Health and Social Care Board

Living Well Moyle
Reaching Out

THE DALRIADA PATHFINDER PARTNERSHIP

LIVING WELL MOYLE

FINAL EVALUATION REPORT

AUGUST 2020

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Foreword

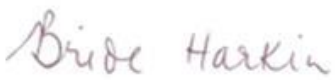
As Chair of the Dalriada Pathfinder Partnership, I am delighted to present this evaluation of Living Well Moyle.

This evaluation focuses on the period from the inception of Living Well Moyle in October 2016 to October 2019. The information presented relates to the experiences of 158 participants with a particular focus on the 48 people who were discharged and for whom information relating to 6 months post discharge was available thus providing a full analysis of the impact of support. In addition, we have sought to reflect the wealth of community involvement in the Living Well approach as well as reflecting the experience of those participating in supporting the individuals.

It is important to note that this analysis involves a period to period service use comparison approach. It has not been possible to use a control group or matched cohort, given the issues of sourcing data and although this would provide a further degree of assurance regarding the validity of the emerging trends, we are confident that there is sufficient information associated with the existing data to present the findings.

The Dalriada Pathfinder Partnership is delighted to share the outcomes as it is now clear from the information, the case studies and the feedback from a wide range of stakeholders, that this approach is proving to be very worthwhile in addressing the needs of those who require support in the community. It is also evident that this approach leads to improved and health wellbeing of participants and early evidence is that it has reduced reliance on unscheduled care services.

I hope you will find this report both interesting and stimulating.



Bride Harkin
Assistant Director of Commissioning, Health and Social Care Board
and Chair of Dalriada Pathfinder Partnership

1.0 STRATEGIC CONTEXT

In October 2016, a 10 year approach to transforming health and social care was launched, *Health and Wellbeing 2026: Delivering Together*. This plan was the response to the report produced by an Expert Panel led by Professor Bengoa tasked with considering the best configuration of Health and Social Care Services in Northern Ireland - *Systems, Not Structures: Changing Health and Social Care.*

"Delivering Together" outlines the need to enable people to stay well for longer and where possible to provide care or support in the community setting. It emphasises the requirement to prioritise prevention and early intervention with a view to producing better health and wellbeing outcomes and reducing demand on already over stretched acute services. It will also help us tackle what the Expert Panel Report calls "striking health inequalities" in our society.

In describing how our society is getting older and people are living longer, often with long-term health conditions, there is an acknowledgement that this presents a huge and growing challenge in terms of the demands and pressures on health and social care services.

The plan articulates the need for a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing and states: "We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing".

In line with the recommendations of the Expert Panel's Report, *Delivering Together* states how we need to empower local providers and communities to work in partnership to deliver new ways of supporting people to maintain their health and wellbeing and independence.

At the launch of Living Well Moyle in November 2016, the then Minister for Health commended the partnership working and the involvement of the local community in the design and delivery of Living Well Moyle.

2.0 BACKGROUND

In November 2014, the Northern Health and Social Care Trust (NHSCT) proposed the closure of Dalriada Hospital in Ballycastle as part of its contingency savings plan that year. There was significant public concern in Ballycastle and the surrounding area and a local campaign group 'Save the Dal' was formed, culminating in a judicial review of the closure. The legal challenge was successful and the Hospital, which comprised community rehabilitation beds and MS beds, remained open. The then Moyle District Council commissioned a piece of work looking at possible options for the future delivery of health and social care in the Ballycastle area and commended the group to look at different models of care, including the Living Well approach from Cornwall. Dr Mary McLister, a local General Practitioner (GP), and other members of the 'Save the Dal' group then approached the Northern Local Commissioning Group, a committee of the Health and Social Care Board (NLCG) and the NHSCT to explore this option in more detail and out of those discussions emerged the Dalriada Pathfinder Partnership (DPP).

The Partnership explored the work of the Newquay Pathfinder which had piloted an approach based on targeted wraparound support motivating "at risk" older people to achieve their aspirations through a guided conversation. Individuals were supported by an Age UK worker to identify their goals and to co-ordinate a management plan delivered by bringing together statutory and community services and support. The support using volunteers, aims to build individuals' social networks making them better connected to their community and more resilient.

The outcomes achieved by the initial Newquay pilot demonstrated:

- ✓ 23% improvement in people's self-reported wellbeing;
- ✓ 87% of practitioners say integration worked very well and their work was meaningful;
- ✓ 30% reduction in non-elective admission cost;
- ✓ 40% drop in acute admissions for long term conditions; and
- ✓ 5% cost reduction and reduction in demand for adult social care.

The Story so Far

The Dalriada Pathfinder Partnership promotes health and wellbeing in the local area of Moyle including Bushmills, Ballintoy, Armoy, Ballycastle, Cushendun, Cushendall, Rathlin and the Glens of Antrim. The Partnership involves the local community and voluntary sector and GPs working together with Age NI, the Health and Social Care Board (HSCB), the Public Health Agency (PHA), the Integrated Care Partnership (ICP), the Northern Health and Social Care Trust (NHSCT), Causeway Coast and Glens Borough Council and the Community Navigator.

Geographical area covered by Living Well Moyle

Living Well Moyle (LWM) was introduced by the Dalriada Pathfinder Partnership to identify people in the community over the age of 18, who are dealing with ongoing health issues and who may be lonely or isolated. Individuals who are patients of five GP practices in the area living with a long term condition, and who have had a recent hospital admission or Emergency Department attendance, are identified by the GP or health and social care professionals or voluntary and community organisations working in the locality and the GP approves an onward referral. The Living Well Co-ordinator subsequently visits the person and provides the necessary support to enable them to identify what might help to improve their wellbeing. This may involve ongoing support from a volunteer or an introduction to various clubs and activities which will help to integrate them back into their local community.

Living Well Moyle also benefits from the input of a pharmacist. If the Living Well Moyle Co-ordinator identifies any issues or concerns regarding medication, a referral is made to the pharmacist with the person's consent. The pharmacist will visit to undertake a medicines optimisation/adherence assessment and any adjustments or recommendations will be documented in writing to the GP practice and community pharmacist. Any proposed changes will be monitored on an ongoing basis by the pharmacist.

Living Well Moyle relies heavily on volunteers and community groups and also on organised activities. Many of the activities such as reminiscence evenings, films, art and musical events have been organised by Arts Care NI.

The initial stakeholder meeting was held on the 21st January 2016, bringing together those who had expressed an interest in developing the Living Well model in the Moyle area. Following this on the 17th February 2016, a workshop was convened and facilitated by two individuals who had led on Living Well in Cornwall. This provided information to a wide range of staff and other stakeholders in order to ensure that there was mutual understanding of the model and agreement to the introduction of Living Well in the Moyle area. A study visit was undertaken to Cornwall by representatives from the Partnership in May 2016 which proved very valuable in providing an opportunity to understand the processes involved in the roll out and operation of Living Well. It also provided insight into the importance of relationships between all the parties involved in the management and delivery of Living Well.

A community mapping exercise took place in April 2016. This brought together over 70 people from the local community representing voluntary and community groups and enabled a comprehensive mapping exercise of services and activities which would subsequently inform and support the Living Well model.

Members of the Dalriada Pathfinder Partnership and Department of Health officials pictured with the then Minister for Health and the launch of Living Well Moyle in November 2016

Living Well Moyle was formally launched by the then Minister for Health, on the 30th November 2016. Representatives from other statutory bodies, the voluntary and community sector and local schools all attended. The launch was a clear demonstration of the Partnership working and the Minister highlighted the need for services to be *"driven by co-production by building capacity with communities and by learning from communities and projects exactly like this one."* The event also incorporated the launch of the Living Well Moyle logo designed by a pupil from one of the local schools as part of an art competition.

The Dalriada Pathfinder Partnership Project Board has continued to meet on a monthly basis since April 2016 to provide direction and oversight for the work of Living Well Moyle. A Project Team was established to provide operational input and it also meets monthly.

Both Teams receive a monthly highlight report from the Living Well Co-ordinator which provides details of referrals, describes outcomes achieved and outlines other partnership work undertaken in the local community.

The themes considered by the Project Board are wide ranging and reflect the interest and diversity of the membership. Examples are listed below:

- Agreement on Project Initiation Document – objectives, criteria, membership and roles;
- Appointment of Living Well Moyle Co-ordinator;
- Referral Pathway;
- Engagement with community, staff and primary care;
- Funding;
- Issues regarding volunteers;
- Communication with stakeholders;
- Alignment of Living Well Moyle with wider strategic priorities;
- Work with Arts Care;
- Intergenerational work;
- Partnership working; and
- Evaluation – collection of data and information for monitoring.

A Celebration Event was held on the 1st May 2018 to commend and thank all those from the community, the voluntary sector and others such as health and social care staff, local schools and Arts Care who have contributed to the successful journey of introducing and embedding Living Well Moyle. Over 80 participants heard from people who have been supported by Living Well Moyle, volunteers, staff and a local GP. They also enjoyed a short film made by Screen NI on "Remembering the Lammas Fair" with input from local older people and traditional music.

Representatives from the Dalriada Pathfinder Partnership with Dr Tony Stevens, Chief Executive, NHSCT

Members of Ballintoy over 55 Club enjoying the Celebration Event on 1st May 2018

To date over 100 referrals have been received with a significant number of personal goals realised. Many of these goals involve signposting to other services such as Good Morning Ballycastle, North Coast Community Transport, Rural Transport and Age NI. Versus Arthritis, Advice and Advocacy, Arts Care NI and walking groups have also proved invaluable.

Referrals have also been made to a range of health and social care professionals such as the pharmacist, nurse specialists, social workers and allied health professionals. Schemes within the local Council such as Affordable Warmth and Home Safety Checks and other schemes such as Floating Support, Handy Man Service, Library and Fire Safety services have all been used to support people to continue to live in their own homes and to achieve enhanced health and well-being.

There are currently 20 volunteers supporting various people in the community. Many linkages which have been made with local community groups involve a volunteer providing the initial assistance to support the person engaging with Living Well Moyle to participate and re-engage in community life.

3.0 OUTCOMES FRAMEWORK

In order to establish whether the Living Well approach was achieving benefits for those being supported in the community, the Dalriada Pathfinder Partnership adopted a similar outcomes framework to the Newquay Pathfinder. Initially three outcomes were proposed:

Outcome 1 - *Improved health and well-being of the LWM participants*

Outcome 2 - *Improved experience of those delivering services*

Outcome 3 - *Reduced cost of care and support*

In developing the Living Well Moyle model, it became clear that a further outcome associated with Community Development was emerging.

In light of this, the following fourth outcome was adopted:

Outcome 4 – *The benefit to wider community development*

The evaluation of the outcomes noted above has been wide-ranging. The following information has been gathered and collated using both quantitative and qualitative methods to illustrate the extent to which the four outcomes have been achieved.

Outcome 1: Improved Health and Well-being of Living Well Moyle (LWM) Participants

IMPACT

Methodology

This section outlines the process by which Outcome 1 was monitored and evaluated. A mixed method approach was adopted which involved utilising three validated measurement scales, supplemented with follow-up interviews collecting some qualitative data.

Measurement Tools

The validated measurements scales used to measure the impact of Living Well Moyle are:

- Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)
- Living Well Scale (based on the Rockwood Scale)
- Loneliness Scale

Each measurement scale and their usage are outlined in the sections below.

Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)

This measurement scale is used to measure mental wellbeing. It is generally used to provide a collective picture of the self-reported level of mental wellbeing across a group of people. The scale contains 7 statements, designed to measure levels of mental wellbeing. Those completing it are encouraged to consider the previous two weeks and their general level of wellbeing over this time, before providing an answer as to the degree to which they agree with each statement. The scale for each of the 7 statements is:

- None of the Time - translates to a '1'
- Rarely – translates to a '2'
- Some of the Time – translates to a '3'
- Often – translates to a '4'
- All of the Time – translates to '5'

The highest possible score a person can have is 35, which suggests they have excellent mental wellbeing and the lowest possible score is 7. In order to measure any changes in levels of mental wellbeing, SWEMWBS can be completed at various intervals to allow for comparison of scores.

Living Well Scale (based on the Rockwood Scale)

This scale measures self-reported levels of physical health. It can be used to provide an overall picture of levels of physical health within a group and can also give insight in to individual improvements in physical health. It contains 9 stages of physical health, shown below:

- Fit and Well - translates to a '1'
- Living Well – translates to a '2'
- Managing Well – translates to a '3'
- Generally Well – translates to a '4'
- Needing Help – translates to a '5'
- Supported – translates to a '6'
- Dependent – translates to a '7'
- Very Dependent – translates to a '8'
- Terminally Ill – translates to a '9'

Each of the nine stages is accompanied by a description of the characteristics you would expect to see from someone placed in each category - the lower the score, the better the person's physical health. The Living Well scale can be completed at various intervals in order to determine change. The highest possible score a person can get is 9, which suggests extremely low physical health. A score of 1 would suggest excellent physical health.

Loneliness Scale

This scale measures level of self-reported loneliness. It can provide an overall picture of levels of loneliness across a group or give insight in to individuals' change in feelings of loneliness. It contains 3 statements which focus on indicators of loneliness such as, relationships, social contact and feelings of loneliness. The loneliness scale encourages those completing it to consider the previous two weeks and their general level of loneliness over this time, before providing an answer as to the degree to which they agree with each statement. The scale for each of the 3 statements is:

- None of the Time - translates to a '1'
- Rarely – translates to a '2'
- Some of the Time – translates to a '3'
- Often – translates to a '4'
- All of the Time – translates to '5'

The Loneliness scale can be completed at various intervals in order to determine change. The highest possible score someone can have on this scale is 15 and the lowest is 3. A score of 15 suggests you are not experiencing loneliness and a score of 3 suggests the person is very lonely.

Evaluation Process

Outcome 1

Service users involved in Living Well Moyle will go through the following stages to ensure their needs are being met and appropriate data is being collected to evaluate and demonstrate impact:

- 'Guided conversation' – this utilises the principles of motivational interviewing in order to ensure it is as person-centred as possible, therefore empowering service users to set their own goals. The three measurement scales (SWEMWBS, Living Well scale and Loneliness scale) are completed by each service user during the 'guided conversation'. These 'guided conversations' take place on a 3-month basis, during which the goals are revisited and each of the three measurement scales are completed.

- Follow-up evaluation – when a service user's involvement in Living Well Moyle ends, they are offered the opportunity to take part in a follow-up phone call/visit. This is carried out by the Impact and Evaluation Manager of Age NI who gathers service evaluation data, as well as details on impact.

