Section A: CPHE to complete	
Name:	Deryn Bishop
Job title:	Health Behaviour Specialist, The Training Tree
Address:	*PDG member*
Guidance title:	Behaviour change
Committee:	Programme Development Group
Subject of expert testimony:	Behaviour change – Evidence into practice
Evidence gaps or uncertainties:	

Provide the PDG with an overview of Making Every Contact Count – evidence into practice, including:

- The evidence base that informs the intervention
- Core training and competencies
- Outcomes and evaluation

Section B: Expert to complete

Summary testimony:

Making Every Contact Count; what it is?

MECC means making the most of every opportunity to raise the issue of healthy lifestyles; systematically promote the benefits of healthy living and signpost people to further support where necessary. It is a programme adopted by NHS Midlands and East as one of their top 5 ambitions. MECC may be delivered opportunistically or as part of routine practice.

Why is it important?

Unhealthy lifestyle behaviours place a resource and financial burden on the NHS and Society as a whole , and generate inequalities in health outcomes, not only because people in more deprived areas are less likely to follow healthy behaviours but when they suffer ill health as a consequence, their outcomes are not as good as people from more affluent areas.

- Smoking prevalence 19% -22%
- 25% of people are drinking at increasing risk or high risk levels.
- 22 - 26 % of men are obese and 24 -28 % of women are obese
- 61% of men and 71% of women do not meet the recommended physical activity levels
- Only 25 % of men and 29% of women regularly eat 5 portions of fruit and vegetables a day
- Average life expectancy in “Middle Earth” (East, EMids and WMids) is as low as 65.5 years in some areas and just over 90 years in others

In Europe, 33% of the entire disease burden is thought to be caused by five reducible population risk factors: tobacco consumption, excessive alcohol use, a high blood pressure,

high LDL cholesterol levels, high Body Mass Index and high blood sugar levels.

There is an increasing trend in the incidence and prevalence of lifestyle-related chronic diseases. More than 75% of cardiovascular disease results from smoking, high blood pressure or cholesterol, or their combination. High cholesterol causes more than 4 million premature deaths a year; tobacco almost 5 million, and high blood pressure 7 million worldwide. The future priorities for EU health policies(1) show a shift in healthcare policy from a clinical, curative focus to the development of a preventative one.

Cost-Effectiveness; Costs to UK economy: Diabetes £9bn pa (2), physical inactivity £8.2bn and obesity £2.5bn pa (3). Alcohol costs NHS £3.5 bn pa, CJS £11bn and cost of lost productivity is £7.3bn.(4)

Utilising our best assets (our frontline staff)to Ask, Advise and Assist on healthier lifestyles can lead to a reduced demand for future healthcare .When people adopting healthy lifestyles do establish disease it is likely to be later in life, and people are likely to have better treatment outcomes.

Where we can expect an impact:

1. **Primary prevention:**

Poor health is not just an individual's problem but relates to the lifestyle of the whole community. North Karelia Project: Programmes were held in churches, supermarkets, schools etc to encourage individuals and groups to adopt a healthy lifestyle (5); and had a significant impact on premature death.

However, 2 US studies examining the effectiveness of preventative interventions aimed at influencing the adoption of a healthy lifestyle showed no real improvement whilst a third had reasonably good results (6, 7, 8)

2. **Secondary prevention:**

Early identification of individuals at high risk (e.g. with high cholesterol and high blood pressure) and giving them pharmacological treatment is both clinically and cost effective (9). Early diagnosis and treatment of people with diabetes resulting from obesity can have a major impact on reducing cardio vascular events, kidney failure, dialysis cost and future heart failure activity (10)

Formal screening for cardiovascular risk in GP surgeries coupled with opportunistic use of "teachable moments" can result in the early detection, effective treatment and follow up of patients with raised blood pressure. The clinical and cost-effectiveness benefits of early diagnosis and treatment of many cancers are well documented (11). MECC can be a way of encouraging people to participate in all sorts of screening programmes.

Tertiary prevention:

Sign-posting and advice on chronic disease management facilities or appropriate access to unscheduled care services could significantly improve access to health care services and enhance service response that reflects the profile of patients being referred.

