Healthcare Improvement Scotland | ihub

Midlothian Wellbeing Service

First phase evaluation supported by Healthcare Improvement Scotland's Improvement Hub (ihub)

May 2018

Midlothian

thistle Foundation

NHS Lothian

Overview

Healthcare Improvement Scotland's Improvement Hub (ihub) supports health and social care organisations to redesign and continuously improve services.

In March 2016, the ihub was asked to support work to develop an approach to evaluating the house of care collaboration in Lothian, focusing on the Midlothian Wellbeing Service - a personal outcome focused service.

The purpose of this summary is to describe the evaluation and key findings.

Midlothian Wellbeing Service

- In September 2015, a Wellbeing Service, provided by Thistle Foundation and NHS Lothian, started working with people with complex social and health needs in two Midlothian GP practices.
- The Wellbeing Service funded by the Midlothian Health and Social Care Partnership (HSCP) is currently being provided in eight Midlothian GP practices.
- The approach is based on a 'good conversation' focusing on personal outcomes and building people's strengths, assets and community support. Through the good conversation approach, people are supported to explore coping strategies, express their own needs and priorities, and reflect on their progress.
- The service is being provided on a one-to-one basis (between 1 to 10 sessions) and through group support, and people are supported to access local services.

The ihub approach to the development of outcomes and data collection

The ihub was guided by its stakeholders in Midlothian as to what was important to them in their approach to demonstrating impact. It was important to develop an approach to evaluation that the HSCP was able to sustain as well as building local knowledge and skills in how to use data and intelligence gathered, to shape and refine the service delivery model.

The ihub coordinated an expert panel (evaluation group) that included representation from health, social care, third and independent sectors, and people who had experienced the house of care model.

The approach to evaluation, developed over a period of time, combined improvement support from the ihub to understand aims at a strategic and systems level and a theory-based approach to the evaluation.

The ihub commissioned an independent consultant, Dr Ailsa Cook who has experience in evaluating personal outcome approaches, to work with Midlothian Wellbeing Service stakeholders at three locally delivered workshops to look at applying outcome chains to illustrate a theory of change to support project evaluation.

Midlothian Wellbeing Service outcome chains

Two outcome chains which guided data collection and analysis were developed by the Midlothian Wellbeing Service and the ihub as part of these facilitated workshops:

1. Raising awareness of the wellbeing work, for example primary care practitioners understand what the service offers and refer their patients.

2. Supporting people to improve wellbeing, for example someone starts to understand the importance of wellbeing – has the confidence to access services and thus is more able to participate in their family or work life.

The table below illustrates the outcome chains and the scale of the data collected in relation to the source outcome developed by the service. The ihub also supported health service utilisation analysis (delivered by an ihub health economist) which was enabled through a data sharing agreement.

		Data collected	
		Outcome chain 1	Outcome chain 2
What we do	Raise awareness with primary care colleagues about wellbeing and the support we provide. Provide support to the person to focus on outcomes in one-to-one sessions and groups. Build relationships with other agencies and refer participants to them. Engage in ongoing reflective practice, improvement, evaluation and share learning.	• Number of awareness sessions.	• Number of people referred to the service/ engaged in facilitated groups. • Source of referral, for example GP or practice nurse.
Who with	Participants Practitioners Primary care teams Wider health and social care system Third sector and community services Community Planning Partnership		• Demographic of people attending the service: - Gender - Age - Health Condition - Scottish Index of Multiple Deprivation (SIMD).
How they react	This is a valuable and effective service Wellbeing is important This will help us achieve our outcomes	• Interviews with GPs. • Analysis of notes from learning cycles.	• Review of case notes to identify service users' view of service.

	Data collected	
	Outcome chain 1	Outcome chain 2
What they know and can do Primary care know about and understand the service. Participants know what matters and have the knowledge, confidence and skills to change. Practitioners and participants know the support available and how to access it. The project team have skills in reflective practice, evidence and evaluation. People across the system know what is working and what can be improved.	• Number of referrals to the service and source of referrals.	• The % of people who use the service with a recorded personal outcome. • Review of case notes to identify what service. users can do.
Change to practice Primary care make appropriate and informed referrals. Participants make changes and actively manage their health and wellbeing. Participants are referred to and access support from appropriate agencies. Learning is shared. Evidence is used to make the changes required.	• Review of notes from learning cycles.	• Review of case notes to identify what people who use the service can do now.
Outcomes People in need of support to manage their health and wellbeing engage with the service. Participants have improved wellbeing, live better lives and are able to participate in society. Participants get the ongoing support they need. Resources are used appropriately across the system. The system is more preventative and person centred.	• Use of primary care and secondary care resources: - GP attendance - prescribing - hospital attendance.	• Change in: - Warwick Edinburgh Mental Wellbeing (WEMWB) score - coping score - confidence score.

