# MAKING EVERY CONTACT COUNT: VALUES FOR MONEY

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CONTACT COUNT

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## Objectives

Making Every Contact Count (MECC) is intended to support and encourage NHS and LA staff and volunteers to engage in brief, constructive chats with members of the public to help them to improve health and wellbeing. Topics supported include: smoking, alcohol, activity, diet, weight, mental wellbeing and community group support but can expand to many other aspects of wellbeing.

MECC is part of a culture change programme towards a society fully engaged in whole person and whole community health and wellbeing as called for by Derek Wanless (2002), addressing the causes of inequity and poor health identified by the Marmot Review (2010).

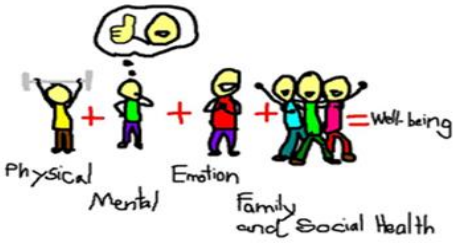
It enhances the roles of those delivering MECC, helps them manage their own wellbeing and develops social capital, linking support services and groups and helping staff work together across organisations, encouraging a joined up approach to health and social care and supporting co-production. Thus MECC supports specific behaviour outcomes and wider NHS and LA values.

## Social Impact Matrix (SIM)

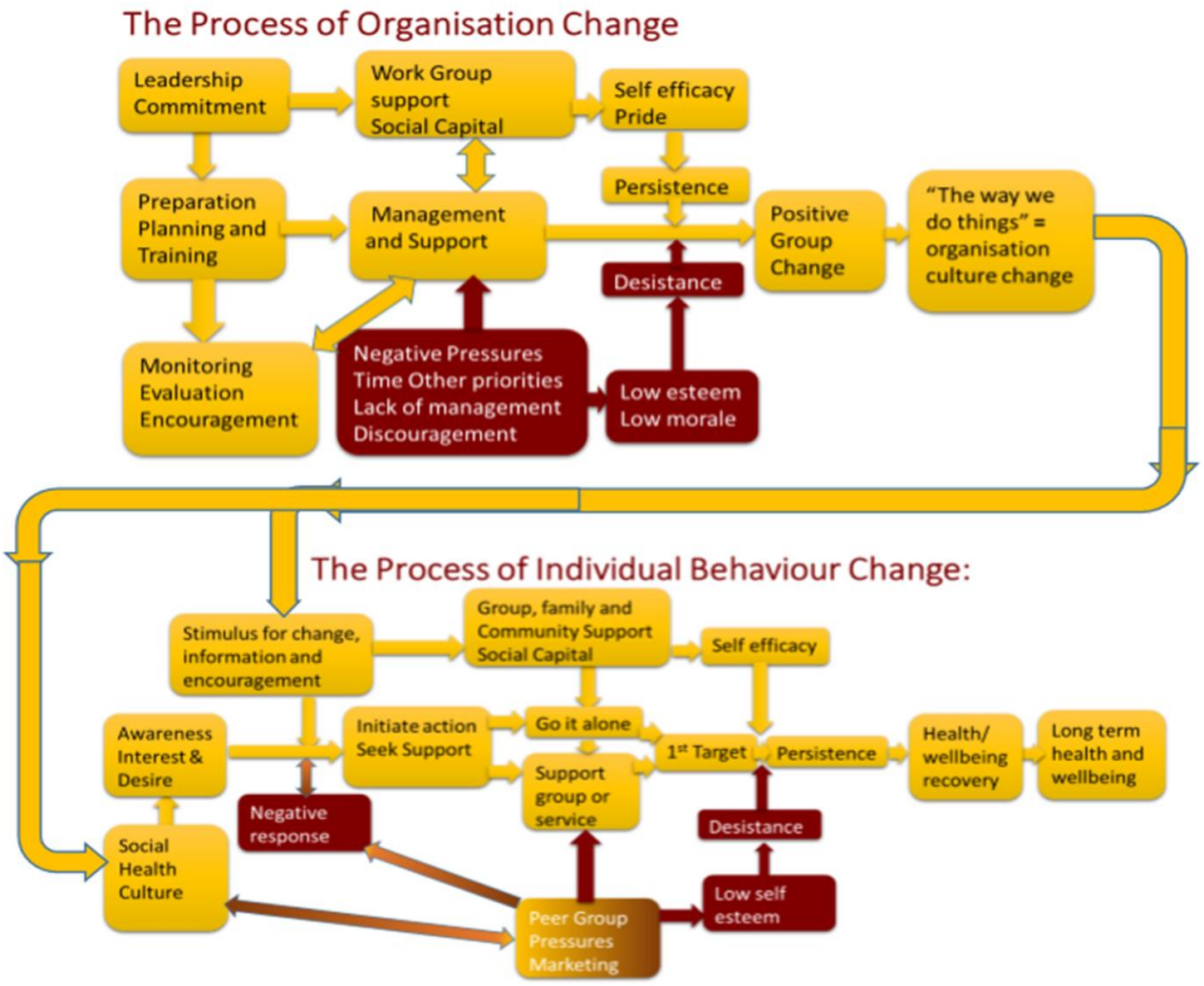
These objectives are set out in a draft SIM for discussion with local stakeholders.

