

Abstract

Purpose: an evaluated case study of the Wellbeing Coordinator (WBC) service in Cheshire (UK). WBCs are non-clinical members of the GP surgery or hospital team who offer advice and support to help people with long-term conditions and unmet social needs remain independent at home.

Design: a mixed method design assessed the outcomes of care for recipients and carers using interviews, diaries and validated wellbeing measures. Service utilization data, interviews and observations of WBC consultations enabled investigation of changes in processes of care. Data were analysed using simple descriptive statistics, established instrument scoring systems and accepted social science conventions.

Findings: the WBC complements medical approaches to supporting people with complex health and social care problems, with support for carers often a key service component. Users reported improvements in their wellbeing, access to social networks, and maintenance of social identity and valued activities. Health and social care professionals recognized the value of the service.

Practical implications: The WBC concept relieves the burden on health and social care professionals as the social elements of ill-health are addressed. A shift in thinking from ill-health to well-being means older people feel more able to regain control over their own lives, being less dependent on consulting professionals.

Originality: The WBC is a new service focusing on the individual in their health, social and economic context. Process and outcomes evaluations are rare in this field.

Key words: Active ageing, Health promotion, Community services for the elderly, Person centred care, Service evaluation, Patient experience.

Article classification: case study.

Introduction

The NHS England's 5 Year Forward View (5YFV) (NHS England 2014) presents a radical approach to health care taking a broader perspective from prevention to treatment, and across health and social care, breaking down barriers between sectors. The focus is strongly upon the needs of individuals and their social network, offering people greater control over their own care should they so wish and the ambition to develop person-centred and flexible models of care are key to the 5YFV. The Health Foundation (2014) offers a model of person-centred care, based upon affording patients respect, dignity and compassion; offering coordinated and personalized care and support, and helping people to recognize their own strengths and abilities so that they can live a fulfilling life (p.6). Important elements of this approach can be seen within the self-management literature where emphasis is placed upon understanding people's social context, appreciating their priorities and negotiating the role of professionals and the nature of their support. This leads to improved care relationships, outcomes that are better aligned to people's aspirations and strengthening individual capacity (Kennedy et al, 2007; Morden et al, 2014). With the rise in multimorbidity and the challenge of designing appropriate care (Porter et al, 2015) person-centred approaches have become more prominent as they can address the complexity of care required.

In Cheshire the Clinical Commissioning Groups, Local Authorities and Age UK (Cheshire and Cheshire East) have worked together to develop a service that fits with the above direction of travel. The Wellbeing Coordinator (WBC) service provides the

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3 option for patients with long-term conditions and unmet social needs to be referred to
4 a non-clinical member of the team at the GP surgery or hospital. The WBC
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7 endeavours to signpost and provide the person with the information and support they
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10 require in order to help them to remain independent in their own homes for as long as
11 possible and reduce their future reliance on health and social services. The service
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13 aims in particular to support those patients who are socially isolated and/or lonely, or
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15 at risk of becoming lonely. Research (Hawton et al. 2011; Holt-Lunsted, 2015) has
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17 shown that these factors may predispose people to be admitted to hospital, require
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19 more GP visits or care services.
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25 The WBC service therefore represents a new approach to care that focuses on the
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27 individual in their health, social and economic context. Published evaluations of such
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29 an initiative are currently rare. Two separate evaluations of the service have been
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31 carried out in Cheshire: one focusing on Cheshire East (GP practices in four towns),
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33 and another covering Cheshire West and Chester (one large city GP practice and a
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35 specialist centre based in a community hospital). This case study presents the results
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37 of the Cheshire West and Chester evaluation, carried out during 2015 and which had a
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39 wider dataset. Its aims were: to assess the *outcomes* of the WBC service in terms of
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41 benefits experienced by recipients and carers; to understand the *processes* of care and
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43 the way in which they are perceived by WBCs and other service providers.
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52 **Methods**

