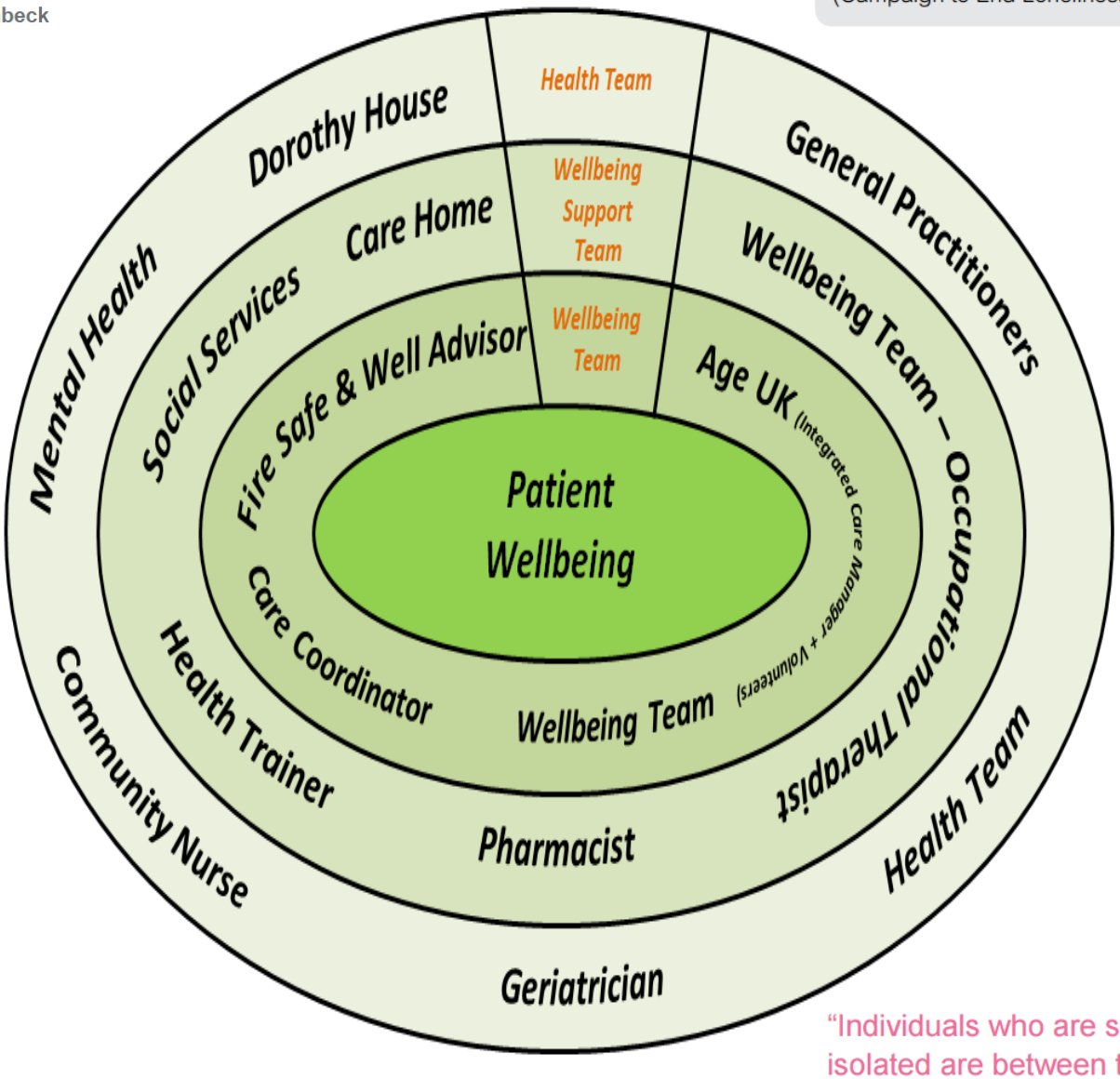
HATHAWAY MEDICAL PARTNERSHIP TRANSFORMING CARE FOR OLDER PEOPLE 2017-2019

"WELL-BEING PROJECT"

"A sad soul can kill you quicker, far quicker, than a germ"

John Steinbeck

Over three quarters of GPs say they see between one and five lonely people a day (Campaign to End Loneliness Poll, 2013)]



"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely."

