Public Health England

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Everyday Interactions:

A refresh

March 2020

Contents

Foreword

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England, and the UK more broadly, has experienced a steep increase in life expectancy in the last 150 years and with this has come a shift in the leading causes of death, from infections and poor sanitation to non-communicable disease. Yet, despite their intrinsic differences, these health threats share a common solution; as John Snow removed the handle from the water pump to end a cholera outbreak in 1854, so non-communicable diseases too require action at the source.

In January 2019, the NHS long-term plan was published, focussing on the need to tackle the social determinants of health, and acknowledging that 'prevention is better than cure' – and not just for the individual themselves but also for NHS sustainability.

Making Every Contact Count (MECC) is an important part of the prevention agenda, supporting health and care professionals to engage with the people they meet and to find out what matters to them in order to support them to live healthier lives. We know that there is strong evidence of the important health impacts of MECC conversations, but without data to demonstrate the conversations being had, it is difficult for services to claim those impacts as their own.

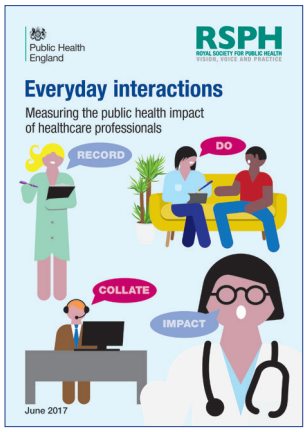
The Everyday Interactions toolkit, first launched in 2017, aims to provide support to health and care professionals who wish to not just have MECC conversations, but also to record these interactions and extrapolate impact for commissioners and others working in their service.

This 2020 refresh of the toolkit provides up to date impact pathways for 11 topic areas, as well as an evaluation of the toolkit so far. It is clear that while the toolkit has been well received in many quarters, a number of system-level factors have held back its full incorporation into the lives of public health professionals. We hope that this evaluation will start a new conversation about the direction of travel for public health and take a small step towards the cultural change that will be necessary to put prevention at the heart of the NHS.

Making Every Contact Count, supported by the Everyday Interactions impact pathways, is an important way to address the 'pump handles' at the source of health inequality. We hope that this toolkit will provide validation to health and care professionals that their brief interventions are important and necessary, and that they have a central role to play in health improvement in the multitude of settings they inhabit.

Shirley Cramer CBE
Chief Executive, RSPH
February 2020

Introduction



In 2017, Royal Society for Public Health (RSPH) with Public Health England (PHE) published 11 impact pathways to support healthcare professionals (HCPs) to record and measure their public health impact. The pathways were published in a report entitled 'Everyday Interactions'.

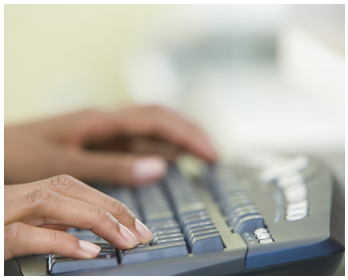
The impact pathways support the use of Making Every Contact Count (MECC), and as such, each pathway encourages all users to start with an awareness of the principles of MECC as a basis for working through the pathways. The pathways also support the All Our Health (AOH) framework developed by PHE, with each of the 11 impact pathways linking to one of the AOH topic areas.

This report is a refresh of the impact pathways for 2020 and also contains findings from an evaluation into the Everyday Interactions toolkit. The evaluation includes a survey, telephone interviews and case studies.

We have also produced a new generic impact pathway for healthcare professionals to develop and use in their own practice. We are aware that people often have multiple morbidities and will need multiple impact pathways to tackle the issues they face. The generic pathway can be used to combine pathways or to add in public health priorities not covered by the 11 separate pathways.

On page 18, there is also some new information on the financial benefits of incorporating MECC into clinical practice.

We believe that the impact pathways offer an important and easy-to-use method of demonstrating public health impact to commissioners. Healthcare professionals should concentrate on the first two columns, 'Do' and 'Record', trusting in the evidence base that this will contribute to the impacts listed, as well as having a positive impact on other sectors, such as social care and fire and rescue. Individual clinicians do not need to monitor for the impacts themselves.



For information on using the pathways and information about how they were originally developed, please refer to the 2017 report, available here. There is also e-learning to support the use of the pathways, available here.

Evaluation:

Survey

In early 2019 (January-April) we carried out a survey to ascertain whether the pathways were being used, by whom and any ways in which they could be improved.

When originally designed, it was with Allied Health Professionals (AHPs), pharmacists, dentists and nurses in mind, however, we were interested to know whether other groups were also using the pathways. The survey was disseminated widely through professional bodies and networks.



Survey findings

We had 399 responses to the survey. Of these, nurses (38% of responses), physiotherapists (10%), orthoptists (5%), dietitians (4%) and doctors (4%) made up the largest groups of respondents.