53 Settings and intervention

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3 The evaluation focused on two settings: the Centre for Healthy Ageing (CHA), a
4 specialist community based centre attached to an acute hospital and with an explicit
5 philosophy of care that aims to demedicalise ageing and focus on supporting older
6 people to maintain health and well-being; the CW Medical Centre (CW), a large city
7 centre GP practice that aims to provide holistic team based care and support that falls
8 outside of the medical remit. The formal target population for the service at CHA
9 was: anyone aged 90 years or above; people 75 years or above from a care home;
10 persons 75 years or above with 2 or more pre-existing conditions (dementia, history
11 of falls, risk of repeat admissions, incontinence etc) plus those under 75 years if they
12 were frail and had complex health needs. The CW service was available to anyone
13 aged over 75 years and frequent attenders at the practice with nonmedical issues
14 relevant to the WBC service such as debt problems, housing problems, loneliness
15 and social isolation, low level mental health concerns, disability and lack of
16 mobility. In both settings, doctors and nurses were mainly responsible for
17 identifying individuals who they thought needed the WBC service but referrals
18 could be made by other members of the health and social care team such as
19 therapists, pharmacists and staff working in social care and third sector
20 organisations.
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45 Within the CW and CHA the WBC worked as a member of the team, establishing
46 referral pathways to preventative and wellbeing services and activities. After the
47 WBC received a referral an initial assessment was arranged, either at the client's
48 home or at the clinic. This would be a face-to-face encounter held in private. On
49 completion of the assessment achievable goals were agreed in terms of any actions or
50 changes in lifestyle that the client would undertake, specific support that the WBC
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3 intended to provide and a realistic timeframe. If necessary, and acceptable to the
4 client, long-term follow-up support was arranged and a Personal Wellbeing Plan
5 completed. Regular reviews of progress were agreed. Follow-up contacts could be in
6 person or by telephone. The frequency of contacts ranged between a couple of times a
7 week to once a month. A face-to-face sign-off session either confirmed the
8 achievement of identified goals or WBC's assessment that goals have not been
9 reached.
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12 Individuals recruited to the WBC posts were required to have good communication
13 and listening skills and an ability to recognise mental and physical health
14 problems. Having a health, social care or counselling qualification was seen as
15 desirable. Once recruited, the WBCs received an ongoing package of training including:
16 emergency first aid, lone worker training, falls prevention training, motivational interviewing,
17 winter warm/energy training, living well dying well training, adult safeguarding training and
18 dementia friends training.
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20 21 22 Study design

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24 A realistic evaluation perspective was adopted in order to answer the question, what
25 works for whom under what circumstances, thus examining the following
26 relationship:
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50 Mechanism (intervention) + context = outcome
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3 The study design was also informed by the Normalisation Process Theory (NPT)
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5 (Finch and May, 2009) which helps to clarify the way in which people make sense of
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7 an intervention, their decision to participate and action it – including adaptation to
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9 their role or that of their team – and how they monitor its impact.
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11 12 13 Data collection

