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| **To:** | **Trust Board** |
| **From:** | Director of Communications and External Relations |
| **Date:** | **28 June 2012** |
| **CQC regulation:** | |

**Trust Board Report – Paper L**

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| **Title:** | **Making Every Contact Count, (MECC)** |

**Author/Responsible Director: Mark Wightman / Rebecca Broughton**

**Purpose of the Report:**
**To brief the board on MECC and seek endorsement for the Trust's proposed approach.**

**The Report is provided to the Board for:**

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| Decision | | Discussion | |
| Assurance | | Endorsement | x |

**Summary / Key Points:**
**'Making every contact count' has been agreed by the SHA Cluster Board as one of the regional priorities for this year.**
**In speaks to the fact that NHS organisations, especially acute providers and their staff are designed to deliver *health care.* However we are uniquely placed to also deliver health advice… with the aim of preventing illness.**

**Recommendations:**
**The Board is requested to endorse the approach to MECC described in this paper.**

**Previously considered at another corporate UHL Committee?**
**NO**

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| **Strategic Risk Register**<br>**NO** | **Performance KPIs year to date**<br>**See implementation plan** |

**Resource Implications (eg Financial, HR)**
**There is a CQUIN attached to this work worth in the region of £1m PA.**

**Assurance Implications**

**Patient and Public Involvement (PPI) Implications**
**We will be working with Members and other stakeholders to refine the approach / enlist their help.**

**Equality Impact**

**Information exempt from Disclosure**
**NA**

**Requirement for further review?**
**As part of the quarterly performance reviews / CQUINs.**

**University Hospitals of Leicester NHS Trust**

**REPORT TO:** Trust Board

**REPORT BY:** Rebecca Broughton, Head of Outcomes & Effectiveness

**REPORT FROM:** Mark Wightman, Director of Communications

**SUBJECT:** Midlands and East SHA CQUIN Scheme 12/13
"Making Every Contact Count"– Promoting Health (MECC)

**DATE:** 28th June 2012

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## INTRODUCTION

The Darzi Review (2008), *High quality care for all* set out the need to put prevention first.

More recently the NHS Future Forum (2012) recommended that every healthcare professional should make every contact count and 'build the prevention of poor health and promotion of healthy living into their day-to-day business.'

The SHA Cluster Board and PCT cluster Chief Executives across the Midlands and East have agreed five ambitions, one of which is to:

> *"make every contact count" using every opportunity to deliver brief advice to improve health and wellbeing* - otherwise known as MECC

Making Every Contact Count (MECC) is about encouraging people to make healthier choices to achieve positive long-term behaviour change for better health and wellbeing among patients / service users and staff themselves

MECC is about staff using the contact they have with service users (inpatients and outpatients) and the public to give healthy lifestyle information.

The expectation is that organisations which adopt MECC will see improvements in service quality, improvements in service user and staff health and wellbeing, reduced inappropriate use of services, reduced staff absence, increased productivity and ultimately cost savings

As an NHS organisation we have a responsibility to protect and improve the overall health and wellbeing of our staff and service users

MECC is about staff taking the opportunity to deliver healthy lifestyle information. There are 4 key strands:

- stopping smoking
- drinking alcohol within recommended limits
- having a healthy diet and maintaining a healthy weight
- undertaking the recommended levels of physical activity

As well as the positive impact on service users, MECC also has vast potential to improve staff health and wellbeing.

Across UHL there are over 10,000 staff who collectively have thousands of contacts with the public every year

- If each staff member delivers MECC just 10 times each year there will be 100,000 new opportunities to change lifestyle behaviour every year

- If one in 20 of these people go on to make a positive change to their behaviour a total of 5,000 people would be improving their health and wellbeing.

**The importance of MECC**

We know that 80% of heart disease, stroke and type 2 diabetes cases and 33% of cancers could be prevented by following a healthy lifestyle. Lifestyle factors, particularly smoking, are also one of the biggest contributors to health inequalities in England and locally.