Evidence Base:

Studies have shown that delivering health messages is associated with an increase in participation in health-related behaviour (12), most frequently related to smoking, alcohol consumption and physical activity.

1. Interventions associated with smoking cessation increase quitting rates from 1-3% (13),(14),(15);
2. Interventions targeted at heavy drinkers are effective in decreasing alcohol use in the adult population(16).
3. Providing health advice increases physical activity levels (17).
4. Less is sometimes more: 5 minutes brief advice by trained professionals is as effective as 20 minutes counselling in preventing and reducing excessive alcohol

consumption(18).

Noar at al 2007 (19) showed that messages were associated with greater effectiveness when they were tailored to represent some of the underpinning theoretical constructs (e.g. attitudes, self-efficacy and self management).

"G*oal setting, monitoring behaviour, receiving feedback, and reviewing goals in the light of feedback are central to self management and behavioural control* (20).

The EPIC study carried out in Norfolk 1993 to 2006 looked at survival according to healthy lifestyle behaviours.(21).

The overall impact was a 14 years difference in life expectancy between those undertaking all four behaviours and those not following any, with increased benefits with each lifestyle behaviour followed.

The clustering of unhealthy behaviours over time also informed MECC (22), as most often people are following more than one unhealthy behaviour.

MECC Potential

Tens of millions of people come into contact with the NHS each year.eg in ME Cluster there were over 5 million visits to A&E in 2010/11.

Brief advice takes up to 5 minutes to deliver. If everyone did this 10 times a year it would take less than an hour per staff, and add up to millions of opportunities to motivate someone. Staff benefit too, through better health, higher moral, less time off sick, increased skills etc

As PH integrates into local authorities, MECC is also being rolled out to council, union and voluntary sector staff.

Theory Base:

Ajzen's Theory of Planned Behaviour; Motivational Interviewing skills, Prime Theory. Fits in with the Ladder of Interventions and NICE Guidance.

Skill Base: Active listening skills, Motivational Interviewing skills, FRAMES

Tools to support MECC:

Competency framework:

Competency framework covering 4 levels of behaviour change competency requirements.

Levels I and II are associated with skills and competencies required to increase the awareness of health related behaviour and its influence on individuals' health as well as brief interventions which help individuals to take action. Level III is associated with selecting and using appropriate techniques aiming to change health related behaviour. Level IV is associated with specialised/advanced health behaviour approaches such as Cognitive Behavioural Therapy or Motivational Interviewing.

Whilst MECC is concerned with Level I competencies, it can optimise the access and use of NHS services associated with remaining 3 levels of competencies included in the framework.

Every Contact Counts E Learning suite: Brief Encounters and Motivating Change modules. Includes Knowledge Bank, case study scenarios, videos and quizzes as well as a Learning Journal. Can be delivered as stand alone or as part of blended learning package.

Organisational, Team and Individual Assessment tools: encourage leadership, ownership, sets out expected milestones etc

Exemplar CQUINs to incentivise delivery in acute and community care settings

Insight Research: showed staff seen as credible messengers, their own lifestyles are important etc

Metrics: Links into PH framework; outcome measures etc; taking into account health

inequalities

Prompt cards for staff: tailored prompts for staff from different areas eg Fire Service, Learning Disabilities, Acute Care etc.

Communications Kit: sets the scene, links to organisational values etc

Outcomes and Evaluation:

- Improving Healthy Lifestyle pilots
- West Midlands Clinical Champions and Brief Intervention Training/Train the Trainers
- Every Contact Counts E Learning Suite review

MECC examples: adopted by WMFS staff for Vulnerable Person's Home Checks; smoking and alcohol brief advice delivered by acute care staff (OPD, gynaecology, maxillo-facial, cardiology); Learning Disabilities Teams; Council staff, HR staff and Union Staff; Adopted into undergraduate curricula;; Adult Social Care staff;

MECC Opportunities:

1. Other topics eg sexual health, breastfeeding, falls prevention and fuel poverty can be part of MECC
2. Quality assurance of staff's communication skills
3. Synergies between behaviours can be addressed
4. Impact on wider determinants/transport/streets, planning departments etc can be addressed