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17 Methods used to assess the impacts of the service for WBCs, other members of the
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19 health and social care team, recipients and carers, included semi-structured
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21 interviews. A decision was taken to focus primarily on interviewing WBCs and health
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23 and social care staff with areas of questioning including: perspectives on the concept
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25 of the WBC service, how individuals were dealt with before and after the introduction
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27 of the WBC service, its impacts on professionals' work and on individuals using the
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29 service. Shadowing of WBCs and observations of WBC consultations, were used to
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31 further understand the ways in which the service involved change at the WBC,
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33 professional, team and organisational level. The WBCs also collected quantitative
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35 processes of care data on the number, demographic and health characteristics of their
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37 referrals and the type of support provided.
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44 In addition to a limited number of semi-structured interviews, client and carer impacts
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46 were explored by the completion of self-reported narrative case studies and
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48 unstructured diaries (each for 1 week at two time intervals). The client case studies
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50 and diaries selected for analysis were chosen at random from the total WBC team
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52 caseload.
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57 Finally, the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMBS)
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(Tennant et al 2007) and the Office for National Statistics (ONS) life satisfaction and social trust questions (ONS 2015) were used to obtain “before and after” assessments of recipients’ wellbeing. The SWEMBS is a validated instrument used across most of AgeUK Cheshire which focuses on the positive aspects of mental health. This focus differs from many other tools that predominantly examine negative aspects. Client responses to a series of seven questions are aggregated to give an overall score which can range from 7 to 35 with higher scores indicating a higher state of wellbeing. The ONS questions focus on people’s perceptions regarding life satisfaction, happiness, feeling anxious, whether they think the things they do make life worthwhile, and their level of trust in other people. Client responses in relation to ONS questions are scored individually and can range from 0 to 10. For most questions, higher scores indicate a higher state of wellbeing. The exception concerns the question about anxiety where lower scores indicate a reduced state of anxiety. The WBCs were asked to distribute the Wellbeing and ONS questionnaires to each of their clients for self-completion at appointments when they first met them and again when clients were discharged from their care (or at a time as close as possible to their discharge date).

Data analysis and ethical approval

The WBCs anonymised client responses to the SWEMBS and ONS questionnaires before sending them to the evaluation team for analysis using the scoring system referred to previously. Simple descriptive statistics were used to analyse the anonymised details of referrals supplied by the WBCs. All interviews were audio recorded and fully transcribed. A coding framework was developed through careful reading of the transcripts and iterative comparison across the dataset. The analysis allowed for themes to emerge, and these were then compared against the NPT

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3 construct of coherence. Differences in perspectives were identified between clients,
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5 carers, WBCs, health and social care professionals. These differences formed the
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7 framework for reporting the findings.
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11 The study team accessed the “Is my study research?” tool (Medical Research Council/
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13 NHS Health Research Authority 2017) before commencing the project. The tool
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15 poses three questions: “Are participants in your study randomised to different
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17 groups?”; “Does your study protocol demand changing treatment/ patient care from
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19 accepted standards for any of the patients involved?”; “Are your findings going to be
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21 generalizable?”. A negative response to each of these resulted in the study being
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23 classified as a service evaluation, and not requiring approval from an NHS ethics
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25 committee. However, before agreeing to take part, study participants were given
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27 information about the nature of the evaluation, (where relevant) asked to sign consent
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29 forms to indicate if they were happy for anonymized quotes from their semi structured
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31 interviews to be reported, and assured that their anonymity and confidentiality would
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33 be maintained when project results were disseminated.
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41 **Results**

