# Homeless Health
# 'Making Every Contact Count' (MECC)
# Evaluation Report

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**Contents**

## 1. Background

Tower Hamlets has the 9th largest homeless population in the United Kingdom.[1] Homelessness can be a determinant of poor health but poor health can also be a determinant of homelessness. Homeless people experience health inequalities, including a higher prevalence of disease and ill health than other population groups and barriers to accessing health services. Resolving health issues and behavioural triggers can be an important step to supporting individuals to build a life away from the streets.

Making Every Contact Count (MECC) is a national initiative which encourages those who work with the public to make the most of every opportunity to have a conversation about health and lifestyle issues and to offer signposting information to facilitate behaviour change. MECC has been delivered in Tower Hamlets for the last three years and more than 1,000 frontline staff have been trained across over 100 organisations, including those working with homeless people. Close working with some of these organisations led to the development of a bespoke MECC for staff working with homeless people. This was in recognition of the breadth of health issues affecting the homeless population and that a more stepped approach might be needed to tackle some of the health behaviours which are the focus of the 'general MECC' training, such as smoking and alcohol.

The London Borough of Tower Hamlets (LBTH) Health Scrutiny Sub-Committee completed a *Scrutiny Review of Health & Social Care Provision for Homeless Residents* in March 2018.[2] This made a series of recommendations to improve the services which provide support the local homeless population, including two recommendations about training:

- For the Tower Hamlets Clinical Commissioning Group (CCG) to provide training to staff in GP surgeries and for other health professionals to support them to deal with some of the behaviours which may be encountered when engaging with homeless people.
- For the London Borough of Tower Hamlets Adult Social Care and the CCG to explore the possibility of providing all frontline workers and auxiliary staff (i.e. staff in ideas stores, parks service) with training and awareness raising sessions to help them identify and signpost the hidden homeless, and how to ask the appropriate questions without offending them. Information on provision for homeless people should be made available at all public facing council services.

Although the aims of MECC are slightly different, MECC training for staff working with homeless people complements these other training ambitions in the borough.

## 2. Introduction

At the start of 2018, the Tower Hamlets MECC Steering Group agreed to fund a small pilot Homeless Health MECC Training Programme, which would be evaluated to inform future funding decisions. A Project Working Group was established to take this forward with representatives from Providence Row Charity, RESET (Tower Hamlets' specialist drug and alcohol service), Groundswell and Public Health at Tower Hamlets Together. The pilot included two half-day training sessions with space for up to 32 members of staff to be trained and the development of training materials, including slides and an accompanying Homeless Health Handbook. It was based on the established general MECC

[1] London Borough of Tower Hamlets Health Scrutiny Sub-Committee, Scrutiny Review of Health & Social Care Provision for Homeless Residents, March 2018, https://democracy.towerhamlets.gov.uk/documents/s123991/Homeless%20Health%20Scrutiny%20Report%20V3.pdf

[2] https://democracy.towerhamlets.gov.uk/documents/s123991/Homeless%20Health%20Scrutiny%20Report%20V3.pdf

training programme but tailored to the needs of staff working with homeless people. The Project Working Group produced the materials for the training and the organisation of the training was coordinated by members of the Tower Hamlets Community Education Provider Network.

This evaluation report provides a detailed overview of the pilot and the feedback received from staff who attended.

## 3. The pilot training

### 3.1 Aims

The aims of the pilot training were for staff to:

- Be able to identify opportunities to raise health and lifestyle issues with homeless service users but also with colleagues, friends, family and members of the public
- Have the confidence to raise health and lifestyle issues with service users
- Have awareness of common health issues affecting homeless people and know where to signpost them for support.

### 3.2 Training resources

#### 3.2.1 The Homeless Health Handbook

The Project Working Group pulled together a list of 22 health topics for the Handbook, which were felt to be most pertinent to the needs of staff working homeless people. These were based on local and national research on the health needs of homeless people;[3] topics covered by Groundswell's Health Action Cards;[4] topics included in the 'general MECC' training; and experience of members of the Project Working Group in their work with homeless clients. They included both health conditions and health behaviours.

These were:

- Abscesses
- Alcohol
- Blood borne viruses
- Breathing difficulties
- Chronic pain
- Diabetes
- Drugs
- Dual diagnosis
- Eyes
- Foot health
- Healthy eating and nutrition
- Leg ulcers
- Mental health
- Physical activity
- Pregnancy and women's health
- Sexual health
- Skin conditions
- Sleeplessness
- Smoking
- Suicide
- Teeth
- Tuberculosis (TB)

[3] Crisis, Homelessness: A silent killer. A research briefing on mortality amongst homeless people, December 2011; Healthy London Partnership, Resource Pack: Homelessness and Health, https://www.healthylondon.org/resource/homelessness-health-resource-pack/; Groundswell and Healthy London Partnership, More than a statistic https://www.healthylondon.org/wp-content/uploads/2017/10/More-than-a-statistic.pdf; St Mungo's, Health Topic Guidance Tool: Hammersmith & Fulham http://handfhomelesshealth.org/Resources/Health%20Topic%20Toolkit%20H&F.pdf; London Borough of Tower Hamlets, JSNA Factsheet: Homelessness 2017

[4] http://groundswell.org.uk/what-we-do/information-for-action/

It was decided that the Handbook should have an introductory section around homeless health and barriers to accessing healthcare and a summary of the MECC approach. Due to the high and often inappropriate use of Accident & Emergency by homeless people (reflecting a combination of health needs reaching a crisis point, through lack of access to early intervention support, and a lack of awareness of how to access appropriate health services) it was felt that the Handbook should also have a whole section at the start covering 'accessing the right healthcare at the right time'.

The information in the handbook on the health topics was structured around the 4 A's of MECC:

- ASK - Raise the issue neutrally and non-judgmentally, and find out what your client already knows.
- ADVISE - Provide tailored information taking your lead from their concerns and priorities.
- ASSESS - How does the client feel about making a change?
- ASSIST - Discuss with the client about what they would like to do next and how you can support them.

For each topic, ideas for how staff might approach a conversation with a client on that topic were given, alongside evidence-based 'key facts' and advice on the topic and information to signpost clients to local services and other resources. At the end of each topic, readers were signposted to other relevant topics in the Handbook for example the 'drugs' topic was referenced on the 'abscesses' page, since abscesses are more common in intravenous drug users.

