MAKING EVERY CONTACT COUNT IN SOLIHULL

Strategy 2013 – 15

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1. Summary:

1.1 This paper presents an initial two-year Strategy for roll out of the MECC programme in Solihull.

1.2 Most important preventable causes of ill-health, deaths and use of health and social care services in Solihull are caused by lifestyle related conditions.

1.3 There is a need for a big culture change amongst organisations highlighted in a number of key national policy drivers towards prevention to bring the promotion of mental and physical health and wellbeing into the mainstream and develop the skills of appropriate frontline staff – doing this has become known as 'Making Every Contact Count' (MECC).

1.4 MECC is an evidence-based initiative and is both cost and clinically effective.

1.5 MECC requires organisation readiness and leadership; Staff readiness and training; and the routine delivery of brief advice, signposting and referral to behaviour change services.

1.6 The plan takes a systematic approach to develop and sustain behaviour change interventions on an industrial scale in a range of organisational settings.

1.7 The ambition is to exploit the full potential of the MECC programme by embedding it in all relevant public, private and third sector organisations in Solihull by 2015.

1.8 Led by Public Health, a MECC programme implementation group will be set up.

1.9 MECC training to frontline staff is key to programme success. Training will be predominantly via E-learning supported by bespoke additional face- to- face training if required and available.

1.10 During the first year of implementation, the focus will be upon training frontline staff working in selected NHS Trusts and Local Authority Departments.

1.11 The estimated cost of implementation of the MECC programme in year 1 will be around £20,000.

1.12 Initiatives such as MECC align with the mission, values, and approach to health improvement being promoted by Public Health England

2. Definitions & Glossary

The Terms Brief Intervention and Brief Advice are often used interchangeably. However, they are different types of intervention, and defined below:-

2.1 Brief Advice (BA)

Describes a short intervention of usually up to 5 minutes duration, delivered opportunistically and normally focused on the service users reason for seeking help. It can be used to raise awareness of, and assess a persons' willingness to engage in further discussion about healthy lifestyles issues. Brief Advice is less in-depth and more informal than a Brief Intervention and usually involves giving information about the importance of behaviour change and simple advice to support behaviour change.

2.2 It has also been suggested that an even more minimal approach than brief advice could be beneficial – whereby staff merely raise awareness of an unhealthy lifestyle, without offering further advice. This could be termed **Very Brief Advice**.

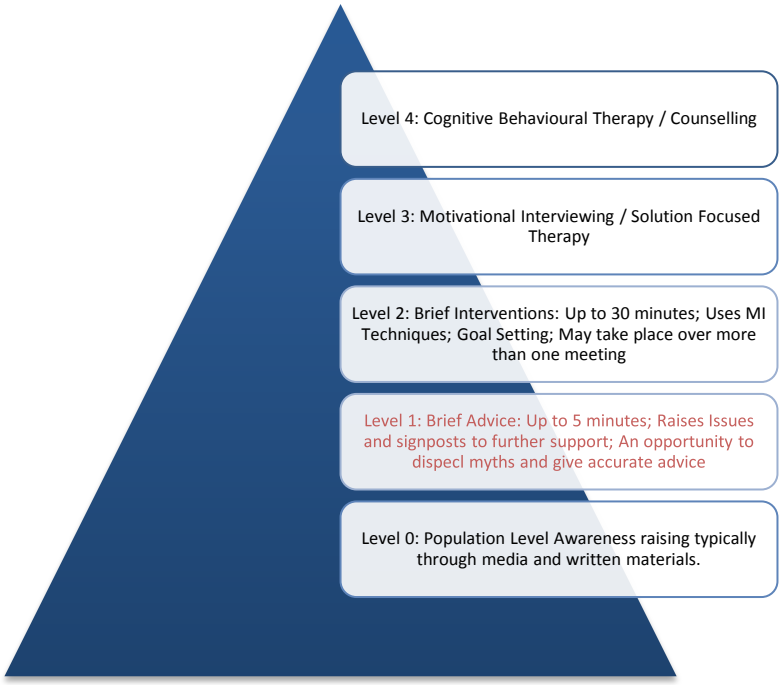
2.3 Brief Intervention (BI)

Provides a structured way to deliver advice and constitutes a step beyond Brief Advice as it involves the provision of more formal help, such as arranging follow-up support. Brief Interventions aim to equip people with tools to change attitudes and handle underlying problems. As part of a range of methods, brief interventions may contain brief advice and may use a motivational interviewing approach in the delivery.