42 Study participants

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50 The results in Table 1 give details of referrals to the WBCs in the two settings.
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52 Referrals to the WBCs in CHA were older, reflecting the fact that this service is
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54 located in a hospital setting. There were also differences between the settings
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56 in terms of the sources of referral.
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12 In the CHA the main sources were through the consultant geriatrician (37%), the
13 specialist nurse (34%) or the occupational therapist (12%) with the main reasons for
14 referral recorded by WBCs being providing information (40%), signposting to a
15 befriending service (14%) and offering benefits advice (5%). Other reasons for
16 referral included offering advice and/or signposting to services covering falls
17 prevention, dementia, transport and aids and adaptations. The mean time between
18 referral and discharge from the WBC service was 27.5 days (range 0-155days) with
19 most clients (74.1%) having only face to face contacts with the WBC, 22.5% only
20 having telephone contacts, while 3.4% of clients had a mixture of face to face and
21 telephone contacts.
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36 Within the CW practice referrals came predominantly from the GP (60%) but also
37 from the practice nurse (12%), and directly from receptionists (14%). The latter route
38 appeared to be on the increase as receptionists gained an understanding of the role of
39 the WBC and could thus save the client having to see the GP first. The main reasons
40 for referral were recorded as general wellbeing assessment (22%), social isolation or
41 loneliness (20%), need for care (17%) or falls prevention (6%). Here the mean time
42 between referral and discharge from the WBC service was 29.1 days (range 1-94
43 days) with 36.4% of clients having only face to face contacts with the WBC, 27.3%
44 only having telephone contacts, while 36.4% of clients had a mixture of face to face
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5 Remaining findings focus on the impacts of the service for clients and carers, WBCs
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7 and other health and social care staff. They draw on data gathered from: semi-
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9 structured interviews with 2 clients, 1 carer, 3 GPs, 1 consultant, 3 health
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11 professionals, 2 administrators, 1 social worker and 2 WBCs; 5 observations of WBC
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13 consultations; 2 patient diaries; and 16 client case studies. In addition, 11 clients from
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15 the CHA and 15 from the CW GP practice completed all or parts of the SWEMWBS
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17 and ONS questionnaires.
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27 The 5YFV emphasizes the provision of holistic, person-centred care and the clients
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29 relayed experiences that reflect this ambition. Many people lived with multiple
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31 conditions, and had to cope with financial, practical and social issues that exacerbated
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33 their ill-health. They expressed the interplay between health and social aspects of their
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35 lives and felt that the WBC could assist with negotiating that interface. Support
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37 ranged widely, and included financial advice. For example, Mrs A was put into
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39 contact with the “Supporting You” team who did a home visit and helped her
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41 complete the blue badge form. She also was referred to the falls prevention team for a
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43 full assessment of safety in her home (CHA case study 1, Jan 2015).
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50 The integrated approach to health and social needs whereby the WBC puts together a
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52 package of care in discussion with the client who can express their preferences is
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54 typified by the example of Mrs B. She was estranged from her family, had back and
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56 neck pain, and suffered with anxiety and depression. She rang the GP and out of hours
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3 service regularly when she was struggling to cope. The WBC liaised with the GP,
4 arranged regular contact by Silverline [a telephone helpline], alongside her own ‘safe
5 and well’ calls, arranged transport for her to go to the Salvation army Christmas
6 dinner and referred her to the AgeUK befriending scheme in order to set up longer-
7 term social support (CHA case study, Jan 2015).
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12 Finally, addressing emotional needs such as alleviating loneliness or lack of
13 confidence is core to the WBC intervention. In the words of one client:
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18 *“One of the main things about talking to them is they feel confident, and that gives*
19 *you confidence. It makes you feel that all is not lost, that you will be fine and that you*
20 *can do things. And every little problem gets ironed out. And it is very comforting to*
21 *know that you are not by yourself, that you can ring someone.”* (CHA interview 1,
22 and reiterated in her daily diary)
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36 The WBC also tries to create more sustainable solutions such as facilitating a
37 reconnection to or maintenance of social networks, and in some cases finding new
38 networks for people.
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45 The quantitative assessments of changes in clients’ wellbeing through the
46 SWEMWBS and ONS questions are given in Tables 2, 3 and 4. At the CHA, the
47 mean period of follow-up was 5 weeks (range 3-8 weeks) and at the CW GP practice
48 7.7 weeks (range 3-16 weeks).
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3 An improvement in SWEMWBS scores was observed in just over half of the group
4 from the CHA. At the CW GP practice, improvements in wellbeing were reported in
5 the majority of people, with 2 staying the same and no-one reporting deterioration.
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12 Insert Table 2 here.
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16 At both settings, most clients' perceptions in relation to each of the ONS questions
17 posed either improved or stayed the same. However, the level of improvement was
18 modest and from a relatively low baseline.
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32 Offering services to carers is equally important as they may need access to
33 information and advice, support for their emotional needs, reassurance or help to
34 arrange respite care (Crellin et al, 2014). Maintaining a sense of self and identity is
35 crucial for carers to continue with their responsibilities, and regular relief and time
36 away are seen as essential aids (Orgeta and Sterzo, 2013). A woman who looked after
37 her husband who had Alzheimer's said:
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47 *"At times you think 'I cannot do this anymore' [...] and then my daughter comes and*
48 *rescues me: 'come on, get your coat on, we are going up town' [...] Yes, you forget*
49 *how to go out and enjoy yourself really."* (CW, interview 3)
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3 The day and respite care provided her with time and reassurance that her husband was
4 safe, and thus freed her mind. She gained the mental space to reconnect with what she
5 enjoyed doing with her daughter.
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11 At times, the WBC has to negotiate a delicate balance between the needs of the client
12 and the carer. Furthermore, often it happens that the prime client turns out to be the
13 carer who may have greater needs than expected. The WBC has to continually adapt
14 to dynamic changes relating to fluctuations in ill-health and social context.
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20 21 22 23 24 25 The WBC perspective. 26