The evidence base for the benefits of following a healthy lifestyle is demonstrated by the EPIC study, carried out in Norfolk (1993 to 2006), which looked at survival according to healthy lifestyle behaviours.

The overall impact was a 14 year difference in life expectancy between those undertaking all four healthy lifestyle behaviours (not smoking, eating a healthy diet, drinking alcohol within the recommended limits and undertaking the recommended amount of physical activity) and those not following any.

**MECC Aims**

The overarching aim is that all patients who have lifestyle risk factors e.g. smoking, alcohol misuse, physical inactivity, obesity etc. are identified, provided with brief opportunistic advice (which is empowering and culturally sensitive), and signposted or referred to local healthy lifestyle services.

**MECC CQUIN**

In Leicester, Leicestershire and Rutland, the CQUIN has been agreed for both UHL and LPT and will be monitored by Public Health. The CQUIN value for UHL is just under £1 million.

CQUIN REQUIREMENTS

Following discussion with both Commissioners and Public Health within LLR, the thresholds for receiving CQUIN payment have been agreed (Appendix 1).

In summary these are:

<u>Quarter 1</u>

An Implementation Plan which has been signed off by the Trust Board[1] to include details of specific specialty areas for inclusion

Confirmation of Named Board Level Lead and Named Implementation Lead

Evidence of LLR wide engagement

MECC training strategy – to include details of staff groups, types of training

Quarters 2, 3 and 4

Progress against Implementation Plan, to include:
Numbers of staff trained (specifically in Quarter 2)
Numbers of patients being given brief intervention

**MECC IMPLEMENTATION**

At the SHA Launch on 18th May, it was acknowledged that implementation of MECC would be different across all organisations, taking into account the needs of the local population and also the current health promotion services in place.

It was also recognised that implementing MECC could involve all members of staff (ie not just clinical) and that the health and lifestyle of the workforce was inextricably linked.

Support from human resources and an effective communication strategy was therefore considered to be invaluable and the SHA have provided a "Comms Toolkit" to support the latter. (Appendix 2)

A number of tools and resources have been designed by the SHA to assist organisations with the implementation of MECC.

Whilst there are 4 main strands of MECC, the priority for UHL during 12/13 has been identified as smoking cessation and alcohol reduction.

It was recognised at the SHA launch that rolling out 'physical activity and health eating' brief interventions will be more challenging and also that there are not clear referral pathways in place.

Within LLR there are services available to support people wishing to increase activity and to eat more healthily however, these are normally accessed via the GP Health Checks.

## 3.0 PROMOTING HEALTHY LIFESTYLE WITHIN UHL

Currently within UHL there are identified services supporting patients wishing to improve their health in respect of smoking and alcohol.

[1] Evidence of sign off by the board, e.g. extracts from board minutes indicating intent

These services are also available to teach staff (having contact with patients) about how to give advice to patients who have risk factors for smoking or alcohol abuse.

There has been a 'Smoking Cessation' CQUIN for the past 2 years and there has been a 'smoking cessation lead' in post to support this work.

The STOP smoking cessation service has also been heavily involved in supporting the CQUIN and there has been a significant increase in the number of patients referred to the service from UHL – further encouraged by being able to use iCM to make referrals. The number of UHL referrals to STOP has increased ten-fold over the past 4 years and are currently averaging around 300 a month.

UHL has an Alcohol Liaison Service available for patients seen either in the Emergency Department or admitted as an inpatient and who have been identified as at risk of harm through alcohol. The service has recently recruited additional staff and will therefore be able to expand the referral criteria to the LGH and Glenfield.

Healthy eating and exercise are included as part of some patient education programmes such as the Morbid Obesity Clinic, Diabetes, predominantly led by the Dietetic Service but currently there is not a service available within UHL for advice or referral for all patients identified with lifestyle risk factors in respect of physical inactivity and obesity.

