MAKING EVERY CONTACT COUNT

A Health Behaviour Change Framework and Implementation Plan for Health Professionals in the Irish Health Service

Feidhmeannacht na Seirbhíse Sláinte
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A Health Behaviour Change Framework and Implementation Plan for Health Professionals in the Irish Health Service

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Publication Date: December 2016

This framework was developed by the Health Behaviour Change Workstream, Health and Wellbeing Clinical Programmes Team, under the leadership of Dr. Orlaith O'Reilly, National Clinical Advisor and Programme Group Lead.

To be cited as: Health Service Executive (2016). *Making Every Contact Count*: A Health Behaviour Change Framework and Implementation Plan for Health Professionals in the Irish Health Service. Health Service Executive. ISBN No 978-1-78602-038-3

Acknowledgement

The name of the programme "Making Every Contact Count" was first used in the UK in the NHS Yorkshire and the Humber for the *Prevention and Lifestyle Behaviour Change Competency Framework*. This term was further adopted by other NHS areas to implement similar programmes. It is with kind permission from Public Health England that we are using the term *Making Every Contact Count* here in Ireland for our Health behaviour change programme.

Foreword

As a country we are facing a significant challenge with the increasing incidence of chronic disease. The treatment of chronic diseases puts an unsustainable pressure on the current health services in acute hospitals and primary care services and has many personal impacts on those suffering with a chronic disease. These chronic diseases can be prevented through the promotion of positive health and wellbeing, adopting healthy lifestyle behaviours and making healthy choices.

Evidence shows that health advice and interventions have the potential to unlock significant behaviour change for patients. Our services and our healthcare teams have enormous potential to influence the health and wellbeing of the people for whom we provide care.

The *Making Every Contact Count* framework aims to capitalise on the opportunities that occur every day for every health professional to support patients to make a lifestyle behaviour change.

The *Making Every Contact Count* framework supports the implementation of Healthy Ireland throughout the Health Service. Implementation of this framework is a key strategic action in reducing the burden of chronic disease. The delivery of the *Making Every Contact Count* will require leadership at all levels throughout the organisation but clinical leadership will be particularly important in changing the culture towards the disease prevention agenda. *Making Every Contact Count* provides a unique opportunity for health professionals to support their patients in changing their lifestyle behaviours.

I look forward to seeing the *Making Every Contact Count* framework come to life across our Hospital Groups and Community Healthcare Organisations and to this framework having a positive impact on the people for whom we provide care.

Dr. Stephanie O'Keeffe
National Director, Health and Well Being Division.

Introduction

Addressing the prevention and management of chronic disease is a pressing priority for the health service both in Ireland and internationally. The TILDA[1] study has shown that 38% of Irish people over 50 years have one chronic disease and 11% suffer from more than one. The major chronic diseases of diabetes, cardiovascular and respiratory disease (over 65 years for respiratory disease) will increase by 40% (2007 – 2020) due to an ageing population and increased obesity[2,3]. Incidence of all cancers in the Irish population are predicted to increase from more than 28,480 in 2014 to between approximately 60,000 to 65,000 cases in 2040[4]. This increase in the prevalence of chronic disease will have large resource demands on the health service.

Ireland, in common with other developed countries, is reforming its health services to meet this challenge. The publication of *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013 – 2025*[5] and the publication of *Healthy Ireland in the Health Services National Implementation Plan 2015 – 2017*[6] have provided a blue print on how prevention should be addressed. An essential element in addressing both primary and secondary prevention is engaging health professionals in preventative activities as part of their routine clinical consultations.

Ireland has a population of almost 5 million, there are approximately 30 million contacts within the health service annually, 14 million of these in General Practice settings. Over 90% of the population attend their GP at least once a year and the average number of visits is 7 times per year. Hence it is important to harness the wider health professional community and *Make Every Contact Count* in clinical settings.

This Framework was developed in a number of phases. The research and development phase included; establishing a detailed rationale, carrying out a review of the evidence of effectiveness, discussion with key informants, surveying and reviewing previous health behaviour change training, reviewing policies in other countries and finally developing a draft model for *Making Every Contact Count* and briefing document for consultation. A detailed formal consultation was carried out with health service staff and external stakeholders, the findings of which were used to identify the essential pre implementation steps which needed to be carried out and the actions which needed to be included in an implementation plan. The plan for implementation rightly reflects the principles outlined in the HSE Corporate Plan 2015-2017 goals. This plan provides the actions required by Corporate Divisions and by each Hospital Group and Community Healthcare Organisation to implement *Making Every Contact Count* as part of their Healthy Ireland Implementation Plans.

Prevention is everybody's business and all health service managers, health professionals, support staff and funders need to play their part if we are to successfully address the challenge of chronic disease. Clinical leadership will be essential in demonstrating support for *Making Every Contact Count.* By adopting and implementing this framework we are supporting people who access our health service to be healthier and helping to reduce the burden of chronic disease.

Dr. Orlaith O'Reilly
National Clinical Advisor and Programme Lead, Health and Wellbeing.

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Introduction

The Health behaviour change framework sets out how interventions to support lifestyle behaviour change need to be integrated into our health service. Health professionals are being asked to make each routine contact that they have with patients count in terms of chronic disease prevention. Therefore, the phrase *Making Every Contact Count* will be used when referring to the framework and implementation plan.

The adoption of this framework by health professionals will result in the people who access the health service on a daily basis being supported in their efforts to make health behaviour changes in order to reduce their risk of developing a chronic disease. It will require that all clinicians, frontline staff and leadership teams respond to their responsibility in implementing *Making Every Contact Count* for improved health outcomes for all.

Context and Background

Chronic diseases, comprising of cancer, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and diabetes, are the leading cause of mortality in the world. Despite the fact that the immediate risk factors for the development of chronic diseases are known and most are modifiable, tackling them continues to be one of the major challenges both now and into the future. Whilst we know that the development of chronic conditions is hugely influenced by our lifestyle behaviour, why we adopt lifestyle behaviours that are known to be unhealthy for us is complex and is best illustrated through the social determinants of health model.

People with chronic diseases are more likely to attend their GP, to present at emergency departments, to be admitted as inpatients and to spend more time in hospital, than people without such conditions. Approximately 80% of GP consultations and 60% of hospital bed days are related to chronic diseases and their complications.

Health professionals have millions of contacts each year with patients and these are all potential opportunities to improve the health and wellbeing of their patients. *Making Every Contact Count* is about health professionals using their routine consultation to empower and support people to make healthier choices to achieve positive health outcomes. The *Making Every Contact Count* framework is an evidence informed document and supports the agenda of policy documents in Ireland for improving the health and wellbeing of the population. It is an innovative process of making the *Healthy Ireland* framework real in the health services. The development of this framework involved a review of the evidence of the effectiveness of lifestyle behaviour change

interventions in relation to individual approaches for behaviour change. The evidence concluded that behaviour change interventions are effective both for individual lifestyle behaviours and collectively for all behaviours.

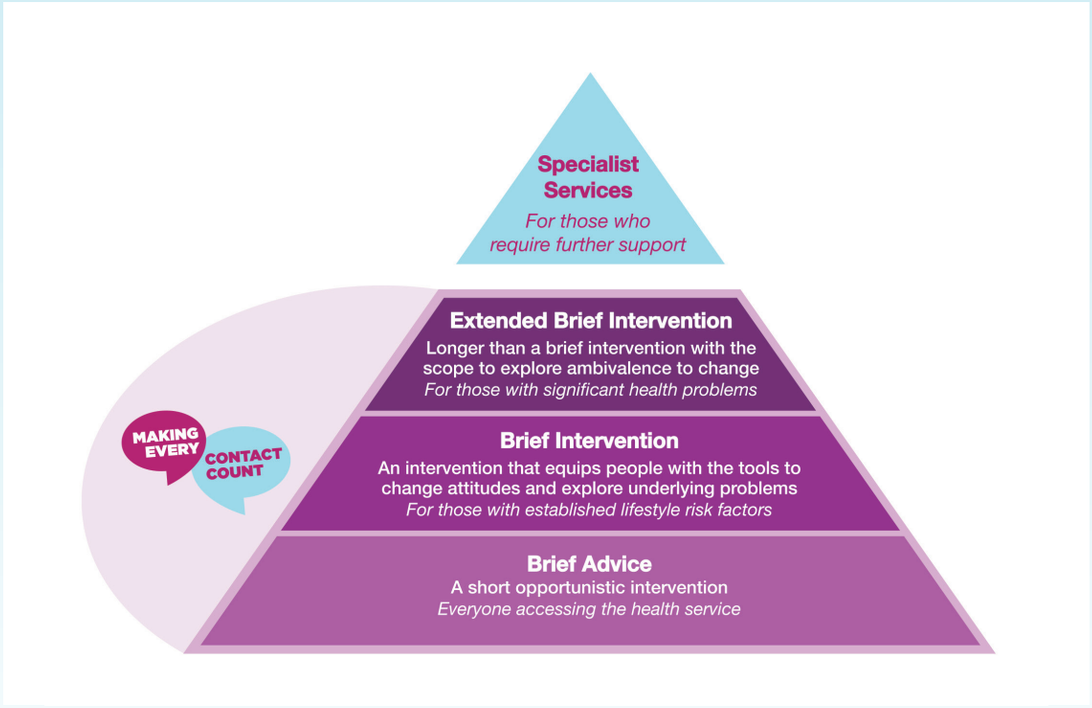
Within the health service a review of the number of staff trained in health behaviour change was carried out in 2015 and this showed that over 8,300 staff received health behaviour change training between the years 2010 – 2014. The majority of training took place in the area of brief interventions, with a total of 6,398 people trained.

Making Every Contact Count Vision and Model

The aim of *Making Every Contact Count* is chronic disease prevention. It is about enabling health professionals to recognise the role and opportunities that they have through their daily interactions with patients in supporting them to make health behaviour changes. The health behaviours which are the focus of attention at the outset are the four main lifestyle risk factors for chronic disease; tobacco use, physical inactivity, harmful alcohol consumption and unhealthy eating.

The model for *Making Every Contact Count* is presented as a pyramid with different levels. Each level represents an intervention of increasing intensity with the low intensity interventions at the bottom of the pyramid and the specialised services at the top. Implementing the *Making Every Contact Count* approach seeks to begin the process at the basic level of brief advice and brief intervention. In practice this will mean that all health professionals and healthcare assistants will be trained to a level that enables them to conduct a brief intervention with their patients when appropriate.

Model for *Making Every Contact Count* in the Irish Health Services



Adapted from NHS Yorkshire & Humber Prevention & Lifestyle Behaviour Change Competence Framework (2011)[1] and NICE (2014)[2]

Implementation of *Making Every Contact Count*

Making Every Contact Count needs to become part of everyday care in the health service and systems need to be in place to support this. The guiding principles for implementation outline the complexities involved for all those engaged with the health services in *Making Every Contact Count* a reality.

The comprehensive integration of *Making Every Contact Count* into the health service will involve actions at strategic and operational levels. These actions will be focused in four key areas: organisational level, external and internal partnerships, staff engagement and patients. Using these four areas as a backdrop the implementation plan outlines the key high level actions that need to happen for the successful implementation of *Making Every Contact Count* in our health services and these are presented under the following themes: leadership; partnership and cross-sector working; staff engagement, training and supports, and monitoring and evaluation.

References

1. NHS Yorkshire and the Humber (2011) Prevention and Lifestyle Behaviour Change A Competence Framework. National Health Service
2. NICE. Behaviour change: individual approaches. (2014) National Institute for Health and Clinical Excellence. Public Health Guidance no 49. Jan 2014.

Section 1

Context and Background

Introduction

The Health behaviour change framework sets out, how interventions to support lifestyle behaviour change need to be integrated into our health service. Health professionals are being asked to make each routine contact that they have with patients count in terms of chronic disease prevention. Therefore, the phrase *Making Every Contact Count* will be used when referring to the framework and implementation plan.

