Public Health England

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Making Every Contact Count (MECC): Developing plans to implement MECC in NHS organisations in Cheshire and Merseyside

Insight work with senior healthcare leaders

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Contents

Executive summary

Making Every Contact Count (MECC) is a key cross-cutting prevention priority for Cheshire & Merseyside Health & Care Partnership.

Eight senior leaders were recruited, drawn from NHS trusts, commissioning organisations and strategic bodies in Cheshire and Merseyside. In-depth qualitative semi-structured interviews were undertaken in early 2019.

Participants reported that MECC activity was taking place, either in the form of pilot projects, or part of a wider prevention or holistic agenda. Much of the current activity was not branded or described as 'MECC' and tended to occur in clinical or professional silos – for example, smoking-related questions and referrals to smoking cessation services in respiratory services. Routine questioning regarding social and behavioural factors was commonly part of admission and other processes, but did not always lead to an effective interaction or appropriate referral. Understanding of MECC varied and leaders would value clarity on the scope of the programme and how it can be applied in outpatient, inpatient and community settings. National guidelines would be welcomed, but these should be supplemented with local interpretation according to need. Public health leadership is of great importance here.

Trusts are already finding it challenging to meet current rising demands on their organisations. Boards tend to focus on urgent issues and other strategic and clinical priorities. MECC is seen as valuable but difficult to justify in the face of competing demands and other important programmes.

The leaders interviewed were concerned about placing additional work pressures on already overburdened staff. Training was welcome but a mandatory approach was not seen as the best way of delivering it. Content should focus on increasing confidence in having potentially challenging conversations.

MECC can be facilitated by streamlining processes and using technology (such as well designed electronic patient record documents) to facilitate prompting, data collection, advice and referral. Every effort should be made to make the interaction as easy and quick as possible, including the development of a service directory or automatic referral process.

For MECC to cut through, messages will need to be tailored to specific audiences. Some need evidence of effectiveness, others need stories and more emotive framing. Patients may also need to be prepared for a MECC interaction so it is an expected part of each healthcare encounter.

The widespread implementation of MECC is unlikely to occur or be successful unless it is commissioned and incentivised. The system must work with commissioners and providers to ensure prevention is a core part of contracts and service specifications. Novel contracting arrangements for integrated care and outcome-focused commissioning are excellent opportunities to embed prevention in all healthcare services.

Successful implementation will require a whole organisation approach; from finance and target-setting, to training of staff, updating of policies and creation of technologies that facilitate MECC interactions. This means a culture of prevention from commissioner, to board, to manager to frontline staff. One suggestion is the reframing of MECC and prevention as person-centredness – a holistic approach that considers an individual's needs and frees staff to care for the whole person.

Each organisation or locality will need to develop its own strategy and culture, but there are many actions that can be taken at a system level, including:

Health and Care Partnership and wider system

Understand local need

Local public health experts to work with commissioners to understand local need and highlight areas for focus.

Define MECC clearly

Give a clear message on what MECC means for that population and the trusts that serve it.

Share evidence on why and how

Share evidence and learning with trusts to demonstrate the benefits of MECC and how it can be implemented with simple aims, approaches and outcomes.

Deliver staff training

Offer engaging training to staff which aims to overcome personal barriers, support behaviour change conversations and enable them to build on the conversations they are already having. Alternatives to mandatory training should be considered, possibly including in staff induction processes.

Create a Cheshire and Merseyside service directory

Provide tools such as a referral directory to make taking the next step simple and clear for staff.

Develop a Cheshire and Merseyside Communications Strategy

Create a communications strategy that offers appropriate messages to commissioners, senior leaders, staff and patients, offering evidence, patient success stories and simple actions to take to effect change.

Commissioning organisations

Commission for prevention

Prevention to be written into service specifications and appropriately incentivised and performance managed.

Trusts

Identify and support sponsors/champions

Trusts to nominate executive sponsors/champions for prevention and have it as a standing item on board meetings.

Foster a person-centred approach

Support trusts to develop a culture of holistic assessment and care which incorporates MECC principles as part of a whole person approach, appropriate to the setting and organisation.

All partners

Promote public awareness

Develop greater public expectation/awareness that staff will ask about healthy behaviours using ward info packs, electronic displays and check-in kiosks. Interactions could be recorded. New social prescribing programmes in primary care networks.

Establish a professional movement

Create a MECC network to share good practice and access to continuing professional development events/webinars. Launch learning sets to promote staff development and innovation.

