Making Every Contact Count

Report to Health and Wellbeing Board

January 2018

Public Health

Ealing
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Our vision is to empower Ealing residents to live longer and healthier lives by changing the way we all talk about lifestyle behaviours.

Making Everyone a Catalyst for Change

Executive Summary

1. MECC is a cost-effective method of embedding prevention in everyone's business. It empowers residents to take control of their lifestyles and make healthier choices.

2. MECC is a national programme and has attracted increasing attention over recent years across London and the NorthWest London Sustainability and Transformation Partnership (STP).

3. Ealing's Health and Wellbeing Strategy 2016-2021 aims to increase the use of 'Making Every Contact Count', and this in turn contributes to other workstreams, most notably:

    a. Reduce smoking prevalence
    b. Increase physical activity
    c. Help improve people's mental health
    d. Reduce alcohol admissions

4. MECC contributes to Future Ealing priority 4: Residents are physically and mentally healthy, active and independent.

5. This document is an update to *Making Every Contact Count Vision 2015-2017* which laid out the rationale and intentions for a Making Every Contact Count programme from 2015-2017. The programme attracted investment from Health Education NorthWest London and Ealing CCG and was extended until March 2018.

6. It is notoriously difficult to measure the full health and wellbeing impacts of preventative activities or the return on investment of prevention programmes. However, our data suggest that in its first year the programme will deliver an estimated 74,000 MECC conversations and 38,000 lifestyle changes, at a cost of less than £3 per lifestyle change.

7. To date, the MECC programme has delivered outputs, outcomes and impact over and above what was expected, and it has enhanced the reputation of Ealing Council and the HWB locally and across London.

8. Funding is to cease at the end of March 2018. It is therefore timely to consider options for the future of the programme.

Recommendations

The following recommendations are drawn from the audits performed of Ealing's progress against the national MECC Implementation Toolkit and the draft London MECC Pledge

1. Identify budget and resources to progress MECC post-March 2018 including to:

    a. cascade face-to-face and online MECC training further for example to the housing sector, departments other than ASC within council, additional pharmacies and GP practices, more voluntary sector, fire service, police service, hairdressers and barbers, nail salons, dentists.

    b. further evaluate impact on service users, referral rates and uptakes and staff wellbeing

    c. design and deliver MECC Training the Trainers programme

    d. design and deliver MECC Action Learning Sets or refresher training

    e. deliver MECC celebration / awards events

    f. develop and communicate MECC resources – e.g. e-learning, London MECC hub, signposting and referral resources

    g. develop strategy to increase trainees involvement in MECC strategy development

    h. explore potential for income generation of MECC and other behaviour change training

2. Identify MECC Lead post-March 2018

3. Identify MECC Implementation Team membership (including HWB and Council Executive Board leads) and ToR.

4. Deliver MECC communications to Chief Exec, department heads and councillors e.g. presentation, taster training, full training – one-off plus regular updates

5. Identify key personnel who can support changes to infrastructure across local health and social care organisations such as ensuring health is in all organisational policies and that MECC is included in standard reporting procedures, job descriptions, person specifications, mandatory training, supervision, team meeting agendas and appraisals.

6. Identify criteria, role and support needs of MECC champions

7. To further improve healthy workplace initiatives eg active travel schemes, healthy vending machines, healthy catering contracts.

Contents

Introduction

This document is an update to *Making Every Contact Count Vision 2015-2017*. This described the critical impact of people's lifestyle choices on healthy life expectancy and on the public purse, costing the country 100's of billions of pounds a year.

In the UK non-communicable diseases cause an estimated 89% of deaths, the most significant cause being the major diseases of the health and circulatory system (coronary heart disease and stroke). These conditions are also, to a significant extend, preventable and the costs, in human, social and economic terms, are largely avoidable. The World Health Organisation identifies the four most important modifiable risk factors for these diseases as tobacco use, physical inactivity, the harmful use of alcohol and unhealthy eating.[1]

Around 40% of premature mortality in the UK is caused by preventable cardiovascular disease, diabetes, cancer and chronic obstructive pulmonary disease.[2]

There is a crucial need for population-level behaviour change, and the evidence is that Making Every Contact Count can contribute significantly and effectively to this.

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations. Drawing on behaviour change evidence[3], MECC maximises the opportunity within routine health and care interactions for a brief or very brief discussion on health or wellbeing factors to take place.[4]

Making Every Contact Count is designed to be a very brief, or brief individual behaviour change intervention as mapped on the triangle below.

MECC is not an add-on to what staff already do. Instead it is a style; a way of approaching and structuring a conversation so that it is:

1. Brief, and
2. Effective

MECC skills can be transferred to other settings, to other health behaviours and to the wider determinants of health, eg employment, housing, oral health, sexual health, etc. However it is not intended to be a panacea for all situations.

[1] https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf accessed 21/12/17

[2] Written evidence from UK Health Foum (NHS01420 quoted in https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf accessed 21/12/17

[3] 2 Michie, S. et al, (2011) The behaviour change wheel: A new method for characterising and designing behaviour change interventions, Implementation Science 20116:42

[4] Making Every Contact Count (MECC): Consensus statement. Public Health England, NHS England and Health Education England et al. April 2016

MECC activity is detailed in the 2 layers at base of the pyramid below

Behaviour change interventions mapped to NICE Behaviour Change: Individual approaches/PH49

Behaviour change interventions diagram by Health Education England – Wessex Team

Many of Ealing Council's over 3,000 employees interact with residents, and each interaction can influence people's lifestyle choices. It is our responsibility to ensure these interactions are empowering, encourage independence, boost people's mental and physical wellbeing, and that they encourage and enable people to make healthier choices. MECC works from evidence of what works in individual behaviour change[5], and where appropriate builds this into every possible interaction.

MECC recognises that even just asking someone about their lifestyle behaviour can influence change, and it is of value to provide people with a safe temporal space to reflect on their choices and consider whether to, and how to change.

MECC itself was developed in 2009 by NHS Yorkshire and Humber as a long-term strategy to help create a healthier population and thereby reduce NHS costs. It aimed to radically extend the delivery of public health advice to the public by training non- specialist staff from a wide range of service organisations for minimal investment, in the basic skills of health promotion and prevention and thus create an "extended sales force for healthier living".[6] The initial aim of MECC was couched as

[5] NICE public health guidance 49: Behaviour change: individual approaches, January 2014
[6] Ion V (2011) Making Every Contact Count: a simple but effective idea. *Perspectives in Public Health* Vol. 131, No. 2 , March 2011

mobilizing the greatest asset of the NHS, its workforce, in delivering simple and timely advice to the vast potential number of service users they come into contact with on a daily basis.[7,8]

Our long-term vision is for everyone in Ealing – employers, employees and residents – to facilitate improvements in lifestyle behaviours – Making Everyone a Catalyst for Change. We want to empower Ealing residents to live longer and healthier lives by changing the way we all talk about lifestyle behaviours.