2.4 As indicated above, the delivery of a brief intervention might be enhanced through the use of techniques, such as **Motivational Interviewing (MI)**. Motivational Interviewing is described as a *process of exploring a persons' motivation to change through interview in order to assist them towards a state of action. The techniques are adaptations of counselling skills and particular attention is paid to the listening skills of the interviewer. Motivational Interviewing can be understood as an approach that can be adopted for delivering brief interventions*.

2.5 Staff Competencies: The Staff competencies required to deliver each of the above differs and could be acquired. Training and interventions are often referred to in Levels 1 -3; level 0 refers to the provision of key messages through media such as posters, leaflets, websites and plasma screens.

Figure 1 The Behaviour Change Triangle



3. Introduction:

3.1 Making Every Contact Count (MECC) is an initiative developed by NHS Midlands and East. It was one of five SHA cluster ambitions outlined in the Regional Commissioning Framework 2012/13. The ambition was to utilise the human resources of the NHS to inform and enable people to make positive changes to their life.

3.2 MECC is about encouraging people to make healthier choices to achieve positive long-term behaviour change for better health and wellbeing among patients or service users and staff themselves.

3.3 MECC will be achieved through the systematic delivery of health improvement using consistent and simple healthy lifestyle advice combined with appropriate signposting to lifestyle services (Figure 2 below).

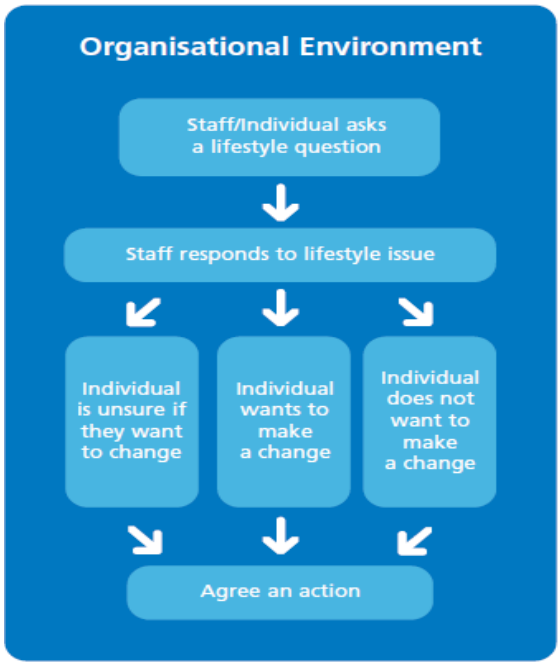


Figure 2

3.4 Most commonly a lifestyle issue will be about encouraging people to:

- Stop Smoking
- Eat Healthily
- Maintain a Healthy Weight
- Drink alcohol within the recommended daily limits
- Undertake the recommended amount of physical activity

3.5 Initially this work has focused predominantly within NHS organisations, given the large number of patients and staff involved in these organisations and the need to deliver this by March 2013. However, it was intended to develop this project in such a way that it is also be rolled out to all other relevant organisations, with a particular emphasis on the Local Authority.

3.6 Every day organisations have millions of opportunities to improve the health and wellbeing of service users, the public and colleagues by Making Every Contact Count (MECC). This involves:

- Systematically promoting the benefits of healthy living across the organisation
- Asking an individual about their lifestyle and if they want to make a change
- Responding appropriately to the lifestyle issue/s once raised
- Taking the appropriate action to either give information, signpost or refer service users to the support they need

3.7 To deliver MECC, organisations need to build a culture and operating environment that supports and encourages continuous health improvement to help to reduce health inequalities. Any implementation model to make this happen needs three core components: organisational readiness; staff readiness and enabling and empowering the public.

3.8 Responsibility for delivery of the MECC initiative sits within the Solihull Public Health Directorate.

4. Solihull Public Health Context for MECC

4.1 Adopting the MECC programme (supported by evidence based approaches[1] to encouraging, educating, signposting and helping people to make a lifestyle change) is a key strategic approach to increasing healthy life expectancy of Solihull residents.

4.2 Unhealthy lifestyle behaviours create a financial and resource burden on the NHS, Local Councils, businesses and society as a whole, and generate inequalities in health outcomes. Across Solihull it is estimated:

Table 1

Lifestyle risk issue	Solihull (%)	West Midlands
Adults smoking	15.8	20.1
Binge Drinking	17.6	18.8
Adults not meeting healthy eating standards	72.4	74.3
Adults not meet recommended physical activity levels	11.5	10.3 (England Average)
Obese adults	23.8	26.4

Source Solihull JSNA 2012

4.3 People who follow all four healthy lifestyles live 14 years longer on average than those who follow none. Reducing the burden of preventable, non-communicable disease is a priority for Solihull. Solihull's three biggest killers are strongly correlated to lifestyle factors with smoking alone directly attributable to:

- 1 in 4 of all cancers,
- 1 in 5 deaths from cardiovascular disease (heart disease and stroke),
- 1 in 3 of all deaths from respiratory disease.

