

**NHS MECC REVIEW**

Pan London

November 2017

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# Key Facts

# Infographic of high level data from survey

Use data in progress table below

# Executive Summary

|  |  |
| --- | --- |
| Progress & achievements so far:  * MECC is recognized as a priority across the London Sustainability and Transformation Plan * All 5 STP have identified champions and there is evidence that there is STP lead on developing and coordinating MECC across London * Behaviour change training is a priority across London. * 7 CCGs, 5 CEPNS, 7 Acute & Tertiary Trusts, 9 Community Trust Providers & 4 Mental Health Trust Providers are leading MECC training * Aiming to provide MECC training to at least 8,300 Health and Social care staff through NHS organisations by March 2018 * All three Health Education Teams have commissioned MECC training programmes. * Community Pharmacy Scheme has achieved good attendance | Top priorities & actions for the future:  * Encourage full cooperation across all NHS and Public Health leads. * Additional support is needed to raise profile of MECC across CCGs, Acute and Community Trusts * Explore the role and links to wider behaviour change training such as Social Prescribing, Health Coaching and PHASE training as an enabler to raise profile of MECC * Explore economies of scale to develop cultural, environmental and infrastructure resources. * Support consistency and sustainability of MECC across London. |
| Support Needed: Participants who took part in this mapping project welcomed support in the form of:   * There is a need to raise the profile and benefit of MECC across NHS Trusts and CCGs and Make MECC a part of every organisations business policy. * Additional support to keep MECC programmes sustainable * Develop communications and resources to improve MECC but also encourage senior management buy in. * Create a solution to record MECC activity on health and social care systems * Unify and deliver the same MECC message, continuity of information and avoid duplications | |
| Recommendations:  * There are opportunities to improve links and consistency with the Local Authority/ Public Health MECC programmes and HEE national guidance * Explore if there are opportunities to influence routes and access to training, such as pan London CQUIN or agreement to include MECC as a mandatory requirement through commissioning. * There are Cost Benefit Analysis and Return on Investment tools that provide a template to evaluate and support business case development for MECC * Health Education South London have a strong commitment to support development of Community Education Provider Networks – these could be explored as a vehicle and an enabler for MECC training. * There could be further engagement with the Academic Health Science Network to develop the evaluation components and New Models of Care and Vanguards for cardiovascular disease and cancer with the aim of prioritizing MECC within the NHS workforce * There could be further engagement with the front of house pharmacy teams could be an asset . * Develop a shared platform for resources, tools, directory of services and e-learning | |

# Background

The impetus for this project arises in 2016, from the Association of Directors of Public Health’s (ADPH) London Sector Led Improvement (SLI) programme that looked into childhood obesity. An action arising from this was to “*map MECC programmes across London with a view to adding value for money by sharing resources”*.

The mapping was undertaken in 2016 and aimed to review MECC provision across NHS, Local Authorities, community and voluntary sectors. This would help identify priorities, support required and opportunities for collaboration.

The review encapsulated the majority of activity undertaken across public health and Local Authorities and made several recommendations. As part of these recommendations, it was proposed that a strategy or steering group be established to develop pan London MECC opportunities over the coming years.

Healthy London Partnership, ADPH London, PHE London, London Councils and the Academy of Public Health initiated the Making Every Contact Count steering group in January 2017. The group aims to continue building momentum through the creation of strong partnerships and plans to support the delivery of MECC in London, as part of making health and wellbeing and prevention an important part of everyone’s business.

The MECC Steering Group has developed the following strategic aims for London:

* To provide a consolidated view of what MECC is and what it can achieve
* Develop organisations committed to providing the leadership, environment, culture and tools to have health and well-being conversations
* Deliver an informed and empowered workforce who are motivated, confident and competent to have conversations about health and well-being
* Develop an informed and empowered population who know how to seek support and take action for their health and well-being

To achieve these aims the MECC Steering Group has developed the Healthy London Partnerships Workplan (HLPW) for 2017-18

Working in partnership with key stakeholders, four key activities will form the Health Promoting Places and Making Every Contact Count Programme

* Creating a social movement for Health Promoting Places and MECC across London
* Sharing learning and supporting innovation
* Developing and enhancing tools to support implementation
* Supporting evaluation and building the evidence for impact

As noted in ADPH MECC Briefing for London, there is not a coordinated and strategically planned focus on how MECC can be systematically rolled out to the NHS work force. Given the range of different NHS organisations that could, or do, deliver MECC, there is a challenge to develop a consistent and sustainable approach for MECC training. These include how to deliver core skills; how to link with appropriate continuing professional development that is outlined as a learning pathway; is flexible enough to be incorporated into new job roles; and can show measurable impact.

In order to appraise the most relevant options and opportunities, the MECC Steering Group commissioned an NHS MECC Review that will support the development of shared resources, best practice, learning and tools and will highlight innovations, gaps and opportunities.

# Purpose of this Project

DALHP, through the steer of the Healthy London Partnership and maintaining consistency with the ADPH MECC Mapping Report, will focus on the:

* Identification and review of existing and best practice examples and evidence of MECC based on the HLP definition and 5 core topics for Very Brief Advice (VBA) across NHS sites in London.
* Collation of a suite of good practice tools and resources based on culture, environment, skills training and infrastructure (including levers)
* Creation of a map and gap analysis Of MECC activity across NHS organisations to support STP MECC projects
* Collate best practice and gaps in MECC evaluation

# Project Timescales

This project was carried out between August 2016 and October 2016

# Limitations

In line with the ADPH MECC London Stocktake, this document records a snapshot in time. The primary focus is on MECC related activities in NHS organisations, such as Clinical Commissioning Groups, Community Provider Trusts and Acute Hospital Trusts and therefore does not comprehensively report on updates of activity through Local Authority and Public Health Teams.

# Methodology

In conjunction with Healthy London Partnership a series of potential interview questions were developed that would be concordant with the ADPH London Stocktake and meet specific HLP aims of exploring how to embed MECC into NHS culture, environment and infrastructure. These were agreed and ratified by the MECC Steering Group.

The NHS structure across London presents a complicated picture of organisations spanning a range of different responsibilities and requirements. A base line map of providers was established who may be directly involved in the delivery of MECC, have staff trained in this approach or be strongly linked to a related communication skills training strategy. These included:

* London CCGs
* London Community Education Provider Networks
* London Community Provider Trusts
* London Acute Hospital Trusts
* Sustainable Transformation Plan leads
* Community Pharmacists
* Sector wide groups
* Pan London groups
* London education stakeholders such as HEE

Engagement of the stakeholders and organisations identified above will be critical for the key success of this project. A single engagement methodology would not be effective therefore a variety of formats will be deployed, such as face to face, easy access, on-line or dial in.

An e-mail communicating the aims and outline of the survey was sent to STP leads and previous MECC stakeholders. This was followed by an e-mail shot to learning and development leads in NHS services. A snow balling exercise was undertaken to distribute the survey request by contacting STP leads, Learning and Development Leads, HEE contacts, Public Health contacts, Local Pharmacy Committees and related charities.

