Making Every Contact Count: From Research to Implementation

Re-scheduled date - Friday 26th April 2013 – 9:30am-12:45pm

4th Floor Seminar Suite, Teesside University Darlington Campus

We are pleased to announce that the Fuse *Quarterly Research Meeting* originally postponed in January has now been re-arranged in partnership with the North East School of Public Health.

Making Every Contact Count (MECC) http://www.sphne.org.uk/building-public-health-futures/MECC brings together evidence and practice aimed at encouraging people to lead healthier lifestyles, preventing disease and promoting and protecting health and wellbeing. The principles of MECC are underpinned by the wider determinants of health while the outcomes contribute to reducing health inequalities. MECC was first conceptualised as a way of making clinical encounters take account of the potential for healthy lifestyle interventions, however within the North East, since its inception MECC has been a vehicle for maximising opportunities presented by any face-to-face encounters within workplaces and communities. The School of Public Health North East has MECC as part of its vision for public health capacity.

This meeting will explore how research can inform the implementation of MECC across the North East using the capacity building model adopted by the School of Public Health. The programme comprises presentations of research examining how work with individuals, communities and at a strategic level can inform MECC, followed by a workshop to identify gaps in the research evidence base and the challenges of implementing MECC. The outcomes from the morning session will form part of the planning process for the School of Public Health North East in taking forward the implementation of MECC.

Who should attend? The meeting will be of value to anyone with an interest in promoting health and reducing health inequalities as well as those with an interest in exploring how research can inform policy and practice in the implementation of Making Every Contact Count. It will be of interest to researchers, commissioners, public health practitioners and policy makers from across the North East.

Programme

09:30-10:00 – Arrival and registration

10:00-10:20 – Welcome and background to MECC. Professor Ann Crosland, Sunderland University

10:20-10:40 – Building relationships with communities: the role of the health trainer programme in MECC. Dr Shelina Visram, Durham University

10:40-11:00 – The importance of place in shaping behaviours, a potential role for local government: tackling obesogenic environments. Dr Tim Townshend, Newcastle University

11:00-11.20 – Refreshment Break

11:20-11:30 – Questions to speakers – from pre-refreshment session

11:30-12:30 – Workshop: What are the challenges for academics and practitioners in implementing MECC? Annie Wallace, University of Sunderland

12:30-12:45 – Feedback from workshop session and closing remarks: Professor Ann Crosland, Sunderland University

On-line **registration** is available for this QRM on the Fuse website at: http://forms.ncl.ac.uk/view.php?id=4399

Please note spaces are limited, so early registration is advised.

This QRM is jointly organised between Fuse and Building Public Health Futures, one of the three strands of the School of Public Health North East. More information about the School, including work around Making Every Contact Count is available at www.sphne.org.uk. Find out about Fuse at www.fuse.ac.uk

Finding Teesside University Darlington Campus

By Road

From the A1 North and South: leave at junction 59 towards A167 Darlington. At the roundabout take first exit at A1150 and follow sign for A66 Stockton/Middlesbrough. At the mini roundabout go straight across, continue to the traffic lights and straight across again. At the next roundabout take third exit on B6279 on Stockton Road. Stay on this road, go straight across the first set of traffic lights. At the next set of traffic lights go straight across and then take the next left turn. Darlington College is on your right, continue on this road and Teesside University Darlington is on your right.

From A66 Stockton/Middlesbrough: at roundabout with A1150 junction go straight across and follow sign for A1 (North), second exit. At next roundabout take first exit. Stay on this road, go straight across the first set of traffic lights. At the next set of traffic lights go straight across and then take the next left turn. Darlington College is on your right, continue on this road and Teesside University Darlington is on your right.

By Rail

Teesside University Darlington is a 15-minute walk from the train station. Exit the station and continue down the hill until you reach the main road. Turn right onto Park Lane and follow this road, taking the first right, then left onto Parkgate. Take the first right opposite the Black Swan Hotel onto Borough Road. Continue past the Civic Theatre on your left until you reach the Bannatyne Spa. Turn right here onto Haughton Road, and take the first right after crossing the railway, passing Darlington College, before reaching Teesside University Darlington, just behind the college.

Teesside University Darlington is a 5-minute taxi ride from the train station. Campus map:

http://www.tees.ac.uk/docs/docrepo/about/CampusMap_darlington.pdf

Making Every Contact Count

Fuse Quarterly Research Meeting

School Of Public Health North East

Workshop

What are the challenges for academics and practitioners in implementing MECC?

What is MECC? A reminder

- An opportunity to raise health and well-being with the public, offer signposting, brief advice/intervention or longer term intervention
- Health and well-being in their broadest sense
- MECC doesn't work in isolation it needs to take account of the context in which people make decisions
- MECC is about building and supporting resilience in communities and individuals
- An Opportunity to create a climate where prevention is the norm and talking about health is everyone's busines

MECC organisational roles

Broadly, there are nine possible roles:

- Influencing
- Self care, looking after own health
- Environmental scanning
- Informational, supporting health campaigns
- Signposting and brief advice
- Brief intervention
- Longer term interventions
- Contracting and commissioning
- Promoting healthy environments.

Challenges in evaluating MECC

- What we really want to know is does it make people healthier/save us money/reduce inequality
- MECC is huge with poorly defined outcomes
- MECC has a lot of layers, organisations need to be ready for MECC, people need permission to deliver it and they need to know how to deliver it
- Unpicking what works where and in what circumstances with what skill set and what workforce
- There is a lot of research out there (have a look at the Fuse web-site) we need to make the connections
- MECC is being seen as something new?

