Making Every Contact Count for alcohol...

Learning from the West Midlands
We’ve a time-bomb ticking...

- Ageing population living longer than ever... and living with years of poor health
- Hospital admissions for alcohol still rising
- Liver disease on the increase
The picture in the UK today

- 20% of the population still smoke
- 25% drink more than the recommended guidelines
- Most people do not meet the required physical activity levels nor eat 5 fruit and vegetables a day
- Most people have more than one unhealthy habit
- People who follow all 4 health lifestyles may live on average 14 years longer than those who follow none

‘...every contact must count as an opportunity to maintain, and where possible, improve their mental and physical health and wellbeing’

Future forum report

‘...preventing poor health and promoting healthy living is essential to reduce health inequalities and sustain the NHS for future generations’

Future forum report
What is **MECC**?

**MECC** means making the best of every appropriate *opportunity* to raise the issue of healthy lifestyle

• Systematically **promoting** the benefits of healthy living

• **Asking** individuals about their lifestyle and changes they may wish to make

• **Responding** appropriately to lifestyle issues once raised

• Taking the appropriate *action* to either give information, signpost or refer service users to the support they need.
Achieving MECC

• Skilling up the workforce across health, social care and community services to deliver brief opportunistic advice
• Support from top to bottom including champions, implementation leads and communications strategies
• Blended learning opportunities: E Learning suite; face to face training; supervision
• Data capture on a big scale
• A chance to look at workforce well-being
Big challenges ahead

• Steep learning curve: the engagement of non-health staff to deliver IBA routinely

• Good practice examples from Fire Service, Domestic Violence services, Housing staff and Adult Social Care; but still some difficult challenges eg Police

• **Workforce well-being**: getting small and large businesses involved

• **Not diluting** alcohol IBA in the broader **MECC** agenda
Alcohol – the MECC potential

Up to 18% are drinking at increasing risk levels
Up to 6% are drinking at high risk levels

- IBA changes drinking behaviour of one in eight people to within lower risk levels
- For a PCT with 310,000 population the cost to deliver MECC to 10,000 increasing risk drinkers = £48,000
- 1,250 will change drinking behaviour to lower risk as a result
- This means reduced acute admissions and A&E attendances
- Estimated cost benefit to NHS = £126,000
- £2.60 back for every £1 spent
- The NON-HEALTH benefits are also crucial
Organisational Environment

Staff/Individual asks a lifestyle question

Staff responds to lifestyle issue

Individual is unsure if they want to change

Individual wants to make a change

Individual does not want to make a change

Agree an action
What can MECC achieve?

• Big impact on health inequalities possible
• Putting prevention at the forefront
• A chance to put alcohol on the public health agenda
• A great opportunity to get alcohol on everyone’s agenda…too good to be missed?
# MECC lessons from Insight Research

## Patients say
- They know the dangers of unhealthy lifestyles and they know if they need advice
- Sceptical re effectiveness of advice
- Most likely to respond to brief advice if they have a problem or are already thinking about change
- They DO expect to be asked, particularly by NHS staff
- Staff seniority not important
- Staff lifestyle and appearance important but not crucial
- Think staff are too busy so reluctant to ask for advice

## Staff say
- **MECC** is a great opportunity to improve patient care, treatment and outcomes
- Clinicians feel non-clinicians not appropriate advice –givers
- Staff are more confident once trained
- Don’t believe their appearance or lifestyle makes a difference
- Don’t think they have enough time to deliver brief advice
MECC challenges...for commissioners

• How do you “sell” MECC to non-health staff?
• How do you sell “prevention” to health staff whose main role is acute care or chronic disease management?
• How do you incentivise MECC?
• How do you get staff skilled up rapidly to deliver on the agenda?
• How can you embed MECC in the workforce well-being agenda?
• How do you measure activity on MECC and how do you measure the impact of interventions that may not come to fruition for years?
• How do you ensure that alcohol doesn’t drift in importance?
MECC roll-out

- **MECC** implementation team and resource toolbox
- Blended learning opportunities
- E-Learning tool on NHS Local Every Contact Counts: Brief Encounters
- Solihull have **MECC** as QIPP priority, incentivised by CQUINs in HEFT and with support of a clinical champion
- Sandwell used CQUIN to roll out alcohol and smoking in Acute Care and Community Care
- Dudley combined smoking and alcohol CQUIN in acute care target populations
- Birmingham IBA in health checks
- Staffs Fire Service signed up to IBA and **MECC**
- Importance of pathways and SPOC as well as staff take-up
Really making the case for **MECC** and alcohol: Ethics not Evidence as a base for IBA in untested and unproven settings

- Do good
- Do no harm
- Fairness
- Sustainability

- How important is alcohol as a health issue to local communities?
- How can we ensure that alcohol IBA will not cause harms?
- Does alcohol IBA help to promote fairness and equity?
- Will alcohol IBA lead to positive, sustainable effects on society at large?
MECC and alcohol IBA

- It’s a great opportunity
- We’ve got the drivers, the alcohol tools, the evidence base and the champions
- A whole toolbox for MECC, including training aids, data capture aids,
- Individual and staff assessment tools
- Let's not end up with alcohol losing out at the last minute