Making Every Contact Count (MECC): Consensus statement

Produced by Public Health England, NHS England and Health Education England, with the support of partner organisations identified below

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Headline consensus message

This consensus statement describes the commitment of the organisations signed below to work together to maximise support for population behaviour change, and help individuals and communities significantly reduce their risk of disease. Many long-term diseases affecting our population are closely linked to known behavioural risk factors, with 40% of the UK's disability adjusted life years lost being attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive[1].

The signatories of this statement recommend that the evidence-based Making Every Contact Count approach should be applied across all health and social care organisations, and it describes our commitments to support organisations adopting the MECC approach.

This statement has been developed by the undersigned national organisations to provide clarity on what is meant by MECC, to highlight the evidence base, and to illustrate the population and workforce benefits of this behaviour change approach.

It is intended to provide the basis for organisational action and the adoption of the MECC approach within the NHS, local authorities, the allied and wider health and care workforce, and relevant agencies; as an essential contribution to the prevention agenda, and as part of our commitment to work collaboratively to improve the health of our population.

Please note this document uses recent evidence on population health and behaviour change, but does not include a systematic review of the evidence.

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1 Newton JN, et al (2015) Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013; Public Health England. Lancet 2015; 386: 2257–7 4

1. Introduction

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations. Drawing on behaviour change evidence[2], MECC maximises the opportunity within routine health and care interactions for a brief or very brief discussion on health or wellbeing factors to take place.

A MECC interaction takes a matter of minutes and is not intended to add to the busy workloads of health, care and the wider workforce staff, rather it is structured to fit into and complement existing professional clinical, care and social engagement approaches. Evidence suggests that the broad adoption of the MECC approach by people and organisations across health and care could potentially have a significant impact on the health of our population.

1.1 Examples of local impact

MECC is an effective and evidence-based approach. Birmingham Children's Hospital, for example, has trained over 120 staff using MECC and saw benefits that included staff having conversations about their own health, increased demand and uptake of lifestyle services by staff and an increasing number of referrals to external lifestyle services[3].

Within community pharmacy, there are now over 3,500 qualified health champions working in over 2100 Healthy Living Pharmacies[4] who are engaging members of the public, by using every interaction as an opportunity for a health promoting intervention, making every contact count.

With local authorities having statutory responsibility for public health a wide range of partners and frontline services are becoming engaged in core MECC delivery; ranging from allied health and social services to fire and rescue and housing services. Staffordshire County Council's MECC delivery work with the local Fire Service demonstrates the benefits of this broader reach.

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2 Michie, S. et al, (2011) The behaviour change wheel: A new method for characterising and designing behaviour change interventions, Implementation Science 20116:42
3 Health Education West Midlands (2013) Making every contact count examples from practice
4 http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

2. Our shared definition of MECC

2.1 Core MECC definition

MECC is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing.

MECC supports the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations:

- for organisations, MECC means providing their staff with the leadership, environment, training and information that they need to deliver the MECC approach
- for staff, MECC means having the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them
- for individuals, MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health

This definition of MECC has been agreed by a number of organisations listed at the end of this document. It represents the core of MECC and aligns with the NICE behaviour change guidance and the improving healthy lifestyles approach to prevention agreed by NHS England, Health Education England and PHE in the Five Year Forward View. It maps to Level 1 MECC competencies as set out in competency frameworks, such as those available from Skills for Health and encompasses existing approaches such as healthy conversations and health chats.