Michael Marmot (2010) – Fair Society, healthy Lives (The Marmot Review)

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BACKGROUND

Hathaway Medical Practice have been following the success of social prescribing projects since first hearing about "The Cornwall Project" in the autumn of 2015. The details of this project were circulated to the Chippenham Health & Social Care Forum CH&SCF and discussed at the locality Integrated Team Meetings. More recently members of the practice and CH&SCF have visited a project being delivered from Salisbury Medical Practice and have been in discussion with both CH&SCF and Age UK to design a project that will work for the patients of Hathaway Medical Partnership. This project is supported by CH&SCF who will also help with obtaining resources for the project.

AIM

The Living Well programme

The Living Well programme aims to move people away from unscheduled use of health and social care. This is typically characterised by unplanned acute admissions and ED attendances, frequent crisis management in both health and social care and inappropriate use of health services often as a social crutch.

It targets service users who are currently or at risk of becoming high consumers of health and social care. It seeks to reduce this as well as flattening out what otherwise may be future peaks in the use of health and social care services for example around crisis points.

The fundamental elements to the theory of change of the Living Well approach are:

- Proactive case finding using risk stratification and local knowledge, targeted towards people with specific long term conditions and/or a social care package
- Guided conversation – a goal-oriented conversation between the individual and a voluntary sector worker trained in motivational interviewing techniques, which initiates and/or contributes to an anticipatory care plan
- Primary care forms an integral part of the change through liaison to embed the approach within locality planning and thus release GP capacity
- Care co-ordination by an integrated care team based around a GP practice, facilitated by and including the voluntary sector co-ordinator
- Volunteer support on a 1:1 and group basis to help people become more physically and socially active within their community
- Community mapping to identify and link local assets and key 'community makers' – this is the foundation for low level support and rehabilitation
- Facilitated workforce development through local practitioner workshops.

This project outcomes are to:

- Improve the resilience of primary care
- Improve the "well-being" of the patient population
- Reduce the number of times identified patients access primary and secondary care

Why change

At Hathaway the original TCOP concept was to allow GPs to have longer appointments with patients at risk of admission. While this impacted by reducing the admissions of elderly patients, we often found ourselves fighting to support very sick patients in the community, delaying rather than preventing admissions, often within a health-economy not fully resourced to achieve this outcome through the lack of basic support services.

As the project used GPs to deliver much of the work, this model did not improve resilience.

In summary the project failed to improve the resilience of primary care, often only delaying (rather than preventing) admission of unwell patients and failed to improve the well-being of the population.

The basic principle of the Well-being Project is to identify patients who are high users of primary and secondary care, whose symptoms result from poor well-being rather than an underlying medical problem and work with these patients through a wide range of agencies to improve their well-being so that they use less health resources. The benefits to the patients are that their underlying issues are addressed and they are supported to achieve whatever is required to improve their well-being. As a result, these patients are shown to reduce their demand on primary, secondary, community health and social care services; a win-win for everyone involved.

WHAT IS WELL-BEING?

Defining well-being

For our purposes, well-being is most usefully thought of as the dynamic process that gives people a sense of how their lives are going. This feeling will be through the interaction between their circumstances, activities and psychological resources or 'mental capital'. Mental well-being is now largely accepted as covering two perspectives:

1. The Hedonic perspective of well-being focuses on the subjective experience of happiness (affect) and life satisfaction.
2. The Eudaimonic perspective of well-being focuses on psychological functioning, good relationships with others and self-realisation. This is the development of human potential which when realised results in positive functioning in life, and covers a wide range of cognitive aspects of mental health.

High levels of well-being mean that we are more able to respond to difficult circumstances, to innovate and constructively engage with other people and the world around us. As well as representing a highly effective way of bringing about good outcomes in many different areas our lives, there is also a strong case for regarding well-being as an ultimate goal of human endeavour.

