation proposal are to:

1. Explore how MECC is integrated across the Physiotherapy Department of Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group
2. Provide recommendations in respect of the service and its on-going evaluation

3.2 Stage one - Methodology

This part of the project will comprise documenting and mapping what the Physiotherapy Department are commissioned to provide in relation to MSK treatment.

Data collection utilises methods developed through small-scale evaluation principles⁴ and in this instance require members of the department to respond to questions and give their views on models that were recorded using post-it notes and annotating models during an interactive session. This allows qualitative data to be collected in a structured but more interactive way and can be more suitable for a busy department that contains different shift patterns. As such all those who work in the Fairfield MSK physiotherapy services will be eligible to take part. Consent to use comments posted on post-it notes for data analysis and dissemination is implied by completing them, and no names will be taken.

From this first step, we hope to understand what the Fairfield MSK Physiotherapy Services do that would be considered part of their 'commissioned service' (i.e. the targets the Physiotherapy Department are set by the commissioning body) and then what could be considered as going beyond this service, which relates to the incorporation of MECC

⁴ For example those set out by development focus - http://www.developmentfocus.org.uk/Development_Focus/Training_files/participatory%20methods.pdf

principles. The added value gained by service users by MECC within the provision of the added value service is reported as going beyond the required commissioned service.

The researchers worked with two of the senior staff (Caroline Moss – MSK Team Leader and Deborah Bancroft - Advanced Physiotherapy Practitioner) to understand how/where MECC is integrated and map out the processes and types of interactions. This provided a diagram where MECC conversations are likely to occur with patients, who conducted them, and what sort of conversations they may be having. Through this, it was also possible to identify any missed opportunities or areas where more support/training may be needed. This was then shared with the wider team during an interactive session to allow them to provide comments around how they use MECC in their practice. During this process, we also asked those working in the service what they understand about MECC and what they thought about the different ways of working.

3.3 Stage one – Results

The aim of the results of stage one of the evaluation is to provide an understanding of the local context where the MECC activities are taking place and what those working within the Fairfield MSK Physiotherapy Services think about MECC.

3.3.1 Staff views around MECC

Within the department, staff were asked what they thought about integrating MECC related conversations into their everyday practice. Among those that provided an answer, the overwhelming view was that MECC was positive for the staff, the department, patients and the wider stakeholders the department interacts with. Responses show that MECC can support a holistic system change enabling principles to be embedded throughout all aspects of the working day. The main themes were:

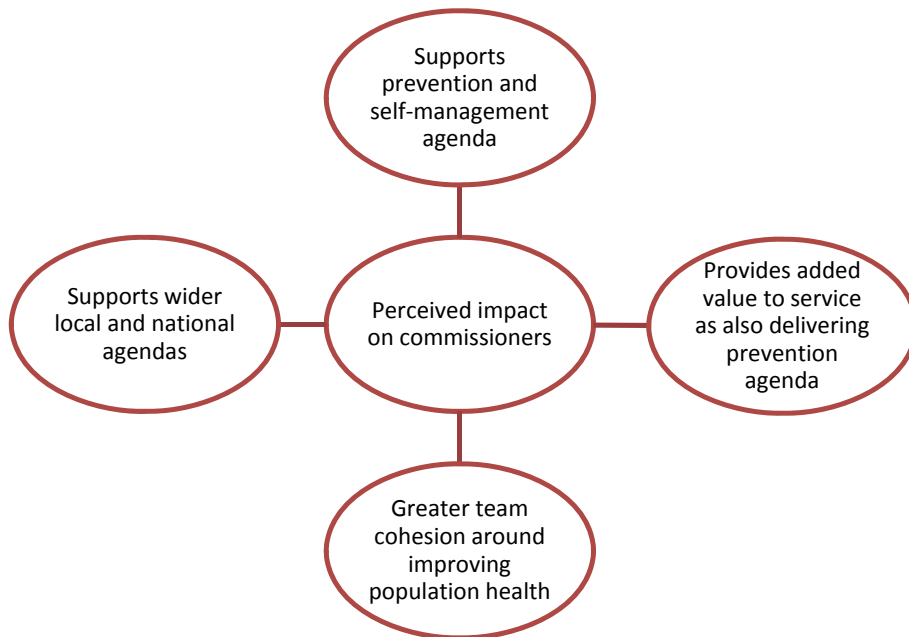


The staff were also asked how they felt integrating MECC could have a potential impact on the Trust and other stakeholders (e.g. services they refer into, CCGs, other hospital areas).

Those who responded only highlighted positive responses around this way of working. Comments ranged from the impact on staff wellbeing, improved practice, better-integrated working with those outside of the service through to engagement. The main themes were:



As with the responses to the impact on the NHS trust and other stakeholders, the views of those in relation to the impact on commissioners was also perceived as being positive to them and the wider health sector. This was primarily in relation to supporting the delivery of national and local strategies around health and wellbeing. The main themes were:



Finally, staff were asked what they thought the impact was on patients who used Fairfield MSK Physiotherapy Services, and it was felt that this was likely to be overwhelming positive.

This perception was driven by the service taking a more holistic view to patient care and wider factors that may influence recovery. By having a positive impact on patients, it was also felt this then affected the department's outcomes and use of referrals. The main themes were:



Although the view was overwhelmingly positive in terms of the impact on themselves and the wider stakeholders, when it came to the practical resources needed to support these conversations there was more of a mixed view, as shown by the responses below:

Resource available	Requests for resource responses	Unclear outcomes
<i>Posters donated by IWYIW helps open discussions around physical activity (PA)</i>	<i>Workout at work video requested by staff</i>	<i>Weighing machine use for patients and staff/ Weight/BMI/BP machine in department</i>
<i>Yellow lifestyle sheets</i>	<i>MECC training needs pathway</i>	<i>Logic models to measure impact</i>
<i>e-learning training</i>		<i>Guide to keeping workforce active</i>
<i>Workforce capability questionnaire helps identify training needs</i>		<i>Provision of champions to support learning: PA, stop smoking, dementia, healthy weight, mental health</i>
		<i>System to record and measure impact</i>

		<i>Healthy cubicles make healthy conversation easier</i>
		<i>Training opportunities, weight machine, partnership working support</i>
		<i>YouTube PA workout at work video etc.</i>
		<i>Motivational interviewing</i>

3.3.2 The routes through the service in relation to MECC

To begin to explore where MECC occurs within the service and how the MSK physio service operates, we worked with two senior physiotherapists to map the MSK services offered. The Physiotherapy Department have a number of different routes (as shown in **Error! Reference source not found.** below) that patients can move through and a large number of opportunities where the principles of MECC can be embedded into practice in order to deliver brief advice to those attending. Through this exercise, two different ways MECC has been integrated into practice were identified:

1. Primary locations - those where MECC conversations were always likely to have occurred.
2. Secondary locations - those where these conversations can reinforce initial conversations, are not a primary occurrence or may be places that they do not occur but have opportunity to.

Notes on Figure 2:

Those in the cardiac rehab group and pulmonary rehab group are not fully under the MSK service but may come into contact with the MSK pathways, as such MECC conversations are also likely to occur with these groups. The cardiac rehab group referrals come from a consultant and include a multi-disciplinary assessment before moving into their own group. Similarly, those in the pulmonary rehab group are referred by either a consultant or GP and undergo an initial physio assessment.

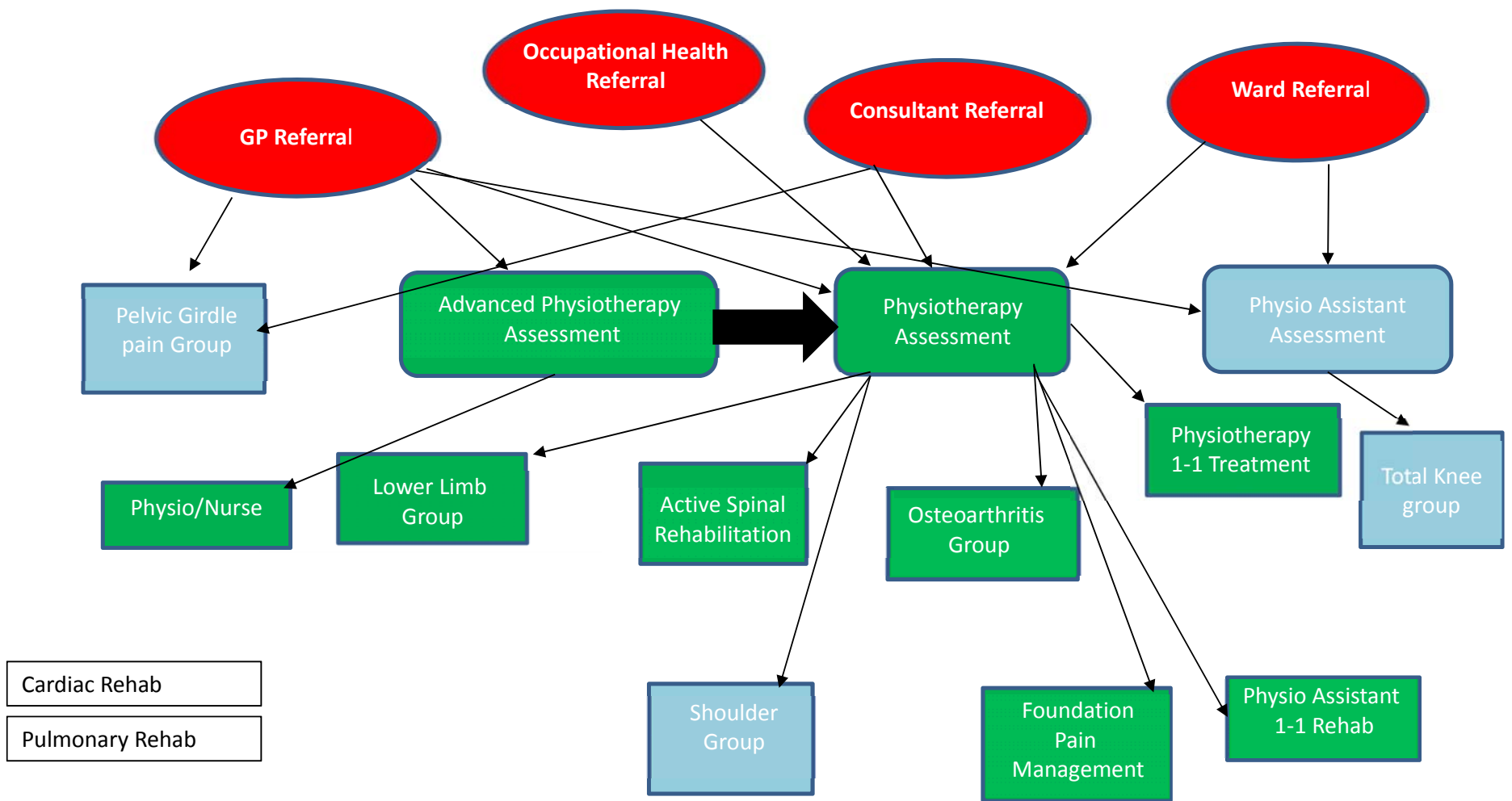


Figure 2 Conceptual map of the MSK pathways through the service

KEY:
 ● Source of Referral
 ■ Primary location of MECC
 ■ Secondary location of MECC

Overall although it was felt, there were many opportunities to include MECC into the department there were also two initial challenges highlighted to the overall practice. These related to:

1. MECC conversations not always occurring around people's long term management.
2. When MECC conversations occur they are not always documented at the early stages of rehabilitation. This means that it can be unclear what conversations have occurred and this limits practitioner's ability to build on initial conversations or to conduct those conversations if they have not already been started.