2.2 Broader MECC definition (MECC Plus)

It is recognised that partner organisations such as local authorities may also adopt a broader definition for the MECC approach, which we have referred to as MECC plus. This may include conversations to help people think about wider determinants such as debt management, housing and welfare rights advice and directing them to services that can provide support. This may lead to specific information requirements that are not included within the scope of the core definition above.
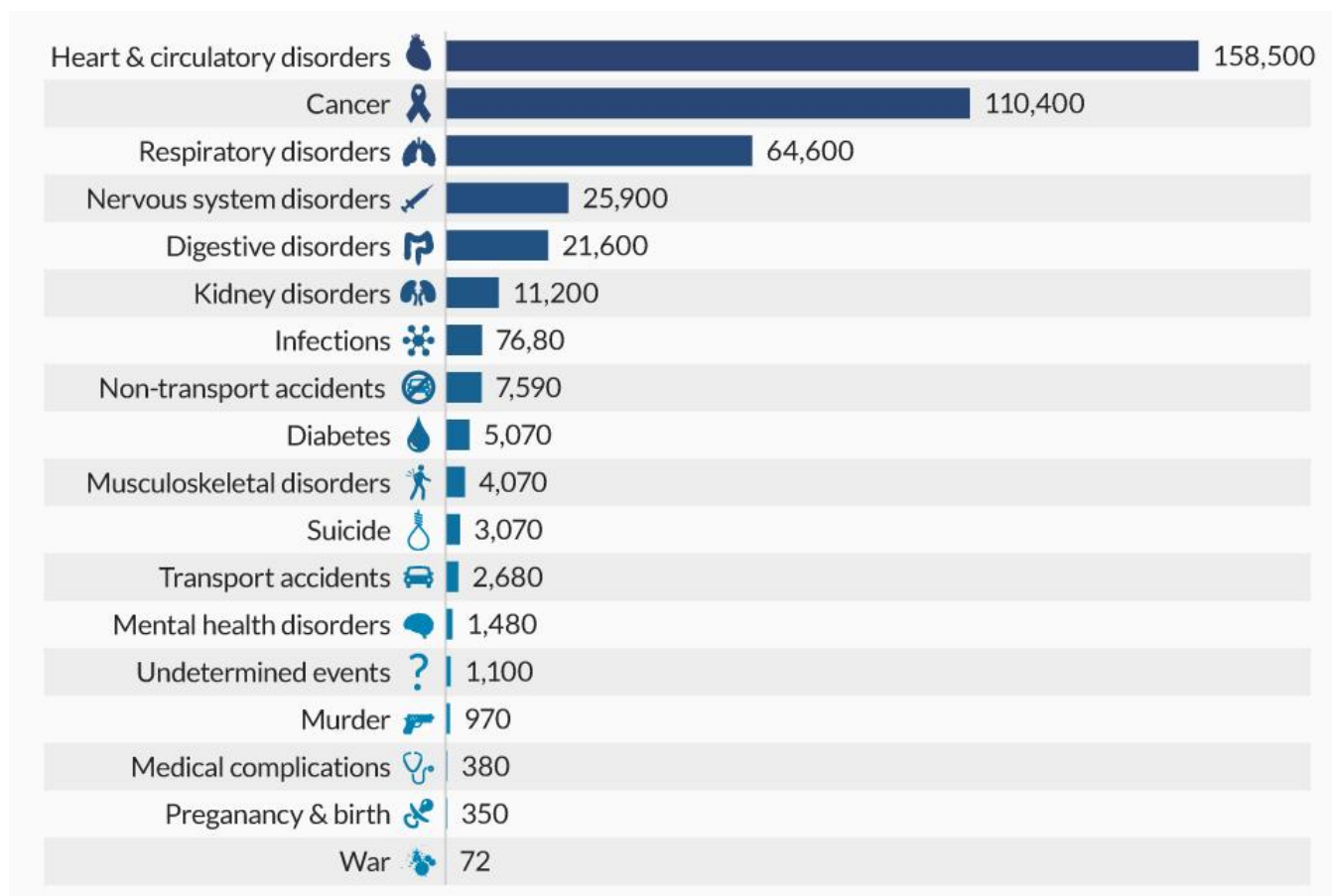
Organisations may also wish to train staff in level 2 and 3 behaviour change competencies such as those available from Skills for Health.

3. Our shared purpose

All our organisations have a role to play in improving the health and wellbeing of our population and developing the workforce to be able to do this. The conditions that are the major causes of premature death in the UK, commonly known as the 'five big killers', are cancer, heart disease, stroke, respiratory disease and liver disease.

These conditions impact on a person's quality of life leading to both physical and emotional ill health, and account for over 150,000 deaths annually among the under-75s in England.

Leading causes of death in England 2013 (all age)[5]

Cause	Deaths
Heart & circulatory disorders	158,500
Cancer	110,400
Respiratory disorders	64,600
Nervous system disorders	25,900
Digestive disorders	21,600
Kidney disorders	11,200
Infections	76,80
Non-transport accidents	7,590
Diabetes	5,070
Musculoskeletal disorders	4,070
Suicide	3,070
Transport accidents	2,680
Mental health disorders	1,480
Undetermined events	1,100
Murder	970
Medical complications	380
Preganancy & birth	350
War	72

Source: www.statista.com/chart/3643/what-kills-english-people/

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5 Leading causes of preventable early death in those aged under 75 years of age in 2012 included: Cancer (62,000 deaths); cardiovascular diseases (33,000 deaths); respiratory diseases (14,000) and liver conditions (8,000 deaths).