IMPACT - 1st Oct 16 - 31st Oct 19

86% of service users reached their goals

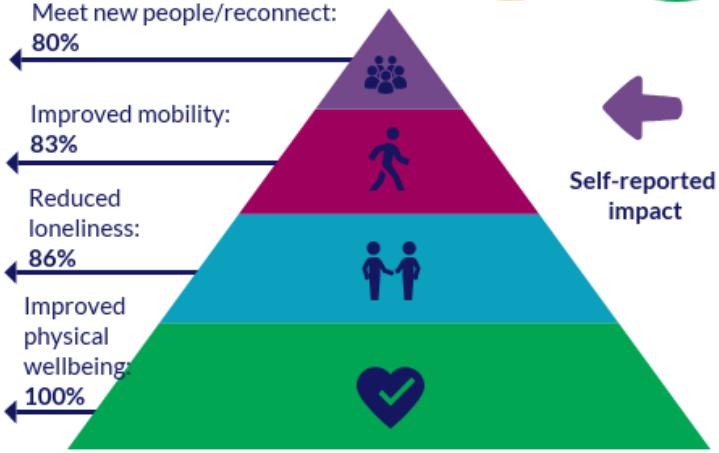
71% of service users started new activities

71% of service users will continue their activities

100% of service users felt Living Well Moyle helped them

100% of service users would recommend involvement

100% of service users felt listened to



Self-reported impact

Service evaluation

Service user views

"Got out of bed and left the house which I was not doing previously."

"Having someone come to visit has helped - could have gone all day and not seen anyone."

"One of the most invaluable services I have ever come across."

"People who called out were all nice and easy to talk to. Listened to what I had to say."

Measurement scales - Baseline, interval ratings comparison (SWEMWBS, Living Well Scale, Loneliness Scale)

Mental wellbeing

24% improvement in mental wellbeing experienced by service users

11% improvement in mental wellbeing experienced by volunteers

25% improvement in mental wellbeing experienced by female service users

21% improvement in mental wellbeing experienced by male service users

Physical health

4.89% improvement in physical health experienced by service users *(between 0-3 months)*

Loneliness

26% reduction in loneliness experienced by service users

Findings

Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)

Each service user is invited to complete a SWEMWBS on a three-monthly basis however there are occasions when this was not possible. Reasons service users may not be able to complete each three monthly SWEMWBS would include, leaving the service before the next 3-monthly interval, not feeling up to considering their mental wellbeing at that time etc. Also, as we are looking at data from a particular period of time, not all service users will have completed five separate SWEMWBS within that time. Therefore, Table 1 provides a breakdown of the numbers of completed SWEMWBS received, across the various intervals.

Table 1: Number of SWEMWBS completed at each interval

Interval	SWEMWBS Completed
Baseline	127
3-month	89
6-month	68
9-month	42
12-month	25

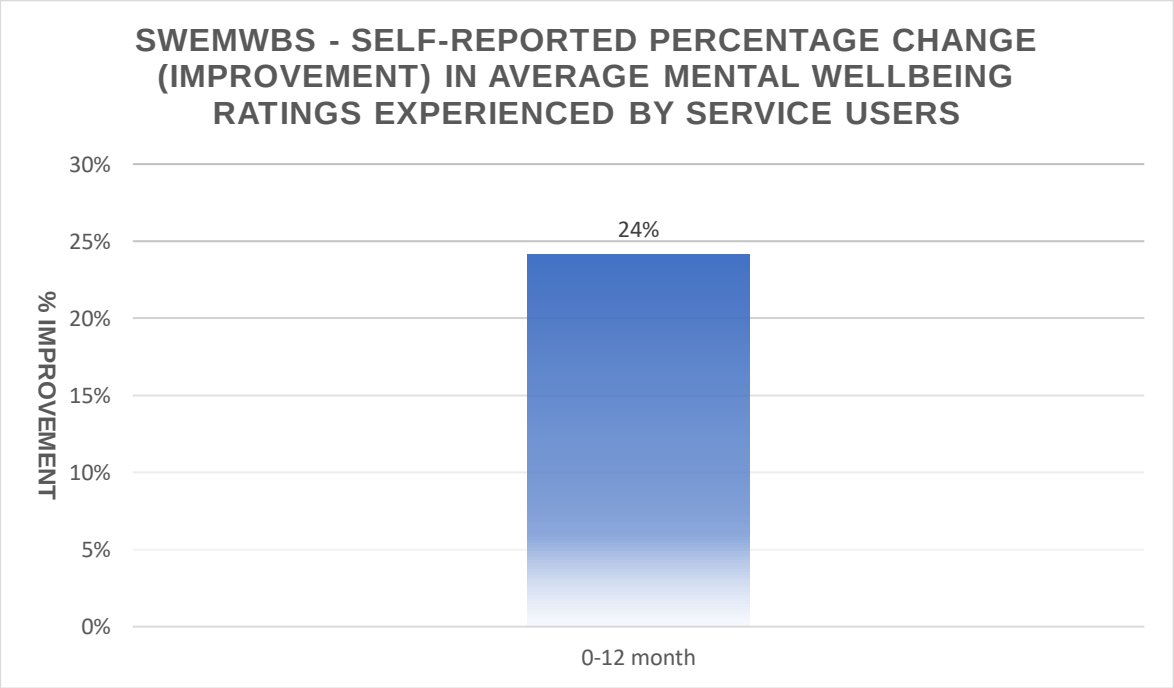


Figure 1: Percentage change (improvement) in average mental wellbeing ratings experienced by service users overall. This is an encouraging statistic as not only are those supported through Living Well Moyle experiencing improved mental wellbeing, but the degree to which they have improved is considerable.

Living Well Scale

The Living Well Scale is based on the scale produced by Geriatric Medicine Research, Dalhousie University, Halifax in Canada. The scale ranges from 1 to 9, 1 meaning the person is fit and well and 9 meaning the person is terminally ill. Therefore, a reduction in average ratings across all service users would suggest an improvement in physical health.

Table 2 shows the number of service users who provided ratings at each interval.

Interval	Service users
Baseline	129
3-month	91
6-month	68
9-month	44
12-month	28

The figures below show the findings from the Living Well scale:

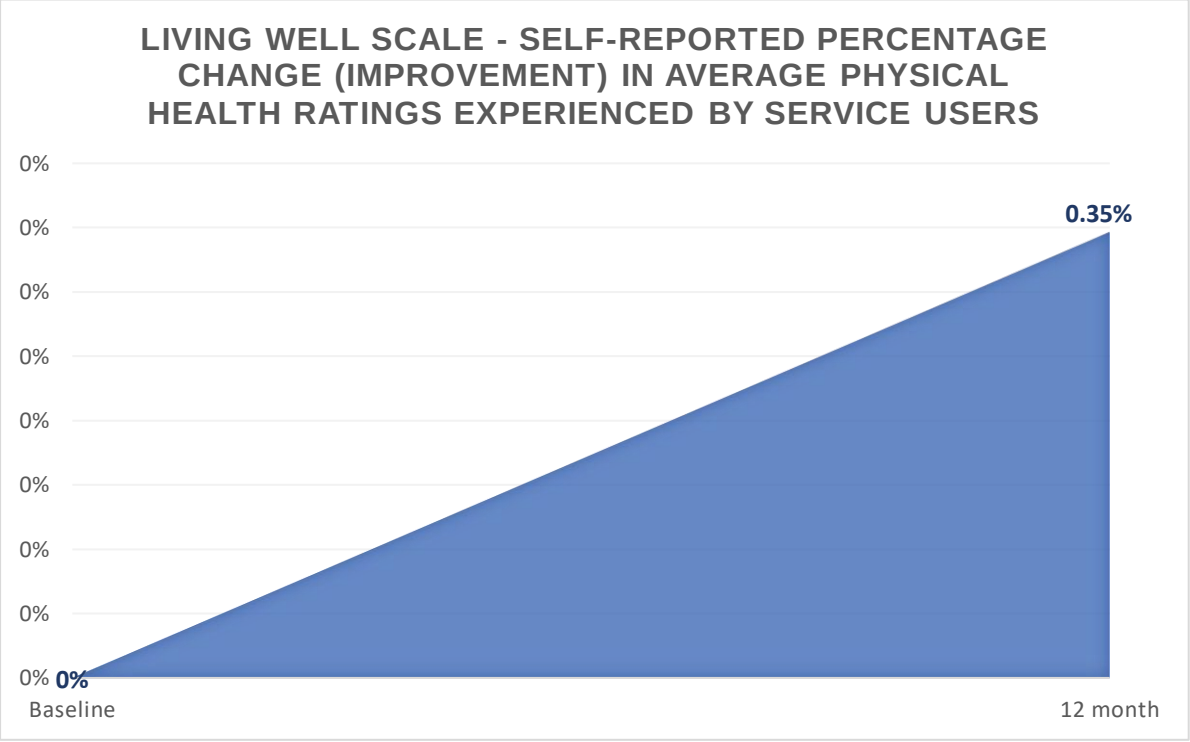


Figure 2: Percentage change (improvement) in average physical health ratings experienced by service users overall.

Figure 2 shows that the percentage change in average physical health ratings between the baseline and 12-month interval increased minimally (0.35%), which suggests reduced physical health. Living Well Moyle aims to improve access to healthcare, however those involved in the service do have chronic health conditions which may deteriorate over time. This is beyond the control of the service; however, the service improves access to healthcare services and supports people to manage their condition. The low level of reduced health (0.35%) could suggest that the service is successfully supporting health management.

Loneliness Scale

This is a 3-item scale which focusses on determining levels of loneliness. The scale contains 5 ratings, 1 represents 'none of the time' and 5 represents 'all of the time'. Higher ratings suggest low levels of loneliness and low ratings suggest high levels of loneliness. Therefore, increasing averages suggest reduced loneliness.

Table 3 shows the number of service users who provided ratings at each interval.

Interval	Service users
Baseline	129
3-month	90
6-month	67
9-month	42
12-month	24

The graphs below show the findings from the Loneliness scale:

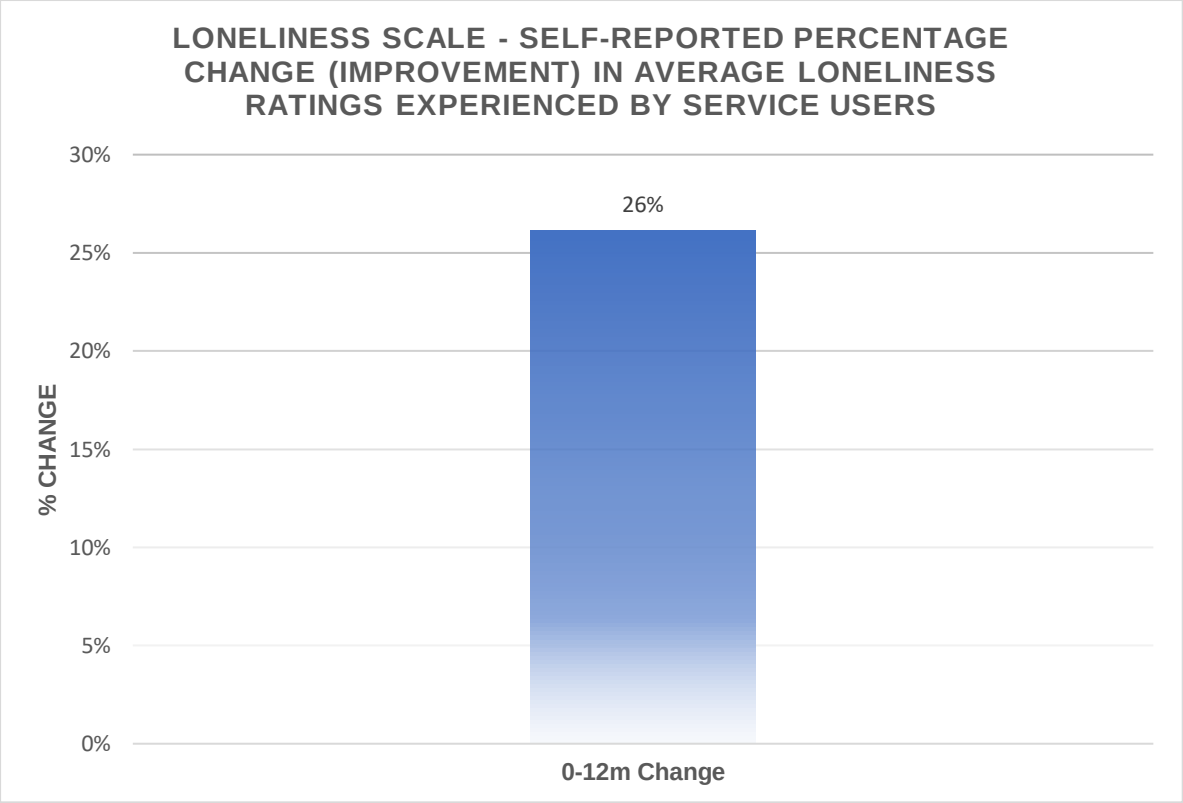


Figure 3: Percentage change (improvement) in average loneliness ratings experienced by service users overall, highlighting a reduction in loneliness.

A 26% reduction in loneliness is a substantial change for the service users to experience and therefore indicates that Living Well Moyle does impact significantly on levels of loneliness.

Follow-up Evaluation

Service users were provided with the opportunity to take part in one-to-one interviews with Age NI's Impact and Evaluation Manager. These interviews took place when a service user's engagement with Living Well Moyle came to an end and prompted service users to reflect on their time on the service and share their reflections. Two key areas were covered in the follow-up evaluation interviews:

- Service evaluation – identifying the service users' level of satisfaction with the service, their achievements whilst involved in the service and any areas for improvement

- Impact – identifying any impacts which service users felt occurred as a result of their involvement in Living Well Moyle. Some of the impacts are the same as those measured by the validated tools, however in this dataset service users are asked retrospectively if certain aspects of their lives have improved.

In total, 7 service users availed of the opportunity to participate in a follow-up evaluation interview. Therefore, the findings outlined in this section are based on 7 people. Going forward, increased emphasis will be placed on the option of a follow-up interview in order to increase the sample size.

Service evaluation

As part of the follow-up interview, services users were asked for feedback on the service itself and for their views on how effective (or otherwise) it was. The areas covered within the service evaluation aspect of the interviews were:

- Goals achieved
- New activities started and continued
- Extent to which LWM has helped
- Extent to which their views were taken on board
- Would they recommend involvement with LWM
- Areas for Improvement
- Overall comment

Figure 4 shows the percentage of service users who reported that they had reached their goals on Living Well Moyle.

