Midlothian Wellbeing Service: beyond medicine

The population in **Midlothian** is increasing and people are living longer, healthier lives.

As society changes so do the health and care needs of our communities.
Midlothian Health & Social Care Partnership agreed that people should be supported to

- look after and improve their health
- live independently as long as possible

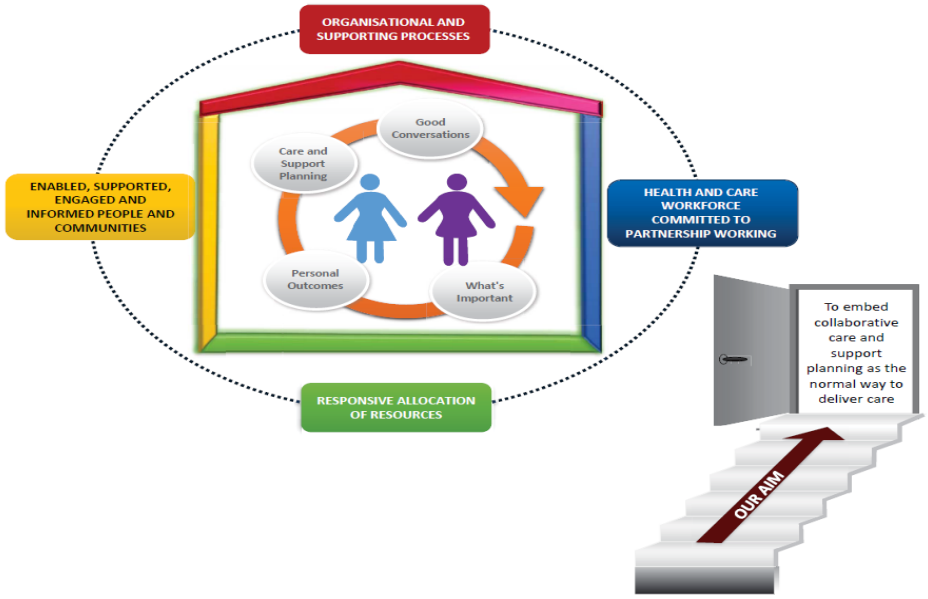
In addition the Partnership made a commitment to work to reduce health inequalities.

Midlothian GP Practices

The **Wellbeing Service** is a pioneering collaboration delivering a service in eight Midlothian GP Practices.

It is generally acknowledged that people have complex lives and are trying to manage social, financial, health and other matters which weigh heavily upon them. Self management support, a vital element of person centred care, was hard to access for many.

The Wellbeing Service is providing person-centred care and support: care that treats people as equal partners, focuses on personal outcomes, supports their role in managing their health and wellbeing, and recognises the importance of prevention and anticipatory care and support.



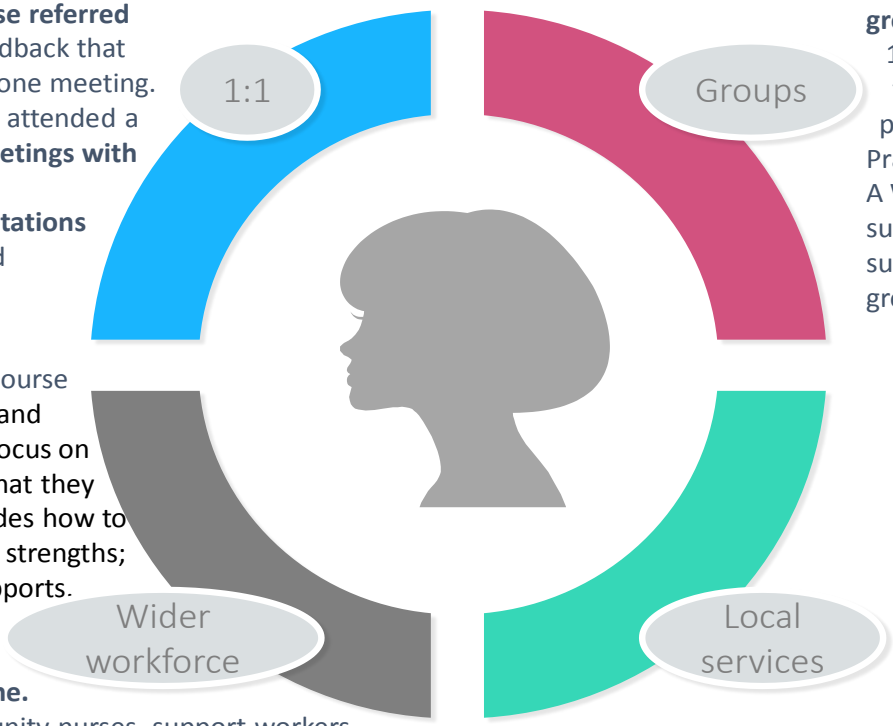
The model adopted for delivering person-centred, integrated care in Lothian is called the **House of Care**. The key elements of the house of care metaphor are as follows.