3.1 Physical health and wellbeing

Many of the long-term diseases highlighted above are closely linked to behavioural factors. In fact 40% of the UK's disability adjusted life years lost are attributable to tobacco, hypertension, alcohol, being overweight or being physically inactive[6].

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people significantly reduce their risk of disease. Supporting people to make these behaviour changes can help reduce premature deaths and disability, helping achieve long-term health, social care and public sector savings[7].

The aim of the MECC approach is to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. The intervention is underpinned by evidence and links closely to the Wanless 'fully-engaged' scenario[8].

Recent figures for England[9] show:

- 2 in 10 adults are smokers
- 7 in 10 men and 6 in 10 women are overweight or obese
- a third of people have drinking patterns that could be harmful
- half of women and a third of men do not get enough exercise
- a quarter of the population engages in 3 or 4 unhealthy behaviours[10]

3.2 Clustered risk factors

The higher the number of unhealthy behaviours an individual engages in, the greater their risk of poor health. Someone in mid-life who smokes, drinks in excess of recommended limits, is physically inactive or has an unhealthy diet is four times more likely to die within the next 10 years than someone who does none of these[11]. The correlation between healthy life years lost in the population and risk factors is outlined below.

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6 Newton JN, et al (2015) Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013; Public Health England. Lancet 2015; 386: 2257–7

7 https://www.nice.org.uk/advice/lgb7/chapter/Introduction

8 Wanless D (2002) Securing our future health: taking a long-term view. London: HM Treasury

9 Health Survey for England - 2012 Trend tables (2013) Health and Social Care Information Centre

10 11 Buck, D, Frosini, F (2012) Clustering of unhealthy behaviours over time Implications for policy and practice, The King's Fund

Links between risk factors and disability adjusted life years for the adult population of England.
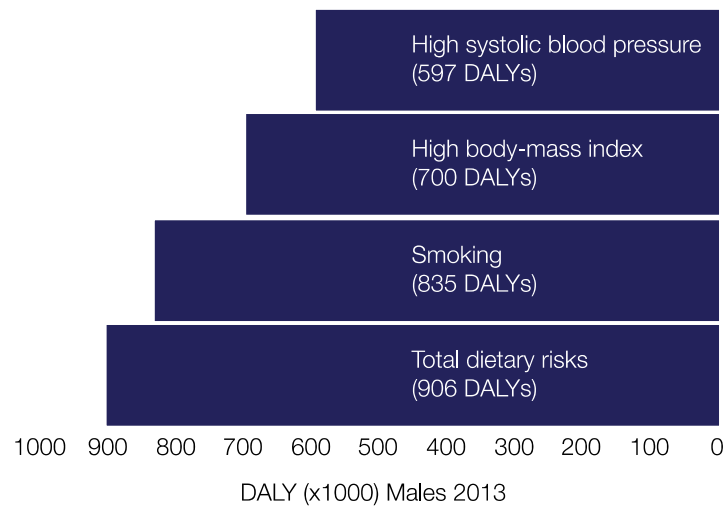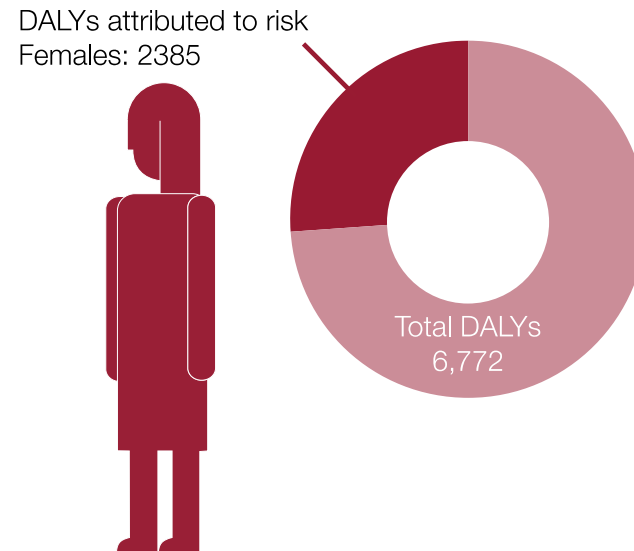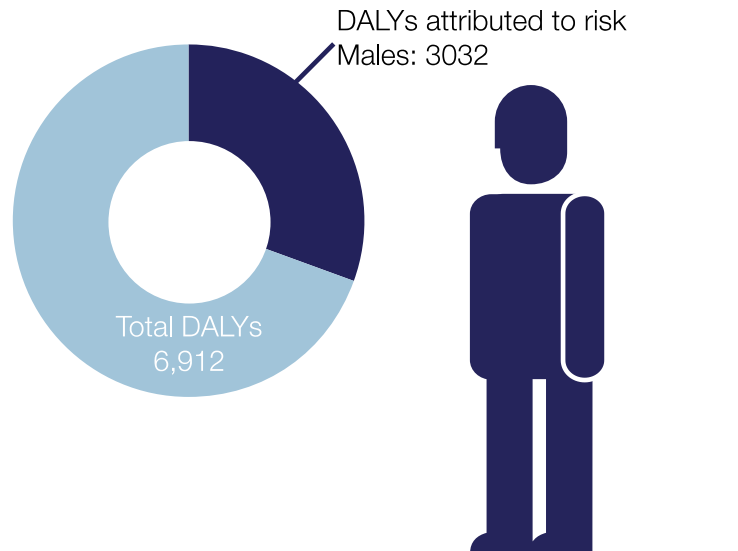**DALYs attributed to largest risk factors, by gender 2013   Public Health England (2015)**