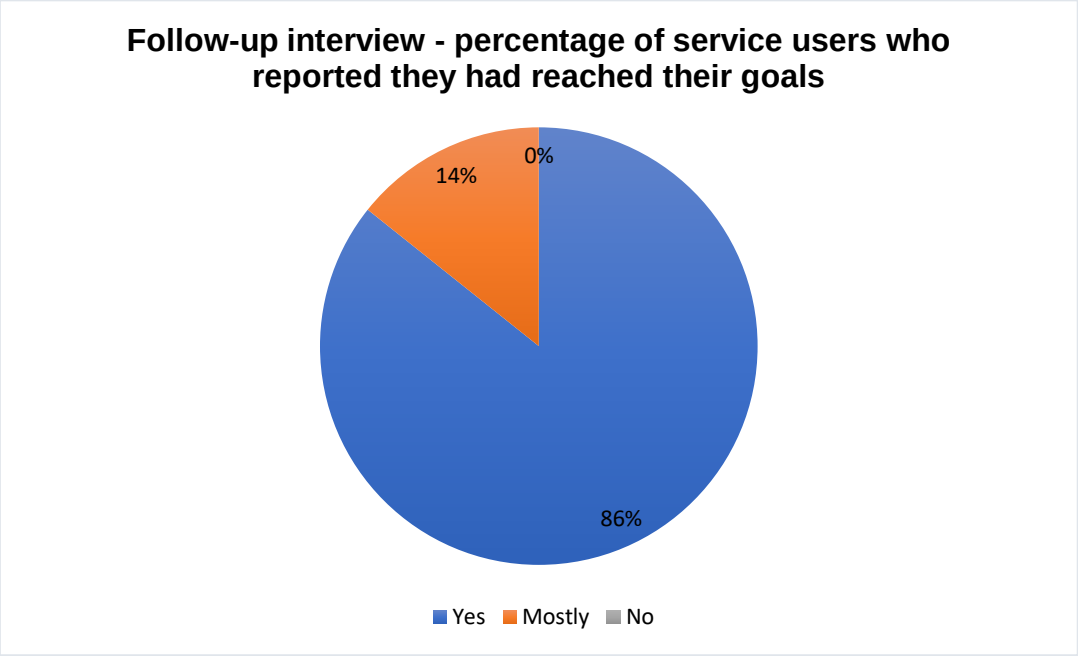


Figure 4: This is a very positive finding as a key aspect of Living Well Moyle is to empower older people to live their lives in the way that they choose. Goals are set by the service users themselves. Analysis of a larger sample size could provide a stronger basis for this assumption.

Impact

As part of the follow-up interview, services users were asked to provide feedback on certain anticipated impacts of Living Well Moyle. The areas of impact covered in the interview were:

- Meet new people/reconnect
- Improved physical wellbeing
- Improved mobility
- Reduced Loneliness

As with the service evaluation aspect of the follow-up interview, 7 service users provided feedback on the impacts they experienced. Figure 5 shows the percentage of service users reporting the various impacts. The below statistics are only based on those service users who felt the impact area was applicable to them.

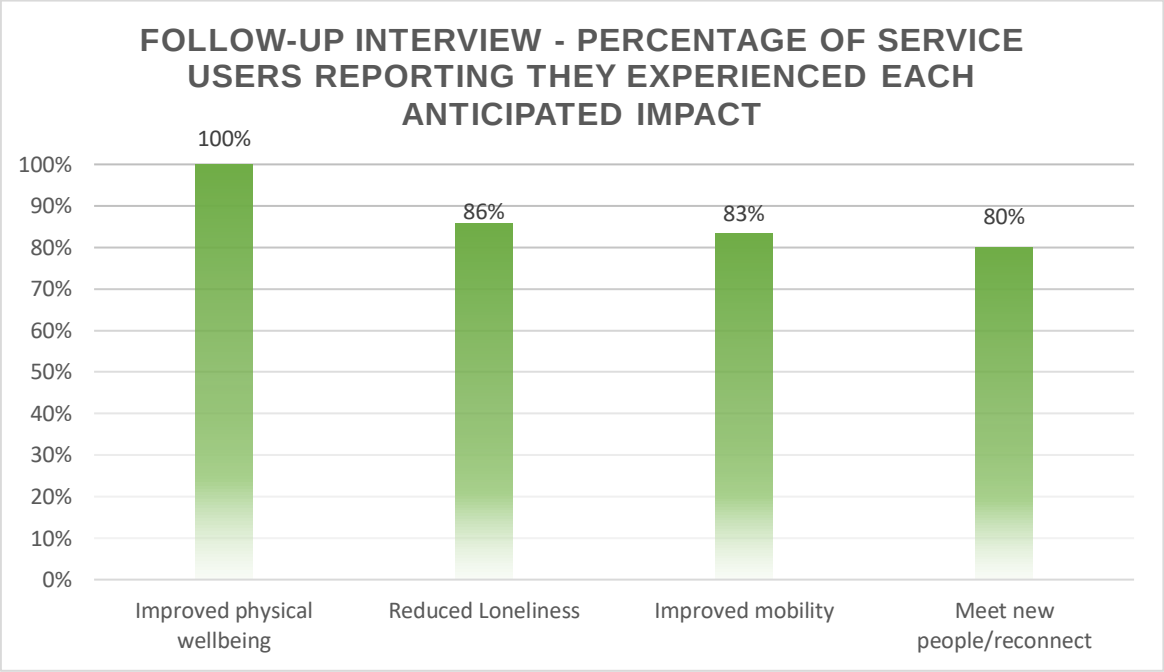


Figure 5: Percentage of service users who reported that they experienced each anticipated impact.

This is reflective of the improvement in physical health demonstrated by the Living Well Scale. Some of those who reported an improvement in physical wellbeing shared how Living Well Moyle enabled them to get out of the house and join a new group:

Helped me get involved in walking group, which I had to then give up due to back pain but now that feeling better might go back. [Living Well Moyle co-ordinator] took me to the chemist to get my medication put into blister packs which means I can be sure I am taking what I need to at the correct time.

A considerable percentage 86% (n=6) of the service users, who completed an interview, reported a reduction in their feelings of loneliness. Some of whom shared the ways in which Living Well Moyle led to them feeling less lonely:

Night time can be very lonely but now moving to residential setting and very excited and LW visits helped.

Got involved in knit and natter and another group.

Having someone come to visit has helped - could have gone all day and not seen anyone.

Of the service users who completed an interview, 83% (n=5 **one respondent felt the question was not applicable to them*) reported they have improved mobility. They shared how access to transport, mobility aids and volunteer support enabled them to get out and about more:

Able to access transport as was not able to drive. Live in a very rural area.

Wheelchair - couldn't leave house before.

Walking aid has helped steady me.

Finally, 80% (n=4 **two respondents felt the question was not applicable to them*) service users reported that they were able to meet new people, or reconnect with those they lost touch with, as a result of Living Well Moyle. Some of those who reported this shared their thoughts:

Been to Arts Care programme.

In new housing.

Have met new people.

Summary – Outcome 1

The findings presented suggest that Outcome 1 (improve health and wellbeing) has been met, with service users experiencing the following between baseline and 12 months:

- 24.0 % improvement in mental wellbeing
- 4.89 % improvement in physical health
- 26.0 % reduction in loneliness

Importantly, service users were still experiencing considerable improvements in mental wellbeing between the 9-month and 12-month period (7%), suggesting that Living Well Moyle provides a sustained level of support regardless of the length of time a service user has been on the service. Qualitative data collected further emphasised the impact of Living Well Moyle with service user's self-reporting the following impacts:

- Helped to meet new people/reconnect
- Improved physical wellbeing
- Improved mobility
- Reduced loneliness

Findings from data collected via validated measurement scales and retrospective interviews suggest that Living Well Moyle has had a positive impact on the majority of those involved.

The following case studies illustrate the range of issues which Living Well Moyle addresses. As can be seen from the examples the ongoing developing relationship with the Living Well Co-ordinator and subsequently the volunteers and individuals being supported, results in very positive and sustainable outcomes and impacts on health and wellbeing.

Case Study: Jean

Introduction: Jean was referred to Living Well Moyle by her Social Worker. Although she did not identify any goals at the first Guided Conversation, it was agreed visits from the Living Well Co-ordinator to offer support would be helpful in light of a recent bereavement. Jean uses a wheelchair and requires assistance for personal care as a result of a long term condition.

Action Taken: It was agreed that the Living Well Co-ordinator would visit weekly to offer support.

Outcomes: The Living Well Co-ordinator visited Jean for a period of 3 months. At her last review, Jean advised that the support came just at the right time and that she had benefited from the visits.

Jean has since set a goal to get out more which she is accomplishing and has reported that she had gone out with a friend which was a great step forward and also had been out on social outings with her family. Jean's overall well-being has improved.

Case Study: Grace

Introduction: Grace was referred to Living Well Moyle by her Social Worker. Grace had been admitted to hospital three times in the previous 12 months. Grace lives on her own in a rural area. The Living Well Co-ordinator found Grace in ill health on her first visit and it was evident that she was in pain and had other medical issues. The Living Well Co-ordinator contacted Grace's GP who actioned appropriate medical intervention.

On discharge from hospital, the Living Well Co-ordinator carried out an initial guided conversation. Grace identified a need to become connected with others, to become independent and to have a car again. Until this goal was achieved, Grace was enrolled with Rural Community Transport.

Action Taken: The following signposting/referrals were made:

- Rural Community Transport
- Blue Badge Scheme
- Age NI Advice & Advocacy
- Support with PIP process
- Signposted to over 55's group
- Christmas food hamper
- NI Fire Service – home safety/fire check – installation of smoke alarms
- COAST home safety check – advice & installation of home security items
- Car purchased
- Medicines blister pack

Outcomes: Grace has regained her independence and is able to drive to and from appointments, to town for shopping and socialising and visits friends. By supporting and signposting G she has been able to connect with life again as well as empowering her to pursue good outcomes in her health.

Case Study: Margaret

Introduction: Margaret was referred to Living Well Moyle by her Social Worker to explore her social needs, as well any emotional help and support required, as she had been diagnosed with a long term condition.

An initial guided conversation with Margaret identified an aspiration to get out and about. Her initial goal was to be able to walk her dog again at the seafront which she was enabled to accomplish. By establishing a relationship with Margaret, the Living Well Moyle Co-ordinator was able to assist her at a time when she was progressing through change in moving house and dealing with ongoing pain as she was awaiting surgery. By supporting her emotionally and liaising with her Social Worker, she was able to make the transition to interim accommodation until her new bungalow was found.

Action Taken: Margaret has been matched with a Living Well Moyle volunteer who is also one of her Homecare Workers and is aware of Margaret's very specific condition and needs. Several referrals to organisations have also been made:

- Warmer Home Scheme NI
- Handyman scheme
- Safer home check
- Installation of key safe
- Blue Badge
- Community physio for assessment for rollator
- OT regarding recent falls
- Liaison with family and friends to answer queries and assist with signposting etc.
- Falls prevention alert technology
- Dance therapy through Arts Care
- Referral to Otago (Strengthening and Co-ordination/Falls Prevention Exercises) by Living Well Moyle trained volunteer on a one-one basis in M's home.

Outcomes: Through Living Well Moyle, and in conjunction with other statutory services and friends and family, Margaret has been supported to continue to live a fulfilled and outgoing life. She has been able to continue to get out and about and it is now hoped with the assistance of her volunteer to do this in a supported way.

Also, after being part of the Arts Care Programme in one of the Over 55s clubs, she wishes to become a member which will give her a greater circle of social connection. This will contribute to maintaining and improving her mental and emotional well-being and outlook.

Margaret will continue to be supported by Living Well Moyle Co-ordinator with review visits and as and when required to assist with ongoing concerns and queries raised by her volunteer or family/friends.

Case Study: Ellen

Introduction: Ellen was referred to Living Well Moyle after her family contacted Age NI Head Office with concerns for their mother's social isolation and loneliness. The initial Guided Conversation with Ellen identified a need and aspiration to get out from time to time and also that she would be keen for a visitor/volunteer. Although Ellen felt she was coping well she did say that the day can be long and lonely. She does not have family close by, her children visit when they can (fortnightly/monthly), with the occasional visit from acquaintances.

Action Taken: Ellen was matched with a Living Well Moyle volunteer in July 2018. A referral was also made to Community Physiotherapy to re-assess for a rollator to allow her to get out and about.

Outcomes: Ellen has been out with a volunteer who visits on a regular basis. This has improved Ellen's outlook, which is evidenced in Warwick, Edinburgh Mental Well Being Scale. Improved scores in this evaluation, as well as the Loneliness Scale, which is completed on a 3 month basis alongside follow up visit/review, have been recorded for Ellen.

Having the contact of a volunteer gives Ellen's family reassurance that their mum has social contact as well as knowing that the Living Well Moyle Co-ordinator who is calling on a 3 monthly basis, will report/sign-post any issues with the appropriate service/organisation.

Outcome 2 – Improved Experience of those Delivering Services

In order to evaluate this outcome, in addition to the data collected and analysed using SWEMBS, focus groups have taken place with volunteers and staff. The Living Well Co-ordinator and a representative from the Voluntary and Community Sector have been interviewed. Surveys have been conducted with GPs and Practice Managers and with other stakeholders following a World Quality Day event. The findings are presented in the following section.

Volunteers

Volunteers involved in Living Well Moyle will go through the following stages to ensure they are adequately supported and that appropriate data is being collected to evaluate and demonstrate impact:

- Supervision – volunteers are provided with 3-monthly supervisions to allow them to discuss any additional training/support they may need and to collect evaluation data, via the SWEMWBS measurement scale.
- 1:1 interview/focus group – volunteers are provided with the opportunity to take part in 1:1 interview and/or focus groups in order to provide further feedback. This is carried out by the Impact and Evaluation Manager, Age NI, who gathers service evaluation data as well as details on impact.

Yvonne Carson from the NHSCT Health and Well Being Team and Fiona Kennedy, Living Well Moyle Co-ordinator with a number of volunteers involved in Living Well Moyle

Table 4: Number of SWEMWBS completed at each interval.

Interval	Service users
Baseline	15
3-month	7
6-month	3

The volunteer numbers for SWEMWBS are low, due to a low return rate in completed SWEMWBS, during this time. The process has now been changed with volunteer completing SWEMWBS at the end of supervision rather than relying on postal returns.