We need and want to embed MECC in the culture of public sector, voluntary and provider organisations, thereby contributing to improving public health outcomes[9] such as:

2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)
2.11ii - Average number of portions of fruit consumed daily (adults)
2.11iii - Average number of portions of vegetables consumed daily (adults)
2.12 - Excess weight in Adults
2.13i - Percentage of physically active and inactive adults - active adults
2.13ii - Percentage of physically active and inactive adults - inactive adults
2.14 - Smoking Prevalence in adults - current smokers (APS)
2.18 Admission episodes for alcohol-related conditions – narrow definition (Persons)
2.23iv - Self-reported wellbeing - people with a high anxiety score

In the medium term we want everyone that works with Ealing residents to confidently ask about lifestyle behaviour, and if appropriate, and with consent, to offer some brief advice and assistance.

In the short term our plan was to provide MECC training to at least 660 staff by April 2018, focusing on community health professionals, primary care staff, adult social care staff, and voluntary sector staff and volunteers. The training was also to be offered to anyone else working with the public from the NHS, Council, Voluntary Sector, and provider services.

[7] Approximately 83% (51,220,337) of this population is registered with GP practices (The Health and Social Care Information Centre, 2010). In 2009 16,232,579 people were admitted to the NHS hospitals, 11,004,867 attended the first visit in outpatients' clinics (The NHS Information Centre, Hospital Episode Statistics for England. Outpatient statistics, 2008-2009) and 18,8 million individuals attended the A&E Departments from April 2008 to March 2009 (The NHS Information Centre, Hospital Episode Statistics: Accident and Emergency Attendances in England - experimental statistics, 2008-2009)
[8] Implementing 'Making Every Contact Count': a scoping review, Kent, Surrey, Sussex Final Report November 2014 Jane Wills and Vince Ion London South Bank University
[9] http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000009/iid/22304/age/164/sex/4 accessed 20/04/17

National and Local Context

MECC in Ealing is integral to the delivery of significant national and local initiatives and strategies:

1. The **NHS Five Year Forward View**[10] argues that 'the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness.'

2. **NICE** Behaviour Change Guidance[11] makes the following recommendations to which MECC is aligned:
    - Develop a local behaviour change policy and strategy
    - Ensure organisation policies, strategies, resources and training all support behaviour change
    - Commission interventions from services willing to share intervention details and data
    - Commission high quality, effective behaviour change interventions
    - Plan behaviour change interventions and programmes taking local needs into account
    - Develop acceptable, practical and sustainable behaviour change interventions and programmes
    - Use proven behaviour change techniques when designing interventions
    - Ensure interventions meet individual needs
    - Deliver very brief, brief, extended brief and high intensity behaviour change interventions and programmes
    - Ensure behaviour change is maintained for at least a year
    - Commission training for all staff involved in helping to change people's behaviour
    - Provide training for behaviour change practitioners
    - Provide training for health and social care practitioners
    - Assess behaviour change practitioners and provide feedback
    - Monitor behaviour change interventions
    - Evaluate behaviour change interventions
    - National support for behaviour change interventions and programmes

3. MECC is supported by:[12]
    - Public Health England
    - NHS England
    - Health Education England
    - Royal Society for Public Health
    - National Institute for Health and Care Excellence
    - Association of Directors of Public Health
    - NHS Employers
    - Royal College of Nursing
    - Local Government Association
    - Care Quality Commission

[10] NHS Five Year Forward View October 2014
[11] NICE public health guidance 49: Behaviour change: individual approaches, January 2014
[12] Making Every Contact Count (MECC): Consensus statement. Public Health England, NHS England and Health Education England et al. April 2016

- NHS Improvement

4. Health Education England have produced a **MECC Implementation Guide and Toolkit**[13]

5. The London MECC Steering Group have developed a draft **London MECC Pledge**[14]

6. MECC is written into the **NHS Standard Contract**:[15]
    - '8.6 The Provider must develop and maintain an organisational plan to ensure that Staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance.'

   Any provider of healthcare services, including the independent sector e.g. care homes and the third sector, commissioned under an NHS Standard Contract is eligible for the NHS England CQUIN[16]. CQUIN is a financial incentive designed to support the ambitions of the Five Year Forward View and drive transformational change across the healthcare system. Included in the 2017-19 CQUIN are two targets specifically relevant to MECC:
    - Improving Staff Health and Wellbeing
    - Preventing ill health by risky behaviours – alcohol and tobacco

7. Ealing's **Health and Wellbeing Strategy**: MECC contributes to all four long-term ambitions within the strategy.
    - Create and sustain good mental and physical health for children and adults at every stage of life
    - Reduce health inequalities by improving outcomes for neighbourhoods and communities experiencing poor health
    - Enable people of working age to participate as fully as possible in working life, to improve the health and economic outcomes for them and their families
    - Enable everyone to be healthy and independent for as long as possible, helping to prevent or delay the need for social and acute care

8. **Future Ealing**: MECC can make a significant contribution to delivering outcome 4 of Ealing Council's Future Ealing programme:
    - Residents are physically and mentally healthy, active and independent

   One of the strategic objectives for Ealing CCG as part of the CWHHE Collaborative of CCGs is to enable patients to take more control of their health and wellbeing. The key deliverables for this are to focus on the **self-care agenda** and to ensure that 'patients taking more care of their health' becomes a mantra in each of the service transformations that the CCG undertakes. Self-management support means moving patients away from patients as passive recipients of care to a collaborative relationship where patients are active partners in their own health. To do this, patient need to develop their knowledge, skills and confidence to make informed decisions and adapt their health related behaviours. They need to be supported by health professionals with the skills, expertise and confidence to support them in making informed decisions, achieving their goals and overcoming barriers.[17] To support

[13] Insert reference
[14] Insert reference
[15] NHS Standard Contract 2016/17 Service Conditions
[16] Commissioning for Quality and Innovation
[17] Ealing Self Care Strategy FINAL Oct 2015

self-care as part of the **Models of Care** scheme Ealing CCG has committed to implement 'Making Every Contact Count' initiatives[18]

9. **Better Lives** – The Adult Social Care workforce are moving towards 'strengths based practice' which, just like MECC, "is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets..."[19] MECC has been integrated into a substantial Motivational Interviewing training programme which has been delivered to nearly 200 Adult Social Care staff and volunteers.

10. **To improve health and wellbeing, the North West London health and care partnership is working together on these priorities[20]:**

    - **Supporting local people to live healthier lives -** support all residents to live longer and healthier lives by preventing illness and promoting physical and mental wellbeing
    - **Promoting mental wellbeing and reducing loneliness -** support individuals to have the best possible mental health as an active member of their community
    - **Giving children the best start - s**upport vulnerable families to improve their children's life chances and reduce likelihood of needing longer-term mental health support.
    - **Roll out of the national Making Every Contact Counts** *(sic)* **programme -** train relevant non-specialist staff to have helpful health and wellbeing conversations with public, patients and families.