DALYs attributed to risk
Males: 3032

Total DALYs
6,912

DALYs attributed to risk
Females: 2385

Total DALYs
6,772

High systolic blood pressure
(597 DALYs)

High body-mass index
(700 DALYs)

Smoking
(835 DALYs)

Total dietary risks
(906 DALYs)

High systolic blood pressure
(473 DALYs)

Total dietary risks
(598 DALYs)

High body-mass index
(569 DALYs)

Smoking
(605 DALYs)

1000 900 800 700 600 500 400 300 200 100 0

DALY (x1000) Males 2013

0 100 200 300 400 500 600 700 800 900 1000

DALY (x1000) females 2013

DALYs add the years of life lost due to early death and years spent living with disability or ill-health together.

3.3 Mental health and wellbeing

MECC includes at its core a focus on mental health and wellbeing. Our mental wellbeing underpins our capability to make and sustain health behaviour change, for example through our levels of motivation, self-efficacy, resilience and exposure to stress.

Mental wellbeing, or psychosocial factors, can help explain the links between social conditions and lifestyle behaviour and that for some people behaviours such as smoking, unhealthy eating or harmful use of alcohol are how they may cope with the stress of their living conditions or of managing symptoms or conditions such as anxiety or depression.

This holistic approach is increasingly being adopted, and can be seen in many examples of wider MECC plus delivery by local authorities who are helping to drive innovation in MECC locally. Psychosocial factors also directly influence poor health via strongly associated physiological pathways.

Preventing mental health problems will also benefit physical health outcomes. This is important as it is known mental health problems are common within our population, with 1 in 4 people in the UK experiencing a mental health problem each year, and:

- approximately 20% of people with a long-term physical health condition such as diabetes or long-term kidney disease will experience depression
- depression is between 2 to 3 times more likely in a person with a long-term physical health condition than in those in full health[12]
- only 30% of the population with depression, anxiety, eating disorders, perinatal conditions or obsessive compulsive disorder currently access treatments[13]
- 9.7% of the population have mixed anxiety and depression[14]
- 17% will experience suicidal thoughts over their lifetime[15]
- there is a known relationship between mental health and inequality

3.4 MECC: Behaviour change principles

MECC draws on behavioural science approaches such as COM-B[16] and other dual-process models, recognising that an individual's choices are affected by both automatic

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12 NICE (2009) Depression in adults with chronic physical health problem CG91

13 Geraldine Strathdee (2014), National Clinical Director Mental Health, NHS England

14 15 The Health & Social Care Information Centre (2009), Adult psychiatric morbidity in England, Results of a household survey.

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

and reflective aspects of decision making; and that internal and external events can impact on an individual's decisions and choices.

A MECC brief intervention[17] aims to enable positive change in an individual by increasing their psychological capability to undertake a behaviour change. This may be through increasing their knowledge of the risks for a particular behaviour, such as for smoking. Or by helping increase an individual's motivation to initiate a behaviour change, for example by raising their level of understanding of the positive actions they can take, such as with stopping smoking.

A brief intervention can help communicate to an individual that by them taking positive action, they can reduce their risks for many conditions. A brief intervention can deliver a persuasive message; helping raise an individual's awareness of their risk factors, while contributing to their motivation to take action.