The figures below show the findings from SWEMWBS completed by the volunteers:

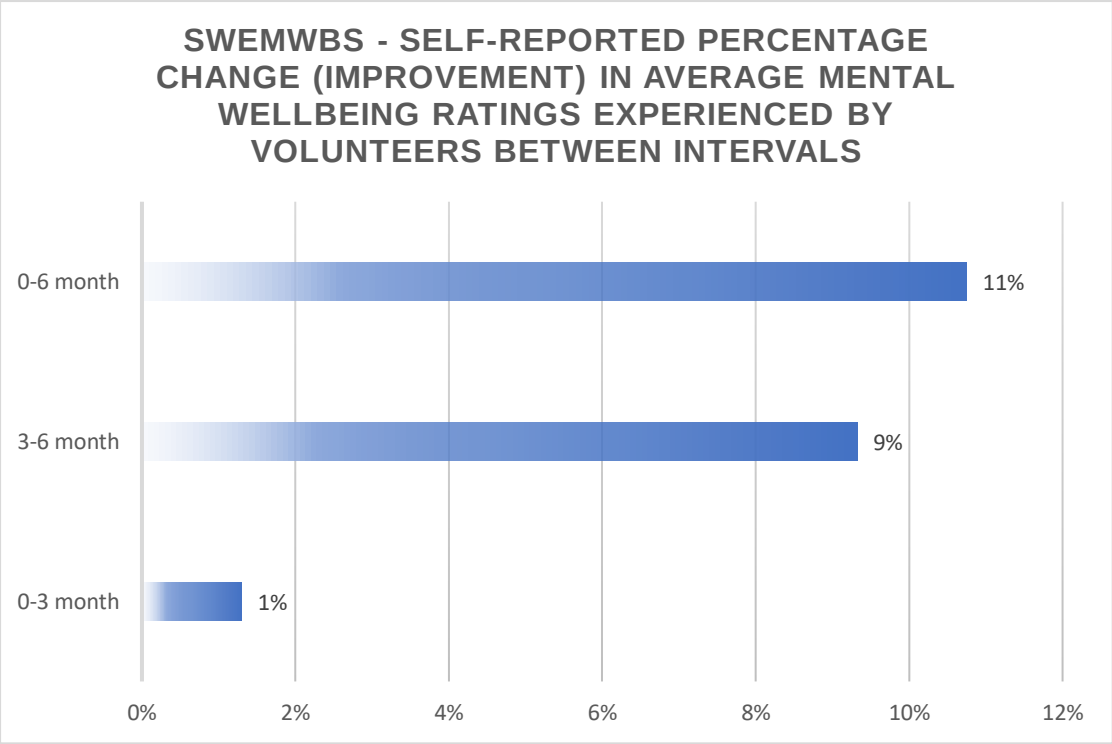


Figure 6: Percentage change (improvement) in average mental wellbeing ratings experienced by volunteers overall, between each interval.

The least level of change was experienced between baseline and the 3 month point. This could potentially be explained by the fact that volunteers often go through a period of training and support in order to prepare them for the service. It could be assumed that this stage would involve less direct involvement with service users, which may be a factor towards the smaller level of improvement.

The findings suggest that the volunteer aspect of Outcome 2 (improved experience of those delivering services) has been met, with volunteers experiencing a 29% improvement in mental wellbeing between baseline and 6 months. Volunteers also

showed improvements in their wellbeing between baseline and 3 months (2%) and 3 months and 6 months (27%).

Volunteer findings suggest that Living Well Moyle provides an environment in which mental wellbeing can improve even when volunteers have been with the service for some time. This is highlighted by the 9% increase in mental wellbeing between 3 and 6 months. 50% of volunteers experienced a 'meaningful' change (3-8-point difference) in their mental wellbeing and 83% experienced improved mental wellbeing. Through improving volunteers' mental wellbeing, it can be assumed that this will lead to an improved experienced for volunteers involved in Living Well Moyle.

A focus group was held with 10 volunteers to explore their experience of volunteering with Living Well Moyle. Overall the consensus was that it was very worthwhile to help people in the local community and that as a volunteer you are helping people to stay in their own homes.

"Family said it was a lifeline."

During the discussion they described how people had turned their lives around with the support of the volunteers and had gone from being housebound and lonely to engaging in activities and feeling motivated and confident again. The full group said they would recommend volunteering with Living Well Moyle to others and felt the experience had also benefited them in many ways.

"I get great satisfaction being able to help someone."

During the period of the evaluation the volunteers provided over 700 hours of support. The support ranges from participating in arts and crafts activities to taking the person out for coffee, shopping and a chat.

Staff

A focus group was held with a multidisciplinary group of 8 staff to explore their experience of Living Well Moyle. All of those present were aware of the Living Well approach and were very positive about the impact on their clients:

"One person had a fantastic volunteer and they built up a great relationship, there was a big change in the person's emotional and physical wellbeing."

"One person was really hesitant of having a social worker. This was a less intrusive way of providing support and there was time for therapeutic input."

One theme which emerged very strongly was the fact that the Living Well Co-ordinator is based in the same office as the Trust multidisciplinary community team in Ballycastle. There was consensus that this gave the team a clear insight into what could be offered as support in the local community.

One concern was that the criterion which stipulates a recent hospital attendance or admission results in people who would benefit from the preventative nature of the service being excluded.

"This is a unique service which we are privileged to have in this area. We can see the benefits."

Living Well Co-ordinator

A one-to-one interview was conducted with the Living Well Co-ordinator in post during the period of the evaluation, to gain her perspective on Living Well Moyle.

Overall the LWC is very positive about her experience, having been inspired in the first place by the overall ethos of the Living Well approach in being person centred. Throughout the interview the emphasis was on the key issue of building relationships with the people being supported, the multidisciplinary teams and the community and how this has been successful and contributed to the overall development of Living Well Moyle.

The LWC has gradually built up a relationship with the GP practices. The LWC attends multidisciplinary meetings on a monthly basis in two of the practices and as necessary in the other practices, with the aim of discussing involvement and outcomes relating to those patients of the practices who have been referred and supported. In addition to providing feedback regarding the support, the LWC also uses the opportunity to highlight any issues which may have been observed during visits.

There have been challenges such as supporting the GPs to refer patients to Living Well Moyle on an ongoing basis and ongoing capacity to support both volunteers and individuals while building relationships with staff and the community.

"This is what is unique about Living Well Moyle – spending the time to build a relationship and trust."

COAST

A one to one meeting was held with the Manager of Causeway Older Active Strategic Team (COAST) to explore her experience of Living Well Moyle. COAST is an inter-agency partnership which aims to improve the health and wellbeing of those aged 60 and over in the Causeway Coast and Glens Borough Council area.

As a member of both the Project Group and Project Team, the Manager is well informed but expressed the view that there are still people in the community who do not know about Living Well Moyle. Being a member on both the groups has provided networking opportunities. One of the main issues highlighted during the discussion was the need to ensure complementarity of services locally and to improve communication between local providers of services so that there is an awareness of what each group and approach offers individuals in need of support. The role of volunteers in providing support was acknowledged.

"Volunteers can give so much more of themselves - they have time to give themselves fully to the person. Volunteers are there because they want to be. Volunteers are the key to any project especially Living Well Moyle. You couldn't pay staff to do all that."

It was also highlighted that there is a need to consider the growing demands on the capacity of the voluntary and community sector as people are encouraged to seek support from local community resources.

GP Feedback

A survey was undertaken with the 5 GP Practices who participate in Living Well Moyle. A range of feedback was received from 12 GPs and Practice Managers.

All agreed that they were sufficiently informed about Living Well Moyle and 8 out of the 12 responses considered the referral process to be definitely straightforward with the others saying it was to some extent.

Of the 12 who had responded, 8 said their patients had benefited significantly and 3 said they had benefited to some extent, 1 did not respond. 7 responded that being involved had significantly benefited them and their practice, 4 said to some extent and I did not respond.

Additional comments ranged from noting how the approach has supported those who need help/advice and has encouraged involvement in the local community, thereby addressing social isolation.

"Living Well Moyle has given the Practice another pathway to help patients refocus and being able to engage in activities offered in the community. The GPs have noticed a positive change in some of their patients' attitudes to their own wellbeing."

One issue raised by the participants in the survey was the eligibility criterion that requires those living with a long term condition to have had a recent emergency department attendance or hospital admission. Concern was expressed that this excluded many individuals who could otherwise have benefited from Living Well Moyle. The inclusion of this criterion at the outset was to try to measure the cost-effectiveness of this approach in terms of showing a reduced reliance on hospital unscheduled care services.

The overall consensus is that this is too restrictive and it should be revised to enable more people with a long term condition to avail of the approach.

World Quality Day Event

Introduction

As part of World Quality Day, a “Delivering Quality through Partnership” event was held on the 8th November 2018. The event provided an opportunity to showcase and celebrate the effective partnership working which is leading to the delivery of quality care. The event took a speed dating approach whereby attendees spent a short time with each other outlining their work and the opportunities for collaboration before moving on. The event provided a platform to share information on Living Well Moyle.

In order to determine if attendees felt the event was useful and to determine if in fact attendees felt they learned more about Living Well Moyle, a Survey Monkey evaluation was distributed to attendees.

Findings

In total, 19 attendees completed the post-event evaluation and 89% said it was useful. 78% of respondents indicated that they learned something at the event. Those respondents who indicated that they learned something new at the event were invited to share details on what they learned.

Some of the quotes are noted below:

"Wide range of support available in the local community".

"I had the opportunity to speak to different healthcare professionals and learn what their job entails and how we can better work together for patient centred care."

"The variety of community/voluntary services available for service users and how keen they were to engage with statutory services and service users."

76% of respondents indicated that their knowledge of Living Well Moyle improved as a result of the event; 88% of respondents indicated that they created new connections at the event; 94% of respondents indicated that they felt events like this should take place regularly.

Outcome 3 – Reduced Cost of Care and Support

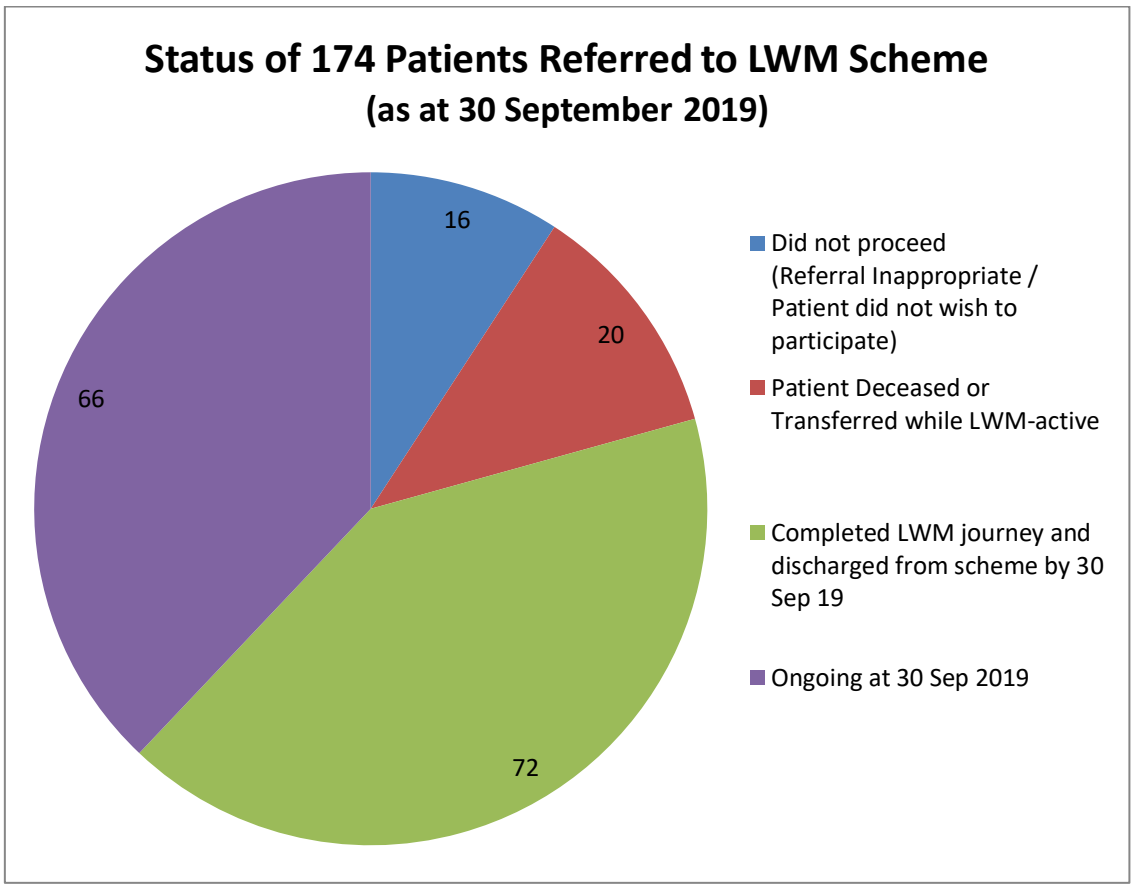
Analyses of Living Well Moyle Impact

Comparison of pre, during and post-intervention use of services

The information and charts that follow provide some analysis of the impact of the Living Well Moyle programme. The focus of these analyses is *"Outcome 3: Increased Cost of Care and Support".*

The analyses have been carried out using data extracted 30 September 2019, and reflect activity and caseload up to and at that snapshot period.

In total, 174 patients were referred to the Living Well Moyle programme by their GP by the reference date of 30 September 2019. Of those, 16 did not proceed as either they did not meet the referral criteria or the patient did not wish to take part, leaving 158 patients who participated in the programme. At 30 September 2019, 72 patients had completed their Living Well Moyle journey and been discharged from the programme, and 66 patients were still active. The remaining 20 patients' participation on the programme had ceased on account of the patient having died, or having transferred from the referring practice.



Methodology

In order to gauge the impact of Living Well Moyle participation on service usage, data was obtained on each participant's use of health and social care services in the pre-intervention, during-intervention, and post-intervention periods as follows:

- Pre-intervention – the 6 month period immediately prior to each patient's commencement on the LWM programme;
- Living Well Moyle Intervention Period - the duration of the intervention period (variable by individual patient);
- Post-intervention – the 6 month period following completion of LWM participation.

The Reference Group

By 30 September 2019, 72 patients had completed their Living Well Moyle journey, although not all of those had completed a full 6 months post-intervention. This analysis has therefore been limited to only those patients who had completed their LWM journey by 30 March 2019, and had therefore had a full 6 months post-intervention by 30 September 2019 (n=48)

Standardising the figures

This analysis seeks to compare levels of service usage between the different time-periods. It should be noted that because the actual period of intervention averaged 8.56 months per participant (ranging from just a few weeks to over a year), data for that period has been standardised to 6 months, in order to allow meaningful comparison with the pre-intervention and post-intervention periods.

