

Chapter 3 Making every contact count (MECC)

NMC Future Nurse: Standards of Proficiency for Registered Nurses

This chapter will address the following platforms and proficiencies:

Platform 2: Promoting health and preventing ill health

At the point of registration, the registered nurse will be able to:

- 2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and well-being, in the context of people's individual circumstances.
- 2.8 explain and demonstrate the use of up-to-date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments.
- 2.9 use appropriate communication skills and strength-based approaches to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability.

Chapter aims

After reading this chapter, you will be able to:

- identify the key elements that make up a Making Every Contact Count (MECC) conversation;
- demonstrate an awareness and understanding of the challenges that people face when making decisions about their health and well-being;
- explain and describe the use of behaviour change approaches to empower people to manage their own health and well-being;
- demonstrate an awareness of your own communication skills to support others in making positive health choices.

Introduction

This chapter starts with a case study to help illustrate the difficulties that people have when talking about their health, including nurses. Treating people without identifying and changing what makes them unwell can be self-defeating. This thinking has sparked the development of new approaches to improving the health of individuals and communities. This chapter looks at one such initiative, that of making every contact count (MECC). It starts by giving an overview of MECC before looking at its component parts. It looks at the evidence base for MECC and why it has proved so successful. It then explains how to conduct an MECC conversation building on the skills discussed in the previous chapter, before ending with a summary of the key points.

Case study: Michael and Jenny

Michael is a 59-year-old man who has smoked since the age of 14. Like many smokers, he is not happy with his habit and would like to stop. He has booked in to see the GP practice nurse in order to get some help and advice. He has had a morning cough for about ten years and has lately noticed that although he can walk for long distances on the flat, he struggles to walk up slight inclines at anything but a slow pace. He has been trying to pass this off as an ageing process, but he is now unable to keep up with his wife and other friends of a similar age. He fears that his breathing problems may be smoking-related, having recently seen a series of TV adverts.

He is worried that his practice nurse might consider his illness to be ‘self-inflicted’, but he defends this by explaining to himself that he started smoking at a young age when it was common and accepted as the norm among his friends and family. He remembers that there were adverts actively encouraging you to smoke at the time he was growing up.

Jenny is a second-year adult student nurse on placement with the practice nurse. Jenny, who is to sit in on the consultation, is not looking forward to the ‘inevitable’ conversation on stopping smoking, as she is a smoker herself. She knows it is wrong to smoke and has tried giving up, but without success. While she is uncomfortable with such conversations, she is keen to hear what the practice nurse has to suggest and hopes to get some new ideas about stopping smoking. She would never consider asking someone ‘in the profession’ for help, as she ‘thinks she should know better’.

Making every contact count (MECC)

Making every contact count (MECC) is a term used to describe the mechanism of brief advice and behaviour change interventions (Collins, 2015). At its heart, it seeks to make the most of the many contacts that health and social care staff have with those whom they look after and care for, as well as using those contacts as opportunities to hold positive health conversations. MECC was designed, introduced and promoted

as a means of encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. It draws on behavioural science research which suggests that brief interventions can be effective in producing small but important changes in behaviour, particularly if the intervention is motivational in content and offers a degree of hope for the person going forward.

Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can all help people to reduce their risk of poor health as well as have a positive effect on a person's sense of mental well-being. MECC is based on the simple premise that what people do in their everyday lives – what they eat, how much they exercise and how far they follow advice on maintaining a healthy lifestyle – largely determines their health and their need for healthcare (WHO, 2006). The intention behind MECC is to help people make positive choices about their health and well-being, as well as aiming to help people develop a healthy lifestyle. For example, it can include advice on low- or no-cost activity, such as persuading parents to walk their children to school, or, as part of physical activity advice, encouraging increased use of existing community resources such as leisure centres and swimming pools. It does this by building capacity and confidence in people to make change, by supporting them in making lifestyle decisions about their own health, setting health goals and effecting change. It aims to help people to take more responsibility for their health and take early action to prevent or delay illness. This may involve addressing lifestyle areas such as poor sexual health or taking practical steps such as being immunised against contracting hepatitis B. It may also involve ensuring that individuals can access services to support the wider determinants of health (see Chapter 1), such as housing or financial support, which may be barriers to making healthy lifestyle choices. Even if the person has an existing medical condition, such as type 2 diabetes or coronary heart disease, then adopting a healthier lifestyle can make a big difference to how well the person recovers and how they manage their health into the future.