- People with long-term conditions are central to the process - they are supported to express their own needs and decide on their own priorities.
- Self-management support - people should have the knowledge, skills and confidence to manage their condition effectively in the context of their everyday life.
- Tackling health inequalities – the number of long-term conditions and their burden falls disproportionately on people in lower socio-economic groups.

In Midlothian this approach has also been adopted by TCAT (Transforming Care After Treatment, now embedded in the Wellbeing Service), Mental Wellbeing Access Point, Community Health Inequality Nurses, some voluntary sector partners and others.

WHAT THE WELLBEING SERVICE DELIVERED

1,368 people were referred between Sept 2015 & Sept 2017. **64% (874) of those referred attended**. We know from other feedback that some people felt they only needed one meeting. However, **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 1:1 consultations** over the period of evaluation to end September 2017.



50 people engaged in facilitated group programmes varying from 6 to 10 week programmes. This positive figure was reached because people knew the Wellbeing Practitioners first.
A Wellbeing Practitioner also supported the establishment and sustainability of peer support/activity groups – walking & swimming.

Good Conversation training (2 day course on the core set of values, principles and skills which enable practitioners to focus on what matters most to people and what they want to achieve from support. Includes how to harness the role of the person: their strengths; social networks; and community supports.
It was **delivered 4 times** between Aug 2016 & Sept 2017.
64 people completed the programme.
This included social workers, community nurses, support workers, occupational therapists and a GP. The Wellbeing Service also delivered training/information at other local, multi-agency events.

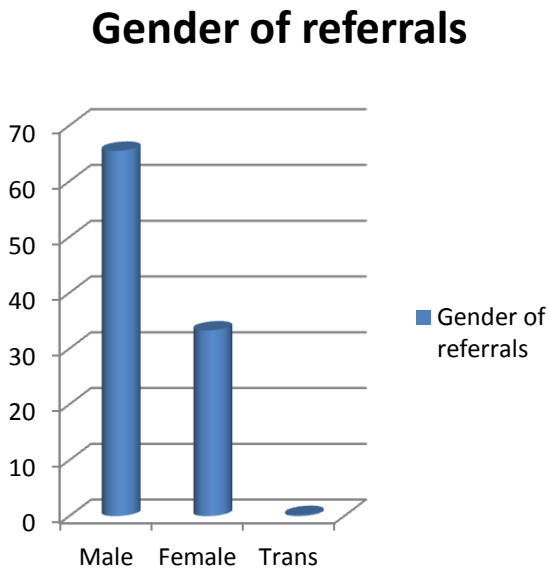
People were **supported to access 56 local services**. This includes Women's Aid, Sporting Memories, Home Energy Scotland, Cycle Club, Health in Mind Trauma Counselling, Midlothian Active Choices (exercise referral programme), Get Ready for College course, Welfare Rights, Food Bank, Weight Management Service, Cooking Group, Family Mediation, and more.