"The only person I talked to was the Tesco delivery driver… One day feeling my life was totally worthless, I visited my GP. She said she had heard about a new thing called 'social prescribing'… She did not offer me pills. This was great! … Now I have friends, I go out for meals; I've been on day trips to the coast, the animal park and other places. There's always something to look forward to."

Contact:
www.varotherham.org.uk

While academic debate continues about precisely how 'well-being' should be defined, for our purposes it is not essential to address all of its finer points. All of the elements cited above play a role in ensuring that people feel their lives are going well, although their importance may vary as circumstances change.

Loneliness – an example

Loneliness may lead to a feeling of poor well-being. Academic research is clear that preventing and alleviating loneliness is vital to enabling older people to remain as independent as possible. Lonely individuals are more likely to:

- Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care (Cohen, 2006)
- Undergo early entry into residential or nursing care (Russell et al, 1997)
- Use accident and emergency services independent of chronic illness. (Geller, Janson, McGovern and Valdini, 1999).

Two of the three outcomes of loneliness listed above are ones that we aim to reduce by improving well-being in whatever way is possible.

ORGANISATIONS INVOLVED IN SUPPORTING THE PROJECTS:

The following organisations have been involved in consultation about this project:

Age UK

- Integrated Care Manager

Chippenham Health & Social Care Forum with representatives from:

- Older people's champions
- Care Home Volunteers
- Patient Advocacy
- Wilshire Council Chippenham Community Engagement Manager
- Local Councillor for Chippenham Cepen Park and Redlands
- Avon & Wiltshire Mental Health Partnership (AWP)
- Carers Support
- Dorothy House
- Patient Representatives
- Carer Representative
- Wiltshire Councillor for Adult Care - including Learning Disability and Mental Health

Chippenham "Living Well" Group with representatives from:

- Patient Representatives
- Age UK
- Dorothy House
- Wilshire Council Chippenham Community Engagement Manager

Fire Service:

- Safe & Well Advisor

Wiltshire Health & Care

- Care Coordinator – we know that WH&C are keen to work with the voluntary service and have a meeting with Dr Chris Weiner (Clinical Director) arranged for 28 Feb 2017.