Although innovations have been developed by a number of localities, MECC's origins are in work done by NHS Yorkshire and the Humber (2010), which aimed to ensure that NHS staff used every opportunity to help patients and visitors make informed choices about their health-related behaviours, lifestyles and health services. This model was in turn based on the National Institute for Health and Care Excellence (NICE) public health guidance on promoting health-related behaviour change (NICE, 2007). MECC was championed at the NHS Future Forum (2012), who made the recommendation that every healthcare organisation should deliver MECC and *build the prevention of poor health and promotion of healthy living into their day-to-day business*. This message was reinforced in the MECC consensus statement issued by Public Health England (PHE, 2016) and included in the *NHS Standard Contract 2017/19* (NHS England, 2016). The latter made it a legal requirement that providers of health develop and maintain an organisational plan to ensure that staff use every contact they have with service users and the public as an opportunity to maintain or improve health and well-being.

Activity 3.1 Critical thinking

Thinking about Michael's situation in the case study above, consider why people may be reluctant to talk about their health and well-being. Michael has smoked for a long time. Can you think of some reasons why Michael may not want to talk about his concerns regarding his health?

An outline answer is provided at the end of the chapter.

Michael may have many reasons for giving up smoking, only some of which he shares at the meeting. The decision to stop smoking, like the decision to engage in any health-related behaviour, is a complex process that is subject to a number of influences (e.g. a person's belief in their ability to give up a particular activity or lifestyle). Michael's inability to keep up when walking with family and friends, advertisements to quit smoking on television and concern for his health led to him booking an appointment with the practice nurse. Activity 3.1 asked you to reflect on Michael's reasons for stopping smoking and seeking help. Activity 3.2 asks you to explore the same situation but this time from Jenny's perspective.

Activity 3.2 Reflection

Reflecting on the case study at the beginning of the chapter, but this time from Jenny's perspective, discuss the following points with your peers and mentor:

- Do nurses have the right to judge people who lead unhealthy lifestyles?
- Should nurses who do not pursue a healthy lifestyle be in a position to give advice to patients about how to manage their health?
- Should nurses act as role models to the public by adopting and maintaining healthy lifestyles (e.g. not smoking, drinking in moderation, taking regular exercise)?

As this activity is based on your own reflections, there is no outline answer at the end of the chapter.

It is not for Jenny or the nurse to judge Michael's reasons for wanting to stop smoking, but to support him in doing so. Smoking cessation is most successful if the person decides that they should stop and then takes the next step of stopping or seeking help. We should seek to understand the reasons for the person wanting to stop or change a behaviour.

MECC should be a conversation that honours autonomy and is grounded in the point of view and experiences of the person. It is important to remember that MECC is not

about telling people what to do, but empowering people to make informed choices as to how they lead their lives. It involves enhancing, identifying and acting on the opportunities to engage people in conversations about their health in a respectful way to help them take action for their own health and well-being.

Having an MECC conversation

Having an MECC lifestyle conversation can be broken down into six parts:

1. spotting opportunities to talk to people about their well-being;
2. being able and confident to start a conversation about a well-being matter;
3. being able and confident to deal with any issues that arise;
4. quickly assessing the motivation a person has to take action to improve their well-being (e.g. taking a small step that will help them);
5. providing information to take action themselves;
6. signposting to relevant services when required.

The COVID-19 pandemic had a profound effect on the way people communicated and sought help. Lockdown, social isolation, physical distancing and the wearing of masks led to anxiety and depression in many people and created barriers to seeking and accessing support. It also had an impact on family functioning and how people went about meeting their needs. Weight gain owing to people not taking exercise during isolation was a real problem.

Perhaps the hardest part of having an MECC conversation is starting it, particularly in the time restraints of the job. These conversations, as that is what they are, are brief, use open questions and assist the person in making positive choices based on the best evidence (see Chapter 2). Furthermore, it should be a respectful conversation. The tone of an interaction is usually set by the way it is opened. What is actually said in greeting, or in opening a conversation, is of crucial importance, and tells each participant a great deal about how the other perceives their relationship and expects the interaction to proceed. A respectful conversation starts with the nurse asking the person's permission to hold a conversation. Asking permission to hold a conversation can help to build rapport, as well as creating trust and co-operation.

Examples of asking permission

- Do you mind if we talk about [insert behaviour]?
- Can we talk a bit about your [insert behaviour]?
- I noticed in your notes that you have hypertension. Do you mind if we talk about how different lifestyles affect hypertension?
- Would you like ...?

Making every contact count (MECC)

- It sounds like ... Can we explore ...?
- Can I take a moment to run through what you said?

In holding an MECC conversation, we need to ask, advise and assist (NHS Midlands and East, 2012) (see Table 3.1). It is by *listening* to the person and what they have to say that we respond appropriately to their concerns. In *advising* the person, we give messages about the benefits of healthy lifestyle change and tips to achieve them. In *assisting* the person, we share information or signpost the person to where they can find local support.