The 'Advise' sections were populated largely by material from Groundswell Health Action cards,[5] supplemented by NHS Choices and also information from the manual which accompanies the general MECC training. Signposting information was based on, and expanded, the list of services promoted in the general MECC training, a directory of health services started by colleagues at Providence Row and service suggestions made in St Mungo's, *Health Topic Guidance Tool: Hammersmith & Fulham*.[6] Groundswell's Health Action Cards are all based on evidence from their consultations with homeless clients and checked by experts in the relevant fields and NHS Choices is an evidence-based site. Where possible, other contents, including signposting information, was checked with local experts in those fields.

Participants were emailed an electronic copy of the Handbook a few days before the training and encouraged to familiarise themselves with its structure before attending. They were also given a hard copy on the day to take away.

### 3.2.2 The training contents

The training content around the MECC approach was taken directly from the general MECC training. This provides an overview of change theory and ambivalence; communication techniques, including asking open questions, giving positive affirmations, reflective listening and summarising; and the 4 A's strategy for having a MECC conversation, with role-playing opportunities to practise having a conversation. Whereas the general MECC training provides an overview of key messages and signposting for the 7 health improvement topics covered by the programme (healthy eating, physical activity, weight management, smoking, alcohol, sexual health and mental health) there was not time within the Homeless Health MECC training session to do the same for the 22 homeless health topics identified above. Instead, the remainder of the training covered a brief overview of homeless health issues; key messages around accessing the right healthcare at the right time; and an overview of the

[5] http://groundswell.org.uk/what-we-do/information-for-action/
[6] http://handfhomelesshealth.org/Resources/Health%20Topic%20Toolkit%20H&F.pdf

contents of the Homeless Health Handbook and how to use it. Participants were then able to practise using the Handbook when role-playing having a MECC conversation during training.

Participants were given a copy of the training slides on the day to annotate and take away. They were also given a 'My right to access health care' card. These are credit-card sized cards, which have been designed in partnership between Groundswell, the Healthy London Partnership and the NHS to help adults who are homeless to register and receive treatment at London GP practices.[7]

### 3.3 Training venue

The training was held at Merchant Street Community Hall, Merchant St, London, E3 4LX, which is close to public transport links and local homeless services.

### 3.4 Training delivery

It was decided that the training should be 3 hours long, the same length as the general MECC training, with a short, 10 minute break in the middle. Both pilot sessions were organised on the same day – 5 June 2018 – the first starting at 9am and the second at 1.30pm. An optional 30 minutes was scheduled at the end of each session for participants to stay behind and take part in an evaluation discussion.

The Project Working Group agreed for the pilot training to be delivered by two trainers –

- The trainer who delivers the general MECC training in Tower Hamlets, who is a psychologist and expert in delivering training around behaviour change and the MECC approach.
- A trainer from Groundswell, with experience of delivering training around homeless health and extensive experience of working with homeless people.

As it had not been possible to have a run-through of the presentation prior to the session, it was unknown whether it would be possible to cover all the contents as intended within the 3 hour window. On the day of the training, the first session started 30 minutes late due to the late arrival of some participants. As such, although completing the training slides there was not time to do the evaluation discussion at the end. The second session overran very slightly and only a handful of people were able to stay to take part in the evaluation discussion. If the session was run multiple times by the same trainer(s), the trainers who delivered the pilot agreed it would be possible to deliver the content as intended within 3 hours.

### 3.5 Promotion of training

The Project Working Group compiled a list of key organisations and staff groups to be invited to attend the pilot training. The aim was to have a breadth of both organisations and roles amongst the 32 participants, to be able to evaluate the usefulness of the training across the homelessness sector.

These included:

- Staff at local homeless resource and day centres including Providence Row's The Dellow Centre; Spitalfields Crypt Trust and Whitechapel Mission

[7] http://groundswell.org.uk/wp-content/uploads/2018/03/My-Rights-to-Access-healthcare-card-guidance-updated-version-20-11-17-1.pdf

- The Street Outreach Team (St Mungo's)
- Groundswell Homeless Health Peer Advocates, working in Tower Hamlets
- Hostel key workers in the borough's hostels (run by Providence Row Housing Association, Look Ahead and the Salvation Army).

Members of the Project Working Group had informal conversations about the training with their contacts in each of these organisations and an email was sent out to service managers 4 weeks before the training with information on how to sign up. Reminders were sent out on a weekly basis and the pilot was also promoted at the borough's Hostels Single Homeless Forum on 22 May 2018.

Participants signed up for the training online through the Tower Hamlets Community Education Provider Network website. The training was not advertised as such on the website and instead a link which took users directly to the event page was sent to all target participants. This was to avoid confusion with the general MECC training on offer, and to ensure that the staff attending the Homeless Health MECC pilot training were from the local workforce working with homeless people.

## 4. Evaluation methods

### 4.1 Pre- and post-session questionnaire

Following the format of the general MECC training, participants were asked to complete a brief questionnaire at the start of the training and a second questionnaire immediately afterwards. These were answered anonymously. Three of the questions were the same in both questionnaires, to allow analysis of the impact of the training on participants' knowledge and confidence around the health issues affecting homeless people and delivering brief interventions on health topics.

Please see **Appendices 1 and 2** for a copy of the questionnaires.

### 4.2 Post session evaluation discussion

The intention was to ask participants a series of discussion questions at the end of each training session to gather additional feedback for the evaluation. As noted above, the timings of the sessions meant that it was only possible to have a 10 minute conversation with 7 participants who were happy to stay behind at the end of the afternoon session. This focussed on whether they felt that the training had been useful for them in their roles and whether they could think of any improvements that should be made to either the Handbook or the training itself. As the full discussion had not been possible, all participants were emailed the additional questions in case they had, had any additional thoughts following the training. Two responses were received. It should be noted that some feedback relevant to these additional discussion questions came out during the training itself. Where comments were made on these topics at any point, these have been incorporated into the feedback below, alongside the results of the pre- and post-session questionnaires.

Please see **Appendix 3** for the additional discussion questions.

### 4.3 Feedback from trainers

The two trainers were emailed immediately after the session and asked for their feedback on the training. Both trainers responded and their comments have been included in the feedback below.

### 4.4 Analysis

The questionnaires had both quantitative and qualitative components, with many of the questions asking for free text responses. Where possible, common themes in the qualitative questions have been grouped and turned into quantitative data, with quotes selected to illustrate some of the points raised.

## 5. The training participants

The training was fully booked but on the day only 28 out of the 32 people turned up. 7 organisations were represented amongst the trainees:

- Groundswell
- London Borough of Tower Hamlets (LBTH)
- Look Ahead
- Providence Row Housing
- Providence Row Charity
- Salvation Army
- St Mungo's.

Participants included a range of professionals working with the homeless, including:

- Hostel Support Workers
- Substance Misuse Workers
- Anti-Social Behaviour Investigation Officers
- Outreach Team
- Homeless Health Peer Advocates
- Social Workers
- Independence Planners
- Training and Enterprise Co-ordinators
- Welcome Area Assistants
- Personal Advisers
- Programme Coordinators.