The adoption of this framework by health professionals will result in the people who access the health service on a daily basis being supported in their efforts to make health behaviour changes in order to reduce their risk of developing a chronic disease. It will require that all clinicians, frontline staff and leadership teams respond to their responsibility in implementing *Making Every Contact Count* for improved health outcomes for all.

Context and Background

Chronic diseases, comprising of cancer, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD) and diabetes, are the leading cause of mortality in the world, representing 60% of all deaths worldwide and 76% of deaths in Ireland[7]. At least 42% of cancers[8] can be prevented and healthy lifestyle behaviours can be a significant contributory factor in this. In addition, 80% of heart disease, stroke and type II diabetes can be prevented through a healthy diet, regular physical activity, reduction in alcohol consumption and avoidance of smoking and tobacco products[7].

Despite the fact that the immediate risk factors for the development of chronic diseases are known and most are modifiable, tackling them continues to be one of the major challenges both now and in the future.

Whilst we know that the development of chronic conditions is hugely influenced by our lifestyle behaviour, why we adopt lifestyle behaviours that are known to be unhealthy for us is complex and is best illustrated through the social determinants of health model (see Figure 1). This model describes the 'causes of the causes', detailing the range of factors that impact on health and wellbeing. These include social and family support networks, level of education, work, in addition to the wider factors such as socio-economic, cultural and environmental conditions. Tackling these determinants requires a whole of government approach as detailed in the *Healthy Ireland*[5] framework to identify solutions at multiple levels. Health professionals supporting people to adopt healthier lifestyles need to be cognisant of the wider social determinants that continue to influence the lifestyle behavioural choices of the patients that they meet during routine consultations.

Figure 1 The Social Determinants of Health

Source: Dalghren and Whitehead 1991[9]

Chronic conditions impact negatively on quality of life and affect the socially disadvantaged disproportionately, contributing to widening health gaps within society. They represent substantial financial costs not only to those affected by them and their families but also to the health and social care system, and result in a significant loss of productivity to the economy.

People with chronic diseases are more likely to attend their GP, to present at emergency departments, be admitted as inpatients and to spend more time in hospital, than people without such conditions. Approximately 80% of GP consultations and 60% of hospital bed days are related to chronic diseases and their complications[10]. The TILDA[1] study has shown that 38% of Irish people over 50 years have one chronic disease and 11% suffer from more than one. A study of general practice patients in Ireland with one or more chronic illnesses, found a significant increase in healthcare utilisation and cost among patients with multimorbidities[11].

People living with chronic conditions often find themselves on their own in managing their condition, with little or no support from family or friends, and very often feel isolated and lonely[12]. Poor social support is a risk factor that is associated with poorer self-management, increased mortality and morbidity for people with chronic conditions. In contrast, receiving social support decreases morbidity rates and increases life expectancy, self-efficacy, medication adherence and self-reported health status[13].

Current life expectancy rates for men are 79 years and 83.5 years for women. However, the number of healthy life years is considerably less, and it has been shown to be on average 71 years for men and 72.5 years for women[14]. This implies that approximately 8 years of life for men and 11 years of life for women will be impacted significantly by disability or poor health, largely due to chronic disease. Hence a renewed focus on prevention both in society and in clinical services is essential in addressing this issue.

In terms of the lifestyle behaviour risk factors for the development of chronic disease there is considerable scope for health improvement as the findings from the *Healthy Ireland* Survey 2016[15] show (Table 1). These figures give an indication of the extent of the problem, but the survey also reports that 92% of people would like to make a change to improve their health and wellbeing.

Health behaviour change is complex and health professionals are in a unique position to support people towards making changes that will have long term health gains for themselves and for society as a whole. There is some evidence to show that service users expect to be asked questions by their health professional about their lifestyle and if they are not asked they assume that there is not a problem[16].

Table 1 Current Health Behaviours of Irish Adults

Health Behaviour	Healthy Ireland Survey Findings
Smoking	**23%** of the population smoke **19%** smoke daily and **4%** smoke occasionally **59%** of smokers are trying to, planning to or thinking about quitting
Alcohol	**37%** of drinkers binge drink on a typical drinking occasion **29%** of those who do not categorise themselves as an occasional binge drinker consume six or more standard drinks at least once a month
Physical Activity	**65%** are aware that people should be active for at least 150 minutes each week **56%** think they undertake a sufficient level of physical activity
Diet and Nutrition	**27%** of the population eat the recommended amount of fruit and vegetables daily (at least 5 portions) **60%** consume snack foods or sugar-sweetened drinks daily
Clustering of Unhealthy Behaviours	**Four** types of unhealthy behaviours were included in this analysis. These were smoking, binge drinking, consuming less than five portions of fruit or vegetables daily and sedentary behaviour [i] **86%** in the population have at least one unhealthy behaviour, with **46%** having multiple (two or more) unhealthy behaviours **59%** of men have multiple unhealthy behaviours, compared to 34% of women

Source: Healthy Ireland Survey 2016[15]– Summary of Findings

i. Spending eight or more hours a day sitting

Rationale for a Health Behaviour Change Framework

There is approximately 100,000 staff employed in the HSE, which translates as millions of contacts annually by frontline staff with their patients (Table 2). In addition, it is estimated that there are 14 million[17] contacts each year with GP services. All of these contacts are potential opportunities to improve the health and wellbeing of the recipient and it is crucial that these are used in *Making Every Contact Count.*

Table 2 Average Health Service Contacts in a Year

4.59 million	People living in Ireland
3 million	Have a consultation with a clinical consultant
5 million	Public health nursing contacts
1.8 million	Have a medical card
1.43 million	People receive either inpatient or day case treatment
68,000	Babies born
20 million	Prescriptions filled
1.3 million	Dental visits
1.2 million	Patients seen in an Emergency Department

Source: Healthy Ireland in the Health Service – National Implementation Plan 2015 – 2017 [6].

Health advice and intervention opportunities have the potential to unlock significant behaviour change for patients. Having supportive conversations about change is one way to encourage people to make lifestyle behaviour changes. In a climate of limited resources, there is a need for systematic change towards disease prevention and health improvement and every health professional has a responsibility to support this approach. Hence making health behaviour change everyone's business in the health service is crucial to this systematic change and this framework provides a structure to do this.

Policy Context

The *Making Every Contact Count* Framework supports the agenda of key existing policies for the Irish health service including the current *HSE Corporate Plan* 2015-2017[18] and *Healthy Ireland 2013-2025*[5]. The *Healthy Ireland* agenda involves improving the health of the whole population through a wide range of policies, guidelines and interventions including a focus on addressing the social determinants of health and a focus on individual lifestyle behaviour change interventions.

The strategic priorities of *Healthy Ireland in the Health Services National Implementation Plan 2015 – 2017*[6] *are:*

1. Health Service Reform
2. Reducing the Burden of Chronic Disease
3. Improving Staff Health and Wellbeing

This framework is an evidence informed and innovative process of making the Healthy Ireland Framework real in the health services through supporting the reduction of the burden of chronic disease.

Gaining support from health professionals for health behaviour change through this framework will fulfil a key recommendation of the forthcoming National Self-Management Support Framework [ii] for chronic disease. It also crosses the implementation of the National Policy Priority Programmes of the health service which include: healthy eating and active living, healthy childhood, tobacco free Ireland, alcohol, positive ageing, wellbeing and mental health, all of which are focused on reducing the incidence of chronic diseases.

Key actions in relation to behaviour change are identified in a number of the key policies which have been developed. These key actions are outlined below:

The *National Physical Activity Plan for Ireland*[19] *(2016)* highlights how physical activity is a key part, not only in the prevention of chronic diseases, but also in the treatment plans of those with certain chronic diseases, particularly in the early stages. The need for staff in the health service to develop the skills to support patients to make health behaviour changes is also emphasised.

The *Tobacco Free Ireland Action Plan*[20] *(2015)* recommends that all frontline healthcare workers are trained to deliver interventions for behaviour change in relation to tobacco use as part of their routine work.

The *National Drugs Strategy (Interim)*[21] *2009 -2016* recommends the implementation of screening programmes and brief interventions against the hazardous and harmful use of alcohol.

The *National Maternity Strategy*[22] *(2016 – 2026)* advocates for a focus on health and wellbeing to ensure that babies get the best start in life and that mothers and families are supported and empowered to improve their own health.

ii. A National Self- Management Support Framework for Chronic Conditions: COPD, Asthma, Diabetes and Cardiovascular disease is currently being developed by the HSE, Health and Wellbeing Division

The Integrated Care Programmes will ensure that ***Making Every Contact Count*** is incorporated within their clinical design.

A *Healthy Weight for Ireland Policy and Action Plan 2015 – 2025*[23] recommends that all health care staff are trained to deliver a brief intervention to promote physical activity and a healthy diet.

Policy in development in the area of mental health will include key actions in the area of health behaviour change.

The *National Standards for Safer Better Healthcare*[24] (HIQA) sets out the key principles of quality and safety that need to be applied to all healthcare settings. Whilst a number of these standards refer to the broad elements of health and wellbeing for patients, Standards 1.9 and 4.1 set out specific criteria which healthcare facilities need to reach in order to support patients to maintain and improve their health. In addition, the standards include the development and support of an environment and culture that promotes better health and wellbeing for both patients and staff, all of which supports the *Making Every Contact Count* agenda.

The development of the *Integrated Care Programmes (Clinical Strategy & Programmes Division)* is a major element of reform to the health and social care system in Ireland. The purpose of the HSE's newly established *Integrated Care Programme for Prevention and Management of Chronic Disease (ICPCD)* is to develop a series of integrated solutions for individuals with chronic disease, to ensure that people can be cared for at the lowest level of appropriate complexity. The five Integrated Care Programmes are; Chronic Disease, Older Persons, Patient Flow, Children and Maternity. Integrated care is a full spectrum of services that are seamlessly joined up for the patient including the integrated care programmes mentioned above and the National Cancer Control Programme.

An essential element in an integrated pathway of care will be helping people reduce and manage their risk factors for chronic disease and prevent chronic disease occurring or deteriorating. *Making Every Contact Count* will enable all health professionals to support patients to do this. The Integrated Care Programmes will ensure that *Making Every Contact Count* is incorporated within their clinical design.

Evidence to support the Health Behaviour Change Framework

There are a series of evidence informed policy documents, both in Ireland and internationally, that advocate for a focus on health behaviour change approaches. In developing this framework a review of the evidence of effectiveness for lifestyle behaviour change interventions was conducted, including the extensive review by NICE in the UK in relation to individual approaches for behaviour change. This review resulted in the development of a summary evidence statement to support the framework. A comprehensive summary of evidence is contained in Appendix 1.

There are four main categories of intervention to support people to change their behaviours. They range from single interventions delivered as the opportunity arises to planned, high-intensity interventions that may take place over a number of sessions. The terms used to describe these interventions are brief advice, brief intervention, extended brief intervention and motivational interviewing. It is important to note that in the literature there is no one clear definition of what constitutes brief advice, brief intervention and extended brief intervention. This creates a challenge in the interpretation and practical application of these interventions. For that reason what constitutes an intervention for brief advice, brief intervention and extended brief intervention has been clearly defined in this framework.

The summary evidence concludes that behaviour change interventions are effective both for individual lifestyle behaviours and collectively for all behaviours (including brief advice, brief interventions, extended brief interventions and motivational interviewing).

While the evidence doesn't clearly indicate which behaviour change intervention is most effective for which topic, there is a collective body of evidence to show that there is benefit from implementing behavioural change interventions in clinical practice.

Current Health Behaviour Change Approaches in the Health Service

Currently, within the health service the main focus of supporting staff to raise the issue of lifestyle behaviour change has been through the delivery of health behaviour change training, with little emphasis on systematic change to support trained staff to use these skills.