As regards staff, "Well-being@Work" includes 'healthy lifestyle' within its workstreams for staff and events such as the UHL Sports Day is a good example of this in action.

## 4.0 PROGRESS TO DATE

An LLR MECC Steering Group has been established which has representation from Public Health and Leicestershire Partnership Trust and has been agreeing an LLR approach to implementing the MECC, taking into consideration the different services available to support health promotion within each of the organizations.

The group has also carried out a review of the currently available training materials to support MECC and agreed sharing of resources.

Smoking Cessation and Alcohol Abuse teaching sessions are available for UHL staff; however, these are not currently part of the Mandatory Training Programme.

Reiterating the importance of asking patients about their smoking status and offering advice and referral to STOP, continues within previous CQUIN areas (Antenatal Clinic, Cardiac/Respiratory Wards, Breast, MaxFax and Vascular Outpatients)

There are plans to widen awareness to oncology services during 12/13.

There has been increased awareness raising of Alcohol Liaison Service following appointment of additional Nurses, particularly at the LGH and Glenfield site. The Alcohol Liaison Workers will also now be in a position to see in-patients on these two sites

Discussions have been held with the Health Improvement Services Lead at LPT about a secondment to:

- Maintain communication links with STOP
- To promote smoking cessation 'brief intervention' and referral to STOP within Oncology and to maintain momentum within already established areas
- Develop links with Alcohol Liaison Service and other agencies and to support awareness raising of services available with staff within UHL
- Confirm services available and referral pathways for patients identified at risk for lack physical activity or unhealthy diet

This post would be funded from the CQUIN monies for 12/13.

A Steering Group has been established to oversee UHL's MECC Implementation Plan for 12/13 (Appendix 3).

## NEXT STEPS

The key objectives for 12/13 will be to:

- Further increase number of patients given brief intervention and offered referral to STOP in the 11/12 CQUIN areas
- Introduce MECC, in respect of smoking cessation within the Oncology Service
- Increase advice about and referrals to the Alcohol Liaison Service within the Acute Medical, Gastro-enterology and General Surgery Wards plus ED
- Smoking Cessation and Alcohol Advice to be incorporated into Mandatory Training for both nursing and medical staff

Further areas for consideration are:

- 'MECC awareness raising campaign' for all staff groups and all areas
- Development of a MECC information leaflet to be given to patients with their own 'lifestyle risks' and services available identified

**Summary & Recommendations:**
With 10,000 staff, 13,000 members, 2.5 million visitors and over a million patient contacts a year, UHL is the centre of the local health community. Our potential to work as a force for change in health promotion and ultimately in improving life expectancy and quality of life is significant.

The Board are requested to endorse this paper.

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| **Local contract ref.** | RWE_5PA |
| **Goal number** | 10 |
| **Goal name** | Making Every Contact Count |
| **Indicator number** | **1** |
| **Indicator name** | **Making Every Contact Count** |
| **Indicator weighting (% of CQUIN scheme available)** | 10.00% |
| **Description of indicator** | Commitment to and implementation of Making Every Contact Count (MECC) |
| **Numerator** | Q1 - Evidence of sign off by the board, e.g. extracts from board minutes indicating intent and Trust to provide MECC implementation plan signed off by commissioner public health leads, to include:<br>- Named Board level lead<br>- Named Implementation lead<br>- Evidence of LLR wide engagement<br>- Reference to specific specialty areas for inclusion<br>- MECC Skills for staff training strategy including:<br>* Identified training lead<br>* Training materials/package<br>* Numbers of staff to be trained<br>* Timescales of training<br>- Investment plan<br>- Data collection and reporting requirements<br>- Completed sustainability checklist<br>- Proposed referral system to enable staff to refer appropriate clients into local lifestyle/behavioural change services e.g. stop smoking, Alcohol, weight management, physical activity<br>- Timescales and milestones should be clearly identified throughout the MECC implementation plan.<br><br>Q2 - Q3 Progress against the implementation plan<br><br>Q4 - Thresholds TBC |
| **Denominator** | n/a |
| **Rationale for inclusion** | n/a |
| **Data source** | Board papers, MECC Implementation plan |
| **Frequency of data collection** | One of submission of information followed by monitoring of implementation milestones and organisational activities as per timetable submitted. |
| **Organisation responsible for data collection** | UHL |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |

| | |
|---|---|
| **Final indicator period/date (on which payment is based)** | Measured according to organisational timetable. |
| **Final indicator value (payment threshold)** | Measured according to organisational timetable. |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | TBC on receipt of organisational timetable |
| **Final indicator reporting date** | 01/05/2013 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No |

**Milestones** (only complete if the indicator has in-year milestones)

| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
|---|---|---|---|
| Apr-Jun 12 | Implementation plan, progress report and Board papers to be submitted | 01/07/2012 | 3.50% |
| Jul-Sep 12 | Progress against implementation plan (specific milestones to be agreed on receipt of plan in Q1) | 01/10/2012 | 1.50% |
| Oct-Dec 12 | Progress against implementation plan (specific milestones to be agreed on receipt of plan in Q1) | 01/01/2013 | 1.50% |
| Jan-Mar 13 | Progress against implementation plan (specific milestones to be agreed on receipt of plan in Q1) | 01/05/2013 | 3.50% |
| | | Total | 10.00% |

If milestones are specified, this total should equal the overall indicator weighting (from cell B6).

| **Rules for partial achievement at final indicator period/date** (only complete if the indicator has rules for partial achievement at final indicator period/date) | |
|---|---|
| **Final indicator value (payment threshold)** | **% of CQUIN scheme available** |
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| | |

Additional milestones and/or rules for partial achievement at final indicator period/date may be added to the CQUIN template.
Please see worksheet *Adding Additional Indicators* for further details.

**Appendix 1**

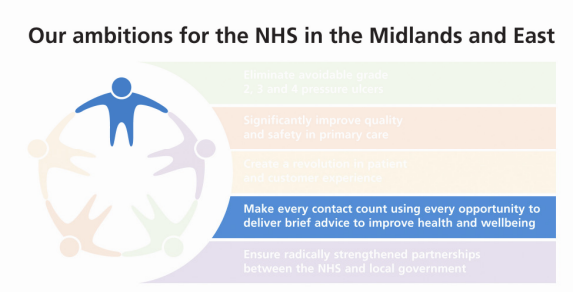
**Making Every Contact Count (MECC)**
**Communications Toolkit 2 – What is MECC?**

This is a communications toolkit aimed at **communications leads**. It is one in a series of MECC communications toolkits and has been designed and written to give you everything you need to launch and support MECC in your organisation.

The contents of this toolkit have been developed by communications and public health experts, however, please feel free to adopt and adapt to suit your organisation and its culture.

Your organisation has been asked to nominate an Implementation Lead who will oversee the embedding of MECC within your organisation. Please work closely with them using the materials provided.

The ambition also has a number of graphic devices (see below) which can be used to brand MECC materials.



If you would like jpegs of these or any other information on MECC and / or the comms toolkit please contact: Norma.harvey@westmidlands.nhs.uk or Jo.baggott@nhs.net

## How to use the staff MECC Communications Toolkit

This MECC Communications Toolkit has a number of elements for you, the comms lead, to use to explain what MECC is to the staff within the organisation you work for.

This toolkit contains:

- An article on MECC
- The Top 5 MECC messages
- Frequently asked questions
- A power point presentation.

### Article on MECC

This copy is for use in your internal staff communications, such as your intranet and staff newsletters. It explains what MECC is to staff and how staff can get involved. The article can be used as it is or adapted to fit your 'house-style'. If you have already implemented MECC and it has a name / brand, please reference it in the article. This is not about creating a new brand.