3.3.3 Referrals into the service (Red on *Figure 2* above)

Currently there are four main routes for referrals into the service - from GPs, Occupational health, orthopaedic specialists and the hospital wards. Although it should be noted that due to the way the system currently records referrals, 'GP referrals' include those from: audiology, midwifery, the cardiac team, or pulmonary rehab, consultants (external to the trust), other health care providers (e.g. podiatry, or OT), dentists and the falls service. Going forward consideration should be given to allowing these groups to be split out on the system in detail.

In terms of the referrals received, those from GPs are often more diagnostic, compared to those which come from wards, with these containing more detailed information. Those that come from GPs often note any outcome from a recent NHS Health Checks for older patients. In addition, often those referred from internal consultants provide information around blood pressure, weight and smoking status as they may have already started some lifestyle conversations. For those who attended the facilitated session it was felt that there was scope to adapt how referrals were provided. This would then allow the physios within Fairfield MSK Physiotherapy Services to have information that would aid MECC related conversations from the outset. It was felt that currently for all of the referral routes, the information provided did not adequately inform wider MECC related conversations. This was especially the case when there was less of a working relationship with the person referring, presumably because they are less familiar with the physiotherapy departments' principles.

Overall recommendations made by staff around referrals were:

- Referrals from midwives contain information about the number of weeks pregnant the person is and if there is any recorded pain. However, there is normally little or no information that links to MECC lifestyle conversations such as BMI, or current lifestyle behaviours.
- Regarding referrals from GPs, it was felt that there was space to include information such as weight, smoking for all not just those with recent health checks. This which would aid a more holistic approach and support lifestyle conversations.
- For self-referrals there was often a lack of the right questions being asked and generally there is no MECC related information on the forms.
- It was felt that when people have an initial contact with the Northern Care Alliance NHS Group that part of this could include screening for lifestyle factors which would then allow this to be signposted and shared with other services across the patient journey.
- It was suggested that going forward it would be useful to be able to have more categories related to where a referral came from, as many are grouped under GP.

3.3.4 Primary locations for MECC to occur (Green on Error! Reference source not found. above)

When considering the primary locations where MECC is likely to occur those attending the facilitated event primarily agreed these were the most likely locations, but they also raised a number of challenges and missed opportunities that may still arise. *Figure 3* below illustrates some of the key facilitators that were highlighted by the staff in relation to MECC occurring within the primary locations.

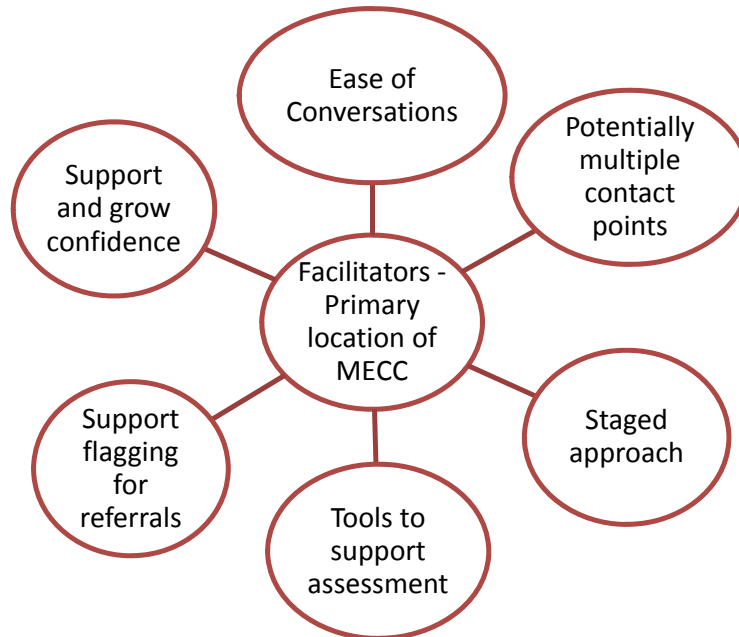


Figure 3 Key facilitators highlighted in relation to primary locations for MECC

It was felt that as people move through the department there are a number of opportunities to have healthy lifestyle conversations and that initially these conversations may be about ‘planting a seed’ around change and then the conversations can progress. Although a challenge with this was knowing what had been talked about or in some cases assuming someone had already been ‘MECC’ed’ earlier in his or her journey. To facilitate this the use of the Health and Wellbeing assessment can help with knowing what has previously occurred but also with reinforcing any messages provided. The whole team ethos around MECC and how this impacted the service was reflected in a comment from one of the band 6 physios who commented that they felt the conversations were getting easier now that they are established as part of the team.

The use of MECC within the service, as outlined earlier, supports taking a holistic view of a person’s treatment. It was felt that this can raise awareness of patients who may be suitable for referral and an increased understanding around how lifestyle factors may be playing a part in any issues. Although in some groups MECC related conversation are seen as being secondary, there are also groups where it was felt that MECC related conversations work well (e.g. Osteoarthritis group, Active Spinal Rehabilitation and Foundation Pain Management). Further to this in some cases (e.g. active spinal rehabilitation and foundation pain management) sections of the programme delivered already focus on healthy lifestyle factors and the impact of these.

Although in many of the previous sections, MECC has been seen as positive there are also a number of challenges that were highlighted, to the integration of MECC within the department's behaviour with patients (*Figure 4*). These related to both the practices within the department but also those using the services of the department.

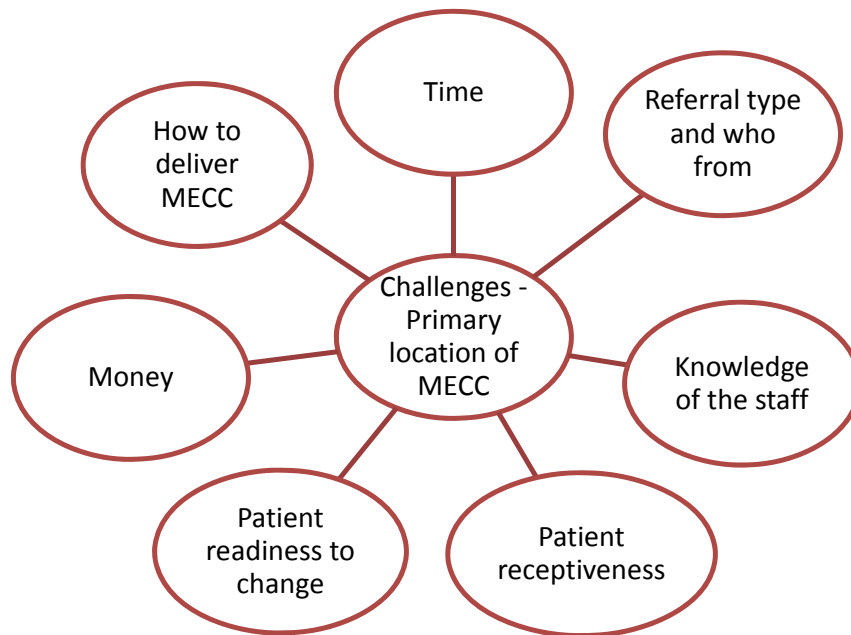


Figure 4 Key challenges highlighted in relation to primary locations for MECC

For a few of those attending the staff event there was a lack of understanding around why they were being asked to integrate this into their practice, and a questioning around what would be next to be added to their workload. As such, there is still work that is needed to support those within the department and address people's readiness to work in a holistic way. Linked to this it was mentioned by one that the directive around the integration of MECC needs to also allow for a supportive or 'light touch' approach to training, sharing practice and mentoring to support those who are less confident in having lifestyle conversations.

Some of the physios expressed concerns around how they approach and start lifestyle conversations with people. Linked to this it was felt that patient's readiness to change may be greater if these conversations have been had with other health care professionals with the team being aware of these through the referral process and notes that have been provided.

In many cases the challenges raised related to the recording of information around lifestyle conversations. In some cases, there can be assumptions that healthy conversations have taken place already. Although there is a desire that lifestyle conversations occur at all stages of the patient journey, there is a concern that not having MECC related conversations should not impact patient treatment, and an absence of a MECC conversation should be captured so that the next person is aware and if suitable can then have these conversations.

As well as challenges that linked to the service there were also challenges raised which linked to the patient. For example: it was felt that in some cases, it may not be appropriate for all patients or in some cases patients may not be expecting the conversation which can make it more challenging. For instance, in the lower limb group, MECC related conversations were

felt to be less common due to the usual demographic of those in the group. Linked to this if the person was not normally a physio's patient then it was felt that these conversations were not revisited routinely or routinely had.

Finally, with the advanced physiotherapy assessment it was felt that there were issues around time and this being a one-off assessment so people were not sure when these conversations would occur prior to them being referred onto another stage. However, this was also seen as a missed opportunity as when people were being referred down the line, they are seen more often and rapport is built so topics that have come up in the initial assessment can be revisited, if they are known about.

Overall recommendations made by staff:

1. It was felt it needed to be clear when MECC related conversations had and had not occurred, to support no wrong assumptions or missed opportunities. It was felt this needed to be recorded on the relevant forms. This approach was also seen to support the potential to revisit lifestyle change conversations at follow-up appointments.
2. When people come into the service not all are aware of their height and weight. As such, it was felt that having easy access to scales and a BMI chart would support relevant conversations. It was reported that carrying out a current health check could take around 10 minutes, which was not always practical within short appointments.

3.3.5 Secondary location for MECC to occur (Blue on *Figure 2* above)

It was recognised by staff that for those attending appointments in the department there were potentially missed opportunities for MECC to occur both in the primary locations and in secondary locations. This shows that there is an understanding of where those working in the service could develop their own practice.

One of the challenges raised around the use of MECC not being seen as primary in some places was around the nature of groups and how this can be harder for these conversations to occur. As outlined a potential issue can be an assumption MECC conversations have occurred during the individual sessions so people can be wary of duplicating these.

Despite the challenges, there were also groups where lifestyle related topics and conversations were being included already. As such, a question was posed around how group settings can offer an opportunity to raise lifestyle topics and ones relating to mental wellbeing that can allow signposting to local groups (e.g. baby & toddler and groups that are not linked to BEATS).

In the total knee group, there were both facilitators and challenges raised. For example, a challenge was raised around the setup of the group and how to time these conversations in this setting. Despite this it was felt there were measures in place to redress the inclusion of MECC conversations, and that the band 6's are taking a project forward around this to weigh patients routinely and then have lifestyle conversations around this.

Further to this in the pelvic girdle group brief advice is provided around BMI after pregnancy, the importance of posture and physical activity levels. It was felt that a current barrier is that people can only access BEATS up until 30 weeks pregnant, but they often see people very late in their pregnancy so referrals are not always possible.

A positive to come out of the staff event was that within the physio assistant assessment, training has now been received around MECC, and highlighted where the support is if need. As such, there is more chance for MECC conversations to occur as confidence builds and from these assessments people can be referred and signposted so conversations may occur earlier. Despite this there was discussion around if initial appointments are suitable for MECC conversations if there were issues around pain being controlled or wound healing, so there was a need to find a balance between wider lifestyle conversations and patients immediate need.