What can we use to support our understanding

- Fuse research includes; work on brief advice/intervention, knowledge exchange/health improvement topic areas/public health workforce
- Recent evaluation of RSPH course CHASE collaboration
- Studies about impact of settings based approaches in particular healthy workplaces

Workshop Aims

- Identify what we already know that contributes to the evidence for MECC
- Be critical about what we think we know about the evidence
- Identify gaps in knowledge
- Begin to think about how we might fill those gaps

What happens after today

- Notes taken in the workshop to inform future plans for MECC evaluations
- No formal feedback session a brief overview at the end of the morning
- Developing evaluation framework(s) to support those implementing MECC

Making Every Contact Count: From Research to Implementation
23.01.13 Teesside University, Darlington Campus

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The importance of place in shaping behaviours a potential role for local government: tackling obesogenic environments

Tim G Townshend,

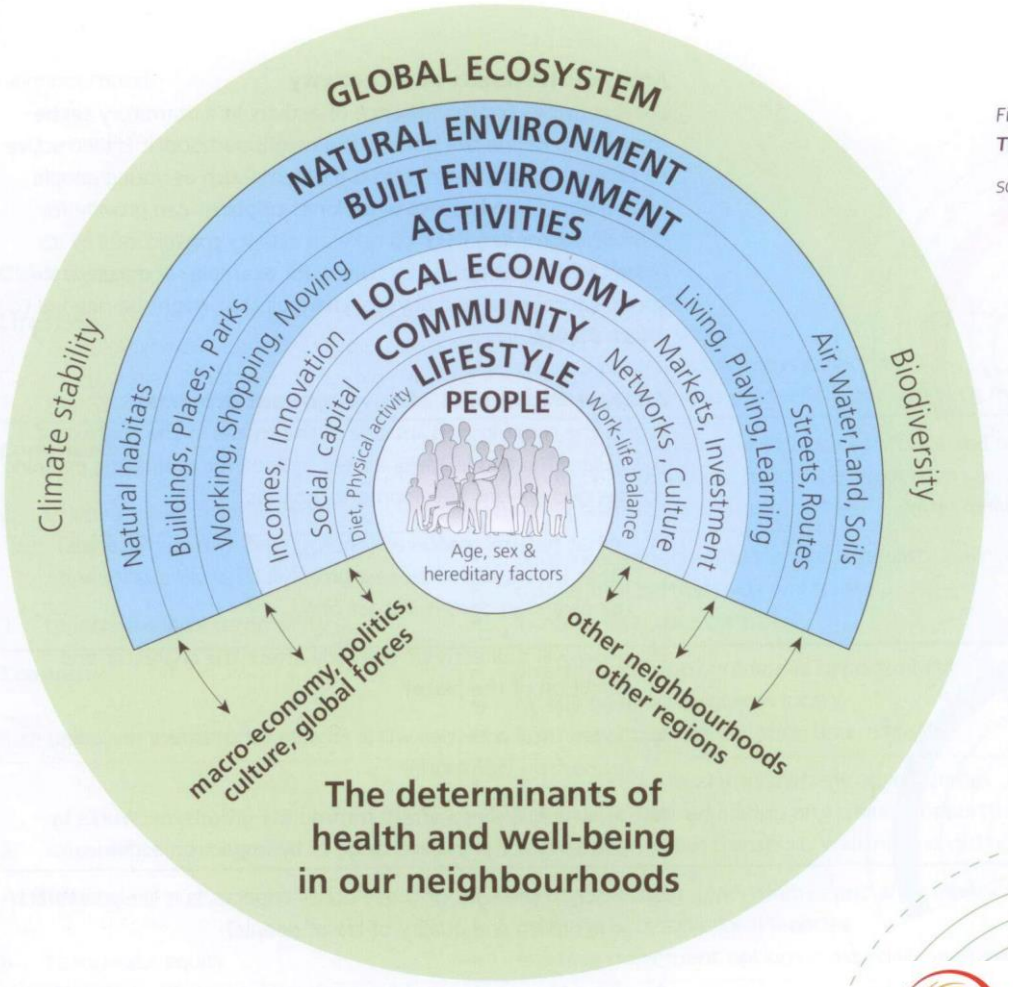
School of
Architecture Planning & Landscape

Newcastle University

Aim of Presentation

- Briefly to…
  - Overview links between built environment and obesity
  - Consider the way planning strategies might be operationalised (i.e. that address these relationships)
  - More broadly consider benefits of planning and health professionals working together
  - Tie all this back to Make Every Contact Count (MECC)