11. **Coaching for Health** training sets out to provide health care professionals with the skills to change the kind of conversations that they will have with patients and service users in order to encourage self-care and to support behaviour change. While MECC provides level 1 behaviour change interventions. Coaching for Health provides level 1-2 interventions.

[18] Ealing Self Care Strategy FINAL Oct 2015
[19] (SCIE, 2014) Care Act 2014: Strengths-based approaches. SCIE, 2015 http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-basedapproach/
[20] https://www.healthiernorthwestlondon.nhs.uk/bettercare/yourgp accessed 21/12/17

Making Every Contact Count Vision 2015-17

A vision document was created in 2015 which laid out the rationale for and intentions for a Making Every Contact Count programme from 2015-2017.

The plan for implementing this programme is to roll out the MECC training in 2015-2017 to a variety of different teams across the borough using a train-the-trainer model. Public Health will start the training in Ealing Council, skilling up key contacts from each of the main stakeholder groups. There will then be an expectation that these key contacts will take responsibility to train up their own teams and provide feedback/numbers on training. After a significant number in Ealing Council have been trained, we shall move into phase two where we look at the voluntary sector, NHS and the CCG and other local organisations which will range from local hairdressers to the fire service.[21]

The intentions expressed in Making Every Contact Count Vision 2015-2017 were as follows:

1. To focus on 'Core MECC[22]' ie very brief interventions about the topics of smoking, alcohol, healthy eating, physical activity and mental wellbeing.

2. To develop and deliver a two-hour training session focusing on:
    a. Key facts on each of the topics, why they are of concern in Ealing, what the national guidance recommends and how an individual can lead as healthy a life as possible
    b. How to provide a brief intervention with a member of the public on each of the topic areas

3. To evaluate the programme as follows:
    a. Pre- and post-course questionnaires to assess knowledge levels
    b. Count of numbers/proportions trained per team
    c. 3-month and 6-month follow-up surveys to assess:
    d. Implementation
    e. Barriers
    f. Further support needs
    g. Case studies
    h. Use of 'MECC referral forms'

Further discussions since September 2016 built on the learning to date and changing circumstance (dedicated funding and staff member) resulted in the following agreements:

[21] Making Every Contact Count Vision, 2015-2017: Ealing Council Public Health
[22] Making Every Contact Count (MECC): Consensus statement. Public Health England, NHS England and Health Education England et al. April 2016

Intended Training Outputs 2016-18[23]

Service Area	Number of courses	Number of Participants
Community Health Professionals (5 out of 6 of: Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists, Psychologists, Pharmacists)	5	**50**
GP practices (eg GPs, Practice nurses, HCAs, receptionists)	**3**	30
Care Coordinators (inc team leaders)	**2**	20
District Nurses	**3**	30
Bedded Units	**1**	10
Home Ward staff	**1**	10
Care Navigators	**1**	10
Community Champions	**1**	10
Urgent Care Centre	**1**	10
DWP	**1**	10
Adult Social Care and Voluntary Sector Partners	**30**	**450**
Voluntary Sector (not already covered in ASC project)	**2**	20
Total	50	660

Intended Training Outcomes 2016-18

	At end of course	At 3-6 month follow up	At 6-9 month follow up
Number of staff improving against identified Learning Outcomes	80%	80%	80%
Proportion of those followed up who report having had MECC conversations at least monthly	-	50%	40%
Proportion of those followed up who report that the MECC training influenced their own lifestyles	-	25%	25%

[23] In bold: figures agreed with commissioners. In plain: assumption is average 10 people per course.

Progress 2015-2017

MECC was initially incorporated into the job role of a member of Ealing Council's Public Health team who delivered eight courses to a total of 37 people between June 2015 and September 2016. Funding was acquired and a full time MECC Training Coordinator role was established with the post being filled in late September 2016. The following data represents only the training delivered since September 2016.

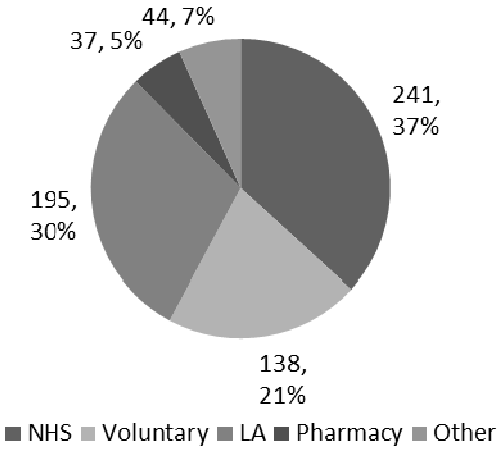
Fifteen month evaluation: 1st October 2016-31st December 2017

Outputs

66 courses were delivered in the 15 months from October 2016-December 2017. These were a mixture of in-house training for individual teams, open multidisciplinary sessions and sessions that were integrated into a larger Motivational Interviewing course for Adult Social Care.

665 people have participated in MECC training,

- 241 NHS; 138 Voluntary Sector; 37 Pharmacies; 195 Local Authority and 44 Other (see chart). A more detailed breakdown of attendees is provided in Appendix 1.



In summary, the number of courses delivered and the number of people participating has exceeded expectations by December 2018, although the distribution of participant roles is different to what was planned.

Outcomes

Various outcome measures were put in place which measured:

- Changes in self-ratings against learning outcomes
- satisfaction levels
- how often particpants were using the training
- to what extent the training influenced particiapnts lifestyles

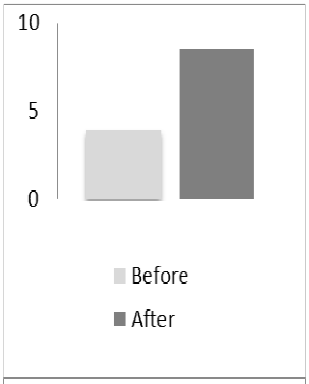
Participants were surveyed immediately after the training, and to gain a view of longer term impact, after three and six months.

Satisfaction

Participants rated the training on average 9.3 out of 10.

Learning Outcomes

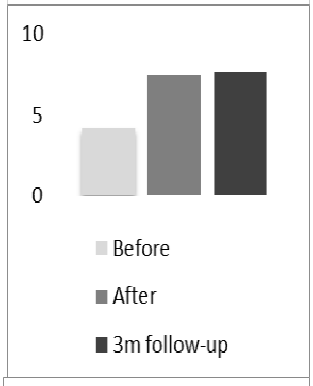
Participants were asked to rate themselves from 0-10 against seven learning outcomes at various points in the programme.



End of Course

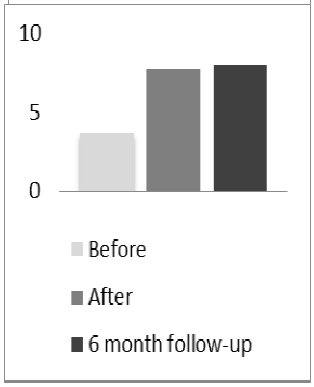
544 end of course evaluation forms were received, in which participants reported improvements in self-ratings against learning outcomes from an average of 3.9 out of 10 before the course to an average of 8.5 out of 10 at the end of the course.

