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## Original Research

## Making Every Contact Count: an evaluation

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## ABSTRACT

**Objectives:** To conduct an initial evaluation of a behaviour change programme called 'Making Every Contact Count' (MECC).

**Study design:** Retrospective interview study.

**Methods:** In depth qualitative interviews with key stakeholders engaged in the delivery of MECC which were digitally recorded, transcribed and analysed thematically using framework analysis.

**Results:** The responses of those involved were generally favourable and although the 'intuitive' nature of the idea of Making Every Contact Count clearly resonated with interviewees, the take up was variable across different organisations.

**Conclusions:** The approach to MECC described here was based on some of the principles outlined in the NICE Guidance on behaviour change published in 2007. The report shows that MECC has considerable potential for changing staff behaviour in relation promoting health enhancing behaviour among members of the general public coming into contact with services.

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## Introduction

This paper reports the initial evaluation of a behaviour change programme called Making Every Contact Count (MECC). Against the background of the well-known association between smoking, over eating, lack of exercise and the misuse of alcohol and the disproportionate contribution of these behaviours to health inequalities, in 2007, The National Institute for Health and Clinical Excellence (NICE) published public health guidance on promoting health related behaviour

change.<sup>1</sup> As a response to the publication of the NICE guidance, in NHS Yorkshire and Humber, a competence framework (Prevention and Lifestyle Behaviour Change: A Competence Framework)<sup>2</sup> was developed to support the idea of making every contact with patients and the public count to help change behaviour. The framework aimed to skill up the whole workforce to do basic health improvement work, supporting health enhancing behaviour change.<sup>3</sup>

This idea was not new. The Wanless Report<sup>4</sup> asserted that building workforce capacity was a key cost-effective action for

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preventing ill health and tackling the wider determinants of health. Wanless argued that a workforce with a broad mix of skills would be required to deliver public health to instigate behaviour change at population level. In 2010 the Marmot Review<sup>5</sup> suggested that prevention should be shared across the NHS, Local Authorities, communities and individuals. Sim, Lock and McKee (2007)<sup>6</sup> identified the need to develop the evidence base to... ‘*permit a shift from theory to an evidence-based identification of the contribution by the wider public health workforce to sustainable health improvement.*’

There is little evidence that these interventions are being scaled up with the associated workforce requirements being considered in the way that both Wanless and Marmot envisaged. The Public Health Skills and Career Framework<sup>7</sup> therefore aimed to: ‘*Provide a consistent and coherent vision across the whole of the public health sector, as well as a means to value everyone’s contribution.*’ However, the framework, whilst helping to benchmark education programmes has not been evaluated in terms of its impact on enabling the wider workforce to contribute to public health interventions.

### **Making Every Contact Count (MECC)**

MECC is a straightforward approach to public health service delivery based on the framework. It extends the delivery of public health advice to the public by training non-specialist staff from a wide range of service organisations, at minimal cost, in the basic skills of health promotion and disease prevention. MECC engages the paid (and unpaid) workforce so they can contribute to health improvement by creating the potential to embed preventive thinking into the everyday work of a wide range of health and social care employees, local authority staff, private and third sector employees. For a relatively modest investment in training<sup>8</sup> it provides employees with the information and skills they need to offer brief, appropriate advice, such as ‘signposting’ services, as part of their everyday contact with members of the public. The ultimate aim is to make health related behaviour change interventions commonplace in a wide range of settings within and beyond the NHS.

The unique aspect of MECC in Yorkshire and the Humber is the Prevention and Lifestyle Behaviour Change: Competence Framework – PLBC<sup>2</sup>. It describes the generic competencies required by staff to enable them to promote healthier lifestyle choices in areas such as long-term conditions, obesity management, smoking cessation and alcohol misuse. Making prevention central to every interaction between employees and members of the public, the PLBC framework encourages front line staff to offer brief but appropriate advice, including ‘signposting’ services, as part of their everyday contact with members of the public. The generic competencies within the framework are structured on three levels, reflecting increasing levels of competence. A fourth level signposts the expert or specialist interventions that are condition specific or require additional specialist training: (see Box 1).