Of the 399 respondents, a fifth (21% - 83 respondents) had come across the pathways before. Of these 83 respondents, a third (30%) were nurses, 14% were physiotherapist, 6% were pharmacists and 6% were dietitians.

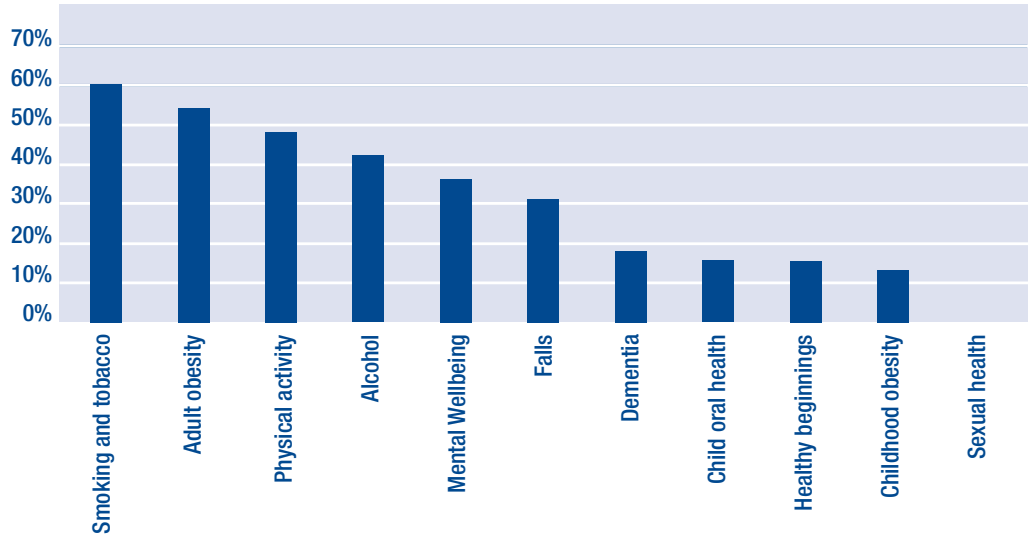
Those who hadn't come across the pathways before were asked whether it would be useful to have a tool that would help them to measure their public health impact. Over two thirds (70%) said that such a tool would be useful.

We then asked those who had seen the pathways before whether they had used them. Nearly two thirds (64%) said that they had used them before. Those who hadn't used them said they hadn't had an opportunity due to having largely non-clinical roles, lack of time or not feeling confident using the pathways.

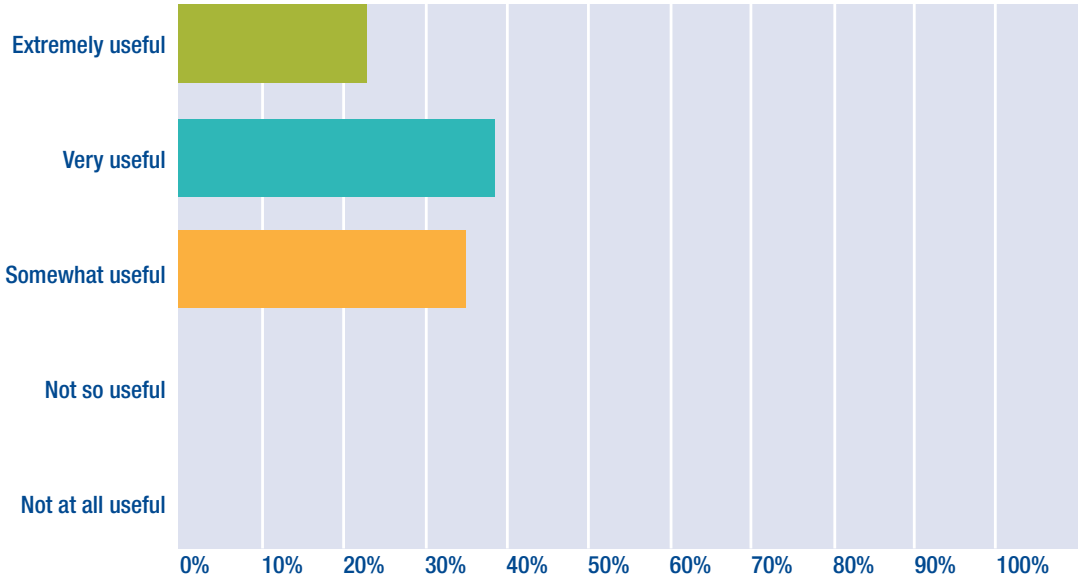
The impact pathways are divided into four different sections: 'Do', 'Record', 'Collate' and 'Impact'. We asked survey respondents which of these sections they had used from one or more pathways. The most widely used section was 'Do', which 87% of respondents had used, followed by 'Record', used by 84% of respondents. Half of respondents (50%) had used the 'Collate' section on one or more impact pathways and a third (34%) had used 'Impact'.