95% of respondents reported that the training had improved their 'competence and confidence to deliver MECC'



Three month follow-up

105 three-month follow up surveys were received, in which participants reported that their learning outcomes increased from an average of 4.1 before the course to 7.5 immediately after the course, to 7.6 after three months. This indicates that respondents felt their learning increased after three months.



Six month follow-up

25 six-month follow up surveys were received, in which participants reported that their learning outcomes increased from an average of 3.6 before the course to 7.7 immediately after the course, to 8.0 after three months. This indicates that respondents felt their learning increased after six months (although numbers are small).

Impact

The impact data was analysed and compared to initial targets, with the results demonstrating that targets have been met or exceeded as demonstrated by the table below.

Training Outcomes to December 2017

	At end of course[24] (actual/target)	At 3-6 month follow up (actual/target)[25]	At 6-9 month follow up[26] (actual/target)
Number of staff improving against identified Learning Outcomes	95%/80%	79%/80%	79%/80%
Proportion of those followed up who report having had MECC conversations at least monthly	-	79%/50%	100%/40%
Proportion of those followed up who report that the MECC training influenced their own lifestyles	-	≥51%/25%	67%/25%

[24] From Sept 2016-Feb 2017 evaluations (n=544)
[25] From 105 responses to 3 month follow-up survey of trainees from Sept 2017 onwards
[26] From 25 responses to 3 month follow-up survey of trainees from Sept 2017 onwards

Qualitative Feedback

MECC training has improved participants' lifestyles

A large amount of qualitative feedback has been gathered from post-course evaluation forms and follow-up surveys. The following comments demonstrate that MECC training has improved participants' lifestyles in very concrete ways:

- Trying to avoid eating biscuits in the office
- Hardly drinking any alcohol and drinking much more water
- More aware of drinking
- I am giving my own health considerations more thought and am doing my best to improve my lifestyle.
- Helped me to be more mindful regarding diet and made me more aware of what is happening around me
- I'm looking at ways to work out at home
- In all aspects including mental wellbeing.
- I have cut down on drinking - no longer drinking in the house. I have started walking more. I have cut lots of rubbish out of my diet. I am trying to make more time for myself.
- I am making an effort to lose weight and have more sleep.
- I have reduced the amount of sugar intake in my tea in order to improve my weight and overall health.
- It has made me think about my own diet and health and looking at ways that I need to improve my diet for a better outcome
- Watching what I eat and exercising
- I have been doing more exercise and have taking control of my diet now and this making me feeling good within myself.
- Being disciplined enough go swimming 3x a week
- Diet and exercise - Taking better care of myself
- I'm now doing regular exercise 4 days a week for an hour each time as a means of weight loss and prevention of type 2 diabetes.
- I am now more careful about my diet and do some exercise few days a week
- I try to walk up the stairs rather than taking the lift
- Think about what I eat, do more exercise. Cut down on drinking. Eating a breakfast every day.

MECC training has changed the way people work

These further comments show how MECC training has changed the way people work. Common themes are that staff are listening more, allowing residents to 'talk themselves into change' and that this is resulting in more efficient use of public resources:

- I have asked several people if they wish to talk about their mental health concerns and have asked if they are aware of the support available.
- Encouraging a resident to contact their GP to discuss alcohol/tobacco consumption
- Recently a customer needed the dentist and the family were reluctant to take him. They wanted staff to take him without them supporting him. I had a discussion with them about how the customer would feel if he was not supported by his mother. I gave them the opportunity to think about how affective the appointment would be if they did not support and how much easier it would be for him if she supported him. She realised how important it was for her to go with him and attended the appointment, which went smoothly.

- Client reported that he was able to do his own personal care and prepare his own meals. However, the carer agency delivery his package of care reported otherwise via email and over the telephone. A joint review was arranged with client and care agency from which client highlighted the importance of maintain his independence. Client also reported although he required support to prepare a nutritious breakfast in the morning he has the ability to use the microwave to heat up his lunch and evening meals. It was acknowledged that he was able to wash and dress independently, but needed minimal assistance with showering due to unsteady mobility and risk of falls.
- He stated he drank 10units a day and had no intention of changing. I briefly let him know what services are available if he ever changes his mind,
- With a friend who has LTCs and is needing to rest/sleep in bed a lot, at the moment but benefits from regular exercise. I got them to think about how they felt when they were doing regular exercise and how it improved their symptoms. They ended up with an action of not staying in bed for too long and getting up and moving around the house, with a longer term goal of going swimming again.
- Made someone aware of stop chewing tobacco while smoking same time, individual did stop chewing after few contacts.
- A friend was worried about her drinking so I asked her to think about what changes she could make. she decided to stop drinking at home
- "Could you please tell Nell Blane that I took her advice from the MECC training….an old lady of 88 could not look after herself and kept on falling in her flat. By listening instead of talking my friends and I managed to get her to agree to move to a lovely residential home in St John's Wood. Do please thank her from all of us."

MECC conversations result in signposting and referrals

A question has been introduced more recently into the follow up surveys about signposting and referrals. Participants are asked if they have signposted or made referrals as a result of MECC. This is a way of measuring potential impact of MECC on other services, especially preventative services which residents might otherwise not have used. Participants have named 23 different signposting and referral routes that they have used in the course of MECC conversations:

1. Age Concern
2. Alzheimers Concern
3. Careline
4. Community Dental services
5. Contact a Family
6. Department of work and pensions
7. Dietician
8. EHAP
9. GP
10. Gym
11. Health visitor
12. IAPT
13. MIND
14. One You Ealing
15. Online info
16. OT Specialist Team

17. Paiwand Advocacy
18. Restore Plus
19. RISE
20. Smoking cessation
21. Stay and Play
22. Twinings
23. Whiltshire Frozen Meals

Potential Return on Investment (ROI)

It is notoriously difficult to measure the impact of preventative activities and MECC is no exception. Some of the reasons for this are:

- As a 'very brief intervention' it would be counterproductive and overly onerous to ask practitioners to record every conversation.
- 'Good MECC' is almost unnoticeable. It is the person who receives it that is actively exploring their lifestyle choices, facilitated and empowered by a trained practitioner who keeps the tone conversational. The recipient will not feel 'done-to' so if asked at a later date, is unlikely to identify that they have had a MECC conversations.
- MECC is a systemwide approach – we have trained over 600 people in Ealing since September 2016, from all different professions. If they are all having regular MECC conversations it is impossible to determine which conversation was the one that promoted any behaviour change.
- Other parts of the system are changing simultaneously for example the self-care agenda, Better Lives programme, public health campaigns and changes to health architecture all aim to empower people to make better lifestyle choices. How can we tell which aspect of systemic change enable someone to change their behaviour?
- Change is a process, not an event, rather like the lifecycle of a plant. If someone hasn't thought about behaviour change a practitioner can plant the seed of an idea of change. If they are already thinking about it, but ambivalent, the practitioner can water the seedling. If they have decided to change, the practitioner can shine some sunlight on the developing plant….and so on. It's impossible to determine which of these actions resulted in the final behaviour change.
- Change tends to be incremental. A sedentary person may at first decide to get off the bus one stop early, then two stops, then three, until they are able to comfortably walk a few miles. Which of these behaviour changes are we measuring?
- How do we know when a behaviour change has prevented ill-health?
- How do we know how much small lifestyle changes save the NHS, Adult Social Care and wider society?