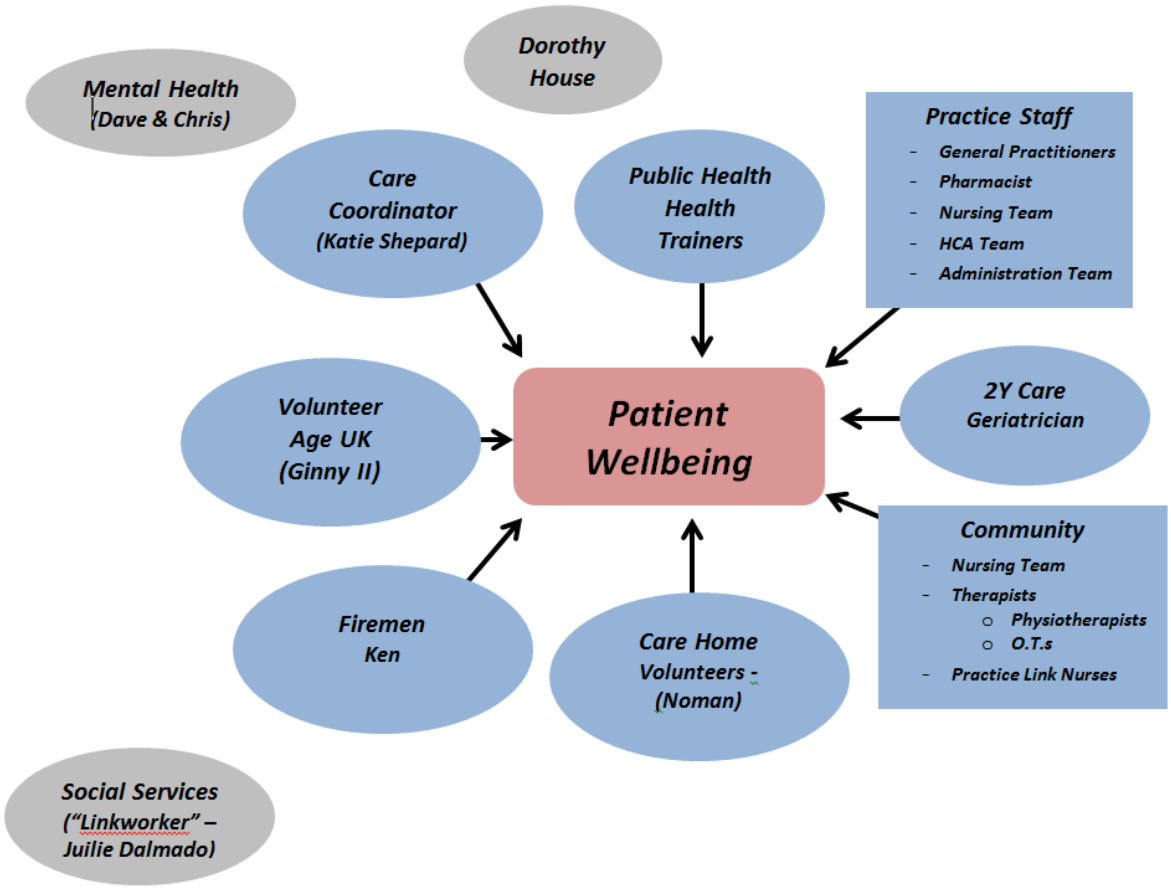
"I love the company. Because of my depression I'm not very sociable so I come for the company. There are people here with lots of skills and I'm still learning skills and I'm still learning things. I know what we are doing is helping other people. I must say I felt at a loss when I retired. I missed the male company and the camaraderie. This place brings us all together"