4.4 The burden of unhealthy lifestyles falls disproportionately on people living in deprived circumstances (see figure 3). In particular, in North Solihull, where the difference in life expectancy amongst the most deprived is 10.8 years for males and 10.3 for women when compared with the least deprived living in the South of Solihull. Around 5 years of this can be directly attributed to smoking. Consequently, CVD accounts for the largest part of the health inequalities in Solihull. The smoking rate in Solihull is lower than the national average (15.8%), however, there is significant variation in smoking prevalence across wards, ranging from

[1] Health Inequalities Intervention Tool

10% in one of the most affluent areas to 41% or more in the most deprived communities. The pattern is similar for obesity and physical activity, with an inverse correlation between deprivation and healthy weight and greater physical activity.

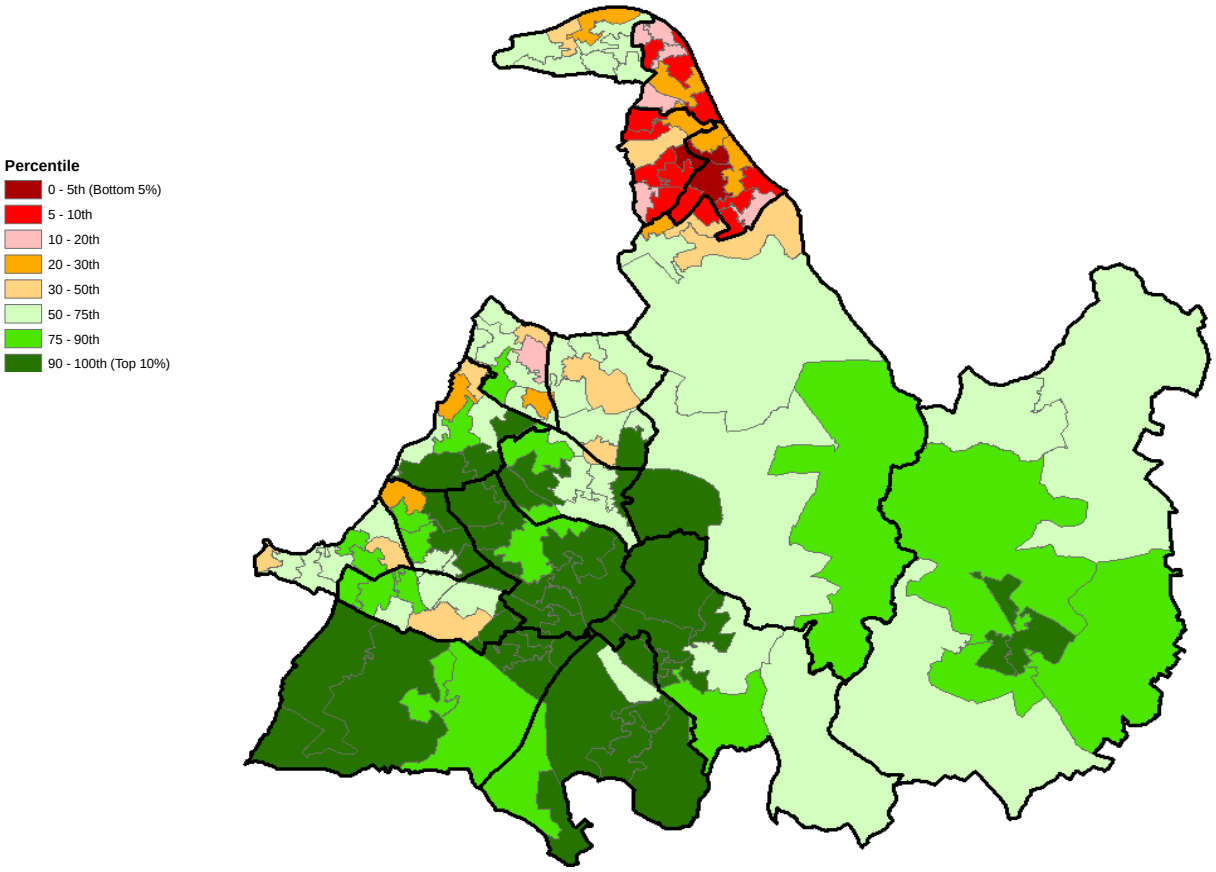


Figure 3

4.5 Reducing the burden of preventable, non- communicable disease is a priority for Solihull.

4.6 Thousands of routine contacts take place each year across the NHS and Local Authority in Solihull; introducing MECC offers the opportunity to add value to a proportion of them so that every aspect of public services can make a positive difference. Brief advice given to just ten service users a year by frontline staff will equal thousands of opportunities each year and yet take up very little staff time.