Having noted some of the reasons why the impact of MECC is difficult to measure, it is also the case that there is considerable evidence for the effectiveness of brief interventions for some behaviours. Brief interventions were found to reduce alcohol consumption, alcohol-related mortality, morbidity, injuries, social consequences and the consequent use of healthcare resources and laboratory indicators of alcohol misuse.[27] 1 in 8 of those receiving alcohol Identification and Brief Advice (IBA - a level 2 behaviour change intervention) will reduce their drinking to lower risk levels, and overall there is a 15% reduction in alcohol consumed following an alcohol IBA intervention. Similarly, 1 in 20 smokers receiving a brief smoking cessation intervention will stop smoking.[28]

While there are tools to estimate the return on investment of various lifestyle interventions[29] [30] [31] [32], there is not one yet that includes MECC activity or training.

27 https://www.nice.org.uk/guidance/ph24/chapter/appendix-c-the-evidence (accessed 3rd January 2018)
28 https://alcoholibablog.files.wordpress.com/2015/03/evidence-of-effectiveness-iba-communityhealth.pdf (accessed 3rd January 2018)
29 https://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-return-on-investment-tool (accessed 3rd January 2018)
30 https://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Alcohol-return-on-investment-tool (accessed 3rd January 2018)
31 https://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/physical-activity-return-on-investment-tool (accessed 3rd January 2018)

The national and London MECC steering groups are looking at evaluation strategies but there is no standardised way to evaluated ROI as yet. However, output and outcome data can be extrapolated, thus providing an indication of how many MECC conversations might be occurring and how many of these are effective, i.e. resulting in some kind of behaviour change. Comparing this to the cost of the programme creates a rough calculation of ROI.

In this way we have calculated that the MECC programme will deliver 74,000 MECC conversations and 38,000 lifestyle changes per year at a cost of under £3 per change (see appendix 2 for calculations).

Unplanned Outcomes

There were a number of unplanned outcomes of note:

1. Having a MECC Training Coordinator created interest, potential, and some additional investment from partners. This resulted in MECC training being delivered more widely across Primary Care, the Voluntary Sector and the Adult Social Care workforce.
2. The success of the programme has led to 'MECC plus':
    a. A programme adapted for people with Learning Disabilities
    b. Investment in Oral Health MECC
    c. Interest in Falls Prevention MECC
    d. Interest in Healthy Homes MECC
    e. Interest in MECC for people who work with under-18's
3. There was an appetite for further individual behaviour change training, e.g. Alcohol Identification and Brief advice, Mental Health First Aid and Smoking Cessation training.
4. Several participants expressed an interest in being trained to deliver MECC training themselves.
5. Organisations and individuals from outside the target groups have expressed interest in attending the training, and potential willingness to pay to attend.

32 https://www.nice.org.uk/about/what-we-do/into-practice/return-on-investment-tools/social-and-emotional-wellbeing (accessed 3rd January 2018)

Learning Points

There are several relevant learning points to be drawn from the MECC programme:

1. What made the programme successful?
    a. The programme exceeded all the key deliverables. Here are some possible reasons for this:
        i. Context: The move towards prevention and early intervention described in the Five Year Forward View and Ealing's Health and Wellbeing Strategy (amongst others) provided a solid context for MECC training. References to these and to the NHS Standard Contract helped to reinforce the validity of the training.
        ii. National resources: Resources like the E-LfH online training and the PHE/HEE Training Quality Checklist grounded the training in quality and respectability.
        iii. Experienced trainer: the trainer had a background in substance misuse and had delivered various behaviour change training courses over nearly 30 years which helped gain credibility with participants.
        iv. Application of Behaviour Change Theories and Therapeutic Techniques: the trainer used and referred to many person-centred techniques including Rogerian counselling, Motivational Interviewing, Brief Solution Focused Therapy, Transactional Analysis, COM-B and Stages of Change, as well as neuropsychology.
        v. Modelling: The trainer attempted to model the MECC technique through the training design, and was explicit about doing this. For example, in giving information, participants were asked what they already knew, were listened to, then asked if they wanted the information, and only then given it.
        vi. Making it personal: The design allowed participants to explore their own relationships with behaviour change, recognising that we all have room for improvement. Rather than an information-giving session about the theory and practice of MECC, it thus became a skills-based session about what helps us change our behaviour. From this it was easy for participants to extrapolate to residents.
        vii. Variety of learning styles: The training was designed for a variety of learning styles with several changes between different activities. Some participants valued the data and stats which were provided via a quiz, others preferred the practice sessions, while others liked the behaviour change theories.
2. Flexibility is important:
    a. Participant numbers varied considerably from 3-30, and training methods were adapted accordingly.
    b. Similarly, participants' previous experience, competence and motivations varied considerably, and again methods required adaptation to fit. For example, some preferred the trainer to demonstrate a MECC conversation before having a go themselves.

c. Training venues varied as did access to IT facilities. One course was carried out in a very small room, and another in a physiotherapy ward complete with beds. Initially a PowerPoint presentation was used but as facilities were not always available the training was adapted to run without. Several people commented that this was a good thing.
d. One barrier to participation was availability of people to attend. It was important to offer a choice of team-specific or multidisciplinary sessions, in-house or away from work, and over one or two sessions. Pharmacy staff in particular had very limited availability, so evening and weekend sessions were delivered for them.

3. Materials are important:
    a. There were many positive comments made about the colourful handouts provided, which included an 'It's Good to Ask' prompt sheet. Several participants said they'd put the prompt sheet up in their office, one group laminating them during the course! One individual gave a glowing testimonial to the handout: She had dyslexia and it was one of the few handouts she'd ever received that she found easy to read.
    b. Many participants were keen to receive a certificate despite the programme not being accredited.
4. Organisation is important:
    a. There are a number of useful tools available to make organising training easier, including EventBrite which manages booking and sends reminders to participants, and SurveyMonkey which sends out follow-up surveys. Much time was spent transferring data between these, and to and from Excel Spreadsheets and Word and PDF documents. A more coherent system for booking, logging, certificating and follow-up participants would be beneficial, with easy linkage to an evaluation system. Investment at an early stage in such software would have been useful.
5. Listening is important:
    a. The trainer noted that the most difficult aspect of the training for participants was listening. Through the training they were able to understand the potential power of listening, that those listened to felt valued and understood, and that by being actively listened to, could work out for themselves why they wanted to change, and how they could do so.

Options for 2018 onwards

It is timely to consider the future of the programme beyond March 2018 when funding ends.