Contact:
www.ageuk.org.uk/exeter/how-we-can-help-you/our-services/men-in-sheds/

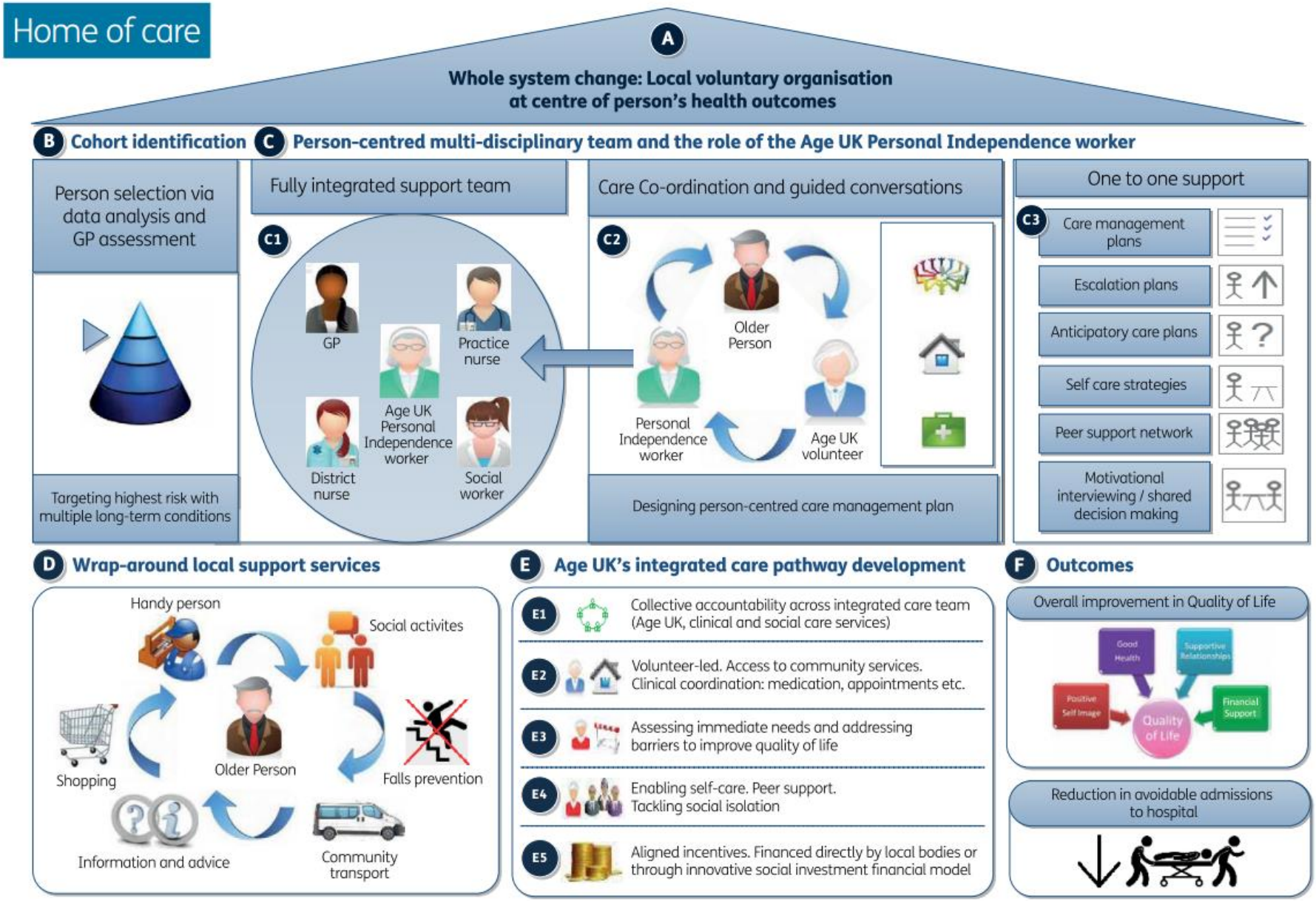
HOW WILL THE PROJECT WORK?

The service will be delivered primarily through an Age UK trained and supported Integrated Care Manager (ICM) embedded into and working from the practice. Referrals will be passed to the ICM who will visit the patient and, through the process of a guided conversation, identify the patient's needs. The ICM will develop a plan to meet the patient needs through the use of Age UK volunteers, other voluntary services, health, public health or social services.

The team will be supported by GPs, an identified Living Well nurse & HCA plus admin support



Examples of what outcomes have been achieved can be found in Appendix 2



This diagram is taken from Age UK's "Integrated Care Services" booklet

RESOURCES REQUIRED

Age UK employed, practice funded, Integrated Care Manager
Wiltshire Health & Care employed Care Coordinator
Fire Service employed Safe & Well Advisor
Designated "Living Well" Room with appropriate phones, desks IT equipment etc.
Link:

- GP
- Nurse
- HCA
- Admin Support

WHAT DOES SUCCESS LOOK LIKE AND HOW WILL IT BE MEASURED?

"My volunteer is a very nice lady and I look forward to her visits. Sometimes we play scrabble and she has taken me shopping, and offered to take me to other places where I might like to go. I count myself lucky to have been given the opportunity to receive visits from a volunteer, it certainly has made a difference to my life."

Contact:
www.royalvoluntaryservice.org.uk

In other projects results have shown a £4 return on every £1 invested in to the projects. It is difficult to capture all savings through the improved well-being of an individual but the project will attempt to identify savings to both health (primary, secondary, mental and community health services and social care. However it should not be forgotten that the primary aim is improving an individual's well-being and that reduced costs are an outcome from that.

Improved "Well-being"

There are a number of scales for assessing well-being:

- Satisfaction With Life Scale (SWLS)
- Scale of Positive and Negative Experience (SPANE)
- Flourishing Scale (FS)
- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- Ryff's psychological well-being scales

It makes sense for practices in Wiltshire who are evaluating well-being to use the same method therefore we are likely to use WEMWBS. Patient's well-being will be assessed prior to and following any intervention/support.