Key leads were identified and initial interviews were sought. The interviews were either face to face or by telephone and would last between 30 to 60 minutes. The interviews were transcribed and incorporated into an agreed case study format. Participants would be able to view the case study and amend before final circulation. However, for the interim report the case studies are included as drafts.

Where stakeholders were unable to take part in an interview, there was an opportunity to respond via an on-line question set hosted by the Smart Survey system.

If an NHS Organisation was identified as not responding, or only partially completing the survey, the learning development or main contact will receive a proactive telephone call to definitively record if MECC is being provided at their Trust.

The Healthy London Partnership have developed a definition and quantified which aspects of MECC training should be included. This sets MECC within the context of a model, pathway or place that is health promoting. The definition provided is:

**‘’MECC is a behaviour change approach that encourages positive health and wellbeing choices through individual, organisational and environmental interactions. It involves enhancing, identifying and acting on the opportunities to engage people in conversations about their health in a respectful way, to help them take positive action to improve their own health and wellbeing.’’**

The five core areas are:

* Smoking
* Alcohol use
* Physical activity
* Healthy Eating
* Mental Health & Well-being

Within the interviews and on-line survey the definition of MECC is not provided; therefore there is an opportunity to assess how correlated existing provisions are with this definition.

PHE and Health Education England have provided a comprehensive tool through their MECC Quality Training Framework and Evaluation Framework. These documents will provide a rating example of existing practice and where improvements in evaluation and quality assurance can be made.

Where there are examples of best practice, strong evaluation or replicable resources, the providers were asked if they would be prepared to share examples of these. As interviews progressed, a note was made of which training providers were used. This would form a MECC resource section and a training provider directory.

As part of the project an updated literature review of MECC literature is being carried out and the evidence will be explored to determine if a systematic review of effectiveness within health organisations can be completed.

1. **Summary of MECC activity**

## Scale of MECC activity

MECC is being implemented through:

* 7 CCGs
* 5 CEPNS
* 7 Acute & Tertiary Trusts
* 9 Community Trust Providers
* 4 Mental Health Trust Providers
* All 5 STP have identified champions
* All three Health Education Teams have commissioned MECC training programmes.

There are approximately 7600 staff who have been or are due to be trained as part of identified targets for MECC training programmes, by NHS organisations, across 2017-18. There has been some difficulty in specifying the exact number of NHS staff, as some programmes will include a health, social care and voluntary workforce. In addition, there are NHS programmes under development that are due to deliver programmes for NHS staff, but have not set a projected target number to train.

## Definition of MECC

The survey requested that providers outline their definition of MECC, with the aim of judging how similar it was with the Healthy London Partnership definition:

**‘’MECC is a behaviour change approach that encourages positive health and wellbeing choices through individual, organisational and environmental interactions. It involves enhancing, identifying and acting on the opportunities to engage people in conversations about their health in a respectful way, to help them take positive action to improve their own health and wellbeing.’’**

The survey respondents focused primarily on the individual and conversational aspect of the behaviour change and did not significantly mention the organisational or environmental aspects.

MECC was frequently used as a term for the training and in the implementation or explanation of the course there was repeated reference to the ‘What MECC is/ What MECC is not’ explanation in the MECC implementation toolkit. The most adopted approach to acting on a MECC conversation was to use the Ask, Advise, Assist, Arrange approach or a variation or enhancement of this approach.

## Behaviour Change models

Virtually all programmes were linked or referred to, including a model of behaviour change as part of their MECC training programme.

There was a clear preference for the use of:

* COM-B model[[1]](#footnote-1)
* Trans- theoretical / Stages of Change model[[2]](#footnote-2)

## MECC Topics

There was a strong overlap between the core topics for MECC identified by HLP and the training provided. Certain Trusts were commissioned to cover specific aspects with identified client groups, for example, the community mental health trusts predominantly focused on MECC as applied to people with mental health issues, and were provided by mental health staff. NHS programmes included two additional topic areas beyond the core five topics; these were drugs and sexual health. In certain cases, Trusts or STPs would use a MECC approach to deliver change in a specific or limited number of core topics.

## MECC Training

The majority of training across NE London had a multi professional focus with the aim of fostering confidence in holding opportunistic or conversational style discussions around the core health topics.

## Approaches to Training

### Duration

There was variation in the duration of the courses provided. The majority of courses included a half-day workshop model of training, but also provided were full day courses and two-day courses. This disparity between the training approaches adopted was dependent on the trainer’s preference to include a more intensive training focus and skills practice, or include a train the trainer focus. There was a strong reflection that the greater the duration of the course, the harder it was to release front line staff to attend.

### Delivery

There was a strong preference for face-to-face training with most NHS providers using this approach.

Several of the Trusts opted to include a train the trainer component with the aim of developing champions and cascading learning.

An interesting approach from Whittington Health provided simulation training as part of their face-to-face training, and used actors to engage in practical role-play, to imbed practice techniques and methods learnt. Where e-learning was part of the training many providers used nationally available packages with the aim of providing a blended approach as part of a pre-course introduction that was incorporated into the face to face training delivery, or a post course resource where key elements could be reviewed to consolidate learning and check understanding. In occasional instances, the e-learning was used as a standalone package. A limited number of Trusts had or are developing their own bespoke, Trust specific e-learning package.

## MECC Training Providers

Most of the Trusts have incorporated a MECC Training delivery role as part of existing staff or team functions. While this may create a capacity issue, it may also be a more sustainable approach as the areas with a commissioned provider identified that the programme may, without continued investment, not be repeated and previous work come to a halt.

External providers were commissioned from some of the Trusts; since they required support with having the time or capacity to deliver a large-scale training course them selves. They also may not have had the required expertise, or in a limited number of cases wanted an accredited provider to deliver.

A list of MECC training providers is included as part of the Appendix C

## MECC Resources

The examples of good resources across London include:

* Case of change or business cases – such as logic models
* Training enablers – such as CQUIN or staff competencies
* Resources for delivery
  + Such as training programmes plans
  + E-learning modules
  + Training the trainer options from CNWL and CLCH
  + Simulation examples
  + Specific approaches for staff or patient groups
  + Specific prompts or tools – such as screening tools
  + Training packs
* Evaluating the impact and potential of training.

## Target Staff Groups for MECC Training

The majority of programmes with high target aspirations had an open approach to training and encouraged any NHS staff, regardless of profession to attend. However, some Trusts had an aim to engage with a particular set of staff groups. There were identified programmes with a strong focus on supporting Community Health Staff, mental health staff, maternity staff, Health Support staff, or had identified a list of allied health professionals to engage in MECC.