This shows that the pilot met its intention of reaching a range of organisations and job roles across the homelessness sector. In fact, the range was wider than anticipated due to the breadth of participants on the borough's Hostels Single Homeless Forum, for example including trainees from the Anti-Social Behaviour Team and Reablement Service at LBTH.

## 6. Participant feedback

This section provides an overview of the feedback participants provided on the training received. 26 of the 28 participants completed the pre-session questionnaire and all participants completed the post-session questionnaire. One post-session questionnaire was only half answered but the answers that were given have been included in the analysis.

### 6.1 Reported changes in participants' knowledge, skills and confidence as a result of training

In both the pre- and post-session questionnaires, participants were asked to rate their knowledge of the health and wellbeing issues which affect homeless people, and their knowledge and confidence

of how best to apply brief interventions related to health and wellbeing on a scale of 0-10, where 0 is the lowest and 10 is the highest. **Figure 1** shows that participants' knowledge and confidence in these areas increased as a result of training, demonstrated by an improvement in average scores and a shift in the minimum scores given by participants from 1 to 6 out of 10.

**Figure 1: Changes in knowledge and confidence around the health and wellbeing issues which affect homeless people and how best to apply brief interventions**

| Topic of question | Pre-session scores | | Post-session scores | | Improvement in average score |
|---|---|---|---|---|---|
| | Average | Range | Average | Range | |
| Participants' knowledge of the health and wellbeing issues which affect homeless people | 6.6 | 1-10 | 8.1 | 6-10 | 1.6 |
| Participants' knowledge of how best to apply brief interventions related to health and wellbeing | 5.7 | 1-9 | 8.1 | 6-10 | 2.4 |
| Participants' confidence of how best to apply brief interventions related to health and wellbeing | 6.0 | 1-10 | 8.4 | 6-10 | 2.4 |

In the post-session questionnaire, participants were asked the extent to which they agreed with a series of statements about their confidence in raising health and wellbeing issues with clients and signposting them to support, and their skills in helping clients to make changes which impact on their health and wellbeing. **Figure 2** shows that the majority (at least 85%) felt that they had more confidence and improved skills in these areas following training.

**Figure 2: Self-reported changes in confidence and skills in supporting clients to improve their health and wellbeing**

| Statements | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree | Number and % agreeing/ strongly agreeing |
|---|---|---|---|---|---|---|
| As a result of this training I feel more confident in raising health and wellbeing issues with clients | 1* | 1 | 1 | 11 | 13 | 89% (24) |
| As a result of this training I feel more confident to signpost clients appropriately to support services | 1 | 1 | 2 | 9 | 14 | 85% (23) |
| As a result of this training I feel I have better skills to help clients to make changes to impact their health and wellbeing | 1 | 0 | 2 | 12 | 12 | 89% (24) |

*It should be noted that the person who put 'strongly disagree' rated all responses in this question similarly but at the same time rated the question on training content as 'excellent' in all areas and gave very positive comments in the feedback. It is possible that the scale construction may have been overlooked by the

respondent: in the question on training content, the answer options range from 'Poor' to 'Excellent' whereas in this question the options were placed in reverse order, namely 'Strongly Agree' to 'Strongly Disagree'.

## 6.2 Reflections on the importance of promoting health and wellbeing and the relevance of the training to participants' roles

In the post-session questionnaire, participants were asked the extent to which they agreed with a couple of statements about the importance of promoting health and wellbeing and their intention to do more of this as a result of training. The data in **Figure 3** demonstrates that promoting health and wellbeing with clients is important to this cohort of trainees and that as a result of training the majority of participants intend to promote health more often with clients when the opportunity presents itself.

**Figure 3: Reflections on the importance of promoting health and wellbeing with clients and intentions to do this more often as a result of training**

| Statements | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree | Number and % agreeing/ strongly agreeing |
|---|---|---|---|---|---|---|
| It is important for me to promote health and wellbeing with clients when the opportunity arises | 1* | 0 | 0 | 7 | 19 | 96% (26) |
| As a result of this training I intend to promote health more often with clients when the opportunity presents itself | 1 | 0 | 2 | 10 | 14 | 89% (24) |

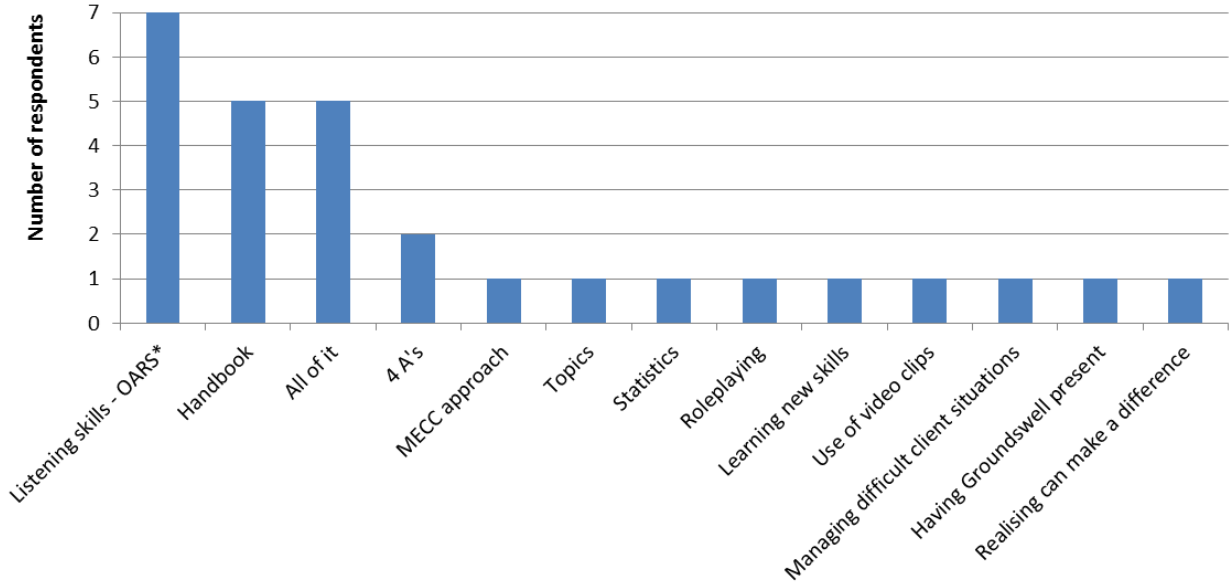
*It should be noted that the person who put 'strongly disagree' rated all responses in this question similarly but at the same time rated the question on training content as 'excellent' in all areas and gave very positive comments in the feedback. It is possible that the scale construction may have been overlooked by the respondent: in the question on training content, the answer options range from 'Poor' to 'Excellent' whereas in this question the options were placed in reverse order, namely 'Strongly Agree' to 'Strongly Disagree'.