Introduction

This project explored the organisational landscape in local NHS trusts through a series of interviews with senior leaders. It identified opportunities to strengthen MECC approaches and potential barriers to its implementation. This will inform our future offer to our partners.

Background

The NHS Five Year Forward View called for a "radical upgrade in prevention and public health" to ensure its sustainability as well as the health and prosperity of Britain.[1] The NHS backs action on obesity, smoking, alcohol and other major health risks. The Next Steps document discussed the Commissioning for Quality and Innovation (CQUIN) target for screening and brief advice for smoking and alcohol consumption in 2017/18 and 2018/19, which continues in a modified form for 2019/20.[2, 3] The incoming Health Secretary placed prevention as 1 of his 3 important early priorities for the NHS and the commitment to prevention was reiterated in the NHS Long Term Plan, which set it in the context of Integrated Care Systems, focusing on delivering better population health outcomes.[4, 5]

A population health approach that focuses on prevention is central to the success and sustainability of the integrated care systems that are emerging across England. By breaking down organisational barriers and focusing on outcomes, local healthcare systems can achieve the best health and wellbeing for the people they serve within the resources available.[6] Interventions around behavioural risk factors in healthcare settings are cost-effective. For example, assessment, very brief advice and referral for tobacco use in hospitals would likely deliver net savings to the NHS within 5 years of implementation.[7]

The Cheshire & Merseyside Health & Care Partnership has placed MECC as a key component of its sustainability and transformation plan to tackle harmful drinking, smoking, poor diet and lack of physical activity.[8] Local NHS providers have a key role in prevention to reduce future demands on the system.

MECC interactions are evidence based, take minutes and the interventions are structured to fit in with busy work practices. However, organisations must support their staff with the leadership, environment, training and information that they need to deliver the MECC approach.[9] NHS England and Public Health England (with other key national partners) produced a consensus statement in 2016, which recommended that the MECC approach should be applied across all health and care settings.[10]

Public health leaders are working through the Champs Public Health Collaborative to develop training and resources to support local healthcare organisations to implement MECC approaches.[11]

Project Aims

1. To understand the organisational landscape amongst local acute, mental health and community trusts.
2. To understand whether MECC, and prevention more broadly, are priorities for local organisations.
3. To understand potential barriers to successful implementation of MECC across the organisations.
4. To understand how the local system can support local trusts to implement MECC, looking at the domains of leadership, people and environment.
5. To make recommendations to the Cheshire and Merseyside MECC Partnership Board on how to support system wide implementation.

Method

Ethical approval and research governance

The project did not require NHS Research Ethics Committee approval.

The project received approval from the PHE Research Support and Governance Office on 4/1/2019.

Participant selection and recruitment

The project aimed to gather the views of senior healthcare leaders from within acute, community and mental health trusts across Cheshire and Merseyside, and from strategic and commissioning bodies in the region. Potential participants were identified by the project team and through professional networks. An invitation was shared through the Cheshire and Merseyside MECC Partnership Board and though the Joint Directors of Nursing and Clinical Commissioning Group (CCG) Chief Nurses' meetings. Additional snowball sampling occurred, as those contacted were asked to suggest other potential participants.

Data collection

The project used semi-structured in-depth interviews. This method is flexible and can be adapted according to previous responses as the interview progresses.

A topic guide was prepared by the project team. See Appendix 2.

Participants gave their informed consent to participate in the understanding that the findings would be presented anonymously but that retrospective identification may be possible given the small pool of potential participants from which they were drawn.

One-to-one interviews took place in non-clinical areas at the participants' places of work between January and April 2019. Interviews were recorded digitally, stored securely and then transcribed (with names and organisations anonymised).

Data analysis

Anonymised transcriptions were analysed using QSR International NVivo 11. The initial codes were simple, descriptive terms, which were combined into broader categories by theme. Coding was inductive – such as the terms used were not selected in advance but created in response to the data. Codes were then organised into themes and presented in the form of descriptive text and direct quotations.

Results

Recruitment

Eight participants were recruited to the project. Their roles and organisation types are shown below. Participants were identified through professional networks and contacts. Initial approaches were by email. Participants were drawn from a variety of organisations across Cheshire and Merseyside. The aim was to gather a range of views rather than to be representative of all roles and organisations.