Ask	Advise	Assist
You said you would like to give up smoking. Have you thought about how you might go about doing this?	Stopping smoking is the best thing you can do for your health. You're four times more likely to quit with help from an adviser compared to alone.	Your local well-being hub has information about local pharmacies and GP practices that provide stop smoking support. I can give you a leaflet, if you like? There are also useful tips and information about quitting on the One You and NHS Smokefree websites.

Table 3.1 Ask, advise, assist

However, if a contact is to truly count, the focus should be on the individual and their needs.

In structuring a conversation, we seek to empower the person to take ownership of their health. This is achieved by focusing on the individual's goals rather than what the professionals want to change and is actioned by developing a collaborative relationship between the nurse and the person. This involves helping people to assess where they are and what they would like to achieve, working collaboratively to help people plan how to achieve their goals and do things that they might have struggled with in the past, and challenging habits and beliefs that might have inhibited people or are barriers to positive change.

Case study: Astral

Astral is a 32-year-old woman who is being seen as an outpatient, who frequently misses her appointments, and at other times shows up without an appointment, often in crisis. She currently uses alcohol and tobacco and has started to use street drugs.

As you have developed a therapeutic relationship with Astral, you learn that she grew up in a household with a violent father who frequently assaulted her mother, her siblings and herself. Although now estranged from her father, the impact of his violence presents itself on a daily basis as Astral struggles to cope with the trauma she experienced.

Astral left school early, has few marketable skills and has never been able to hold a job for more than three months. Astral receives various state benefits which she claims are not enough to live on and often has no money come the end of the month to live on. Astral is currently in a relationship with a woman whom you suspect may be violent.

When we help others to consider and take various actions for themselves, it can help to examine – with them – some of the possible barriers that might impede their progress. It can be useful to do this before they actually take any action, so that they can be realistic in their expectations for success or not. Having a health-promoting conversation with Astral could prove difficult. While Astral leads a chaotic lifestyle, it maybe needs satisfying.

The idea behind an MECC conversation is not to tell the person what they should be doing but to raise the person’s awareness of the problem behaviour and subsequently empowering the person to take action. The nurse does this by being a strong ally who encourages the person when needed. This is best achieved when we focus on the strengths and abilities of people to make lifestyle changes, focusing on the benefits of change and advising them as appropriate. This is largely done through active and reflective listening and challenging the person through the use of questioning, as well as affirming the client’s freedom of choice and self-direction (see Chapter 2).

Concept summary: The WDEP system

When holding an MECC conversation the author uses what is referred to as the WDEP system. The WDEP system was developed by Robert Wubbolding (2011) and derives from Reality Therapy. It helps give structure to a conversation and puts the person at the centre of the problem-solving process, and is as follows:

- W – What does the person want? (e.g. to lose weight)
- D – What is the person doing? (e.g. eating unhealthy food; not taking exercise)
- E – Evaluate. Is what the person is doing helping them to get what they want? Is it taking them in the direction they want to go? Is what they want achievable? Does it help the person to look at it in that way? How hard are they prepared to work at this? Is their current level of commitment working in their favour?
- P – Plan. What plan does the person have for moving in their desired direction? Are they clear about what it is they will do? Is what they plan realistic? How will the person know when they have achieved it? How committed are they to doing it? Can they start doing it immediately?

The system offers individuals a way to discover what they want and to identify what they are doing to obtain or achieve what they want, and to evaluate their behaviour and plan to behave differently. The skill in using such a framework is to pitch these questions to the person in such a way that seeks to support their decision making and at the same time to motivate them.

Summarising an MECC conversation

When a lot of information has been exchanged, closure may be used by either party to summarise or clarify what has been covered and agreed on (see Chapter 2). Summaries are a special type of reflection where the nurse recaps what has occurred in all or part of an intervention or consultation. They can be used to start a conversation ('The last time we talked of you quitting smoking ...'), link points together ('So, you're saying that you're very busy at the moment and it would be difficult to commit to stopping smoking and taking up exercise ...') and end a conversation ('We're due to meet again in a week's time. I'll make sure to bring the literature I promised you on stopping smoking and go through that with you.').

Summaries communicate interest and understanding, as well as calling attention to important elements of the discussion. They may be used to shift attention or direction and prepare the patient to 'move on'. Summaries can highlight both sides of a patient's ambivalence about change, as well as promoting the development of discrepancy, by strategically selecting what information should be included and what can be minimised or excluded. Perhaps the greatest skill of holding an MECC conversation is knowing when to refer the person on to another professional or service. Activity 3.3 asks you to consider this in terms of where you are based.