Overall recommendations made by staff:

1. The Pelvic Girdle Group has a number of opportunities for MECC related conversation, but it was also highlighted through this work that there could be a number of missed opportunities within this group to have healthy conversations.
 - a. It was felt it was a challenge as this is a one off session and there is quite a lot to cover, so there was talk around should this be two sessions to allow more lifestyle and preventive conversations to occur, or could a handout be prepared.
 - b. There was a fear of making this session contain too much information, but also a desire to build in other pathways (e.g. post pregnancy, as there was lots of scope to have these discussions in the first year after pregnancy).
 - c. They do talk about BEATS and how this may help.
 - d. Currently the group does not usually talk about alcohol and smoking unless it is mentioned, but through the event there was conversations around why this was the case and should it be mentioned.
2. It was felt that in the lower limb group and the shoulder group that having MECC related conversation could be more encouraged as although this is a group setting there is one-to-one working.
 - a. For example in the shoulder group looking at the evidence between the shoulder condition and lifestyle factors.

3.3.6 Onward Journey and referrals out of the service

Following attendance within the Physiotherapy department, patients can be signposted to primarily one of three commissioned services within the local authority – Bury’s Exercise & Therapy Service (BEATS)⁵; Bury Lifestyle Team (Healthy Trainers)⁶ or Healthy Minds⁷(Figure 5). Referrals can be through Fairfield MSK Physiotherapy Services or through self-referral.

⁵ BEATS is an exercise referral scheme for patients with a recurring illness or medical condition who would benefit from getting more active through a personal physical activity scheme

⁶ Bury Lifestyle Team provide support for healthy eating, weight loss, stopping smoking and improving sleep.

⁷ Healthy Minds offers support and treatment for those who are experiencing symptoms such as difficulty sleeping, low mood, stress, worry or anxiety, feelings of low self-worth or panic attacks

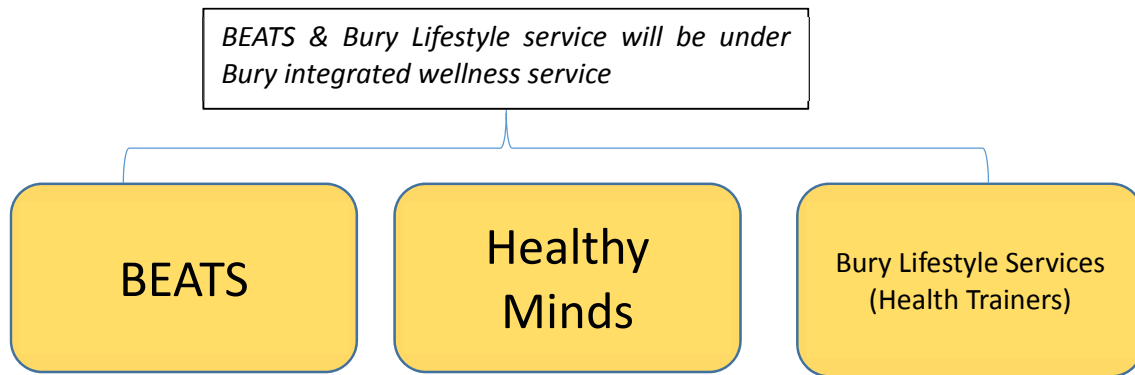


Figure 5 External service providers referred into

Currently it was felt that there is an issue around the referrals and including information about MECC related conversations linked to the time staff have and resources available in the department (e.g. computers and space). It was also felt that in some cases the paper referral system is easier, and that at times people do not want the physios to make the referral, as they want to think about the options. As there is not currently one referral route this was felt by some to be a barrier to referring or signposting people, so a unified approach would be welcomed⁸.

Overall recommendations made by staff:

1. As with having the MECC conversations, the use of referrals also came down to time. To support this and the issues around IT, it was suggested that between every other bay and in reception an iPad could be available to allow referrals to be completed and to act as a social prescribing method in the reception area.

3.4 Public Health England adapted Logic Model for the service

Within the Public Health England and NHS Health Education England '*Making Every Contact Count (MECC): evaluation framework*' they purport the use of a logic model for services to explore what the aims of integrating MECC are, how this can be achieved and then what outcomes are wanted/expected. The aim of this model is to explore local contextual factors that can influence the effectiveness of MECC programmes and what is wanted to be achieved through its integration. Through the completion of this logic model, as well as the mapping task, there is the opportunity to take a strategic view of the service and how to integrate MECC going forward.

⁸ It should be noted this may not be possible as the way referrals occur relates to the services not the physiotherapy department

Project Name	Evaluation of the use of MECC within the Physiotherapy Department				
Local Setting	Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group				
Priorities	To embed the principles of MECC into the practices of the physiotherapy department				
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 outcomes
<p>Training</p> <ul style="list-style-type: none"> • Currently have 1 ½ hour induction to MECC • 1 hour online MECC certified training • Intranet with a MECC folder containing lots of self-directed learning • Appropriate and relevant champion training <p>Department practices</p> <ul style="list-style-type: none"> • Every department meeting MECC & health and 	<p>Needs assessment</p> <ul style="list-style-type: none"> • Induction questionnaire before staff training • Second question after staff training to ascertain change <p>Continued support</p> <ul style="list-style-type: none"> • Ongoing clinical discussions held <p>Patient centred practices</p> <ul style="list-style-type: none"> • Brief advice/ healthy conversations • Signposting • Better referrals <p>Things needed going forward</p> <ul style="list-style-type: none"> • Documentation related to MECC 	<p>Department practices</p> <ul style="list-style-type: none"> • Have champions in the department for different MECC topics who are there to help staff develop • Have partner links to resources to help <p>It is felt that the integration of MECC will affect patients, CCGs, the physio team (including the wider team related to students) and the community services through a change in the way of working.</p>	<p>Things needed going forward</p> <ul style="list-style-type: none"> • Signpost to services which can be accessed by patients • Need to document healthy conversations • Promote outcomes of projects nationally • Need to be aware of exploring how to introduce objective measures (e.g. long terms compliance, number of people making lifestyle changes) and collecting patient opinions (qual & quant) 	<p>Things needed going forward</p> <ul style="list-style-type: none"> • Lease with community teams and share MECC relevant issues • CSP statement • Standards of conduct • HCPC • Clarity around the expectations around linked to health and wellbeing • Greater integration around MECC within job descriptions 	<p>Things needed going forward</p> <ul style="list-style-type: none"> • Annual review of confidence and needs • Look at partner links to the department • Explore ways to feedback to GPs if needed for patients • Aim to increase the number of referrals or signposting that occurs <p>The department's ambition is to become a beacon for</p>

<p>wellbeing is on the agenda</p> <ul style="list-style-type: none"> • Have champions to mentor others <p>Things needed going forward</p> <ul style="list-style-type: none"> • Better electronic data collection systems • Time in consultations • Clarity around roles and responsibilities related to MECC 	<ul style="list-style-type: none"> • Way to audit data collected around this • Using the integration of MECC as a discussion point in supervision and linking to objectives in PDRs 			<ul style="list-style-type: none"> • Look at developing a MECC bulletin – perhaps with this being audio recorded • Training around motivational interviewing <p>Patient centred practices</p> <ul style="list-style-type: none"> • Supports the wellbeing of patients <p>External influences</p> <ul style="list-style-type: none"> • AHP mandated role • Linked to the trusts objectives around wellbeing 	<p>MECC being integrated</p>
<p>Assumptions</p>	<ul style="list-style-type: none"> • Everyone should have a MECC related role • All have had training around MECC • Everyone should be using the forms designed around this for each patient • Everyone should be aware of how to signpost to services • Everyone is confident in integrating MECC into their practice 	<p>External factors</p>	<ul style="list-style-type: none"> • Commissioners – this should be part of the commissioned service (i.e. in the contract so fully funded) • Department objectives • Time (e.g. to do MECC and to do referral) • Targets • Staff engagement – is it on top or is it embedded • Built into assessment sheets • Mixed pressures & priorities 		

3.5 Stage one – Conclusions

Through the mapping exercise and from the discussion had with those who work in the department it can be seen that there are a number of facilitators around organisational readiness for the integration of MECC principles into the department. This is both in relation to the building MECC into contracts for NHS services, but also in relation to the in-house training package and support that has been developed for those coming into the service.

Although there is a great deal of staff positivity around the integration of MECC there are also signs that staff readiness for embedding MECC through the service is not universal. This was based on personal confidence as well as feelings of not being able to integrate it in to the practice due to a number of external factors, including time, confidence and perception of patient needs.

As outlined above there are two delivery types which appear in relation to MECC, those where it is primarily integrated and those where the integration of MECC related conversations can be more secondary.

As outlined throughout this section the staff provided a number of recommendations for how the integration of MECC could be improved, but also in terms of supporting the staff within the department. Many of these related to ensuring the ease of the process the length of appointments was not inhibitive.

4 Stage 2 – Analysis of Referral Data:

4.1 Stage 2 – Methodology

The second stage of the evaluation focused on exploring secondary data from the three main referral locations. This examined referrals made by those working in Fairfield MSK Physiotherapy Services to commissioned services and rates of sustained change in behaviour (i.e. behaviour change that is sustained beyond three months).

Referral data was requested from services commissioned within the Bury Council region which Fairfield MSK Physiotherapy Services refer into – BEATS, Bury Lifestyle Team, Healthy Minds. This data was designed to support an understanding of rates of engagement with referrals, any changes in behaviour captured, and if there was any difference for those who undertook a physiotherapy session with PAHT where MECC is a core aspect to those who were referred from other services, such as primary care.

Anonymised secondary data was requested and aggregated by services so the identity of individuals was protected. Where possible each organisation was asked to provide data their service captured relating to:

- The number of monthly referrals from Fairfield MSK Physiotherapy Services, primary care and 'other sources' from January 2017-April 2018.
- The numbers of referrals by month/by type of referral organisation (Fairfield MSK Physiotherapy Services, primary care, other sources) attending at 6, 12 and 52 weeks post referral for the same time period
- Level of physical activity at referral and at 6, 12, and 52 weeks post referral

- BMI at referral and at 6, 12 and 52 weeks post referral
- Weight at referral and at 6, 12, and 52 weeks post referral
- Smoking behaviours at referral and at 6, 12, and 52 weeks post referral

The physiotherapy department was also asked to provide baseline data relating to number of referrals from January 2017-April 2018 and data relating to physical activity levels; smoking habits; BMI and weight of service users when referred into the department.

4.2 Stage 2 – Data Analysis:

4.2.1 Baseline data from Fairfield MSK Physiotherapy Services

The Physiotherapy team report between 1000-1200 referrals to their department per calendar month. Anecdotal evidence suggests 30% of referrals (n=300-360) do not attend for initial appointment.

The baseline data provided in this report is based on the number of Physiotherapy Service Health and Wellbeing Assessment forms⁹ completed by physiotherapy staff with their patients between April 2017 and April 2018¹⁰. This form asks questions relating to physical activity levels, smoking status, alcohol consumption, weight, frailty and mental wellbeing. Physiotherapists record whether brief advice was given; any comments related to the brief advice; where the patient has been signposted to, if additional support would be beneficial, and whether a health check is recommended.