A review in 2015 among health service staff found that a total of 8,371 health professionals received health behaviour change training [iii] between the years 2010 – 2014[25]. A total of 6,398 people trained in brief interventions and a further 910 staff trained in motivational interviewing. The implementation of the national brief intervention training programmes for smoking cessation and alcohol has resulted in larger numbers of staff trained in these areas.

The review also looked at health behaviour change training at undergraduate level and found that since 2013, training in the area of brief intervention for smoking cessation has taken place. This training has been delivered to students in the following disciplines: nursing, midwifery, dentistry, and health promotion and public health. The numbers trained have increased year on year, with 105 students trained in 2013, 165 trained in 2014 and 235 trained in 2015.

The review concluded that there is a need for an agreed common definition in Ireland for specific health behaviour change terms. The development of structured national training programmes with strong governance and leadership is crucial to the advancement of health behaviour change training. Considering the numbers of staff employed in the health sector, the overall numbers of staff trained to deliver behaviour change interventions in the five year period have been modest.

Considerable competency exists among certain staff groups, e.g. Health Promotion Officers, to deliver brief intervention training particularly in the areas of alcohol, substance misuse and tobacco and will continue to be a valuable resource within the health service to train future cohorts of staff.

The training of staff to deliver interventions is just one aspect of supporting systematic health behaviour change. Whether the training results in the implementation of behaviour change interventions it is difficult to say as follow up has been relatively low. This highlights the lack of information available on the challenges that staff experience in implementing health behaviour change interventions. In addition, it highlights the inadequacy of the supports available within the health service to support staff to carry out interventions.

These issues have informed the development of the framework implementation plan, by highlighting the need for systematic support to embed health behaviour change into routine clinical practices.

iii. Health behaviour change training in this context was defined as training that is aimed at reducing any of the main lifestyle risk factors for chronic disease, i.e. smoking, alcohol, nutrition or physical activity, using any of the following health behaviour change methods: brief advice; very brief interventions; brief interventions; extended brief interventions; motivational interviewing or other methods of health behaviour change, such as cognitive behaviour therapy, solution focused therapy.

Section 2

Making Every Contact Count – Vision and Model

Making Every Contact Count – Vision

The vision for *Making Every Contact Count* is that health behaviour change interventions will become part of routine clinical care delivered by health professionals in the health service.

The core aim of *Making Every Contact Count* is chronic disease prevention. The four main lifestyle risk factors for chronic disease; tobacco use, harmful alcohol consumption, physical inactivity and unhealthy eating, are the health behaviours which will be the focus at the outset.

Making Every Contact Count is about health professionals using their routine consultations to:

- Empower and support people to make healthier choices to achieve positive health outcomes
- Recognise the role and opportunities they have through their daily interactions with patients to support them to make and sustain health behaviour changes
- Give support in a way that is empowering and respectful of the person's circumstances
- Have short focused conversations with people about their lifestyle risk factors, highlighting the healthier choice and supporting them to make this choice in order to improve their health

To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. Doing so will improve the health and wellbeing of patients, staff and the general public, and contribute to reducing health inequalities. While training and upskilling of health professionals is an essential step in *Making Every Contact Count*, ultimately it is about changing the way in which health professionals interact with patients. *Making Every Contact Count* cannot be seen as a separate public health issue but a role that all health professionals have a responsibility and a requirement to adopt. This approach will allow us to move to a position where discussion of lifestyle behaviour is routine, non-judgmental and central to everyone's role, and by doing so support better clinical outcomes.

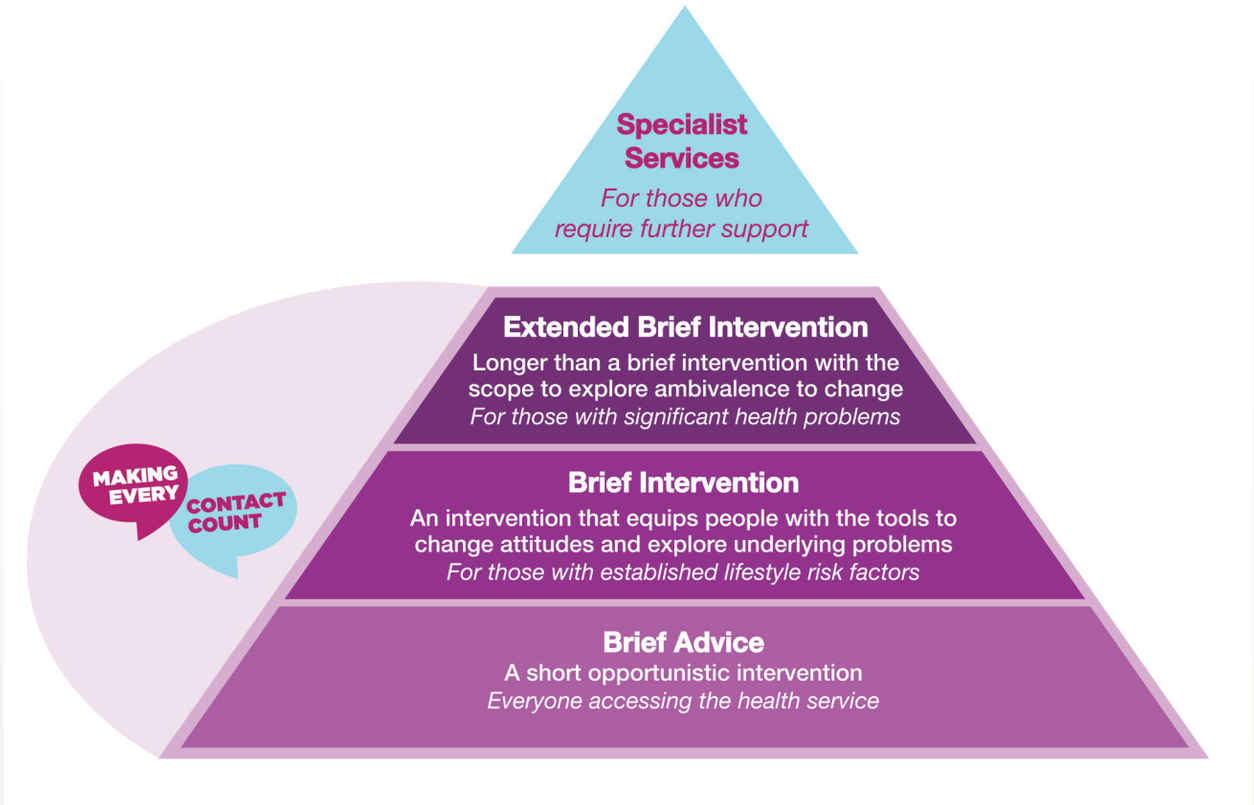
When *Making Every Contact Count* is implemented

- It will result in all patients who engage with services, both in hospital and in primary care, being routinely asked about the main lifestyle risk factors for chronic diseases
- Lifestyle risk factors be recorded on patient data systems along with the intervention carried out by the health professional
- Staff will be supported to routinely carry out these interventions where appropriate, with their patients through appropriate training, information on local supports in the community and clear referral pathways to specialist services
- All of this will take place in a culture within the health service which values disease prevention and health improvement, along with treatment services

Making Every Contact Count - Model

The model for *Making Every Contact Count* is presented as a pyramid with different levels (Figure 2). Each level represents an intervention of increasing intensity, with the low intensity interventions at the bottom of the pyramid and the specialised services at the top.

Figure 2 Model for *Making Every Contact Count* in the Irish Health Services



Adapted from NHS Yorkshire & Humber Prevention & Lifestyle Behaviour Change Competence Framework (2011) and NICE (2014)[26,27]

This approach will allow us to move to a position where **discussion of lifestyle behaviour is routine** and central to everyone's role.

A detailed description for each level of the interventions is provided in Table 3 but a summary is outlined below.

Implementing the *Making Every Contact Count* approach seeks to begin the process at the basic levels of **brief advice** and **brief intervention**. In practice this will mean that all health professionals and healthcare assistants will to be trained to a level that enables them to conduct a brief intervention with their patients.

It is envisaged that **extended brief intervention** will be conducted by health professionals with greater capacity to carry out this more lengthy intervention, because of their specialist role or due to the specific service that they work in. This intervention should be delivered to patients requiring more intensive support in their behaviour change efforts and/or who may be self-managing an existing chronic disease.

The **specialist services** are delivered by practitioners who use specialised or advanced approaches to support patients to change behaviour. These services include smoking cessation and dietetic services, along with services delivered by staff with in-depth counselling skills in the wider arena of supporting people to change.

These services are part of existing clinical pathways for patients and while not the main focus of *Making Every Contact Count* they are an integral part of a comprehensive model for behaviour change, hence their inclusion in the model. In the implementation of this framework health professionals working in these services are being asked to make every contact count in terms of lifestyle behaviour change. In the future the *Making Every Contact Count* model will be an integral part of the clinical pathway for patients.

Table 3 Model for *Making Every Contact Count* in the Irish Health Services

	Brief Advice (BA)	Brief Intervention (BI)	Extended Brief Intervention (EBI)	Specialist Services
What is it	A short opportunistic intervention that directs people where to go for further help	An intervention that aims to equip people with tools to change attitudes and explore underlying problems[28] It involves discussion, negotiation and encouragement with or without follow-up[27].	An extended brief intervention is similar in content to a brief intervention but usually lasts longer and consists of an individually focused discussion and follow-up[27]	A high intensity intervention delivered by specifically trained health professionals to support a patient through a behaviour change
Aim of the intervention	To raise awareness of the impact of lifestyle behaviour on the individual and to refer / signpost the person to further supports.	To raise awareness of the risks associated with the behaviour, to equip people with the skills to change and signpost to further supports.	To raise awareness of the risks associated with the behaviour and to equip people with the skills to change. To explore ambivalence about changing.	To provide intensive support to a patient in relation to a specific health behaviour.

Key Components	- **Ask** about behaviour
	- **Advise** on the need for behaviour change
	- **Act to** refer or signpost people to additional support (3As)
		A client centred discussion using motivational interviewing techniques to:
		- **Ask** about the behaviour
		- **Advise** on the need for behaviour change
		- **Assess** readiness to change
		- **Assist** with
		  - exploration of the barriers and benefits of behaviour change
		  - identifying options for change
		  - goal setting
		- **Arrange** referral to more intensive support if appropriate (5As)
			A client centred discussion using more intensive motivational interviewing techniques to:
			• Explore ambivalence regarding behaviour change with the person.
			• Work with the person to resolve this ambivalence
			• Identify options for change and sets goals.
			This exploration usually results in an intervention that is of longer duration than a brief intervention.
				Components will be determined by the intervention being offered such as:
				Motivational Interviewing; Solution Focused Therapy (SFT); Cognitive Behaviour Therapy (CBT)
				Counselling
				The opportunity to conduct a BI/ EBI for health behaviours other than their area of expertise may be appropriate as part of this intervention.