Learning cycles

As a condition of the Wellbeing Service being based in GP practices, the practice staff agreed to participate in learning cycles. Learning cycles are facilitated, semi-structured sessions designed to encourage participants to reflect on and learn from experience. Practice staff, often GPs and practice nurses take part along with wellbeing practitioners. They take place every 4–8 weeks and usually last between 30 minutes and an hour.

As well as fulfilling a quality improvement role, the learning cycles also provide valuable evidence for service monitoring and evaluation. The sessions build awareness of the service and promote learning from patient stories and wellbeing practitioners' experience thus providing opportunities for spread and scale.

What did the Wellbeing service deliver? (September 2015-September 2017)

Individual referrals – one-to-one sessions

Uptake: 1,368 people were referred to the service, of whom 64% (874) attended. 70.4% (615) of those who attended a session went on to have further meetings with a wellbeing practitioner. In total there were 2,982 one-to-one consultations. Majority of referrals (87%) were made by GPs.

Group (sample survey)

50 people engaged in facilitated group programmes, for example Lifestyle Management, one New Beginnings Group (loss and bereavement), Baby Strollers Walking Group, swimming group.

Wider workforce

Good Conversation training was delivered four times with 64 professionals completing the programme (social workers, community nurses, support workers, occupational therapists and a GP). The Wellbeing Service also delivered training and information at other local, multi-agency events.

Local services (sample survey)

People attending the Wellbeing Service were supported to access over 56 services for example Women's Aid, Sporting Memories, Home Energy Scotland, Cycle Club, Health in Mind Trauma Counselling, exercise referral programme, Get Ready for College course.

Demographic of people using the service

Male	33%
Female	67%
Age	Majority (56%) were aged between 20–49
% reporting that they suffer from a health condition	77%
SIMD	54% resided in SIMD 1&2

The most often reported issue was longstanding mental health issues, followed by family/relationship issues, long term condition(s) and isolation.

What difference did the service make?

Impact on people using the service

Of the people who attended an initial appointment, 87% had at least one personal outcome recorded (for example related to depression, anxiety, living with long term condition, bereavement, alcohol).

Wellbeing, coping and confidence scores all significantly increased at discharge (based on a sample).

	WEMWBS score	Coping score	Confidence score
Number of people	78	81	81
Early baseline mean score (at entry to service)	35.22	3.86	3.93
Later comparison mean score	48.34	6.52	6.57
Difference	13.120	2.66	2.64
P value	<0.001	<0.001	<0.001

Case notes analysis

Of the 30 case notes analysed as part of the evaluation of the Midlothian Wellbeing Service, about 75% of participants reported making changes relating to:

- their physical health (for example doing more exercise, changing medication)
- social isolation (for example making contact with other organisations/getting support, re-engaging with interests), and
- their mental wellbeing (for example using lifestyle management tools).

The following quotes illustrate how much the participants valued the service.

When you see the Doctor you are going to see about your complaint. Here you are getting ideas what to do.'

'My mood has changed. Rather than being in a depressive mood I've more or less learned to love myself as a person again because I was feeling worthless…I'm happier, more content and calmer…If I hadn't been on 'Living life to the full' or seen (name of Wellbeing practitioner), I would have been on medication and signed off sick. Fact 100%.'

'I've been able to become more confident in dealing with the problems I have faced through using the Wellbeing Service. This has made me a lot happier and energetic compared to how I was feeling before I started.'

'The GP looks at everything from a medical point of view to solve through pills/medicine. Coming here it's the complete opposite, try to get to the root of the problem and not meds. Find a solution to deal with it.'

'Back at Gym and enjoying this – is lifting mood and has lost weight, also making friends at gym'.

'Feeling more empowered to speak up with family and staff.'