## Sources of Funding for MECC Programmes

Funding for MECC projects in NHS organisations across London were typically sourced from:

* Local Health Education Team
* Local CCG/ Community Education Provider Network
* Incorporated within existing team functions, for example as part of a CQUIN
* Linked to Public Health/ Local Authority funded programmes
* Alliance funded

All three Health Education England boards provided and resourced a significant amount of funding for a diverse range of NHS provided behaviour change projects. However, there was a variation in the preference for models and approaches. For example, HENWL commissioned a significant number of MECC programmes, while HENCL commissioned one, but had a substantial programme for training NHS staff on Health Coaching.

As identified in the ADPH Stocktake, sustainability was a continued concern with many projects unsure about the future and continuation of programmes once the initial project funding and milestones were completed.

# Sharing good practice - Key learning

#### Healthy London Partnerships’ vision for MECC in London does not see MECC as an isolated training intervention. Rather, it is seen within a model, pathway or place that is health promoting. To step up the MECC agenda in London and therefore, whilst supporting all frontline staff to have the access to the right skills to initiate positive conversations about health and wellbeing, HLP also promote the importance of addressing environmental, cultural and infrastructure enablers to make MECC as impactful as it can be.

Healthy London Partnership defines these key areas as:

* By culture we mean the ability of an organisation to promote and value health and wellbeing (key links to the workplace health charter)
* By environment we mean the ability of the organisational environment to mirror the messages it is promoting (e.g. smoke free) or the environmental prompts or levers which exist to promote conversations about health and wellbeing
* By infrastructure, we are talking about the tools and services we can signpost onto

# 2.1 Key Enablers

**2.1.1 Culture**

The key cultural enabler for MECC was evidence of having a strong representation and call to action for MECC through strategic plans and documents. The majority of STP’s included a clear articulation from the Sustainability Transformation Plan that MECC was a required objective to support their prevention component, in response to the Five Year Forward View. This is a definite lever to support conversations and wider adoption of MECC, even across Trusts where this is not a priority. There is potential to further explore the development of a strong narrative from STP priorities to Trust priorities, strategies and documentation.

A small number of Trusts have used a CQUIN to show organisational ownership and prioritisation of MECC. For example, GSST have a long established 3-year CQUIN focussing on training and up-skilling NHS staff in MECC conversations. In addition, SLAM used the physical health in mental health settings agenda as their cultural enabler to encourage adoption of MECC. While not as directly linked as the GSST CQUIN, SLAM link MECC to their physical health CQUIN goals.

Where a CCG has taken ownership and responsibility for MECC, it appears they have been able to influence its adoption within provider Trusts. Therefore, the CCG’s may have additional levers in terms of highlighting the value of a case for change using local evidence, engaging stakeholders, target setting, seed funding, partnership working and financial influence, with its provider partners to help initiate a change in culture.

Health Education North West and North Central provide a competency based approach for staff that develops their skills and knowledge, but also places it alongside a training pathway linking core competencies to other behaviour change packages such as social prescribing or health Coaching. This could provide a model for other staff groups.

A strong theme that has emerged across London is the value of champions across each level of NHS provision. In some sector there are a number of identified leads and champions in the STP, Acute Trusts, Community Providers and Community Mental Health Trusts. Alongside these NHS champions there are often counterparts in the Local Authority and community enablers or community MECC champions. The agreement by these services to include MECC projects as part of their day-to-day work signifies a strong commitment to the value MECC contributes to prevention activity.

In NHS Trusts, having a clear senior champion in the form of the Chief Nurse appears to be a successful mechanism for showing organisational ownership and priority. One Trust evidences this with an on line MECC briefing video with senior leads articulating the value of MECC, not just for patients but for staff as well.

Most STP’s have identified leads who support the pan London approach to MECC and many of these leads have, or are in the process of developing, an STP wide MECC steering group. These groups can support the development of a consistent and repeated message that are linked to the HLP definitions regarding MECC, and provide greater opportunity for it to be translated into organisational culture.

One NHS organisation highlighted the value of having a strong communications message. Through continuous promotion and reinforcement, there is a perceived greater cultural awareness and adoption of MECC aims.

Several Trusts mentioned the value of adopting a culture of healthier work places alongside the organisational enablers for MECC training. As an example of a cultural enabler, this could be supported and adopted by the Health and Well-being programme across the Trusts.

Many of the Trusts have been developing their Apprenticeship training programmes, while very few have been linked to the MECC programme there is scope that the two projects could be complimentary and could provide an organisational enabler.

**2.1.2 Environment**

Exploring the environmental enablers for a MECC environment was not a priority for many NHS projects. Many of the Trusts have opportunities for health promoting environments, such as bike schemes or on-site gyms, but these were not linked to MECC programmes. Where environments have become more health promoting, the key driver tends to be work place health charters or staff well-being.

The main environmental messages displayed by a couple of NHS Organisations and linked to the MECC programme included:

* Changes to vending machines
* Availability of folding bikes
* Placing healthy signposts on stairwells encouraging stairs over lifts
* Dieticians and occupational health have been working with catering services to change to restaurant menus – food and drink choices changed to healthier options
* Drive around increasing physical activity for staff members
* All sites are no smoking
* Programmes around work-related stress and anxiety, workshops to help staff. Alongside counselling service for staff with work related issues

An enabler identified by an Acute Trust, was the need to work alongside and support the clinical teams to identify how to make environmental and systems changes within their departments. This localised working through champions can help focus key MECC themes in relation to presenting need or departmental speciality.

The key environmental messages displayed by one organisation, CVA, and linked to the MECC programme included:

* Being led by the community as to where to deliver MECC messages
* Imbedding community connectors into GP buildings located in areas of greatest health inequalities.

There were frequent links to the One You programme and resources displayed by Trusts.

**2.1.3 Infrastructure**

There has been strong consideration about how to encourage staff and make them available to attend training. A good example has been providing MECC training at a time and location that is convenient for pharmacists to attend. Given the footfall into this area of healthcare provision, these are excellent partners to encourage the initiation of MECC conversations. The whole pharmacy team can be trained to support MECC conversations, not just the pharmacist, and are especially useful if combined with the Health Promoting Pharmacy scheme, which may provide public health interventions tackling MECC core topics. This can reduce one of the barriers to accessing support.

Where Trust’s organisational, learning and development teams have been involved in the promotion of MECC training, it has helped to increase participation of NHS staff. Including MECC training details as part of regular all staff training, or communication briefings, has help create a sense of ownership by the organisation. Linking MECC training to existing on-line booking systems for wider training reduces the steps and barriers to attendance.

The CVA adoption of the ABCD model shows the value of having dedicated providers, or staff acting as champions for the training appears to facilitate greater access to training. Linking community builders to NHS frontline staff allows space and time to create local prompts, tools and communication to make MECC a relevant component of staff’s contact with patients. The model also encourages the use of communities of practice to develop understanding, learning and resources.

Across London there are several pan London programmes which could support the wider infrastructure and implementation of MECC in a variety of ways. For example, a Health Innovation Academic Health Science Network covers each STP. While none of the projects has made formal links with this resource, there may be scope for previous examples of practice or developed models to support the evaluation of MECC behaviour change initiatives.