The baseline data is based on 741 patient's responses to the Physiotherapy Service Health and Wellbeing Assessment questions - 298 male (40.2%), 438 female (59.1%). Mean age - 51¹¹.

NB: Due to resource limitations for data input, not all Health and Wellbeing data is available for all patients who have completed the forms with their physios. Similarly, due to data input limitations it is unknown what the total number of physiotherapy patients during the 2017/2018 financial year was per month or the recommendations made on discharge for use of commissioned services at a patient level. Despite this the data provided provides some insight into the recorded MECC conversations taking place within Fairfield MSK Physiotherapy Services.

In this report, secondary data analysis will focus on MECC conversations relating to physical activity, smoking status, alcohol consumption, and weight management only.

4.2.2 Baseline data from Fairfield MSK Physiotherapy Services regarding brief conversations related to physical activity levels

Data is available relating to the physical activity levels of 660 of the 741 patients assessed (89%). Therefore, information regarding brief conversations related to PA levels is absent relating to 10.9% of patients who completed the processed Health and Wellbeing Assessment forms with their physios. Activity levels measured using the General Practice Physical Activity

⁹ Part of the 'Everyday Interactions' toolkit developed by the RSPH and PHE launched in 2017.

¹⁰ These are not completed as a compulsory element of the physiotherapists role

¹¹ Approximately 8% of patient referrals between April 2017-April 2018.

Questionnaire (GPPAQ) indicate that 298 patients were identified as physically active; 128 as moderately active; 95 as moderately inactive and 139 as inactive.

Brief advice was given to 302 patients. Assuming brief advice was not provided to the 298 patients identified as physically active, this suggests 83.4% of patients identified as moderately active; moderately inactive or inactive received brief advice.

An additional question asks physiotherapists to identify whether the patient meets the Chief Medical Officer's (CMO) guideline on physical activity (PA). The data suggests 105 patients met the guideline; 128 as not. Data was therefore only available for 233 patients (35%). This suggests some challenges in responding to this question, potentially pointing to a training need relating to the importance of answering the question or in relation to awareness regarding the CMO guidelines on PA.

4.2.3 Baseline data from Fairfield MSK Physiotherapy Services regarding smoking status

Data regarding smoking status is available for 666 (89.9%) patients. Therefore, information regarding brief conversations related to smoking status is absent for 10.9% of patients that completed the Health and Wellbeing Assessment form.

The majority (69.9%) report being non-smokers (n=466), 5.5% light smokers (n=37); 4.2% moderate smokers (n=28); and 2.8% heavy smokers (n=19). 16.9% reported themselves as ex-smokers (n=113). 0.4% are e-cig users (n=3).

Brief Advice was given to 69 patients. This suggests that 79% of those identified as light, moderate or heavy smokers or using e cigarettes had a brief conversation relating to their smoking status

4.2.4 Baseline data from Fairfield MSK Physiotherapy Services regarding drinking habits

In terms of alcohol consumption, the assessment asks 'does the patient meet the CMO guidelines'. Data is available for 580 patients (78%). Therefore, information regarding brief conversations related to alcohol consumption is absent for 161 (21.7%) of patients that completed the inputted Health and Wellbeing Assessment form.

Of the 580 patients questioned, 466 were identified as meeting the CMO guidelines; 114 as not. Brief advice was provided to 71 (62%) patients not meeting CMO guidelines.

This data suggests the physiotherapists are either less confident in responding to this question or in addressing questions relating to alcohol consumption with patients. It suggests physios may be less confident to engage in brief conversations about this topic in comparison to conversations relating to physical activity or smoking status, for example.

4.2.5 Baseline data from Fairfield MSK Physiotherapy Services regarding weight

Self-reported data regarding weight was recorded for 508 (68.5%) of patients. It is not possible to state whether opportunities to have a brief conversation regarding weight were missed with almost a third of patients (n=233) or whether patients are unable to self-report their weight and this limits data collection. Brief advice was provided to 161 patients; 21.7% of the total number completing the assessment tool.

As suggested earlier by the physios it suggests alternative methods of reporting or recording weight may be beneficial to support brief conversations between staff and patients.

4.2.6 Signposting of Fairfield MSK Physiotherapy Services patients to commissioned services

Of the 741 patients assessed using the inputted Health and Wellbeing assessment tool, 142 (19%) were signposted to other commissioned services. This may be via direct referral or encouraging self-referral.

Currently, the data is not available to report on the number of direct referrals made by Fairfield MSK Physiotherapy Services compared with the number of self-referrals recommended. Furthermore, it is not known how many patients asked to self-refer.

4.2.7 Summary of Fairfield MSK Physiotherapy Services MECC baseline data

The data relating to MECC conversations carried out by the physiotherapy team is partial. The baseline data collected using the inputted Health and Wellbeing forms indicates physiotherapists are engaging patients in brief conversations about desired physical activity levels (89%) and their smoking status (89.9%). There is an incomplete picture in relation to brief conversations around weight given the absence of data in relation to almost one third of patients. This suggests discussions around weight are not as effective as they might be and understanding why this is the case would be beneficial. Alcohol consumption is an area that appears to be more challenging for physios to have conversations about and to give brief advice in relation to. Identifying the factors which inhibit these conversations would also be useful. These potentially may be addressed through further training and confidence building.

4.3 Data related to monthly referrals (January 2017-April 2018)

Currently, the data required to assess the success of MECC conversations in signposting patients from Fairfield MSK Physiotherapy Services to commissioned services is not available. Similarly, the commissioned services contacted reported difficulties in reporting data captured at baseline, 6, 12 and 52 weeks in response to the questions posed (*see section 3.1*).

As such data reported within this report from BEATS is for the period September 1st, 2017 – April 30th 2018¹² only. BEATS new data management system, ReferAll pulls through data at an individual level related to the condition(s) people are referred in with rather than reporting against source of referral (primary or secondary). Furthermore, with the adoption of the new system in BEATS, data at 52 weeks is not yet available.

Bury Lifestyle Services (BLS) also report on direct or indirect referrals rather than source of referral although the source of referral is captured. Therefore, identifying monthly referrals from Fairfield MSK Physiotherapy Services, primary care and 'other sources' is currently not available from 01-09-18 through to 30-04-18.

¹² BEATS moved to a new data management system (ReferAll) on 01-09-17.

4.4 Stage 2 – Results

4.4.1 Engagement with commissioned services

4.4.1.1 BEATS

Thirty-nine organisations refer into BEATS. Any patient with MSK issues and one other co-morbidity has to be referred to BEATS from Fairfield MSK Physiotherapy Services. The Fairfield MSK Physiotherapy Services refer more people to BEATS than any other organisation. *Table 1* provides an overview of the significance of referrals from the Fairfield MSK Physiotherapy Services to BEATS.

Table 1 Percentage of total referrals into BEATS provided by Fairfield MSK Physiotherapy Services

Year	Percentage of total referrals into BEATS
2009/2010	6.4%
2012/2013	32.75%
2017/2018	30%

Between September 1st 2017 and April 30th 2018, 367 patients were referred to BEATS by the physiotherapy team. Of these, 218 (59.4%) started a programme with BEATS and 215 (98.6%) continue to actively participate having started on the programme. Only two people had declined to participate and three had left the programme early.

Of the 147 people referred but not yet participating in a PA programme, 8% (n=31) indicated they intended to participate while 116 (31.6%) were 'awaiting processing'. While levels of engagement post referral are principally affected by the capacity of the BEATS team to bring people onto their programme¹³, there is high take up and continued engagement suggesting positive benefits experienced from referral and participation.

4.4.1.2 Bury Lifestyle Service (BLS)

The BLS state that patients can self-refer or be referred by a health care professional (HCP) via telephone, email, paper referral documents or Facebook and Twitter.

There are currently 65 different routes recorded that service users access BLS through. Data related to average length of engagement with BLS post referral is not available.

4.4.1.3 Healthy Minds

No data was provided by Healthy Minds during the timeline of this evaluation.

¹³ In 2007, BEATS received 440 total referrals. In 2018, they received 1255 referrals. The number of staff has remained constant across this period.

4.4.2 Improving physical activity levels post Fairfield MSK Physiotherapy Services referral

PA is not part of the service provision available from BLS or Healthy Minds. However, *Table 2* provides composite data for all PA referrals into BEATS between 01-05-2017 and 30-04-2018.

Table 2 BEATS physical activity referrals - composite data

	<u>Q1</u>	<u>Q2</u>	<u>Q3</u>	<u>Q4</u>	TOTAL
Total number of clients to access BEATS	283	351	369	296	1255
Intend to participate	0	0	31	89	120
Awaiting Processing	0	0	98	193	291
Take Up Levels ¹⁴	0	0	72%	58%	65%

Once clients engage with BEATS, retention levels are high at six weeks (95%), twelve weeks (93%) and at 12 months (77%) (*Table 3*).

Table 3 Ongoing engagement in physical activity programmes at BEATS

	Q1	Q2	Q3	Q4	AVERAGE
6 weeks	97%	92%	96%	Gym staff	95%
12 weeks	95%	91%	93%	93%	93%
12 months	67%	71%	76%	77%	73%
Total active retention	87%	86%	90%	86%	87%

This indicates that those clients who are engaged by the BEATS physical activity programme post referral from any organisation do demonstrate sustained PA behavioural change.

4.4.3 Weight management/BMI post Fairfield MSK Physiotherapy Services referral

Data from BLS shows forty-two patients as being referred from Fairfield MSK Physiotherapy Services between March 2017-March 2018 regarding weight management. BMI and weight were recorded by BLS on referral for 38 people¹⁵ and at seven weeks for 29 people. Outcomes of engagement with the weight management programme are detailed in *Table 4*. BLS does not capture data regarding further monitoring of weight and BMI beyond 7 weeks.

¹⁴ How many clients take up an appointment once referred.

¹⁵ One was a self-report

Table 4 Recorded outcomes of patients referred from Fairfield MSK Physiotherapy Services to BLS regarding weight management

Outcome	Number of clients
Positive change recorded/outcomes achieved	20
Outcome unknown	7
Did not attend BLS post referral	3
Unable to continue	1
Outcomes not achieved	4
Support ongoing	6
Signposted to another service	1
Total	42

The average BMI of service users on referral into BLS was 34.1¹⁶. At seven weeks post referral the average BMI was 32.9¹⁷.

Currently, it is not possible to track how many brief conversations about weight management led to patients being signposted to commissioned services. However, if a pathway between brief advice in the physio clinic regarding weight management to BLS is assumed, this data suggests 25% of those given brief advice are referred.

4.4.4 Changes to smoking status post Fairfield MSK Physiotherapy Services referral

Between May 2017 to January 2018, BLS received 12 referrals from Fairfield MSK Physiotherapy Services relating to smoking status. Seven did not attend or declined support. Carbon Monoxide (CO) readings were taken on referral into the service for 5 individuals. In line with NICE guidance, follow up recordings are taken at four and twelve weeks post referral. Two individuals provided readings at four weeks post referral that showed a significant reduction in CO in the body. By twelve weeks, one individual had stopped smoking (8.3%).

Currently therefore there appears to be limited data relating to smoking cessation or reduction following a referral from Fairfield MSK Physiotherapy Services. The Health and Wellbeing assessments indicate that smoking status is an area physiotherapists (see *section 3.2.3*) give brief advice on however there are limited referrals into BLS specifically to address smoking status. With limited take up post referral, this limited data may point to behaviour change in this area as a challenging one to engage smokers in.