The PLBC framework was launched in the Yorkshire and the Humber Region, by all primary care trusts. The initiative rapidly spread to NHS commissioning and provider organisations and beyond to social care, local authorities and other organisations with a public health remit such as fire and rescue services, social housing agencies and a number of third sector and

voluntary organisations. It supported the commissioning of both services and education within the region, as well as the design of new ways of working and learning. Individuals have used the PLBC framework to identify existing skills and those they need to develop further. Additionally, an online assessment tool was developed to support the process.

The initial evaluation of the MECC programme reported in this paper examined the progress of its dissemination and development within a range of contexts through interviews with key contacts within those organisations. The study was funded by HEFCE’s Higher Education Innovation Fund, South Yorkshire CLAHRC and NHS Yorkshire and the Humber and developed by a partnership formed between NICE, NHS Yorkshire and Humber, Sheffield Hallam University and Manchester University Business School.<sup>9</sup>

#### **Box 1 The Framework.**

##### **The Generic Competences: Level 1**

The worker is able to engage with individuals and use basic skills of awareness, engagement, and communication to introduce the idea of lifestyle behaviour change and to motivate the individual to consider/think about making changes to their lifestyle behaviour(s):

- Ensure individuals are able to make informed choices to manage their self care needs;
- Support and enable individuals to access appropriate information to manage their self care needs;
- Communicate with individuals about promoting their health and well-being;
- Provide opportunistic brief advice.

##### **The Generic Competences: Level 2**

The worker is able to select and use brief lifestyle behaviour change techniques that help individuals take action about their lifestyle behaviour choices which may include starting, stopping, increasing or decreasing lifestyle behaviour activities:

- Ensure your own actions support the care, protection and well-being of individuals;
- Select and implement appropriate brief lifestyle behaviour change techniques with individuals;
- Enable individuals to change their behaviour to improve their own health and well-being;
- Undertake brief interventions.

##### **The Generic Competences: Level 3**

The worker is able to select and use appropriate techniques and approaches to provide support to individuals as they change their lifestyle behaviour(s) and facilitate the individual to maintain these changes over the longer term:

- Enable people to address issues related to health and well-being;
- Enable individuals to put their choices for optimising their lifestyle behaviours into action;

- Enable individuals to maintain lifestyle behaviour changes.

#### Level 4

The worker uses specialist/advanced behaviour change approaches such as CBT, Solutions Focused Therapy, MI etc., to support individuals for whom brief interventions have not been successful in bringing about lifestyle behaviour change, and/or who have more complex needs. Workers at this level will also act as a resource for the support, training and education of others.

This level will also be applicable to those workers who may be working at a strategic level to commission, plan or implement prevention and/or lifestyle behaviour change services across a population.

The fourth level in the framework is intervention based rather than generic and signposts existing specialised and condition specific competences as well as the strategic competences needed to commission behaviour change services.

The competencies within each level were either drawn directly from the Skills for Health National Occupational Standards database, or where existing competencies did not fully reflect the skills needed they were adapted.

## Methods

Data was collected predominantly through conducting semi-structured face-to-face or telephone interviews with 12 stakeholders from a range of professional backgrounds who were actively involved in the delivery, commissioning, or training of MECC. Given the incipient nature of MECC, at the time of this study, the network of stakeholders actively involved in MECC within the regions studied was relatively small. Hence the sampling strategy was largely purposive in its approach with the opportunity for further snowballing of participants on an opportunistic basis. In total 10 practitioners were approached to participate in the study and all of these practitioners took part in interviews. From these initial contacts, an additional two participants were identified (5 & 10; in Table 1) or 'snowballed' into the sample and also agreed to participate.

Semi-structured interviews were conducted with these 12 stakeholders from organisations in the Yorkshire and the Humber and the North West of England regions (now NHS North) between August and September 2011. In all cases, the interviews were recorded using digital voice recorders and the resulting recordings were transcribed in full. The interview schedule was based on the key components and processes which comprise MECC. The themes covered in the interviews are shown in Table 2.

