Making Every Contact Count

Rapid Evidence Review

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1. Introduction

Making every contact count (MECC) is a term used widely to describe the mechanism of brief advice and behaviour change interventions. MECC means that everyone who has contact with the public is enabled to have an impact on public health outcomes by having health chats with people. MECC was proposed to unleash the potential of the wider NHS workforce to promote healthier lifestyle choices and to signpost to relevant services, and was identified as a priority for the NHS in 2014/15 after being recommended by the NHS Future Forum in 2012.[1] Public Health England and HEE are currently looking at having a coordinated national approach to MECC and accredited training.

MECC came about as a new way of describing behaviour change training, using approaches developed by Yorkshire & Humber NHS, who developed *'Making Every Contact Count (MECC) Prevention and Lifestyle Behaviour Change: a competence framework (P&BHCF)'*.[2] This Framework is based on NICE behaviour change guidance (2007) and defines behaviour change in 4 levels:

Level 1: Brief advice and signposting

Level 2: Behaviour change intervention e.g. brief intervention or motivational interviewing.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf
[2] http://www.makingeverycontactcount.co.uk/docs/Prevention%20and%20Lifestyle%20Behaviour%20Change%20A%20Competence%20Framework.pdf

Level 3: Behaviour change intervention programme e.g. weight management programmes.

Level 4: Expert or specialist interventions that are condition specific or require additional specialist training.

There is an 'Every Contact Count Website'[3] which has a range of training resources, impact mapping, competency frameworks, and case studies. There is a self-assessment tool[4] for professionals.

MECC is used to describe several different types of approaches and interventions, and is also used in tackling homelessness[5,6] and public mental health[7] as well as its main use in terms of behaviour change and lifestyle interventions. The literature on homelessness is substantial but this report will focus only on the public health/behaviour change literature. Making every contact count has been used for health visitors, nurses,[8] public health staff, allied health professionals[9], GPs[10] and for voluntary sector organisations.[11] The awareness raising from MECC training can be used at three main levels; in the workplace, at a personal level - thinking about one's health at home with friends and family, and on a professional basis, incorporating healthy lifestyle messages into services. MECC is part of the individual-level approach to population health, which augments policy or community interventions.

The main skill needed for making every contact count is having an understanding of the impact of lifestyle on health, and being able to have non-judgmental health chats with people about their lifestyles and their health.

2. North West Training Package

There is a freely available 40 minute online training package available here; this is a publicly available website so can be shared with anyone to access. It is packaged under Health Education North West (part of Health Education England). The package has a specific section on smoking advice for people with mental health issues.

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

[3] http://www.makingeverycontactcount.co.uk/index.html
[4] http://www.makingeverycontactcount.co.uk/Training%20and%20Resources/SelfAssessTool.html
[5] http://districtcouncils.info/files/2012/08/DCN-Homelessness-Research-Policy-Briefing.pdf
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7597/2200459.pdf
[7] http://www.mentalhealth.org.uk/content/assets/PDF/publications/building-resilient-communities.pdf?view=Standard
[8] http://www.nursingtimes.net/every-nursing-contact-counts-for-improving-public-health/5039946.article
[9] http://www.rsph.org.uk/filemanager/root/site_assets/our_work/reports_and_publications/2015/ahp/final_for_website.pdf
[10] http://www.makingeverycontactcount.co.uk/docs/Literature%20review%20for%20MECC.pdf
[11] http://www.rawm.org.uk/news-events-jobs/sector-news/making-every-contact-count-briefing-voluntary-and-community-sector

The training package includes information that is local to the North West as well as information on lifestyle risk factors to answer questions such as what is a healthy weight; what is a safe level of drinking etc. It frames health chats around the 4 As – **ask, assess, advise and assist.**

The package works best with sound as it has videos and narration. The package works best on PCs and laptops rather than ipads or tablets and individuals should save their certificate to their computer at the end. For organisations with their own eLearning platform that can accommodate SCORM objects, the programme is available for internal delivery; this would mean that organisations could monitor who had accessed the package.