Validating the findings

As this evaluation does not involve use of a control group, we cannot be certain that the changes in levels of service usage are solely as a result of the Living Well Moyle intervention. While consideration was given to adopting a control group approach, it was decided that the challenges it would present in terms of General Data Protection Regulations (GDPR) and the capacity of participating GP practices to extract the required data would be too onerous considering the small scale of this project.

Services included in the Analysis

The areas covered include a range of Acute, Community, and Primary Care based services:

- Acute Care
  - Emergency Department Attendances
  - Hospital Admissions
  - Acute Hospital Bed Days

- Community Care
  - District Nurse Home Appointments
  - Domiciliary Care Hours
  - Intermediate / Community Hospital Bed Days

- Primary Care
  - GP Appointments
  - GP Home Visits
  - GP Callbacks
  - GP Out-of-Hours Consultations
  - Practice Nurse Appointments

The Data

The following table shows (for each of the service areas):

- the combined total level of service usage by 48 participants in the pre-, during-, and post-LWM periods;
- the average usage for each participant in those periods; and
- the percentage change between the 6 months pre-LWM and the 6 months post-LWM periods:

	SERVICES USED BY 48 PATIENTS BEFORE, DURING, AND AFTER LWM				
	SERVICE	PRE-INTERVENTION SERVICE USAGE	INTERVENTION PERIOD SERVICE USAGE	POST-INTERVENTION SERVICE USAGE	% CHANGE pre-intervention to post-intervention
ACUTE CARE	**ED Attendances**	**23**	**28**	**16**	**↓ 30.5%**
	(average per patient)	*(0.48)*	*(0.58)*	*(0.33)*	
	Hospital Admissions (incl Unscheduled)	**18**	**10**	**10**	**↓ 44.5%**
	(average per patient)	*(0.38)*	*(0.20)*	*(0.21)*	
	Acute Hospital Bed Days	**142**	**55**	**31**	**↓ 78.0%**
	(average per patient)	*(2.95)*	*(1.14)*	*(0.65)*	
COMMUNITY CARE	**District Nurse Home Appointments**	**327**	**234**	**386**	**↑ 17.9%**
	(average per patient)	*(6.82)*	*(4.88)*	*(8.04)*	
	Intermediate / Community Hospital Bed Days	**27**	**0**	**102**	**↑ 277.2%**
	(average per patient)	*(0.56)*	*(0.00)*	*(2.13)*	
	Domiciliary Care Hours	**1498**	**2786**	**3052**	**↑ 103.7%**
	(average per patient)	*(31.21)*	*(58.05)*	*(63.58)*	
PRIMARY CARE	**GP Appointments**	**122**	**139**	**89**	**↓ 26.7%**
	(average per patient)	*(2.53)*	*(2.91)*	*(1.86)*	
	GP Home Visits	**17**	**32**	**36**	**↑ 112.4%**
	(average per patient)	*(0.36)*	*(0.67)*	*(0.76)*	
	GP Telephone/ Callbacks	**80**	**74**	**82**	**↑ 1.9%**
	(average per patient)	*(1.67)*	*(1.55)*	*(1.70)*	
	Practice Nurse Appointments	**96**	**102**	**81**	**↓ 16.2%**
	(average per patient)	*(2.01)*	*(2.12)*	*(1.68)*	
	GP Out-of-Hours Consultations	**13**	**27**	**27**	**↑ 106.3%**
	(average per patient)	*(0.27)*	*(0.57)*	*(0.56)*	

This data was used to generate the charts which appear on the following pages. These illustrate at a glance how service usage changed between the pre-, during-, and post-LWM periods within the individual service areas.

Differentiation by Gender and Age

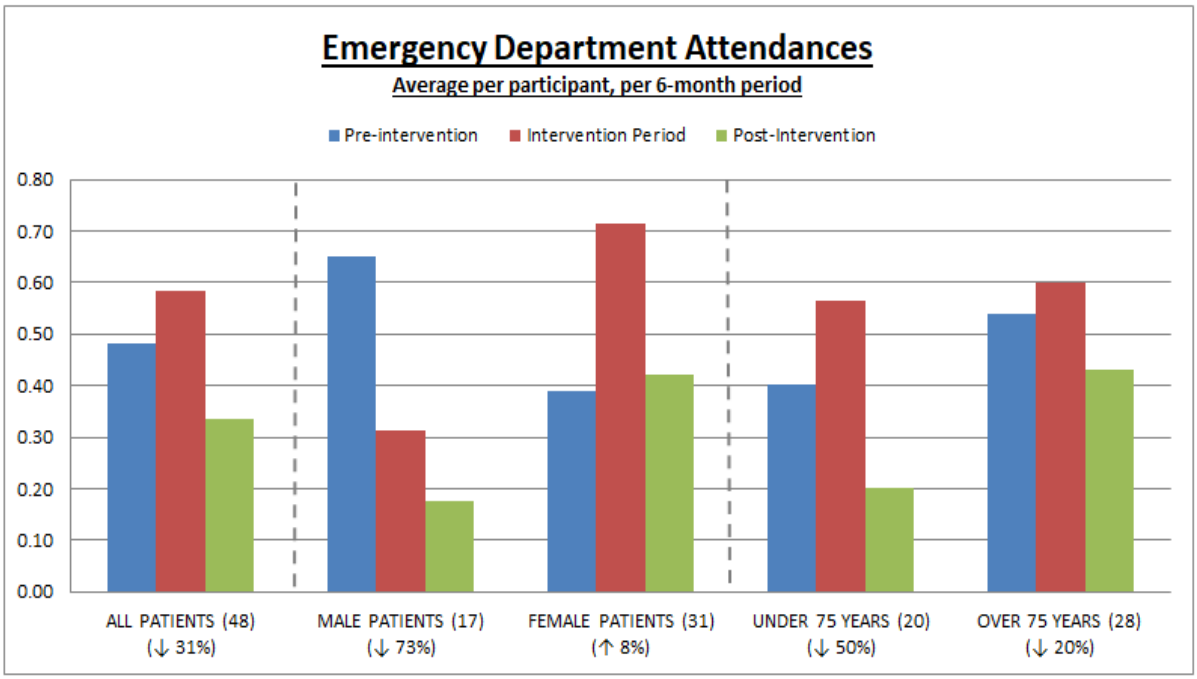
Following initial analysis of service usage for the cohort of 48 patients, the data was further dissected to allow comparison of outcomes

- between males and females; and
- between those under-75 and those over-75 years.

Separate columns have been added to the charts to illustrate this.

Visualising the Changes – Service Usage Charts

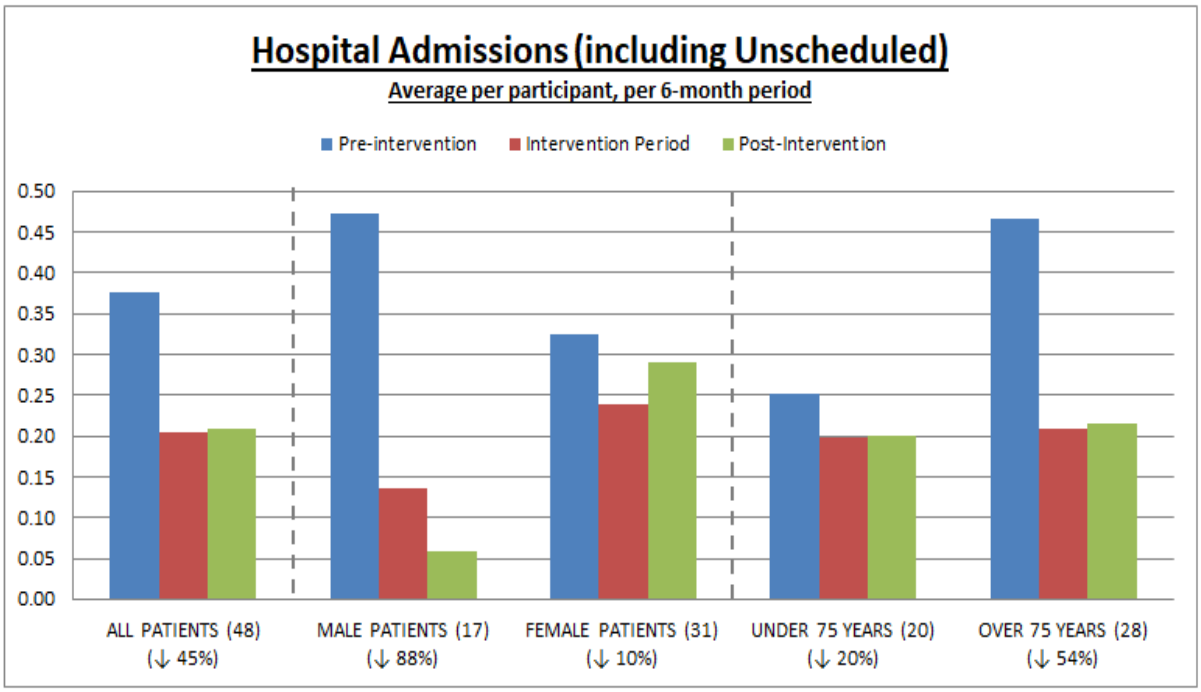
(i) Emergency Department Attendances



Key findings from the data:

- Service usage for the cohort reduced by 31% overall between the pre-intervention and post-intervention periods;
- The reduction was most pronounced in male participants (↓ 73%), but there was a slight increase among the female participants (↑ 8%);
- The data showed a 50% reduction in service usage for those in the under-75 age category, compared to a 20% reduction for those aged over-75.

(ii) Hospital Admissions



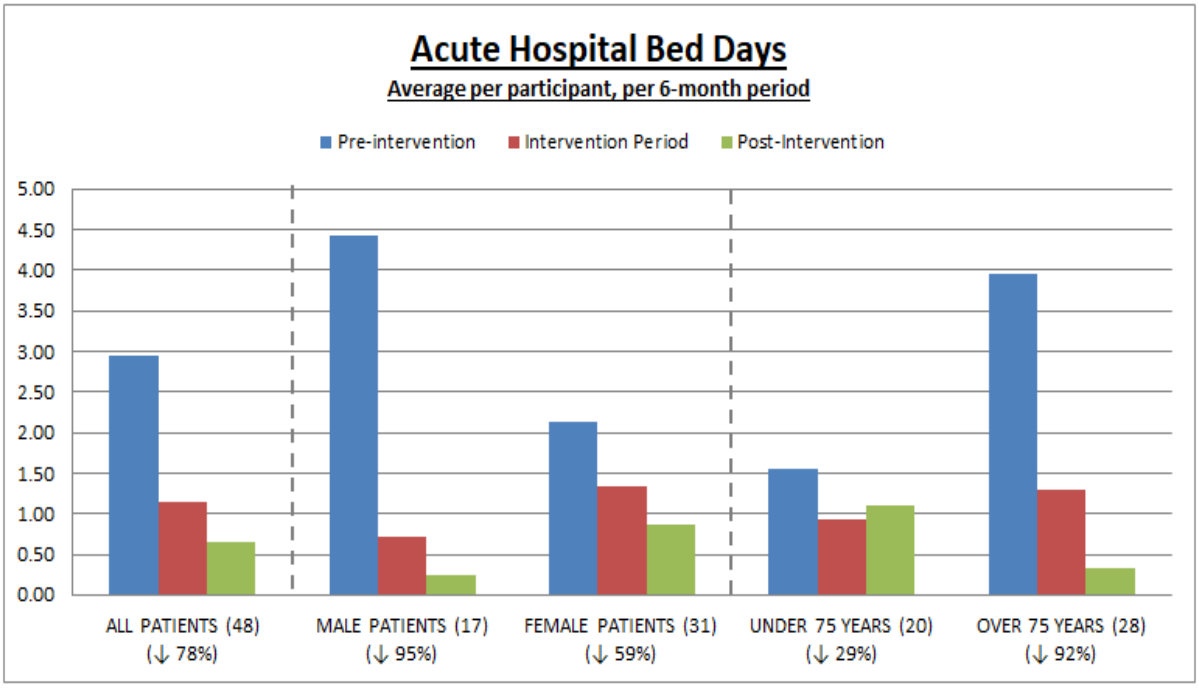
Key findings from the data:

- Service usage for the cohort reduced by 45% overall between the pre-intervention and post-intervention periods;

- The reduction was significantly more pronounced in the male participants (↓88%), than the female participants (↓10%);

- Those in the over-75 age category had almost twice the rate of Hospital Admissions pre-LWM than those aged under-75. Post-LWM rates of service usage were almost level between the two age-groups, meaning that the over-75 group experienced the highest percentage reduction pre-LWM to post-LWM.

(iii) Acute Hospital Bed Days



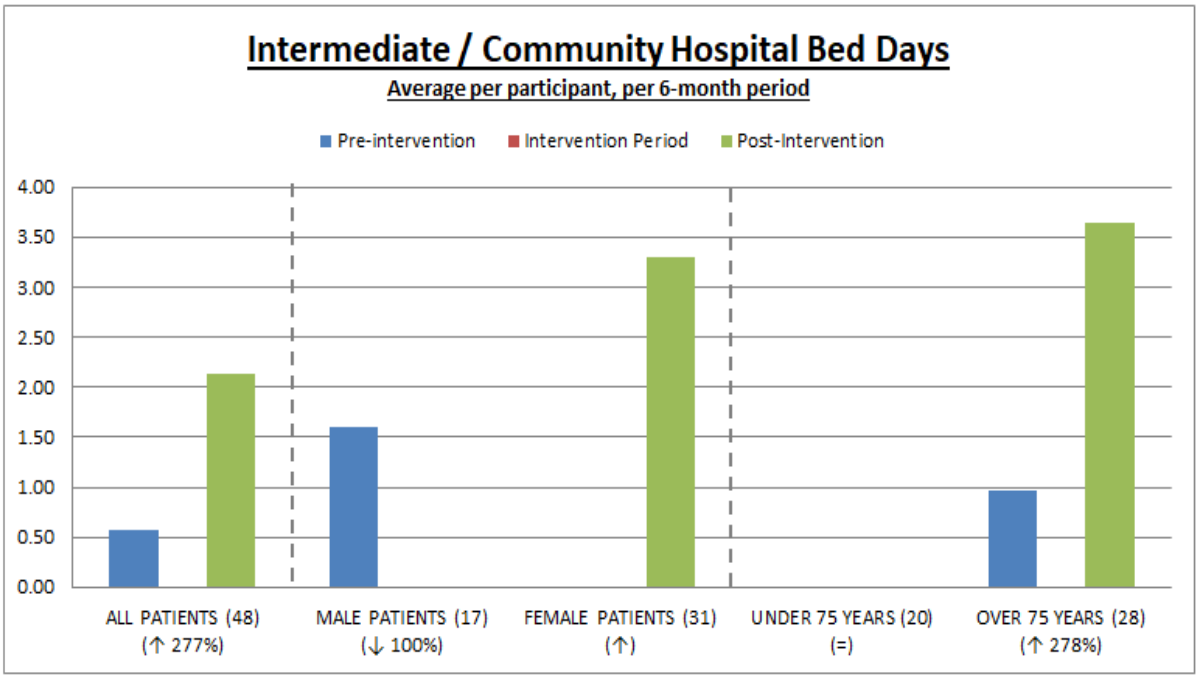
Key findings from the data:

- Service usage for the cohort reduced by a significant 78% overall between the pre-intervention and post-intervention periods;

- Male participants on the programme used almost twice the level of Acute Hospital bed days of female participants in the 6-months pre-LWM, but their usage in the post-LWM period was around a third of that of female participants, resulting in a significant decrease of 95% between the two periods;

- Similarly, the over-75 age group had a much higher level of pre-LWM usage, but a much lower post-LWM level, giving a 92% reduction between the two periods.