	Brief Advice (BA)	Brief Intervention (BI)	Extended Brief Intervention (EBI)	Specialist Services
Who gets the intervention	Everyone accessing the health service	People with established lifestyle risk factors for chronic disease	People who: • are involved in risky behaviour • have been assessed and identified as increased risk of harm • have multiple health problems • engaging in a self- management programme have successfully made changes to their behaviour but need more support to maintain change • have found it difficult to change or have not benefited from brief advice or brief intervention	People will be referred to this specialist support for lifestyle behaviour change who have: • not benefited from lower intensity interventions • been assessed as being at high risk of causing harm to their health and wellbeing • a serious medical condition that needs specialist advice and monitoring
Examples of who could conduct the intervention	All health professionals and healthcare support staff with regular and extended patient contact such as healthcare assistants	Health professionals who have opportunities to see patients on a regular basis. Examples include though not exclusively: - Hospital doctors and consultants - GPs, practice nurses, - All hospital and community nurses and midwives - Allied health professionals such as physiotherapists; occupational therapists and dietitians. - Pharmacists - Dentists	Health professionals who have the opportunity to see a patient on a regular basis and have greater capacity to carry out this more intensive intervention such as - Practice nurses - Clinical nurse specialists and allied health professionals who deliver chronic disease self-management support programmes such as Cardiac / Pulmonary Rehab and Diabetes Programmes. - Smoking cessation advisors	Health Professionals who have intensive / specialist training and /or have a recognised Qualification in the relevant areas such as CBT, SFT and Counselling for examplex: - Smoking cessation practitioners - Dietitians - Addiction counsellors - Psychologists - Counsellors - Mental health professionals trained in CBT

**Please note that the examples of staff or patients given are not exclusive to those named here. In the implementation of this framework service managers will need to identify those who are best placed to conduct and receive the relevant level of intervention*

Section 3

Principles for Implementation

Making Every Contact Count - Guiding Principles

Making Every Contact Count needs to be part of everyday care in the health service. There are five guiding principles (Table 4) which outline the key areas for development required for successful implementation. The HSE Corporate Plan[18] (2015 – 2017) goals provide a fitting backdrop to the guiding principles of the *Making Every Contact Count* framework to embed it in the health service. These guiding principles outline the complexities involved for all those engaged with the health services in *Making Every Contact Count* a reality.

Table 4 *Making Every Contact Count* - Guiding Principles

HSE Corporate Plan Goals	*Making Every Contact Count* Guiding Principles
Promote health and wellbeing as part of everything we do so that people will be healthier	**Principle 1** Promote *Making Every Contact Count* as part of everything we do
Foster a culture that is honest, compassionate, transparent and accountable	**Principle 2** Foster a compassionate person-centred culture for *Making Every Contact Count*
Provide fair, equitable and timely access to quality, safe health services that people need	**Principle 3** Service-user empowerment and access to *Making Every Contact Count*
Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them	**Principle 4** Staff engagement through investment in learning, skills development and partnerships
Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money.	**Principle 5** Innovation and evaluation in our services for *Making Every Contact Count*

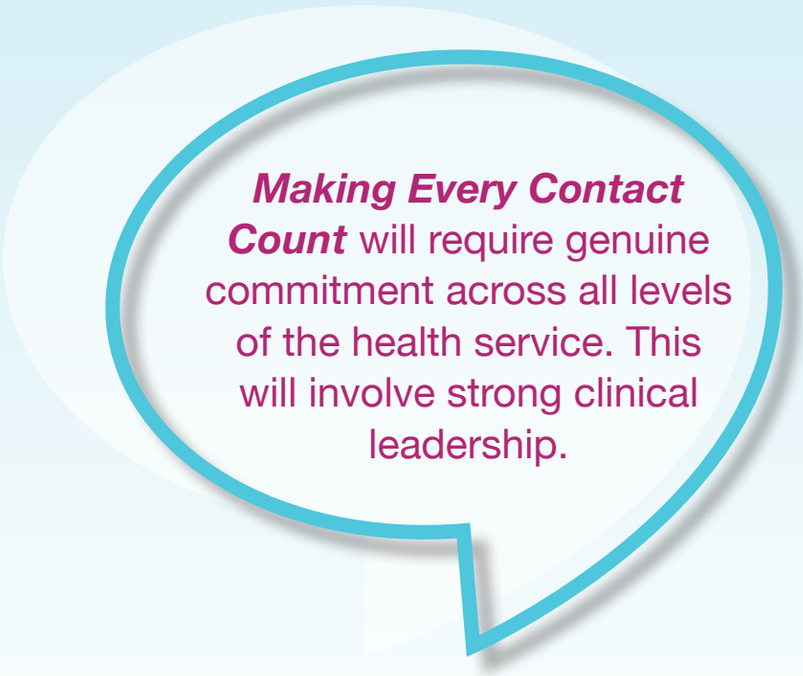
Principle 1

Promote *Making Every Contact Count* as part of everything we do

Promoting *Making Every Contact Count* as part of everything we do implies that patients will be advised and facilitated to make healthy lifestyle choices in all consultations. This will be one way in which the health service can make a positive impact on the health and wellbeing of the large percentage of the population who access its services on a daily basis.

Reducing the risk and impact of chronic diseases is the main focus of *Making Every Contact Count*. The focus will initially be on the four main lifestyle risk factors: unhealthy eating (including weight management), physical inactivity, tobacco use and reducing harmful alcohol consumption. *Making Every Contact Count* will be incorporated into the *Integrated Care Programme for the Prevention and Management of Chronic Disease* and the *Self-Management Support Framework*. Supporting and encouraging staff to look after their own health is also a key aspect of promoting *Making Every Contact Count* within the health service.

Making Every Contact Count will require genuine commitment across all levels of the health service. This will involve strong clinical leadership and ongoing commitment from all frontline staff to support the system wide integration of *Making Every Contact Count*. This leadership will provide clear direction, guidance and support to the key stakeholders during the implementation phase. To embed *Making Every Contact Count* as part of everything we do in the long term, a number of systems and processes are required. The ongoing structural reform within the health service has created an infrastructure to integrate health and wellbeing throughout the Community Health Organisations (CHOs) and Hospital Groups and this will be a key driver for the implementation of *Making Every Contact Count.* Existing ICT infrastructure for patient information systems will be modified to support staff to record outcomes from consultations for *Making Every Contact Count* with patients. This recording will be essential to monitor and review progress on the implementation of *Making Every Contact Count*.



Principle 2

Foster a compassionate, person-centred culture for *Making Every Contact Count*

Changing behaviour is complex; living with a chronic disease can have immense impact on a person's social and emotional health as well as the obvious physical impact. Therefore, fostering a culture that is compassionate and person centred when talking to people about lifestyle behaviour change is particularly important in the implementation of *Making Every Contact Count*.

Engaging with people in this way allows for improved communication and the development of open and respectful professional relationships. It enables honest conversation to take place between the health professional and the patient about their lifestyle behaviour in a way that is supportive and empowering for the person, and respectful of their circumstances. It also allows the patient to hear the health messages and can motivate them to take small steps towards actions that will impact positively on their overall health.

Principle 3

Service-user empowerment and access to *Making Every Contact Count*

It is widely acknowledged that there is a pronounced socio-economic gradient in the incidence of all chronic diseases. People in lower socio-economic groups are more likely to smoke, drink at harmful levels, be overweight or obese, and take less exercise[6]. It is also widely acknowledged that addressing the *'causes of the causes'* of chronic disease will see greater improvement than just focusing on the individual in isolation. In other words, the system and structures to support people to be healthy need to be in place.

This framework is part of creating a system that supports people to make changes to improve their health. It is for all users of the health service and advocates that everyone working in the health service will make their interactions with patients count. Having this integrated approach will ensure that each person, regardless of what service they access in any part of the country, will be offered the opportunity by their health professional to make a health behaviour change in order to maintain or improve their health.

Health literacy will need to be considered, to ensure that health messages and materials are provided in a way that is appropriate, acceptable and clearly understood by the person. Health literacy is also about the person's capacity to be an active participant in decision making. Health professionals will use the "*Teach Back"* method with patients to ensure that their communication is effective. This will influence the person's ability to make informed decisions and feel empowered to make healthier lifestyle choices in their everyday lives. Specific self-management support programmes have an important role to play in developing the health literacy of patients and will be supported by the implementation of *Making Every Contact Count.*

Referral pathways to specialist services should be equitable, appropriate and easily accessible. Signposting to local supports in the community and accurate health information will be a key aspect of patient empowerment for *Making Every Contact Count*.

Fostering a **culture that is compassionate and person centred** when talking to people about lifestyle behaviour change is particularly important.

Principle 4

Staff engagement through investment in learning, skills development and partnerships

For *Making Every Contact Count* to be integrated into the health care system, genuine staff engagement will be required from the outset. Clinical leadership in adopting the practice of carrying out routine lifestyle behaviour interventions with patients will also be required. It is about allowing them to see and take the opportunities which they already have in routine care to discuss lifestyle behaviour change with their patients and is not about adding another job to staff that are already stretched.

Staff will be supported in their own efforts for lifestyle behaviour change by providing access to staff health programmes and signposting towards local supports in the community. This in turn will help to build staff capacity regarding the challenges of behaviour change and develop their confidence in conducting interventions with patients. It will also support staff to engage with the *Making Every Contact Count* agenda.

Exploring health behaviour change with people will, for some staff, be new but for others it is something that they are already doing. Implementation of this framework will support the integration of this into routine practices and job descriptions. Raising awareness among staff about the existence and content of the framework, and exploring with them their role in relation to its implementation, is central to engaging staff. Different approaches will be used to engage staff and these could include workshops, briefings, webinars, and linking into existing events and mechanisms. Identifying local champions for *Making Every Contact Count* through the *Healthy Ireland* implementation groups and leads will provide a means of engaging with staff at a local service level.

For the integration and sustainability of *Making Every Contact Count* the training needs of four groupings of health care professionals will be considered. These are staff currently working in the health system, new staff commencing employment, undergraduate health professionals and key staff not employed by the HSE such as GPs, practice nurses and pharmacists.

Developing the capacity of large numbers of health professionals currently working in the health system to support people around behaviour change is crucial to create a critical mass of trained staff to implement *Making Every Contact Count*. To create this capacity, training in health behaviour change skills will be provided through innovative online and blended learning methods. The training programme will be developed in line with a set of standards and competencies, and will be accredited by the relevant healthcare professional associations. Staff trained will be provided with ongoing support through the development of additional resources such as toolkits, health information hubs, signposting and clear referral pathways.

The sustainability of training for *Making Every Contact Count* will be achieved through the following ways:

- Including training in continuous professional development for health professionals
- In time, including it as mandatory training for specific staff groups
- Ongoing skills development for staff trained in *Making Every Contact Count*
- Developing a *Trainers'* programme for certain cohorts of staff to develop a cascading training model throughout Hospital Groups and CHOs

In collaboration with Higher Educational Institutions, the development of a standardised undergraduate curriculum for health professionals in the area of chronic disease prevention, including behaviour change and self-management support, is a key action to support the long term sustainability of *Making Every Contact Count.* This will be achieved for undergraduate programmes through a collaboration formed between the Health Service Executive and representatives from each Higher Education Institute. This collaboration will develop a standard curriculum so that chronic disease prevention is core to all undergraduate health professional training. The HSE will also work in partnership with postgraduate training bodies to develop postgraduate training in health behaviour change.

Working in partnership will be crucial to the successful implementation of this framework. There are a number of external collaborators to engage with such as GP's, Higher Educational Institutions, Professional Associations and Training Commissioners. It is important that these partners understand and appreciate what this framework is trying to do, see their role in it and value its long term benefits.

Identifying local champions for ***Making Every Contact Count*** will provide a means of engaging with staff at a local service level.