Table 1. Participants' roles and organisation types

Role	Number		Organisation type	Number
(Exec) Director of nursing	4		Acute hospital trust	2
(Exec) Medical director	2		Tertiary or children's hospital trust	1
(Exec) Workforce / human resources lead	1		Mental health trust	1
Director of strategy	1		Community trust	1
			CCG	2
			Strategic organisation	1

Findings by theme

Current Activity

One trust described an ambitious programme piloting MECC in several clinical areas. This was led by a steering group, which represented the areas and staff groups involved.

Everyone spoken to described current activity in their organisations that involved prevention and the tackling of modifiable risk factors. This was not 'badged' as MECC. These risk factors are often discussed and documented during clinical interactions:

"I'd be pretty confident that as part of a routine social history undertaken by both doctors and nurses, things such as smoking and alcohol will be asked about.
Whether that leads to any form of intervention, on a consistent, systematic basis,
I would suggest is probably not the case"

Much of the activity around prevention was taking place in clinical or organisational silos. This was either commissioned to hit a specific target in a service or had emerged to address a specific clinical need (for example, smoking cessation in respiratory services, alcohol specialist nurses in gastroenterology). Participants described how it was easier to introduce these initiatives when they had a direct impact on the relevant service but it was more difficult to justify spreading this across the organisation.

Differing views were given on the value of specialist nurses in this context. They were undoubtedly seen as giving high quality care and delivering preventative interventions effectively. For some, specialist nurses would be an effective route for spreading prevention across their organisations, whereas others noted the potential to deskill frontline staff or give the impression that prevention was a specific person's role, rather than everyone's.

The issue of whose role prevention is was echoed between professional groups:

"…maybe the professional culture and some silo working. Nurses do this, doctors do this, AHPs do this, some blurring around the edges but on the whole we stick to our disciplines and maybe don't assess people holistically as best we can."

It was felt that a specific person may need to be assigned a job to ensure it was done but not repeated, but it was not clear what the most appropriate staff group was for this.

What is MECC?

Everyone spoken to understood the basic concept of MECC as it related to behavioural risk factors, such as smoking and alcohol, but the breadth of issues to be covered was not clear to all. Trusts felt better equipped to discuss these factors than wider issues, such as employment, housing, debt or issues around mental health and wellbeing. These questions were often asked in certain services or as part of routine history taking, but it was felt that these rarely prompted action.

MECC was also felt to be different depending on settings and it was not clear to participants what the system 'ask' was. Was it each interaction in the emergency department (ED), outpatients and inpatients? What about visitors and relatives or those on the site outside doorways? MECC in hospital could be more task orientated due to the episodic nature of the interaction, but in community care was very different:

"When you are working in people's homes… you are immediately aware of people's circumstances. [In Hospital] they are wearing different clothes and are more or less independent than normal and the staff don't know what's in the fridge."

Community care offered longer term relationships and the opportunity to explore issues over multiple interations.

The issues to be included in a MECC strategy could be nationally led but with local interpretation based on local need. Commissioners were using the Joint Strategic

Needs Assessment (JSNA) and tools such as those provided by NHS RightCare to understand variation in need and where the opportunities for improvement were. Trusts understood their local populations but weren't always involved in the strategic discussions around population health.

"We have a very deprived local population with poor health indices, high prevalence of smoking, alcohol, obesity and diseases related to those… It's a big part of our work."

"We don't get to see public health intelligence to see what local priorities or need are. We went with the biggies and the most well known."

Leadership

Prevention was seen as important by all participants and the value to the system was well understood. However, MECC was not being discussed at board level. For the trust engaging in MECC pilots, there was a plan to present the findings at the board once complete. Prevention wasn't a board priority for most organisations:

"[Prevention] hasn't had the same airing at board level as sepsis, VTE (venous thromboembolism), never events, mental capacity and safeguarding, or finances or operational performance, ED or RTT (referral-to-treatment times). Prevention hasn't got that same exposure. That doesn't mean there isn't anything going on."

Competing strategic priorities and lack of resources were cited as the main reasons for not focusing on prevention:

"We understand it academically and intellectually, the importance of prevention, but we just can't afford to do it. The thing then is that you're on a hamster wheel, a vicious cycle of worsening health of your population. So it's about putting resources into these programmes."

There didn't tend to be an executive lead or board champion for MECC/prevention, though people described senior leaders, either for their pilot programme or for specific risk factors (a clinical lead for alcohol or for smoking, for example).

The leaders interviewed voiced their concern about spreading MECC across their organisations.