4.4.5 Changes to alcohol consumption post Fairfield MSK Physiotherapy Services referral

The data related to behavioural change relating to alcohol consumption is absent. Between March 2017 and January 2018, BLS recorded 8 service users attending following referral by Fairfield MSK Physiotherapy Services. The data recorded states that a brief conversation took place and the goals set (to understand the risk to health of current level of alcohol consumption and the danger of developing a physical dependency) were achieved. Further

¹⁶ Based on 38 service users.

¹⁷ Based on 29 service users.

data is not available in relation to units consumed at time of referral or changes in consumption habits across time.

The limited numbers of (Fairfield MSK Physiotherapy Services) service users receiving a brief conversation relating to alcohol consumption from commissioned services suggests that the majority of people who are given brief advice by the physiotherapists do not seek further support from commissioned services. Understanding how many people Fairfield MSK Physiotherapy Services referred to BLS for support in this area, would enable greater understanding of the take up rate post referral.

4.5 Stage two – Conclusions and recommendations

In part as the data is not available from commissioned services, it is currently not possible to identify whether changes in behaviour differed for those who undertook a physiotherapy session where MECC is a core aspect within Fairfield MSK Physiotherapy Services and those who were referred from other services (such as primary care).

To support the evaluation of outcomes relating to the embedding of MECC principles going forwards, **the following recommendations will support future data analysis:**

- A set of criteria to establish whether MECC conversations have taken place between physios and their patients' needs to be agreed at a local level. The joint completion of the Physiotherapy Health and Wellbeing questionnaire may be the vehicle to achieve this.
- If it is this data that the department will measure tracking the success of MECC through Fairfield MSK Physiotherapy Services, the data has to be captured onto a data management system for all patients.
- On the Health and Wellbeing form, details of where and how patients are referred needs to be captured i.e. name of organisation and self-referral or direct referral, for instance. This will enable the department to identify the impact of direct referral versus self-referral.
- It would be beneficial to identify barriers which inhibit or limit the effectiveness of brief conversations relating to PA, smoking status and weight management in clinic. This may indicate individual gaps in knowledge or low levels of personal confidence for instance or structural gaps relating to time demands or confidence that conversations can stimulate behavioural change.
- To track the impact of MECC along the referral pathway, it would be beneficial to agree a set of MECC measurement criteria between Fairfield MSK Physiotherapy Services and commissioned services including timeframes for reporting outcomes which align with local needs and/or NICE guidelines.
- The physiotherapy team could consider a reporting mechanism to update physios on the behavioural changes captured by commissioned services (relating to the timeframes adopted for recording outcomes as outlined above), to demonstrate the successes and challenges associated with long term behavioural change.
- As with the capturing of referrals in to Fairfield MSK Physiotherapy Services, there are issues with capturing of specific referrals into commission services in relation to who they were made by. For example one service explain: *All referrals are from FGH Physio's – although there are different physio silo's – cardiac, pulmonary and general physio... We don't differentiate between which dietician – we only log dietician. If a*

particular department wants us to note where it has come from – our system allows us to add a ‘specific name and details’ – we can then feedback – although we try to avoid this as it makes our system too massive to police (although they added they tend to not get referrals from Dieticians).

- Commissioned services (where appropriate) should be able to refer into each other if they identify a need which perhaps was not identified earlier and a better way of integrated working between commissioned services would be beneficial.
- Feedback from one of the commissioned service also suggested there are improvements that could be made in relation to the working relationship with Fairfield MSK Physiotherapy Services (e.g. having someone from the service based at the hospital at times, running education sessions with the staff, developing automatic pathways for referral upon the identification of certain behaviours or activates and developing a better referral systems which works with both systems being used).

5 Stage 3 – Patient Questionnaire

To understand service users recall of whether and how MECC conversations were taking place in clinic, they were asked to complete questionnaires to address the following key areas: levels of physical activity; personal wellbeing; general health; and an evaluation of the service received (see Appendix 1).

Questionnaires were received from 70 service users. Consent was not provided on eight questionnaires and one individual did not provide demographic data. As such data was extracted for 61 service users. Sixty questionnaires were completed by attendees to the Fairfield MSK Physiotherapy Services. Although it was hoped to look at a comparator AHP group, despite a high number of questionnaires being distributed only one was completed by an attendee to the Dieticians at PAHT. The data captured on this questionnaire was similar to the data reported by service users of the Physiotherapy department in that they indicated high levels of physical activity, were a non-smoker trying to lose weight and were female. They recalled conversations with their dietician in relation to two aspects of MECC – physical activity and healthy eating and made changes to both their levels of physical activity and healthy eating behaviours as a consequence of these conversations. The final dataset in this section of the report is therefore based on sixty responses from service users of the Fairfield MSK Physiotherapy Services. Most of the participants were female (n = 43, 71.6%), 17 were male (28.3%). The age of the participants ranged from 19 to 79, with the mean age being 42 years, and the median being 41 years. The majority of service users’ (91.6%) identified as White British. Full demographic information on the participants can be found in Table 5.

Table 5 Service users' demographics

Demographic data	No of service users (%)
Gender	
Male	17 (28.3%)
Female	43 (71.6%)
Age	
Under 35	8 (13.3%)
35-44	6 (10%)
45-54	11 (18.3)
55-64	20 (33.3%)
65-74	9 (15%)
75 and over	6 (10%)
Ethnicity	
White British	55 (91.6%)
Black, African, Caribbean, Black British	0 (0%)
Asian/ Asian British	2 (3.3%)
Mixed/multiple ethnic groups	1 (1.6%)
Other ethnic groups	1 (1.6%)
Prefer not to say	1 (1.6%)

5.1.1 Levels of Physical Activity

Levels of Physical Activity were identified using the International Physical Activity Questionnaire¹⁸. The data was cleaned in line with the IPAQ (2005) guidelines, which resulted in thirteen service users' responses being excluded from the final dataset for levels of physical activity¹⁹. As a result, for this part of the questionnaire the data from 47 service users made up the final dataset.

Sixty per cent of those completing the IPAQ questionnaire identify as engaging in high levels of physical activity per week; 20.8% reported engaging in moderate levels of physical activity and 18.8% as having low levels of physical activity (Figure 6). Of note, the thirteen cases which were excluded from the analysis were predominately completed by service users over 55 (n=11), had these been included it is probable that they would have changed the overall reporting of levels of physical activity across the population being examined.

¹⁸ Levels were calculated using the Guidelines for Data Processing and Analysis of the International Physical Activity Questionnaire (IPAQ) (2005).

¹⁹ Any data missing relating to time spent or number of days of activity resulted in the case being removed from the analysis.

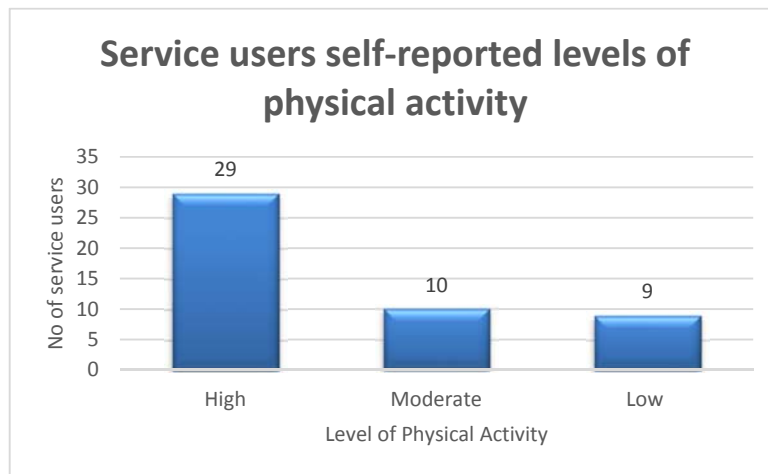


Figure 6: Service users' self-reported levels of physical activity

5.1.2 Services users' wellbeing

In the second part of the questionnaire the emotional wellbeing of patients was assessed using three measures: The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS), the ONS Subjective Wellbeing Scale and the Generalised Trust Question.

The SWEMWBS consists of 7 statements on a 5-point Likert scale (“none of the time” to “all of the time”) and the raw score, calculated as the total across the 7 items, (none of which can be absent) is then transformed via a conversion table into a metric score, suitable for parametric analyses. The metric score for SWEMWBS ranges from 7 to 35, where the highest score indicates greater reported mental well-being. The mean for the metric score of SWEMWBS for all Fairfield MSK Physiotherapy Services participants (n=60) was 22.92. Looking at UK population norms for English adults in 2011 the mean score for participants in this study was slightly lower than the mean score for English adults (23.6) (Taggart, Stewart-Brown & Parkinson, 2016).

The scores based on the seven questions used in the SWEMWBS can be viewed in Figure 7. It is interesting to note when looking at these that on average more ‘cognitive’ focused questions (making up own mind, thinking clearly and dealing well with problems) scored higher than ‘feeling’ questions. This could be linked to the impact or reason for why service users are attending the physiotherapy department.

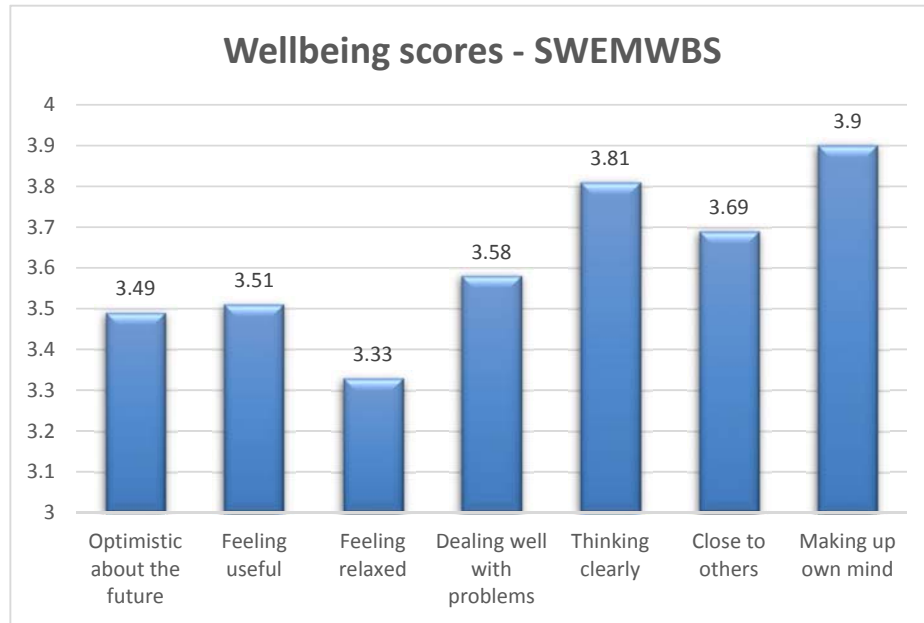


Figure 7: Mean scores recorded using the Short-Warwick Mental Wellbeing Scale (SWEMWBS)

For the second part of the questions around service users’ wellbeing, four personal wellbeing questions (used as standard questions in Office of National Statistics (ONS) questionnaires) were used. The questions are measured on an 11-point scale, where 0 is ‘not at all’ and 10 is ‘completely’. The four questions ask: ‘how satisfied are you with life right now?’, ‘How happy did you feel yesterday?’, ‘How anxious did you feel yesterday?’ and ‘To what extent do you feel the things you do in your life are worthwhile?’. In the following analyses, the mean scores in response to these four questions are reported. Figure 8 below shows the mean scores derived from service users’ responses to the four questions posed.