### Top 5 MECC messages

These are the most important messages to staff about MECC. They should be used in staff-facing communications and could be used in a phased approach (such as a message-a-day / week on your staff intranet).

### Frequently Asked Questions

This is a list of common questions that staff may raise, and their answers – to help communicate MECC. These can be used as a reference or published all together on your intranet or as part of the MECC article in your publications.

### Power point presentation

This is a presentation for use in staff team meetings that introduces and explains MECC to staff. This should be made available to team leaders who should be encouraged to use it with their staff.

**Article on MECC**

**TITLE: What is Making Every Contact Count (MECC)?**

As an organisation we have a responsibility to protect and improve the overall health and wellbeing of our service users and staff. If we help people to have healthier diets, maintain a healthy weight, take regular exercise, drink alcohol within the recommended daily limits, and stop smoking, the benefits to their health, (physical and mental) would be enormous.

Across the East of England, and East and West Midlands area:

- 20% of the population smoke
- 25% are drinking at increasing risk or high risk levels
- 61% of men and 71% women do not meet recommended physical activity levels
- 75% of men and 71% of women do not eat five fruit and vegetables a day.

Their average life expectancy ranges from 68 to 89 years. If a person followed all four of the healthy lifestyles choices they would live 14 years longer on average than those who followed none.

We can do something about this, which is why [name of organisation] is supporting our staff to Make Every Contact Count (MECC). Making Every Contact Count is about staff taking the opportunity to help people – service users, family, friends and colleagues - improve their own health and in turn, that of our population.

The number of staff working in the NHS alone provides millions of opportunities to Make Every Contact Count and change lifestyle behaviour of service users alone each year. Take into account staff working in local authorities, social care, voluntary and the community sectors and the potential to improve health is even greater.

MECC encourages all staff, whether they're clinical or not, to engage in conversations on smoking, healthy diet, healthy weight, exercise and alcohol intake.

This is regardless of the nature of the services user's appointment. It is not anything complicated but about staff providing simple, brief lifestyle information and being able to signpost patients to existing services where appropriate.

MECC is not about adding to staff workloads. It is not about staff becoming experts in services such as smoking cessation; staff becoming counsellors or staff telling anyone how to live their life. It is about taking an opportunity to help someone. For instance a patient may comment 'I really should give up the fags' – this is an opportunity to say: 'If it's something you're serious about I can tell you where you can get help'.

Research carried out with service users and staff in NHS organisations across the Midlands and East of England has found that many patients would welcome the opportunity to talk to staff about lifestyle issues. However they often don't bring it up because they don't want to start the conversation or they assume that staff are too busy to talk.

[name of organisation] is committed to playing our part in Making Every Contact Count to improve the lives of our population. We will be making training resources and a range of tools available to help staff get involved and feel confident in Making Every Contact Count with our service users.

For more information contact: see *weblink* and [name of your Implementation Lead]

## Top 5 MECC Messages

### Making Every Contact Count (MECC) top messages

1. MECC is taking the opportunity when with a service user to offer to signpost to healthy lifestyle information around stopping smoking, drinking alcohol within recommended limits, having a healthy diet, maintaining a healthy weight and undertaking the recommended levels of physical activity.

2. MECC is a fantastic opportunity to improve the population's health; if a person follows all four of the healthy lifestyles choices they would live on average 14 years longer than those who followed none.

3. Research has found that many patients would welcome the opportunity to talk to staff about lifestyle issues. They don't want to start the conversation or assume that staff are too busy to talk. Make it easy for them to ask for help.

4. MECC is not complicated – it does not expect staff to undertake medical diagnosis. Instead it asks staff to give general lifestyle information when the opportunity to do so is presented, and to signpost to local healthy lifestyle services (e.g. smoking cessation).

5. Training and other tools and resources are available for staff so that they can be confident and supported in their delivery of MECC. The *MECC Implementation Guide and Toolkit* is designed to prepare and facilitate organisations' implementation of MECC with tools and resources. Contact [add Implementation Lead] for more information on this.