"If we were going to spread that detailed questioning over OPD [outpatients], over inpatients and the A&E attenders - there would be a huge a volume of work. That's not to say it wouldn't be worth doing, it's just that we're really struggling with the demand that we've got for services."

"If I added relatively small interventions to every single patient to the workflow of individual teams, cumulatively that mounts up to add to an already burdened workforce."

This was seen as a system problem. Individual teams and organisations were struggling with demand and MECC was an additional burden. The benefits might be seen in other

parts of the system and lead times were felt to be long. Why prioritise additional activity that may not help your own service in the near future?

Leaders, especially in acute trusts, described a need for additional resources to double-run, to demonstrate the effectiveness of MECC and to increase preventative (and community) activity whilst coping with current demands on the acute providers.

Frontline staff

Participants were concerned about additional burdens on their own staff. MECC would be seen as additional work for an already pressured workforce. Additional tasks, documents and procedures were frequently added to people's responsibilities and things are rarely taken away:

"What doesn't work is just telling everyone to try and work a little bit harder and just do a bit more. They get asked that all the time. Work a little harder, do a bit more. That's been going on for some time and people are feeling over the past few years that their quality of working life and their work-life balance are deteriorating."

The actual MECC interactions were also seen as potentially problematic for frontline staff. Issues raised ranged from feelings of hypocrisy:

"If you're somebody who's overweight yourself, do you feel able to have that conversation with someone who's overweight?"

to legitimacy and whether it was right to ask patients about risk factors when they were either vulnerable or worried about their main presenting concern:

"What right do I have to talk about their smoking?"

Staff might be worried about opening a 'can of worms' and that they may not have either the skills or time to deal with whatever issues emerge.

The system as is does not support staff to have these meaningful interactions. They may be task-focused or measured on number of activities completed. Ultimately, they must prioritise those with the most pressing needs:

"There's also something about the way the system works around us so it drives us into a focused way of thinking, so it's how many dressings have you done, not how many people have you connected with… Our community teams would tell you that they are under so much pressure that (prevention and holistic assessment) go by the by and they are with the person who is most at risk."

Potential ways around these issues included improving staff health alongside patient health as there seemed to be a synergistic relationship between these 2 approaches. Recruiting clinical champions was felt to be an effective way of spreading enthusiasm at the frontline.

In many ways, many of the questions around MECC are already being asked by frontline staff. What is needed is a way of increasing their confidence and competence in giving advice or making the right referrals so they are taking the next step.

Training

It was felt that all staff would welcome training that would improve the quality of care they were able to deliver. Different groups would need different messages. Some need to be convinced that prevention can help patient health or reduce service pressures. Others need the confidence to have these discussions or to ‘take the next step’. Different clinical specialties and roles will have different baseline understanding of the role of MECC in healthcare interactions.

Content might include motivational interview techniques to equip staff with the tools they need to effect behaviour change in their patients.

Training might promote giving MECC a go:

“People need to try it, safely and have a small success. Once I'd done it once, it made it easier the next time. It's about trying it and feeling supported by your managers and colleagues – especially if the interaction takes longer because you are engaging in a meaningful interaction.”

Training might help reframe MECC interactions so that prevention becomes an essential default element of good quality care. Rather than ‘a nice to have’, prevention becomes a patient-safety issue:

“Why should I die 15 years younger than my brother just because you haven't helped me with my smoking?”

It was felt that training needed to be set in a wider context rather than be an ad hoc exercise on a single topic and that it would not be effective without changes to culture, expectations, appropriate resourcing and the provision of tools to make the MECC interaction easier and more desirable.

Additional mandatory training was not a popular approach:

“That and car parking seem to be the 2 issues that our consultant staff complain about the most.”

Many services and trusts already struggle to meet their mandatory training targets and mandatory can be interpreted as a bureaucratic exercise rather than a meaningful activity. Developing champions and a ‘train the trainer’ approach were cited as potential ways to provide training on an enthusiastic and semi-voluntary basis.

However, it was noted that good training uptake was essential if new initiatives are to be successful:

“In my experience you need probably 80% of your team trained in an area when you're introducing something new or decent so that's the KPI (key performance indicator) we've set - get 80% trained and then go ahead with the pilot… unless you've got that critical mass of staff in an area trained then it won't take off.”

Policies, process and technology

These technical measures can be drivers for ensuring MECC interactions take place and are documented. Electronic patient records can include questions around behavioural and social factors, decision support tools and automation of tasks such as referral. These can make the interactions easier and facilitate evaluation by allowing the rapid creation of reports.