5. Policy overview

5.1 In January 2012, the NHS Future Forum published a Government sponsored report [2] which recommended the MECC approach, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco – whatever their specialty or the purpose of the contact.

5.2 Locally, MECC was an initiative developed by NHS Midlands and East and one of the five SHA cluster ambitions outlined in the Regional Commissioning Framework 2012/13.

5.3 The West Midlands Strategic Health Authority developed an e-learning tool called Every Contact Counts which was launched in November 2011 to support implementing MECC.

5.4 In May 2012 NHS Midlands and East published the MECC Implementation Guide and Toolkit: http://learning.nhslocal.nhs.uk/courses/areas-care/health-management-resources/making-every-contact-count

5.5 The NHS Midlands and East Regional Commissioning Framework 2012 / 13 proposed that success will be measured by evidence of the organisational readiness of NHS organisations and partner organisations. This would be assessed through the following:

- Evidence of board level commitment to implementation
- Board level lead/champion in place
- Evidence of organisational policies and procedures in place, for example organisational health and wellbeing development strategy, suitable data collection and reporting mechanisms, use of induction
- Evidence of activity to support employees own health and wellbeing
- Number of NHS staff completing locally agreed training in delivering lifestyle brief advice
- Increased number of referrals from NHS organisations to local stop smoking services, as a key indicator for delivery of brief lifestyle advice from NHS staff.

5.6 National policy drivers in support of the adoption of MECC include[3]:

- Wanless Review (2004) – fully engaged scenario
- Clustering of Unhealthy Behaviours over time. The Kings Fund (2012)
- Darzi Review (2008) – need to put prevention first
- Marmot Review (2010) - strengthen the role & impact of ill-health prevention
- NICE (2007) – Behaviour Change Guidance
- NICE (2008) – Smoking Cessation Services Guidance
- SIPPs (2008) – alcohol brief advice
- Improving Health Changing Behaviour NHS Health Trainer Handbook (2012)

[2] The NHS's role in the public's health: A report from the NHS Future Forum. DH 2012
[3] http://learning.nhslocal.nhs.uk/features/managing-yourself-and-others/mecc-resource-making-case-presentation

- MINDSPACE (2010) – influencing behaviour change through policy
- COI Communications and Behaviour Change
- DH Health Inequalities National Support Team Health Gain Programme (2011)
- COI Synthesis of key behaviour change documentation (2011)

6. Evidence

6.1 MECC is an example of a systematic, 'industrial' approach to implementing Brief Advice (BA) with the aim of raising an issue and signposting to further support, and to dispel myths and give accurate information.

6.2 There is good evidence to support the delivery of the more intensive Brief Interventions (BI) around specific lifestyle behaviours, particularly in a clinical setting and by clinical staff. There is more limited evidence to support the delivery of BAs, again in the context of defined clinical groups delivering the intervention in specific settings but they have been found to be effective in tackling:

- Smoking
- Physical activity
- Alcohol use

6.3 The evidence base demonstrates the importance of staff being trained to deliver BAs or BIs and of having clear pathways into lifestyle services. Unless staff know where they can refer patients who may express a willingness to change their behaviour they are unlikely to be willing to initiate the conversation.

6.4 There is not as yet a documented evidence base to support the delivery of BA or BI by a generic frontline workforce in a range of settings, as in the MECC approach. However, as MECC is now being delivered across the NHS the evidence base is likely to emerge and grow.

6.5 Much of the work locally has focussed on identification and brief advice around drinking and smoking. There is strong evidence that delivering Brief Opportunistic Advice by frontline staff for both alcohol[4] and smoking are both clinically and cost effective interventions. Consequently, smoking[5] and alcohol[6] had been identified in QIPPP (Quality, Innovation, Productivity, Partnership and Prevention), as target areas where improvements to interventions such as brief advice, are likely to have a significant impact upon patient health and where cost-savings can be demonstrated.