## Analysis

The analysis was carried out through the use of NVivo 9™ and followed the main tenets of framework analysis (Richie and Spencer, 1994).<sup>10</sup> The researchers initially familiarised

themselves with the data through reading the transcripts and cross referencing the main emerging themes with documentary data supplied by the organisations, researchers' notes and the main themes developed within the interview schedule. The data were combined in a long table and analysed to identify the major themes to emerge. These were assigned codes based on the main responses to the original questions and data were sorted and categorised while quotations were selected to be illustrative of the main themes.

## Results

### Initial impressions

The response to MECC and the PLBC framework from most organisations was reported by respondents as being very positive. These included NHS bodies as well as fire and rescue services, children's' services, schools, private leisure centres, community pharmacies and many others. The reason for the appeal of MECC was that 'Its strength is its simplicity'; it does not require a great shift or extra effort from the normal tasks carried out by the staff delivering it. Also, because the amount of time spent on training to deliver MECC at level 1 of the PLBC framework was minimal (usually half a day) and the training was delivered at very low cost to the organisations, this has helped with ensuring 'buy in'.

*It is low investment- the training is free and it's not going to add to your workload potentially in fact it can make the job easier if you are signposting people on to other services to (or) who deal with them. The savings are a lot better than what we have to invest.*

*Quite simple and straightforward – could see from the competency levels how it linked itself into practice*

Many of the participants were already working within programmes and strategies which were closely aligned with the aims of MECC. Thus MECC was seen not as separate, but as complementary. As such MECC was seen as an initiative which offered an approach that provided a 'fit' in terms of their public health strategy:

*The other driver was the work we did with the national support team for inequalities. We were part of the 'Baker's Dozen' - one of the thirteen local authority areas which wasn't making sufficient progress on its health inequalities we got some additional support from that team and one of the priority actions was essentially around Making Every Contact Count and the role that other front line staff within the NHS could play in raising lifestyle issues in supporting behaviour change*

Furthermore, organisations perceived MECC as aligning with their requirement to deliver Commissioning for Quality and Innovation (CQUIN) objectives. Many of the participants felt that engagement with MECC and the PLBC framework offered them the potential to address a perceived need or gap in their public health offer to their local communities. In some cases, the view was that traditional delivery mechanisms

**Table 1 – Participants' role and organisation.**

Role	Organisation	Organisation sector
1. Health Improvement Manager	Public Health Directorate	NHS
2. Assistant Director for Health Improvement	Public Health Directorate	NHS
3. Health Improvement Manager, Neighbourhoods	Public Health Directorate	NHS
4. Public Health Specialist	Metropolitan Borough Council	Local Authority.
5. Healthy Living Programme Manager	Private Sector Leisure Company	Private Sector
6. Training Manager	Training Organisation	Private Sector
7. Public Health Specialist/Commissioner	Primary Care Trust	NHS
8. Wellbeing Practice Development Lead	Mental Health Services	NHS
9. Trainer/Lead Advisor Public Health	Community Health	NHS
10. Consultant in Public Health	Primary Care Trust	NHS
11. Health Promotion Specialist	Primary Care Trust	NHS
12. Public Health Consultant	Primary Care Trust	NHS

were not having the desired impact on some of the hard to shift statistics for their region. Thus MECC offered an alternative and novel approach to addressing these issues. In others it was the observation that practical application of simple messages was not being delivered:

*...we wanted to have a more holistic approach in encouraging people to access our services. Those who do access services do stop smoking and lose weight, but the numbers coming through aren't high when you look at Hull as a whole.*

*There was a gap in our public health knowledge in our workforce knowledge, in particular the practical aspects. There was no join up between theory and practice*

The need to develop a wider public health skill base within the workforce was also cited. There was recognition that the PLBC framework provided the opportunity to release an untapped potential within the wider health service

workforce. Traditionally public health had been confined to delivery by qualified public health professionals. MECC and the PLBC frameworks were seen by many of widening the potential to deliver public health outcomes by engaging a broader section of the workforce and thus having a much greater impact:

*It's the obviousness of it. We do spend the majority of our resources on staff and they have thousands of contacts with patients and those should be health enhancing contacts. It's the simplicity of it that struck me*

*It's what we would do anyway and what human beings do for their friend. It's not about adding a great deal to what you do. It's about asking in a different way, approaching it in a different way, that's the beauty of it you can get more for not a lot more involvement, investment and time. It's about reprogramming how you approach things.*

### The competence framework

The major plank on which the MECC sits is the Prevention and Lifestyle Behaviour Change: Competence Framework. Participants were asked whether they had had experience of using the framework and what their views were regarding its application and usefulness in practice. The majority felt that the framework gave structure to people's expectations regarding what was expected of them and what the organisation could expect of them:

*The Competency Framework crystallised our thinking and we were already delivering around training programmes but what that did is make us make sense of that and to be able to put forward a concept paper – a framework saying this is how we can make sense of what is going on locally and over the last 12-18 months – people have bought in to the approach we have been advocating and the framework has definitely helped us*

*The work that Yorkshire & Humber did with Sheffield Hallam and the development of the behavioural change competency framework and some of the thinking that was coming out again through the national support team and DoH around behaviour change is all coming in and really developed our thinking to get us to the point we are now.*

**Table 2 – Research questions.**

1. Outline the person's role and their involvement in MECC
2. An outline of the programme of work they are involved in
  - a. Staff/groups involved
  - b. The target groups/beneficiaries
  - c. Perceived outcomes
3. Training and development
  - a. Training conducted
  - b. Use of the Competency Framework
  - c. What worked well
  - d. What could be improved
4. Implementation and delivery of MECC
  - a. Key success factors
  - b. Problems/barriers that emerged
  - c. Indirect or unforeseen impacts (e.g. on services; systems)
  - d. Lessons learnt
5. Impact
  - a. How effective has MECC been?
  - b. Feedback from staff?
  - c. Is there evidence locally of impacts on beneficiaries/patients?
6. Sustainability
  - a. Plans to further develop and embed MECC
  - b. Factors which will influence the spread and sustainability of MECC

### NICE guidance on behaviour change

Since MECC and the framework are based on NICE Guidance (NICE, 2007) on behaviour change, the guidance was seen by some as contributing to the acceptance of the principles of MECC within services. The guidance was seen as the touchstone which enabled practitioners to gain approval of the approach within their home agencies and organisations.

*I would expect that even the elected members will understand it the credibility of NICE – Good point – we use them in the health service and will use them even more in the LA*

*We always reference the relevant NICE guidelines to any papers we do to the board. You will be asked; What's the evidence? When you present your papers if you have a reference to NICE guidance it is always extremely useful. Particularly since public health is going into a non-clinical organisation*

The guidance was thus seen as a key enabler and likely to be more so in the future as the public health function migrates to local authorities. For local authorities, facing greater financial stringency than ever the benefit of the MECC approach will not be as widely known or accepted without the necessary objective evidence.

### The importance of a collaborative approach

One of the main points consistently raised was the value of a collaborative approach. This meant that it was important to invest time in consulting with different services to discover what works best for them – and then to tailor the intervention accordingly. Interventions should be sensitive to the audience: what works with public health professionals may not work with fire and rescue officers - awareness of their particular issues and their target groups' issues is important in order to effectively tailor and adapt it to ensure the most effective use of the PLBC framework.

*You get no buy in if you don't sit down with them and ask them what worked and what didn't and we will work with you to make it better. They will buy into that then.*

Coupled with this was the need to identify the right gatekeepers within each organisation who would be able to champion the implementation of the PLBC framework locally and to build a working relationship with them:

*Recognise your gatekeeper and there are different barriers at ward level based on the assumptions and how they operate - they are not all the same – there needs to be a degree of analysis in terms of what is going to work. Not quite as generic as you would think.*

There was also the need, as one participant put it, to 'know which buttons to press'. By that we mean that the implementation of the PLBC framework may work more effectively when it is aligned to other services' targets and priorities

rather than purely trying to change hearts and minds of people when there is no added value for their own objectives. CQUIN, and the need for services to address its requirements, has been shown to represent a useful leverage point for the acceptance of MECC and the PLBC framework into other services.