The seven participants who attended the post-session evaluation discussion felt that the training was relevant to their roles, as did the two who emailed a response to the evaluation questions after the training. One commented that there were no set qualifications for being a hostel key worker and that training such as this was important in up-skilling staff.

## 6.3 What participants found most useful in the training

In the post-session questionnaire participants were asked to comment on the aspects of the training they found most useful. Responses were received from 23 participants and these are outlined in **Figure 4**. Five participants comment they found all of it useful. Where particular elements were cited, the most frequent were the content around listening skills and also the Homeless Health Handbook.

**Figure 4: Reflections on what participants found most useful in the training**




*Note the OARS stand for – Open questions, Affirmations, Reflective Listening and Summarising.

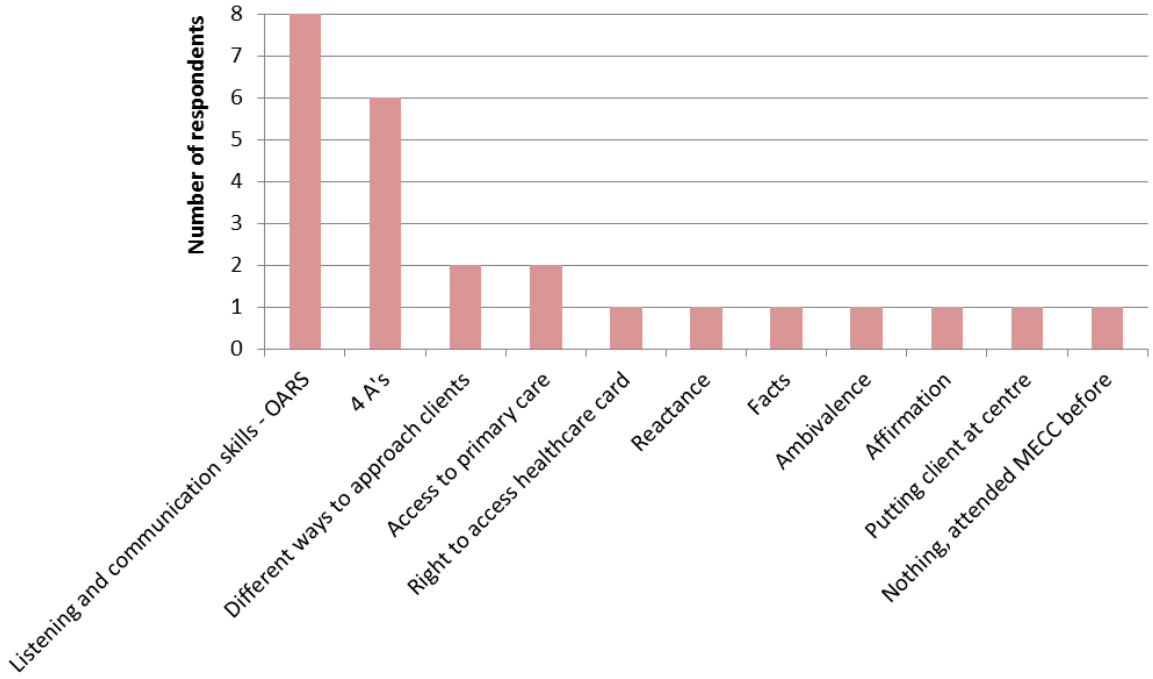
Some quotes from participants:

- *All of the training was useful but the MECC approach I found most useful. It was very interactive/ engaging*
- *The training, trainer and resources provided up to date approaches, case studies to give customers better support*
- *Though the handbook with health information wasn't much discussed in training the handbook is an amazing tool to have in our office for all to access and not to have to feel intimidated by health issues that we don't know everything about but a working document to always reference to. Think equally with having the information on how to communicate to be able to get the information to put the support in place*
- *Learning to listen to clients more, giving them more time.*

## 6.4 What participants learned that was new

In the post-session questionnaire participants were asked to comment on what they had learned that was new. Responses were received from 21 participants and these are outlined in **Figure 5**. Once again, listening skills came out most strongly, cited by 8 participants, followed by the 4 A's of the MECC conversation. Others cited related elements of behaviour change theory covered by the training – reactance, ambivalence and affirmation. Given the challenges faced by homeless people in accessing health services, and the emphasis within the training on supporting clients to access the right care at the right time, it is positive that a couple of participants also citied that they had taken away new learning around this.

**Figure 5: Reflections on what participants learned that was new in the training**




Some quotes from participants:

- *Moving a conversation to a topic. Talking about what they want to talk about*
- *Highlighted the importance of listening and how we react is often the barrier as well as the barriers in accessing the services. Kind of like the root of issues*
- *New approaches towards working with ambivalent clients*
- *Clients can register with the GP with no address and ID.*

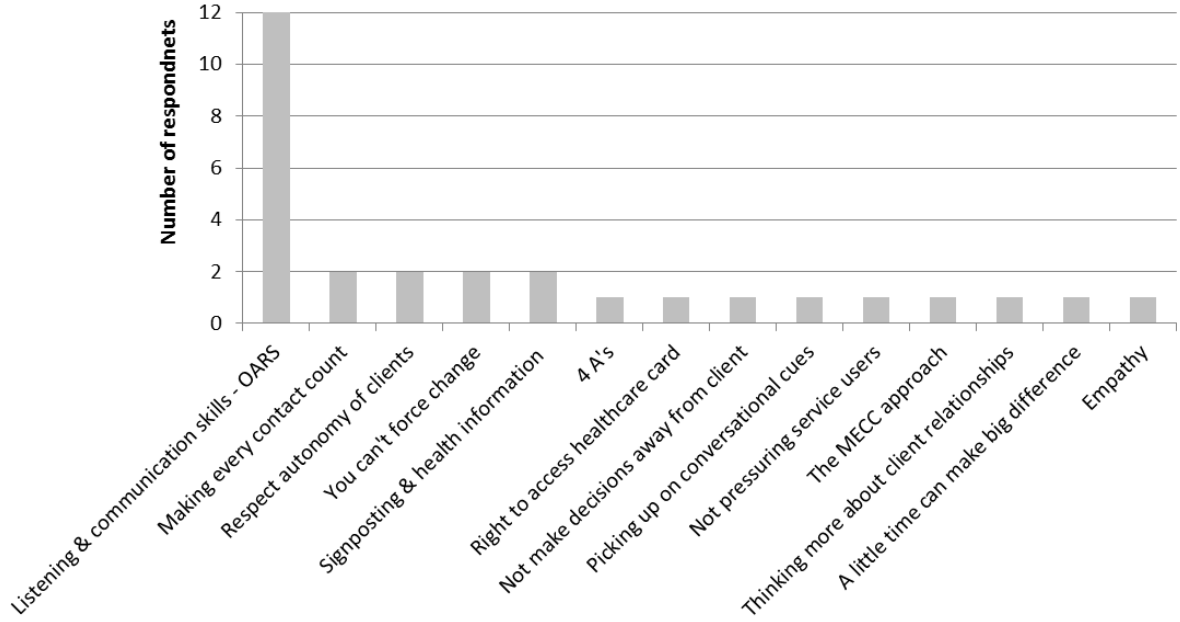
### 6.5 The key messages that participants will take away from training