We also asked which pathways had been used by the respondents. The most popular were the smoking and tobacco pathway (used by 61% of respondents) followed by adult obesity (55%). None of the respondents had used the sexual health impact pathway.

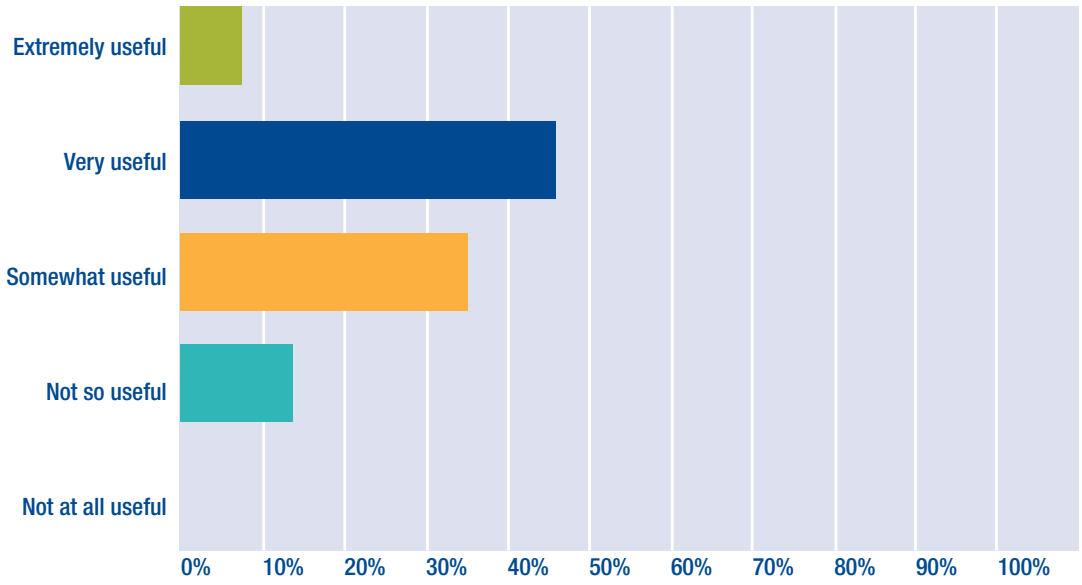
Which of the impact pathways have you used, even if only in part?



All respondents who had used the impact pathways felt they were useful to some extent in supporting them to improve the health of the people they work with:



The majority of respondents felt that the pathways were useful in helping them to measure the public health impact of their work:



We asked respondents in which ways the impact pathways had helped them to measure the impact of their work. The most frequent response was that the pathways provided them with an opportunity to reflect on the practice and delivery of healthy conversations (76%). Over half said that the pathways made it easier to record brief interventions/healthy conversations (61%) and to more routinely record healthy conversations (56%). A fifth (18%) said that the pathways were used to provide evidence to others (including managers and commissioners) of the number of healthy conversations being conducted.

Common challenges of using the pathways were finding time to have healthy conversations and also difficulties of recording the data, particularly collating data over time and also connecting the data to impact.

Of those individuals who had come across the pathways (but not necessarily used them), just under half were aware that there was e-learning available to support their use (46%).

Evaluation:

Telephone interviews

As part of the evaluation, we spoke to five senior health leaders to better understand their views on the impact pathways.

Findings

Of the five people interviewed, one had used the pathways to develop local assessment tools, two had seen them and shared with other colleagues although not used them themselves and two had not come across them before.

The general feedback on the impact pathways was positive. They were felt to be person-centred, intuitive to use and the 'Do' column in particular was highlighted as offering an important guide to best practice.

However, a common theme of the interviews was around the broader issue of encouraging healthcare professionals to use MECC in their daily work. There was still a sense that some healthcare professionals don't see MECC as part of their professional role, while others lack confidence in raising issues with individuals even though they acknowledge the importance of doing so. One barrier identified was lack of local knowledge about services to refer onto, which may inhibit HCPs from having the conversations in the first place.

It was highlighted that there needs to be a systemic shift to bring healthcare to a point where it is able to incorporate the impact pathways effectively. A part of this may be greater emphasis on MECC and healthy conversations during training to embed it going forward. There also needs to be a greater belief that recording interactions is purposeful and useful, and an understanding of how it will contribute to population health more broadly.

It was clear that in order for HCPs to use the impact pathways, they need to be straightforward and easy to employ. A major hurdle to this was seen as current IT systems. It was felt that not only are the necessary data fields not available for inputting information, but that HCPs would view this absence as confirmation that using the pathways was not a priority. In addition, it was felt that if the pathways are seen as having to be used inflexibly, this will also make their use more onerous, rather than straightforward and easy as desired. It was argued that using the impact pathways shouldn't be a mandatory requirement for HCPs.

There were some differing views on the role of targets and payment in increasing use of the pathways. While in some sectors it was felt that fixed term funding to encourage their use could be implemented in the same way as the smoking CQUIN, in other sectors it was felt that payment would not increase engagement and the shift needed to be cultural rather than financial.