*1½% of the contract in CQUIN is meeting certain outcome measures and in public health we are trying to get into those CQUIN contracts and outcome measures in terms of referrals to the stop smoking services.*

Although the use of contract levers such as CQUINs can be advantageous and has been applied in a number of cases it was felt by some respondents that in itself wouldn't lead to the sort of long term culture change required to truly embed MECC in the core practice of organisations and to make it sustainable.

### The advantage of engaging non-professionals

Many of the participants cited the advantage of engaging non-professional staff in the delivery of health advice. They felt that talking to a person such as a hospital porter or a receptionist did not throw up the same barriers based on social status that talking to a health professional would.

*Some of the most effective people I've worked with on MECC training are those who have not been trained or registered. These people are the ones that live in Stockport and the ones that the patients listen to.*

There was a perception that some members of the public were more likely to engage in a frank exchange about their health behaviours with someone who they feel is on the 'same level.'

### Continual support

In order to support effectively the implementation of MECC and the PLBC framework, it was suggested that there was a need for continual follow-up. As one participant put it: MECC can't do it alone. To enable MECC to be sustainable, the support services need to be in place. In some cases, these services were constantly changing:

*It's about having the range of training and not just the brief interventions but that we also have somewhere to refer people on to. When they do need support we don't have a full set of services for people to be passed into particularly in the future when we are 'making every contact count'*

### The influence of the public's wider lifestyle issues

There needs to be an appreciation of the wider lifestyle issues of people in the community, 'don't address the symptom – address the person'. This is linked to the above point about providing follow-up support. An assessment of the extent to which healthy behaviour is supported within the clients'

families and communities was seen as important by some respondents.

### Participants' experiences of training

Participants were asked to outline their experiences of the training, use of the PLBC framework; what worked well and recommendations for further enhancing MECC training. The training at Level 1 was well received. It was seen as pitched at the right level – not too heavy on facts and more about building the social skills and confidence for people to try out the healthy chat. One of the key advantages to the training was that staff don't need a background in public health, as one trainer said, 'If they've got a pulse we can train them.'

*The training is perfect – it's simple and it's easy and it's short. It's very well tailored to lay people and non health professionals and that is fabulous.*

### Flexibility

Another strength of the training was perceived to the flexibility of the approach, since it was based on principles rather than set ways of conducting an intervention. Hence although this is a generic approach insofar as it focuses on developing staff confidence to have a conversation about a client's health, it can be easily tailored to fit different services' and client needs.

*Stockport Team (providers of level 1, Healthy Chat train the trainer provision) is fabulous – it's informal humorous and it's really refreshing. The pitch is dead right and accessible and the way they have introduced the issue – because it's not about people doing the intervention and that is the key message – you are not the expert. There are plenty of people who get paid to do this for a living send them on to them!*

Those people delivering the training felt that since it was aimed at people with no background in public health practice that it was important to focus on building confidence rather than weighing them down with statistics and detail. This view was supported by those people who had gone through the programme.

### Accreditation

One of the participants thought that one way to create buy in with staff would be if the training led to a nationally accredited qualification which would contribute to their professional development and be recognised in staff career development reviews.

*Yes if for staff this was part of the CPD and seen as part of their training and contributed to their registration and maybe if this made a difference to the amount of children we recruited that would be really helpful and then it would lead to signposting to us.*

This was echoed by one of the public health professionals who felt that the professional accreditation acted as an incentive for some of the groups to get involved in MECC:

*We've had to use different selling techniques for different bodies and organisations – in terms of teaching assistants we've got non-attainment in the borough in terms of them achieving a level 2 qualification and we've used that by saying that this can be delivered to anyone 14+ and will give a nationally accredited qualification. It wouldn't really have mattered if it had been in mechanics – the thing was that it was Level 2. That's one reason why we have got so much movement with the programme is that we sell it differently and adapt it to suit different people.*

### Train the trainer

The permeation of the learning through the 'train the trainer' approach has also been effective. The aspiration was that once an initial cohort of people within one service organisation had experienced the training they would act as ambassadors and advocates. They would also have the skills, through training others to create that critical mass to ensure that the MECC messages and practices would spread and be more likely to be sustained. Similarly, it was the aim of one public health specialist to train up all staff to saturate the organisation with capacity to deliver MECC brief interventions.