The Evaluation of the Service

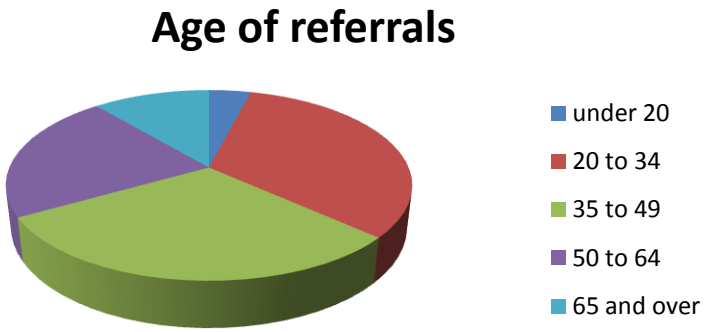
In keeping with the ethos of the project, the approach to the evaluation was collaborative and outcomes focussed. Additional support was welcomed from Healthcare Improvement Scotland - Dr Ailsa Cook and Gary McGrow provided advice and practical facilitation and support.
The data and evidence on which this evaluation is built was primarily collected through the day to day work of the project including data captured from project records, learning cycles and steering group meetings with staff and people in GP practices. In addition a health economist considered use of primary and secondary care services and prescribed drugs. The evaluation covers the period Sept 2015 to Sept 2017 although the service was only available in 2 GP Practices until January 2017.

Demographics

Overall more women (67%) than men (33%) were referred to the Wellbeing practitioners. However this was not the case at Quarryfoot practice, where more men than women were referred to the service (53% men, 45% women and 2% transgender patients referred).

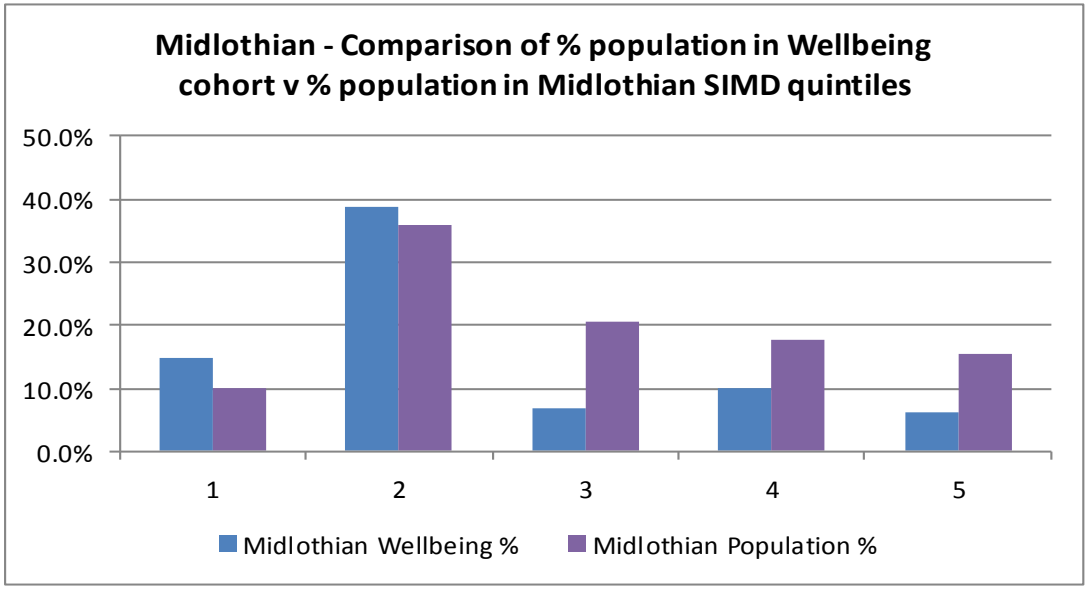


Most patients referred were either aged 20-34 (29%) or 35-49 (27%). Very few patients were under the age of 20. Quarryfoot practice has had higher instances of older patients referred than the other practices, with almost one third (27%) of patients referred aged 65 and over. Conversely Newbattle and Newbyres practices saw the highest percentages of referrals for those aged under 20 and the smallest percentage of those aged 65 and over.



Patient reported health conditions at initial appointment

Over 43.3% of people attending reported that they have a mental health difficulty (anxiety, depression, past trauma, eating disorder, to name a few). Addiction, diabetes, arthritis, weight problems and asthma are examples of other issues reported.



Patient reported health inequalities at initial appointment

During the initial 'good conversation' patients often report a range of issues that relate to health inequalities that can impact on health and wellbeing. The most often reported issue was longstanding mental health issues, followed by family/ relationship issues, long term condition(s) and isolation.