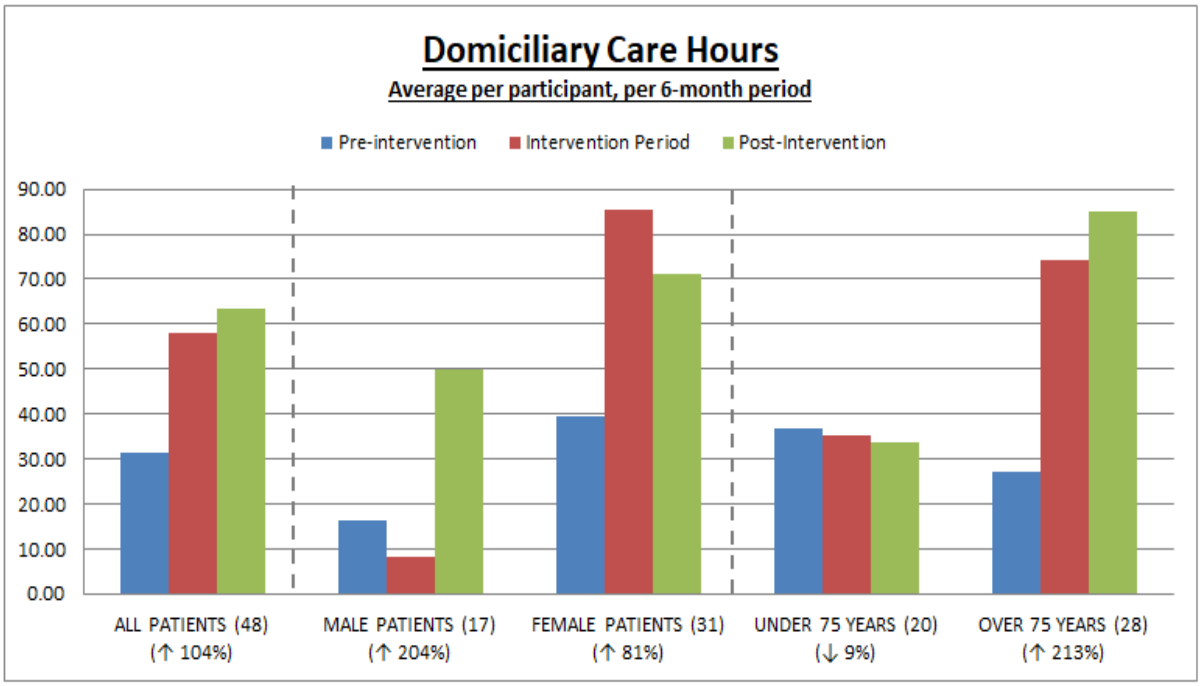
(iv) Intermediate / Community Hospital Bed Days



Key findings from the data:

- Service usage increased by almost 3 times between the pre-LWM and post-LWM period. However, this activity is attributable to only 4 patients (i.e. of the 48 patients in the cohort, only 4 had any Intermediate/Community Hospital usage at all – 1 patient in their pre-LWM phase, 0 patients during-LWM, and 3 patients in their post-LWM period). It would therefore not be appropriate to seek to draw any conclusions or apply the trend shown above to a wider group.

(v) Domiciliary Care Hours



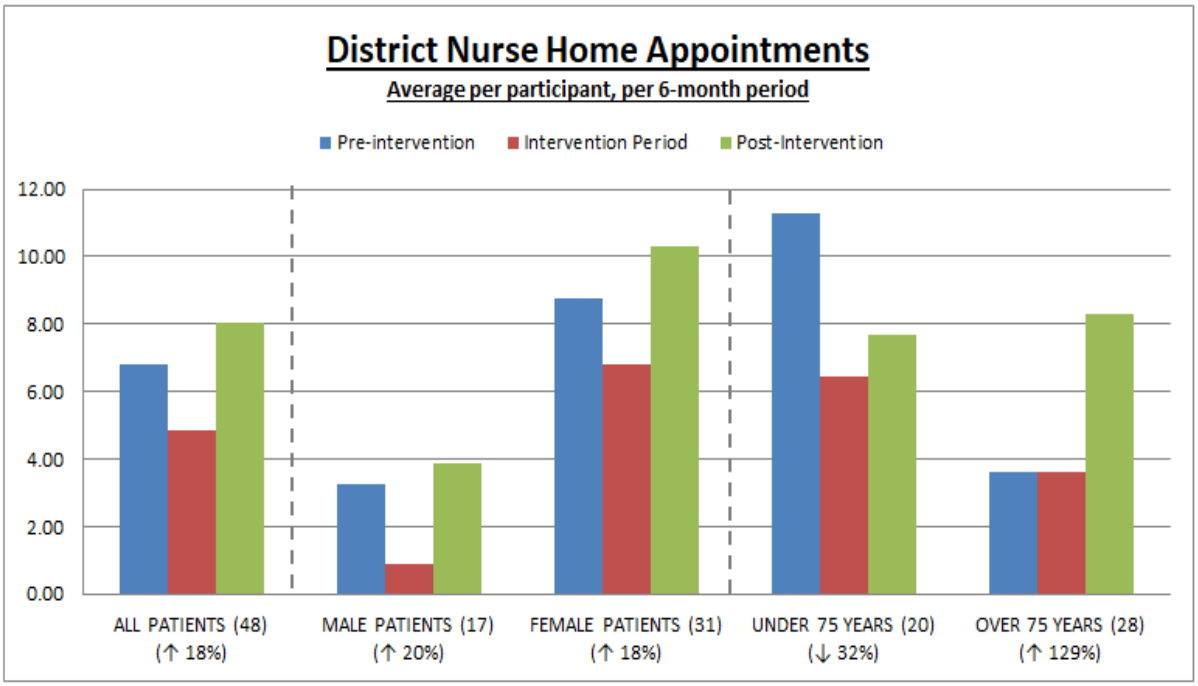
Key findings from the data:

- There was an increase in Domiciliary Care Hours usage between the pre-LWM and during-LWM periods, and between the during-LWM and post-LWM periods. This is not necessarily to be viewed as a negative result, as participation on the LWM programme may have been a contributing factor to participants receiving domiciliary support that was needed. Indeed the receipt of such support would be expected to contribute to a reduction in the requirement for unscheduled care services.

- The increase was most pronounced in males, who had a significantly lower level of domiciliary care usage prior to their participation on LWM than females in the cohort.

- Pre-LWM, those aged under-75 had a slightly higher average level of usage than those over-75, but as a group their usage actually decreased both during-LWM and post-LWM. The majority of the increase is therefore attributable to patients in the over-75 age range (↑ 213%). Again, it would be expected that, in general, an older age-group would be in more need of Domiciliary Care support than those who are younger.

(vi) District Nurse Home Appointments



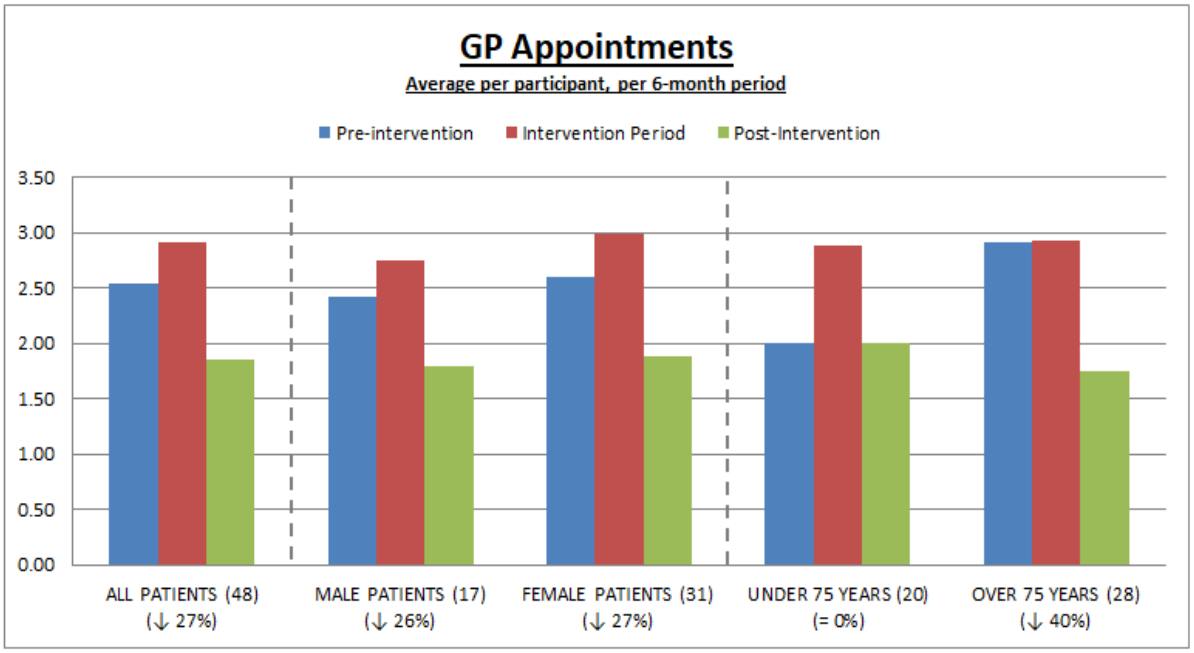
Key findings from the data:

- There was a small increase (↑ 18%) in the number of District Nurse appointments between the pre-LWM and post-LWM period.

- Females had over twice the average level of appointments of males both pre-LWM and post-LWM. However, there was no significant difference between males and females in terms of their percentage increase between the pre-LWM and post-LWM periods.

- In terms of age split, in the pre-LWM period, under-75s had over three times the rate of usage of those over-75. However post-LWM, there was a decrease in service usage by under-75s (↓ 32%), but a significant increase by the over-75s (↑129%), resulting in the under-75s rate falling below that of the over-75s.

(vii) GP Appointments



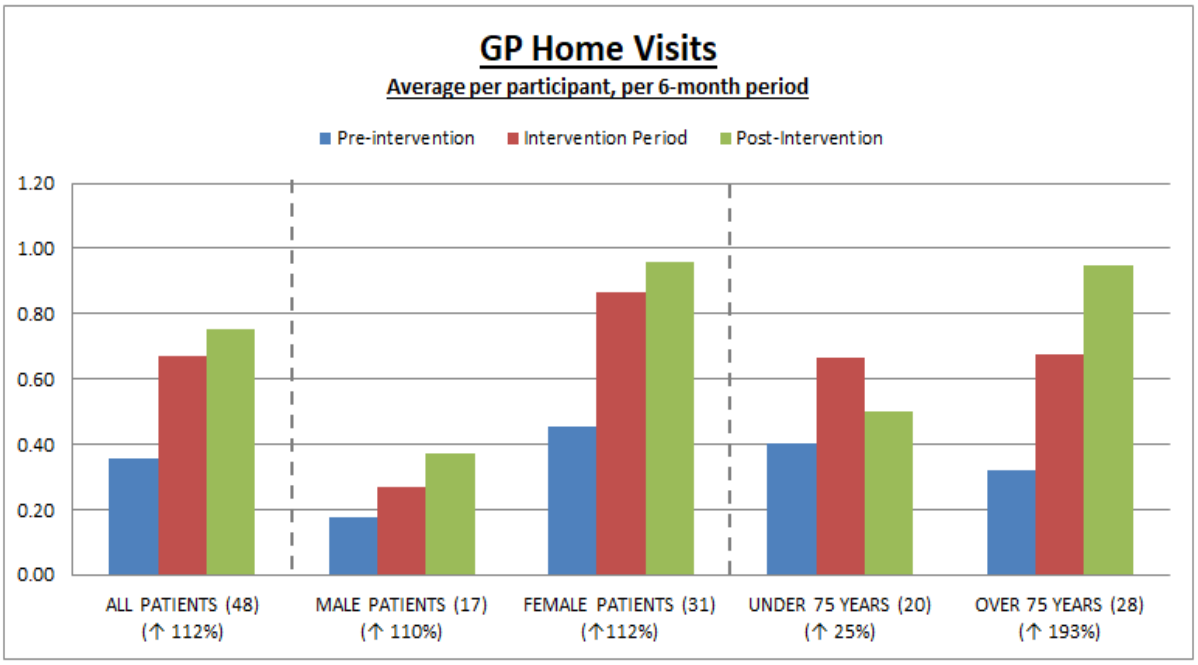
Key findings from the data:

- There was a 27% decrease in GP appointment usage overall between the pre-LWM and post-LWM periods.

- The pre-LWM and post-LWM rates were almost identical between males and females.

- The pre-LWM rate of service usage among over-75s was higher than that of the under-75s. However, in the post-LWM period, the rate among over-75s had dropped (↓ 40%), ending up below that of the under-75s. The under-75s saw no increase or decrease in their rate of usage between the pre-LWM and post-LWM periods.