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29 Given that the WBCs focus on wellbeing represents an asset-based approach, they
30 perceive a key benefit of supporting clients and carers to be facilitating a change in
31 their attitude and raising expectations about what they can do to remain well. A
32 further element is the way in which the WBCs can use their know-how to make
33 practical, financial and social changes that positively impact on individuals' capacity
34 to manage their long-term conditions. Providing support for self-management is an
35 integral part of this approach.
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47 A key aspect of the WBC service is the ability to spend time with people, and stay
48 involved for weeks or months. The observed consultations lasted between 20 and 45
49 minutes, allowing the WBC to discuss issues in depth and to build relationships of
50 trust, and acceptance of previously refused support. One WBC summarized it as
51 follows:
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5 *“the people that we tend to get are people that definitely do need somebody just to*
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7 *have the time to sit with and unpick all their problems and listen and I think that’s*
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9 *probably one of they key things is just to sit as much as anything. Certainly to begin*
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11 *with is to listen, and to really start to unpick what their problems are, what their*
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13 *barriers are and then try to get them to focus on one thing at the time, and just*
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15 *improve things gradually.”* (WBC interview)
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21 The fact that clients can be seen for up to 6 times (with some flexibility for longer
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23 term telephone follow-up) responds to the dynamic nature of long-term, multiple
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25 conditions and changes in social contexts. WBCs consider these two dimensions of
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27 time as one of the main benefits of their intervention.
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32 Other health and social care staff perspectives.
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36 The rise in case complexity as a result of more people living with multiple conditions
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38 and difficult circumstances poses a challenge for many health and social care
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40 professionals. The WBCs are seen to offer an alternative in a number of ways: first,
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42 the provision of an integrated, coordinated package of care for clients that delivers
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44 improved outcomes, such as reduced stress and anxiety. This helps people to better
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46 manage their own care and make informed choices about what service they need to
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48 access. One of the nurses emphasized the fact that people could fall through the
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50 cracks as statutory services do not have comprehensive knowledge of what is
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52 available in the community:
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3 *"...for many people it is about their well-being and participation in society. To be*
4 *part of the community, to prevent cognitive deterioration etc. We joke that [WBC] is*
5 *the fount of all knowledge, but I do feel that she knows and [has an] answer to those*
6 *things."* (HP CHA interview 3).
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14 Second, the philosophy of the WBC service allows for demedicalisation and shifting
15 the focus to letting individuals define what is important to them. The WBC role
16 represents the link between statutory services and the community as referrals come
17 from a wide range of professionals, and it employs the knowledge of community
18 based services and activities to support individuals. The value of this unique expertise
19 is recognized by professionals as exemplified by the following quotation from a
20 doctor:
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32 *"The people I have referred for the most part it is about social isolation and the*
33 *problems that come with that: so you get low mood, not wanting to go out of the*
34 *house at all, things get into disrepair and spiralling out of control [... She [WBC] has*
35 *also been reviewing them, so it is not just go and see them, sort it out and leave them.*
36 *She has been to see them again, how are things going and trying to have a more*
37 *holistic approach."* (HP CW interview 1).
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47 The corollary of this is that the WBC helps professionals to focus on delivering care
48 within their area of expertise, and not 'waste' time and effort to solve the practical
49 and psycho-social issues that the WBC can address more effectively. Many
50 professionals feel that this has a positive effect on their job satisfaction.
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3 Third, multidisciplinary teamwork with the WBC as an equal team member is
4 considered essential in all settings. The everyday demands in health and social care
5 mean that professionals are constantly pressed for time. Furthermore, the
6 requirements in terms of implementing good practice guidelines, meeting targets and
7 constantly changing structures add further pressure. Co-location of the WBC is
8 considered of paramount importance because it makes accessing this service easy and
9 informal, and ‘bumping into the WBC in the corridor’ keeps reminding busy
10 professionals that this complementary service is available. Thus, informal
11 (personalized) referral channels are preferred over formal (anonymous) ones. While it
12 may not be possible to have a permanent WBC presence, rotation around venues may
13 allow good visibility, especially for informal progress updates and speedy referrals.
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30 **Discussion**