Socio-ecological theories of health

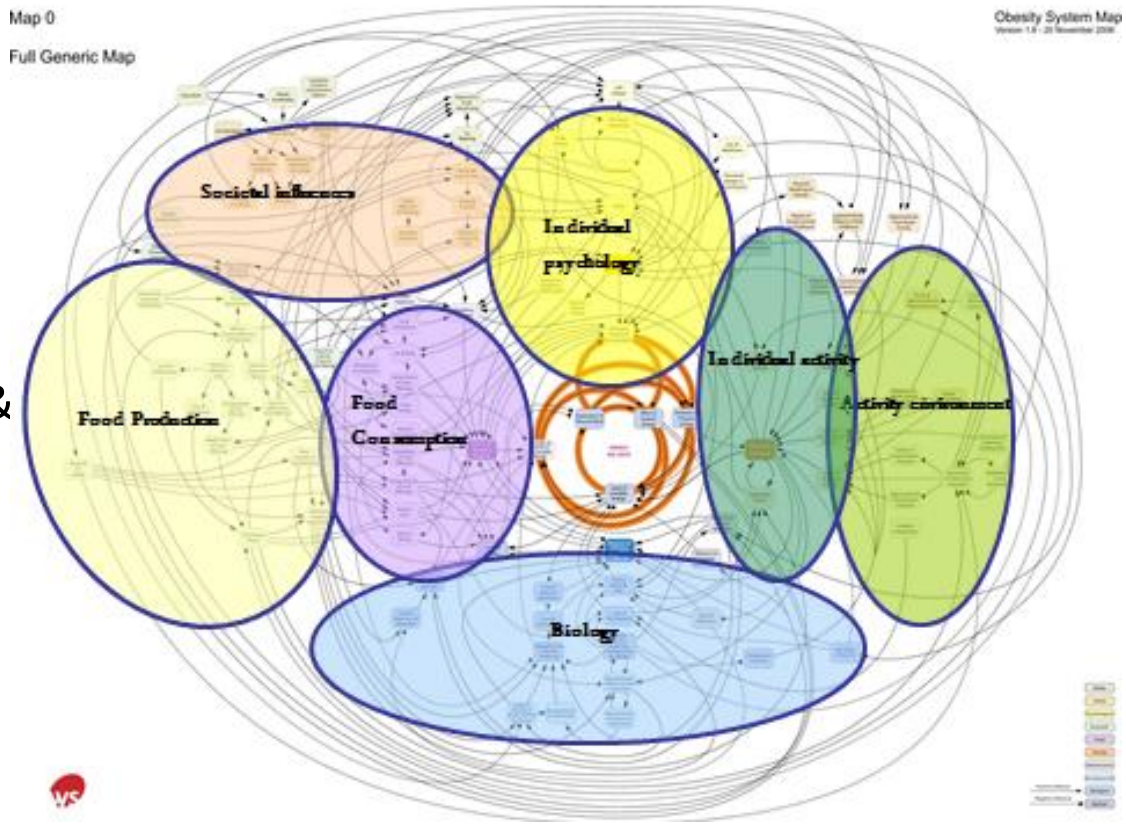


Barton et al

Obesogenic Environment

- ‘the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations’ (Swinburn & Egger, 2002)

- How is the built environment implicated?



Foresight, 2007

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Car dominated urban fabric

Metrocentre, Gateshead

…as opposed to encouraging ‘active travel’

Plus…

Great Park, Newcastle

- Fragmented towns and cities – work, leisure, etc separated from where we live
- Disconnected routes, cul-de-sacs, designed to ‘tame’ traffic
- Built to densities that don’t support local services
- Provided inadequate greenspace

…and furthermore

- Proliferation of energy dense food/low nutrient outlets
- … though N.B. establishing causal pathways has been notoriously difficult

(Re)Integrating Health and Planning

- **National Planning Policy** Framework (NPPF – para 69)– 03.12 – overarching guidance for local authority planners - 'promote healthy communities' + co-operation with 'public health leads' (**Health & Well-being Boards)**
- Robust evidence base take into account strategies to improve health and well-being
- Local plans must take into account and support strategies to improve health and well-being
- **Not necessarily a new direction for planning – but it is a new emphasis + evidence base is crucial to ensure it can be delivered**

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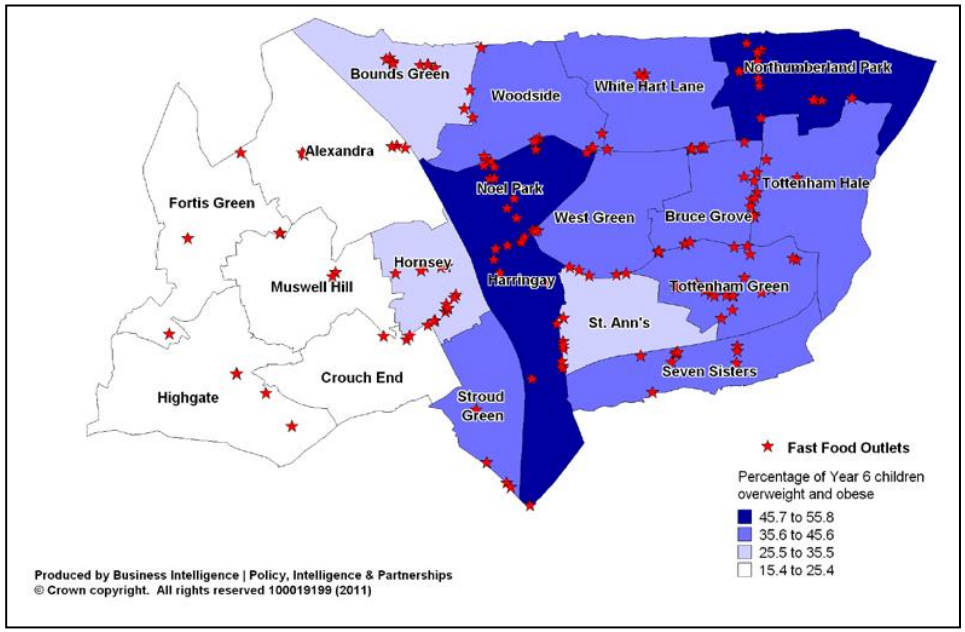
Intervention Strategies



Council	Concentration	Clustering	Proximity
Barking and Dagenham	5% limit on A5 units and/or frontage	No more than two adjoining frontages to be A5; at least two non-A5s between groups of A5	400m around primary and secondary schools (measured from school boundary)
Greenwich	25% limit on non-A1 frontage		400m around primary and secondary schools (measured from school boundary)
Haringey		No more than two adjoining frontages to be non-A1	
Havering	20% and 33% limits on non-A1 frontage	No more than two adjoining frontages to be non-A1	
Kensington and Chelsea	20% and 34% limits on non-A1 frontage	No adjacent non-A1 frontages; no more than three adjoining frontages to be non-A1 [in other areas]	
Newham			400m around secondary schools
Waltham Forest	5% limit on A5 frontage; no A5 within 400m of existing A5 [outside designated areas]	No more than two adjoining frontages to be A5; at least two non-A5s between groups of A5	400m around schools, youth centres and park boundaries

Some evidence that proximity of fast food outlets to schools an obstacle to secondary children eating healthily (e.g. at lunchtime)

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More broadly planners and health professionals working together can…

- Ensure health is ‘golden thread’ through entire planning system
- Reinforce health messages with developers, elected members and senior council officers)
- Involve health specialists in major planning developments

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Linking to Make Every Contact Count

- Currently we are still mainly at the 'theoretical stage' of understanding links between built environment and health issues, such as obesity
- Establishing how neighbourhoods do/do not support healthy choices – through evidence is vital – could there be processes of data collection through MECC? Or at least stimuli for future research/investigation?
- Furthermore through MECC can we get people to reassess their local neighbourhood environment?