*So with that in mind how I've taken this locally is to look at how we can saturate the workforce with level 1 competence - train trainers and therefore the workforce is trained to Level 1 competence – we have oodles of people at level 2 -4 who are all paid to do this for a living- what we need is to get people into these services appropriately and get the main tranche of the workforce able to do this.*

In some sites participants at Level 1 requested further training to attain levels 2 and 3.

### Barriers

Although there was an impressive uptake from a wide range of organisations, some (cultural) barriers remained. Often these were in the health service itself:

*Not surprised by the resistance from the medical profession. There are numerous initiatives whereby primary care are not the people who are early up takers*

*Barriers? Can be down to individuals, it was largely at the individual level. If there is a ward sister who is not interested...being very much into the medical view that 'we are here to treat' no matter how it goes you will struggle. However if you get converts they quickly become champions. But as a programme you need to identify some of the barriers to implementation.*

*I'd like to crack GP practices – they want paying for everything, but GPs recognise they don't want the frequent fliers and revolving doors*

In some cases, objections from staff groups and the unions were based on the perception that MECC was asking them to 'do more' than they were already doing and that this was in the context of an already increasing workload.

*It got picked up that we were going to ask porters to do it. The view was we were doing to change their jobs and they were going to do health promotion. This hospital is very unionised and they came in but when we explained what it was they said 'Oh that's OK then'. We are not asking people to change their jobs; we are asking them to have a chat. We all do that.*

Another concern was centred on the uncomfortable possibility that they might offend clients though what might be seen as a judgemental approach by staff delivering MECC:

*The unions were up in arms about it and had some real concerns about the programme. It took 2 hours of a meeting and they were saying the same thing about 'We are not here to pass judgement on their lifestyle we are here to treat them*

The success of implementing MECC and the PLBC framework was partly a function of being able to recognise the capacity people had within their roles to deliver MECC advice and therefore to target efforts there. For example, in a hospital ward, the professionally qualified staff, like nurses, are likely to experience constant pressure on their workloads. In this context, it is likely to be those roles such as care support workers, who have that vital 'conversation time' with clients in order to have a 'healthy chat' that are going to make more headway:

*Even though we have trained a lot of them up it is usually the unqualified – non registered staff that are delivering this MECC programme - it's not a barrier but a consideration about where you focus your training. You have this traditional vision that having this sort of thing championed is a top down approach but it isn't always – it's sometimes bottom up. If you focus on that and realise that the trained staff have so many competing priorities*

In most cases, however, there was minimal resistance since the MECC approach does not add in any significant way to staff workloads, although that had to be strongly reinforced by practitioners.

### Impact

Participants were asked what the feedback had been regarding the impact of MECC and the PLBC framework. In most cases, assessment of impact was at an early stage. Knowledge of the impact of MECC and the PLBC framework was mostly confined to the impact of training on staff in the various services in which it had been delivered. However there were some findings regarding impact on clients' behaviour:

*We have had a 70% greater take up of the Smoking Cessation Service when we had trained them on the wards. The smoking cessation team did come into the training because they have delivered it before. The staff and the managers bought into this so*

*it was high on their agenda because most people on these wards are smokers*

### The future

Participants were asked about their views about MECC for the future. For example what were the keys to successfully embedding and sustaining MECC within those organisations the which had adopted it, particularly in the context of the dramatic transitions about to occur in health and the wider public services? Clearly these organisations varied so no one answer would necessarily be relevant in all cases. One factor identified in the potential sustainability of MECC within such a variety of different services was the need to create a 'critical mass' of staff who were competent and capable of delivering MECC to the public:

*saturate it so that we have enough people locally to absorb the effect of people moving on so we should have some sustainability and even if those people move on they are likely to move on in the same arenas so they can take the ethos with them*

..while another emphasised its inherent simplicity:

*MECC is about 'People' not facts or knowledge so as long as you keep those people enthused and confident that's what will make it sustainable.*

*So we need to ensure sustainability through this network of health champions plus the fact that the health improvement workers tend to be the ones delivering the training or co facilitating each of those organisations will have a link to a health improvement worker, so that maintains the relationship.*

A consistent view was that MECC and the PLBC framework needed to be aligned to the organisations' wider workforce strategies so as not to be seen as another 'project' and therefore peripheral. Another health practitioner cited the potential value of developing a 'network' with the aim of sharing good practice in

*if we really want this to work, how do you embed that so that it is part of your workforce strategy so that when you are thinking about training for staff, you have used that competency framework so our focus has been so far on level 1 but now you might find that you will have groups of staff who need that higher level of competence so how are you feeding that into your workforce strategy?*

### Discussion

The findings of this exploratory study indicate that the MECC initiative has the potential to deliver a significant and additional public health resource at low cost and with an extensive spread across a variety of contexts and health issues. The findings suggest MECC has taken hold in a wide variety of contexts owing to its simple, non technical, behaviourally based approach, focused on effective dialogue. Another anchor to its acceptance within the practice of a wide variety of

organisations is its alignment with the wider objectives of those organisations, rather than adding an additional process, MECC also helps support the strategic goals encompassed within the Commissioning for Quality and Innovation (CQUIN) agenda relating to health inequalities. The PLBC epitomises this common sense approach and was widely welcomed as serving as an indicator of non-specialist competence and capacity within the workforce. Because MECC is based on objective evidence of best practice on behaviour change as enshrined in NICE guidance, it is more likely to be accepted by the clinical professional establishment, and in the future, by the new guardians of public health in England, local authorities..

Some of the main barriers encountered to its greater acceptance seem to have been based on differing objectives of various professional groups, particularly within the NHS itself. This may be based on differing basic cultural assumptions about the role of health professionals (treat vs prevent). It is for this reason that some of the practitioners we talked to emphasised the need for listening and understanding those objectives and working collaboratively with different organisations in different ways to tailor MECC to be responsive to those needs. Indeed some of the real success stories have come from cases outside the clinical professions, such as fire and rescue services and the lay workforce in general, which in part confirms its generic applicability.

However, a service is only as effective as the system it operates within, and since MECC largely acts as an advice and signposting mechanism to more targeted health advice and treatment, MECC will only be as effective to the extent that those services exist. Therefore MECC should be delivered as part of a wider rich and effective network of follow-up services.

The findings at this stage are tentative and give only limited indications of the potential for MECC to make a substantial impact on the health of communities in the UK. Further larger scale research studies are required to scale up the extent of the range of stakeholders and organisations studied and to assess more directly the medium and longer term impact on the users of this innovative approach to public health.

## Conclusions

Behaviour change techniques designed to help reduce the burden of non-communicable disease have been tried in many different ways and in many different settings. The initial evaluation of MECC and the Prevention and Lifestyle Behaviour Change: Competence Framework described in this paper show the potential for the use of this mechanism to provide an effective way of aligning the everyday activities of front line staff in a wide range of organisations with the aim of health improvement and disease prevention. In order to determine whether this would overall be a good use of the time and resources a cluster randomised controlled trial would be highly desirable combined with a detailed exploration of the processes involved in the delivery of the training

the impact of the training on staff, the ways the staff then behave in everyday encounters with clients. MECC and the PLBC framework are popular with some of the people interviewed in this evaluation. The absence of negative accounts of the experience may reflect a bias in the participants who were interviewed; but it may also suggest a scheme with great promise and one where the mechanisms involved are worthy of further study.

## Author statements

### Ethical approval

None required.

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### Competing interests

None.

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