To support workforce adoption and to prioritize MECC, greater links could be made to the New Models of Care, Clinical Senate programmes, Transforming Cancer Services Team and Vanguards that focus on CVD and Cancer.

Health Education South London has a focus on the value that Community Education Provider Networks can play in delivering population based health training. This is a resource that could adopt and disseminate MECC training at scale to front line primary care staff.

There are innovation hubs across London that can provide additional pan London resources or support. Examples include the Imperial Helix Centre, NW London Behaviour Change Academy or North Central London Innovation Hub for Workforce Transformation.

Survey respondents frequently cited communication channels as key infrastructure enablers. There may be scope to encourage the further adoption of MECC through pan London support for:

* Targeted messages via Communications departments
* MECC discussed and linked to new members of staff at Trust Corporate induction
* MECC linked to Physical Health Workshops
* Details of MECC located on the Trust Intranet
* Promoting MECC training or outcomes through websites and on Twitter

A reported enabler to supporting the MECC infrastructure was a comprehensive and up to date training pack, which contains information on those local services that could support MECC related behaviour change. Many sites mentioned developing these so participants could have copies following completion. Survey respondents recognized the value of having a plan to host material and resources onto on online platform or available through the Trust intranet for staff. This can help consolidate learning, share resources and give staff a referral point in the absence of refresher courses. There could be scope for a London wide easy access version, such as on-line support or health tools, especially if there are gaps in provision for local services.

One organisation reported that they had developed a MECC website which can link to a locally developed e-learning site and have space for MECC champions to link, collaborate and communicate. This could be an interesting development to create a wider community of practice across London.

There do exist Linked in and Facebook MECC profiles to support MECC leads, champions and participants of training.

In terms of promoting MECC messages to patients, one CCG highlighted the value of the digital prompt screens in waiting rooms or pharmacies. This could be an approach that could be developed centrally and then widely cascaded to all partners.

While potentially a source of competition, there are a number of additional behaviour change training programmes that NHS staff have access to. There are good examples of identifying a training pathway – such as linking MECC with the Promoting Change, Social Prescribing, Health Coaching or mental health first aid training; which has the advantage of making MECC related outcomes relevant to the level and opportunity of staff potentially attending.

# 2.2 Barriers to implementation

Potentially the most significant barrier to implementation and improvement of cultural, environmental and infrastructure factors by NHS organisations, is that most of Trusts view direct training delivery as the key component of MECC. This could be a factor of the funding source; since the majority of the MECC projects are funded for a specific time scale and to reach a certain target for training numbers, not necessarily for the wider health promoting factors. Therefore, the additional developments are frequently not identified as being part of the MECC actions or being prioritized. There could be scope for a pan London approach to have a standardized message or requirement to consider the cultural, environmental or infrastructure components in future project development.

**2.2.1 Culture**

While MECC has been identified through the STP plans, in some instances it has been linked to a limited number of core health topics, for example, just smoking cessation. There may not be recognition of the value of MECC across wider health priorities leading to an incomplete cultural adoption. In this case, potentially ignoring the value of MECC in addressing CVD risks. The role and identification of MECC in higher-level documentation in pan London plans or through NHS Providers, Office of **London** Clinical Commissioning Groups or NHS England London based plans is not obvious. Likewise, MECC is not well represented by NHS Professional groups such as the Royal Colleges. Working to raise the benefits of MECC with these groups may help to further develop cultural ownership.

Across many Trusts, MECC is not a widely adopted priority for Acute or Community Trusts across London. This could be due to a lack of focus on this area or there are competing priorities or potentially competing behaviour change training models such as health coaching. However, it does appear that MECC has not emerged as a consistent key feature of key strategic documents. Therefore, there could be scope for a generic MECC paragraph that Trusts could be encouraged to include in commonly occurring strategic documents,

Education, training and development is covered by a range of NHS organisation functions, such as staff development, organisational development, human resources, learning and development and Medical and Nursing education teams. In addition, MECC programmes maybe initiated by champions with a focus within one service or team. Therefore, there are barriers to developing cultural or organisational awareness through lack of ownership by different parts of the NHS structure. MECC does not appear to feature strongly across Medical Education programmes and it is not viewed as part of their responsibility. However, a Cochrane Review[[3]](#footnote-3) advocates that very brief advice conversations, led by medical staff, will significantly result in patients significantly changing their behaviour, such as giving up smoking. Supporting access to this approach through encouraging delivery at undergraduate level or through existing F1/F2 training slots in acute hospital rotations could encourage greater numbers of medical staff to engage in health promoting conversations.

In relation to MECC, the cultural practice between community groups and NHS organisations has been identified. Community or Local Authority services have been reported as more willing, or more able, to release staff for training. While many NHS organisations may value and have a culture of supporting education, learning and development, there is still difficulty in being able to find the time to release valuable front-line staff to attend MECC training.

To improve organisational and cultural adoption of MECC it has been recommended that there should be a uniform and consistent policy, approach and definition of MECC that is adopted across a Borough and potentially the Sector and Pan London.

MECC sits within and alongside a number of wider training programmes in the NHS. However, despite being brief and having the potential to be completed on-line and with the potential for considerable impact, few of the NHS organisations surveyed identified that there was an organisational cultural enabler that would encourage staff to attend training. For example, there were no links to mandatory training or few links to training targets such as CQUINS.

An interesting, but maybe artificial cultural divide that could be preventing an increase in access to MECC training, is the often reported disconnect between NHS and Local Authority programmes. Both this report and the ADPH Stocktake reflect that there are broad similarities between both sets of programmes. There could be greater scope for consistent messages, shared resources; economies of scale and increased training delivery if there was improved communication and coordination between Health and Social care MECC training programmes.

**2.2.2 Environment**

Across London the MECC programmes have been predominantly designed with training delivery and evaluation in mind. None of the projects were explicitly linked with objectives or targets for transformational or organisational redevelopment. While NHS Organisations do show strong evidence of promoting health for their staff, it is typically through Human Resources or Organisational Development teams and not those teams with a responsibility to deliver MECC training. This means the links between staff health and MECC are not as strong as they could be.

Resources to develop staff and patient MECC prompts can be prohibitive across a Trust; in terms of developing a branding, a relevant message and production costs. There is a reported lack of time, expertise or resources to commit to these elements when in competition for using communication channels for promoting awareness of training and encouraging uptake. There could be opportunities through developing economies of scale or central ownership and distribution, for example, similar to the PHE campaigns teams.

**2.2.3 Infrastructure**

Since 2013, the majority of the core health areas addressed by MECC are the responsibility of Public Health functions transferred into Local Authorities. Despite ring-fenced resources, certain localities have de commissioned high-profile services such as the Stop Smoking Services. Therefore, there is a barrier between being aware of and linking patients to the infrastructure and services staff are supposed to assist them to access following identification and motivation.