| Objectives → <br> Stakeholders ↓ | Health and Wellbeing Improvement | Culture change in NHS, LA and society to whole person, whole community care | Improve equity of health and wellbeing and access to support | Improve social capital, personal and community support for H&W |
|---|---|---|---|---|
| **People with health and wellbeing concerns** | Encouragement and specific information to stimulate and enable behaviour change | Increased confidence self efficacy better relationship with NHS/LA other staff | Reduced access barriers for disadvantaged people for language, culture or other reasons | Better access to support services and support groups to help initiate and sustain behaviour |
| **NHS /LA staff and volunteers delivering MECC** | Stimulus to improve their own H&W | Whole person care as a culture for all staff & vol Better relations with public. Pride in Whole Person Care | Confidence in working with people who find it difficult to express needs or access services. | Bonds within work groups providing support for their own health and wellbeing improvement. |
| **NHS, Trusts, and CCGs** | Achievement of H&W goals better coordination with community resources | Reorientation from treatment to health and wellbeing - the fully engaged services. | Achievement of NHS goals for reduced inequity in health access and outcomes | Bridges between organisations and groups reducing professional and organisational barriers for health and wellbeing. |
| **Other organisations supporting H&W inc LA,and Community Organisations** | Better use of signposted services and community support groups <br> Wider wellbeing goals including social capital | Shared goals for H&W <br> Opportunities for working together <br> Co-production with community groups | Engagement with groups previously considered "hard to reach" reduced stigma and better shared understanding. | Links across organisation groups and individuals as a community network for health and wellbeing |
| **Wider society** | Community support for health and wellbeing | Whole community culture that supports health and wellbeing inc community groups and employers | A fairer more equitable society with a common purpose of improving health and wellbeing. | A fully engaged society |

# Behaviour Change Process Map




MECC support for individual behaviour change is crucially dependent upon the adoption of its values and culture at organisational level and its incorporation into the culture of staff and the public. The map of organisational and individual behaviour change is intended to demonstrate this and shows that in nearly all cases people with unhealthy lifestyles or wellbeing issues have some awareness, interest and desire to change as result of the social culture in which they live. MECC encounters may be the further stimulus and information they need to take action to initiate change. The change path they follow may involve "going it alone" or drawing on support services. In either case many will not even reach a first target e.g.: "4 week quitter", "2 dry days a week", "10,000 steps", "5 a day", "joining a cook well club". Many more will not manage to sustain their change for a year or 5 years. They may persist in change if they receive social group support and reinforcement and have sufficient belief in themselves (self-efficacy) to resist pressures to revert. Potential unintended consequence such as lack of ongoing leadership support for organisational change or insensitively provided interventions should also be considered at this stage, in order to mitigate them.



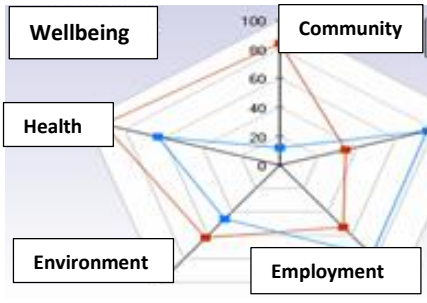
## Logic Model and Data Requirements

A Social Impact Matrix and Process of Change Map helps to clarify the inputs and outcomes at each stage that can be described and if possible measured. It reminds us that achieving Values for Money is not just a number. Its aim is to change the lives and futures of people, organisations and communities, while measureable outcomes are important, culture change is the fundamental goal.