6.6 The National Support Team Health Gain Programme which was built on insight from work taking place across England, highlighted that NHS and health and social care providers are not systematically offering lifestyle support to all those who could benefit from it, and as a result the potential population health benefits are not being achieved. They stated that only with systematic, scaled and sustainable approaches will such activity contribute to measurable change and reduced mortality at population level. The NST HGP highlighted the importance of:

[4] NICE Public Health Guidance 24. Alcohol Use Disorders: Preventing harmful drinking
[5] NICE Public Health Guidance 1 (2006). Brief Interventions and referral for smoking cessation in Primary Care and other settings.
[6] Delivering QIPPP Staying Healthy: Reducing Alcohol Related Harm (2010)

- Leadership
- Coordination
- Workforce development
- Responsive services to support service user need

Further evaluation has shown that:

- 1 in 8 people respond to brief advice about alcohol intake by reducing their drinking behaviour by one level e.g. from increasing risk to lower risk
- 1 in 20 people go on to quit smoking following brief advice.

6.7 **Benefits of Making Every Contact Count**

6.7.1 **Patient / Service User Benefits** – Better health and longer, healthier lives for the people of Solihull. By Providing advice and support for behaviour change, we reduce the risk factors that are the causes of Cancer and Coronary Heart Disease. These diseases are the biggest killers in this region and are also the cause of years of disability for many people.

6.7.2 **Quality Benefits** - One of the main principles of the MECC framework is to work with individuals and communities from their perspective. This requires staff to be understanding and responsive, offering advice tailored to an individual's circumstances. Not only is this likely to be more effective, it will make advice and support services more accessible, as well as community and patient focused.

6.7.3 **Efficiency Benefits** – This approach uses the everyday contacts patients have with a range of frontline services, training and preparing frontline staff to Make Every Contact Count will 'build in' the ability of more and more frontline staff to offer brief advice and interventions to help patients change their behaviour and stay healthy. As this will require the engagement of frontline staff from a range of key organisations (LA, Police, Fire Service, Voluntary Sector), the workforce transformation will be a big step in moving towards the 'fully engaged' scenario described in the Wanless Report as the best way to deliver productivity as well as better health.

6.7.4 **Benefits of MECC Training** – Evaluation has demonstrated that training enables staff to deliver MECC, but importantly it has shown that 65% of those trained improved their own health behaviours and 50% have practiced their skill with family and friends. Training in MECC thus provides potential benefits to staff health as well as population health.

6.7.5 **Financial Benefits** – Applying MECC across the key organisations has the potential to make significant cost savings across the NHS and Social Care systems. Investment in prevention significantly reduces the costs in both Acute and Primary Care. Benefits to other sectors by adopting this approach, including Social Care and Criminal Justice are also likely to be significant. These benefits will be recognised in both the population accessing these frontline services and the employees working within them.

7. Review of current position

7.1 **Background**

The former NHS Midlands and East SHA expected that Primary Care Trusts (PCT's) would want to play a key role in ensuring that the MECC ethos was properly embedded within its health economy by:

- Ensuring that PCT staff had access to healthy lifestyle interventions/services and that the organisation had a robust staff health and well-being programme in place.
- Worked closely with providers to ensure that MECC was robustly and sustainably embedded within their organisational practices;
  - ensuring staff were equipped to deliver brief interventions, lifestyle advice and signposting to lifestyle behaviour change services to patients;
  - Developing an easily accessible directory of local lifestyle behaviour services to facilitate signposting and referral.
- Working within organisation with colleagues in contracts and commissioning teams to ensure that MECC was embedded in contracts in the future.
- Supporting CCGs, Local Authorities and other stakeholders to develop MECC and ensuring that they are equipped to lead the agenda from 2013.

The SHA developed measures at three levels:-

1. Organisational readiness and leadership
2. Staff readiness and training
3. Delivery of brief advice, signposting and referral to behaviour change services

In accordance with the cluster SHA approach to Public Health performance, there was at least one (essential) metric at each level to be included in the Integrated Board Report, as well as other (desirable) measures to provide a more rounded view of progress, reporting quarterly.

The SHA developed an online training package of two modules to prepare staff with the knowledge and skills to deliver brief lifestyle advice to patients and clients. Module one covers the basics with brief opportunistic advice; Module two covers motivation and brief opportunistic interventions in greater depth.