Linked to this, as reported by survey participants, was the challenge in keeping up with changes to services to sign post patients and staff too. The training leads report constantly having to update information as part of their directory of services. This is identified as time consuming and there is little opportunity to quality assure them. There could be scope to develop alternative access routes (such as quality checked on-line support for stop smoking, increasing activity or improved emotional well-being) to support for core health areas.

A further barrier to the development of an effective MECC infrastructure was highlighted to be lack of funding. It appears that NHS organisations may need a degree of project funding to be able to initiate these programmes or to keep them sustainable

# 2.3 Evaluation

From the projects in development and surveyed, there was a strong element of how best to consider and include evaluation within the project. This may have been a function of having to have a robust approach to evaluation to receive funding, but it may also be as a result of greater availability and examples of previous practice of how to monitor and evaluate MECC.

Evaluating MECC can be difficult, with challenges such as ensuring that:

* Organisations are ready to implement MECC training
* That staff are able, motivated and have the opportunity to apply training
* Note is taken of different levels of competency
* Delivery is consistent, through opportunistic, single or multiple interventions
* It is recognized that MECC is the start of the behaviour change process and other factors could influence outcomes.

Based on the Kirkpatrick method of training evaluation, all programmes surveyed included the Reaction phase, that is how the delegates felt about the learning experience, for example in terms of venue, enjoyment or relevance of the training. In addition, there was clear evidence of inclusion of the Learning phase, which evidenced a measured increase in the knowledge before and after the training.

Attempting to evaluate the Behavioural phase, where training is put into practice and implemented, was typically carried out by a follow up survey of participants requesting frequency of MECC conversations or self-report of putting it into practice. As an example, several Trusts were able to use on-line sources to follow up participants and were able to track and monitor self-referrals and links to local health services.

The final component, the Result phase, which explores what is the local population impact of this training, is typically difficult to incorporate. However, Croydon CCG has used a Cost Benefit Analysis (CBA) to capture this aspect. The CBA of the ABCD project could be used as a template for evaluating MECC outcomes. The CBA summarised the costs, outcomes and key assumptions that contribute to the Net Present Public Value (NPPV). It identified the following key benefits (i.e. improved outcomes):

* Improved Mental Health
* Reduced GP appointments
* Reduced A&E attendance
* Reduced GP appointments leading to reduced prescriptions

There is a need and potential to help NHS Organisations identify and apply in an easy and consistent manner, an evaluation framework that can evaluate all aspects of the MECC programme.

Frequently the training providers cited existing documentation in terms of helping them frame their evaluation scheme. These included:

* PHE & HEE Making Every Contact Count Evaluation Framework
* Logic model (examples derived from model above)
* Wessex Making Every Contact Count Evaluation

It was not clear if all projects had implemented an Organisational Readiness needs assessment prior to implementation of training. This would enable clarity, or the steps needed, for the Trusts to successfully embrace or implement MECC.

# Recommendations

# 3.2 London level recommendations

Following the Mapping and survey of NHS MECC providers there are a range of potential opportunities for HLP to support the cultural, environmental and infrastructure components to improve implementation of this training programme. These broadly fall into the following headings:

* Coordinating MECC activity
* Developing a strong case for change
* Ensuring consistency in delivery of MECC training
* Developing resources
* Robust evaluation
* Ensuring MECC is sustainable

|  |  |
| --- | --- |
| Recommendation One | **Support Coordination of MECC Activity** |
| 1.1 | Expand the London wide MECC Steering Group to include partners from Health and Social Care |
| 1.2 | In line with recommendation 1.1 in the ADPH Stocktake, Work with ADPH London, PHE London, Health Education England, Healthy London Partnership, the Academy of Public Health but also include wider NHS providers, Vanguards and NHS E London Commissioners as partners to explore the development of a regional multi-stakeholder MECC strategy |
| 1.3 | Provide infrastructure (terms of reference etc) and support to allow STP level MECC groups to include all health, social care and voluntary sector leads in developing and coordinating local activity |

|  |  |
| --- | --- |
| Recommendation Two | **Developing Case for Change** |
| 2.1 | Explore benefits of ‘up-streaming’ MECC into undergraduate and graduate training programmes and/ or raising MECC profile as part of medical education programmes |
| 2.2 | Explore if HENWL workforce competencies could be applied as part of other professions or within Apprenticeship programmes. |
| 2.3 | Develop case for change to encourage senior management buy in for MECC. |
| 2.4 | Develop core MECC statement aligned to NHS strategic documentations |
| 2.5 | Develop case for change for Trusts wide adoption of mandatory / induction based MECC training, MECC CQUIN or part of CCG commissioning specifications |
| 2.6 | Develop case for change for commissioners of MECC training to include elements of cultural, environmental and infrastructure development and evaluation as part of training grants |

|  |  |
| --- | --- |
| Recommendation Three | **Ensuring consistency in delivery of MECC training** |
| 3.1 | Work with the providers identified in recommendation one to develop and agree a consistent MECC definition |
| 3.2 | Work with providers identified in recommendation one, to develop a London wide Training the Trainer/ Champions model, examples such as Macmillan Sage & Thyme could provide a template for implementation. |
| 3.3 | Explore options for standardizing training provision across London |
| 3.4 | Explore options for imbedding MECC into an organisation culture, environment and infrastructure, for example similar to Smoke free Organisations Pledge |
| 3.5 | Explore if MECC reporting outcomes can be linked to patient management systems across health and social care |

|  |  |
| --- | --- |
| Recommendation Four | **Developing resources for the delivery of MECC training** |
| 4,1 | Develop central repository of MECC training resources and best practice |
| 4.2 | Explore on line/ e-learning platform that can provide agreed training content, data metrics and link to onward evaluation |
| 4.3 | Develop pan London physical and digital resources, which can be locally branded if required |
| 4.4 | Review existing on-line community of practice and see if it can be expanded to be a pan London resource |

|  |  |
| --- | --- |
| Recommendation Five | **Robust evaluation** |
| 5.1 | Work with the providers identified in recommendation one to develop and agree a consistent MECC evaluation framework |

|  |  |
| --- | --- |
| Recommendation Six | **Ensuring MECC is sustainable** |
| 6.1 | Work with commissioners and providers to develop a well-resourced and sustainable MECC training programme |