References (if applicable):

1. White Paper: Together for Health: A Strategic Approach for the EU 2008-2013
2. NHS East of England & Technology Strategy Board.
3. Report of Chief Medical Officer DH 2004
4. NICE Local Government Public Health briefings 2012
5. North Karelia Project Shows The World How To Reduce Heart Disease: http://kantele.com/nwfwebsite/puska_heart.html)
6. Farquhar HW et al. (1990) Effects of community wide education on cardiovascular disease risk factors - the Stanford five-city project. JAMA;264:359-65.
7. Carleton RA et al. The Pawtucket Heart Health Program – Cross-sectional results from a community intervention trial. (1994) Abstract, 34th annual conference on cardiovascular disease. Epidemiology and Prevention, March, Tampa, Florida)
8. Greister E et al. Final risk factor change after 7 years of a multicentre community intervention program – the German cardiovascular prevention study. (1994) Abstract, 34th annual conference on cardiovascular disease Epidemiology and Prevention, March, Tampa, Florida).
9. Nice Review Statins. NICE implementation uptake report: Statins (2008) Available at:http://www.nice.org.uk/media/411/4F/ImplUptakeReportStatins.pdf Hypertension: management of hypertension in adults in primary care.NICE Guidance. (2006) Royal College of Physicians in London).
10. Richards N, Harris K, Whitfield MD et al. (2007) The impact of population based identification of kidney disease estimated glomerular filtration rate (eGFR) reporting. Nephrol Dial Transplant 0: 1–6 doi: 10.1093/ndt/gfm839.
11. The Wanless Report : Securing good health for the whole population, 2004
12. Kahn E.B., Ramsey L, Brownson R.C., Heath G., Howze E. (2002), The Effectiveness of Interventions to Increase Physical Activity. A systematic review. *Am J Prev Med,* 222 (4S).
13. Powell, K. & Thurston, M. (2008). Commissioning training for behaviour change interventions: Evidence and best practice in delivery. Chester: University of Chester, Centre for Public Health Research.
14. Stead, L.F., Perera, R., Bullen, C. et al. (2008) Nicotine replacement therapy for

smoking cessation (Cochrane Review).

15. Meyer C., Ulbricht S., Baumeister S., Schumann A., Rüge J., Bischof G., Hans-Rumpf J. and John U. (2007). Proactive interventions for smoking cessation in general medical practice: a quasi-randomized controlled trial to examine the efficacy of computer-tailored letters and physician-delivered brief advice. *Addiction.* 103; 294.
16. Fleming M F; Manwell L B; Barry K L; Adams W; Stauffacher E A. (1999) Brief physician advice for alcohol problems in older adults: a randomized. Proceedings of the Association of American Physicians;111(2):131-40.
17. Ogilvie D, Foster C.E.. Rothnie H., Cavill N., Hamilton V., Fitzsimons C.F., Mutrie N. (2007), Research Interventions to promote walking: systematic review BMJ;334:1204 (9 June), doi:10.1136/bmj.39198.722720.BE.
18. Babor et al., 1994 T.F. Babor, M. Grant, W. Acuda, F.H. Burns, C. Campillo, F.K. Del Boca, R. Hodgson, N.N. Ivanets, M. Lukomskya, M. Machona, (1994) A randomized clinical trial of brief interventions in primary care: summary of a WHO project. *Addiction* 89, pp. 657–660.

Also unpublished SIPS research currently undergoing peer review

19. Noar, S.M., Benac, C.N. & Harris, M.S. (2007). Does tailoring matter? Psychological Bulletin, 133, 673–693.O'Cleirigh, C., Ironson, G., Weiss, A. & Costa, P.T. (2007).
20. Michie S., Abraham C., Whittington C., McAteer J., Sunjai G., Effective techniques in healthy eating and physical activity interventions: A Meta Regression. *Health Psychology.* 2009, 23:6.
21. EPIC study. Khaw et al. PLoS Med 2008 Jan 8: 5 (1): e12
22. Buck D and Froseni F: The clustering of health behaviours over time: implications for policy and practice. The Kings Fund