Most people referred to the service resided in the two most deprived SIMD quintiles (54% in SIMD 1 and 2). This supports the claim that the majority of people referred to the service are experiencing elements social deprivation.

87% of referrals to the Service have been made by GPs (where a source of referral is recorded

What difference does the service make? The outcomes for people were measured/recorded in a range of ways.

Comparison of WEMWBS scores for discharged patients, earliest and latest recorded scores

WEMWBS	earliest v latest WEMWBS scores
Number of patients	78
baseline mean	35.22
comparison mean	48.34
difference	13.120
P value	<0.001 Highly significant

Comparison of COPING scores for discharged patients

COPING	earliest v latest coping scores
Number of patients	81
baseline mean	3.86
comparison mean	6.52
difference	2.66
P value	<0.001 Highly significant

Comparison of CONFIDENCE scores for discharged patients

CONFIDENCE	earliest v latest confidence scores
Number of patients	81
baseline mean	3.93
comparison mean	6.57
difference	2.64
P value	<0.001 Highly significant

People with (*highly significant*) increased levels of confidence, coping and mental wellbeing are more likely and able to make and sustain positive changes in their life.

Participants report …..

'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'

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

'Taking control of my weight and exercise'

'Given me to acknowledge that I am good at some thinas'

'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%'

Practice staff are reporting…

'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, 25th May 2016, in relation to Wellbeing model)

'Wellbeing approach of continued engagement regarding DNAs opposed to the traditional 2 strikes and out is much better.' (Practice C, 8th June 2016)

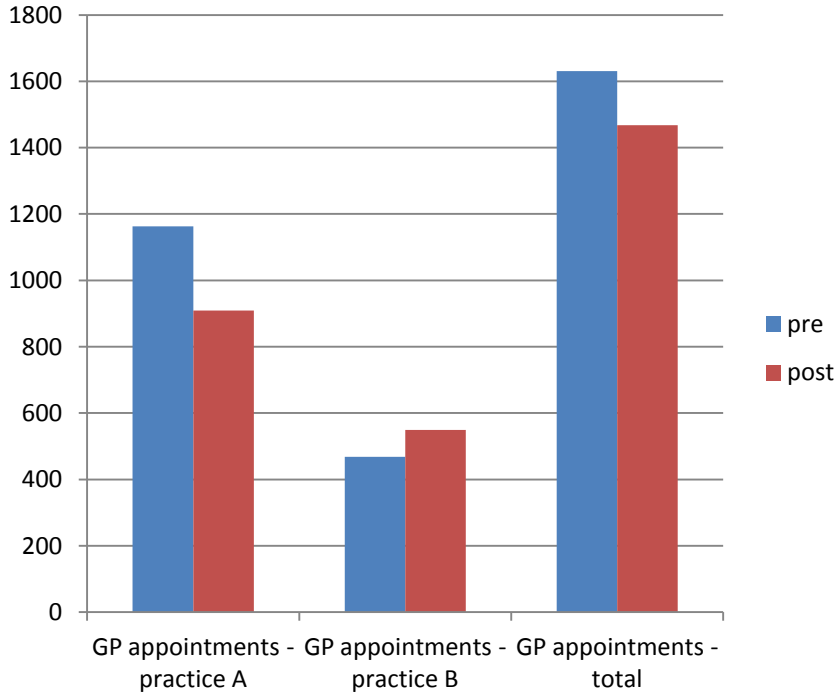
'When I refer people to Wellbeing I tend to not see them again'

'She (Dr. X) had noticed with a few of the people she had referred "greater self-determination" and a "shift in dependency"

Impact on services

The complex health and social situations of those referred to the service should be acknowledged when looking at the following table. Many people referred have had long standing, complex issues and they are often people that GPs have seen regularly over several years. It is therefore optimistic to expect a change in the use of primary and secondary care services over such a short time period.