Evaluation:

Case Studies

We have included six case studies of how the impact pathways have been used in different parts of England, plus a case study highlighting how IT systems can support MECC implementation.

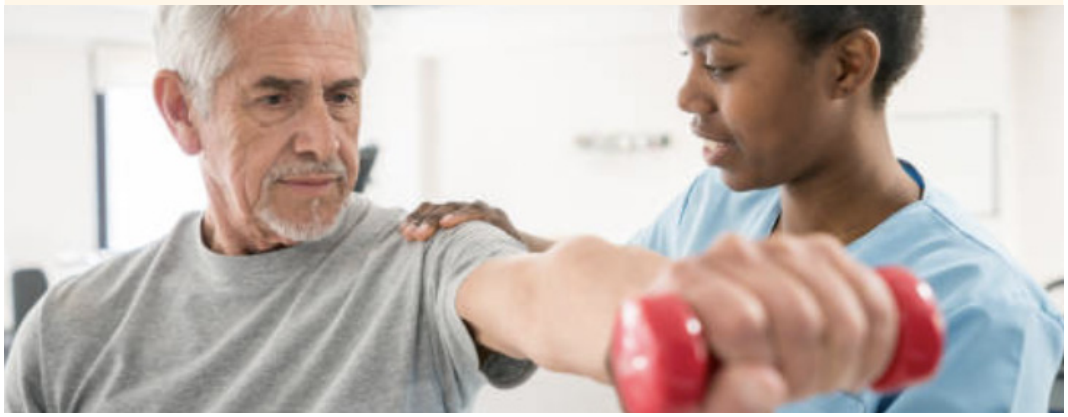
1. Case study

Niamh Keating, Physiotherapist, Royal Free London NHS Foundation Trust

The Royal Free Hospital is a specialist centre for vascular surgery and many of the patients on the vascular ward are smokers. As AHPs we have a role to play in supporting patients to quit smoking, however we do not always do so. A quality improvement project was initiated on the ward to encourage and enable AHPs to routinely give very brief advice (VBA) on smoking cessation. The smoking impact pathway was used to develop our protocol, and as a guide to selecting the most appropriate outcomes to record and collate, in order to effectively determine the public health impact of the intervention.

To record the data we updated our vascular therapy assessment forms to include smoking status, whether VBA was given, and the outcome of the VBA – referred to Stop Smoking Services (SSS), referred for Nicotine Replacement Therapy (NRT) or declined – and created a similar electronic record (excel file) to record and calculate the percentage of patients given VBA, referred for NRT and referred to SSS on a monthly basis

Our data collected over one year showed that when AHPs routinely gave VBA to patients who smoke, one third of patients accepted a referral to the local SSS. This shows that AHPs on the vascular ward are well-placed and effective at empowering patients to take steps to give up smoking. Our vision is for this intervention to be embedded into routine practice for all AHPs across the hospital and to facilitate this, all new and current AHPs in the hospital are being trained in how to give VBA. In addition, all inpatient therapy assessment forms have been updated, to prompt and record smoking conversations and outcomes.



2. Case study

Abi Henderson, Professional Advisor, Chartered Society of Physiotherapy

When I was a team lead for paediatric physiotherapy in Bradford, I worked with a musculoskeletal (MSK) team.

We decided to create a quality improvement collaboration to maximise the value of each contact with a child and their parent. While we were already trying to encourage increased levels of physical activity, we weren't quantifying how much physical activity children should be doing.

The quality improvement collaboration began with a baseline survey within the team. We found that there was a lack of awareness about the national physical activity guidelines. We also did a snapshot audit about what was being recorded by staff.

To address knowledge gaps, we brought in a Public Health England physical activity clinical champion to run training across the trust. The training included why physical activity was important, the national recommendations for physical activity and also some training on brief conversations. There was a lightbulb moment across the team about the need to emphasise the importance of physical activity, not just for MSK health, but for the rest of a child's health too.

The physical activity impact pathway gave validity to my desire to start measuring interactions and provided reassurance that it was acceptable to just record process measures, for example, that a MECC conversation had taken place, rather than the impact of that conversation.

Staff were signposted to the physical activity pathway, but I found that the important thing was that there was a key person who was aware of it and could adapt it and cascade it out in the format that was going to best work for our service.

We then implemented an intervention for children aged 0-19 years. We focused initially on children with MSK conditions but the enthusiasm from staff led to an adoption across a range of settings including special schools and neuro rehabilitation community settings. Our focus on physical activity came from a holistic health and wellbeing perspective and considered how to be inclusive to enable children to access, for example, school sports activities, rather than activities specially for children with MSK difficulties. We made this a normal part of the consultation, not an extra.

To enable us to record physical activity conversations, we added a MECC code to our computer systems.