This training is most suitable for people who have contact with the public but can also raise awareness of individual or workplace lifestyle issues. It is only meant to be an aid to learning; either a precursor to face to face behaviour change training, or to reinforce existing training i.e. 6 months later – as part of a blended learning package. It may not be useful for people who already work in public health or behaviour change and have a good knowledge of lifestyle risk factors and behaviour change techniques. The training package can help to provide an organisational commitment to public health and raise consciousness about health being everyone's business. This training package maps to most competencies of level 1 of the *'Making Every Contact Count (MECC) Prevention and Lifestyle Behaviour Change: a competence framework (P&BHCF)'*.[12] For some staff it may be useful to back up this package with additional behaviour change training, for instance, at one point Liverpool Community Trust staff did this training then went onto behaviour change training. This training might be useful for staff within the council to think about their colleagues' health and improving lifestyle, and practising the five ways to wellbeing.

This training was developed for Health Education North West, based on an earlier package which was released in 2012 which was widely used but had some out of date references to organisations like SHAs, PCTs.

North West Training Package - Evaluation

There has been no formal evaluation of this training resource but the previous version was widely taken up, for example Wirral CVS had it on the front page of their website, community pharmacies used it, and Edge Hill and Manchester Metropolitan Universities used it as part of their training programmes for health staff. Over 1800 staff had completed the first version of the training. We do not have much detail about how other areas are implementing this training but it can be made available from the website or hosted internally.

[12] http://www.makingeverycontactcount.co.uk/docs/Prevention%20and%20Lifestyle%20Behaviour%20Change%20A%20Competence%20Framework.pdf

3. What is the Opportunity?

Making Every Contact Count is intuitive, it is not about complex technology or psychological theory, which is why it has gone viral as an idea. It is about having a whole systems approach where services are all singing from the same hymn sheet, so thinking about the classic example of a person who sees the doctor who tells them to stop smoking, then walks out and sees a nurse smoking outside the surgery. MECC is an industrialisation of what should be happening anyway. MECC breaks down the silo approach to improving people's lives and promotes a holistic view of person.

For MECC, Public Health moving to Local Authorities is a chance to further spread the message of the impact of lifestyle risk factors and the opportunity to reduce ill health by tackling them. Public health can spread this message beyond classic health services to services such as social care, looked after children, environmental health, trading standards, housing, parks, leisure and recreation, libraries, benefits advice as well as the council workforce and the people who provide services that are funded by the council. MECC gives LA employees a skillset for health messages that can be used in places like carehomes and childrens centres. There is an opportunity for police, and fire and rescue services – Merseyside Fire & Rescue Service have a MECC approach already in asking people about smoking and alcohol use, which are linked to an increased risk of domestic fires. The MECC approach could also be used with large employers, training people as health advocates in the workplace.

The Kings Fund carried out an influential piece of work about how unhealthy lifestyle behaviours often cluster together[13]; this means that there is an opportunity for individuals to gain many years of healthy life by changing their behaviour. There is quite a lot of spare capacity in some public health services in Wirral, so for instance weight management and smoking cessation have both had lower uptake than targeted so having mechanisms to refer more people into these services should make the system more efficient. Some services like sexual health services have actually had more activity than was planned. More interactions with public services are becoming automated so there are fewer face to face contacts with council services, but MECC also fits in with the self-care agenda and empowering individuals to improve their lives and potential reduce the need for public services; this fits with the principles of asset based community development (ABCD) as well. For example in Croydon MECC has involved ABCD community connectors.[14]

There may be opportunities for online behavioural self-help tools like Puffell or free online mental health self-help tools. There is a link between debts and anxiety and depression so integrating messages around help for mental health problems with functions like council tax payments may be an option. But any local implementation needs to be handled carefully with clear objectives.