Principle 5

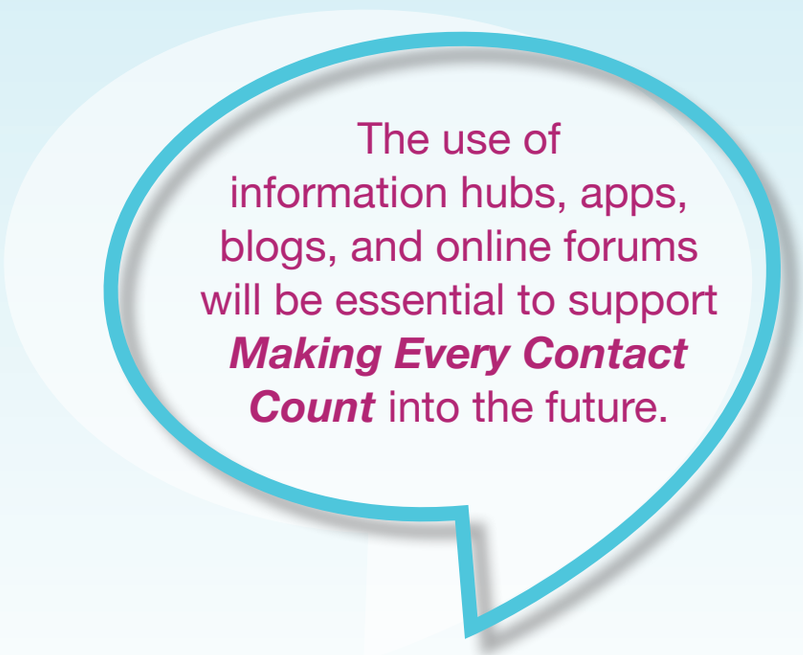
Innovation and evaluation in our services for *Making Every Contact Count*

Innovation in our services means using all the resources we have in the health service in the most efficient and effective way. The development and implementation of *Making Every Contact Count* in itself is using our services in an innovative way to support the prevention of chronic disease.

Development and changes in technology and the way that we communicate have made vast differences to everyone's lives. The health service will use these improvements in digital resources to communicate more effectively with staff, patients and the public, to implement *Making Every Contact Count* into all services. This will include the use of digital technology to develop tools to support staff in implementing *Making Every Contact Count* and to support patients in their efforts in making a behaviour change. The use of digital advances including information hubs, apps, blogs, online forums and other relevant forms of social networking will be essential to support *Making Every Contact Count* into the future in line with National eHealth Strategy[29]. The planned investment in ICT infrastructure in the HSE will be essential to supporting the increased traffic towards online systems and improve accessibility for staff to training and resources for *Making Every Contact Count*.

A key measurement tool consisting of a minimum dataset to record lifestyle risk factors and behaviour change interventions will be developed for inclusion in national ICT patient data systems and will support the integration of *Making Every Contact Count* into clinical practice. These measurement tools will allow the tracking of the application of *Making Every Contact Count* across the Divisions, CHOs and Hospital Groups.

Ongoing evaluation will identify barriers and challenges to implementation, and will assess emerging staff needs and patient support needs. In response to these identified needs, new and innovative tools and resources to support implementation and improve the effectiveness of interventions will be developed and implemented.



Section 4

Implementation Plan

Consultation to inform Implementation plan

In October and November 2015 a national consultation[30] took place with health service staff and other key stakeholders to:

- Raise awareness about the development of a health behaviour change framework
- Ascertain commitment
- Identify obstacles and propose solutions
- Design the training and governance arrangements that create the necessary conditions for success

This consultation also set out to inform the development of the implementation plan for this framework and determine the level of support and organisational readiness that exists for this approach.

The methodologies used in consulting included:

- One to one interviews with key national leaders within the HSE
- 10 focus groups in four geographical locations aimed at practitioners and managers in which 150 people attended
- Those who were invited to attend the focus groups but were unable to do so were invited to complete an online survey
- Written submissions were also invited from key voluntary agencies and professional bodies including, but not exclusively, the Asthma Society of Ireland, CROI, Diabetes Ireland, Irish Heart Foundation, Royal College of Surgeons, in Ireland and the Association of Occupational Therapists of Ireland

Based on the findings from the consultation a number of recommendations were made relating to four main themes. These have been used to inform the development of the implementation plan for this framework.

Implementation Overview

The comprehensive integration of *Making Every Contact Count* into the health service will be multi-dimensional involving actions at strategic and operational levels. These actions will be focused in four key areas: - **organisational level, external and internal partnerships, staff and patients.**

The actions at an **organisational level** are concerned with leadership and having systems in place to track and monitor the progress of implementation. Strong clinical and professional leadership and commitment will be a key requirement for implementation. This will be demonstrated by Hospital Groups and CHOs embedding *Making Every Contact Count* into their *Healthy Ireland* plans. Along with this, the organisational structures and systems need to be in place to monitor and track the implementation. Monitoring of the implementation of *Making Every Contact Count* will be facilitated through key actions and KPIs in operational plans for each CHO and Hospital Group. The monitoring of the progress will be facilitated through the collection of data in Primary Care, CHO and Hospital Group patient recording systems. This information will record both the assessment of lifestyle risk factors and the behaviour change interventions conducted by staff in their interactions with patients.

The strengthening of existing **partnerships** and the development of new ones will be an essential component of implementation. This will involve collaboration with the Higher Educational Institutions, professional associations, training bodies and health professionals employed external to the HSE. For *Making Every Contact Count* to be implemented in a seamless way, cross-divisional work and the strengthening of internal partnerships within the HSE will also be crucial.

Engagement with **staff** regarding the concept of *Making Every Contact Count* is crucial to the successful implementation along with the provision of appropriate training, referral pathways and additional supports in the area of health behaviour change.

The ultimate goal of *Making Every Contact Count* is to improve the health of each **patient** accessing the health service on a daily basis. Successful implementation will result in patients, expecting their health professional to ask them about their lifestyle behaviour and feeling genuinely supported by him/her to make changes that will improve their health.

Using these four areas as a backdrop the implementation plan outlines the key high level actions that need to happen for the successful implementation of *Making Every Contact Count* in our health services. The actions are presented under the following themes:

- Leadership
- Partnership and cross-sector working
- Staff engagement, training and supports
- Monitoring and evaluation

The Governance arrangements and Terms of Reference to oversee the implementation of these actions are described in Appendix 2.

Making Every Contact Count Implementation Plan 2017-2020

No	Actions	Lead	Partners	Start Date	Completion date
	Leadership				
1	Set up National *Making Every Contact Count* Implementation Group to oversee the implementation of *Making Every Contact Count.*	AND HP&I	PPP Leads; MECC Team; HI Lead; H&WCPT	2017	Q2 2017
2	Hospital Groups, CHOs and Priority Policy Programmes will embed actions in their Implementation Plans that support the delivery of *Making Every Contact Count.*	Healthy Ireland Lead; HI Leads in Hospital Groups & Heads of Health & Wellbeing in CHOs, Priority Policy Programme Leads	MECC Team	2017	Q4 2017
3	Develop and implement a *Making Every Contact Count* communication plan including the development of branding, print, online and social media resources.	MECC Team	Communications Division	2017	2020
4	*Making Every Contact Count* included as part of all job descriptions for Health Professionals and Healthcare Assistants.	Human Resources	MECC Team, HI Leads in Hospital Groups & Head of Health & Wellbeing in CHOs	2018	2020
	Staff Engagement, Training and Support				
5	Collaboration with Higher Education Institutions in Ireland to develop and support implementation of a standard undergraduate curriculum for Chronic disease prevention including health behaviour change.	NCAGL	HEI's, MECC PM, SMS Lead,	2016	2017
6	Collaboration with Higher Education Institutions and Post graduate Colleges to develop and support implementation of a standard and post graduate curriculum for Chronic disease prevention including health behaviour change.	NCAGL	HEI's, MECC PM, SMS Lead, PPPL's Royal Colleges, ICGP	2017	2019
7	Promote and secure agreement for the inclusion of *Making Every Contact Count* training in CPD and mandatory training schedules for Health Professional training bodies.	MECC Team	RCSI, RCPI, CORU, PNA, ICGP, NMBI, Medical Council	2018	2020

No	Actions	Lead	Partners	Start Date	Completion date
8	Engage with representatives from external service providers such as GPs, Practice nurses and Pharmacists to support training of their staff and to ensure commitment for the implementation of *Making Every Contact Count.*	MECC Team	NMPDU's; PPPL's , ICGP, IPA, Practice Nurses Association, BIU	2017	2020
9	Complete feasibility study in the GP setting and identify learning to inform implementation of *Making Every Contact Count* in this setting.	NCAGL	MECC Team, H&W,ICGP, Identified GP Practices	2017	2019
10	Support the Implementation of *Making Every Contact Count* as part of the National Framework for Self-Management Support for chronic disease (COPD, Asthma, Diabetes & CVD).	SMS Team	MECC Implementation Group, SMS Advisory Group	2018	2020
11	Include *Making Every Contact Count* as an essential element in the Integrated Care Programme for the Prevention and Management of Chronic Disease.	Integrated Care Programme Team	SMS Team MECC Team	2017	2020
12	Develop a process for training and monitoring the implementation of *Making Every Contact Count* in external agencies funded by the HSE.	MECC Team	HP&I, HI Oversight Group, Procurement, HSE Divisions, External Agencies	2018	2019
13	Healthcare professionals to have an awareness of, access to, and attend appropriate training for *Making Every Contact Count.*	CHOs Hospital Groups, MECC Team	HEI, HP&I, Professional Organisations, Healthcare Professionals	2017	2020
14	All Healthcare Professionals are required to engage in discussion with patients on lifestyle risk factors and if appropriate to carry out behaviour change interventions.	All Health Care Professionals	Professional Organisations, CHOs and Hospital groups	2017	2020
15	Commission the design and development of an online and blended learning training programme for *Making Every Contact Count* to ensure that staff have the required knowledge, skills and attitudes carry out behaviour change interventions.	MECC Team	PPPL's, Procurement, External Provider	Q1 2017	Q4 2017
16	Develop and implement a 5 year training plan, with prioritisation of across disciplines for the implementation of Brief Intervention Training across all CHOs and Hospital Groups.	MECC Team	MECC Implementation Group, PPP Leads	Q2 2017	2020

No	Actions	Lead	Partners	Start Date	Completion date
17	Promote and support behaviour change efforts of staff through the HSE staff health and wellbeing programme.	HR, Staff H&WB Programme	HI Leads in Hospital Groups & CHO Health & Wellbeing Leads, HP&I	2017	2020
18	Procure the scope and design of a lifestyle hub for signposting and supports for health behaviour change in conjunction with SMS; NERF; Health Behaviour Patient Management System PMS and Priority Policy Programmes.	HP&I	PPP leads SMS team MECC Team, National Communications	2017	2018
	Monitoring and Evaluation				
19	Develop and implement a minimum dataset to record lifestyle risk factors and interventions on existing and on any future national IT systems in Hospitals CHOs and General Practice systems which includes developing a data dictionary, testing minimum dataset.	NCAGL, CIO	ICT; HSE Divisions ICGP; MECC Team;	2017	2020
20	Include the delivery of *Making Every Contact Count* into contractual relationships with GPs and other external providers.	HSE Divisions	HSE Contractors	2017	2020
21	Develop a monitoring and accountability framework for *Making Every Contact Count* including Key Performance Indicators.	MECC Implementation Group	PPP's, Planning and Performance Unit, MECC Team	2018	2019
22	Build the delivery of *Making Every Contact Count* into Activity Based Funding for all services and External contractors.	Healthcare Pricing Office	MECC Team	2018	2020
23	Commission an action research project to assess the overall implementation of *Making Every Contact Count* in the Irish context to develop an evidence base to inform future practice, and implement its findings within the system.	MECC Team	HRB, MECC Implementation Group, Funding and research partners	2019	2020