3. Case study

Aideen Larmer, Senior Physiotherapist, Connect Health (Camden)

After seeing the impact pathways developed by the RSPH, I put together a proposal to collect some main health outcomes within our physiotherapy services. The impact pathways that were most relevant to our work were physical activity, falls, mental wellbeing and adult obesity, so I concentrated on these.

I put together a list of questions that our physiotherapists could consider during consultations, for example, 'Would regular, sustained physical activity improve the presenting condition?', 'Could excessive weight be contributing to this person's current condition?' and 'Has this person displayed any risk factors of poor mental health that may benefit from the physical or social aspects of physical activity?'. I also suggested measures that could be used to collect data, such as whether brief advice had been given and whether the person was signposted to local opportunities or other services.

This proposal helped to shape the development of a questionnaire that is now given out to a sample of patients quarterly. The questionnaire asks patients what topics were discussed with them during their consultation (with a check list including smoking, sleep, falls, physical activity, weight, diet and mental health and wellbeing) and whether they were signposted to other services or activities. We use this data to report on the impact of physiotherapy on wider determinants of health to the CCG. Quarterly stats suggest that 70-90% of patients are receiving public health advice.

My ambition is to make this digital in some way. This would then allow the physio to fill in an online form and we could collect data on the interactions with every patient rather than just a sample.

I found the impact pathways a really useful starting point for this project because they simplified the issue of measuring public health impact and made it clear the sorts of things that could be measured.

4. Case study

Katrina Kennedy, Associate Director of Allied Health Professionals, Hampshire Hospitals NHS Foundation Trust

As a trust we have been working hard to support staff with their health and wellbeing. We now have seven MECC trainers and are rolling out 45 minute MECC taster sessions aiming to train 40 people a month. We also have a full course running every month with 20 staff places. Staff involved include physiotherapists, occupational therapists, speech and language therapists, dietetics, alcohol team, operating department practitioners and the multi-professional Quit4Life team.

As part of our MECC steering group over the last few months we have been looking at the RSPH impact pathways and seeing how MECC principles can be used.

The falls pathway

Do

Clinicians tend to use MECC open discovery questioning to complete their risk assessments, however we tend to use SPLATT – Symptoms, Previous, Local environment, Active, Time, Trauma sustained.

Record

All parameters captured in the Comprehensive Geriatric Assessment requirements.

Collate

In acute trusts we tend to collate person centred risk assessment and care plans which are specific; re-ablement and community falls services collect numbers of people attending classes.

Impact

Public health population health parameters are looked at rarely. We realise we should be doing more for prevention and using this information to redesign our pathways.

The alcohol pathway

- We have used the **DO, RECORD AND COLLATE** to influence the information we have uploaded to the Hospedia screens via the Alcohol Button.
- The patients can complete Audit C and have immediate advice and guidance.

The smoking pathway

- We are aiming to be **Smoke free Trust** by October 1st and have used the pathway to influence our driver diagram.

Our overall MECC strategy is based on three steps devised following a review of all the impact pathways:

STEP ONE

Take the One You Health quiz: www.nhs.uk/oneyou/how-are-you-quiz

STEP TWO

Have a healthy conversation - Making Every Contact Count (MECC)

STEP THREE

Use the *Health and Wellbeing* directory to signpost people so they can take action, either from printed guidance or on the Trust website: www.hampshirehospitals.nhs.uk/patients-visitors/health-information-point-hip/useful-links

5. Case study

Lucy Knott, Team Leader in MSK Outpatients, Physiotherapy department Fairfield General Hospital, Bury & Rochdale Care Organisation

The following case study demonstrates the DO section of the alcohol impact pathway; asking questions, using the Audit C tool, offering brief advice and referring to community specialist alcohol services. The impact pathways have had a significant positive impact on my own practice. I now consistently use the Audit C tool to start the conversation around alcohol and I've grown in confidence about raising the topic in general. I relate alcohol to their presenting condition e.g. liver, medication and sleep disruption and if people do not wish to be referred to alcohol services then brief advice and literature is available. A recent audit in the department found that 63% of the team were asking about alcohol and providing brief advice.

Mr H, 63, was referred to physiotherapy with lower limb weakness and a history of falls. He had several pre-existing conditions; inflammatory arthritis, osteoarthritis, prostate enlargement and diabetes. He reported frequent falls at night and was clear that these were not related to pain. He felt that his prostate issues were the main factor. During the lifestyle section of my assessment I asked about his alcohol intake and we used the Audit C tool. His score was 16 indicating a possible dependence on alcohol. I asked further questions around his alcohol consumption and he reported a daily consumption of between 16-18 units. Brief advice around his alcohol intake included probable link with his falls at night. His wife had indicated that she had tried to persuade him to reduce his intake too but with no success. He consented to a referral to the community health trainers at Bury Lifestyle Services for alcohol support. He has now reduced his alcohol intake considerably and has three alcohol free days a week with his average intake now 3-4 units. He has had no further falls at night and his wellbeing and physical health have also benefited. His original score on the MSK-HQ questionnaire was 21 and on discharge was 54.