An example of a completed WEMWBS assessment

Statements	None of the time	Rarely	Some of the Time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5
Scores	0	0	4 x 3 = 12	4 x 4 = 16	6 x 5 = 30

Reduced Activity in Primary and/or Secondary Care

In the initial stages, before referrals freely flow from GPs and partner organisations, one of the methods of identifying patients that are appropriate for referral to the ICM is through "frequent fliers" into both primary and secondary care.

A baseline activity over the previous 6 or 12 months will be compared to the 6 or 12 months following any intervention/support.

Reduced Activity in a Partners Organisation

The intention is that the benefits of the project will be accessible to any partner organisation i.e. community health services, mental health services, social services etc. Referrals to the project will require a baseline activity prior to and following any intervention/support.

Minimal GP/nurse input

Improving general practice resilience is through patients being supported through different models of care than GP/nurse input. While GP and nurse time will be required to support the project, as will secondary care, mental health, community

health and social services, they should be called upon when needed and not the primary assessor for patients entering the project.

KEY PERFORMANCE INDICATORS

A summary of our success criteria, KPIs and audits are contained in Appendix 1

Quantitative

The quantitative target is that, for identified patients, the scheme delivers a calculated reduction in costs that gives the following all heath & social care savings based upon a comparison between actual activity prior to and after the intervention:

Year	ROI
1	110%
2	200%
3	250%

Qualitative

The qualitative targets are that:

1. Assessment of well-being improves for 90% of patients
2. Patients are satisfied with the how the service has supported them
3. The staff involved are satisfied with how the system has been established and how it runs.

APPENDIX 1 – SUCCESS, KPIS AND AUDITING

Quantitative		
No of patients seen in service		
Well-being Assessed Prior Support	90%	
Well-being Assessed Post Support	90%	
Average well-being increase?		
GP & Hospital Activity Assessed Prior Support	90%	
GP & Hospital Activity Assessed Post Support	90%	
Qualitative		
Patient satisfaction questionnaire completed by patient	90%	
Integrated Care Manager 6m Satisfaction Questionnaire	100%	
GP Satisfaction??		
Care Co-ordinator Satisfaction		

Identification of service gap		

Identified reduction in cost – all health & social care based upon reduction in activity	Year 1 110% of budget	

PRACTICE REPORT

1. Create a financial summary of where the funding has been spent against the proposal plan. This should detail increases in staff levels, either permanent, locum or extra sessions worked.
2. Section 2 will identify how the ICM has worked with patients and identified benefits/outcomes, patient stories etc
3. Section 3 will identify baseline activity/cost and will develop to identify post intervention activity/costs and "savings" made.

LIVING WELL PROJECT CASE STUDIES

ABSTRACT

Julian Kirby
CEO Age UK Wiltshire

Nora's story

Nora had once run a bustling B&B from her home. Then, having lost both her husband and her sister in a short space of time, Nora grew concerned about being seen as a burden to others. A comment from her friend's daughter reinforced her fear. Nora lost confidence and her mood was very low. Nora had mobility difficulties and had experienced falls – she used a wheeled walker but felt less and less motivated to move around her house. Nora had frequent, sometimes daily, contact with her GP and Community Matron because of her low mood and pain in her knee. Nora also has diabetes.

How we helped

With our help, Nora was able to pinpoint the main issues for her – being a burden and losing independence. She worked with us to create a management plan and identified that she hadn't been attending podiatry appointments, despite having difficulties with her feet. This presented a high risk for hospital admission and so an appointment was arranged for the following week. We talked about pain management and Nora's sleep pattern and prepared questions for Nora to take to her next GP appointment. A medication review was also arranged and we talked about the importance of keeping on top of the medicines she was taking.

Nora was referred to the Age UK Postural Stability Instructor and had a functional assessment, joining a local balance and stability class 3 weeks later. Meanwhile, her wheeled walker was serviced.

Nora worked with the volunteer to create a mood diary and used smiley faces to focus on the positives that she had achieved, which started to appear within a few weeks.

Two months later.