| Measures → Elements ↓ | Inputs | Interventions | Intermediate Outcome Measures | Long Term Impacts |
|---|---|---|---|---|
| **Preparation Baseline** | Current health & wellbeing<br>Behaviour change services and their costs.<br>Relationships between staff public and organisations | **Data on current H&W status and behaviour risks and cost implications for NHS LA etc.**<br>Mapping of local services and community groups i.e. a directory of support services | Discussions with and feedback from staff public and support services on current barriers to action for health & wellbeing | **Health and wellbeing outcomes, for example as assessed by the IHME and relevant NHS, LA and other costs.** |
| **Preparation Organisation** | **Set up actions and costs inc staff time, resources and training** | Leadership action<br>Engagement of staff groups<br>Training offered by level<br>Discussions with public and local behaviour change orgs | Expressions of support and Commitment<br>Number of people trained by level and topic.<br>Contacts between services and community re MECC | Improved morale<br>**Staff H&W improvement**<br>Self help support groups<br>Extent of culture change<br>Improved cooperation across organisations |
| **Delivery of MECC** | Staff input to deliver MECC<br>**Costs of delivering MECC**<br>Learning updates and info<br>Additional appointment time<br>Support for contact with disadvantaged people | **Number of MECC interventions by: smoking, activity, alcohol, diet, mental wellbeing weight management and other.**<br>**No of signposts made for each**<br>**Costs of MECC for signposts** | No of people initiating action for H&W behaviour change<br>**No contacting signpost**<br>**No disadvantage people aided**<br>**Reduced unplanned and A&E**<br>Positive response from public | **Public H&W improvement**<br>**Reduced health and care costs, to NHS and LA**<br>**Reduced family costs**<br>**Increased use of support services and groups** |
| **Ongoing Support** | Leadership engagement<br>Quality of evaluation process<br>Time and cost of evaluation<br>Feedback & shared learning | Action to build on lessons<br>Innovations in delivery & topics<br>Positive feedback from staff<br>Public and other LA services | Staff and volunteer attitudes<br>Take up of training offered<br>Increased volunteering<br>Public attitudes<br>Awareness/ interest in H&W | Attitudes of staff at all levels and professional cadre<br>Relationships across organisations and community |
| **Further Development** | PHE Support for innovation<br>NHS investment support<br>Shared learning opportunities | Development and extension of MECC principle to<br>Engage LA/Community groups<br>GPs and other self care groups | Public attitudes to staff and to H&W self care<br>Social capital for H&W | Improved culture for H&W<br>Less stigma<br>Greater involvement in H&W from all sectors & community |

## Data, Evidence and Assumptions

The logic model indicates the data needed for full evaluation of MECC. Within this the requirements for a quantitative evaluation of behaviour change outcomes above the level that would otherwise be expected are set out in bold type. All social and economic evaluation requires clear social objectives and comparison with a baseline (what would happen without the change) or alternative as a basis for investing for a better future for individuals, families and communities.



## The MECC Values for Money Tool

The Excel based tool uses the data identified on the previous page. It allows the entry of set up and ongoing annual costs, which may include the opportunity cost of time, and the cost of services to which people are signposted. Records or estimates of the number of MECC encounters by topic and the number and success of signposts are also entered. This basic data is used to estimate the lifetime impact on health and wellbeing above the estimate for people who would have changed without MECC, by drawing on a range of current studies of the effectiveness of behaviour change in each field. Outcomes calculated include savings to NHs and LAs, the Incremental Cost Utility (cost per QALY) of MECC programmes or of specific elements of the programme and the Social Return on Investment (the value created for all stakeholders for each £1 spent). The tool makes it possible to weight the Social Return for MECC impact on equity and also facilitates Sensitivity Analysis.

The Tool identifies areas for further research to develop the evidence base. It also provides a useful basis for training staff and testing idea. As an illustration, test data suggests that a MECC project costing £100,000 p.a., training 1000 staff, each with 100 MECC encounters per year, across all topics could result in lifetime savings to the NHS of some £500,000 and could produce health gains of 140 Quality Adjusted Life Year, while saving money to the public sector. It could show a return of £10 for each £1 spent and would be expected to save households and employers some £28 for each £1 spent, by reducing spending on cigarettes, alcohol and care and improving employment and income.

### Incremental Cost Utility

| Lifetime Health Gain QALYs | Net cost or Savings to NHS over long term £ | Net cost or Saving (-) to NHS Per Health Gain £ per QALY | Net LA/NHS/CJS/FR Cost or Savings £ | Net cost or Saving (-) Per Health Gain £ per QALY |
|---|---|---|---|---|
| 140.44 | -£479,779 | -£3,416 | -£305,234 | -£2,173 |

### Social Return on Investment for each £1 spent

| Social Return on Investment using DH Guidelines | £10 | Benefits to families and community | £28 |
|---|---|---|---|

MECC Potential

**Better health and wellbeing**

**+**

**Saving money for the NHS and LAs**

**+**

**Lifetime benefits to families and communitv**

### Thank you to:

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