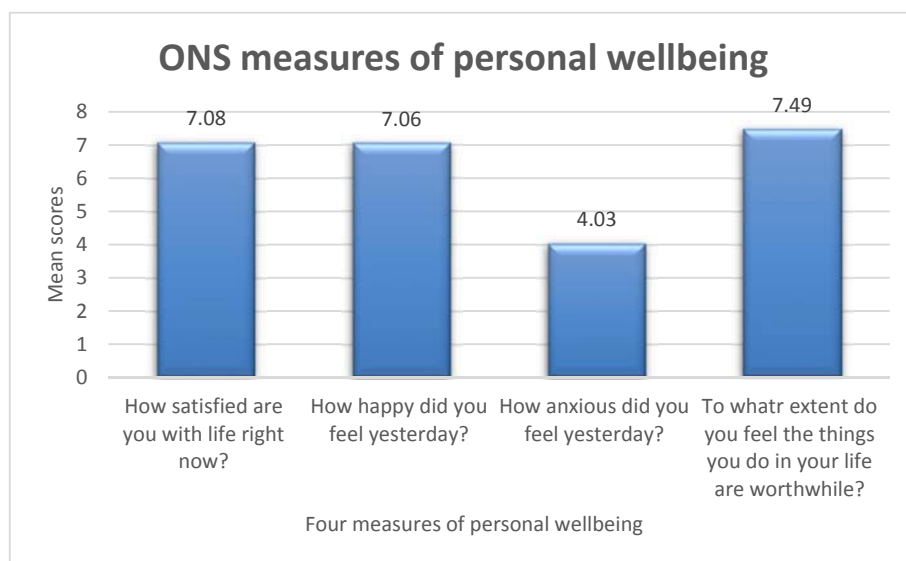


Figure 8 Mean scores recorded using the ONS scale of personal wellbeing

Through using ONS data, it is also possible to evaluate the mean scores provided by service users against the mean scores recorded for Bury and the national means for the UK, in response to the same questions. Table 6 provides an overview of the mean scores provided by the Physiotherapy Department’s service users using the ONS scale of personal wellbeing in comparison to mean scores for Bury residents and UK mean scores.

Table 6: Comparisons of mean scores of service users, Bury and UK mean scores

	Service users’ mean scores	Bury mean scores (ONS, 2017/18 ²⁰)	UK mean scores (ONS, 2017/18)
Life satisfaction	7.08	7.62	7.69
Happiness	7.06	7.57	7.89
Worthwhile	7.49	7.88	7.88
Anxiety	4.03	3.01	2.89

From this data it can be seen that service users of the Physiotherapy department reported lower mean scores in relation to life satisfaction (7.08) than both the mean score for Bury (7.62) and the UK national mean score (7.69). They also reported lower scores (7.06) than the mean scores for Bury (7.57) and UK national average (7.89) on happiness and feelings of worthwhileness (7.49 v 7.88). The national mean score across the UK for anxiety is 2.89, whereas in this evaluation service users indicate lower wellbeing in relation to levels of anxiety reporting a mean score of 4.03. This may be a reflection of the challenges service

²⁰ Office for National Statistics (2018). Personal well-being in the UK: April 2017 to March 2018. Headline estimates of personal well-being from the Annual Population Survey (APS): by counties, local and unitary authorities, year ending March 2012 to year ending March 2018

users are experiencing physically and it would be useful to identify, through further research, whether these higher reported levels of anxiety are linked to physical challenges or wider issues impacting on personal wellbeing.

5.1.3 General Health Questions

In the third part of the questionnaire service users were asked questions relating to smoking, which were derived from the Global Adult Tobacco Survey (GATS), and weight management. Although smoking rates in Bury are higher²¹ (19.1%) than the national average in the UK (15.1%²²), most service users (90.16%) reported that they were non-smokers (Table 7). In the evaluation six service users reported that they smoked, five of these daily and one less than daily. Looking at those that smoke in more detail, three reported that they smoked manufactured cigarettes and three reported that they smoked hand rolled cigarettes.

Table 7 Current smoking habits of service users participating in this evaluation

Smoking behaviour	Number of service users (n=61)	Percentage of service users
Smoke daily	5	8.19%
Smoke less than daily	1	1.64%
Are non-smokers	55	90.16%

Twenty participants (33%) reported smoking in the past, and although it is not clear when they stopped smoking this does suggest that changes in smoking prevalence among adult attendees at Fairfield MSK Physiotherapy Services are in line with national trends (NHS Digital., 2018). However, of the four service users who tried to quit smoking in the past 12 months, only one reported now being a non-smoker. This suggest that there may be opportunities, if this group are identified, to refer them to stop-smoking support services.

When asked about their current approach to weight management almost 50% (n=30) of service users indicated they were currently taking active steps to lose weight. Twenty-one (35%) were actively trying not to gain weight. Figure 9 provides an overview of service users current approaches to weight management.

²¹ Greater Manchester Health and Social Care Partnership. (2018). Making Smoking History A Tobacco Free Greater Manchester. Retrieved October 10th from <http://www.gmhsc.org.uk/wp-content/uploads/2018/04/Tobacco-Free-Greater-Manchester-Strategy.pdf>

²² ONS. (2018). Adult smoking habits in the UK: 2017. Retrieved October 4th from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017#the-proportion-who-are-current-smokers-in-the-uk-its-constituent-countries-and-local-areas-2011-to-2017>



Figure 9 Service users' current approaches to weight management

Interestingly, five service users ticked more than one box to describe their current approaches to weight management. Four ticked the boxes which stated, 'I am actively doing things to try to avoid gaining weight at the moment' and the box 'I am actively doing things to try to lose weight at the moment'. In terms of historical approaches to weight management, almost 82% (n=50) of service users had tried to lose weight in the past. Again, this finding suggests that there may be a place for referral to weight management or signposting to where support can be obtained by the group who were actively trying to manage their weight.

5.1.4 Evaluating the service provided by the Fairfield MSK Physiotherapy Services

The final part of the questionnaire asked service users for their views about the physiotherapy team and if they remembered any MECC related conversations. It is encouraging to see the number of conversations service users remember having in relation to physical activity, smoking, alcohol consumption, healthy eating, wellbeing and physical inactivity (as shown in Figure 10).



Figure 10 Service users' remembered conversations when visiting the PAHT physiotherapy department relating to health and wellbeing topics

A significant majority of service users remember conversations with their physiotherapist at Fairfield MSK Physiotherapy Services around their levels of physical activity (n=51, 85%); and smoking behaviours (n=59, 98%). Just over half remembered conversations about wellbeing (n= 34, 57%) and physical inactivity (n = 30, 50%). Conversations relating to alcohol (n = 29, 48%) and healthy eating (n = 24, 40%) were remembered by just less than half of service users. Given the remit of the physiotherapy service, it is perhaps not surprising that conversations relating to physical activity are the most remembered conversations and possible barriers and enablers to participating in physical activities takes place during appointments. In terms of other lifestyle behaviours, it is interesting that conversations around smoking behaviour were remembered/reported to have occurred by almost all service users however conversations relating to healthy eating and alcohol consumption were remembered/reported to have occurred by less than half the population. This suggests barriers limit these conversations currently which corresponds with the evidence identified in section 4.2.4.

In addition to the encouraging numbers of remembered conversations it is also encouraging that as a result of interacting with physiotherapy staff, service users did report changes in health behaviours (Figure 11).

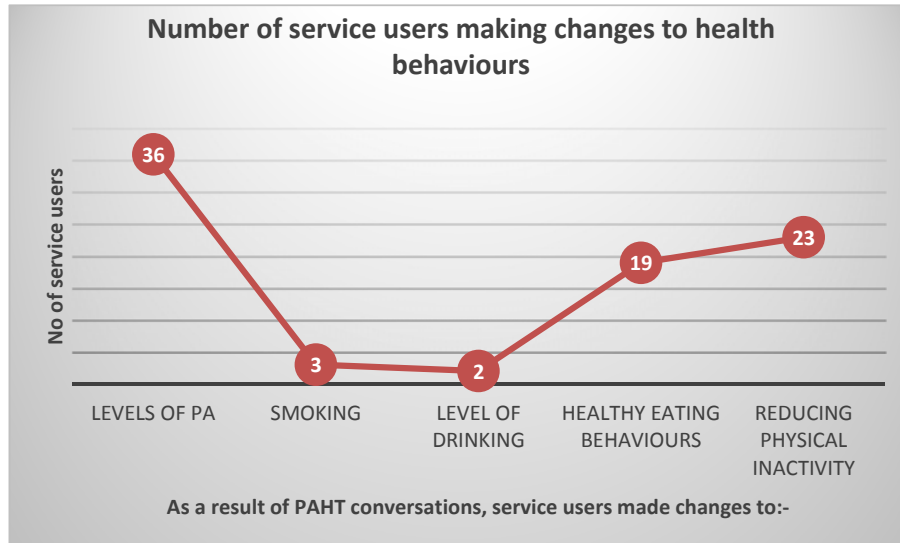


Figure 11 Number of service users making changes to health behaviours

Potentially reflecting the data gathered by the IPAQ questionnaire (section 5.1.1.), the data suggests that conversations around levels of physical activity (70.6%), physical inactivity (76.7%) and healthy eating (79.2%) are resulting in behavioural changes of those service users who took part in the study, indicating they have taken active steps in these areas.

The data suggests that conversations regarding changes to smoking behaviour has initiated change for three service users although further information about what these changes are was not available. However, as previously reported (section 5.1.3) four service users have tried to quit smoking in the past twelve months.

The data also suggests that having conversations around alcohol and initiating change in drinking habits is potentially as, or more, challenging. Only twenty-nine service users reported recalling a conversation around alcohol consumption with their physiotherapist (Figure 10). Of these, two service users (6.9%) reported making changes to their drinking behaviour following these conversations. This may indicate that initiating conversations relating to alcohol consumption with service users is experienced as challenging for physiotherapy staff. It also suggests that initiating change at an individual level in relation to alcohol consumption may be problematic too.

While Figure 11 shows the number of service users who have made changes to their health behaviours following conversations with their physiotherapist, it is interesting to note a pattern in the data which emerges from this question. On average, service users report making changes in one area only, such as reducing physical inactivity or improving healthy eating behaviours for example. In developing sustainable health behaviour changes it may be of interest to understand more about whether a holistic approach to conversations around healthy behaviours (MECC) leads overtime to service users adopting a holistic approach to changing lifestyle behaviours potentially through longitudinal research.

Also of interest is the number of MECC related conversations, service users recalled having with their physiotherapists. MECC currently offers physiotherapists six different aspects of lifestyle behaviours to discuss with service users – physical activity, smoking status, alcohol consumption, healthy eating, wellbeing and physical inactivity. On average, service users recall having conversations with their physiotherapists about three out of six of these areas. Figure 12 below provides an overview of how many service users remember 0, 1, 2, 3, 4, 5 or 6 aspects of lifestyle behaviours being discussed when in conversation with their physiotherapist.