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34 The ageing of the population and the rise in multimorbidity mean that health and
35 social care providers face the challenge of designing services and pathways that offer
36 patients and carers access to care that is appropriate, timely and person-centred
37 (Beech et al 2013; Porter et al, 2015). This paper has focused on the response to this
38 challenge in Cheshire West and Chester: details of service responses elsewhere are
39 available in the report of Age UK’s *Fit for the Future* project (Wigfield et al 2015).
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49 The WBC service represents the provision of holistic, person-centred care that
50 addresses the complexity of clients’ needs. An emphasis is placed upon understanding
51 people’s social context and priorities and negotiating care relationships and outcomes
52 that are aligned to their aspirations and individual capacities (Kennedy et al, 2007;
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3 Morden et al, 2014). The nature of the service also reflects the fact that the
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5 boundaries between different types of care (from the health, social care and third
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7 sectors) can be blurred and requires a move away from 'one size fits all' approaches.
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9 For example, by drawing on a range of services available to support people who are
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11 socially isolated and/or lonely, or at risk of becoming lonely, the WBC service
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13 recognizes that these factors may predispose people to be admitted to hospital and/or
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15 place greater demands on GP or care services (Hawton et al. 2011; Holt-Lunsted,
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17 2015).
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22 At the system level, the significance of the WBC service is promising in that it fits
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24 with policy ambitions that adopt a broader perspective from prevention to treatment,
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26 and across health and social care, breaking down barriers between sectors (NHS
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28 England 2014). Furthermore, it makes a reality of 'empowering' patients and carers
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30 so that they are supported in maintaining the authorship of their own life story.
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32 Finally, through the holistic package of support and mobilizing community resources,
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34 more care can be delivered closer to home.
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41 At the individual level, improvements in SWEMWBS scores were observed among
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43 the majority of clients. At the CHA, the mean improvement across all clients was
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45 small, likely reflecting the fact that at this hospital setting clients present with a
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47 multitude of problems and their mean age is high (85.1 years). Consequently,
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49 improvements in their circumstances are expected to be limited. The results from the
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51 CW GP practice were more positive, most likely because the client population
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53 appeared to be less complex and was younger (mean age 81.8 years).
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3 Its design means that the results of the study in Cheshire West and Chester are not
4 generalisable. However, further evidence about the impacts of the WBC service is
5 available from the previous evaluation in Cheshire East (GP practices in Crewe,
6 Nantwich, Winsord and Knutsford). That study used qualitative approaches (3 focus
7 groups and 27 semi-structured interviews, including 7 with clients and/or carers) to
8 gather information about the WBC service from clients, carers, service commissioners
9 and WBCs (Jones and Edwards, 2015). Its results reflect the findings of the Cheshire
10 West and Chester evaluation.
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22 Referrals to the service in Cheshire East also included older people with long term
23 conditions and/or who were: socially isolated, facing financial difficulties, making
24 regular and unplanned demands on health services. Support for carers was a further
25 key feature of the service. Perceived benefits for clients and carers included improved
26 feelings of confidence and wellbeing and of being more in control of their health/
27 lives. In turn, such benefits were seen as reducing their unplanned demands on health
28 services. Health staff spoke of clients and carers having access to a service that
29 allowed time for them to discuss their needs and the range of whole system services
30 available for addressing those needs.
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45 The promising initial gains of the WBC service in Cheshire led to continued and
46 expanded funding for 2016 by Clinical Commissioning Groups, Local Authorities and
47 Housing Associations. However, a number of barriers need to be mentioned: lack of
48 knowledge by referrers of the service, short-term nature of funding, co-location not
49 always realized, reduction in community based support services, insufficient
50 communication and inconsistent data collection. These are systemic issues reflecting
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3 organizational and professional boundaries that persist despite policy calls for better
4 integration between health and social care, preventive and curative services, and
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7 community based and hospital care.
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11 Perceived deficiencies in the current evidence base to support the introduction of
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13 WBCs may also act as a barrier. Whilst offering valuable information to inform the
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15 development of the WBC service, the pragmatic design of the service evaluation
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17 reported here (with the WBCs collecting much of the data needed for the study
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19 alongside their everyday tasks) did have implications for the scope and quality of the
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21 results produced. Future studies could adopt a more standardized approach to data
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23 collection and recording and aim to recruit a larger sample of participants.
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29 For example, a more systematic way of recording the characteristics of users of the
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31 WBC service: the evaluation reported here relied on the classification approaches
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33 used by the WBCs and these varied somewhat across settings. Also, the study
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35 described here did not obtain details about the number of individuals who: chose not
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37 to access or did not fully engage with WBC service; declined to complete the
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39 SWEMBWS and ONS questionnaires. Again, these deficiencies could be addressed in
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41 a future study. In addition, its design could include a formal evaluation of the health
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43 economics implications of the service, although feedback from health professionals
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45 did indicate that it allowed them to devote their time to their clinical role in the
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47 knowledge that clients' wider support needs were being addressed by the WBCs.
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49 Finally, although the current study used recognized approaches for assessing changes
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51 in the quality of life and wellbeing of clients, the number completing questionnaires
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53 was relatively low and the period of follow-up relatively short (average around 6.6
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3 weeks). A study with a larger sample size could assess whether the improvements in
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5 client wellbeing that were observed in this study would be replicated elsewhere and,
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7 by repeating the measures after 6 or 12 months, ascertain whether any gains are
8
9 maintained. Results from the Fit for the Future project (Wigfield et al 2015) do,
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11 however, suggest that WBC type services can have longer term benefits for the
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13 mental wellbeing of clients.
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16 17 18 **Conclusions** 19