We have audited our MECC performance using the MECC Implementation Toolkit and the draft London Pledge. The detailed analysis are shown in appendices 3 and 4. Both show a positive picture, although several areas are at risk if the programme ceases, including:

a. MECC Leadership and coordination
b. MECC training delivery

There are several areas for potentially easy improvement:

c. Increase senior leadership involvement
d. Identify a board level MECC leader
e. increase the membership of MECC Team (currently Public Health and CCG) – for example to include primary care, community health, voluntary sector, housing, pharmacies
f. Ensure easy access for staff and patients to national and regional resources through the London MECC hub
g. Ensure MECC Champions in place
h. Ensure MECC sits within mandatory training
i. Ensure Health promotion is within organisational policies

The exercise also identified some areas that would require more effort or investment:

j. Include MECC within team meeting and supervision agendas, staff appraisals, job descriptions, person specifications and codes of practice
k. Include MECC messaging on name badges
l. Ensure vending machines have healthy food
m. Ensure Healthy catering contracts (if relevant)

Finally the exercise identified areas that would require additional investment:

n. Provide action learning sets / refresher training for MECC trainees/champions
o. Develop and implement a Train the Trainer programme
p. Ensure strong engagement and collaborative working with local resources and services
q. Develop systems and processes to embed MECC and modify existing infrastructure to support staff to deliver MECC
r. Ensure routine data capture of MECC conversations
s. Ensure MECC is within standard reporting procedures
t. Monitor of MECC referrals
u. Deliver MECC celebrations and awards

In summary, the greatest potential for improvement lies in increased organisational leadership and embedding, and in continuation and expansion of the training programme. This would require further investment.

A further point regards the reputational gain of Ealing Council and HWB from our MECC programme, for example:

1. Ealing is the local authority representative on the London MECC Steering Group, which is coordinated by Healthy London Partnership in partnership with Public Health England, Health

Education England, London Councils and the Association of Directors of Public Health. The purpose is to provide system-wide leadership and oversight for a strategic, pan London approach to underpin and enable local strategies for MECC and behaviour change to improve Health and Wellbeing.

2. The NorthWest London STP consulted frequently with our MECC lead in order to develop the STPwide MECC strategy. This was due to Ealing being more advanced in MECC delivery than other boroughs.

The success of the programme has identified potential to generate income via charging for training, expanding the training to other behaviour change areas or techniques, and delivering a Training the Trainers package. To release this potential would require initial investment.

Conclusions and Recommendations

To date, the MECC programme has, for low cost, delivered outputs, outcomes and impact well over and above what was expected, and it has enhanced the reputation of Ealing Council and the HWB locally and across London.

Funding is to cease at the end of March 2018, which puts the programme at risk. It is therefore timely to consider options for the future of the programme.

The following recommendations are drawn from the audits performed of Ealing's progress against the national MECC Implementation Toolkit and the draft London MECC Pledge

8. Identify budget and resources to progress MECC post-March 2018 including to:
    a. cascade face-to-face MECC training further eg to housing sector, departments other than ASC within council, additional pharmacies and GP practices, more voluntary sector, fire service, police service, hairdressers and barbers, nail salons, dentists.
    b. further evaluate impact on service users, referral rates and uptakes and staff wellbeing
    c. design and deliver MECC Training the Trainers programme
    d. design and deliver MECC Action Learning Sets or refresher training
    e. deliver MECC celebration / awards events
    f. develop and communicate MECC resources – e.g. e-learning, London MECC hub, signposting and referral resources
    g. develop strategy to increase trainees involvement in MECC strategy development
    h. explore potential for income generation of MECC and other behaviour change training
9. Identify MECC Lead post-March 2018
10. Identify MECC Implementation Team membership (including HWB and Council Executive Board leads) and ToR.
11. Deliver MECC communications to Chief Exec, department heads and councillors e.g. presentation, taster training, full training – one-off plus regular updates
12. Identify key personnel who can support changes to infrastructure across local health and social care organisations such as ensuring health is in all organisational policies and that MECC is included in standard reporting procedures, job descriptions, person specifications, mandatory training, supervision, team meeting agendas and appraisals.
13. Identify criteria, role and support needs of MECC champions
14. To further improve healthy workplace initiatives eg active travel schemes, healthy vending machines, healthy catering contracts.

Appendix 1: Breakdown of Participants

665 people trained:

- 278 NHS Professionals:
  - 115 Primary Care staff from 27 GP Practices
    - 34 from Gordon House Surgery
    - 11 from Hillcrest Surgery
    - 10 from Mattock Lane Surgery
    - 7 from Oldfield Family Practice
    - 6 each from Chiswick Family Practice and Somerset Family Health Practice
    - 5 from Mansell Road Practice
    - 4 each from Acton Lane Medical Centre, Argyle Surgery, Featherstone Road Health Centre and Florence Road Surgery
    - 2 each from Dormers Wells Medical Centre, Eastmead Surgery, Horn Lane Surgery and Perivale Medical Centre
    - 1 each from Allendale Road Surgery, Belmont Medical Centre , Boileau Road Surgery, Care UK, Featherstone Road Health Centre, Greenford Medical Centre, Islip Manor Medical Centre, Meadow View Surgery, Northfields Surgery, Randolph Surgery, West End Surgery and Western Avenue Surgery
  - 122 Community Health Professionals
    - 43 Physiotherapists
    - 29 Podiatrists
    - 10 Speech and Language Therapists
    - 3 Occupational Therapists
    - 37 Pharmacists
      - 6 from Puri Pharmacy
      - 5 each from Mattock Lane Pharmacy and Temple pharmacies
      - 4 from Alpha Chemist and Greenford chemist
      - 3 from Parade Pharmacy2 each from Ashlex ltd, Boots, Gill Pharmacy and Sherrys Chemist
      - 1 Locum and 1 from Well
  - 41 Other NHS staff
- 195 Local Authority staff:
  - 178 Adult Social Care staff
    - 30 from Cowgate Day Centre (several attended twice as they had refresher sessions)
    - 16 from Occupational Therapy Team
    - 15 from Choice - Outreach
    - 14 from Reablement
    - 13 from Michael Flanders Centre
    - 8 each from Funding Officers and Ealing Direct, Short Breaks Service and Southall Locality Team (Adults)

- 7 each from Acton Locality Team (Adults), Central Ealing Locality Team (Adults) and Community Team for People with Learning Disabilities
- 6 from Greenford Northolt and Perivale Locality Team (Adults)
- 5 each from Adults OP Duty Team and Younger Physical Disabilities
- 4 from Hospital Assessment Team
- 3 from Safeguarding Adults
- 2 each from Deprivation of Liberty Safeguards, Homeward, Promoting Independence Managers, Repairs and Adaptations and Student Nurse - Cowgate
- 1 each from Adults OP Intake Team, Commissioner - physical disabilities, Community Benefits Team, Disabilities Team Managers, Forensic Social Work Team, Hospital Discharge Team, Independent Living Team, Leaving Care Team, Operational Commissioning, Shared Lives, Substance Misuse Team Administrator, Tenancy Sustainment Officer