[13] http://www.kingsfund.org.uk/audio-video/david-buck-clustering-unhealthy-behaviours-over-time
[14] http://cvalive.org.uk/abcd/building-health-partnerships/

4. What is the Evidence?

There are few high quality published studies of MECC in journals; most of the evidence is in policy papers. There are two studies carried out by University of Southampton [15] [16] which evaluated 'healthy conversation skills' training in children's centres and found that staff were more confident in their skills one year on, particularly in creating opportunities, asking open discovery questions, and listening. They found that compared to women from a control group of children's centres, the intervention did not significantly improve women's diets and physical activity levels, but it had a protective effect on intermediate factors—control and self-efficacy. University of Southampton have also been evaluating training provided by Health Education Wessex which has been piloted in NHS Hampshire Hospitals (therapy services, occupational health, & diabetes services), in Portsmouth City Council housing services17 and in Southern Health NHS Trust Minor Injuries Unit. Wessex School of Public Health recently evaluated their MECC education programme and found that it was successful in changing practice but that more needed to be done to ensure that middle managers facilitated the right environment for staff to implement their MECC skills in practice and that organisations created a MECC culture.

There is also a review carried out for NICE but this focuses mainly on the workplace implications rather than the evidence of effectiveness.[18] There is good evidence for the cost effectiveness of brief interventions for alcohol and smoking, but this is not explicitly tied to the MECC approach. MECC works on a principle of 'playing the numbers game'– if someone trained to make every contact count has just one health chat a week, once this is amplified across the whole sector the number of health chats and the capacity for change is huge.

One source of evidence that has been quoted in reports around MECC is the NICE Guidance 'PH6: Behaviour change' (2007), partly updated with 'PH49: Behaviour change: individual approaches' (2014). The initial guidance emphasised having a life course approach and focusing on the opportunities at transition points such as leaving school, entering the workforce, becoming a parent, becoming unemployed, retirement and bereavement. The 2014 update said that commissioners of health, local authority and voluntary sector organisations, local education and training boards, and managers and supervisors of staff delivering behaviour change interventions should commission training for relevant staff to cover activities, from a very brief intervention offered when the opportunity arises to extended brief interventions which include assessment of people's behaviours and needs.

[15] Lawrence, W., Black, C., Tinati, T., Cradock, S., Begum, R., Jarman, M., ... & Barker, M. (2014). 'Making every contact count': Evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. *Journal of health psychology*, 1359105314523304.
[16] Baird, J., Jarman, M., Lawrence, W., Black, C., Davies, J., Tinati, T., ... & Inskip, H. (2014). The effect of a behaviour change intervention on the diets and physical activity levels of women attending Sure Start Children's Centres: results from a complex public health intervention. *BMJ open*, *4*(7), e005290.
[17] http://democracy.portsmouth.gov.uk/documents/s2997/HSC13Feb14mec.pdf
[18] http://www.makingeverycontactcount.co.uk/docs/Literature%20review%20for%20MECC.pdf

NICE PH49 Recommendation 9 says:

"Encourage health, wellbeing and social care staff in direct contact with the general public to use a very brief intervention to motivate people to change behaviours that may damage their health. The interventions should also be used to inform people about services or interventions that can help them improve their general health and wellbeing.

Encourage staff who regularly come into contact with people whose health and wellbeing could be at risk to provide them with a brief intervention. (The risk could be due to current behaviours, sociodemographic characteristics or family history.)

Encourage behaviour change service providers and other health and social care staff dealing with the general public to provide an extended brief intervention to people they regularly see for 30 minutes or more who:

- are involved in risky behaviours (for example higher risk drinking)
- have a number of health problems
- have been assessed as being at increased or higher risk of harm
- have been successfully making changes to their behaviour but need more support to maintain that change
- have found it difficult to change or have not benefited from a very brief or brief intervention.

Encourage behaviour change service providers and practitioners to provide high intensity interventions (typically these last more than 30 minutes and are delivered over a number of sessions) for people they regularly work with who:

- have been assessed as being at high risk of causing harm to their health and wellbeing (for example, adults with a BMI more than 40 – see Obesity, NICE clinical guideline 43) and/or
- have a serious medical condition that needs specialist advice and monitoring (for example, people with type 2 diabetes or cardiovascular disease) and/or have not benefited from lower-intensity interventions (for example, an extended brief intervention)."