6. Case study

Paul McCallion, Advanced Physiotherapist – Respiratory Medicine Freeman Hospital, Newcastle upon Tyne Hospitals NHS Foundation Trust

I am a physiotherapist with a specialist interest in respiratory disease. One of the main priorities of my job is to improve patients' self-management of their condition. I review patients in both inpatient and outpatient settings, and include several public health strategies in my assessments. The two main targets include increasing physical activity and where appropriate, smoking cessation.

I use the Medical Research Council dyspnoea scale to assess patients' functional breathlessness. If they score 2-5 I will recommend either home, community or hospital based exercises programmes. The physiotherapy team lead a breathlessness management class called Pulmonary Rehabilitation. This has a significant evidence base demonstrating improved quality of life, exercise tolerance and reduced anxiety and depression scores in patients with chronic lung disease.

The impact pathways include "Higher levels of local population meeting PHOF increased physical activity" – we contribute to this by supporting patient participation in exercise classes. We use the "6 minute walk" exercise tolerance test to prove that increasing physically activity (8 week cohort) correlated with improved exercise tolerance and breathlessness. We also use the HADS score which is a validated anxiety and depression score.

Additionally I will assess all patients smoking status and record status, brief intervention provided and referrals local smoking cessation services. Each clinic review I will record if patients have reduced or stopped smoking, we also measure lung function at each clinic review.

Most of the data is recorded in paper form but occasionally electronically with clinic letters.

IT can be a barrier to recording MECC interventions, but in some areas, IT systems have been adapted to support data collection and overcome this barrier. The following case study highlights this.

7. Case study

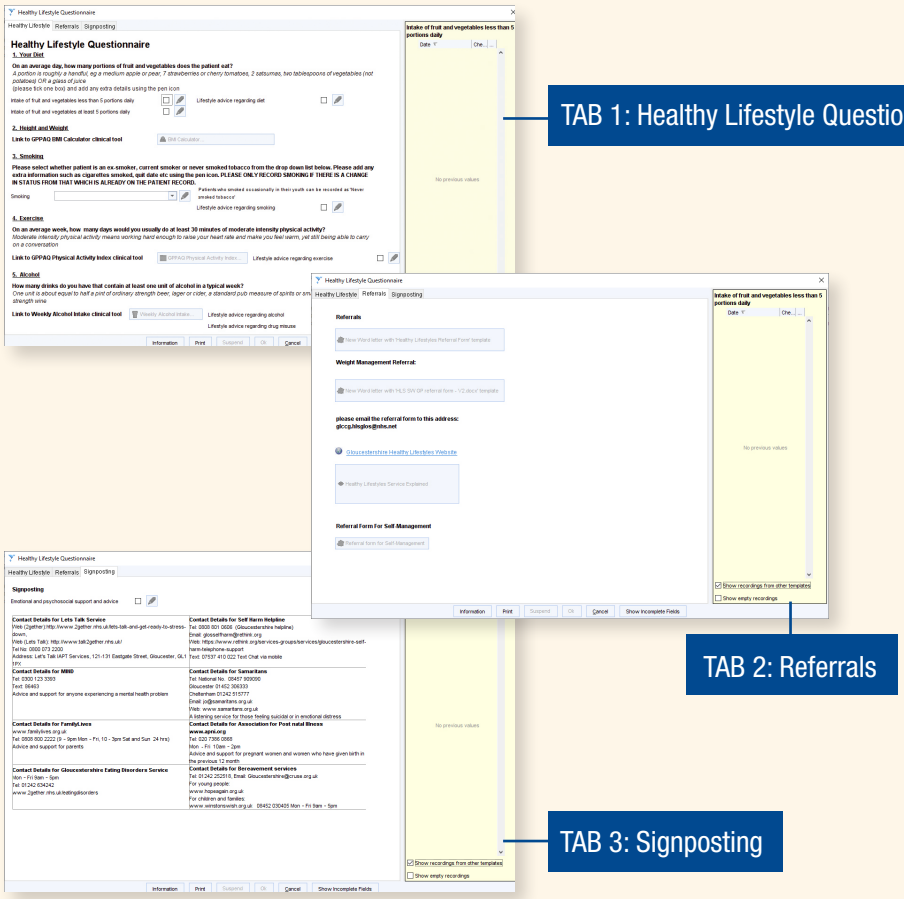
Sarah Morton, Professional Head of Adult Physiotherapy, Gloucestershire Health and Care NHS Foundation Trust

In 2015/6, I led on a small project to develop and test out a system for embedding Healthy Lifestyles conversations into clinical contacts and to support clinicians to make an onward referral using Read Coded templates that could be used to evidence activity.