In the post-session questionnaire participants were asked what key messages they would take away from the training. Responses were received from 22 participants and these are outlined in **Figure 6**. As with the other questions, although a variety of key messages were cited, listening and communication skills came out as the strongest learning point.

Some quotes from participants:

- *Not to pressure a service user, but to pick up on opportunities to talk about health and encourage them to address it*
- *Listen more without asking questions*
- *Ask the person to talk about [the issue] so they can hear themselves out loud and may come up with their own solutions*
- *Not to assume what people are saying/ meaning*
- *Both information and communication needs to be prioritised in order to support and break barriers, which is often key in people's health being neglected*
- *Communication is the key to positive engagement and to actively listen so all feel heard and valued*
- *Trying to see and understand that we cannot push someone to change*
- *Information to signpost/ understand multiple health problems that affect homeless people.*

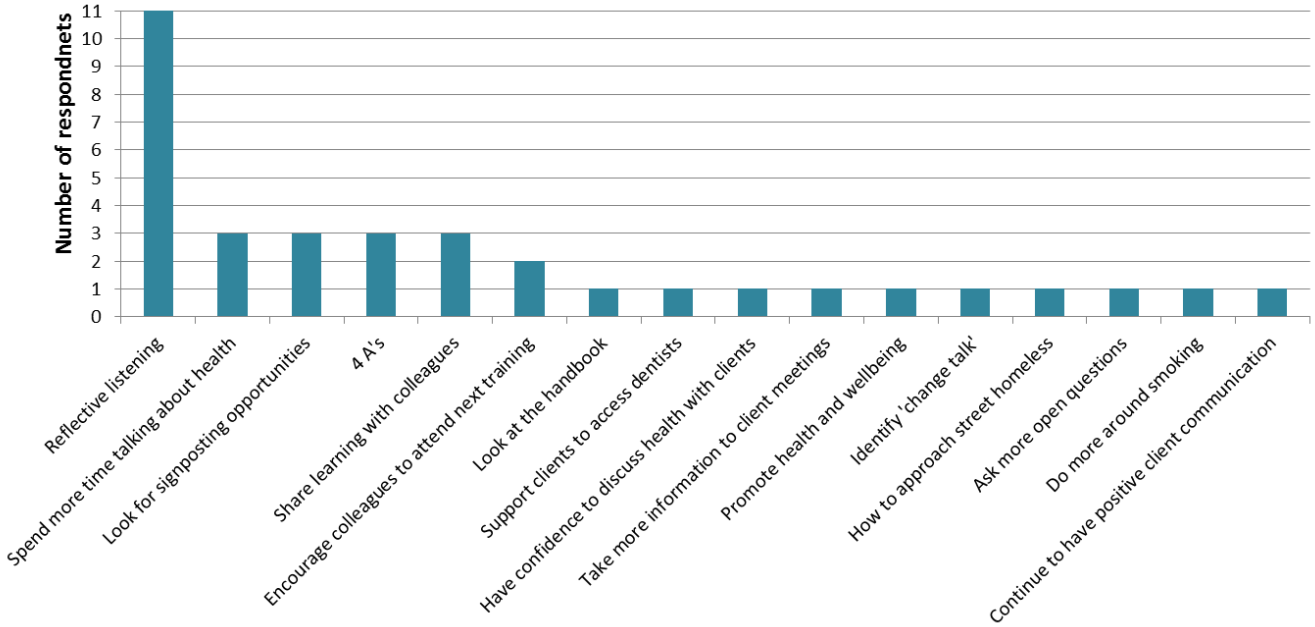
**Figure 6: Reflections on what key messages participants will take away from the training**




## 6.6 Things participants agreed to action as a result of training

In the post-session questionnaire participants were asked to name two things they would action as a result of the training. Responses were received from 22 participants and these are outlined in **Figure 7**. A range of actions were cited, the most common again being around their listening and communication skills. Three participants commented that they would spend more time talking about health with their clients. Three said they would share their learning from the training with colleagues and two would encourage colleagues to attend future training sessions.

**Figure 7: Actions participants agreed to do following the training**



Some quotes from participants:

- *1) Hand out the booklet and feedback training to the rest of the team 2) I will change and work on some of the phrases I use and input the 4 A's strategy*
- *Give more time to clients. Focus more on their health problems*
- *When you see someone in the street how can one implement support at that time to a homeless person? – I have now acquired the knowledge from Providence Row staff who have told me what I need to do.*

The third quote above highlights the value of inter-professional learning, in providing opportunities for staff to share knowledge and experience and understand each other's roles.

## 6.7 Perceived barriers to implementing MECC at work

Although this information was not collected formally as part of the evaluation (due to there not being time to complete the post-session evaluation discussion) three potential barriers to implementing MECC were voiced during the training itself. The first was from the representatives from the Anti-Social Behaviour Team, regarding how a client-led approach, which recognises that clients will only change when they are ready to change, does not neatly fit with the team's responsibilities around enforcement and issuing court orders around anti-social behaviour. The group discussed that MECC is not an approach which will work in all situations but that the way we communicate with clients can make a difference, which may bring about change over a longer period and facilitate positive working relationships in the shorter term.

The second barrier raised was around the services homeless clients are signposted to and how they may be treated by them, given what we know about the barriers faced by some clients in accessing health services. The recommendations around training from the Health Scrutiny Review noted above, were discussed and the hope that these would complement the MECC training programme to reduce these barriers over time. This will also be supported by the wide-scale distribution and promotion of 'My right to access healthcare cards' by Groundswell and the Healthy London Partnership.