3.5 Health inequalities and the benefits of MECC

The Marmot Review[18] highlighted a social gradient in health, where the less affluent a person's position, the worse his or her health and provided evidence for reducing health inequalities. It described the importance of measures to address the wider determinants of health as well as interventions to prevent ill health by improving health behaviours.

MECC and MECC plus approaches can help to tackle health inequalities by supporting individual behaviour change across a range of behaviours, and addressing wider determinants of health at the individual level. For example, some local services are using the MECC plus approach to engage local populations in managing debt, action towards gaining employment or in tackling housing issues. The population level approach of MECC can also help address equity of access, by engaging those who will not have otherwise engaged in a 'healthy conversation' or considered accessing specialised local support services, such as for weight management. Resources that may be useful for local leads include:

* primary care practice profiles include CCG summary for comparison and practice deprivation decile (http://fingertips.phe.org.uk/profile/general-practice)
* atlas of variation (www.rightcare.nhs.uk/index.php/nhs-atlas)

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17 Brief intervention is defined in NICE PH49 as: 'oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support. Brief interventions can be delivered by anyone who is trained in the necessary skills and knowledge.'
18 Marmot, M (2010) Fair Society Healthy Lives; the Marmot Review, Policy object F commentary on pp140-141
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

4. Our context for supporting behaviour change

The Five Year Forward View[19] calls for a radical upgrade in prevention and public health. It outlines the importance of increasing the support available to help people to manage and improve their own health and wellbeing in achieving long-term sustainability for the health and care system and the wider economy.

It emphasises the importance of ensuring that behavioural interventions are available for patients, service users and staff to support them to understand the impacts of smoking, alcohol, weight and diet and activity levels on their health and to make behaviour changes to address these. The NHS Standard Contract[20] now includes a requirement that providers develop and maintain an organisational plan to ensure that staff use every contact that they have with service users and the public as an opportunity to maintain or improve health and wellbeing.

The Department of Health[21] has highlighted the key role of local authorities in both commissioning and delivery of the MECC behaviour change approach in local areas. Many local authorities are driving innovation in MECC delivery, for example by building MECC into service specifications for local integrated health improvement services.

The MECC approach aligns with many of PHE's priorities[22] to improve the nations' health including tackling obesity, reducing smoking and reducing harmful drinking.

The PHE All OUR Health programme will also provide information on the evidence base, interventions and measures for impact on a range of health topics relevant to MECC delivery. All OUR Health will be available from April 2016.

Anyone working with the public can promote good health and wellbeing as part of their day-to-day work, and it is recognised that the third sector will have a significant contribution to make in this, with their engagement and delivery within a wide range of populations and communities.

To achieve the radical upgrade in prevention and public health described in the Five Year Forward View, it is key that promoting health and wellbeing is embedded into the

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19 https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
20 https://www.england.nhs.uk/nhs-standard-contract/
21 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216709/dh_131898.pdf
22 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

work of public services, enabling staff to use every relevant contact that they have with a member of the public as an opportunity to improve health.

To be effective, individual behaviour change approaches, such as MECC, need to be delivered in an environment that supports behaviour change[23]. This includes the socioeconomic, cultural and environmental conditions in which people live, and the organisational environment and culture in which MECC is delivered.

Organisations delivering MECC need to ensure that their policies, strategies, resources and training all support behaviour change. This includes supporting staff to make positive changes to their own behaviour via opportunities in the working environment such as active travel policies and access to healthy food choices, access to individual support (such as help to stop smoking), provision of behaviour change training and supervision, and the inclusion of MECC in appraisal processes or job descriptions for relevant posts.

5. The evidence base for MECC

The National Institute for Health and Care Excellence (NICE) estimates that the annual cost to the NHS of physical inactivity is £1,067 million, of smoking £2,872 million, of alcohol misuse £3,614 million, and of obesity and being overweight £6,048 million[24].

The evidence for behaviour change interventions is set out in NICE guidance on individual approaches to behaviour change[25], as well as NICE guidance on alcohol[26], obesity[27], physical activity[28] and smoking cessation[29].

The guidance proposes how different intensities of behaviour change interventions should be integrated within clinical pathways. Based on evidence-based guidance they set out the range of behaviour change interventions that can be delivered. Professional competency frameworks have been developed to support the delivery of effective interventions.