There is also a NICE Pathway around behaviour change.[19] There is a body of evidence on alcohol screening and brief advice which has indicates that it is effective and cost effective in reducing alcohol related disease.[20] There is a report by NHS East Midlands Health Trainer Hub; "An Implementation Guide and Toolkit for Making Every Contact Count: Using every opportunity to achieve health and wellbeing" which has a section on evidence, but perhaps disappointingly, the evidence is about the burden of ill health that is due to behavioural lifestyle issues, rather than the specific success of MECC as a method to improve outcomes.

[19] http://pathways.nice.org.uk/pathways/behaviour-change

[20] http://www.unialliance.ac.uk/blog/2015/02/17/making-every-contact-count-to-reduce-harm-from-drinking-alcohol/

5. How have Areas Implemented MECC?

There have been many case studies of MECC being implemented in local authorities[21] and in the NHS[22], although in many different ways. The LGA's report which has LA examples focuses on how MECC was implemented, but there do not seem to be any examples of changes in outcomes, such as those on the PHOF, that can be directly attributed to implementing MECC.

Case Study: Hull

The idea of MECC started in Hull. The vision in Hull started from thinking about scenarios; like that of man who has a heart attack and is taken to hospital in an ambulance. The porter in a hospital is pushing him in a wheelchair for a chest x-ray – wouldn't it be a good opportunity if the porter and the patient could start a conversation about lifestyle. Or a scenario where someone comes to the local authority to pay their rent, and in the course of this interaction the council worker finds that the person has had a cough for a few weeks. The worker wonders is it because of where the person is living, or is it COPD; do they smoke? Wouldn't it be great if the council worker had a technique for starting a conversation around behaviour change. Hull have worked with a big petrol company and had tanker drivers do training about behaviour change, with the result being that some lost weight, and some started a five-a-side football team. They said that a healthcare programme put in place by employer makes you feel more valued, and improving lifestyle makes you feel better. If you have a few individuals in an organisation who complete behaviour change training, it is empowering and rewarding for them, as well as planting the seeds for others to improve their lifestyles. In Hull healthcare and other staff working on the cardiology and respiratory wards of Castle Hill Hospital received blended (e-learning / face-to-face) brief intervention training to enable them to better support patients with making healthier lifestyle choices. Staff from dental practices in Hull were also trained as MECC trainers.[23]

Summary of Case Studies from LGA Report

Wigan – Had some staff trained to RSPH Health Improvement level 2 (one day training).[24] More than 1000 health champions trained, with two thirds from the public sector.

Salford – 1500 staff trained across all public services, through website (MECC in Salford) and learning workshops. Training includes financial, welfare and housing advice but is mainly wellbeing, health and lifestyle. Evaluated by LJMU/NWPHO.

[21] http://www.local.gov.uk/documents/10180/5854661/Making+every+contact+count+-+taking+every+opportunity+to+improve+health+and+wellbeing/c23149f0-e2d9-4967-b45c-fc69c86b5424
[22] http://www.england.nhs.uk/wp-content/uploads/2014/06/mecc-case-studies.pdf
[23] This is based on a video interview with Dr Wendy Richardson, who was the DPH for Hull.
[24] https://www.wwl.nhs.uk/Library/Trust_Board/FT_Mins/2011/July/Making_Every_Contact_Count.pdf

South Tyneside – Had 2 levels of training – level 1 was a one hour introduction while level 2 was a three hour course involving behaviour change and motivational interviewing. Includes CAB staff. Evaluated by Sunderland University.[25]

Warwickshire – Started as an NHS programme, now written into all contracts, aim is that 20% of staff every year do training. Library staff seen as one key group.

Derbyshire – Embedded MECC as part of integrated wellbeing approach. Trained 65 'workplace champions'.

6. What are the Risks of the MECC approach?

Intuitively MECC should be an efficient way of keeping behaviour change high in an individual's thoughts but this may not necessarily be the case; it may that it is more efficient for professionals to spend their scarce time on the job they have been trained for. Many public services have seen staffing cuts in recent years, staff may feel they are having to do more with less, morale may be low, staff may not be receptive to being told they need to have health chats with people as well. There may tensions between MECC as a strategic priority and day to day operational priorities.