# Appendix B:Resources Identified

|  |  |  |  |
| --- | --- | --- | --- |
| **Organisation** | **Type of resource** | **Brief description** | **Available from** |
| Guys & St Thomas’s NHS Trust | MECC CQUIN | Example of a Trust wide CQUIN covering MECC training and delivery | Sharon Hudswell  Health and Improvement Practitioner  Sharon.hudswell@gstt.nhs.uk  02030495245 |
| Guys & St Thomas’s NHS Trust | Video | GSST have developed their own bespoke video to support their MECC programme and highlight focus the organisation has on encouraging staff to take part. | <https://vimeo.com/185995266> |
| South London & Maudsley NHS Trust | Physical Health CQUIN for mental health services | Example of Trust wide CQUIN which supports MECC as an enabler to improve physical health outcomes for people with mental health issues | Damian Larkin   |  | | --- | | damian.larkin@slam.nhs.uk | |  |   07787520146 |
| Tower Hamlets Together | MECC Logic Model | THT applied logic model to support the implementation and evaluation of their MECC programme |  |
| Haringey CCG | On line training | Link to eLearning platform recommended by CCG | [**http://www.haringey.gov.uk/making-every-contact-count-mecc-e-learning**](http://www.haringey.gov.uk/making-every-contact-count-mecc-e-learning) |
| Camden & Islington CCG | On line training | Link to eLearning platform recommended by CCG | [**https://www.islingtonmecc.org.uk/e-learning**](https://www.islingtonmecc.org.uk/e-learning) |
| One You | Web based resource | Link to One You PHE programme | <https://www.nhs.uk/oneyou#UMr5csegf6vWMFFT.97> |
| Central North West London NHS Trust | SUFARI screening tool | Substance Misuse screening tool, linked to MECC programme | Claudia  Salazar  Head of Integrated Education (Goodall Division) Central and North West London NHS Foundation mobile: 07590808803  E-mail: [claudiasalazar@nhs.net](mailto:claudiasalazar@nhs.net) |
| West London Mental Health Trust | On-line learning platform | MECC on line learning platform focusing on links to mental health services | |  | | --- | | Priya Patel | | priya.patel@wlmht.nhs.uk | | 02083548252 | |
| Croydon CCG | Cost Benefit Analysis | Cost Benefit Analysis of MECC/ ABCD programme and example of determining potential impact of programme delivery |  |
| Croydon CCG & Croydon Voluntary Action | Evaluation example | Example of previous evaluation of MECC/ ABCD project |  |
| Hounslow CCG/ LA | Referral form | Example of physical activity referral form |  |
| Camden & Islington CCG./ LA | Evaluation presentation | Example of a presentation on the outcomes of MECC programme |  |
| RM Partners | MECC Briefing | Outline of how cancer Vanguard could support MECC agenda |  |
| HENWL | MECC Education and competency project | Examples of resources and competencies that support MECC training for Health Support workers |  |
| HENCL | Health Coaching project documents and framework | Example of project documentation to support behaviour change programme |  |
| Allied Health Solutions | PHASE programme incorporating MECC | Example of a more in depth training programme including MECC | Link to Public health Allied Health Support  <http://www.alliedhealthsolutions.co.uk/PDFs/SupportWorkforce/PHE-AlliedHealthSupportWorkerStudyReport.pdf> |
| SE London STP steering group | Strategy presentation | Example of STP strategy presentation outlining STP approach to MECC |  |
| NICE | Return on Investment | NICE return on investment tool for MECC core topic areas | <https://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools> |
| University of Southampton | Wessex MECC pilot evaluation | Frequently cited template for idea about how to support evaluation on NHS based MECC projects | <http://www.wessexphnetwork.org.uk/media/22802/Wessex-MECC-Evaluation-Report-Final-110615.pdf> |

# National Resources

## Making Every Contact Count – National Programme

**Consensus Statement** <http://mecc.yas.nhs.uk/media/1014/making_every_contact_count_consensus_statement.pdf>

**Making Every Contact Count (MECC): implementation guide**

<http://mecc.yas.nhs.uk/media/1015/mecc_implementation_guide.pdf>

**Making Every Contact Count (MECC): quality marker checklist for training resources**

<http://mecc.yas.nhs.uk/media/1012/mecc_training_quality_marker_checklist.pdf>

**Making Every Contact Count (MECC): evaluation framework**

<http://mecc.yas.nhs.uk/media/1013/making_every__contact_count__mecc__evaluation_framework_march_2016.pdf>

**Examples of implementation**

<http://makingeverycontactcount.co.uk/implementing/>

**Examples of evaluation**

<http://makingeverycontactcount.co.uk/evaluating/>

**Communities of Practice**

<http://makingeverycontactcount.co.uk/community-of-practice/>

### Additional Resources

**Quality Marker Checklist**

**A self-assessment checklist to support organisations in implementing and sustaining MECC programmes.**

[More >](http://makingeverycontactcount.co.uk/media/1012/mecc_training_quality_marker_checklist.pdf)

**MECC Pocket Guide for Healthcare Staff**

**A guide to support healthy conversations within a healthcare setting.**

[Read >](http://makingeverycontactcount.co.uk/media/1040/012-mecc-pocketbook-for-healthcare-staff-june-15.pdf)

**MECC Workbook**

**A workbook to support the delivery of healthy conversations in healthcare settings.**

[Read >](http://makingeverycontactcount.co.uk/media/1041/013-mecc-workbook-db-health-pdf.pdf)

**Lifestyle Essex App**

**An app developed by Essex County Council, with advice on healthy lifestyle topics and links to local support services.**

[View >](https://www.essex.gov.uk/Health-Social-Care/Health/Pages/Health-Wellbeing.aspx)

**Supporting Behaviour Change**

**This RCN module gives an overview of motivational interviewing and provides a 'change toolkit' to use with clients.**

[View >](https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change)

**Mental Health Promotion and Prevention Training Programmes**

**Emerging practice examples of training available for the public health workforce.**

[Read >](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/558676/Mental_health_promotion_and_prevention_training_programmes.pdf)

**Mental Health Toolkit for Employers**

**A toolkit for organisations to help support employee mental health and wellbeing.**

[View >](http://wellbeing.bitc.org.uk/all-resources/toolkits/mental-health-employers)

**National Centre for Smoking Cessation and Training**

**Programmes based on the competences**

### Wessex Making Every Contact Count Programme

Wessex Making Every Contact Count Implementation Toolkit

[www.wessexphnetwork.org.uk/mecc](http://www.wessexphnetwork.org.uk/mecc)

Wessex The Healthy Conversation Skills training has been accredited by the Royal Society of Public Health (RSPH).