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Final thoughts…

- Planning and health are not miles apart in professional goals – but have, different cultures, priorities, language – what is considered ‘evidence’

- Role of the built environment may be modest in relation to health issues – but given its longevity (many generations) and it operates across whole populations – the potential impact is hugely significant

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Building relationships with communities: the role of the health trainer programme in Making Every Contact Count (MECC)

Shelina Visram

26th April 2013

www.fuse.ac.uk

Background

- In spite of overall improvements to the health of the UK population, the inequalities gap continues to widen
- In 2008, people with no qualifications were more than 5x as likely as those with higher education to engage in four unhealthy behaviours, compared with only 3x as likely in 2003
- 2004: 'Choosing Health' set out action required to enable people to make healthy lifestyle choices
- 2010: 'Healthy Lives, Healthy People' emphasised individual lifestyles and personal responsibility for health

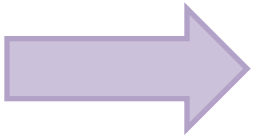
"Healthy choices are often difficult for anyone to make, but where people do not feel in control of their environment or their personal circumstances, the task can be more challenging" (DoH 2004, p.13)

Health trainers

- Introduced in ‘Choosing Health’
- An entry-level public health workforce role, described as:
  - Part of a shift from “advice from on high to support from next door”
  - In touch with the realities of the lives of the people they work with
  - Accredited by the NHS to have skills in supporting lifestyle change
  - A guide for those who want help, not an instructor for those who do not
  - Offering practical advice and connections into local services

Aims of the health trainer role

1. Target 'hard to reach' and disadvantaged groups
2. Increase healthier behaviours and uptake of preventative services
3. Provide opportunities for local people to gain skills and employment in health



Reduce health inequalities

"In targeting those people who would like to change behaviours relevant to their health, and have previously been hard-to-reach via other services, the health trainer has the potential to reduce inequalities" (Michie, 2008)

Existing literature

- Peer support has been widely used to promote behaviour change and self-care across diverse conditions and groups
- Most published examples come from North America but limited data exist on their number, use and scope of work
- Reviews reveal consistent but modest positive effects, particularly in increasing access to health care (Swider 2002; Lewin *et al.* 2005; Viswanathan *et al.* 2009; Carr *et al.* 2011)
- Benefits have also been found in the use of LHWs to promote immunisation, breastfeeding and breast cancer screening, and to improve outcomes for selected infectious diseases

Gaps in the evidence base

- Mixed evidence of the ability of specific lay-led strategies to yield health impacts that are sustained over time
- There is also a lack of research exploring service user views and experiences, which could provide valuable insights
- Before lay-led interventions can be advocated as potential solutions to public health problems, questions relating to feasibility, effectiveness and safety need to be answered
- Qualitative studies can shed light on intervention processes and expected outcomes, as well as access barriers
- Consistent with the MRC framework (2008)

PhD research

- Aim: to explore user engagement and health-related behaviour change in the NHS Health Trainers Initiative
- Methodology: qualitative longitudinal study, with data analysed using the constant comparative approach
- Setting: 3 local health trainer services in the north east of England employing contrasting service delivery models
- Sample: 26 service users, 13 health trainers and 5 managers or supervisors (total n=44)
- Methods: in-depth interviews with users at 0, 3, 6 and 12 months, and with staff at 0 and 12 months

Findings:

1. Making contact

2. Making it count

Findings 1: Making contact

Barriers to accessing health promoting services

- Lack of motivation
- Shyness, self-consciousness and fear of the unknown
- Communication barriers
- Poor health, associated with age and disability in particular
- Caring responsibilities
- Timing or scheduling issues
- Cost of activities, transport and childcare

Sometimes it's the timetable of when the courses are on affecting your life – it won't fit into your schedule, you know. So a lot of things like that affect it, as well as where the course is and how much it's going to cost to get there. (Client 4)

Engagement routes: professional referral

- Three main modes: (i) professional referral, (ii) self-referral, and (iii) community engagement or outreach activities

  The community dietician and the diabetic dietician have took us to heart, I suppose. They really see the value of the support – the one-to-one support – that we can give, in between them seeing them. And we're giving the same information. They've got, obviously, more in-depth knowledge as being trained dieticians, whereas we've got infor... We've got knowledge but we're obviously not as well trained – highly trained – as they are. But they see the value in the support that we can give, and we meet up with them and they make sure we're all singing from the same hymn sheet. (Health trainer 2)

Engagement routes: self-referral

- Contact initiated by service users, e.g. stopping the local health trainer to ask for advice in the street or supermarket
- Importance of word of mouth and personal recommendations

> *[The health trainer] is working with clients around, sort of, quite a few of them around smoking and then they're talking to friends, family or whatever, who are then saying "Oh, well I'll go along and see [the health trainer]." "Go along and see [name]. He's a nice bloke, he'll look after you." And we tend to get quite a few referrals that way.* (Manager 3)

Engagement routes: community outreach

- Contact initiated by health trainers, who are often known in their communities and seen as having "*street credibility*"
- Importance of listening skills and the ability to "*grasp any opportunity*" to promote the service

There's always some way of going out and advertising what we're doing. You know, doing our research around the area to put things out – it's really important. Because that's another way of getting people to where we are at. You know, instead of just through your GP or, "Oh, I want to go to the gym". It's like working with other projects that are going around and… Simple things like the corner shop or the supermarket. If they're willing to put out information then we'll advertise as much as we can. (Health trainer 5)

Reaching the ‘hard to reach’

- Concerns about accessing the most vulnerable or isolated groups

> *Because we are opportunistically doing work in communities, you do worry about those people who are perhaps completely isolated in their own homes. And again, it is about networks and you hope that through neighbours, etc, you would perhaps get to know those people. But I do worry about those people who are so isolated. I think this is the best approach we can take, but I do think there will inevitably be some people that we don’t manage to reach. You know, so it’s about continuing to look at that and think of different ways of doing it. And literally knocking on doors – which we do do some of – standing outside of the Post Office, wherever it is that somebody is very likely to go.* (Manager 4)

Findings 2: Making it count

Flexible, person-centred approaches

- Addressing 'health' in the broadest sense, e.g. debt, employment, stress, marital problems, etc
- Being sensitive and mindful of complex needs, without stigmatising
- Working with client to determine their needs and priorities