Activity 3.3 Decision making

The final part of an MECC conversation is knowing when to refer a person to a particular service or not. Make a list of services within your local community that provide public health support. You may be surprised at the number you arrive at. Try to make time to visit some of these and learn more about what they have to offer. This will put you in a better position to help people. For example, Paul, one of the authors, has an interest in veteran mental health. There are a number of local charities and services where he lives in Norfolk that offer help and support to ex-servicemen and women with a mental illness, and that accept referrals outside of the NHS. The Walnut Tree Health and Well-being charity is one such service that has won national recognition (see www.walnuttreehealthandwellbeing.co.uk).

As local resources will differ from locality to locality, there is no outline answer at the end of the chapter.

MECC as an intervention

Health promotion interventions may be directed at a population or community, the systems that affect the health of those populations and/or individuals and their families. As an intervention, MECC is aimed at individuals and is based on the NICE (2007) behaviour change guidance, which defines behaviour change in four levels. MECC falls within levels 1 and 2 of these interventions.

Level 1 interventions consist of very brief interventions and the signposting of services, delivered whenever the opportunity arises in routine appointments and contacts. Very brief interventions 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.

Level 2 interventions consist of brief interventions, such as **motivational interviewing**, aimed at people whose health and well-being could be at risk (e.g. patients with high blood pressure who are overweight and at risk from a heart attack). This level of intervention uses brief intervention to hold a health/lifestyle conversation and may lead to referral for other interventions or more intensive support. An MECC conversation at this level can be broken down into three distinct parts:

1. asking individuals about their lifestyle and changes they may wish to make, when there is an appropriate opportunity to do so;
2. responding appropriately to the lifestyle issue(s) once raised;
3. taking the appropriate action to either give information, signpost or refer individuals to the support they need.

Level 3 interventions are extended brief interventions used by staff who regularly come into contact with people for 30 minutes or more (e.g. behavioural change programmes such as smoking cessation programmes) and are targeted in what they have to offer.

Level 4 interventions are expert or specialist interventions that are condition-specific or require additional specialist training, such as with people who are at higher risk of either illness or disease owing to such things as a compromised immune system (e.g. cancers of the immune system such as leukaemia, immune complex diseases).

It is important to note that in the literature there is no one clear definition of what constitutes brief advice, brief intervention and extended intervention. This creates a challenge in the interpretation and practical application of these interventions. It also highlights the need for the nurse to work within their limitations and you should only engage in conversations that you are happy holding. If you feel uncomfortable in the conversation, then this could be an indicator that you need to refer the person on or signpost them to a particular speciality or service. This again is an important part of the nurse's role and one that is sometimes neglected in clinical practice.

Hopefully, you have developed a sense that by holding even a very brief MECC conversation, you can have a positive impact on an individual's health and well-being. Healthcare is not just about providing for the sick and ill but recognising that it encompasses health-enhancing activities such as MECC. It is also about recognising that health promotion works on different levels and that nurses, as well as other healthcare professionals and workers, have an important role in promoting the health of others.

Chapter summary

MECC is about raising awareness of health and well-being and motivating people to make change. It can be considered a model of change intervention and provides a framework with which to guide health-promotion practice. The key message behind MECC is the same as the one running throughout this book: it is more effective to support and empower people to change than to enforce change on a person. When people come up with their own solutions, they are more likely to put them into action and maintain the changes that they make. However, it is important to remember that you are not responsible for the choices people make. In order to carry out a health-promotion intervention, nurses and other healthcare practitioners need to appreciate how health needs change over the lifespan, as well as incorporating this knowledge into our interventions with others in order to maximise the health and life chances of an individual. MECC is the responsibility of all those who work in health and social care.

Activities: Brief outline answers

Activity 3.1 Critical thinking (page 40)

People may be reluctant to talk about their health concerns because they:

- feel overwhelmed with the task of managing their health;
- have little confidence in their ability to have a positive impact on their health;
- misunderstand their role in the care process;
- have limited problem-solving skills;
- have had substantial experience of failing to manage their health and have become passive in managing their health;
- say that they would rather not think about their health.

Further reading

Nelson, A, de Normanville, C, Payne, K and Kelly, MP (2013) Making Every Contact Count: An Evaluation. *Public Health*, 127(7): 653–60.

This was the evaluation of the NHS Yorkshire and Humber competence framework, 'Prevention and Lifestyle Change', on which MECC is based.

Useful websites

www.makingeverycontactcount.co.uk

This website houses information on the MECC scheme and has a useful 'Linked Resources' section.

<https://stpsupport.nice.org.uk/mecc/index.html>

This page on the NICE website looks at the underpinning evidence base on which the MECC scheme is based.

www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources

These documents support the local implementation and evaluation of MECC activity and the development of training resources.