References

1. Barrett A, Burke H, Cronin H, Hickey A, Kamiya Y, Kenny RA, Layte R, Maty S, McGee H, Morgan K, Mosca I, Normand C, O'Regan C, O' Sullivan V, Savva G, Sofroniou N, Timonen V, Whelan B. Fifty plus in Ireland 2011: The Irish Longitudinal Study on Ageing (TILDA). Dublin: Trinity College Dublin, 2011.
2. Balanda, K. P., Barron, S., Fahy, L. (2010). Making Chronic Conditions Count: Hypertension, Coronary Heart Disease, Stroke, Diabetes. A systematic approach to estimating and forecasting population prevalence on the island of Ireland. Dublin: Institute of Public Health in Ireland, 2010.
3. Institute of Public Health Ireland (2010). Making Chronic Conditions Count. 5. Chronic Airflow Obstruction. A systematic approach to estimating and forecasting population prevalence on the island of Ireland. Dublin: Institute of Public Health in Ireland, 2010.
4. National Cancer Control Programme (2014). Report on the Implementation of "A Strategy for Cancer Control in Ireland 2006". NCCP-REP-003 Rev 2., National Cancer Control Programme, Dublin, Ireland.
5. Department of Health (2013) Healthy Ireland: A Framework for Improving Health and Wellbeing 2013 – 2025. Dublin: Department of Health 2013.
6. Health Service Executive (2015) Healthy Ireland in the Health Services *National Implementation Plan 2015- 2017* Health Service Executive.
7. Jennings, S. (2014). Preventing Chronic Disease: Defining the Problem. Report from the Prevention of Chronic Disease Programme. Health Service Executive.
8. Parkin DM, Boyd DL, Walker LC (2011). The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010. *British Journal Cancer*, Dec 6, 105 (Suppl.) S77-S81.
9. Dahlgren G and Whitehead M. (1991). Policies and strategies to promote social equity in health. Stockholm: Institute for Future Studies.
10. Department of Health and Children (2008). Tackling Chronic Disease: a Policy Framework for the Management of Chronic Diseases. Department of Health and Children, Dublin, Ireland
11. O'Shea B, Darker C, O'Kelly F. (2013). Chronic Disease Management in Patients attending Irish General Practice Training Practices. Irish Medical Journal. 2013; 106 (7), 207-9.
12. National Voices & Nesta, (2015). Peer Support: What is it and does it work? Summarising evidence from more than 1000 studies: www.nesta.org.uk
13. Heisler M, (2006). Building Peer Support Programmes to Manage Chronic Disease: Seven Models for Success; California Health Care Foundation www.chcf.org/programs
14. Eurostat(2016). Mortality and life expectancy statistics. http://ec.europa.eu/eurostat/statistics-explained/index.php/Mortality_and_life_expectancy_statistics and Healthy Life years statistics http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthy_life_years_statistics
15. Department of Health (2016) Healthy Ireland Survey 2016; Summary of Findings. Dublin Stationary Office.
16. Wright. J., (2013) Very brief advice can be effective in encouraging Smokers to Quit. http://guidelinesinpractice.co.uk/jan_13_wright_smoking_jan13
17. Teljeur, C., Tyrell, E., Kelly, A., and O'Dowd, T. (2013) Getting a handle on the general practice workforce in Ireland, *Irish Journal of Medical Science;* Jun;183(2):207-13.

18. Health Service Executive (2015) Building a High Quality Health Service for a Healthier Ireland Health Service Executive Corporate Plan 2015 – 2017. HSE

19. Department of Health (2016) Get Ireland Active! National Physical Activity Plan for Ireland. Dublin: Department of Health 2016.

20. Department of Health (2015) Tobacco Free Ireland Action Plan. Dublin: Department of Health 2015

21. Department of Community, Rural and Gaeltacht Affairs (2009) National Drugs Strategy (Interim) 2009-2016. Dublin, Ireland.

22. Department of Health (2016) National Maternity Strategy *Creating a Better Future Together* 2016-2026, Dublin: Department of Health 2016.

23. Department of Health (2016). A Healthy Weight for Ireland. Obesity Policy and Action Plan 2015-2025. Dublin, Department of Health.

24. Health Information and Quality Authority (2012). National Healthcare Standards for Safer Better Healthcare. Dublin: HIQA, 2012.

25. Health Service Executive (2015) Health Behaviour Change Training - Review of Current Practice in Ireland. HSE; Health and Wellbeing Division *(unpublished report)*

26. NHS Yorkshire and the Humber (2011) Prevention and Lifestyle Behaviour Change *A Competence Framework.* National Health Service. UK.

27. NICE (2014). *Behaviour change: individual approaches.* N*ational Institute for Health and Clinical Excellence. Public Health Guidance no 49.*National Institute for Health and Care Excellence , UK.

28. Powell, K. and Thurston, M (2008). Commissioning training for behaviour change interventions: Evidence and best practice in delivery. *University of Chester, Chester: Centre for Public Health Research;* 2008

29. Department of Health (2013) eHealth Strategy for Ireland. Dublin: Department of Health 2013.

30. McMurray A., and Crimmins, J., (2015) Implementing the Health Behaviour Change Framework – *Making Every Contact Count* Report on National Consultation. Health Service Executive: Health and Wellbeing Division December 2015 (*unpublished)*

Abbreviations

AND HP&I	Assistant National Director Health Promotion and Improvement
BA	Brief Advice
BI	Brief Intervention
BIU	Business Information Unit
CBT	Cognitive Behaviour Therapy
CHO	Community Healthcare Organisations
CIO	Chief Information Office
COPD	Chronic Obstructive Pulmonary Disorder
CORU	Health & Social Care Professionals Council
CVD	Cardiovascular Disease
EBI	Extended Brief Intervention
HEI	Higher Education Institute
HI	Healthy Ireland
HIQA	Heath Information Quality Authority
HP&I	Health Promotion and Improvement
HRB	Health Research Board
HSE	Health Service Executive
H&W	Health and Wellbeing
H&WCPT	Health and Wellbeing Clinical Programme Team
ICGP	Irish College of General Practitioners
ICPCD	Integrated Care Programme for Prevention and Management of Chronic Disease
ICT	Information and Communication Technologies
IPA	Irish Pharmacist Association
KPI	Key Performance Indicator
MECC	Making Every Contact Count
MECC PM	Making Every Contact Count Project Manager
MI	Motivational Interviewing
NACGL	National Advisor and Clinical Group Lead
NALA	National Adult Literacy Agency
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
PNA	Practice Nurse Association
PPP	Policy Priority Programme
QID	Quality Improvement Division
RCPI	Royal College of Physicians Ireland
RCSI	Royal College of Surgeons Ireland
SFT	Solution Focused Therapy
SMS	Self-Management Support
TILDA	The Irish Longitudinal Study on Ageing

Section 5

Appendix 1 Evidence Statement

Evidence statement of the effectiveness of health behaviour change interventions

Summary Evidence Statement: On reviewing the evidence it can be concluded that behaviour change interventions including brief advice/ very brief interventions, brief interventions, extended brief interventions and motivational interviewing are effective both for individual topics and collectively for all topics. While the evidence doesn't clearly indicate which behaviour change intervention is most effective for which lifestyle behaviour there is a collective body of evidence to show that there is benefit from implementing behaviour change interventions in clinical practice.

Introduction

There is now a sizeable body of evidence to show that adopting a healthy lifestyle is beneficial to health and longevity[1]. Consequently, there is an increasing focus on how to help people make lifestyle changes at an individual and a population level. Increasingly, professional bodies are advocating a focus on helping the individual at the clinical consultation with a recent joint American and European Societies of Cardiology guideline stating that *'health care organisations should integrate healthy lifestyles interventions into the medical model as a standard of care*'.[2] Moreover, a number of countries are addressing this culture shift and systematizing the approach to maximising the consultation based on a growing body of evidence demonstrating the effectiveness of lifestyle behaviour change approaches. This approach within the NHS in the UK is known as *Make Every Contact Count.*[3] The purpose of this statement is to clarify the evidence and consensus on techniques to achieve health behaviour change (HBC) in healthcare settings.

Methodology to review the evidence

Due to the large body of existing evidence and reviews of evidence in this area, a review of reviews was considered to be sufficient to provide an evidence base for this framework. The review of evidence for the effectiveness was limited to reviewing existing systematic reviews in relation to brief interventions.

The following process was used to identify relevant reviews:

- A search of the literature was undertaken for English language reviews published between 2000 and 2015. These key reviews were reviews of primary research that had been conducted in Ireland and internationally into the evidence for brief interventions and lifestyle behaviour change.
- A search of Cochrane review website was carried out to identify relevant reviews in relation to brief interventions and motivational interviewing.
- Consultation with key informants in Ireland in the areas of behaviour change and each topic was undertaken to cross match the evidence found in the literature search with current evidence statements used to underpin current work in the area in Ireland.

A number of substantial bodies of evidence which are key sources of reviews in relation to behaviour change were identified.

- NICE – A number of large scale reviews had been conducted by NICE into the evidence base for behaviour change initiatives. www.nice.org
- Cochrane Reviews www.cochrane.org
- Previous work in Ireland to look at the evidence for brief interventions by Evans et al (2011)[4] into behaviour change and brief interventions.

Evidence for Behaviour Change

The following provides a summary of some of the evidence that exists in relation to the effectiveness of brief advice, brief interventions and motivational interviewing and behaviour change in relation to lifestyle behaviours of smoking, drinking alcohol, diet and physical activity. Quite a substantial body of evidence exists in relation to smoking and alcohol. The body of evidence relating to diet and physical activity is not as large but reports some significant findings indicating the effectiveness of brief interventions to support behaviour change in relation to these lifestyle behaviours.

Smoking

Brief Advice

- Strong evidence that brief advice (including advising on the best way to quit and an offer of help) is effective in supporting clients to quit smoking.[5]
- Advice from doctors helps people who smoke to quit. Even when doctors provide brief simple advice about quitting smoking this increases the likelihood that someone who smokes will successfully quit and remain a non-smoker 12 months later. Pooled data from 17 trials on brief advice showed significant increase in rate of quitting (RR 1.66; CI 1.42-1.6). Estimated effect from more intensive interventions was higher but not significantly. Assuming an unassisted quit rate of 2 to 3% a brief advice intervention can increase quitting by a further 1 to 3%.[6]

Brief Intervention

- Strong evidence that multi session smoking interventions is effective at aiding cessation in those motivated to quit.[6]
- Strong evidence exists to show that multiple session smoking cessation delivered at individual level is effective in increasing abstinence among patients with cardiovascular conditions or previously undetected mild to moderate airway obstruction.[6]
- Evidence from earlier NICE guidance[7] indicated Brief interventions (including referral to specialised stop smoking services) were effective at getting adult smokers to quit.

Motivational Interviewing

- Strong evidence that motivational interviewing appears to help more people to quit smoking than brief advice or usual care when provided by general practitioners and by trained counsellors. Meta-analysis of motivational interviewing vs brief advice yielded a modest but significant increase in quitting (RR 1.26; 95% CI 1.16-1.36).[9]
- Shorter motivational interviewing sessions (less than 20 minutes per session) were more effective than longer ones.[9]
- A single session of treatment appeared to be marginally more successful than multiple sessions, but both delivered successful outcomes.[9]
- In pregnant women cognitive behaviour therapy, motivational interviewing and self-help and support from *NHS Stop Smoking* services were found to be effective.[9]
- Intensive counselling interventions that begin during a hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (Odds Ratio 1.65 CI 1.44-1.90). Sessions that began in hospital but had less than one month supportive contact did not show benefit.[10]

Alcohol

Context for Alcohol and screening tools

Following two decades of assessment, initiated by the WHO, systematic review[11] of the literature has concluded that the AUDIT is the best screening instrument for the whole range of alcohol problems particularly in primary care, as compared to other questionnaires such as the CAGE and the FAST.[12]

Following screening with AUDIT tool, four levels of risk are noted for purposes of follow up:

- Zone I refers to low risk drinking or abstinence
- Zone II, consists of alcohol use in excess of low risk guidelines, and is generally indicated when the AUDIT score is between 8 and 15. A brief intervention using simple advice and patient education materials is the most appropriate course of action for these patients
- Zone III is suggested by AUDIT scores in the range of 16 to 19. Harmful and hazardous drinking can be managed by a combination of simple advice, brief counselling and continued monitoring, with further diagnostic evaluation indicated if the patient fails to respond or is suspected of possible alcohol dependence
- Zone IV is suggested by AUDIT scores in excess of 20. These patients should be referred to a specialist for diagnostic evaluation and possible treatment for alcohol dependence

The 2007–2012 Programme for Government indicated an intention to:

'*Provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking'*. *National Substance Misuse Strategy, 2012*[13] recommended that screening should facilitate identification of people with hazardous and harmful alcohol use who require brief, time-limited interventions, and identify those people who need to be referred for more comprehensive assessment.