Individuals may get intervention fatigue or feel they are 'being lectured' by the 'fun police' or the 'nanny state' so having the right kind of soft skills and approaching the conversation informally and flexibly is important; MECC should be 'support from next door' not 'advice from on high'. There may be some risk of unqualified people providing advice that goes beyond their role or their capabilities; 'a little bit of knowledge can be a dangerous thing'. MECC is not a top down way of working and its simplicity is a feature, but there is a risk of someone having a dozen contacts which count in a dozen different ways. Ideally we want a situation where messages can be delivered in different ways but should be reinforcing the same core messages. There may be a risk that if someone feels they have talked to a professional about a health problem they do not need to seek further help.

If MECC training is optional rather than mandatory then it might be that nobody does it, or might mostly be done by people who are already well motivated to support change, but even if it is only these most well motivated people at least the training will give these people more tools and information to have health chats. Staff may feel that they are already working hard and that MECC is asking them to take on extra work, so getting people on board and explaining that MECC is just a way of increasing the understanding of lifestyle risk factors and empowering individuals to have health chats and signpost or refer onto services where appropriate.

[25] http://www.ahsn-nenc.org.uk/project/246/

Whether MECC works or does not work in improving population health or increasing referrals may be difficult to measure, the best measure may be if public health services get more referrals from a wider pool of professional groups, like library staff, allied health professionals, CAB staff etc. but measuring this is dependent on source of referral being accurately collected by services. It may be difficult to attribute health improvements to MECC.

7. Recommendations

- Make it clear what MECC is trying to achieve – the opportunity to improve health and reduce health inequalities.
- If Wirral is going to implement MECC, there needs to be high level engagement and sign up in organisations, and clear objectives of what needs to be achieved.
- Consider how other departments/teams in the council (e.g. housing, childrens, leisure) should lead on MECC, it should not just be public health led.
- Start by engaging with staff and understanding how they think the health and wellbeing of the population could be improved, and how they would like to play their part, and what skills or information they need to do that.
- Treat MECC as an ongoing process of engaging with staff and making them aware of health and lifestyle issues for themselves, their friends and family, their colleagues, and the members of the public that they come into contact with as part of their role.
- Make sure that staff understand that MECC does not mean a change in their job roles and they should not feel that more responsibilities are being imposed on them; rather it is a way of giving them tools to have chats about health and lifestyle as part of being empowered to provide a more holistic service. This is particularly important where staff are in situations where their numbers are diminished, they feel they are having to do more with less, and morale may be low. The Salford MECC website[26] has questions and answers for organisational leads and front line workers which answer some common concerns.
- Consider asking all council and health staff who have contact with the public to complete the online MECC training.
- Consider whether training should be adapted to different groups. Training needs to be adequately resourced and flexible.
- Training does not mean that members of staff suddenly have to initiate health chats at every contact, only when there is an appropriate opportunity.
- Audit whether people who have completed the training have subsequently had ‘health chats’ with people and referred people on for more help. Try to understand if individuals have had journeys through lifestyle services that have started from health chats.

[26] http://www.meccinsalford.org.uk/faqs/534c8c5bf53f8e007c8b4570

- Consider giving staff the opportunity to have further behaviour change training to become ‘health champions’ in the workplace – this could be similar to how people are nominated to be fire wardens or first aiders. This could be linked to an organisational approach to health & wellbeing that includes incentives and staff pledges.
- Use the opportunity to check if the system of referring people on to public health and other support services is as slick as it can be - is there a phone/online single point of referral? Can someone in a library or a social worker book someone in for their first appointment with a stop smoking advisor or with the wellbeing service?
- It might be worth starting with an informal review of previous public sector initiatives around health and wellbeing in Wirral and how they have worked.
- Wirral could discuss with PHE/HEE or look at bidding to NIHR about having an evaluation of the roll out of MECC.
- We could do a further piece of work contacting areas to understand whether they have seen concrete outcome improvements as a result of MECC, as much of the current evidence is process or output based, or based on individual vignettes or anecdotes.