Example of Train the Trainer programmes

[www.wessexphnetwork.org.uk/mecc](http://www.wessexphnetwork.org.uk/mecc) For more information on the Train-the-Trainer approach see the Implementation toolkit or contact  [Annemarie.Hankinson@hee.nhs.uk](mailto:Annemarie.Hankinson@hee.nhs.uk)

### Royal Society Public Health Workforce Champions Training

RSPH Workforce Health Champions Training <https://www.rsph.org.uk/event/workplace-health-champions.html>

RSPH e learning <https://www.rsph.org.uk/resources/shop.html?category=health-improvement-and-behaviour-change>

NHS Employers – Evaluating Health & Well-being Interventions for Healthcare Staff

### 

### E Learning for Health & On-line training packages

The eLearning is available at: <http://www.e-lfh.org.uk/programmes/making-every-contact-count/>

**Requires Log-in:** [**http://tlds.learningpool.com/course/index.php?categoryid=86**](http://tlds.learningpool.com/course/index.php?categoryid=86)

**Health Education North West On-line training – including smoking cessation and mental health challenges**

<http://www.nwyhelearning.nhs.uk/elearning/northwest/shared/shareable_packages/every_contact_counts/index.htm>

### Social Media

**Facebook** <https://www.facebook.com/groups/MECCcommunity>

**LinkedIn - insert**

# Appendix C: Directory of trainers

# Identified Training Providers

Apart from those organisations who champion and provide internal training provision, there have been several independent and external training providers identified who have delivered MECC training in and around London. These include:

**Royal Society for Public Health Accredited Training providers**

* **Social Marketing Gateway** <http://www.socialmarketinggateway.co.uk/>
* **Healthy Dialogues** <http://www.healthydialogues.co.uk/>
* **Innovate Health** <http://www.innovative-health.uk/>

**Non-Accredited Training Providers**

* **The Training Tree** <http://thetrainingtree.org.uk>
* **Reed & Momenta** <http://reedmomenta.co.uk/mecc/>
* **Croydon Voluntary Action** [www.cvalive.org.uk](http://www.cvalive.org.uk/)
* **Central London Community Healthcare**
* **Allied Health Solutions** <http://www.alliedhealthsolutions.co.uk/>
* **Thrive Tribe** <https://thrivetribe.org.uk/>

**On-Line Training Platforms**

The following links connect to the on-line MECC training platforms that have been used across London by NHS organisations

[**http://www.haringey.gov.uk/making-every-contact-count-mecc-e-learning**](http://www.haringey.gov.uk/making-every-contact-count-mecc-e-learning)

**Camden & Islington** [**https://www.islingtonmecc.org.uk/e-learning**](https://www.islingtonmecc.org.uk/e-learning)

[**https://www.e-lfh.org.uk/programmes/making-every-contact-count/**](https://www.e-lfh.org.uk/programmes/making-every-contact-count/)

<http://reedmomenta.co.uk/mecc/>

# Making Every Contact Count survey

**1. Introduction**

**Healthy London Partnership (HLP) is funded by the 32 CCGs across London and works across health and social care to address some of London’s core health challenges. One of the programmes within HLP focusses on supporting the prevention of ill health and wellbeing across London.  
  
Making Every Contact Count (MECC) has been identified as an important part of this prevention work and as a priority in all of London’s Sustainability and Transformation Plans (STPs). You may also know of this approach as Very Brief Advice (VBA) or Ask/Acknowledge/Advise/Assist (AAAA).  
  
For more information on this scheme of work please visit: (https://www.myhealth.london.nhs.uk/healthy-london/programmes/prevention/making-every-contact-count)  
  
We recognise some great work is being done and our primary goal is to capture what MECC activities are happening within healthcare organisations. We are also keen to explore further opportunities to support MECC activity where there is an interest to do so.  
  
We would like your help with this mapping review through completion of this survey, and in return we would be keen to share with you the outcomes of the review. This would help support:  
  
• Sharing learning and best practice  
• Developing and enhancing tools and resources which can be used to assist with implementing and evaluating MECC  
• Identifying common themes and barriers we can address at STPs or pan-London level  
• Identifying partnerships/synergies across organisations  
  
The survey should not take more than 30 minutes to complete and you should be able to save your progress and return to it, if needed.**

**2. About You:**

A few details about your organisation.

### 1. Is your NHS organisation a:

|  |  |
| --- | --- |
|  | Clinical Commissioning Group |
|  | Primary Care Service - GP or CEOP |
|  | Acute Hospital Trust |
|  | Community Provider Trust |
|  | Mental Health Trust |
|  | NHS Vanguard |
|  | NHS New Models of Care Project |
|  | NHS Alliance - such as Clinical Senate |
|  | Health related Charity organisation |
|  | Other (please specify):   |  | | --- | |  | |

**3. Contact details**

 2. Please provide your contact details as MECC lead. **\***

|  |  |  |
| --- | --- | --- |
| Name | |  | | --- | |  |   \* |
| Organisation | |  | | --- | |  |   \* |
| Email | |  | | --- | |  |   \* |
| Contact number | |  | | --- | |  | |

 3. Which STP does your organisation cover, please tick all that apply:

|  |  |
| --- | --- |
|  | North West London |
|  | North Central London |
|  | North East London |
|  | South East London |
|  | South West London |

### 4. Which CCG does your Organisation cover? please tick all that apply:

|  |  |
| --- | --- |
|  | Barking and Dagenham |
|  | Barnet |
|  | Bexley |
|  | Brent |
|  | Bromley |
|  | Camden |
|  | Central London - Westminster |
|  | City and Hackney |
|  | Croydon |
|  | Ealing |
|  | Enfield |

|  |  |
| --- | --- |
|  | Greenwich |
|  | Hammersmith and Fulham |
|  | Haringey |
|  | Harrow |
|  | Havering |
|  | Hillingdon |
|  | Hounslow |
|  | Islington |
|  | Kingston |
|  | Lambeth |
|  | Lewisham |

|  |  |
| --- | --- |
|  | Merton |
|  | Newham |
|  | Redbridge |
|  | Richmond |
|  | Southwark |
|  | Sutton |
|  | Tower Hamlets |
|  | Waltham Forest |
|  | Wandsworth |
|  | West London - Kensington & Chelsea |

### 5. Do you give permission for your contact details being shared with relevant NHS organisations/MECC leads where we identify potential partnerships/synergies? **\***

|  |  |
| --- | --- |
|  | Yes |
|  | No |

**4. Planning/initiation**

### 6. Is your organisation planning to implement MECC, in the implementation stage of delivering MECC, or evaluating an existing MECC programme?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

### 7. What was the driver for implementing MECC in your organisation?

|  |  |
| --- | --- |
|  | National policy |
|  | Local Policy, including Health & Well-Being Plan |
|  | STP plans |
|  | CQUIN target |
|  | Contractual fulfilment |
|  | Support Public Health Outcomes Framework |
|  | Physical Health in Mental Health Settings |
|  | Health Education England initiative |
|  | Targeted health theme initiative, such as Cancer Vanguard |
|  | Other (please specify):   |  | | --- | |  | |

### 8. How does your organisation define MECC? **\***

|  |
| --- |
|  |

### Did you use a theory or model to inform your MECC training?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please list models used:

|  |
| --- |
|  |

### 9. Which types of conversations does your training encourage?

|  |  |
| --- | --- |
|  | Very Brief Intervention- Ask, Advise & Assist |
|  | Very Brief Intervention- Ask, Acknowledge, Advise & Assist |
|  | Brief Intervention - more than a couple of minutes including discussion, negotiation or encouragement |
|  | Other (please specify):   |  | | --- | |  | |