> *You kind of get the feel of how long your person is going to want to talk after the first... first visit, really. Some people just want the information, they're there, they're gone. Other people, you can be there for an hour. One of my colleagues at [name of community venue] said "What are you doing with your clients – you've been in there for ages!" "I was talking, man" (laughs)... And again, it's on an individual person's aspect. With some people you end up talking about everything and anything. Other people it's straight and to the point.* (Health trainer 3)

Signposting to other services

- Having knowledge of the services available in the local area
- Appreciating that some people need help to make the first step

To some of the health trainers – I would say the majority – nothing is a bother. If it involves signposting to another service or possibly taking you to a first visit somewhere else because you're a bit nervous, say, going to the dentist or you want to get benefits advice – they would, within their remit, could, you know, escort somebody there and help them out for that first one. Or if they say they want to do line dancing – I'm not sure some of them could cope with line dancing themselves (laughs) – but they'll take them along to the first appointment and try and get them feeling comfortable with the group, until they're happy to do the exercise or take the service that's offered. (Manager 2)

Behaviour change tools and techniques

- Delivering tailored interventions using theory- and evidence-based strategies, e.g.:
  - Barrier identification
  - Goal setting
  - Action planning
  - Behavioural regulation
  - Relapse prevention

They set their own goals, we just help them, you know, guide them through it, and give them realistic ones. You know, like if somebody said to me "I've got to lose a stone in a fortnight. I'm going to a wedding." I'll go, "Well, you know, we'll start by breaking that down a bit", you know, getting realistic. Get in the real world (laughs). (Health trainer 1)

Building confidence

- Helping people to help themselves, not doing it for them

  How do we help them to move from those barriers? Building their confidence in themselves... A lot of [clients]… Sometimes it's as if they want to ask questions, but they don't know who to ask. Or they think, "Are we allowed to ask questions?" you know. And they, you just... Because they seem to come from a background where you don't question anything, you know. "The doctor has told me to lose weight, but he didn't tell me how to do it." So I said, "Well did you ask him for any help?" "Well, no... because you don't ask." Things like that. [...] Just by talking to them, you say "Well, there's some kind of help out there. Do you want to access it?"... Helping them access it, not accessing it for them. Encouraging them along the way. (Health trainer 2)

‘Back to basics’

- Starting from wherever the client is, in terms of their knowledge, personal situation and capacity to make lifestyle changes
- Taking the time to explain and demonstrate new skills

The information that we give could be the same information that everybody gives out, but if you can sit down with somebody in a nice, relaxed manner and they’ll take their time and talk to you about things and explain things to you... One of the things we had the other day – when I was out with one of the health trainers – was a lady who was middle-aged who’d never sliced a pepper before. And the health trainer sat there and explained how to do it and then what the person can do with it, you know – you can slice it this way or you can slice it that way, you can cook it like this or you can keep it whole and put rice and things in it and have it as a stuffed pepper. And it’s things like that that they bring to the table that possibly other people don’t have. (Manager 4)

Informal, peer-based approach

- The health trainer role was perceived as "*not like a paid job*" in terms of getting a "*personal touch*"; no clock watching
- Examples of humour and 'banter' between staff and clients

I think with [the health trainer], you see, she's very down-to-earth and she speaks her mind. She's well known and she's well liked and people have known her for a long time. And you get used to the same person. Nobody likes change. And nobody likes to be patronised or dictated to by somebody. So to have an outgoing person like [name] is very good. I mean, there's nothing you can't say to her, really. She just laughs at you. And that's the way I like people – down-to-earth, you know. (Client 1)

Self-reported outcomes

- Health-related behaviour changes and physical health improvements

  I'm a diabetic and it has actually, it brought my sugar levels down because I was getting exercise. [...] And then when I had my blood results, and even the dietician, she was so pleased. It had come from 9.1 or something to 8, you know. So she said, "Oh, keep it up", which as I say, I'm going to. Get down a bit further. Definitely, yeah. (Client 24)

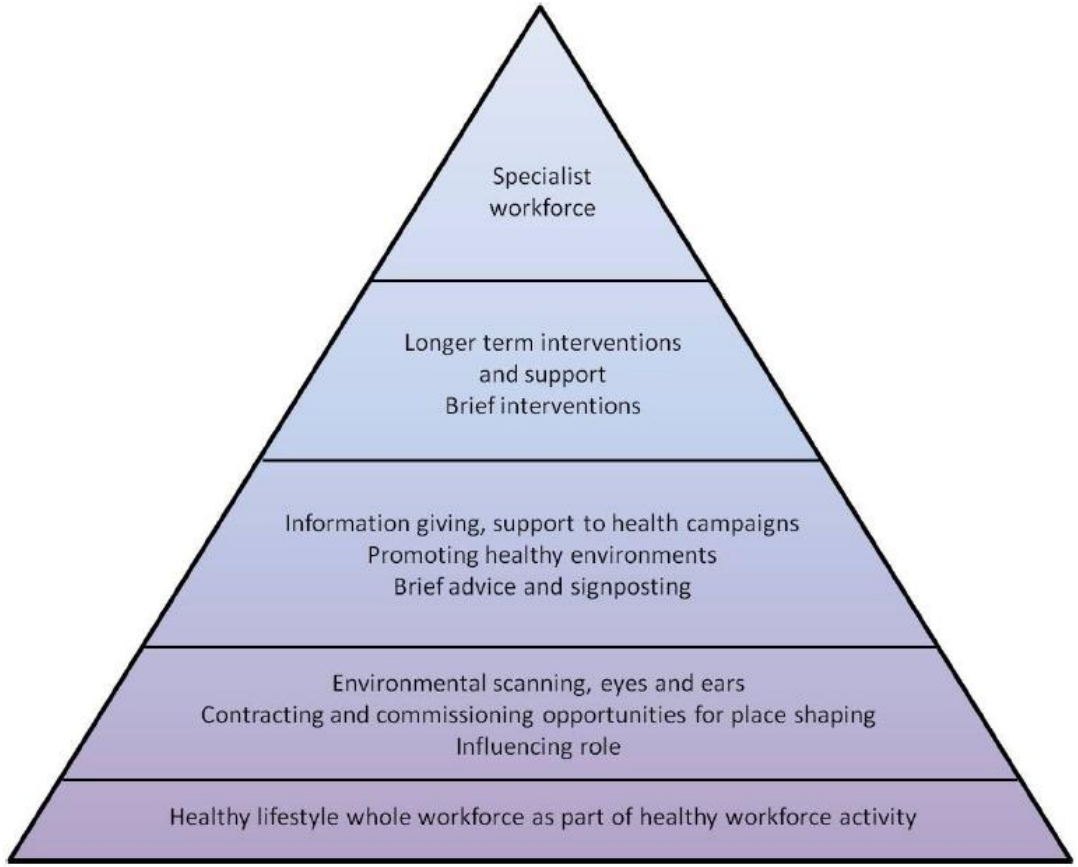
- Improvements in confidence and self-esteem