- 17 other Ealing Council staff

- 138 Voluntary Sector staff from 37 different organisations:
  - 69 from Neighbourly Care
  - 10 from Ealing Live at Home
  - 6 from RISE
  - 5 from Treat Me Right
  - 4 each from Age UK Ealing and Healthwatch Ealing
  - 3 from Scope
  - 2 each from Brentford FC Community Sports Trust, Certitude, ECIL, Greenfields Children's Centre, Help Through Crisis Project, St Mungos and Twining Enterprise
  - 1 each from Alina Healthcare, Asian Cancer Support Group (West London), Beanstalk Charity, British Muslims for Secular Democracy, Cancer Research UK, Dadaal Service, Dementia Concern, Ealing Carers' Centre, Ealing Dyslexia Association, Ealing Equality Council, Ealing Swimming Club, ECVS, ESAS – MIND, ESWCA, Family Lives, GOSAD, Greenford and Northolt Community Forum, Grove House Nursery School and Children's Centre, HADEA, I Love Thunder, PACE Charitable Trust. SPECTRA and West London Somali Society

- 44 attendees from other organisations:
  - 24 from DWP
  - 14 from A2 Dominion
  - 5 from Children's Centre
  - 1 Independent

Appendix 2: Return on Investment Estimates

Above it was noted that is notoriously difficult to provide robust evidence of the impact of preventative activities, with MECC being no exception. There is national and Londonwide work going on to develop a MECC evaluation strategy. Meanwhile we have extrapolated Ealing's output and outcome to provide an model of how many MECC conversations might be occurring and how many of these are effective, i.e. resulting in some kind of behaviour change. Comparing this to the cost of the programme creates a rough calculation of ROI. The calculation is as follows:

C = ((365D+52W+12M+Y)/100) x P

C = Number of MECC conversations per year
D = percentage of participants who report at follow-up that they are using MECC every day
W = percentage of participants who report at follow-up that they are using MECC a few times a week
M = percentage of participants who report at follow-up that they are using MECC a few times a month
Y = percentage of participants who report at follow-up that they are using MECC less than a few times a month
P = number of participants in training

N = C x (I/100)

N = Number of lifestyle changes per year
I = percentage of participants who report at follow-up that the training has influenced their own lifestyle

(*N.B*. D, W, M and Y are likely to lead to underestimate, whereas I is likely to lead to overestimate. These are likely to balance each other out to some degree).

Cost per lifestyle change = N / investment in training

Using this model we can compare expected versus actual costs, as follows:

	Number of MECC conversations per year	Number of lifestyle changes per year	Cost per lifestyle change (£)
HEENWL Target	300	88	571.43
CCG Target	700	233	215.05
Extrapolation from 105 3 month follow-up survey respondents	74,052	38,094	2.63

Clearly there is a wide margin of error in this model, but what can be seen is that actual results compare very favourably to expected results and that Ealing's programme delivers lifestyle changes *en masse* at low unit cost.

Appendix 3: Making Every Contact Count (MECC): implementation guide: Ealing Audit

The Making Every Contact Count (MECC): implementation guide[33] was produced by Public Health England and Health Education England to help organisations assess their progress in implementing MECC.

Comparing London Borough of Ealing's progress against the guide demonstrates good progress in all areas, identifies areas still to be developed and those that are at risk without continuing attention.

Brief Audit of Ealing's progress against the Making Every Contact Count (MECC): implementation guide

Action point	Indicate: Achieved Part achieved or Development area	Action required to implement MECC within team/service/organisation
1. Organisational strategy **To shape why MECC should be taken forward.** □ what is your organisation's vision? □ how does MECC fit the organisations goals? □ are there shared goals? □ what are other organisations within your area or region doing in relation to MECC? □ have you identified where MECC activity can fit into wider health improvement plans or activity across your area or region? □ have the benefits for patients/ clients and staff been identified?	**Achieved**: • We have a written MECC vision and strategy. • Our vision is to empower Ealing residents to live longer and healthier lives by changing the way we all talk about lifestyle behaviours: Making Everyone a Catalyst for Change • MECC fits within both the Future Ealing priorities and the Health and Wellbeing Strategy • Benefits identified via MECC Consensus Statement[34]	None
2. Senior leadership **Senior leadership buy-in is crucial to the successful implementation of MECC.** □ is the organisations senior leadership aware of MECC? □ is there an opportunity to increase senior leadership involvement? If so, who needs to be involved and how?	**Part achieved:** • There is an opportunity to increase senior leadership involvement.	• Comms to Chief Exec, department heads and councillors e.g. presentation, taster training, full training – one-off plus regular updates

[33] http://mecc.yas.nhs.uk/media/1015/mecc_implementation_guide.pdf

[34] www.gov.uk/government/uploads/system/uploads/attachment_data/file/515949/Making_Every_Contact_Count_Consensus_Statement.pdf

3. Planning **To implement MECC, a team of people is needed to lead and champion the approach. This section will assist you to identify key individuals to support implementation.** □ who will lead the MECC implementation (developing, reviewing, monitoring an action plan) in the organisation and teams? □ do you need to form a 'MECC implementation team from across the organisation to lead the programme? □ who are the key stakeholders who should be involved? □ who will be the MECC champions? □ how will you identify and engage them? □ do you need MECC meetings? Should they be face to face or virtual? Who will attend and how often do meetings need to happen?	**Mostly achieved, but at risk:** • There is a MECC Training Coordinator, and a MECC meeting consisting of Public Health and CCG. • There is an opportunity to increase the membership of MECC Team – for example to include primary care, community health, voluntary sector, housing, pharmacies • There is an opportunity to identify MECC champions.	• Identify MECC Lead post-March 2018 • Identify MECC Implementation Team membership and ToR. • Identify criteria, role and support needs of MECC champions
4. Identifying resources **Identify what resources are needed and available to support implementation.** For example: □ time □ budget □ staff capacity for training □ how will training be delivered? (eg, delivery using a train-the-trainer model; at face-to-face workshops; or distance learning) □ facilities and equipment needed? Eg, rooms, laptops, etc. □ physical areas where staff work, eg, are there any barriers to holding healthy conversations?	**Achieved, but at risk** • Budget and resources have been available but there is no plan to continue this post-March 2018	• Identify budget for continuation post-March 2018
5. Infrastructure – systems and processes **Consider what systems and processes are required to embed MECC and whether the existing infrastructure can be modified to support staff. How can MECC be embedded and sustained long term**? Issues to consider include: □ activity and outcome monitoring – how will you know how many healthy conversations have taken place? □ can you integrate monitoring forms into existing systems? If so, how?	**Development Area**	• Identify key personnel who can support changes to infrastructure • Identify budget and resources to progress this