The third barrier raised was around the restrictions on time some services have in consultations with clients and the other demands on that time to meet different service objectives. This was in view that the MECC approach was not designed to be a 'tick-box' exercise but instead was intended to be client-led, for which some flexibility was needed to allow conversations to evolve spontaneously when the opportunity presents. It was, however, recognised by participants that a MECC conversation was supposed to be brief and no-longer than 5 minutes. Participants also cited the importance of having colleagues undertake the same training, as well as service managers, so that the MECC approach could be built into 'business as usual' for services in a more sustainable way.

## 6.8 Feedback on training contents and improvements to training

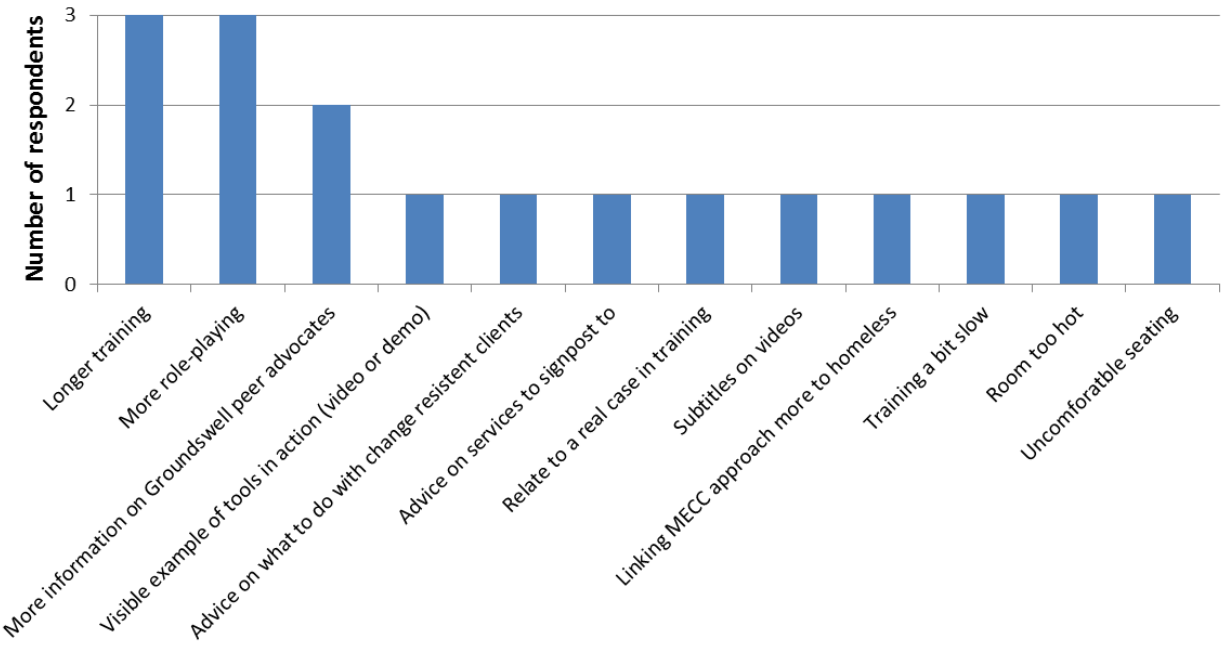
In the post-session questionnaire, participants were asked to rate elements of the training content on a scale from poor to excellent. As **Figure 8** shows, all of the elements were considered by participants to be either satisfactory or better, with the majority (75%) finding the contents very good or excellent.

**Figure 8: Feedback received on the different components of the training**

| Components of the training | Poor | Satisfactory | Good | Very Good | Excellent |
|---|---|---|---|---|---|
| Introduction to Making Every Contact Count | 0 | 2 | 5 | 7 | 14 |
| Health issues which affect homeless people | 0 | 0 | 7 | 7 | 14 |
| Overview of the homeless health MECC handbook | 0 | 0 | 4 | 9 | 15 |
| Listening Skills | 0 | 0 | 2 | 12 | 14 |
| The 4A's (Ask, Advise, Assess & Assist) | 0 | 1 | 4 | 10 | 12 |
| Role play opportunities | 0 | 1 | 5 | 11 | 11 |

Participants were also asked to comment on what they felt would improve the training. Nine respondents left this question blank and a further six said there was nothing they felt would improve the training. The suggestions for improvements made by the remaining 15 participants are shown in **Figure 9**.

**Figure 9: Suggestions made for how the training could be improved**




Some quotes from participants:

- *Linking the homeless angle to the second part of the training*
- *Little highlight regarding deaf awareness as a hard of hearing staff member. Both audios used song and video and did not have subtitles therefore could not comment on those activities. Subtitles are good practice as not just hard of hearing people benefit from them and easy to input*
- *More information on Groundswell in the presentation, their location, referral process.*

Having a longer training and more role-playing opportunities were the most frequently cited improvements. These are also comments which are frequently raised in the feedback about the 'general MECC' training. Whereas in the design of this training an attempt was made to factor in more time for participants to practise having a MECC conversation, due to the late running of the first pilot session and the fact that this was the first time the trainers had delivered the training in this way, this did not happen on the day. This is, however, something it is recommended is prioritised in the delivery of future sessions.

Having a visible example of a MECC conversation 'in action' was something raised in both the questionnaires and in the post-session discussion, for example through a role-play demonstration during the training or a pre-recorded video. This was felt to be a good way to show the Homeless Health Handbook being used. Another suggestion made in the post-session discussion was including a 'success' story of where the MECC approach had been used with a homeless client, and had led to a positive impact. This is also something which should be considered for future sessions.