The trust engaging in MECC pilots had built forms within their electronic patient record to document this activity in their patients. However:

“If you and I spoke outside A&E about your smoking, there's nowhere for me to document that.”

Also, policies and technology can increase the quantity of MECC interactions but will not drive quality without the other measures that make up a strategy:

“You can get it into policies and documents but people won't take ownership of it. There are so many tick boxes in there that are mandatory before you move to the next screen. Do you embrace it or do you click it to get to the next screen. The change wouldn't be sustained.”

Communication

As discussed above, MECC hadn’t 'cut through” in the same way other issues had. It wasn’t felt to be as high on the broader agenda as topics such as safeguarding, mental health or Better Births. For some, the term MECC wasn’t important. Prevention was understood and felt to be important, even if MECC itself wasn’t.

Organisations want simplicity and clarity in what issues need to be addressed, how MECC should be implemented and what benefits they can expect from introducing it.

Prevention rarely has stories attached that emphasise its meaning and importance:

“The reason we know about sepsis, safeguarding or mental health campaigns is because something terrible has happened. You hear the stories…

There was a burning platform and there was a call to action. What's the call to action with MECC when there isn't that burning platform?”

Boards have other issues that may attract negative publicity or hear of individual cases where a failure of care has led to an adverse outcome.

Trusts will need to be segmented by organisation type and then seniority, role, clinical or non-clinical area and interests so that the right message reaches the right person:

“It's important that we understand something about those who are receiving the message [staff and patients]. We can do Mosaic et cetera. One size doesn't fit all. Behaviour change is a complex and interesting thing. We don't have it in nurse training.”

Some will need to see evidence of impact on services, whereas others may need more narrative. Frontline staff may be sceptical of their capacity to intervene and alter behaviours in the individuals they are seeing and need to be convinced of the population benefits of MECC.

MECC itself was described as an unhelpful term in some instances:

“Staff are very sensitive to anything that's contrived - MECC sounds contrived.”

An approach with mandatory training, additional mandatory documentation and prescribed activity could be seen as a ‘tick-box exercise’, additional work and a low-value intitiative. Caution needs to be taken in how MECC is framed.

Patient engagement

Several participants touched on the patient and public aspects of MECC. Concern was raised that patients may not expect these discussions or consent to them when attending for an ‘unrelated’ matter. Conversely, most felt that having these discussions is a reasonable expectation for every healthcare interaction:

“If you only see that person once, you've got one chance and you've got to seize it. They may not enter the system again and hear another public health message so it's a wasted opportunity if we don't do something.”

One participant discussed how patients from more deprived areas may have more adverse risk factors but also lower expectations for their own health and an element of fatalism about whether serious diseases can be avoided.

Information packs on wards, electronic displays and check-in kiosks were all discussed as potential places to inform patients that MECC interactions would be part of the clinical encounter. Gathering feedback on the encounter was also seen as important and amending the Friends and Family test was one way of effecting this.

Commissioning

“If we look as a system, all too often we are contracting against our constitutional targets, which is right and proper. But in my head we should be thinking about what we could be doing before then. We focus on 4-hour wait but if we commissioned for health and wellbeing, you wouldn't need your 4-hour wait target. You're commissioning for ill health and not commissioning for good health.”

“Commissioners probably don't appreciate the extent to which providers are driven by their contract and the art of keeping the show on the road when it comes to service delivery.

Senior leaders in both commissioning bodies and providers noted the potential for incentivising prevention in local contracting arrangements. This could be written into individual service specifications.

CQUINs were one such route but there was some concerns that providers might ‘chase the payment’ and provide evidence to show compliance without embracing the purpose of the target.

Novel models, such as outcome-focused commissioning as part of an integrated care system were too new to have demonstrated their effectiveness, but intuitively would reward preventative activity such as MECC.

Public health input was seen as valuable for both commissioners and providers. It has taken some time to understand and improve the relationships between public health teams in local authorities and the NHS:

“Our DPH (director of public health) has brought a really different perspective. She will bang the drum around inequalities and the upstream. As a board, we were previously more focused on health, but that has been dead helpful.”

“It's how you shift to commissioning for outcomes. I would like to see public health having the leadership that it used to have. It's how we bring that expertise back across and have them lead so that commissioners are led by public health and not just what's in the HSJ [Health Service Journal] or the DoH [Department of Health] are worried about so you can have that true population focus…commissioners weren't accountable to them anymore. The dotted lines are too dotted. Some of them have grown their expertise but they're not the experts in population health.