▯ how will the referrals and signposting to other services be managed? who will be responsible for collating the information on services to signpost to? how will you monitor signposting/referrals? ▯ will MECC be an agenda item at team meetings or at one-to-one meetings with staff? How can support be made available to staff when required, eg, via information displayed in organisational surroundings and staff intranet? ▯ can MECC be written into organisational policies, processes and procedures? Can MECC link with or build on existing projects or initiatives within the organisation? ▯ can reporting on MECC activity be incorporated into existing core annual reports? ▯ can all new staff be trained in MECC? can MECC training be part of an induction programme? ▯ can MECC be included in job descriptions, person specifications or as part of organisational codes of practice, or outlines of professional duties? ▯ consider how MECC activity can be captured and reflected during staff appraisals, eg, via a MECC KPI. Can your organisation consider role-modelling with a MECC champion? ▯ consider activity to support self-wellbeing for all staff		
6. Staff readiness and engagement Consider how staff can be engaged, empowered, and their inside knowledge used to maximize opportunities to promote health and wellbeing. ▯ which workforces will be identified to be trained and engaged in MECC delivery? ▯ what criteria will be used to determine which teams/groups/departments are selected? ▯ how will teams/groups/ departments be recruited? ▯ how can staff be engaged from the beginning to support the implementation and to sustain MECC? ▯ what can staff do to support the process of implementing MECC? Eg, questionnaires for staff/ suggestion boxes or input into forms and systems/processes ▯ how can staff assist with the identification and understanding of	**Part achieved:** • Over 600 staff trained including 195 in Local Authority • There is an opportunity for staff to assist with the identification and understanding of departmental pressures/barriers and the opportunities to embed MECC • There is an opportunity for staff to share their challenges and learning from providing healthy	• Identify personnel to develop strategy to increase trainees involvement in MECC strategy development

departmental pressures/barriers and the opportunities to embed MECC? □ is a facility available for staff to share their challenges and learning from providing healthy conversations?	conversations	
7. Implementation – training **MECC is about organisational change and workforce development. Use this section to plan to prepare staff to MECC.** □ what knowledge and skills do staff have already? How will you identify these and any gaps? □ how will the training be implemented? How will you accommodate roles/shift patterns, etc? □ training the trainers – who will become trainers? □ how will staff be introduced to MECC? □ how will staff be trained? E-learning for knowledge and face to face healthy conversation skills training delivery. How will it be contextualised to fit with staff roles? □ how will training be evaluated? □ in addition to the initial training are subsequent skills practice or training opportunities identified for staff?	**Part achieved:** • Training programme delivered – in-house/bespoke offered to individual teams and voluntary sector, in addition to multidisciplinary open to anyone. • Evaluation scheme in place and providing regular reports on outputs and outcomes, including follow-up surveys • Opportunity to develop and deliver Training the Trainers – need to develop criteria for trainees • Opportunity to deliver refreshers trainings	
8. Review and evaluation **To ensure that MECC implementation has been effective, it is essential to monitor and review the process, outcomes and impact of activity in order to improve future delivery.** □ how will you know whether the systems for monitoring progress are effective? □ how will you provide evidence of impact? □ will you capture outcomes from patients/clients where possible? □ will this include assessing the impact of MECC on patients/ clients' levels of motivation and outlook for health related behaviour change? Eg, what action did they take following the MECC intervention/healthy conversation? □ have you considered using the friends and family test to capture feedback on MECC? □ how will you capture feedback on	**Part achieved:** • Outputs and outcomes of training evaluated, including follow-up surveys at 3 and 6 months. This includes impact of training on participants' own lifestyles and on their work. • Opportunity to evaluate impact on service users and referral levels • Opportunity to further evaluate impact on staff wellbeing. • ROI tool in	• Identify staffing and budget to further evaluate impact on service users, referral rates and uptakes and staff wellbeing. • Identify staffing and budget to cascade MECC further eg to housing sector, departments other than ASC within council, additional pharmacies and GP practices, more voluntary sector, fire service, police service, hairdressers and barbers, nail salons, dentists.

uptake of referrals? ▯ are there wider benefits beyond helping service users/patients/ clients? o staff health and wellbeing, staff sickness levels o staff feedback o cost savings, monitoring of outcomes o credibility of the benefits ▯ who do you need to keep informed, of what and how? How will you report and share the benefits and findings with others? **WHAT NEXT** ▯ how will you further cascade MECC? ▯ which other teams within and outside your organisation could take MECC forward?	development. • Opportunity to further cascade MECC	

Appendix 4: London MECC Pledge: Ealing Audit

The London MECC Steering Group is in the process of developing a London MECC 'Pledge' which provides a good indication of the direction of travel of MECC in the next few years, and good practice for organisations' approach to MECC.
Comparing London Borough of Ealing's progress against the draft pledge produces a patchy picture as demonstrated by the brief audit below.

Brief Audit of Ealing's progress against the London MECC Pledge

Level	Area	Pledge	RAG	Notes
Bronze	**Training**	MECC E-learning available for all staff		Trainees and anyone unable to attend face-to-face training are directed to e-learning[35]
	Infrastructure	Easy access for staff and patients to national and regional resources through the London MECC hub		London MECC hub[36] is a recent development and has not yet been incorporated into Ealing MECC resources. This can easily be done.
	Culture	Identify a board-level MECC leader		Easy to achieve.
	Environment	Health promotion and signposting posters/leaflets		Displayed around Perceval House and elsewhere.
Silver	**Training**	Face-to-face training programme provided for staff groups		Training will be available to end of March 2018[37]. There is currently no funding to continue beyond then.
	Infrastructure	Directory of local resources and services readily available for staff		Local websites are provided for staff in MECC resources as starting points for signposting.
	Culture	Active travel schemes such as cycle to work		Achieved.
		MECC Champions in place		One MECC Training Coordinator in post until end of March 2018
		Healthy Living Ambassadors in place		Requires administration
		MECC within staff appraisals		Requires board level support
	Environment	Staff badges		Requires board level support
		Smokefree environment		Achieved
		Healthy vending machines (if relevant)		There are some healthy options in vending machines in Perceval House. Recently changed so difficult to achieve.
Gold	**Training**	Action Learning sets for MECC		Requires trainer

[35] https://www.e-lfh.org.uk/programmes/making-every-contact-count/
[36] https://www.healthylondon.org/our-work/prevention/making-every-contact-count/
[37] https://making-every-contact-count-ealing.eventbrite.co.uk

		trainees/champions		
		Train the Trainer programme developed and implemented		Requires trainer
	Infrastructure	MECC within mandatory training		Discussions are underway to make MECC e-learning mandatory
		Strong engagement and collaborative working with local resources and services		Training has had wide reach including numerous GP practices, pharmacists and voluntary sector organisations.
		Routine data capture of MECC conversations		Requires organisational support
	Culture	Health promotion within organisational policies		Future Ealing priority 4 is: Residents are physically and mentally healthy, active and independent.
		MECC within standard reporting procedures		Requires organisational support
		MECC celebrations and awards		Requires MECC champion
	Environments	Healthy catering contracts (if relevant)		School catering contracts are healthy. Perceval House café has healthy options.
		Health and wellbeing initiatives for staff		Ealing Council has 'excellent' status on London Healthy Workplace Charter.