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23 http://guidance.nice.org.uk/PH49
24 http://guidance.nice.org.uk/PH49/CostingStatement/pdf/English
25 http://guidance.nice.org.uk/PH49
26 http://www.nice.org.uk/Guidance/PH24
27 http://www.nice.org.uk/Guidance/PH53
28 http://www.nice.org.uk/Guidance/PH44
29 http://www.nice.org.uk/Guidance/PH1

5.1 MECC model

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

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

Behaviour change interventions diagram by Health Education England – Wessex Team

MECC Level 1: Very brief intervention – a very brief intervention can take from 30 seconds to a couple of minutes. It enables the delivery of information to people, or signposting them to sources of further help. It may also include other activities such as raising awareness of risks, or providing encouragement and support for change.

MECC Level 2: Brief intervention – a brief intervention involves oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support.

6. Why we support the MECC approach; the benefits of MECC

6.1 Evidence of effectiveness

The size of the public health, NHS and public sector workforce means there are many opportunities on a daily basis to engage the population in healthy conversations. For example, there are 1.2 million health-related visits to community pharmacies daily – amounting to 433 million visits a year – which provide a huge opportunity for health promoting interventions, and MECC activity.

The delivery of very brief or brief interventions and signposting by frontline professionals has been shown by NICE to be both effective and cost-effective in supporting people to reduce their tobacco and alcohol use, and in improving their physical activity levels and diet. NICE guidance 'Behaviour Change: individual approaches'[30] highlights that the delivery of brief interventions is well below the NICE cost per quality-adjusted life-year (QALY) thresholds. NICE reached this decision following review of evidence that included systematic reviews and meta-analyses.

In addition, MECC has also been shown to generate lifestyle and behaviour change among workforces where MECC activity, training and support have been provided. For example, with South Tyneside's Every Contact a Health Improvement Contact (ECHIC) programme, the local street cleansing team lost a combined weight of 15 stone, after putting advice received as part of the MECC training into practice for their own health and wellbeing.

6.2 Our support for strengthening the evidence base

It is vital that MECC programmes incorporate evaluation activity within them from the outset, while also ensuring that any intervention is in line with the evidence base for effectiveness. Any novel or new approaches used for MECC delivery should also be evaluated, to help establish their degree of benefit and efficacy. Monitoring of MECC activity can take a number of different forms and could include review of individual measures; of organisational measures of staff engagement and motivation; of the use of ROI tools; and a review of qualitative and or quantitative data.

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30 NICE Behaviour change: individual approaches   http://guidance.nice.org.uk/PH49

To support local evaluation efforts, PHE, Health Education England and the national MECC advisory group have developed a suite of tools:

- training quality marker checklist
- MECC Implementation guide
- MECC Evaluation framework, provides a guide and a menu of potential indicators
- toolkit for measuring the population health impact of healthcare professional interventions (to be developed by PHE and the RSPH, available summer 2016)

7. Conclusion

Recent policy statements such as the NHS Five Year Forward View call for a radical upgrade in prevention and public health, and outline the need to increase the support available for people to improve their health and wellbeing.

We, the signatories of this document, are committed to the MECC approach as a way of supporting positive behaviour change. The size of the public health, NHS and public sector workforce provides millions of opportunities to engage the population and effect positive behaviour change, and to also bring positive impact to our own staff's health and wellbeing.

This is why we recommend that the evidence based MECC approach should be applied across all health and social care organisations.

8. Our commitments

As partners in this statement, we recognise the increasing opportunity to incorporate MECC principles into the training and development of the wider public health, health care and social care workforces.

We agree to maximise opportunities for raising awareness of population behaviour change approaches including MECC, within relevant national communications activities and strategies. Health Education England will work in partnership with PHE and others to embed the principles of MECC where possible into training pathways, to support the translation into the everyday practice of frontline staff across health and social care.

9. List of partners

Public Health England
NHS England
Health Education England
Royal Society for Public Health
National Institute for Health and Care Excellence
Association of Directors of Public Health
NHS Employers
Royal College of Nursing
Local Government Association
Care Quality Commission
NHS Improvement

10. Relevant resources

PHE, HEE and the national MECC advisory group MECC practical resources

Making Every Contact Count website

HEE North West – Introduction to Behaviour Change eLearning programme

HEE West Midlands – Every Contact Counts eLearning module

HEE Wessex Team – MECC Toolkit and resources

Public Health England – All OUR Health Website

Royal College of Nursing – Support behaviour change Module

Local Government Association – Behavioural insights and health (case studies)