  I am coping. So it's sort of like a little reminder I can do stuff, you know. It's nice having family to fall back on but, you know… it's not the end of the world. So, it just feels better, you know, that I feel like I can manage it. [...] I'll say to myself, "Well, I'm calming down, I'm relaxing and I'm not letting this get on top of me." I mean, the situation's still the same, it's just my perception of it is trying to be different, you know. (Client 6)

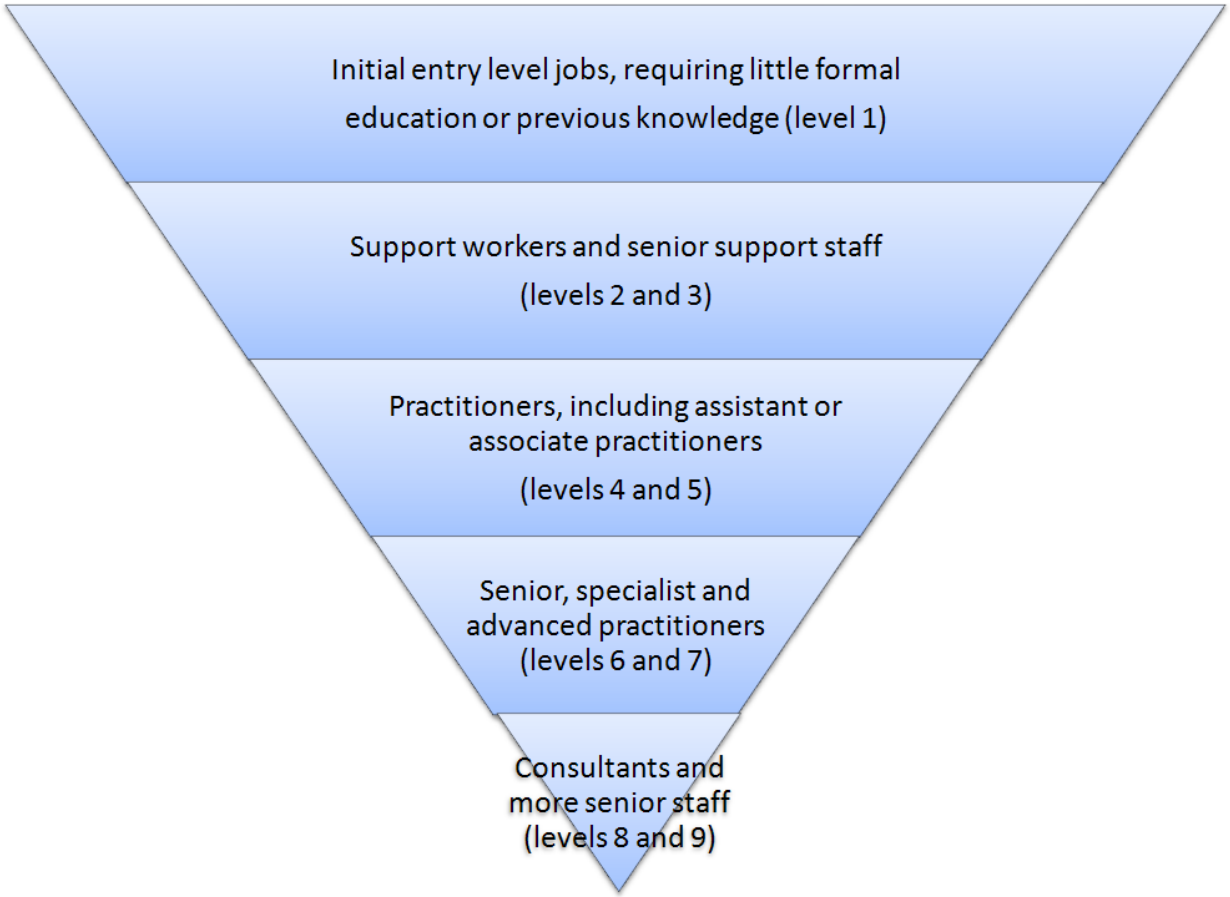
Discussion

- Peer-based approaches are known to be successful in providing information and advice in culturally competent ways
- Fit with the 'fully engaged' scenario and the 'Big Society' policy idea of empowering local people to take an active role
- Growing evidence base that health trainers have the potential to improve population health and reduce inequalities through behaviour change (e.g. Gardner *et al*, 2012)
- The programme meets the underpinning values of MECC:
  - Equity, social justice and a commitment to tackling inequality
  - Asset based
  - Respect for the context in which people make healthy choices
  - Being ethical and professional: walking the talk

Workforce supporting MECC



NHS Careers Framework



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Professor Martin White, Newcastle University

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Making Every Contact Count

Fuse Quarterly Research Meeting

Aims

- To set the scene and give some background to MECC
- To place MECC in the context of an overall strategy to improve well-being and health

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What is MECC?