Brief Advice

- The delivery of brief advice is most effective through one-to-one personal contact. However, longer or more intense intervention does not provide additional gain. In some studies, those who did not receive the brief advice (control group) also reduced their alcohol consumption, which may suggest that the alcohol screening part of the intervention can be beneficial in itself[14, 15].
- The recent e-interventions (computerised or web-based) have shown positive impact, although the gains are not as strong as direct personal contact. However, with groups hard to reach such as young people, it can provide benefits and at a low cost.[16]
- Alcohol screening and brief advice is an important intervention at the individual level and needs to be delivered across the drinking population. However, if alcohol control policies are not in place, even with widespread reach of screening and brief advice, a reduction in alcohol-related harm at the population level is unlikely.[17, 18]

Brief Intervention

- There is a significant body of evidence indicating that brief interventions in primary care and brief interventions including elements of motivational interviewing and goal setting are effective interventions at reducing alcohol intake in adult problem/hazardous drinkers.[8]
- A trial conducted in the UK Primary Care Practices reported that providing brief interventions for alcohol misuse resulted in cost savings of five times the expenditure on health, social and criminal justice service. *The UK Alcohol Treatment Trial*.[19]
- Brief alcohol intervention is particularly effective with hazardous and harmful drinkers who are not seeking treatment (unaware of their alcohol-related risk or harm).[16]
- Brief alcohol intervention in primary care has shown consistent reductions in alcohol consumption (quantity, frequency, intensity),[16] and is cost effective.[20]
- Brief alcohol intervention has shown promise across different settings - emergency care, general hospital, educational and community settings).[16]
- A review of brief alcohol interventions with hospital patients (heavy alcohol users) showed a reduction in alcohol consumption at follow-up (six and nine months) but was not maintained after one year, although fewer deaths were reported. [21]
- However, challenges remain in the delivery of brief alcohol interventions in some settings. A recent study across different hospital emergency departments recommended confining the intervention to screening with simple clinical feedback and alcohol information, given the challenges in such settings.[22]

Extended Brief Intervention

Multi-session extended behaviour change interventions among pregnant and postpartum women are effective at altering alcohol consumption behaviour.[8]

Physical Activity

Brief Advice

- Delivery of brief physical activity advice to adults in primary care showed significant effect.[23]
- Brief physical activity advice from a healthcare professional, supported by written materials, is likely to be effective in producing a modest, short term (6–12 weeks) effect on physical activity.[23]

Brief Intervention

- Brief physical activity interventions in primary care (containing advice and/or motivational interviewing, follow up calls or an activity plan) were effective across all adult groups.[8]
- Evidence supports the effectiveness of brief physical activity advice and brief physical activity intervention by healthcare professionals to increase physical activity levels among the general population and, in particular, inactive adults.[24]

Extended Intervention

- Strong evidence that physical activity interventions (with an additional dietary component) delivered over multiple sessions at either one on one or combined one on one and group level are effective at physical activity among cardiovascular patients compared to usual care.[8]
- Diabetes: Moderate evidence suggests that multi-session, remotely delivered interventions may be effective at improving physical activity among Type 2 diabetes mellitus patients compared to usual care.[8]

Diet and Weight Management

The body of evidence to support brief interventions and diet is much less than for smoking and drinking alcohol. Healthy eating, as recommended by the current guidelines in the food pyramid, is a collection of behaviours and choices so the evidence to support brief interventions and behaviour change in relation to diet tends to focus on specific areas e.g. adapting a high fibre diet, increasing fruit and vegetable intakes rather than looking at healthy eating as a collective behaviour. In addition, some of the evidence with regard to healthy eating focuses on the benefit of brief interventions for weight management

- Evidence from earlier NICE guidance[7] indicated the following individual level interventions were effective at changing diet in the specific populations:
  - Nutritional counselling in adults
  - Lifestyle interventions targeting diet to prevent new cases of diabetes were effective in those at high risk of diabetes or who had pre-diabetes
  - Large, diverse, multi-faceted lifestyle interventions including a dietary element were also effective in pregnant women and new mothers
- Evidence review update from 2014[8] reported the following: Overall, multi-session interventions resulted in small, significant effects across the utilised modes of delivery (face to face interventions delivered on an individual or group basis). At risk of CVD: Overall, these interventions resulted in a wide range of effects, both in terms of size (very small to large) and significance. Limited evidence suggests that multi-session face to face interventions delivered on a combined one on one and group level may be effective at encouraging dietary changes among individuals at risk of cardiovascular conditions.
- There is good evidence to suggest that multi-component approaches which provide support on both physical activity and diet together produce more effective outcomes than single component interventions.[26]
- A review of 33 studies found that brief intervention can improve dietary behaviour.[27] This review found that counselling patients can improve dietary behaviours, including reducing dietary fat intake and increasing fruit and vegetable consumption. More intensive counselling and counselling directed to higher risk patients generally produced larger changes than less intensive interventions delivered to low risk populations.
- Brief behavioural counselling to encourage fruit and vegetable consumption carried out by nurses in primary care settings has been shown to be effective amongst low income groups.[27]
- Brief interventions delivered in primary care to tackle obesity has been shown to be cost effective but are associated with relatively low QALY gains.[26]
- A literature review of brief intervention and childhood obesity concluded that given the nature of brief interventions and the likelihood that many professionals already provide brief advice, sign posting and referral, it is likely that these interventions are of value.[28]

Weight Management

There is good evidence that brief interventions can lead to at least short term changes in behaviour and body weight if they focus on diet and physical activity, are delivered by practitioners trained in motivational interviewing, incorporate behavioural techniques, e.g. self-monitoring, are tailored to individual circumstances and encourage the individual or patient to seek support from other people. However, most sustained changes in behaviour and body weight appear to require more intensive interventions conducted over an extended period.[29]

Conclusion

The specific evidence relating to alcohol, smoking, diet and physical activity are outlined above. While the evidence indicates a modest effect in terms of effect size (diet (0.33), smoking (0.28) and physical activity (0.22))[8], when applied to a population this can have a sizeable impact. Evidence reports, that for people who receive a brief intervention it is effective for 1 in 8 in relation to alcohol[30] and for 1 in 20 in relation to tobacco[31]. When you apply this in the context of a population where there are 30 million contacts every year throughout the health service this has the potential for a very large impact.

Evidence Statement – References

1. Ezzati M, Riboli E. Can non communicable diseases be prevented? Lessons from studies of population and individuals. Science 2012; 337: 1482-1487.
2. Arena R, Guazzi M, Lianov L, Whitsel L, Berra K, Lavie CJ et al. Healthy lifestyle interventions to combat non-communicable disease—a novel non-hierarchical connectivity model for key stakeholders: a policy statement from the American Heart Association, European Society of Cardiology, European Association for Cardiovascular Prevention and Rehabilitation, and American College of Preventive Medicine. EHJ (2015) 36, 2097-2109. doi.org/10.1093/eurheartj/ehv207 .
3. East Midlands Health trainer Hub, NHS Derbyshire County (2011), Using every opportunity to promote health and wellbeing: Guide to support positive lifestyle behaviour change in the East Midlands.
4. Evans DS, Martin L, Neeson B, O' Brien M, Cahill D (2011). Brief Interventions and Motivational Interviewing. Literature review and Guidance for practice. Health Service Executive.
5. NCSCT Local stop smoking services. Public Health England (2014): West R, Fidler J (2011) Smoking and Smoking Cessation in England 2010. London: Vasco-Graphics. www.smokinginengland.info Aveyard P, Begh R, Parsons A and West R (2012) Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance. Addiction. 2012 Jun;107(6):1066–73. doi: 10.1111/j.1360-0443.2011.03770.x. Epub 2012 Feb 28.
6. Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T."Physician advice for smoking cessation". Cochrane Database of Systematic Reviews 2013, Issue 5. Art. No.: CD000165. DOI:0.1002/14651858.CD000165.pub4.".
7. NICE (2007). Behaviour change principles for effective interventions. NICE public health guidance 6. www.guidance.nice.org.uk/ph6
8. NICE (2014). Behaviour change: individual approaches. NICE public health guidance 49. www.guidance.nice.org.uk/ph49
9. Cochrane review (2015) Lindson-Hawley N,Thompson TP, Begh R. "Motivational interviewing for smoking cessation. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD006936. DOI: 10.1002/14651858.CD006936.pub3.
10. Rigotti N, Munafo' MR, Stead LF. Cochrane review (2008) Interventions for smoking cessation in hospitalised patients. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD001837. DOI: 10.1002/14651858.CD001837.pub2."
11. Fiellin, D.A., Carrington, R.M. and O'Connor, P.G. Screening for alcohol problems in primary care: a systematic review. *Archives of Internal Medicine* 160: 1977-1989, 2000.
12. Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG. World Health Organization (2001) Department of Mental Health and Substance Dependence. The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care. WHO/MSD/MSB/01.6a
13. Department of Health, Ireland. National Steering group report on a National Substance Misuse Strategy, February 2012
14. Kypri K et al (2007). Assessment may conceal therapeutic benefit: findings from a randomized Controlled trial for hazardous drinking. *Addiction,* 102(1), 62-70

15. McCambridge J & Day M (2007). Randomized controlled trial of the effects of completing the Alcohol Use Disorders Identification Test questionnaire on self-reported hazardous drinking. *Addiction*, 103(2), 241-248.

16. Kaner E (2012). Health Sector responses. In: Anderson P, Møller L, Galea G, eds. *Alcohol in the European Union: Consumption, harm and policy approaches*. Copenhagen: WHO Regional Office for Europe.

17. Heather N (2012). Can screening and brief intervention lead to population-level reductions in alcohol-related harm? *Addiction Science & Clinical Practice*, 7:15. doi:10.1186/1940-0640-7-15

18. Shakeschaft A, Doran C, Petrie D et al (2014). The effectiveness of community action in reducing risky alcohol consumption and harm: A cluster randomised controlled trial. *PLoS Med 11* (3): e1001617. doi:10.1371/journal.pmed.1001617

19. UK Alcohol treatment Trial (2005). Effectiveness of treatment for alcohol problems. Findings or randomised UK alcohol treatment trial. (UKATT). British Medical Journal. Vol. 331, No. 7516, (Sep.10, 2005); pp 541-544.

20. Anderson P, Møller L, Galea G (2012). *Alcohol in the European Union: Consumption, harm and policy approaches*. Copenhagen: WHO Regional Office for Europe.

21. Queen J, Howe TE, Allan I et al (2011) Brief interventions for heavy alcohol users admitted to General hospital wards. *Cochrane Database of Systematic Reviews*, 8: CD005191.

22. Drummond C, Deluca P, Coulton S et al (2014). The effectiveness of alcohol screening and brief Intervention in emergency departments: A multicentre pragmatic cluster randomized controlled trial. *PLoS ONE,* 9(6). E99463. Doi:10.1371/journal.pone.0099463.

23. NICE (2013). National Institute of Health and Clinical Excellence. *Physical activity: brief advice for adults in primary care*. NICE public health guidance 44. Guidance.nice.org.uk/ph44

24. Nice (2006). National Institute of Health and Clinical Excellence. *A rapid review of the effectiveness of brief interventions in primary care to promote physical activity in adults.* 1–49 (NICE, 2006).