The following table outlines the number of GP appointments that those referred to the Wellbeing Service before August 2016 attended prior to their referral date and for up to one year after. The figures are for 321 patients. Only 64% of this group will have engaged in the service. We await the breakdown of the figure for the group who engaged in the wellbeing service and the group that GPs thought could benefit, hence their referral yet they did not engage.
While there appears to be reduction in GP appointments that is statistically significant for Practice A (p= <0.01) there may have been other factors at play, for example changes to appointment systems or other changes at the Practices.
Some GPs reported that while the patient may still attend, the appointment is more productive.



Cost of the Service

Fund	projected annual cost at current level
Integrated Care Fund	**£130,000**
Thistle Foundation	**£13,200**
Primary Care Transformation Funding	**£136,000**
NHS Lothian	**£45,000**
	£324,200

For consideration:

- Should the service continue?
- If so
  - funding required from April 2018
  - expansion to the remaining 4 Practices
  - review model and adapt in light of lessons learned

- The service is partially funded by short-term funds such as the Primary Care Transformation Fund. This comes to an end in March 2018. Funding needs to be identified by 31st December 2017 in order to avoid redundancy/redeployment of Wellbeing staff.

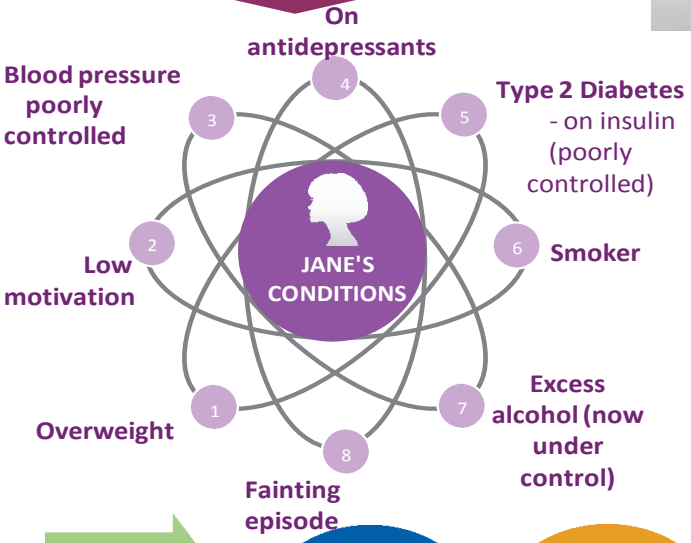
WELLBEING SERVICE

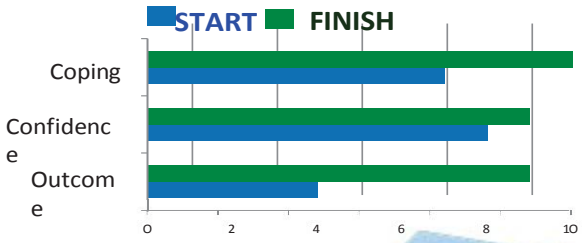
JANE'S STORY

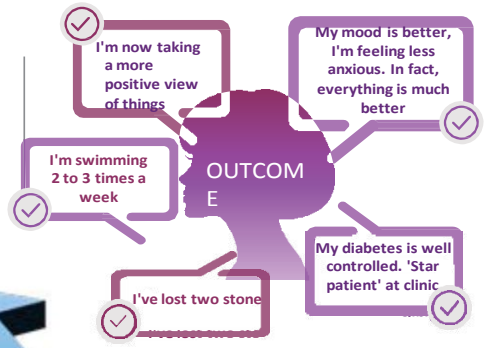
Jane is a retired health worker. She is:

- married with 3 children and has grandchildren
- a carer for her brother who is blind
- worries a lot about a close family member with alcohol problems

GP concerned about diabetes & blood pressure







WEMWBS*: from 52/70 to 67/70

Motivational interviewing to stop smoking - referring Jane to smoke free

Signposting Jane to VOCAL for carer support

Highlighting the positive things that Jane's already doing

Finding out about her home and caring responsibilities

Talking about her assets and strengths, assertiveness, diabetes and diet awareness

Discussing Janes's best hopes and outcomes

Jane attends 5 wellbeing sessions that use a person-centred approach to providing the support that helps achieve her goals

Jane's hopes

- Moving towards volunteering
- Being and keeping motivated
- Feeling less guilty about things
- Feeling better about life

*Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

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