Nora hosted a coffee morning in her home and subsequently joined the group of ladies who attended, so now they all meet fortnightly. Nora has also joined a cinema club and goes to the 'silver screening' fortnightly. She attended the Lane Theatre evening group a couple of times and is involved with the local charity knitting group, which meets regularly for a cream tea.

During her time with the Pathfinder, Nora did have a hospital admission due to pneumonia. The integrated team was able to arrange an early discharge with support at home. Nora's wellbeing score has improved from 18/35 to 29/35.

Wilma's story

Before we met Wilma, she had been in the acute hospital for 12 days due to heart failure, and she also had sciatica, and suffers from hypertension and arthritis. Wilma had limited mobility and she used several aids, had a 6-week package of care, and was supported by the Community Matron. However, Wilma was anxious about getting out and losing her independence, as she had lost confidence and lived alone.

How we helped

Together, we set a goal for Wilma to get out of the house and get involved with social and physical activities.

Wilma's priority was to make her kitchen more accessible. A volunteer gave her some help and they sorted things into baskets. Within a couple of weeks this was achieved. We also arranged home care – an hour every fortnight.

We decided to set small and realistic goals and review them regularly so that Wilma's confidence would increase and she would be inclined to take on more ambitious challenges.

Three months later.

Wilma's wellbeing score has improved from 14/35 to 27/35.

We accompanied Wilma to the local Breathers' Group and a balance and stability class and within a month she was able to attend independently.

Wilma joined a shopping trip at Morrison's, which she greatly enjoyed, particularly eating a meal with others as she usually eats alone.

Wilma also joined the cinema and theatre groups and attended a mental health wellbeing course accompanied by a volunteer, for 2 hours a week over 6 weeks.

She attended the local coffee group and commented that it was "so nice to have something to look forward to". Wilma made a particular effort with her appearance. By now, Wilma has been to at least 20 coffee groups held at various venues around Newquay and in other people's homes. Her confidence improved to the point that Wilma is herself a 'networker' and will share her experience with new groups.

Wilma was one of the contributors to the original Pathfinder DVD.

Wilma has had no further admissions to hospital and she's had her kitchen completely refitted.

Ruth's story

Until recently, Ruth had enjoyed an active life including parachute jumping and horse riding. Then Ruth lost her husband and was living alone. She fell in her garden and was stuck there for ten hours. After that, she had a six week package of care, was in frequent contact with her GP and was very low in mood. As well as that, a chronic digestive problem had caused Ruth to lose a lot of weight. She needed to be close to the bathroom, which left her with low confidence and she was anxious about leaving her house.

Ruth also has hypertension, osteoporosis, Meniere's disease, depression and memory loss.

How we helped

Ruth's priority was to feel confident enough to get out of the house. We arranged for a volunteer to work with her to build her confidence, starting with talking with her over a cup of tea at home, to going out once a fortnight to a nearby café.

We worked with the GP to arrange nutrition meals and drinks that Ruth would like and wouldn't cause her further stomach problems. We also arranged a medication review.

We referred Ruth for a functional assessment from the Age UK Postural Stability Instructor with a view to attending a balance and stability class.
Within a few weeks, Ruth had additional support and was starting to engage with social activities.

And now.

With the help of a volunteer, Ruth planned and undertook a trip to see her sister, who had been taken poorly. She was interviewed and filmed for a Radio feature.

Ruth regularly attends a walking group with another lady from the Pathfinder, accompanied by a volunteer. She has also joined a coffee morning group.

Ruth's confidence has improved, she has gained weight and she is able to socialise and has shared her experience of grief with other people. Ruth's initial wellbeing score was 17/35 and is now 32/35.

Ruth says she is delighted at having things to look forward to and be part of.

Beatrice's story

Beatrice lives alone with a small dog. She has diabetes and got very breathless at times, which caused her a lot of anxiety. Beatrice had a stroke a recently leaving a lot of pain in her right arm. Beatrice is also partially sighted. She was highly dependent on support and relied on carers for most daily tasks, having four visits a week. She was in regular contact with her GP and District Nurse and had support from the community mental health team to help manage her anxiety.