- An opportunity to raise health and well-being with the public, offer signposting, brief advice/intervention or longer term intervention
- Health and well-being in their broadest sense
- MECC doesn't work in isolation it needs to take account of the context in which people make decisions
- MECC is about building and supporting resilience in communities and individuals
- An Opportunity to create a climate where prevention is the norm and talking about health is everyone's business

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History of MECC National

Wanless (2002, 2004) identified the benefits of the fully engaged scenario:

- Cost effectiveness in using the NHS encounter to promote healthy lifestyle as well as signpost to effective use of services
- Cost effectiveness in shifting a largely disease based agenda towards a more pro-active approach to health
- More active support in helping people choose healthy lifestyle options including better access to services
- Support to reduce health inequalities

Healthy Lives, Healthy People

More recently the **NHS Future Forum (2012)** made the recommendation that every healthcare organisation should deliver MECC and 'build the prevention of poor health and promotion of healthy living into their day-to-day business.'

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Development of MECC Local

Local

- Embedded within Multidisciplinary School for Public Health vision and is the overarching objective for Building Public Health Futures (wider workforce capacity building)
- Embedded as a principal within North East public health strategy
- Embedded within Local Education and Training Board structures as a principal for educational development
- North Cluster (North East, North West and Yorkshire and Humber) priority

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A map of the human habitat

SCHOOL OF PUBLIC HEALTH NORTH EAST

Capacity Building Framework

Action areas	Examples
Organisational Development	• Vision statements, policies and procedures • Health Champions at executive level • Inclusion in contracts/job descriptions and appraisal systems
Workforce Development	• All aspects of training and development • Support and supervision
Resource allocation	• Takes account of health impact of resource allocations • Financial, human and physical resources allocated health improvement budget • Use of public health intelligence in resource allocation
Partnership	• Shared goals • Partners involved in planning and evaluating
Leadership	• Strategic vision and articulating the priorities for health improvement • Managing the resources

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Programme

- Building relationships with communities: the role of the health trainer programme in MECC. Dr Shelina Visram, Northumbria University
- The importance of place in shaping behaviours, a potential role for local government: tackling obesogenic environments. Dr Tim Townshend, Newcastle University
- Workshop: What are the challenges for academics and practitioners in implementing MECC? Annie Wallace, University of Sunderland

Quarterly Research Meeting – Summary Report

Making Every Contact Count: From Research to Implementation

Friday 26th April 2013 – 9:30am-1:00pm

Teesside University Darlington Campus

Introduction

This report summarises the content of the speaker's presentations and some of the workshop debates at the April Quarterly Research Meeting held on the topic of "Making Every Contact Count". The QRM was jointly organised between Fuse and Building Public Health Futures, one of the three strands of the School of Public Health North East. More information about the School, including work around Making Every Contact Count is available at www.sphne.org.uk. The QRM was followed by a meeting organised by the School held on the same day.

Welcome and background to MECC - Professor Ann Crosland, University of Sunderland

Following a general introduction to Fuse, Ann explained the background to "Making Every Contact Count" (MECC) (see Slide 2), describing MECC as a concept to influence health and well-being in the widest sense, in every setting, and to increase influence in local communities and build resilience. The specific aims of MECC are set out in slide 3 entitled "What is MECC?" With reference to the history of MECC (slide 4), Ann indicated that its origins were in the Wanless reports of 2002 and 2004, which included the then new concept of the fully engaged scenario, whereby society as a whole would be incorporated within the promotion of healthy lifestyles.

Ann described how MECC was related to current structures, particularly those emerging following the NHS reforms (slide 5). Slide 6 illustrating the human habitat (a series of concentric circles showing how people are placed within society and the wider natural environment) was used as a reminder to the audience to think strategically about MECC in the broadest possible way. The capacity building framework is set out within Slide 7, listing examples under the sub-headings of organisational development, workforce development, resource allocation, partnership and leadership. Ann described a workshop day held in Gateshead as an example of the practical working of MECC. The capacity building framework is also to be found on the School for Public Health North East website (see web-link, above).

Building relationships with communities: the role of the health trainer programme in MECC. Dr Shelina Visram, Durham University

In spite of overall improvements to the health of the UK population, the inequalities gap continues to widen. In 2008, people with no qualifications were more than five times as likely as those with higher education to engage in four unhealthy behaviours, compared with only three times as likely in 2003.

Shelina gave an overview of the job of Health Trainers. Health Trainers (HTs) work within different organisations but generally on the equivalent of band 2 or band 3 on the NHS

scale. To use the title 'Health Trainers' you have to have gained a City &Guilds Qualification. The aim of HTs is to target disadvantaged people to try and tackle inequality, isolation and ill health. The range of HTs work tends to be more generic than other health professionals as they can work with members of the public who need advice on various health behaviours e.g. not just one scheme such as breastfeeding or stop smoking.

The role of HTs has flexibility in terms of how they work, with different areas maybe using different models as guidance in how they approach their clients.

How do they make contact?

HTs can make contact with clients through three main modes: (i) professional referral, (ii) self-referral, and (iii) community engagement or outreach activities.
The different routes allow HTs to make contact through different means such as word of mouth or advertising the services within the local community.

How can HTs make contact count?

The contact can be person centred and individualised to each clients' needs. This can often be wider than health issues. If a client is struggling with house or money problems a HT is able to signpost them to the appropriate services that can work with their problems. Therefore it is important that HTs keep up to date with what is happening in the community and make themselves known and accepted in their communities.

HTs have faced some criticism about their skills, experience and knowledge. However, interventions they use are based on theory and evidence based strategies e.g. Barrier identification, Goal setting, Action planning, Behavioural regulation, Relapse prevention.

Many of Shelina's interviewees confirmed how HTs had helped them and how contact with them had improved their health. Shelina also found that it empowered people within the community and allowed informal peer support to take place.

The programme meets the underpinning values of MECC:

- Equity, social justice and a commitment to tackling inequality
- Asset based
- Respect for the context in which people make healthy choices
- Being ethical and professional: walking the talk

Growing evidence base that health trainers have the potential to improve population health and reduce inequalities through behaviour change (e.g. Gardner *et al*, 2012).