## Frequently Asked Questions

### Staff – general Q&As

**How realistic is this, how will staff be able to have these difficult conversations?**

MECC isn't about providing a diagnosis or complicated clinical advice; it's about starting an appropriate conversation with a patient about a lifestyle issue and signposting to lifestyle services and / or providing standard low level information. It can take a little as 30 seconds. The *MECC Implementation Guide and Toolkit* will support organisations in delivering MECC. The training tools will help staff become confident in having these conversations.

**How will success be measured**?

A standard set of measurements (or metrics) have been agreed to determine the success of MECC. These include whether the organisation has named board level champions and implementation leads, the number of eligible staff completing training, the change in staff knowledge and confidence (by use of a staff survey before and after training sessions) and the number of contacts to raise lifestyle issues by all trained staff with other staff and / or patients. The number of clients referred from organisations to Stop Smoking Services who attend and the number of 4-week quitters among referrals will also be measured.

**How will staff know when to have the conversation, when is it the right time?**

Training isn't vital and staff that are confident and are already having these conversations shouldn't stop having them. However, training is available, as featured in the *MECC Implementation Guide and Toolkit*, and is accessible by all staff through NHS Local or ESR. This will help to staff recognise and take appropriate opportunities to raise lifestyle issues with patients and colleagues and support them in doing so.

**Will discussing lifestyle with patients put them off accessing services in the future?**

Most people want to be healthy and even to improve their own health – we know that 70% of smokers want to quit and that most people would like to maintain a healthy weight. Our insight research has shown that patients respect NHS staff members giving information delivered in a credible and structured way. Our aim is to create a culture where asking for, as well as giving information is positively encouraged.

**What is the evidence base for this, in each setting?**

There is much evidence relating to the prevalence of unhealthy lifestyles across the Midlands and East of England. Even looking at just alcohol, national studies have shown that alcohol brief advice changes the drinking behaviour of one in eight people. The cost of identifying and providing brief advice to new GP registrants is estimated at approximately £4.80 per head. For a PCT with a population of 310,000 the estimated number of increasing risk drinkers would be 50,000 based on 16% prevalence, to deliver brief advice to a fifth of these drinkers would cost £48,000 based on the DH 'Ready Reckoner' for alcohol services. As a result 1,250 will change drinking behaviour, resulting in reduced acute admissions and A&E attendances with estimated benefits to NHS of £126,000, giving a return on investment of £2.60 for every £1 spent.

**Why should I bother with MECC – this is above and beyond my day job?**

All organisations responsible for the health, wellbeing, care and safety of the public, such as the NHS, have the opportunity to improve a person's mental and physical health and wellbeing, to help them stay well and improve their quality of life. MECC is a vehicle to help NHS staff succeed in achieving this – to make every contact with service users count. We also know that people using NHS services view NHS clinical staff with some authority. MECC isn't intended to be difficult or time-consuming, it is a small part of the contact that you already have with your service users. Our research tells us that service users are likely to listen to and act on information if it is delivered in a structured way, backed up with information that can be taken away.

**How will I know what information to give to patients?**

MECC is not always about being able to give advice or more formal help to patients. Sometimes it is as simple as starting an appropriate conversation with a patient

about a lifestyle issue. MECC is also about helping staff to take the opportunity to talk to people using NHS services about other aspects of their health and wellbeing (such as stress or diet) and recommend support where needed and appropriate. This could involve giving information about the importance of behaviour change to support or influence behaviour change.

Patients value being signposted to, or actively being given, relevant material. Some patients miss visible displays of information and might not think to look at a notice board. Our research tells us that patients are more likely to act on information, either verbally or written, from clinical staff, especially doctors.