It can be done in a networked way.”

Discussion

The interviews revealed that senior leaders in trusts, strategic bodies and commissioning organisations in Cheshire and Merseyside believe that MECC is valuable in our trusts. However, all see barriers in terms of competing priorities, lack of resources and limited understanding amongst leaders and frontline staff.

To implement MECC successfully, several interconnected components are required. Each of these offers a way of influencing the process, either at a local or system-wide level. This is summarised below. The process is summarised in Figure 1.

1. Commissioners need a good understanding of national priorities and local need as well as opportunities for improvement. Tools to assist include the JSNA and NHS RightCare. Public health leadership was felt to be extremely valuable.
2. Prevention must be commissioned from trusts. This can include specific terms in contracts or specifications or the use of incentive payments like CQUINs. Payment models that are body system specific or activity-based are barriers to “discretionary” activity such as MECC. Newer contracting models focusing on population level outcomes as part of an integrated care system are exciting opportunities to design prevention into local systems and incentivise initiatives such as MECC.
3. Trust boards need to give MECC and prevention the same importance as other issues. They don’t feel it’s as high on the broader agenda as other topics (like sepsis, patient safety, safeguarding and others). Some need hard evidence that it is important and effective, others need the “stories” – examples of people coming to preventable harm. It is difficult to allocate staff time and resources to preventative activities as trusts are already struggling to meet current rising demand. Respondents didn’t have senior leads or champions for “prevention” or MECC and nor was it a regular discussion item at board level. The ask around MECC isn’t always clear to senior leaders and simple implementation advice would be welcomed.
4. Other leaders (such as senior medical staff, ward managers) may not all be convinced of the value of MECC. It is perceived as unlikely to help them meet their targets, with any benefits felt elsewhere in the system or in several years’ time.
5. Frontline staff need training to overcome misunderstandings or personal barriers and increase confidence in having discussions around MECC. They need to be supported and enabled to spend additional time to talk. Training might encourage people to try a MECC interaction one or two times to overcome initial fears. Specialist nurses can help, but MECC needs to be a job for everyone.

Training

Training should be evidence based to ensure that staff change their behaviours and deliver MECC interventions competently, confidently and sustainably which, in turn, lead to behaviour change in patients and service users. The system may wish to seek advice from specialists in behavioural sciences to facilitate this.

Patients may need to be warned that MECC interactions are to take place. This can happen through promotional material in clinical areas. Over time, it will become an expectation for every encounter. Who else should be engaged – families, visitors? How can this be recorded and rewarded?

The conversation may already be happening as part of routine admission documentation or within certain clinical specialties. It can be facilitated with appropriate technology (for example, forms in electronic patient records) and policies but care needs to be taken to avoid it becoming a tick-box exercise. Staff need to be supported to take the next step and turn initial questions into meaningful encounters. In time, many of these steps could be automated so that staff are free to focus on the conversation.

Each conversation needs an outcome. Staff should be able to use motivational interview techniques to deliver advice that will effect behaviour change. If additional support is needed, staff can't keep up with the range of local services. They would welcome an easy referral directory. In time, these referral processes should be integrated within the provider's native electronic patient record to make the interactions as efficient as possible and ease data collection.

MECC, as part of a programme of prevention, needs to be evaluated. A quality improvement approach could show trends and incremental gains in volume and quality of MECC interactions. These evaluations need to be presented at board level and shared system-wide through local forums. This can provide evidence to other departments and providers that MECC can be implemented successfully.