(viii) GP Home Visits



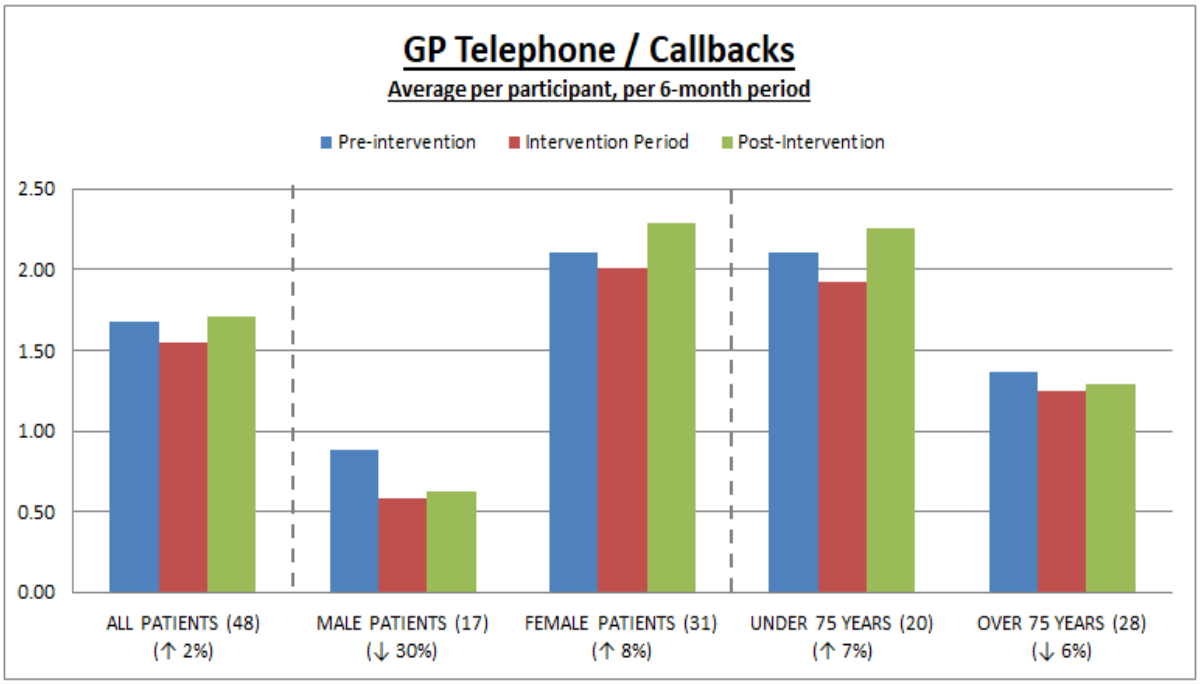
Key findings from the data:

- Use of GP Home Visits more than doubled between the pre-LWM and post-LWM periods.

- The rate of increase was similar between males and females, but it is notable that males on average had about half the number of GP Home Visits of females to begin with.

- The increases were significantly higher in the over-75 age group (↑ 193%), than in the under-75s (↑ 25%).

(ix) GP Telephone / Callbacks



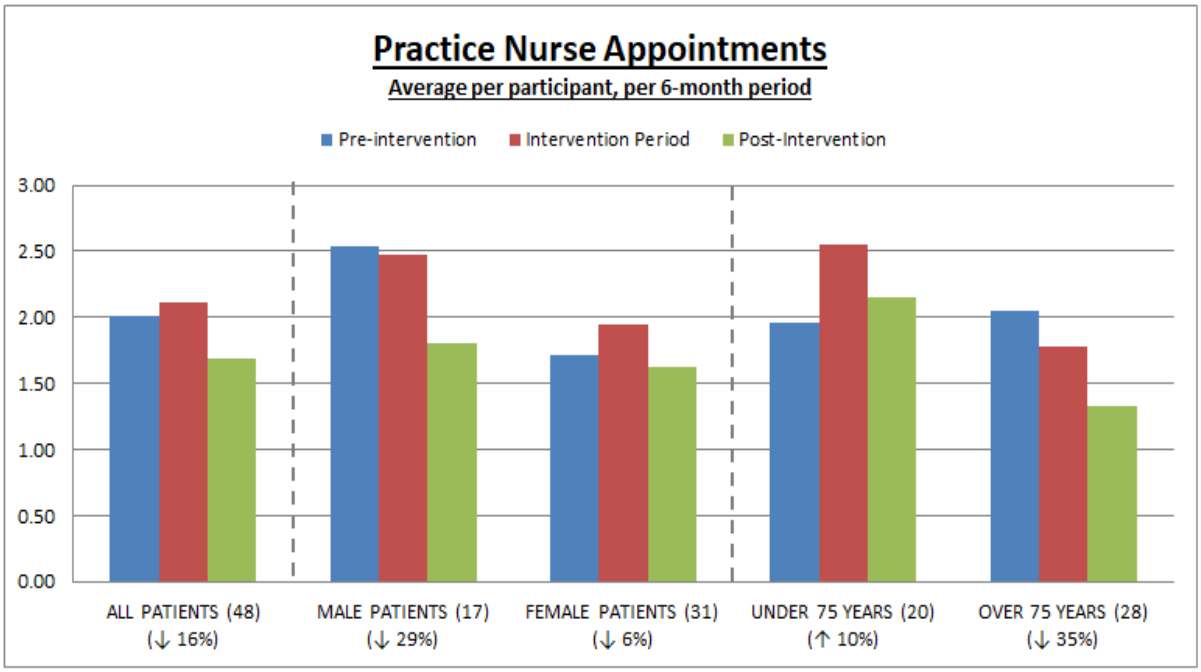
Key findings from the data:

- The number of callbacks stayed largely static between the pre-LWM, during-LWM, and post-LWM periods across the whole cohort of 48 patients.

- In terms of breakdown by gender, male participants had fewer than half the average number of GP callbacks of female participants across the three time periods.

- Under-75s had a significantly higher use of GP callbacks than over-75s.

(x) Practice Nurse Appointments



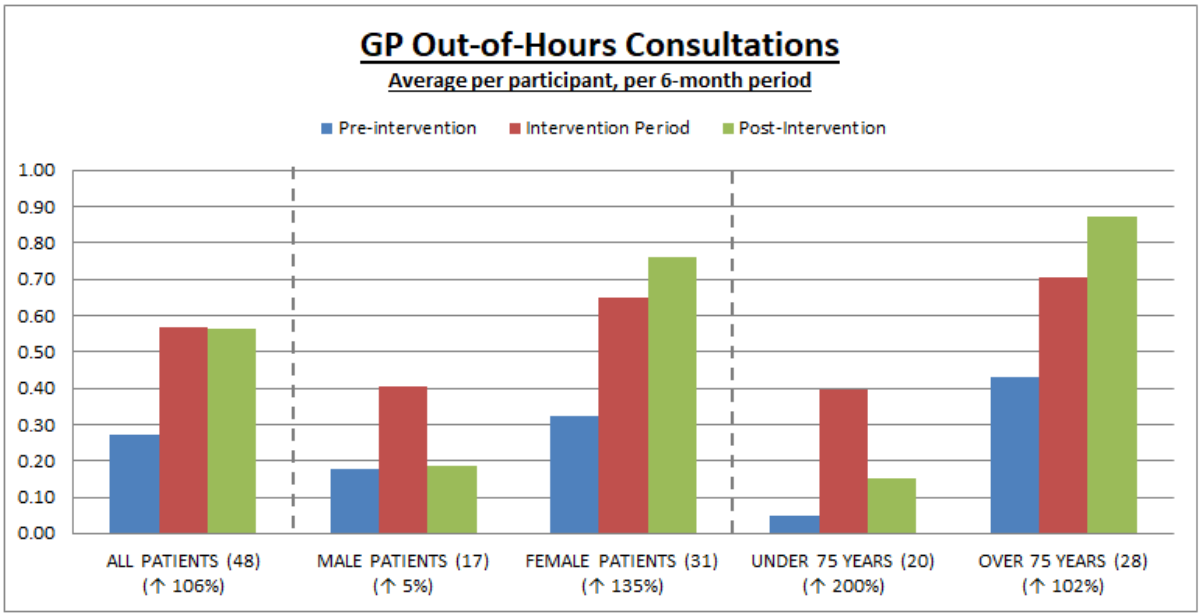
Key findings from the data:

- The number of Practice Nurse Appointments fell by a small margin (↓ 16%) between the pre-LWM and post-LWM periods.

- The decrease was greater among male participants than female participants, although males had a higher rate to begin with.

- The decrease was greater among the over-75s than the under-75s.

(xi) GP Out-of-Hours Consultations



Key findings from the data:

- The number of GP Out-of-Hours consultations doubled between the pre-LWM and post-LWM periods.

- The increase was mostly attributable to the female participants (↑ 135%), compared to the male participants who had only a marginal increase (↑ 5%).

- Under-75s accounted for significantly fewer OOH consultations than the over-75 age group across the three time periods.

FINANCIAL RETURN ON INVESTMENT

(i) Cost of Running the Living Well Moyle Scheme

The cost of running the Living Well Moyle Scheme for the 3-year period 1 October 2016 to 30 September 2019 was £139,665. Based on the total cohort of 158 patients who participated in the scheme during that time, this equates to an average running cost of £884 per participant:

COST OF RUNNING THE LIVING WELL MOYLE SCHEME	
October 2016 – September 2017	£46,200
October 2017 – September 2018	£46,200
October 2018 – September 2019	£47,265
3 YEAR TOTAL COST	**£139,665**
Total Number of Participants during the 3 years to 30 September 2019	158
Average Cost per Participant	**£884**

(ii) Healthcare Services Cost Changes and Financial Return on Investment

Unit costs were obtained from the Department of Health for each of the service areas measured within this evaluation. By applying these costs to the activity undertaken, changes in activity levels can logically be translated into service cost changes.

The following sets out 2 separate methodologies for calculating the service changes and return on investment:

Methodology 1:

The following table applies the various unit costs to give the actual pre-LWM and actual post-LWM costs for the cohort of 48patients. The total reflects a cost saving of £34,548 between the pre and post periods, an average of £720 per person. This was for a 6-month period, so translates into a £1440 saving per participant annually.

ACTUAL COSTINGS FOR COHORT OF 48 PATIENTS				
SERVICE	Actual PreLWM Cost (48 Patients)	Actual Post-LWM Cost (48 Patients)	Difference between 6mths pre-LWM and 6mths post-LWM	Difference Annualised
ED Attendances	£5,359	£3,722	-£1,636	-£3,273
Hospital Admissions (incl Unscheduled)	No cost for an admission - cost is calculated per hospital bed day			
Acute Hospital Bed Days	£84,677	£18,589	-£66,088	-£132,175
District Nurse Home Appointments	£12,117	£14,288	£2,172	£4,343
Domiciliary Care Hours	£28,983	£59,049	£30,066	£60,132
GP Appointments	£4,010	£2,940	-£1,070	-£2,140
GP Home Visits	£1,724	£3,662	£1,938	£3,875
GP Telephone/ Callbacks	£2,089	£2,128	£39	£78
Practice Nurse Appointments	£3,918	£3,284	-£634	-£1,268
GP Out-of-Hours Consultations	£627	£1,293	£666	£1,332
Total Cost for 48pts	**£143,503**	**£108,955**	**-£34,548**	**-£69,096**
Avg per person (i.e. divide by 48)	**£2,990**	**£2,270**	**-£720**	**-£1,440**
Multiplied by 158 total patients	**£472,364**	**£358,643**	**-£113,721**	**-£227,441**

Total 3yr cost of running LWM Scheme	**£139,665**
Financial Return on Investment (£227,441 / £139,665)	**£1.63**

Cost of running LWM Scheme per user (£139,665 / 158)	**£883.96**
Financial Return on Investment (£1439 / £883.96)	**£1.63**

If the £1440 saving is applied to the full cohort of 158 total participants on the scheme over the 3 year period, it comes to a total potential saving of £227,441/yr.

Dividing this saving by the cost to run the LWM programme (139k), gives Financial Return on Investment of £1.63 per £1.

Methodology 2:

The following table shows the ACTUAL 6 months pre-LWM activity for the full cohort of 158 participants on the scheme over the 3 year period to September 2019. As a full 6months post-LWM activity is not available for this group, the percentage increases/decreases realised by the cohort of 48 patients (as shown on the data table on page 46) were applied to give a CALCULATED post-LWM cost for all 158 patients.

The total reflects a cost saving of £202,433 between the pre and post periods, an average of £1281 per person. This was for a 6-month period, so translates into a £2562 saving per participant annually.

ACTIVITY & COSTINGS FOR 158 PATIENTS (Using their Actual pre-LWM Service Usage, and a Calculated post-LWM Service Usage)					
SERVICE	PRE-INTERVENTION SERVICE USAGE ACTUAL USAGE FROM GP/NHSCT DATA	Actual PreLWM Cost (158 Patients)	Calculated Post-LWM Cost (assuming the same saving/increase percentage realised from the cohort of 48)	Difference between 6mths pre-LWM and 6mths post-LWM	Difference Annualised
ED Attendances	139	£32,248	£22,400	-£9,848	-£19,696
Hospital Admissions (incl Unscheduled)	123	No cost for an admission - cost is calculated per hospital bed day			
Acute Hospital Bed Days	1031	£616,538	£135,349	-£481,189	-£962,379
District Nurse Home Appointments	1633	£60,437	£71,269	£10,832	£21,663
Domiciliary Care Hours	13228	£255,962	£521,484	£265,522	£531,044
GP Appointments	374	£12,342	£9,049	-£3,293	-£6,587
GP Home Visits	107	£10,807	£22,952	£12,145	£24,289
GP Telephone/ Callbacks	300	£7,800	£7,945	£145	£291
Practice Nurse Appointments	312	£12,680	£10,627	-£2,052	-£4,105
GP Out-of-Hours Consultations	104	£4,992	£10,299	£5,307	£10,614
Total Cost for 158pts		**£1,013,806**	**£811,373**	**-£202,433**	**-£404,865**
Avg per person (i.e. divide by 158)		**£6,416**	**£5,135**	**-£1,281**	**-£2,562**

Total 3yr cost of running LWM Scheme	£139,665
Financial Return on Investment (£404,865 / £139,665)	£2.90

Cost of running LWM Scheme per user (£139,665 / 158)	£883.96
Financial Return on Investment (£2562 / £883.96)	£2.90

This reflects a total potential saving of £404,865 per year.

Dividing this saving by the cost to run the LWM programme (139k), gives a Financial Return on Investment of £2.90 per £1.

(iii) Limitations

It should be noted that Intermediate/Community Hospital bed days have been excluded from this cost analysis, as the activity was attributable to only 4 patients (as discussed on Page 41), meaning it was therefore not be appropriate to extrapolate those figures to a wider group.