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22 The combined results from the evaluations of the WBC service in Cheshire provide
23
24 evidence of the positive impacts that it can have on the wellbeing of clients, carers
25
26 and their social networks. The benefits to professionals and the contribution that the
27
28 WBCs make to the effective integration of health, social and third sector services are
29
30 equally important.
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33 34 35 **Acknowledgements** 36

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41 this study. The authors of the paper have no conflicts of interest in terms of the
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43 material presented.
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Table 1: Referrals and their characteristics

<u>Heading</u>	<u>CHA</u> <u>N (%)</u>	<u>CW</u> <u>N (%)</u>
Number of referrals n (%)	130 (100.0) ⁵	65 (100.0) ⁶
Sex, n (%):		
Female	80 (61.5)	43 (66.2)
Male	50 (38.5)	22 (33.8)
Mean age in years (range)	85.1 (72-108)	81.8 (62-103)
Disability code, n (%) (<i>covers 134 individuals</i>):		
Physical disability	81 (60.4)	26 (40.0)
Mental health condition	46 (34.3)	8 (12.3)
Long term condition	1 (0.8)	9 (13.8)
Deaf	1 (0.8)	0 (0.0)
Other sensory disability	5 (3.7)	0 (0.0)
No disability	0 (0.0)	5 (7.7)
Unknown	0 (0.0)	17 (26.2)