**How will I know what lifestyle services are available so I can advise my patient where they can seek help?**

A lot of information already exists for patients and staff, in a wide variety of forms of communications materials such as leaflets, posters and multi media campaigns. A database of lifestyle and support services is also being developed that staff can access to find, and print, appropriate information, organisations and services that might be useful to patients**.** Most NHS organisations use specific lifestyle services that can be signposted to. NHS Choices website - www.nhs.uk – contains lots of information on lifestyle changes.

**Am I qualified to provide advice to people using NHS services?**

MECC isn't always about providing information, handing over a leaflet or signposting people to a service. Sometimes it is as simple as starting an appropriate conversation with a service user about a lifestyle issue which the service user then takes away and mulls over in their own time. Through regular contact with service users, staff can take small steps to offer low-level advice and information. You may have adopted healthier behaviour yourself – such as lost weight or got fitter, making you well positioned to provide information to others.

**We already have a similar initiative in our organisation – does this mean we have to stop that and start again with MECC?**

No, MECC is intended to build on existing initiatives and service delivery, and where good practice already exists, we want to recognise it and spread it. We believe that

MECC will help you to further drive your local initiative and bring benefits to staff and service users. It will enable your organisation to review its current practice and identify areas where it can get even better at improving the health and wellbeing of its service users.

**What do I do if a service user reacts negatively when I raise a lifestyle issue with them?**

Making Every Contact Count is not about being part of the 'nanny state' and forcing people to change their behaviour. Most people want to be healthy and even to improve their own health – 70% of smokers want to quit and most middle-aged people want to lose a bit of weight. Making Every Contact Count is about making it easier for people to make those changes, and even if the final response is that the person does not want to do anything further, that is okay too. What is important is initiating and conducting a constructive and appropriate dialogue and then responding in a relevant manner. Our insight has shown that patients will be receptive to making lifestyle changes at different times and in different situations and if they are not at that stage now, they may be in the future. We need them to know we're there to help when they're ready.

**Will this mean extra work for me?**

This is not the intention. We want MECC to build upon existing initiatives and service delivery so should not put too much of an extra burden on staff. We know that people using NHS services view NHS clinical staff with some authority and you are well placed to make it easier for people to make any lifestyle changes they want to make. MECC isn't intended to be difficult or time-consuming, it is a small part of the contact that you already have with your service users.

# UHL Making Every Contact Count (MECC) Implementation Plan - 12/13



| Work Stream | Action | Exec Lead | Lead Officer | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | RAG | Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MECC | UHL MECC Board Lead confirmed | MLL | | | | | | | | | | | | | | | |
| MECC | UHL MECC Implementation Plan approved by Trust Board | MW | RB | | | | | | | | | | | | | | |
| MECC | UHL Implementation Lead confirmed | MW | | | | | | | | | | | | | | | |
| MECC | Establish UHL MECC Steering Group (linked to LLR MECC Steering Group_ | MW | RB | | | | | | | | | | | | | | |
| MECC | Assessment of lifestyle risk factors to be incorporated into new Nursing Documentation | CR | JB | | | | | | | | | | | | | | |
| MECC | Recruit MECC Advisor | MW | RB | | | | | | | | | | | | | | |
| MECC | MECC Communication Strategy agreed and implemented | MW | TJ | | | | | | | | | | | | | | |
| MECC | MECC Smoking Cessation, Alcohol Reduction Training Programme agreed and incorporated into existing Educational Programmes focusing on priority areas | MW | EM / JM | | | | | | | | | | | | | | |
| MECC | MECC 'Smoking Cessation' and 'Alcohol Reduction' training tools developed (taking into account currently available packages and UHL's | MW | MP (SC) SK (AR) | | | | | | | | | | | | | | |
| MECC | Smoking Cessation and Alcohol Reduction training sessions delivered and numbers of staff trained monitored | | | | | | | | | | | | | | | | |
| MECC | Scope appropriateness of incorporating MECC as part of core job descriptions | MW/ KB | ES | | | | | | | | | | | | | | |
| MECC | Review MECC for Staff and how ties into Well-being@Work | MW / KB | tbc | | | | | | | | | | | | | | |
| MECC | Review of STOP data to inform future priorities and to look at their referrals to other services | | | | | | | | | | | | | | | | |
| Smoking Cessation | Feedback of 11/12 Audit results and reinforce 'smoking cessation advice and referral' within: High risk inpatient areas (Respiratory, Cardiac, SAU and Breast Surgery Outpatient clinics' (TIA, Diabetes, MaxFax, Vascular and Breast Antenatal Clinic Pre-op assessment | MW | JB / SM | | | | | | | | | | | | | | |