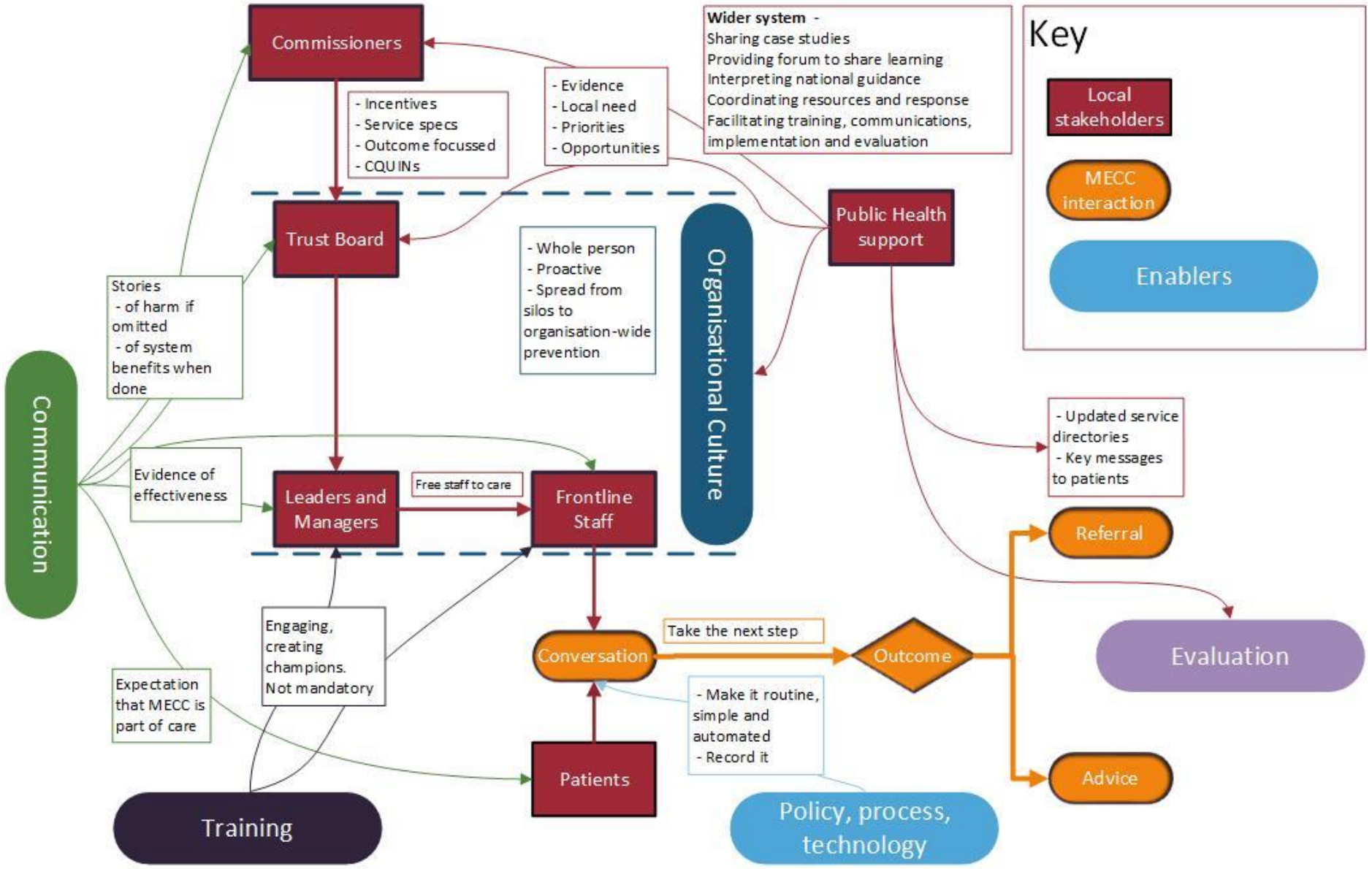

Figure 1. Making an MECC interaction

Culture and framing

MECC can be implemented in a range of organisational types and settings. Those piloting it in acute trusts may benefit from specific targets, policies, procedures and technical support. MECC can be seen as an essential component of high quality and safe care that must be incorporated into busy clinical interactions in a slick way that doesn't impinge on throughput and departmental performance.

It was recognised that MECC needed to be part of a wider organisational culture that incorporated prevention:

"If we don't set it within a wider set of principles for how we provide care then it becomes tokenistic."

Culture might be of professional groups or clinical specialties, with the need to overcome siloed working practices. Alternatively, it could be a whole organisation culture.

Some leaders did report that MECC itself wasn't always a helpful term for staff, but conversations about prevention can be framed as part of a holistic way of managing care. Person-centredness was proposed as a way of shifting the focus onto a whole person conversation, which enabled frontline staff to work in the way that they want to work.

"Staff are very sensitive to anything that's contrived – MECC sounds contrived…

"We've had an organisational development strategy – complete turnoff, because it's contrived. When we talk about person-centredness, we're doing essentially the same thing as MECC."

This thinking leads us to consider whether MECC is appropriate in all contexts. It may be that each organisation needs to develop its own culture that incorporates prevention as part of a holistic assessment and is based on local population health needs. A shift from discussing MECC to discussing person-centredness may facilitate this.