### 10. Does, or will, your MECC training include the following components?

|  |  |
| --- | --- |
|  | Link to impact on individual and population outcomes |
|  | Include local data |
|  | How MECC links to organisation and individual roles |
|  | Outlines models of behaviour change |
|  | Link to latest evidence on living a healthy lifestyle |
|  | How to start or hold healthy conversations |
|  | Link to local services that staff can sign post |

### 11. Were/will a particular patient/service user group be targeted?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please specify:

|  |
| --- |
|  |

### 12. Did you/will you target specific staff groups for training?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

### 13. If yes, which groups did you/will you target?

|  |  |
| --- | --- |
|  | Medical/dental |
|  | Nursing |
|  | Allied health professionals |
|  | Pharmacists |
|  | Health care assistants |
|  | Porters |

|  |  |
| --- | --- |
|  | Cleaners |
|  | Catering staff |
|  | Reception staff |
|  | Volunteers |
|  | N/a |
|  | Other (please specify):   |  | | --- | |  | |

**5. Implementation**

### 14. At what stage of implementation is your organisation?

|  |  |
| --- | --- |
|  | Planning |
|  | Implementation |
|  | Evaluation |

### 15. How many staff have been trained/are due to be trained?

|  |
| --- |
|  |

### 16. Were staff trained/will staff be trained via e-learning or face to face?

|  |  |
| --- | --- |
|  | E-learning - developed own resource |
|  | E-learning - used the national or independent training provider version |
|  | Face to face |
|  | Includes a Training the Trainer approach |

### 17. Was the training/will the training be voluntary or mandatory?

|  |  |
| --- | --- |
|  | Voluntary |
|  | Mandatory |

### 18. What topics were included/will be included in your training?

|  |  |
| --- | --- |
|  | Smoking |
|  | Healthy eating |
|  | Healthy weight |
|  | Alcohol |
|  | Physical exercise |
|  | Mental health and wellbeing |
|  | Other (please specify):   |  | | --- | |  | |

### 19. What is the funding source for MECC in your organisation?

|  |  |
| --- | --- |
|  | CCG funded |
|  | Trust funded |
|  | Charity funded |
|  | Local authority funded |
|  | Alliance Funded, such as by Vanguard, New Models of Care or Clinical Senate |
|  | Health Education England |
|  | Public Health England |
|  | Other (please specify):   |  | | --- | |  | |

### 20. Did you use an internal/external training provider?

|  |  |
| --- | --- |
|  | Internal |
|  | External |

### 21. If external, please provide your training provider's details:

|  |  |  |
| --- | --- | --- |
| Company name | |  | | --- | |  | |
| Contact name | |  | | --- | |  | |
| Email | |  | | --- | |  | |
| Telephone number | |  | | --- | |  | |

### 22. What is the cost of their training package?

|  |
| --- |
|  |

### 23. What does this training package include?

|  |
| --- |
|  |

### 24. How did the Training Provider evaluate the quality of it's training?

|  |
| --- |
|  |

### 25. How satisfied were you with the quality and outcomes of the training provided on a scale of 1-10 (10 being the most satisfied)?

**6. Please identify the strategic oversight for your MECC programme:**

### 26. Did you/do you have any strategic documents relating to MECC?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please list:

|  |
| --- |
|  |

**7. Communications**

### 27. How did/ will you communicate and promote MECC training to staff?

|  |
| --- |
|  |

### 28. How did/ will you communicate and promote MECC to patients?

|  |
| --- |
|  |

**8. Environment**

We are interested in the sort of environment MECC takes place in and how this supports the message being given. Such as whether the premises is smoke-free, what types of food are available to staff and visitors, and are there visual prompts in the building or office (e.g. posters that state the benefits of taking the stairs or that promote mental wellbeing).

### 29. Did you/do you plan to make any changes to the environment in which MECC would be taking place?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please specify:

|  |
| --- |
|  |

### 30. What were/are the key enablers that made your organisations’ environment MECC friendly?

|  |
| --- |
|  |

### 31. What were/are the key barriers or challenges to making your organisations’ environment MECC friendly?

|  |
| --- |
|  |

**9. Culture**

Culture is key to the success of MECC, in terms of the support of senior leaders and managers, staff behaviour, etc.

### 32. Did you/will you have MECC champions?

|  |  |
| --- | --- |
|  | yes |
|  | no |

### 33. Is MECC referenced in your organisations visions, values or ethos statement?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please provide the statement:

|  |
| --- |
|  |

### 34. What do you see as the key enablers to make your organisation embed MECC into your organisational culture?

|  |
| --- |
|  |

### 35. Were there barriers/challenges to embedding MECC into the organisational culture?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If yes, please provide details:

|  |
| --- |
|  |

**10. Infrastructure**

Infrastructure in MECC refers to the services and resources available to refer patients to for self-care or help from others.

### 36. What were the key infrastructure enablers in your organisation (Any services/resources that enabled MECC sign posting/referrals)?

|  |
| --- |
|  |

### 37. What were the key challenges or barriers in terms of infrastructure?

|  |
| --- |
|  |

**38. Please indicate which of the following your local area/Borough has easy access to.**

|  |  |
| --- | --- |
|  | A smoking cessation service |
|  | An exercise programme (exercise on prescription, healthy walk scheme, etc) |
|  | A weight management programme |
|  | A service to help people with problem drinking |
|  | Emotional health and well-being programme (books on prescription: 5 ways to wellbeing, time to thrive, seasons, etc) |

**11. Evaluation**

### 39. How did you, or will you, quality assure the MECC Training?

|  |  |
| --- | --- |
|  | Follow a published implementation and development guide |
|  | Use existing workforce competencies to inform learning and objectives |
|  | Use existng Quality Marker for Training |
|  | Follow a published evaluation framework |
|  | Other (please specify):   |  | | --- | |  | |

### 40. What outcomes or impact are you/will you be measuring?

|  |
| --- |
|  |

### 41. How are you/will you be evaluating these outcomes?

|  |
| --- |
|  |

### 42. Please provide examples of data, evidence or evaluations in terms of number, changes and impact (including ROI).

|  |
| --- |
|  |

**43. Can staff attend refresher or follow up training?**

|  |  |
| --- | --- |
|  | Yes |
|  | No |

**12. Next Steps**

HLP are keen to create and improve the environment, culture and infrastructure to support MECC training. We would like to hear your views on how this could be developed.

### 44. What support or resources would be helpful to you or others undertaking MECC?

|  |
| --- |
|  |

### 45. Would you like your data to be anonymised as part of the final report?

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| --- | --- |
|  | Yes |
|  | No |

1. Michie, S., van Stralen M.M. & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. Implementation Science, 6, 42 [↑](#footnote-ref-1)
2. Prochaska, J. and DiClemente, C. (1983) Stages and processes of self-change in smoking: toward an integrative model of change. Journal of Consulting and Clinical Psychology, 5, 390–395. [↑](#footnote-ref-2)
3. http://www.cochrane.org/CD000165/TOBACCO\_does-advice-from-doctors-encourage-people-who-smoke-to-quit [↑](#footnote-ref-3)