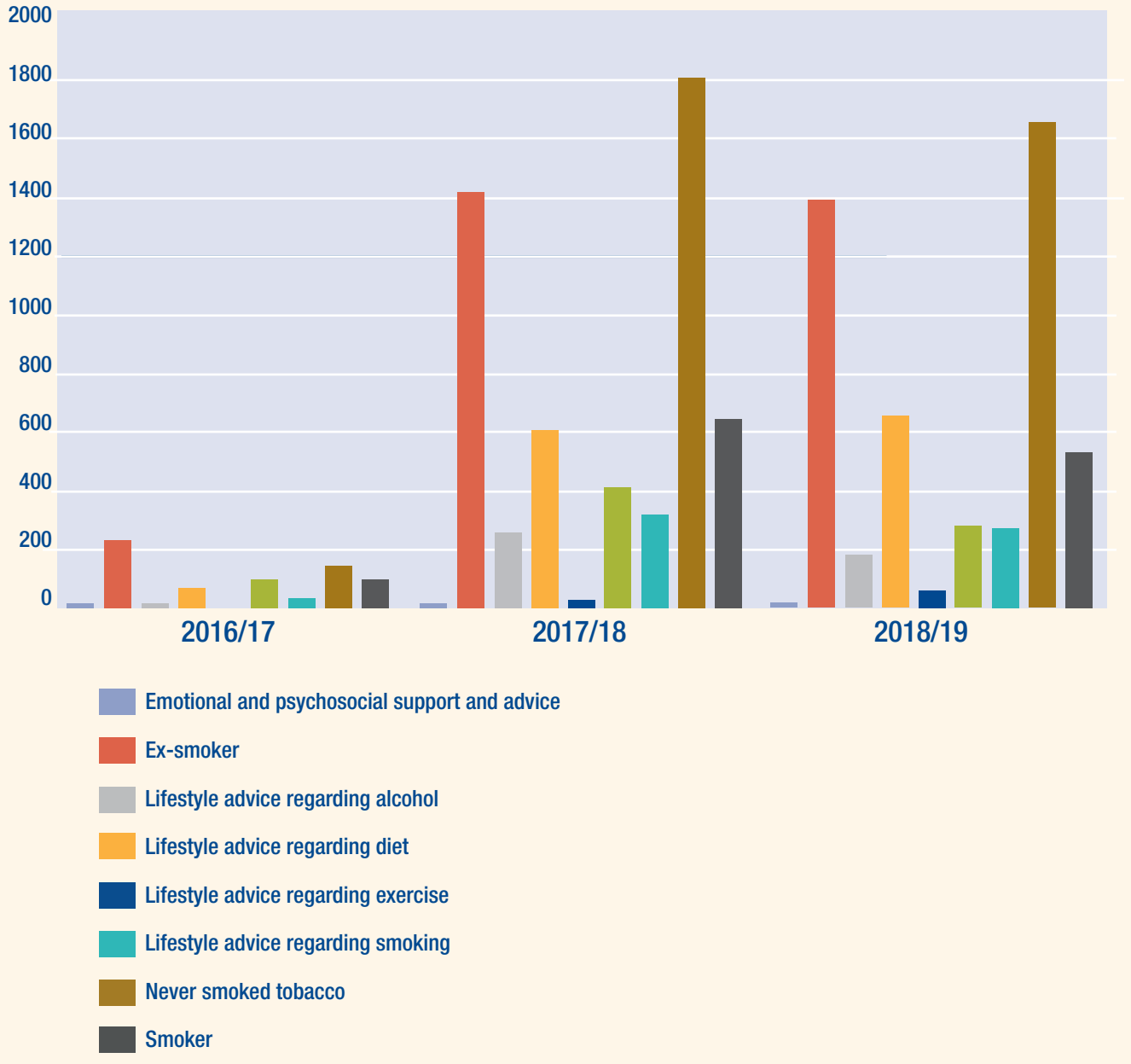
We did this by:

- Identifying training for clinicians – Making Every Contact Count
- Identifying Leading Teams and clinicians to attend training
- Developing a Healthy Lifestyles template to support clinicians in SystmOne
- Linking our Healthy Lifestyles Directory to SystmOne

Below is the template that was added into SystmOne. It consists of three tabs, each able to collect a range of information on lifestyle behaviours.



We can now see the types of conversations being had across the Trust by a range of different clinicians. The below graph highlights some of the conversations since 2016, as well as recording individuals' smoking status.



Training has progressed since 2015/6 and we are continuing to develop our services in this area. Clinicians are trusted by service users to have Healthy Lifestyles conversations and many clinicians have now been trained in motivational interviewing and health coaching.

Examples: benefits from delivery of MECC brief interventions

Following the launch in 2017 of the Everyday Interactions toolkit, there have been a number of enquiries with local leads who were seeking information that could be used when making the case for MECC (Making Every Contact Count) with local commissioners and within local systems.

As mentioned earlier, MECC is an approach to behaviour change that uses the millions of day-to-day interactions that health and care services have with people to support them in making positive changes to their physical and mental health and wellbeing.