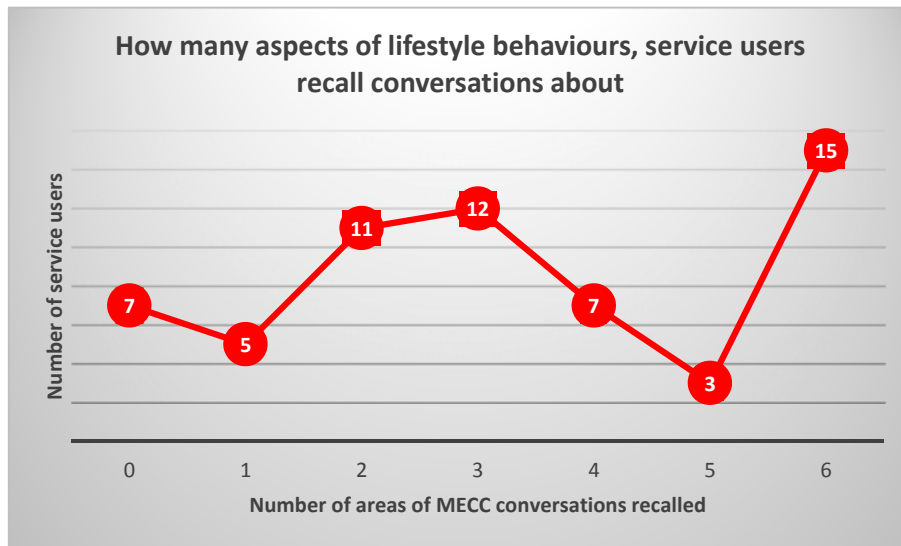


Figure 12: The number of aspects of MECC, service users recall having conversations about

With a range of ‘zero recall’ through to recalling six aspects of lifestyle behaviours being discussed, this suggests there may be considerable variability in the conversations being had and an absence of a standard approach to engaging in conversations across all MECC areas across the department. This is supported by the variability in data capture identified in section 4.2.1. captured in the Physiotherapy Health and Wellbeing Assessment forms

When asked about any referral they received at the time of this questionnaire, the most service referrals were made to BEATS (n= 25; 41.6%) (Figure 13), which is in line with the focus on physical activity and improving levels of physical inactivity.

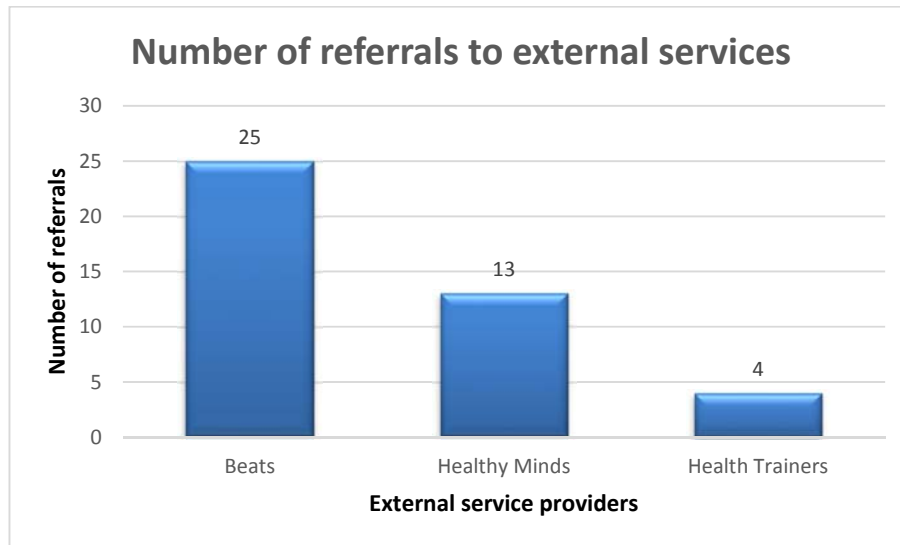


Figure 13 Number of referrals to external services

To gain a greater insight into service users views around MECC related conversations two open ended qualitative questions asked about their interactions with Fairfield MSK Physiotherapy Services staff. The first asked for the name of the member of staff the service user was seen by and anything from the conversation that they were happy to share. The second asked if there was anything further the service user wanted to provide feedback on either in relation to the service received from the department or in related to the conversations about health and wellbeing.

The first question received responses from 48 service users (78.7%). Twenty-seven of the forty-eight responses (56%) directly referenced a physiotherapist by name. Twelve members of staff were individually identified as providing service. Multiple references were made to two of the physiotherapists who initiated and supported this project. This suggests these two members of staff were particularly proactive in asking service users to complete questionnaires. Generic references to physiotherapists, therapists and senior physiotherapists were made by 10 individuals (20.8%). The second open ended question was answered by 21 (34.4%) service users. From this it was possible to identify five themes, which are shown in Figure14:



Figure14: Themes arising from service users' feedback on the physiotherapy service

The qualitative comments indicate that the professional warm approach staff take to service users is welcomed and influential in encouraging some service users to practice the lifestyle behaviours and exercises recommended. The holistic approach to health was welcomed by some users, while others reflected more specifically on advice related to their current injury.

Table 8 Theme map and quotes related to MECC conversations

Theme heading	Theme definition	Illustrative comment
'Getting to know you'	Ways in which service users positioned their initial session with their physiotherapist	<i>'General discussion - 'getting to know you' first session' (P1)</i> <i>'[Name] and just generic questions and how I feel in myself' (P24)</i>
Service signposting	Service users' descriptions of services they have been signposted to	<i>'I was given advice and referred for help to quit smoking by [Name]'</i> (P21) <i>'[Name], who referred me to the gym sessions'</i> (P57) <i>'[Name] suggested BEATS and I now have an appointment and she also told me about other social activities in the areas'</i> (P67) <i>'Advice on BMI/Weight loss and Lifestyle service @bury.gov.uk provided'</i> (P51)
Taking a holistic approach	Service users' responses to broader health and wellbeing conversations with their physiotherapists	<i>'Very good. Felt it was a 'total package' health discussion as part of 'getting to know you' during first session, with ideas for future discussions at subsequent sessions'</i> (P1) <i>'These topics were part of the initial assessment and I was glad to be asked about overall well-being'</i> (P5) <i>'Talked through all with therapist. Gave advice on healthy living'</i> (P16) <i>'I am delighted to be seen by a physiotherapist and very glad of the holistic approach in the sense of lifestyle impact on current problems and I have seen great improvement in the last month, thank you'</i> (P5) <i>'[Name] asked how active I was, what my job role was, if I smoked and if I drank. I was over the recommended level of alcohol for a female'</i> (P54)

Theme heading	Theme definition	Illustrative comment
Technical advice and support	Some service users focused exclusively on interactions specifically related to receiving physiotherapy advice	<p><i>'The need to strengthen my left hip and core to improve balance' (P7).</i></p> <p><i>'[Name] introduced me to the health machine' (P23)</i></p> <p><i>'Making exercising easier' (P30)</i></p> <p><i>'Spoke with physio about when ok to start using gym again and what the best exercises to do post-surgery' (P62)</i></p> <p><i>'Very helpful explaining what they thought might be helpful to improve movement in my upper body' (P42)</i></p>
Professional warmth	Service users' responses to interactions with staff	<p><i>'Very friendly staff and always willing to help and talk. They push you to try everything' (P58)</i></p> <p><i>'I do feel [Name] 'listened' to me regarding my depression especially as I was there with an Achilles problem and it was completely unrelated' (P63)</i></p> <p><i>'[Name]. I thought the conversation was optimistic and encouraging. Also, very professional'(P49)</i></p> <p><i>'Since coming to physio dept., [Name] has helped me with my physical activity and with my confidence, as she has been really nice I have wanted to try the activities and stretches she has put for me' (P11).</i></p> <p><i>'Lady was brilliant. Made me feel very comfortable and content' (P16)</i></p> <p><i>'All the physios are very kind and always felt that they care about your wellbeing' (P27)</i></p> <p><i>'I am a nurse and health adviser so MSK specialist respected my expertise as we discussed pain limitations and other medical problems (lupus & fibromyalgia)' (P53)</i></p>

Theme heading	Theme definition	Illustrative comment
Improving services	Service users' suggestions for improving services	<p><i>'Injury rehab should be done alongside ACT- Acceptance and commitment therapy' (P8)</i></p> <p><i>'I saw physios following 2x ankle injuries w/in 6m - the second was significant and I feel should have been seen advance physio earlier. I felt I was being asked to do more than I could' (P8).</i></p>

6 Conclusions

Throughout this report we have aimed to evaluate the use of Making Every Contact Count (MECC) within the Physiotherapy Department of Bury & Rochdale Care Organisation (Fairfield MSK Physiotherapy Services), part of the Northern Care Alliance NHS Group.

From the initial stage of the evaluation it can be seen, that for those staff who took part, that they had a positive view of the MECC, but also felt that a system change to integrate these conversations was needed. It was also felt by the staff that having MECC related conversations would support the patients, other key stakeholders and staff health and wellbeing, due to the holistic view it drives the department towards. Staff also felt that it can help them when they are working with patients to have a greater insight into what may be impacting patients and as such the reason why they are making use of the service. However, despite the positive view around MECC related conversations being integrated, staff did feel that there were issues around resources for this, including time and staff training/readiness, which can impact the delivery. Although there is a great deal of staff positivity around the integration of MECC there are also signs that staff readiness for embedding MECC through the service is not universal. This was based on personal confidence as well as feelings of not being able to integrate it in to the practice due to a number of external factors, including time, confidence and perception of patient needs.

Through this evaluation it was possible to identify that currently there are two locations to offer this service – primary locations for MECC related conversation (those where MECC conversations were always likely to have occurred) and secondary locations (those where these conversations can reinforce initial conversations, are not a primary occurrence or may be places that they do not occur but have opportunity to). It was promising that at the staff event, Fairfield MSK Physiotherapy Services staff identified where improvements could be made in the secondary locations and where missed opportunities could be addressed going forwards. To help facilitate this there is a need to develop a method for documenting MECC conversations, so any future practitioners are more aware. This would then allow conversations to build over the course of the contact with patients and enable a more longitudinal perspective of health behaviour change to be gained.

Within the second part of the study looking at referral data there was a significant challenge in relation to the data that was held by the three organisations and the format of this. It was clear that there is no universal way of being able to collect and report data, and that the challenges around data are likely to have a number of impacts. Given the issues with the current data it is not possible at the moment to identify whether changes in behaviour differed for those who undertook a physiotherapy session where MECC is a core aspect within Fairfield MSK Physiotherapy Services compared to those who were referred from other services (such as primary care). It was found though that the Fairfield MSK Physiotherapy Services team referred more people into BEATS than other services, and of these 59.4% started (with many of those not started waiting processing) and 98.6% of those actively participated in the programme (with retention levels high at 6 weeks, 12 weeks and 12 months). It was also found that for those referred in relation to weight management that after seven weeks the average BMI was lower (34.1 vs. 32.9). There were less success and fewer referrals when it came to smoking status and alcohol, indicating this is an area where perhaps the team need more training around having these conversations and about referrals.