Over 400 Solihull frontline Provider Staff have completed Module One and almost half have gone on to complete the second. The table below shows the numbers from each Trust locally:

Table 2: Solihull Provider Staff Trained in Brief Advice and Brief Interventions (as of 26/03/13)

Trust	Module One	Module 2
HEFT	235	112
BDH	-	-
B&SMHFT	20	11
Sol PCT	42	29
Solihull MBC	3	1
Solihull CCG	1	0
NHS Birmingham & Solihull	1	0
Total	400	153

7.2 Initial work within the NHS focused on developing CQUINs (Commissioning for Quality and Innovation) with the main provider trusts to incentivise signing up to MECC and to screen and give brief advice for smoking and alcohol. CQUINs on MECC were included in the contracts with all Foundation Trusts, except UHB, for 2012/13. Each Trust had to demonstrate the three SHA measures:

1. Organisational readiness and leadership
2. Staff readiness and training
3. Delivery of brief advice, signposting and referral to behaviour change services

with the latter being monitored through levels of referral to Stop Smoking Services as data flows are already well established and of reasonable quality which can act as a proxy for other referrals to lifestyle services.

7.3 **Current Position**

7.3.1 Clinical Commissioning Groups (CCG's)

Solihull CCGs are not as yet directly involved in MECC, other than as part of succession planning. The SHA had indicated that CCGs would be leading the agenda on implementation of MECC in their Provider contracts from April 2013. There was a commitment to taking this forward at the annual accountability review meetings held in May and June 2012.

7.3.2 **NHS** & **Health Providers**

The Brief Advice component to MECC for Smoking and Alcohol, have been agreed as a reporting requirement within the Quality Schedule of the 2013/14 HEFT Acute and Community Contracts. This will cover all outpatients and the vast majority of inpatients. HEFT are confident that have already met the requirements for Organisational Commitment so this is not being reported as a Quality Requirement for 2013 /14 Contract Monitoring purposes.

	MECC	Smoking	Alcohol

HEFT - Acute	-	✓	✓
HEFT - Community	-	✓	✓
BDH	✍	✍	✍
B&SMHFT	✍	✍	✍

Providers of Lifestyle Services, commissioned by Public Health, including Health Trainers, Dietetics, Weight Watchers, Stop Smoking Service, SIAS etc have also been requested by PH Commissioning Managers to ensure that staff have completed the online ECC training and use the MECC approach for areas outside of their specialism.
Discussions have started to take place with Primary Care to ensure frontline staff who have not received the training are encouraged to do so.

7.3.3 **Local Authority**

MECC has yet to be rolled out within the Local Authority. MECC is cited as an action within the Health & Well Being Strategy and Public Health have already held a number of events / presentations to inform relevant colleagues about the benefits of MECC. Many Council Departments have expressed an interest in implementing MECC. So far, informal discussions have taken place with Children's Services, Schools, Library Services, Housing, Police, Fire Service, Welfare Services and frontline staff going into the new north Solihull Village Centres.

7.3.4 **Third Sector**
Opportunities are being discussed and taken forward with the emerging Residents Groups such as CHASE and PLUSH in North Solihull and with Sustain.

7.3.5 **Business Sector**
Some local businesses have expressed an interest in MECC. John Lewis Partnership have agreed to train all of their Health & Safety staff locally to deliver MECC to their workforce.

8. The Aspiration of MECC across Solihull

8.1 **Clinical Commissioning Groups and Provider Trusts**
CCGs have taken on responsibility for the commissioning and performance management of Provider Services, including MECC. MECC should continue to be a standard rolling Quality Requirement embedded within the main NHS Provider Contracts from 2013/14, with the potential for further CQUINs to roll out MECC in the future. MECC is a key role for Public Health. This should be included as part of the Public Health offer to CCGs, helping them to understand and implement MECC and the healthy lifestyles Information Requirements in Provider contracts.

8.2 **Public Health**

Public Health leads will keep CCGs, Provider Trusts and other sectors delivering MECC informed of changes in provision and access to Lifestyle Services which support MECC delivery, such as Stop Smoking and Weight Management.

If MECC is to be a key strand of a local health improvement strategy, and widely implemented across the Local Authority and other public sector services, it will require support and input at all levels in the Public Health Team to make the case for MECC and promote its implementation effectively.

The SHA e-learning modules may not be accessible or suitable for all staff; they may require face to face training either instead or in addition to the online options. Providing training for the delivery of MECC is potentially an important role for the Public Health team to ensure wider and successful implementation. This would require resources, which could be:

- provided 'in-house' by members of the Public Health team
- commissioned from a training organisation – possibly jointly across an area wider than just Solihull
- Incorporated as part of the contracts for Lifestyle Services, which often include some elements of training already and could be orientated towards MECC.