The importance of place in shaping behaviours, a potential role for local government: tackling obesogenic environments. Dr Tim Townshend, Newcastle University

Tim Townshend explored in his presentation the links between built environment and obesity.

In a diagram extracted from Barton et al (2010: 25), there was an attempt to explain the socio-ecological theories of health. He mentioned that his research focuses on the outer

blue area of the circle which includes consideration of the natural and built environment in relation to health and well-being (see slide 3).

As demonstrated by Foresight, (2007) obesity is multi-factorial and this is summed up by Swinburn and Eggers definition of the obesogenic environment as "the sum of influences that the surroundings, opportunities, or conditions of life have on promoting obesity in individuals or populations" (2002). He then explored how the built environment could affect obesity. He suggested that over the past 50 years we have largely designed our urban areas around the needs of the private car rather than active travel, that is walking and cycling and gave the example of the Metro centre in Gateshead to illustrate this point. He also mentioned that towns and cities are fragmented and people need to travel long distances to go to work, leisure or schools. In addition, the increase in density of residential areas are often insufficient to support a good range local services (e.g. local shops) and inadequate green space provision further does not encourage people to walk, or cycle.

On the other side, there is a proliferation of local shops which offer energy dense low nutrient food. However, he noted that identifying cause-effect and pathways between the built environment and obesity is notoriously difficult.

He then turned his attention to planning. The new National Planning Policy Framework (NPPF) places emphasis on the need for planners to promote healthy communities and encourages them to work closely with Health & Well-being Boards. However decision making between planning and public health are not very obvious and the evidence base is crucial to ensure that strategies to improve health and well-being can be delivered.

Tim then mentioned that there is scientific evidence that proximity of fast food to schools can be an obstacle for children to eat healthily. Planning systems can control the distance of fast food from schools, for example. However, sometimes attempts to control such developments end in appeals. These are dealt with by the Planning Inspectorate and whether the planning decisions are upheld, or overturned very much depends on what is defined as 'evidence'. In general he believes that if planners and health professionals work together they can ensure that health is the 'golden thread' throughout the entire planning system. There is still a need for scientific evidence to support the links between built environment and obesity, for example, and scientific evidence can change quickly. However, he questioned if make every contact count (MECC) could support the process of data collection and/or further research to establish how neighbourhoods could support healthy choices. MECC can also help people to reassess their local environment.

Finally, he concluded that planning and health are not too separate in their professional goals but cultures and priorities may differ. He stated that although sometimes the contribution of built environment to health might be seen as modest, their impact can be hugely significant and last many generations to come.

References

Barton et al. (2010) *Shaping Neighbourhoods for Local Health and Global Sustainability* 2nd Ed, Routledge, London.

Swinburn, B., & Egger, G. (2002) Preventive strategies against weight gain and obesity, *Obesity Reviews*, 3(4) 289-301

Workshop: What are the challenges for academics and practitioners in implementing MECC? Annie Wallace, University of Sunderland

Annie Wallace introduced the workshop discussion groups. The overall title of the workshop is as given above. There was a brief reminder to the audience of what MECC is (slide 3); the kind of roles that people might undertake to implement MECC (slide 4) and challenges in evaluating MECC (slide 5). Annie outlined current research work and evaluation being undertaken to support the underlying understanding of how MECC is working out in implementation (slide 6). The workshop aims are set out in slide 7 and included:

- Identifying what is already known about what contributes to the evidence for MECC
- Being critical about what we think is known about the evidence
- Identification of gaps in knowledge
- Beginning to think about how the gaps might be filled

There were six workshop groups on the day at the QRM. The notes taken in the workshop sessions will be used to inform plans for future MECC evaluations.

Feedback from workshop sessions (for two groups)

Group 1

- No time to access public health evidence – cost involved on website to some external links, not a lot of evidence.
- Alcohol/smoking need interventions from health trainers, going into homes, poor emotional health and wellbeing, money issues.
- There are pressures from CMG on reducing hospital admissions, can you prove what you're doing is making an impact, very hard to show this. Need to set process timelines to know what is being influenced.
- Important to know where next lot of money is coming from.
- Local Authorities have different views, they need value for money but don't want to sound like politicians saying that cost matters.
- Important to push out training schemes before local elections.
- How do we sell MECC in the voluntary and public sectors? They need to know what they will get in return. Important to have MECC as a lever.
- A need to write into commissioning contracts, needs hearts and minds in it, possible incentives like badges to say completed training now a health champion, this is very empowering and often starts conversations.
- Need to understand the different ways to sell to different institutions, best to ask what people need in order to get in, offer something for free.
- Socio-Economic – sometimes funding is limited and have rules which don't actually agree with what the community wants, comprehensive guidance is needed.

- How do you do cross-cutting research on this to show how to move around organisations, Councils are changing and this needs doing rapidly, people want examples from MECC (case studies).

Group 2

- We came to the workshop to learn about MECC, beneficial to link with health trainers.
- Dedicated resource to support health and wellbeing with North East.
- Evidence – public health capacity programme.
- Health Awareness Project – fire service, housing, foundation – NHS, problems engaging wider work force.
- Generic responsibility use people who are non-judgemental, health inequalities are growing, something not working.
- Community Health Service – Making every staff member have MECC mandatory training and lifestyle questions for patients.
- Slow approach – empower staff to have confidence to challenge life style behaviours.
- Healthy maternity – understanding and giving skills to give brief advice.
- Become part of mandatory training all ready for RGNs, good and bad results from challenging people – put in bulletin for information, not judging – offering information.
- Not looking at mental health issues, wellbeing awareness of the illness and increasing awareness of the illness.
- Apprehensive of broaching the subject of mental health.
- Obesity for example often a result of mental health.
- Cancer awareness – care group now look at other illnesses and how they link with mental health, suicide awareness – need specialist help.
- Gap in terms of translation: How to change that into practice.
- Have good practice awareness – not necessarily what has been done at home but what has worked elsewhere.
- Research evidence abroad, has policy played a part in this.
- Welfare not taking into account smoking and alcohol with benefit cuts these are being addressed.

Closing remarks from Professor Ann Crosland, University of Sunderland concluded the meeting.

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