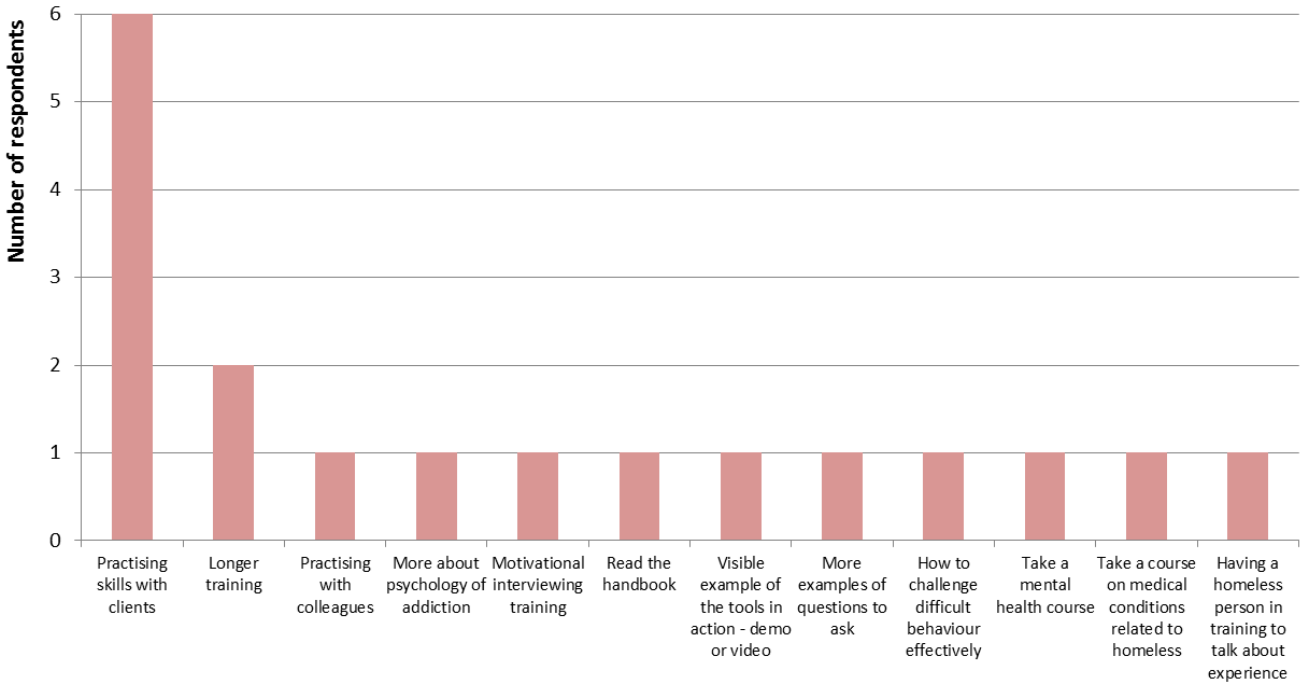
The training was structured so that the overview of homeless health came before the introduction to the MECC approach to behaviour change. One participant mentioned that the MECC approach section would benefit from having more of a homeless health link. This was also a reflection made by the trainers. One way to improve this would be to have a role-play demonstration, based around one of the health topics in the Homeless Health Handbook included as part of the training, as suggested above. The other would be to encourage participants to look at the Handbook in advance of the training and be prepared to use it as part of their practise during the session. Whereas participants were sent an electronic version of the Homeless Health Handbook by email prior to the training, this ended up being only circulated three working days before the training. In future sessions, it would be beneficial to send this out at least a week prior to training and provide more specific instructions for participants by way of course preparation to allow them to familiarise themselves with the material in advance: for example asking them to familiarise themselves with the structure of the Handbook and read two health topics, one that they are familiar with and one that is new to them, which they could choose to use within the training session.

During the training a couple of participants unfortunately made stigmatising comments, which may have offended others in the room. The trainers handled the situation during the training but reflected afterwards that future sessions would benefit from setting a learning agreement at the start, eliciting items from the participants and adding to the agreement should it be necessary, to ensure that areas such as being respectful, are included. This is important given both the experiences staff being trained may have had through working with clients or lived experience of homelessness themselves and the sensitive nature of some of the topic areas covered, for example suicide.

### 6.9 Support participants would like to further develop the skills learned in training

In the post-session questionnaire participants were asked what they thought would help them to further develop the skills they had learned in this training, so they could use them in their daily practice. Responses were received from 16 of the participants and these are outlined in **Figure 10**. The most common thing cited was to practise what they had learned in interactions with their clients. One also felt practising with colleagues would help. A couple wanted to attend further training on related topics such as motivational interviewing or a course around health, particularly health issues which impact the homeless population.

**Figure 10: Ideas for what would help participants to further develop the skills learned in training**




Some quotes from participants:

- *I think the training gave enough of this and the rest is practice and putting it into play*
- *[Practise] asking the right sorts of question to the person so they can start thinking for themselves if they want to accept help*
- *A whole MECC day.*

## 6.10 Other comments

In the post-session questionnaire participants were asked if they had any other comments. 13 responses were received, outlined below:

- *Thanks*
- *Great talk*
- *No, great training, thank you*
- *Well presented*
- *It was useful*
- *It was really good and informative*
- *Well done and thank you. I enjoyed the training*
- *Enjoyed the trainers*
- *Very interesting and engaging trainers.*
- *This was a very beneficial training. Trainers make the training equally good as well as the information given. Thank you.*
- *Community dentists will do home visits if client cannot access easily*
- *I would like more on professionals having the right attitude/ behaviour – that gives out positive vibes for others to encourage, like being caring!*
- *Trainers were great. They are both engaging trainers. I thoroughly enjoyed the course. However I have concerns whether those who contribute to making courses like these a success really practice what they preach.*

This last point highlights something which is recognised within the general MECC programme: the importance of embedding the MECC approach within whole organisations, through having whole teams, including managerial staff, trained and for MECC to be embedded within job descriptions and reporting systems, to ensure a shift-change in the way we interact with service users around health issues and to support frontline staff to maintain their skills following training.

## 7. Summary

The Homeless Health Making Every Contact Count programme has been designed as a bespoke training package to meet the needs of staff working with homeless people within Tower Hamlets. Although the training around the 'MECC approach' is very similar to the 'general MECC' training programme on offer, the health topics have been substantially expanded and changed. There is no other similar initiative available in the borough and this training complements other training planned for frontline workers working with homeless people in the borough, recommended by the recent LBTH Health Scrutiny Review.

Participants in the pilot came from a range of different roles and organisations across the homeless sector. Their feedback on the training they received was very positive. Participants enjoyed the training and found the content relevant for their roles. They reported increased knowledge, skills and confidence around promoting health and wellbeing following training and intend to give more support to their clients around health issues as a result. The comments received also demonstrate that they benefited from learning in a multi-disciplinary forum, which gave opportunities to understand each other's roles.

The evaluation has shown that the training represents a valuable addition to support available for staff working with homeless clients locally and it is recommended that the programme continues. Participants and trainers involved in the pilot made a few suggestions, however, for how the programme could be improved, which have been incorporated into a series of recommendations outlined in **Section 8.**

## 8. Recommendations

### Expanding pilot

1. It is recommended that the Homeless Health Making Every Count Programme in Tower Hamlets continues and that potential funding streams are investigated to allow this to happen.
2. It is recommended that the local homeless support services and their staff are mapped to understand who should be included in future training sessions.
3. It is recommended that members of the Project Working Group work with colleagues at the CCG and LBTH responsible for taking forward the training recommendations from the recent *Scrutiny Review of Health & Social Care Provision for Homeless Residents* to ensure that any potential synergies between Homeless Health MECC training and other training for frontline staff around homelessness are recognised.