Further to the data requested from services that the department refers into, baseline data from the health and wellbeing assessment forms was also explored. However, again there was an issue that the majority of these were not yet on the system and there was a big backlog building around the input of these. This limited the ability to gain a fuller picture of those accessing the service. Through the baseline health and wellbeing questionnaires, MECC related conversations appear more common in relation to physical activity levels and smoking status, but there is an incomplete picture around conversations relating to weight and alcohol which could be an indication these are less common or developed conversations.

The final part of this evaluation was to understand from service users how they report the MECC related conversations and also aspects of their health and wellbeing. A limitation with this section was that only one questionnaire was received back from the comparator AHP service, as such it was not possible to make a comparison. Those who completed the questionnaire reported that their physical activity was mostly high or moderate, which could have been impacted by reasons they were accessing the service. When looking at reported wellbeing and life satisfaction the scores for those in the sample was found to be slightly, but not significantly, lower than the UK population norm. Again, it is not possible to know how this is impacted by the reasons they are accessing the service. In contrast to the UK and Bury average most of those in the sample reported that they were not currently smokers, which is a positive. However almost half indicated that they are currently taking active steps to lose weight which seems to be an indication that there is scope to improve the referrals and support offered around this.

Finally, we asked those using the service about MECC related conversations specifically, and it was encouraging how many service users reported remembering having conversations about: physical activity, smoking, alcohol, health eating, wellbeing and physical inactivity. On average, service users recall having conversations with their physiotherapists about three out of six of these areas. Nevertheless, with a range of 'zero recall' through to recalling six aspects of lifestyle behaviours being discussed, this suggests there may be considerable variability in the conversations being had and an absence of a standard approach to engaging in conversations across all MECC areas across the department. It is also encouraging that for areas related to level of physical activity, health eating behaviour and reducing physical inactivity there were good level of service users reporting changing their behaviour. However, when looking individually on average, service users report making changes in one area only, such as reducing physical inactivity or improving healthy eating behaviours for example. As such there may be a need for the physios to consider what conversations they are having and when in relation to the importance of them. From the qualitative question it can be seen that the professional warm approach staff take to service users is welcomed and influential in encouraging some service users to practice the lifestyle behaviours and exercises recommended. The holistic approach to health was welcomed by some users, while others reflected more specifically on advice related to their current injury. As such it is clear that those using the service feel they are more than just a patient and that they are supported by those they see.

Overall there are many positives which can be drawn from this evaluation, and it is clear that the service is working towards taking a holistic view of all their patients through the use of MECC to support this. It is also clear that this is welcomed by the service users who returned the questionnaire. Despite this, it is also clear from this work that there are challenges around data both in relation to the department and the services they refer into. This report has also

highlighted clear strengths which can be built on, and areas where those working in the service may need some more support.

7 Overall Recommendations

From the recommendations that have been provided at the end of each section throughout the report, the key recommendations have been grouped into four themes – staff development, delivery, audit and evaluation and external providers and commissioners. These key recommendations are outlined below:

7.1 Staff development

1. The more experienced staff should explore with staff where delivery of new opportunities to introduce or reinforce MECC related conversations can occur and what support/training may be needed to help this.
2. The department should develop a set of criteria to establish whether MECC conversations have taken place between physios and their patients' (e.g. the joint completion of the Physiotherapy Health and Wellbeing questionnaire)
3. Further work with staff needs to be undertaken to understand gaps in knowledge, levels of personal confidence, and other pressures (e.g. time demands) around having MECC related conversations. Gaining support from senior management to overcome these would be beneficial. Of particular value, will be identifying why conversations are experienced as challenging and agreeing strategies for engaging service users positively in these conversations.
4. Developing a MECC update process for the team may produce dividends. This could include latest training, news, future audit outcomes, successes of previous service users, tips etc. that can disseminated across the team.
5. Making sure all are aware of the training available and then consider quarterly MECC skill top-ups or meetings to support this becoming embedded more consistently within the department.

7.2 Delivery

1. Develop recording systems so it is clear when MECC related conversations and referrals to external providers have or have not occurred, such as the effective completion of the Health and Wellbeing Assessment Tool. This approach, when supported by the required IT infrastructure, will support reducing missed opportunities and provide more robust data to measure service provision.
2. Establish a way of having easy and practical access for patients to use scales and to measure their height (if they are not aware of this), to then allow them to view a BMI chart which would support relevant conversations. Taking height and weight measurements could/should become standard practice for all new service users on arrival at clinic for the first time.
3. Explore the resources available to staff to make referrals (e.g. linked to IT issues) or for patients to self-refer e.g. through iPads. These could be positioned between bays or in the reception area
4. Consider what materials and resources would support staff in delivering and having these conversations e.g. in some classes would a more tailored handout be suitable

5. Review at six monthly intervals how many health and wellbeing topics are being covered on average by physiotherapists when in conversation with their service users
 - a. For example, using iPads, this data could be collected through a short online survey repeating the evaluation questions addressed within the questionnaire (Appendix 1: section D).
 - b. Or this data could be captured within patient notes by adapting the current form which records MECC related details.

7.3 Audit and evaluation

1. The Physiotherapy team should explore with the Audit Office the best ways to capture data (including the Health and Wellbeing Assessment data) going forwards and how best to utilise existing data held by the Fairfield MSK Physiotherapy Services.
2. The Physiotherapy team should discuss with the Audit Office, resource opportunities for data input support to clear the backlog of Health and Well-being questionnaire data not yet inputted and to understand what support is available to gain an initial analysis of this data.
3. To remove the need for manual data entry, funding or resource provision should be sought to move towards using technological enhanced systems (e.g. iPads) to collect individual data, including Health & Wellbeing questionnaire data
4. The Physiotherapy team should establish if it is possible to develop a set of MECC measurement criteria between Fairfield MSK Physiotherapy Services and commissioned services, including timeframes for reporting outcomes, which align with local needs and/or NICE guidelines.

7.4 External providers and commissioners

1. The Physiotherapy team would benefit from disseminating the outcomes of the holistic approach taken within the Physiotherapy department in relevant communications. They may find benefit in seeking support from Trust librarians to identify possible routes for dissemination
2. Explore if it is possible to make improvements to the referral system to allow more categories to be captured around where the referral came from e.g. currently the code related to referrals from GPs covers a number of other organisation as well as GPs so there is a loss in detail
3. Potentially there is an opportunity for physiotherapists to request as a matter of routine a more holistic understanding of the service user when referrals come in that would include more general health and wellbeing information such as smoking status. For instance, there is normally little or no information that moves beyond the physical need to be addressed and puts it into a wider health context such as BMI or in relation to current lifestyle behaviours.

8 References

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9 Appendices

Appendix 1: Service users' questionnaire



University of
Salford
MANCHESTER

Service user's evaluation of 'Making Every Contact Count' (MECC) within Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group

Audit Number logged with PAHT: 2018 061

University of Salford ethics number: HSR1718-035

Please will you take a moment to complete the short questionnaire attached. These questions are trying to find out about you and your experience of service provision at Bury & Rochdale Care Organisation, part of the Northern Care Alliance NHS Group to support your needs. This questionnaire is divided into a number of short sections. You do not need to provide your name. All information provided is anonymous and will be treated confidentially.

Section A: Physical activity questionnaire

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, and at home, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

1. During the **last 7 days**, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

_____ days per week

_____ No vigorous physical activities

2. How much time did you usually spend doing **vigorous** physical activities on one of those days?

_____ hours per day

_____ minutes per day

_____ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace? Do not include walking.

_____ days per week

_____ No moderate physical activities

4. How much time did you usually spend doing **moderate** physical activities on one of those days?

_____ hours per day

_____ minutes per day

_____ Don't know/Not sure

Think about the time you spent **walking** in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

_____ days per week

_____ No walking

6. How much time did you usually spend **walking** on one of those days?

_____ hours per day

_____ minutes per day

_____ Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting on a week day**?

_____ hours per day

_____ minutes per day

_____ Don't know/Not sure

Section B

Wellbeing Questionnaire²³

Below are some statements about feelings and thoughts. Please choose the answer that best describes your experience of each over the last two weeks.

Please tick one box on each line

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my mind about things					

Below are some more questions about feelings. Please give a score of 0 to 10 where 0 means extremely dissatisfied/ unhappy or not at all anxious/ worthwhile and 10 means extremely satisfied/happy/ anxious/ worthwhile.

Please tick one box on each line

Questions	0	1	2	3	4	5	6	7	8	9	10
Overall, how satisfied are you with your life nowadays?											
Overall, how happy did you feel yesterday?											
Overall, how anxious did you feel yesterday?											
Overall, to what extent do you feel the things you do in your life are worthwhile?											

Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people? Please give a score of 0 to 10, where 0 means you can't be too careful and 10 means that most people can be trusted.

Please tick one box

Can't be too careful							Most people can be trusted				
0	1	2	3	4	5	6	7	8	9	10	

Section C: General health questions

Q1. Do you currently smoke on a daily basis, less than daily, or not at all? Please tick one box only.

Daily	Less than daily	Not at all	Don't know

²³ Taken from the NEF Guide

Q2. If you currently smoke, what do you smoke?

Please tick one box on each line (if applicable).

	Daily	Less than daily	Not at all	Don't know
Manufactured cigarettes				
Hand rolled cigarettes				
E-Cigarettes				
Pipe tobacco				
Any others? Please specify.				

Q2. If you do not currently smoke, have you smoked in the past?

Yes No

Q3. In the past, have you smoked on a daily basis, less that daily or not at all? Please tick one box only

Daily	Less than daily	Not at all	Don't know

Q4. During the past 12 months, have you tried to stop smoking?

Yes No

Q5. Which of the following best describes you now?

Please tick one box only

I am actively doing things to try to gain weight at the moment	
I am actively doing things to try to avoid gaining weight at the moment	
I am actively doing things to try to lose weight at the moment	
I am not doing anything in particular at the moment related to my weight	

Q6. Have you tried to lose weight in the past?

Please tick one box only

Yes, many times	
Yes, occasionally	
No, never	

Section D: Evaluation Questions

Q1: When attending the physiotherapy service do you remember if you have had any conversations about:

Please tick all boxes that apply

Physical activity	Smoking	Alcohol	Healthy Eating	Wellbeing	Physical inactivity

Q1a: Can you tell us who talked to you about these topics and anything you remember from the conversations you are happy to share

.....

Q2: As a result of being under the physiotherapy service have you made any changes to:

Please tick all boxes that apply

Levels of physical activity		Smoking rate		Level of drinking		Healthy Eating behaviour		Reducing physical inactivity	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Q3: Have you been referred to any of the following services:

Please tick all boxes that apply

BEATS	Healthy minds	Health trainers	Other (please identify service)

Q4: Is there anything else you would like to let us know about the service in relation to the physiotherapy department and conversations about health and wellbeing?

.....

Section E: About you

Q1: What gender do you identify as?

Please tick one box only

Are you:	Male	Female	Transgender	Gender neutral	Prefer not to say

Q2: How old are you?

Please tick one box only

Are you:	Under 35	35-44	45-54	55-64	65-74	75 or over	Prefer not to say

Q3: What is your ethnicity?

Please tick one box only

Are you:	White British	Black, African, Caribbean, Black British	Asian / Asian British	Mixed/multiple ethnic groups	Other ethnic group	Prefer not to say

Please take a moment to ensure that you have answered all the questions.

Thank you very much for your help