Furthermore, the figures shown above for the cost of running the Living Well Moyle scheme were for the Living Well Moyle coordinator post and volunteers expenses only. No attempt has been made to financially quantify the invaluable contribution made by volunteers in terms of their time investment, and it is acknowledged that the cost savings generated were only possible because the service was delivered on a volunteer basis rather than by individuals who were paid for their time.

Outcome 4 – Benefit to wider community development

An integral part of Living Well Moyle has been the ongoing involvement of the local community in the design and delivery of the process.

From the first community mapping event held in 2017, the local community has worked alongside Living Well Moyle providing valuable support. Representatives from the local community and voluntary sector are representatives on the Project Group and the Project Team and their expertise is invaluable.

Arts Care has played a key role in delivering workshops and other activities which have engaged the community widely ranging from young people at school to groups and people being supported by Living Well Moyle in their own homes.

The local community has also contributed financially, having recognised the worth of Living Well Moyle.

A stakeholder group involved in planning and scoping local needs commissioned the Dalriada Pathfinder Partnership to produce an assessment of need and work is ongoing with this group to identify gaps and opportunities for further developments.

The following section provides more detail about the above initiatives.

Arts Care

Strategic Context

The All-Party Parliamentary Group (APPG) on Arts, Health and Wellbeing has undertaken a major review into the role of the arts in health and wellbeing. The APPG report, "Creative Health: The Arts for Health and Wellbeing July 2017", contains compelling evidence of ways in which arts engagement can improve the public's health. This includes helping with self-management, improving mental health, promoting healthier ageing and tackling health inequalities.

Dalriada Pathfinder Partnership has a very successful relationship with Arts Care. Arts Care, founded in 1991, is a unique Arts and Health Charity based in Northern Ireland. Believing in the benefits of creativity to well-being, Arts Care makes all forms of art accessible to patients, clients, residents and staff in health and social care settings and in the community. There have been three main aspects of the work with Arts Care and Living Well Moyle:

- the provision of activities in community groups;
- the production of a film; and
- the intergenerational work involving the schools.

Activities in Community Groups

In 2017/18 and again in 2018/19, five community groups participated in a variety of activities ranging from music and dance to visual art, storytelling, photography and mixed media collage work.

Members of the Over 55 Clubs in Moyle who participated in the Arts Care events with Fiona Kennedy, Living Well Moyle Co-ordinator, Jenny Elliott, Chief Executive, Arts Care and Ciara O'Malley, Arts Care.

The sessions were delivered by artists from Arts Care and took the form of either one off events or a series of sessions delivered over a three to four week period. The Living Well Moyle Co-ordinator was able to refer people to the groups to participate in the activities. It is important to note however that the provision of the activities

has also been very beneficial to the existing members of the groups.

Feedback from one of the groups, which was made up of 22 people ranging in age from 60 to 79, was very positive. The artist said:

Representatives from local groups who attended the Celebration Event on 1st May 2018

"The ladies were very proud of what they had accomplished and this was obvious by the fact they had put initials, dates or words or meaning in the clay."

Participants said:

"That was so interesting – I'm relaxed now."

"Oh look at that! I didn't know I could do that!"

When the groups were offered the opportunity to participate in similar sessions in 2018/19 they were all very keen and all agreed that they had benefited from the activities.

Remembering the Lammas Fair

This project involved creating an intergenerational film 'Remembering the Lammas Fair', which includes archive film, live music, new footage and interviews created during reminiscence sessions, delivered in the months preceding the film screening at the 2017 Fair.

Community and voluntary representatives along with PHA representations and Linda Robinson, Chief Executive Age NI, Fiona Kennedy, Living Well Moyle Co-ordinator

These intergenerational workshops were facilitated by Ciara O'Malley (Arts Care), Sam Cunningham (Living Well) and Sinéad Bhreathnach-Cashell (Northern Ireland Screen). Participants were invited each week over a period of six weeks, to watch archive film, share photographs and record their memories of the fair as well as aspirations for the future of the Lammas fair. To widen access for Living Well clients unable to attend the workshop sessions in person, Sam

Cunningham, the Living Well Co-ordinator at the time, offered clients the opportunity to have their stories recorded and included in the final film.

In total fourteen people participated in the reminiscence sessions and seven young musicians accompanied by Maire Kinney and Dominic McNabb, were involved in the intergenerational music session.
Working alongside the facilitators as a young Digital Reporter, Media student Athena Hajaig assisted with filming and reminiscence sessions. Her post was funded by the BFI's Film Audience Network.

Participants in the Ballycastle Archive and Moyle Living Well films with the producers Sinead Breathnach-Cashell, NI Screen and Athena Hajaig, media student at the Northern Regional College

In partnership with Living Well Moyle and facilitated by Northern Ireland Screen's Heritage and Archive Department, 'Remembering the Lammas Fair' was showcased at the Auld Lammas Fair, August 2017 in a pop up cinema on the seafront in Ballycastle. Arts Care and NIS Heritage and Archive Department staff were on hand to explain the film, the wider health and wellbeing programme and the work of Living Well Moyle to the public.

Local musicians providing the entertainment at the Celebration event in May 2018

The film produced in the intergenerational workshops was accompanied by a short promotional film featuring the experience of Living Well volunteers.

Excerpts of the film were also screened at the Living Well celebratory events and DVDs of the finished film were made available to participants. At the May 2018 event Tony Stevens, Chief Executive of the Northern Health and Social Care Trust, spoke of "the value and power of film ... to link the community with itself and the outside world".

Intergenerational Work with Schools

In 2017, meetings were held with Principals from four post primary schools in the Moyle area in order to introduce them to the concept of Living Well Moyle and to seek their involvement in a competition to design a logo. Over 120 entries were received and the winning entry and runners up were announced at the Launch event in November 2017. The entries were subsequently displayed in Causeway Hospital and then the winning entry and runners up were framed and displayed in the Dalriada Health Centre.

Young people from local schools showing the then Minister for Health the winning logo for Living Well Moyle at the launch event in November 2016

Participation in the art competition has led to ongoing involvement of these schools in Living Well Moyle. Pupils have joined groups for a storytelling event, have worked on an ongoing basis with one of the community groups and attended the Celebration Event.

The pupils also had the opportunity to discuss career opportunities in health and social care with the Chief Executive of the Northern Health and Social Care Trust and other senior managers. Media students from the local Regional College produced a film which was shot in various locations capturing the Arts Care activities within the community groups. This was used to showcase the collaboration at the Celebration Event.

Feedback from the pupils involved indicates that they find involvement with Living Well Moyle to be positive, enjoyable and something good for the community. As taking part and developing community work is a high priority for the schools, there will continue to be opportunities to involve young people within Living Well Moyle.

Brian Dillon, President of Ballycastle Probus, Paul McClean, Principal Cross and Passion, Ian Williamson, Principal Ballycastle High School, and Fiona Kennedy discussing intergenerational work

A meeting was held with the Principals of the schools who had participated in the work with Arts Care to discuss their perceptions of Living Well Moyle. Overall they felt they had good knowledge of Living Well Moyle and that the feedback from the pupils was very positive in respect of their involvement. They would consider participating on an ongoing basis but it would be important that any tasks would link with the school's curriculum. The pupils would clearly benefit from being involved with health and social care professionals and in volunteering in some way with Living Well Moyle. They certainly considered that ongoing involvement is very important as pupils are part of the community and should be aware of opportunities to help others.

Pupils from Cross and Passion School, Ballycastle and Athena Hajaig from the Northern Regional College with Dr Tony Stevens, Chief Executive, NHSCT, Mr Paul McClean, Principal Cross and Passion and MLAs Mervyn Storey and Philip McGuigan at the Celebration Event in May 2018

Rathmoyle Stakeholders Group

The Rathmoyle Stakeholders Group is made up of local people who were involved in planning a supported living facility following the closure of the Rathmoyle Residential Home. Following an issue with the funding for the proposed development, the group agreed to explore possible ways forward to best meet need in Ballycastle.

In November 2017, the Rathmoyle Stakeholders Group commissioned the Dalriada Pathfinder Partnership (DPP) to undertake an analysis of the needs of older people in the Moyle area, with a view to developing a menu of options to meet independent living needs. This task emerged from the knowledge that the DPP had successfully introduced Living Well Moyle and that local solutions co-designed with the local community are best placed to garner support and to deliver sustainable solutions.

The DPP is keen to take this initiative forward in terms of considering other health and social care related projects in the area.

Members of the Rathmoyle Stakeholders Group with representatives from the Dalriada Pathfinder Partnership and a Department of Health official

Ballycastle Rotary Club Presentation

A generous donation was presented to the Dalriada Pathfinder Partnership (DPP) from Ballycastle Rotary Club to support the ongoing work of Living Well Moyle.

On receiving the cheque, Bride Harkin, Chair of DPP said; *"We are delighted to receive this donation from Ballycastle Rotary. It clearly demonstrates their support for the work of Living Well Moyle and will help to provide much needed support and activities to people in the local community".*

A coffee morning held locally provided an opportunity to bring the community together and the Living Well Co-ordinator and others from DPP engaged with people at the event.

Over £9,000 was raised by the organisers for the Dalriada Community Hospital.

Members of the Rathmoyle Stakeholders Group with representatives John Ward, President of Ballycastle Rotary Club presenting a donation to Dr Mary McLister and members of Dalriada Pathfinder Partnership in October 2018

4.0 CONCLUSIONS

Key Messages:

OUTCOME 1: IMPROVED HEALTH AND WELLBEING OF LWM PARTICIPANTS

- ***Participants report sustained improvement in their physical and mental well-being:***
  - 24% improvement in mental wellbeing
  - 26% reduction in loneliness
  - 5% improvement in physical health

OUTCOME 2: IMPROVED EXPERIENCE OF THOSE DELIVERING SERVICES

- ***Staff and volunteers involved in delivering services report a benefit to the individual and to themselves as a result of the living well approach.***

  "I get great satisfaction being able to help someone."

  "One person had a fantastic volunteer and they built up a great relationship, there was a big change in the person's emotional and physical wellbeing."

OUTCOME 3: REDUCED COST OF CARE AND SUPPORT

- ***Analysis of data indicates the reference group of 48 LWM participants had a significant reduced reliance on unscheduled care services post the LWM intervention:***

  - 30.5% reduction in ED attendances
  - 44.5% reduction in hospital admissions
  - 78% reduction in acute bed days

  There were increases in the use of some primary and community services, notably use of domiciliary care services which increased by just over 100%, with the greatest increase in use observed in those over 75. This shift in the use of services from acute to primary/community care is clearly in keeping with the overall strategic direction outlined in *Health and Wellbeing 2026: Delivering Together*.

- ***Significant savings can be demonstrated***

The Evaluation Report outlines two different approaches to calculating the savings which can be attributed to the change in the use of services:

- The first approach is based on the actual pre LWM and post LWM service use of 48 participants, and demonstrates:

    - ***An annual average saving of £1440 per participant.***

  When this is considered within the context of the £884 cost per person to run the LWM scheme:

    - ***The Financial Return on Investment (FROI) is £1.63 per £1.00.***

- The second approach is based on the actual pre LWM service use for the total cohort of 158 participants, and a calculated post LWM level of service usage (calculated by applying the same percentage increases/decreases realised by the reference group of 48 patients)and demonstrates:

    - ***An annual average saving of £2,562 per participant.***

  When this is divided by the £884 cost of participation in LWM:

    - ***The Financial Return on Investment (FROI) is £2.90 per £1.00.***

The first method of presenting the FROI is the more robust when considering only those 48 patients who had completed their LWM journey at least 6 months prior to the evaluation reference date of 30 September 2019. However, that approach does not take into consideration the proportionately higher pre-LWM service use levels attributable to the wider cohort of 158. Although the level of post-LWM service usage for the remaining 110 participants may not necessarily follow the same trend as the cohort of 48, it could reasonably be argued that by having a higher pre-LWM service usage level, this group has more scope for reductions to be made. Both approaches are therefore valid and present very compelling results based on actual changes in service usage by a significant cohort of people over a period of time.

OUTCOME 4: THE BENEFITS TO THE WIDER COMMUNITY

This evaluation provides clear evidence that Living Well Moyle is an approach which benefits people who are experiencing challenges in maintaining their health and wellbeing.

What is undeniable is that the impact demonstrated in this evaluation would not have been possible without the commitment and dedication of the many people involved. The local community supported many of the Living Well Moyle participants by involvement in different groups and activities supported by organisations such as Artscare NI. Local schools became involved and there was mutual benefit with both young people and LWM participants gaining from the experience.

On behalf of the Dalriada Pathfinder Partnership, I want to thank the volunteers, the local community, the voluntary organisations, the Living Well Co-ordinator, the GPs and their practice teams, the local multi-disciplinary staff teams, the Project Team and the Project Board members all of whom have played a significant part in supporting people engaged with Living Well Moyle to really live life to the full.

DALRIADA PATHWAY PARTNERSHIP (DPP): PROJECT BOARD MEMBERS

CHAIR: Bride Harkin, Health and Social Care Board

Age NI
Paschal McKeown

Ballymoney Community Resource Centre (BCRC)
Bronagh McCrorry (nee McFadden)

Causeway Coast and Glens
Elizabeth Beattie

COAST
Jenna Allen

General Practitioner/Medical rep
Dr Mary McLister

Health and Social Care Board
Pat Smyth

Integrated Care Partnerships (ICPs)
Dr Albert Clyde

Local Community Group representatives
Donal Cunningham
Thelma Dillon
Reamai Mathers
Dr Fionnutan McCarry
Nevin Oliver

Northern Health and Social Care Trust
Yvonne Carson
Pamela Craig
Fiona O'Neill

Public Health Agency
Hilary Johnston
Jayne McConaghie

DALRIADA PATHWAY PARTNERSHIP (DPP):
PROJECT TEAM MEMBERS

CHAIR: Fiona O'Neill, Northern Health and Social Care Trust

Age NI
Fiona Kennedy
Mandy Wilson

Causeway Coast and Glens
Damian McAfee

General Practice

Susan Gallagher

Good Morning Ballycastle
Kate Elliott

Health and Social Care Board
Pat Smyth

Northern Area Community Network Health Improvement
Veronica McKinley

Northern Health and Social Care Trust
Robin Anderson
Nicola Arbuckle
Yvonne Carson
Maureen Hetherington
Sandra Kane
Enrica Kennedy
Anne McCambridge
Bridget O'Neill

Older People's Panel
Thelma Dillon