### Changes to the training

4. It is recommended that the half-day format of training continues, as a compromise between staff time out of work and the time needed to cover the necessary material. However, it is recommended that the training time is expanded by 30 minutes to allow for additional role-playing opportunities.

5. The pilot training worked well having one trainer with expertise around homeless services and homeless health and another with expertise around behaviour change. If in future only one trainer delivers the training, consideration should be given as to how the training package itself could be strengthened to ensure that the experience of homeless people and the expertise of staff delivering services to homeless people is incorporated, without necessarily needing the trainer themselves to bring these to the delivery of the training. Participants attending the pilot training felt it would be useful to include a 'success' story of where the MECC approach had been used with a homeless client, and had led to a positive impact.
6. It is recommended that an electronic copy of the Homeless Health Handbook is sent out to participants at least a week prior to training (in addition to giving them a hard copy on the day). In preparation for the course, participants should be asked to familiarise themselves with the structure of the document and have read through two of the topics, one that they feel more familiar with, and a second that is less familiar, so that they can use these as part of the practice exercises during the training.
7. It is recommended that there is at least 45 minutes-1 hour at the end of the training session to allow the trainer to do a 'role-play' demonstration and for participants to practise having a full 'MECC conversation' at least twice in pairs, with support from the trainer. This would allow them to practise conversations around at least two different health topics.
8. Consideration should be given to filming a 'MECC conversation' on a homeless health topic which could be incorporated into future training sessions.
9. It is recommended that participants are asked to set their own learning agreement or 'ground rules' at the start of the session, ensuring that behaviours such as being respectful are covered. It is also important for participants to be reminded that some sensitive material may come up in discussion given that the Handbook covers topics such as suicide and to be mindful of other people's personal experiences either of homelessness or working with vulnerable homeless clients.
10. If using video clips within the training content, consideration should be given to adding subtitles to ensure that participants who are hard of hearing are able to participate.
11. It is recommended that additional information is added to the training slides around how to refer to the Groundswell Homeless Health Peer Advocacy Service and their location.
12. It is recommended service managers as well as frontline staff are encouraged to come on the training to support a whole team and whole organisation approach to supporting clients around health issues.

## Changes to the training resources

13. Feedback from participants on the structure and contents of the Homeless Health Handbook was very positive. It is recommended that this continues to be used and updated as relevant. It is recommended that funding to have the Handbook professionally designed and printed is built into any future business case for funding.
14. If available, it is recommended that participants continue to receive a 'My right to access healthcare' card to take away after training.

## Evaluation

15. It is recommended that the same pre- and post-session evaluation questionnaires are used in future training sessions, as they provided useful feedback. This will also allow comparisons to be made across time.
16. Consideration should be given to running a follow up survey with participants 2 months after completing training to see how MECC has been used in their work and their thoughts on the Homeless Health Manual, and to evaluate the impact over a longer time period.

## Future ambitions

17. It is recommended that members of the Project Working Group work with organisations who have had staff trained in MECC, to embed the approach and health promotion in general within their workplaces. For example, this might include ensuring that the environment for staff and service users is health promoting and that MECC is included within job descriptions and reporting systems.
18. It is recommended that further scoping work is undertaken to consider whether this programme could be expanded London-wide in the future.

**9. Appendices**

**Appendix 1**

# Homeless 'Making every contact count' (MECC) training Evaluation Form

## Pre-course questionnaire

**Date of training:** **Role:** **Organisation:**

We would like your feedback to enable us to improve future planning and delivery of training. We are also interested to find out about your views of the training session, what you have learnt and what you might do as a result of attending. Please answer the following questions as **honestly and instinctively** as possible.

**Before you start the session can you please complete the 3 questions below based on your current knowledge, confidence and understanding around applying brief interventions related to health and wellbeing.**

**On a scale of 0 - 10 please score your knowledge of the health and wellbeing issues which affect homeless people:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

**On a scale of 0 - 10 please score your knowledge of how best to apply brief interventions related to health and wellbeing:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

**On a scale of 0 - 10 please score your confidence of how best to apply brief interventions related to health and wellbeing:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

**Appendix 2**

# Homeless 'Making every contact count' (MECC) training Evaluation Form

## Post-course questionnaire

Now that you have undertaken the training, please complete the below questions

**On a scale of 0 - 10 please score your knowledge of the health and wellbeing issues which affect the homeless after the course:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

**On a scale of 0 - 10 please score your knowledge of how best to apply brief interventions related to health and wellbeing after the course:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

**On a scale of 0 - 10 please score your confidence of how best to apply brief interventions related to health and wellbeing after the course:** (where 0 is the lowest and 10 is the highest)

1 2 3 4 5 6 7 8 9 10

Please rate the training content on the following areas by ticking the appropriate box, using the rating scale below:

1 = Poor 2 = Satisfactory 3 = Good 4 = Very Good 5 = Excellent

| TRAINING CONTENT | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Introduction to Making Every Contact Count | | | | | |
| Health issues which affect homeless people | | | | | |
| Overview of the homeless health MECC handbook | | | | | |
| Listening Skills | | | | | |
| The 4A's (Ask, Advise, Assess & Assist) | | | | | |
| Role play opportunities | | | | | |

**Please read the following statements and tick the appropriate box**

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|---|---|---|---|---|---|
| **Importance**<br>It is important for me to promote health and wellbeing with clients when the opportunity arises. | | | | | |
| **Intention**<br>As a result of this training I intend to promote health more often with clients when the opportunity presents itself. | | | | | |
| **Confidence in raising the issue**<br>As a result of this training I feel more confident in raising health and wellbeing issues with clients. | | | | | |
| **Increased skills**<br>As a result of this training I feel I have better skills to help clients to make changes to impact their health and wellbeing. | | | | | |
| **Confidence in signposting clients to support services**<br>As a result of this training I feel more confident to signpost clients appropriately to support services. | | | | | |

**What did you find most useful about this training?**

**What did you learn that was new?**

**What are the key messages you will take away from this training?**

**Please state 2 things that you will action as a consequence of the training:**

**What would help you further develop the skills you have learned in this training so you can use them in your daily practice?**

**Are there any changes we could make to improve the training?**

**Any other comments?**

**Appendix 3**

**Questions for post-session evaluation discussion**

1) **What did you think of the relevance of the MECC approach to your role?**

2) **What barriers (if any) can you foresee to implementing MECC at work?**

3) **Do you have any comments on the manual and how we could improve it?**

4) **Do you have any comments on the training itself?**

5) **Do you have any comments on how the training was promoted and how we could encourage participation in future?**

6) **Can you think of staff groups who would benefit from this training?**