Public Health Service commissioning leads should also ensure that MECC implementation is included in all contracts with providers of services.

8.3 Local Authority

Effective implementation of MECC in the Local Authority will require senior, strategic Board level support from DPH and Chief Executive. MECC complements the LEAN approach and will require a culture and infrastructures supportive of lifestyle improvement.

Given the scale and variety of services that could potentially deliver MECC, implementation might require prioritisation and a phased approach. Services where MECC could make the most impact are those serving clients in more vulnerable groups and communities and which already have a welfare role, such as Social Services, Integrated Family Support Teams, Neighbourhood Offices, Housing, Employment Children's Centres etc. Other services such as Leisure and Libraries have a proportion of staff and clients who are probably more interested in health and receptive to MECC.

8.4 Third Sector

Public Health will lead on rolling out partnership with Voluntary Sector organisations to promote MECC within this sector through Sustain. An implementation plan with Sustain will be agreed within the 2013/14 contract for their staff to cascade MECC information through their network.

Dissemination of MECC to local community organisations and groups could also be included in future commissioning of community development /engagement initiatives or services.

8.5 Business Sector

Selected businesses will be approached via their HR teams and offered, as part of a menu of Lifestyles Services on offer, the opportunity to train their Occupational Health staff in MECC.

9. Operational Delivery

9.1. Supporting Delivery

To enable frontline staff to support the delivery of MECC, a number of supporting mechanisms need to be in place. These are outlined above in Figure 4 (below).

Health and Wellbeing Strategy; Senior Management sign off; Board Level Champion and Senior Key Champions; Budget Allocation; Staff Wellbeing Programmes. Care Pathways; PH Portal; Measurement Systems in place

Induction Training; Job Description; Cue Cards; MECC Training; Contractual; Attitude Change

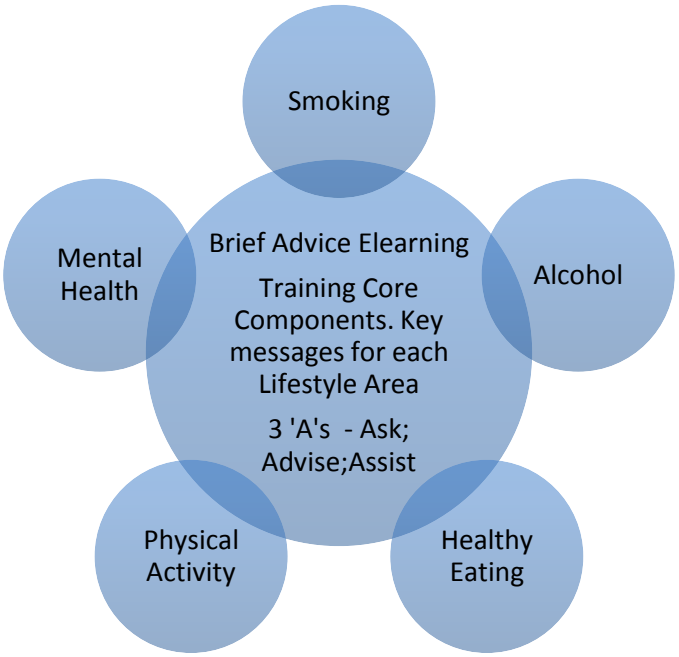
Communications regarding service user expectations via Plasma screens; Posters; Lanyards; Events Calendars; Community Hubs; Single Point of Contact; Healthy Living Pharmacies; Maternal Obesity Pathway; Z Cards.

Figure 4

9.2 An Implementation Plan will be developed which will outline in detail, how the ambitions outlined in the Strategy will be delivered.

9.3 Issues to be raised

The five core Public Health priorities which are included in the Brief Advice are identified are: outlined in figure 5 (below)



- Figure 5
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1. Smoking
2. Alcohol
3. Healthy Eating
4. Physical Activity
5. Mental Health

This list is not an exhaustive list and face to face training can be tailored to staff teams who regularly deal with a number of other issues and therefore may also include other priority areas such as:-

- Sexual Health
- Domestic Abuse
- Breastfeeding
- Falls
- Winter Warmth
- Substance misuse
- Fuel Poverty

- Debt Advice
- Parenting support
- Dental Advice

An example of some of the topic key messages currently used in Coventry can be seen below:-

Key Messages:

Stopping smoking

The single most important thing you can do to improve your health.
You are up to 4 times more likely to quit if you get help from the NHS Stop Smoking Service. To find your local service call 0800 085 2917 or text LIFE to 80800.