25. Department of Health (2012) National Healthy Eating Guidelines www.health.gov.ie

26. North West Public Health Observatory. Synthesis, Changing Health Choices. *A review of the cost-effectiveness of individual level behaviour change interventions.* Health and Wellbeing Alliance: Feb 2011

27. Ammerman, A., Pignone, M., Fernandez, L., Lohr, K., Jacobs, AD., Nester, C et al Counselling to Promote a Healthy Diet. *Systematic evidence review no 18* The Agency for Healthcare Research and Quality; 2002

28. West, D., and Saffin, K., *Brief interventions and childhood obesity for the North West and London Teaching Public Health Networks:* Literature review. Public Health Projects NHS; 2008 www.phru.nhs.uk

29. National Health Service. Brief interventions for weight management. *National Obesity Observatory* NHS; 2011

30. Moyer, A., Finney, J., Swearingen, C. & Vergun, P. (2002). Brief interventions for alcohol problems: A meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations. Addiction, 97, 279–292.

31. Silagy, C. & Stead, L. F. (2003). Physician advice for smoking cessation (Cochrane Review). In The Cochrane Library, (Issue 4). Chichester: Wiley.

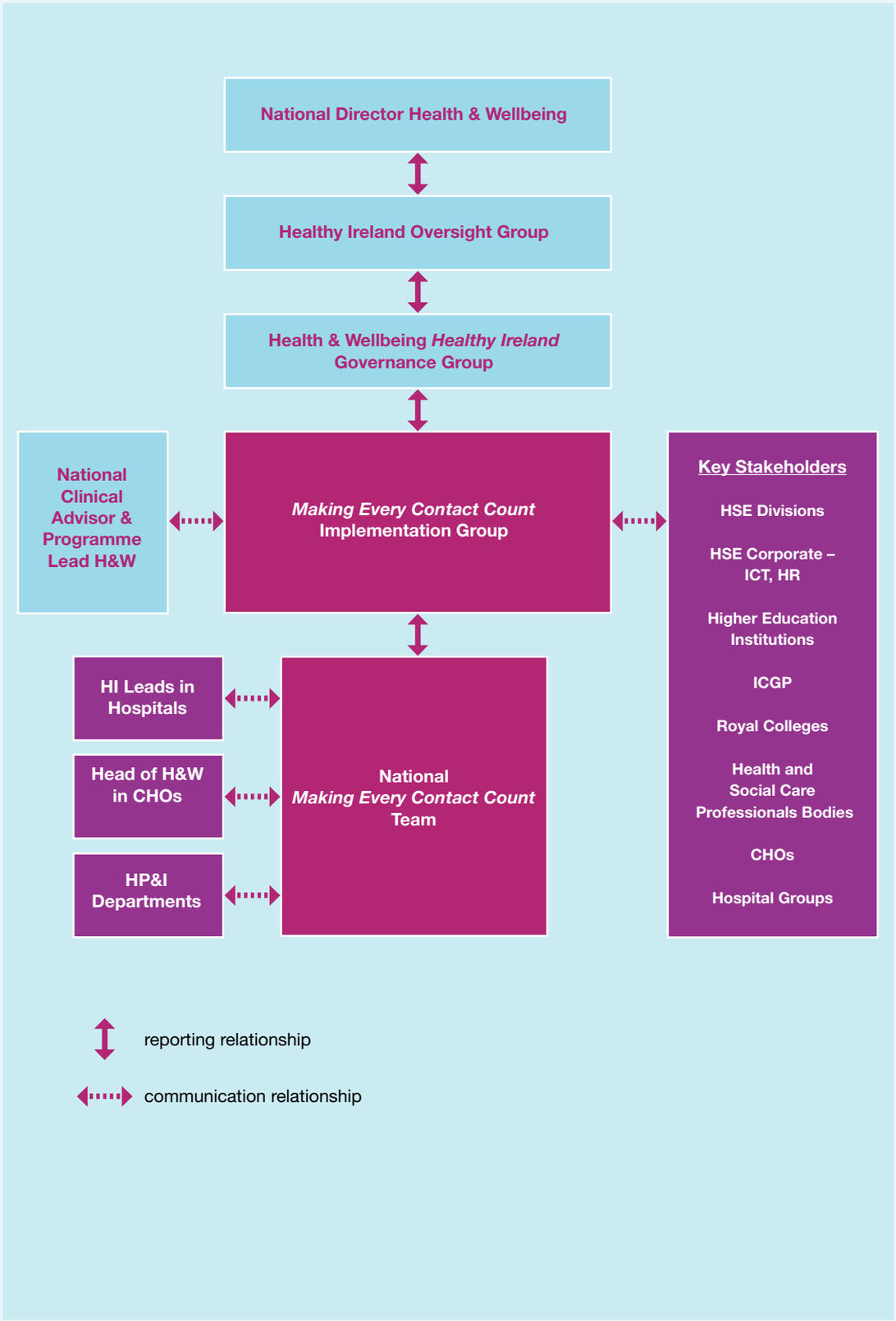
Appendix 2

Making Every Contact Count Implementation Group – Governance Structures and Terms of Reference

A National *Making Every Contact Count* Implementation Group will be established to oversee the implementation plan at National level. A diagram outlining the reporting relationships and membership of this group is provided below. The group will be chaired by the Assistant National Director in Health Promotion and Improvement and will report to the Healthy Ireland Oversight Group through the Health and Wellbeing Healthy Ireland Governance Group. The Terms of Reference for this Group including membership is outlined below. The National Clinical Advisor and Group Lead will liaise with the group as necessary.

At an operational level a National *Making Every Contact Count* programme team will be established to co-ordinate the delivery of the implementation plan across the service. At a local level the Hospital Group *Healthy Ireland* Leads and Head of Health and Wellbeing in CHOs will have the responsibility of embedding *Making Every Contact Count* across their respective organisations. This will be actively supported by local Health Promotion and Improvement staff.

Governance Structure for *Making Every Contact Count*



Making Every Contact Count Implementation Group Governance and Terms of Reference

Making Every Contact Count is a key programme within the *Healthy Ireland in Health Services Implementation Plan*. The Governance arrangements to oversee implementation of the framework are outlined below. The development of the *Making Every Contact Count* Framework has been led by the National Clinical Advisor and Programme Group Lead for Health and Wellbeing and Clinical Strategy and Programmes, with support from Health Promotion and Improvement.

The implementation of the framework will be the responsibility of Health Promotion and Improvement. The National Clinical Advisor and Programme Group Lead will continue to lead on key actions relating to development of a standard undergraduate curriculum for health behaviour change, postgraduate training for healthcare professionals, engagement with the ICGP and continued engagement with CIO to develop a minimum dataset for recording lifestyle risk factors and behavioural change interventions on national IT systems. In addition, the National Clinical Advisor and Group Lead will continue to provide an additional supportive role in the development and the maintenance of key partnerships. *Making Every Contact Count* is also a key work stream under the Integrated Care Programme for Chronic Disease which supports the Health and Wellbeing development and reform priorities under the 2017 National Service Plan.

Governance

National *Making Every Contact Count* Implementation Group

The National *Making Every Contact Count* Implementation Group will oversee the implementation plan at National Level. This group is chaired by the Assistant National Director Health Promotion & Improvement. The National Clinical Advisor and Programme Group Lead will liaise with the group as necessary. The Implementation Group will report through the Health and Wellbeing Healthy Ireland Governance Group to the *Healthy Ireland* Oversight Group.

Membership of *Making Every Contact Count* Implementation Group

- AND Health Promotion and Improvement (Chair)
- General Manager HP&I with responsibility for *Making Every Contact Count*
- National Group Programme Manager Health & Wellbeing & Clinical Programmes
- Policy Priority Programme Leads for Alcohol, Tobacco, Healthy Eating and Active Living.
- General Manager from the office of National Director for Health and Wellbeing
- Healthy Ireland National Lead
- *Making Every Contact Count* Team Project Managers
- National Communications Representative
- Specialist in Public Health Medicine
- CHO H&W Lead Representative
- Hospital Group Healthy Ireland Lead Representative

**It may be necessary to co-op additional members to the Implementation group for specific elements of the work programme.*

The overall aim of the group is to ensure the implementation of the *Making Every Contact Count* Framework and Implementation Plan within the HSE and through key external partnerships/ stakeholders including ICGP, Higher Education Institutions, Health Professional Associations and Training Bodies.

Terms of Reference of the *Making Every Contact Count* Implementation Group:

i. To provide strategic direction and advice to support the implementation of the *Making Every Contact Count* Framework and relevant actions in Healthy Ireland.

ii. To ensure the key principles identified in the *Making Every Contact Count* Framework and Implementation Plan underpin the implementation at local level.

iii. To agree annual priorities for the implementation of *Making Every Contact Count*.

iv. To ensure that the identified priorities are included in the annual service plans and operational plans of CHO and Hospital Groups.

v. To build support for and embed the *Making Every Contact Count* programme within CHOs and Hospitals Groups.

vi. To participate in working groups as necessary.

vii. To engage as appropriate with partners and stakeholders and support the development of the *Making Every Contact Count* stakeholders group.

viii. To support the procurement, design and development of a lifestyle hub for information, signposting and supports for behaviour change.

ix. To monitor, evaluate and report on progress regarding implementation of the programme.

x. To develop appropriate key performance indicators for *Making Every Contact Count Programme.*

xi. To evaluate progress at specific intervals and revise implementation plans if necessary.

xii. To engage with experts to progress delivery of relevant actions as and when required.

xiii. Review and approve all supporting resources for the *Make Every Contact Count* Programme that may be developed.

- The Group will be chaired by the Assistant National Director for Health Promotion and Improvement
- The Group will meet a minimum of six times each year.
- Members must attend at least 75% of meetings each year. In exceptional circumstances and only with prior agreement of the Chair is substitution allowed.
- Substitutes must be fully briefed, be capable of and have authority to make decisions on behalf of their nominating Division/CHO/Hospital Group. In the event of a substitute being required for more than one meeting, the same person must act as substitute.

Sub-Groups of *Making Every Contact Count* Implementation Group

A number of sub-groups of the *Making Every Contact Count* Implementation Group will be established to support the work of the *Making Every Contact Count* team and the *Making Every Contact Count* Implementation group.

These subgroups will be chaired by a member of *the Making Every Contact Count* Implementation Group. Membership of the subgroups will be wider than just the membership of Implementation group as necessary to complete the work.

Proposed groups:

- *Making Every Contact Count* Training Development Group
- *Making Every Contact Count* Communications Group
- *Making Every Contact Count* Programme Team
- *Making Every Contact Count* Stakeholder Group

Additional subgroups will be created as required.

At an operational level the National *Making Every Contact Count* Programme Team will work with key stakeholders, within the HSE and externally to deliver on the implementation plan. At local level the CHOs and Hospital groups will have responsibility for implementing *Making Every Contact Count* through their *Healthy Ireland* implementation plans. They will be supported to do this by Health Promotion and Improvement staff through the provision of training, guidance and direction.

Appendix 3

Members of Health Behaviour Change Workstream

This Framework and Implementation Plan was developed by the Health Behaviour Change Workstream, Health and Wellbeing Clinical Programmes Team, in consultation with key stakeholders.

Health Behaviour Change Workstream members:

- Dr Orlaith O'Reilly, National Clinical Advisor and Programme Lead, Health and Wellbeing Division
- Dr Maria O'Brien, Project Manager, *Making Every Contact Count* Programme
- Aileen Scott (Workstream Lead), Senior Health Promotion Officer, Health Promotion & Improvement
- Mairead Gleeson, National Group Programme Manager Health and Wellbeing & Clinical Programmes
- Dr Siobhan Jennings, Consultant in Public Health Medicine, Department of Public Health

The members of the workstream would like to acknowledge the contribution made by those who participated in the consultation processes and provided feedback throughout the development stages of this framework.

Feidhmeannacht na Seirbhíse Sláinte
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