⁵ December 2014 through May 2015

⁶ 27th January 2015 through 20th May 2015

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Table 2: Changes in SWEMWBS scores⁷ for users of the WBC service

CHA (n=11)		
	Before	After
Mean client score (range)	19.75 (11.25-26.02)	21.10 (17.89-30.70)
Number of clients who improved	6	
Number of clients who worsened	5	
CW (n=14)		
	Before	After
Mean client score (range)	21.07 (14.75-35.00)	24.21 (19.25-35.00)
Number of clients who improved	12	
Number of clients who worsened	0	
Number of clients who stayed the same	2	

⁷Scores can range from 7 to 35 with higher scores indicating a higher state of wellbeing

Table 3: Changes in ONS scores for users of the WBC service at the CHA

“Overall, how satisfied are you with your life nowadays?” (n=11)⁸		
	Before	After
Mean client score (range)	4.36 (1-10)	4.81 (1-10)
Number of clients who improved	4	
Number of clients who worsened	2	
Number of clients who stayed the same	5	
“Overall, how happy did you feel yesterday?” (n=11)⁸		
	Before	After
Mean client score (range)	4.82 (2-10)	5.00 (1-10)
Number of clients who improved	4	
Number of clients who worsened	2	
Number of clients who stayed the same	5	
“Overall, how anxious did you feel yesterday?” (n=11)⁹		
	Before	After
Mean client score (range)	4.09 (0-9)	5.09 (1-10)
Number of clients who improved	2	
Number of clients who worsened	5	
Number of clients who stayed the same	4	
“Overall, to what extent do you feel the things you do in your life are worthwhile?” (n=10)⁸		
	Before	After
Mean client score (range)	5.20 (0-10)	5.80 (2-10)
Number of clients who improved	5	
Number of clients who worsened	4	
Number of clients who stayed the same	1	
“Generally speaking, would you say that most people can be trusted, or that you can’t be too careful in dealing with people?” (n=11)⁸		
	Before	After
Mean client score (range)	4.36 (2-6)	4.82 (2-10)
Number of clients who improved	3	
Number of clients who worsened	1	
Number of clients who stayed the same	7	

⁸Scores can range from 0 to 10 with higher scores indicating a higher state of wellbeing

⁹Scores can range from 0 to 10 with lower scores indicating a higher state of wellbeing

Table 4: Changes in ONS scores for users of the WBC service at CW

“Overall, how satisfied are you with your life nowadays?” (n=15)⁸		
	Before	After
Mean client score (range)	5.5 (0-8)	7.2 (5-10)
Number of clients who improved	12	
Number of clients who worsened	1	
Number of clients who stayed the same	2	
“Overall, how happy did you feel yesterday?” (n=14)⁸		
	Before	After
Mean client score (range)	5.9 (0-10)	7.6 (5-10)
Number of clients who improved	10	
Number of clients who worsened	1	
Number of clients who stayed the same	3	
“Overall, how anxious did you feel yesterday?” (n=14)⁹		
	Before	After
Mean client score (range)	4.7 (1-10)	2.6 (1-6)
Number of clients who improved	11	
Number of clients who worsened	0	
Number of clients who stayed the same	3	
“Overall, to what extent do you feel the things you do in your life are worthwhile?” (n=14)⁸		
	Before	After
Mean client score (range)	5.6 (1-10)	7.4 (5-10)
Number of clients who improved	8	
Number of clients who worsened	1	
Number of clients who stayed the same	5	
“Generally speaking, would you say that most people can be trusted, or that you can’t be too careful in dealing with people?” (n=12)⁸		
	Before	After
Mean client score (range)	6.8 (3-10)	7.1 (2-10)
Number of clients who improved	4	
Number of clients who worsened	2	
Number of clients who stayed the same	6	

⁸Scores can range from 0 to 10 with higher scores indicating a higher state of wellbeing

⁹Scores can range from 0 to 10 with lower scores indicating a higher state of wellbeing