Maintain a healthy weight

Maintain, or aim for, a healthy weight (BMI 20-25). Eating a healthy diet - Eating at least 5 portions of fruit & vegetables each day and cutting down on fat, salt and added sugar is the most effective way to loose weight if you are overweight or obese.

Being physically active

Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more, one way to approach this is to do 30 minutes on at least 5 days a week. Exercise is important for everyone in staying healthy and maintaining a healthy weight.

If you drink, keep within sensible limits

If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. You can use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

Look after your sexual health

This means enjoying the sexual activity you want, without causing yourself or anyone else any suffering, or physical or mental harm. Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both.

Mental Health

Manage your stress levels. Talking things through, relaxation and physical activity can help. Have a good work/life balance. Developing interests outside of work can help reduce stress and improve productivity.

Taken from the 12 key Public Health Messages, for full list see pull out poster

9.4 **Training**

There are three types of training:-

Brief Advice:

There will be an expectation that all frontline staff will have received training in Brief Advice. This may be the online training; online training with additional face to face training or bespoke face to face training only.

Brief Intervention:

For certain staff groups, it may be beneficial to build upon the Brief Advice Training and Brief Intervention Training may be a useful addition.

Train the Trainer:

The idea behind this is that it may be appropriate to train some members of teams to become Trainers themselves and to cascade the training on Brief Advice to other members of their team.

10. Recommendations

10.1 To establish a consistent approach to delivery across organzsations that meets the competency framework and to ensure, as far as possible, that all MECC work is captured.

10.2 it is recommended that all work on MECC is co-ordinated through a Solihull MECC Implementation Group and this Group will then report to the Health & Wellbeing Board. It is recommended that the MECC Implementation Group has representation from PH, HR, Coventry & Warwickshire MECC Team; Communications, LEAN Team; CCG; Senior Management from main Provider Organisations.

10.3 That all Provider organisations within and outside of the NHS, have Board Level Commitment to delivery of MECC and this is implemented through a local action plan overseen by the implementation lead.

10.3 The use of CQUIN's and other contractual arrangements such as Memorandums of Understanding (MOU's) and the Core Offer are used to assure that organisations sign up and deliver MECC.

10.4 That this Strategy will focus upon Level 0 and Level 1 (Brief Advice) at this stage.

10.5 All frontline staff trained within 2 years in the NHS and Partner Organisations.

10.6 As a basic requirement to be considered competent as an individual and organisation to deliver MECC, staff should undergo Level 1 NHS Local Training.

10.7 Development and securing additional resources to support the implementation of MECC, through local pilots and match funding commissioning for training where appropriate and necessary.

10.8 That Public Health will lead the MECC agenda across Solihull supporting the implementation of MECC across organisations. Specifically through developing a shared ambition and implementation promotion / championing the MECC agenda, working with organisations to understand and secure the resources to deliver this ambition and leading the monitoring/evaluation of the programme.

10.9 There are clear pathways into the key Lifestyles Services. The planned Single Point of Contact should help facilitate this.

10.10 MECC is included in induction, mandatory training and Job Descriptions in partner organisations.

10.11 To work in conjunction with Coventry & Warwickshire MECC team

11. Outcomes & Monitoring

11.1 **Indirect Outcomes** will include:-

The overall success of this plan will be measured through the achievement of a number of high level performance indicators taken from the Public Health Outcomes Framework (and Health Profiles), including:-

- Reduction in smoking at time of delivery
- Reducing the smoking prevalence – adults (over 18's)
- Reducing the proportion of adults with excess weight
- Increasing the proportion of physically active adults
- Slowing the increase in the rate of alcohol-related hospital admissions to below the forecast trajectory
- Reduction in A & E for alcohol related injuries / conditions
- Increase in the uptake of the NHS Health Checks Programme
- Improvements in self-reported wellbeing as measured on the Warwick – Edinburgh Mental Wellbeing Scale

11.2 **Direct Outcomes** will include: -

- Reported frontline Staff attitude and behaviour (including intention) towards using a MECC approach
- Referrals into Lifestyles Services (Stop Smoking Service)
- Patient Surveys (asking about awareness of the Role of Frontline staff in MECC / have they received Brief Advice).

11.3 Monitoring:

The actions within this plan will be monitored through a series of multi-agency groups including the Public Health Senior Management Team, Local Strategic Partnerships and Boards, with progress reported on a regular basis to the Health and Wellbeing Board.