Impact on primary care team and health service

The work of the Wellbeing Practitioners role was understood and was seen as valuable and effective by primary care staff.

> *'We're referring the "hard ones" and R is making head way with some of the most intractable situations. Patients have coped in a way they haven't done for 20 years.' (Practice A)*

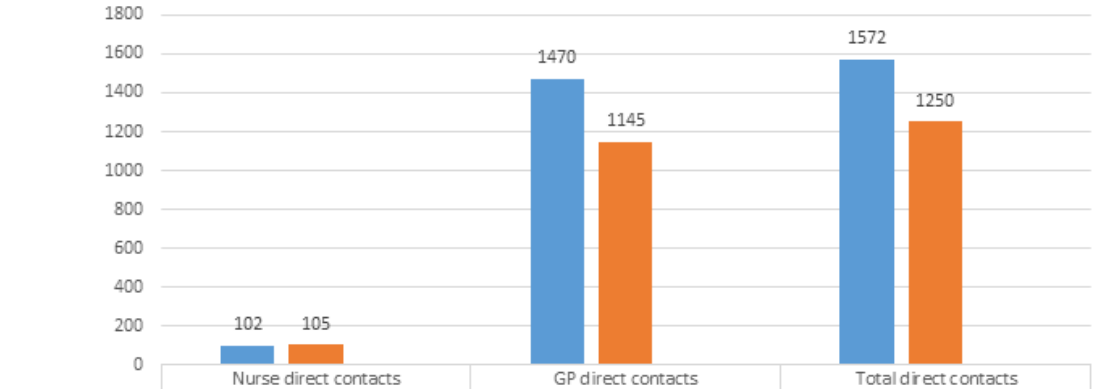
> *'When I refer people to Wellbeing I tend to not see them again.' (GP)*

> *'That's great I could not have got all the strands of what was going on for that woman.' (GP)*

Healthcare utilisation analysis suggested the following.

- There was a significant decrease in GP direct contacts after accessing the service.
- There was no significant difference in prescriptions before and after accessing the service.
- There were no statistically significant differences in mean costs associated with acute episodes, maternity, mental health episodes, geriatric long stay episodes, outpatient, A&E, and community prescribing before and after attending the service.

Direct contacts 6 months before and after participation
(based on data for 187 patients)



	Nurse direct contacts	GP direct contacts	Total direct contacts
Pre-attendance	102	1470	1572
Post-attendance	105	1145	1250
p-value	0.83	0.01	0.01

Discussion and conclusion

Strategic leadership support and close working relationships with the third sector and other stakeholders were pivotal in the development of the Midlothian Wellbeing Service. Key to success was the culture developed by Midlothian HSCP senior leadership team, across the HSCP, to encourage wider stakeholder engagement, staff participation and positive risk taking. Midlothian HSCP committed time and capacity, (infrastructure) through learning cycles, to analyse data and reflect with all those involved, which was integral to the development and spread of the wellbeing service to other GP Practises.

Evaluation

The evaluation suggests that the Wellbeing Service is well received and valued both by primary care practitioners and people using the service, supporting them to define and work towards achieving personal outcomes. Early indications that the Wellbeing Service improves people who use the service perceptions of their wellbeing, coping and confidence, all of which are important to positive behaviour change The impact on health service utilisation is less clear and should be further explored.

Conclusions and suggestions for further evaluation

Further work should seek to understand how to further engage people in the Wellbeing Service and understand reasons for people both choosing and choosing not to attend the service. The suitability and effectiveness of the service for particular groups (such as people recovering from cancer, or those coming out of prison) could also be explored. As the service engaged people aged under 50 with complex social needs, it can be viewed as a preventative intervention. A long term evaluation is required to determine long term impact. Any evaluation should also seek to explore the long term effect of the service on personal outcomes and the impact the Wellbeing Service has on health service utilisation as well as engagement with primary care practitioners.

For more information visit **www.ihub.scot/a-z-programmes/evidence-and-evaluation-for-improvement/**

or contact the Evidence and Evaluation for Improvement Team:
hcis.EEVIT@nhs.net

Credits:

Midlothian Health and Social Care Partnership
Thistle Foundation
NHS Lothian
Midlothian Council
Midlothian General Practitioners
Dr Ailsa Cook, Outcome Focus

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The Improvement Hub

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

0131 623 4300

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.ihub.scot