A MECC intervention is a brief (or very brief i.e. under two minutes) intervention that is delivered opportunistically as part of a routine health or care appointment and engages an individual in a conversation about their health, for example smoking, alcohol or physical activity, and then signposts and refers the individual to further sources of support.

Below are two examples that highlight some of the potential benefits from the delivery of brief interventions to support behaviour change linked to key behavioural risk factors.
Further examples on the effectiveness of brief interventions for example in smoking cessation, can be found within the Health Economics Evidence Resource (HEER) published by Public Health England. This is a collection of economic evidence underpinning public health interventions, located at https://www.gov.uk/government/publications/health-economics-evidence-resource

Example 1: Brief advice on physical activity (reproduced from HEER row F15)

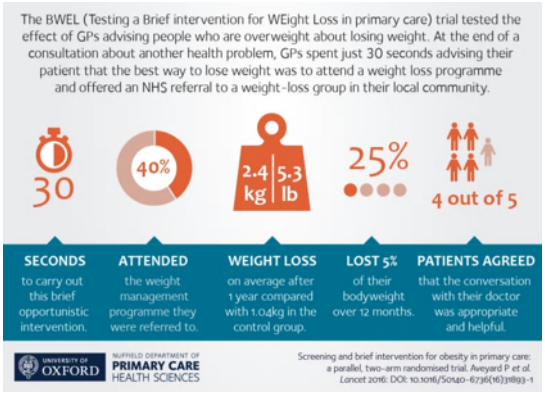
Brief advice delivered on physical activity has been found to potentially generate benefits in monetary terms of approximately £93 pounds per person, exceeding the cost of the delivery of the intervention (estimated at £9.50 per person). This calculation estimated each QALY gain at £20,000.

Further detail on the economic modelling for example 1:

A Markov decision model with annual cycles was used to compare the lifetime costs and outcomes of a cohort of 100,000 people exposed, at age 33 for one year, to brief advice for physical activity in comparison with an unexposed population. By the end of the first year the cohort was either 'active' or 'inactive' (based on national definitions) and they could have one of three events (non-fatal CHD, non-fatal stroke, type 2 diabetes), remain event free (i.e. without CHD, stroke, or diabetes) or die either from CVD or non-CVD causes.

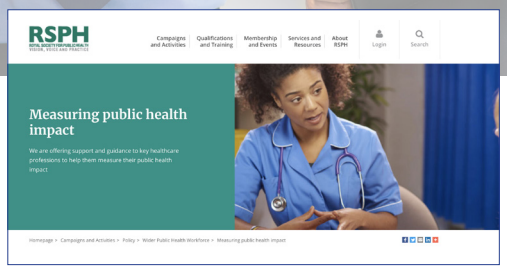
A probabilistic sensitivity analysis showed at a threshold value of £20,000/QALY, that there was a 99.9% chance that brief advice on physical activity would be cost-effective.

Example 2: Brief interventions on weight loss, the BWeL trial



BWel Brief intervention on weight loss trial findings via https://www.phc.ox.ac.uk/research/research-themes/health-behaviours-theme/research/bwel-brief-intervention-on-weight-loss-trial

Impact Pathways



The 11 impact pathways, plus the new generic pathway can either be accessed via the **Everyday Interactions** homepage on the RSPH website or directly via the following links:

Adult Obesity

Alcohol

Childhood Obesity

Child Oral Health

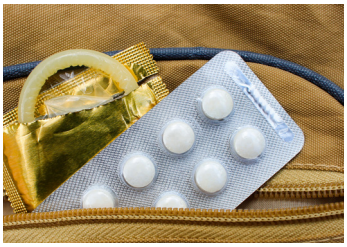
Dementia

Falls

Healthy Beginnings

Mental Wellbeing

Physical Activity



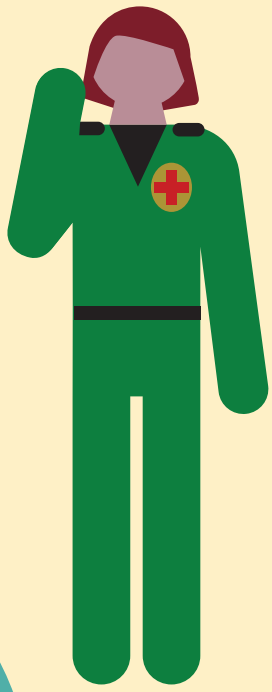
Sexual and Reproductive Health and HIV

Smoking and tobacco

New Generic Pathway

Conclusion

Where they are being used, the impact pathways are viewed positively. We are encouraged by examples of them being developed in line with individual clinicians' needs and being used to inform wider pieces of work. Despite this, there is still much scope for greater use by healthcare professionals. Our survey and telephone interviews suggest that increasing their use will be reliant upon other changes in the system, notably IT development.



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