MECC	Person-centredness
• Technical • Prescriptive and imposed • Additional work and demand • Reduced job satisfaction • Dated • Tick-box • Not well understood • What matters to the system – may not be well received by patient	• Holistic • Bespoke to the organisation • Freeing staff to look at the whole person • How staff want to work • Empowering • Improved job satisfaction • What matters to the person

Table 2 - Reframing MECC

Conclusion and next steps

We must acknowledge the tremendous pressure our trusts are under at present, and we thank the participants for taking part in this project.

We would also like to thank Dawn Leicester and the Champs public health collaborative for their assistance in developing and facilitating this project.

The report will be shared with all participating organisations and presented to the MECC Board and Prevention Board of the Cheshire & Merseyside Health & Care Partnership before disseminating to local authority public health teams and our trusts.

MECC at scale has the potential to effect population level improvements in health by taking advantage of the thousands of healthcare interactions that take place in Cheshire and Merseyside each day. It is an investment now that should reduce demands on the system in future, but we recognise the difficulty in implementing it without additional resource.

MECC projects can be facilitated with training for staff and tools to help document encounters and signpost to further support. If adding additional tasks, however, care must be taken so that MECC doesn't become a burden or a tick-box exercise.

Training and technical support measures are insufficient to ensure successful implementation and high quality interactions. To work, MECC needs to be part of a whole-system strategy for prevention and proactive care.

Funding gaps, staff shortages and increasing demand make it difficult to prioritise MECC over other urgent issues. The pressures reported do appear insurmountable but trust leaders do support MECC in principle and the system can help them take action in meaningful ways with more modest investments:

Health and Care Partnership and wider system

Understand local need

Local public health experts to work with commissioners to understand local need and highlight areas for focus.

Define MECC clearly

Give a clear message on what MECC means for that population and the trusts that serve it.

Share evidence on why and how

Share evidence and learning with trusts to demonstrate the benefits of MECC and how it can be implemented with simple aims, approaches and outcomes.

Deliver staff training

Offer engaging training to staff which aims to overcome personal barriers, support behaviour change conversations and enable them to build on the conversations they are already having. Alternatives to mandatory training should be considered, possibly including in staff induction processes.

Create a Cheshire and Merseyside service directory

Provide tools such as a referral directory to make taking the next step simple and clear for staff.

Develop a Cheshire and Merseyside Communications Strategy

Create a communications strategy that offers appropriate messages to commissioners, senior leaders, staff and patients, offering evidence, patient success stories and simple actions to take to effect change.

Commissioning organisations

Commission for prevention

Prevention to be written into service specifications and appropriately incentivised and performance managed.

Trusts

Identify and support sponsors/champions

Trusts to nominate executive sponsors/champions for prevention and have it as a standing item on board meetings.

Foster a person-centred approach

Support trusts to develop a culture of holistic assessment and care which incorporates MECC principles as part of a whole person approach, appropriate to the setting and organisation.

All partners

Promote public awareness

Develop greater public expectation/awareness that staff will ask about healthy behaviours using ward info packs, electronic displays and check-in kiosks. Interactions could be recorded. New social prescribing programmes in primary care networks.

Establish a professional movement

Create a MECC network to share good practice and access to continuing professional development events/webinars. Launch learning sets to promote staff development and innovation.

Though there are disagreements about how, or what it is called, MECC is seen as the right thing to do. Trusts need clear guidance and appropriate incentivisation to undertake these programmes at scale. Training staff will help, but MECC can not be imposed on them or their organisations. Communicating the benefits to the system and the individual is key to motivating both trusts and their staff. We need to create an environment where everyone is free to deliver the whole-person care that they want to give.

“We need to create a professional movement”.

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Appendix 1 – Topic guide

Public Health England

Topic Guide – Making Every Contact Count (MECC)
Developing plans to implement MECC in NHS organisations in Cheshire and Merseyside: Insight work with senior healthcare leaders.

1. Can you tell me about your role here?
2. To what extent is MECC and, more broadly prevention, a priority for your organisation?
    a. Discussed at Board level
    b. Senior leadership team responsibility
    c. Part of policies, procedures and workflows
3. What MECC activity is already happening in your organisation?
4. How is this work measured or evaluated?
5. What are the real or perceived barriers to widening the implementation of MECC in your organisation?
6. What support would help your organisation with successful implementation of MECC?
    a. Leadership, incentives
    b. People, training
    c. Environment, tools, technology, onward pathways
7. Is there anything else you think is important to capture on this topic that we have not touched upon?