MW = Mark Wightman; CR = Carole Ribbins
KH = Kevin Harris; AT = Abi Tierney
RW = Ruth Ward; SA = Sanjay Agrawal
JB = Julia Ball; RB = Rebecca Broughton
TJ = Tiffany Jones

Scoping / Baselining
Work in Progress
Completion

# UHL Making Every Contact Count (MECC) Implementation Plan - 12/13



| Work Stream | Action | Exec Lead | Lead Officer | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | RAG | Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Smoking Cessation | Smoking Cessation Advice and Referral' education and awareness raising sessions in Oncology | MW | JB | | | | | | | | | | | | | | |
| Smoking Cessation | Smoking Cessation Posters for both patients and staff to be displayed in all clinical areas. Referral form will be attached to the posters. | KH | SA | | | | | | | | | | | | | | |
| Smoking Cessation | Re-audit previous CQUIN areas and baselining then re-audit in Oncology | MW | JB | | | | | | | | | | | | | | |
| Smoking Cessation | Pilot Smoking Cessation 'hot clinics' within COPD to include evaluation of benefit and ongoing resource requirements | KH | SA | | | | | | | | | | | | | | |
| Smoking Cessation | Review and revise the UHL Smoking Cessation Policy. | AT | RW | | | | | | | | | | | | | | |
| Alcohol Reduction | Appoint additional Alcohol Liaison Worker | DS | SK | | | | | | | | | | | | | | |
| Alcohol Reduction | Confirm Priority Areas for 12/13. Potentially:<br>Gastroenterology – (Ward 29, 30) and related departments<br>ED, EDU, AMU 15 &16 (short stay Unit if resurrected)<br>Metabolic medicine – (ward 31 and 38)<br>Surgical - 18 LRI and 26, 27 LGH<br>Stroke services – Ward 25, 26<br>Neurology – Brain Injury Unit<br>other departments eg. ENT, Endoscopy | DS | SK | | | | | | | | | | | | | | |
| Alcohol Reduction | Finalise joint employee alcohol awareness raising campaign in collaboration with LPT | DS | SK | | | | | | | | | | | | | | |
| Alcohol Reduction | Review and amend the Leics Emergency Dept Paddington Alcohol Test (LEDPAT) risk assessment tool in collaboration with ED | DS | SK | | | | | | | | | | | | | | |

MW = Mark Wightman; CR = Carole Ribbins
KH = Kevin Harris; AT = Abi Tierney
RW = Ruth Ward; SA = Sanjay Agrawal
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Scoping / Baselining
Work in Progress
Completion

# UHL Making Every Contact Count (MECC) Implementation Plan - 12/13



| Work Stream | Action | Exec Lead | Lead Officer | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | RAG | Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol Reduction | Increase presence of ALW within ED and EDU to promote brief interventions and referrals | DS | SK | | | | | | | | | | | | | | |
| Alcohol Reduction | Extend ALW service to Glenfield and LGH wards, to include staff training on 'brief interventions' and raising awareness of referral process to ALW | DS | SK | | | | | | | | | | | | | | |
| Healthy Eating / Exercise | Confirm referral pathway for Primary Care services to support Exercise and Healthy Eating | MW | | | | | | | | | | | | | | | |
| Healthy Eating / Exercise | Raise awareness and identify priority areas for Healthy Eating and Exercise signposting in 13/14 | MW | | | | | | | | | | | | | | | |

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