How we helped

Over a period of weeks, we helped Beatrice to build her confidence and increase her social activities.

We arranged for her to have telehealth support to help manage her diabetes and have a functional assessment with an exercise buddy to help her improve her balance and stability, initially doing exercises at home.

Three months later...

With the help of an exercise buddy, Beatrice now attends a balance and stability class.
Beatrice joined a group on a shopping trip that we organised and now attends a ladies social group.

Her confidence has grown and she recently hosted a coffee morning in her own home.

Eight months later...

Beatrice's wellbeing score has increased from 19/35 to 29/35.

Beatrice took the initiative in reducing her own social care package from four visits a week to two.

She has less contact with the community mental health team as she is learning to self-manage her anxiety.

Mrs C's story

Mrs C lives with her husband but had felt that she was becoming increasingly reliant on him, which was causing tension. She had lost confidence to go out on her own and had found her social world had shrunk. Mrs C has diabetes, heart disease and dementia, among other conditions. She didn't have a package of care but often visited her GP and was missing her diabetes appointments.

How we helped

Mrs C wanted to be able to do the things that she used to enjoy. We spent time finding out what those things were as well as identifying ways to help her manage her diabetes more effectively. We initiated social activities and attendance at support groups over a period of a few weeks, building on Mrs C's confidence incrementally, so that she was able to take on more activities and challenges.

Two months later…

Mrs C attended a Stress Buster course accompanied by volunteer. This had an additional benefit as she was able to socialise with other attendees.

Mrs C also attended a diabetes support group and shared her experiences with others. She keeps her regular appointments with the podiatry service and diabetes nurse.

Mrs C and her husband enjoy bowling and have joined the theatre group. Mrs C also attends the Memory Cafe and a coffee group, independently.

She has had fewer visits to her GP and her husband said that the support they both received probably prevented him from having a breakdown.

Mrs D's story

Mrs D lived alone and had recently spent long periods in hospital following repeated falls. Mrs D had 'chronic legs', asthma and dementia. She was living in one room of her large house, where

she slept, ate, watched TV and had all her personal care done. District Nurses visited Mrs D four times a week and she had a care package of four visits a day.

How we helped

After talking to Mrs D and understanding how she used to live, we found that the key to her goal setting was her desire to get her hair properly washed and cut. She wanted to be able to get to her bathroom to have her hair washed, instead of staying in the same room where she spent all of her time. Health staff were concerned about the risk of mobilising.

We arranged for Mrs D to have a functional assessment with the Age UK Postural Stability Instructor and for her to work with Mrs D to improve her mobility. We set an appointment for a mobile hairdresser to visit, and for a British Red Cross therapist to give Mrs D a neck massage and manicure.

Two months later…

Mrs D's mobility has improved and she can bend with her head down so that her hair can be washed over the sink in the bathroom.

The District Nurse visits have reduced to one a fortnight and Mrs D hasn't had any more admissions to hospital.

Mrs D has not left her house yet but has increased her mobility and has achieved what was important to her. The next step will be to agree a new goal and achieve bigger challenges.

Mrs G's story

Mrs G has angina and dementia, amongst other conditions. Mrs G had repeated falls and was in regular contact with out of hours services and had been in hospital four times last year. She has been housebound for a number of years and both her and her husband were depressed and anxious. Her husband is her main carer, who was struggling to care for his wife and wanted some time to himself.

How we helped

Through talking to Mrs G, it became apparent that her main goal was to take her dog for a walk on the beach, but she was anxious about falling and after being housebound for such a long time she thought this was unachievable.

We arranged for Mrs G to have a functional assessment and an exercise buddy helped her with balance training at home. Gradually, her mobility improved.

A short while later...

Mrs G's mobility improved sufficiently for her to attend a regular social event, giving her husband a chance to go out. Mrs G and her husband are more independent and able to remain at home together. She has had no further hospital admissions and she enjoys throwing a ball for her dog on the beach.