Evaluation of the A&E WellFamily Pilot Service – Hackney

Final Report – Family Action

February 2018
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Any enquiries about this report should be directed to: corporate@apteligen.co.uk
Executive summary....................................................................................... i
Acknowledgements..................................................................................... 1

Part 1: Background and methods ............................................................. 2
  1 Background................................................................................................ 2
    1.1 About this report.................................................................................. 2
    1.2 About Family Action ........................................................................ 2
    1.3 A&E WellFamily in Hackney.............................................................. 2
    1.4 Basis of the service model .................................................................. 3
    1.5 Overarching assumptions.................................................................. 3
    1.6 A&E WellFamily – evidence of need.................................................. 4
    1.7 A&E WellFamily – overview of the delivery model............................ 5
    1.8 Intended outcomes and impact within the Theory of Change .......... 5
    1.9 Experiences of the service to date....................................................... 8
  2 Methods.................................................................................................... 8
    2.1 Objectives of this research................................................................. 8
    2.2 Development of the Theory of Change............................................. 9
    2.3 Interviews with key stakeholders..................................................... 9
    2.4 Service user interviews ................................................................... 10
    2.5 Analysis of service activity and outcome data .................................. 10

Part 2: Findings .......................................................................................... 11
  3 Service activity and reach to the target population............................... 11
    3.1 Number of referrals to the service.................................................... 11
    3.2 Source of referral............................................................................. 12
    3.3 Demographic profile ...................................................................... 15
  4 Complexity of the user profile............................................................... 17
    4.1 Reason for referral............................................................................ 18
    4.2 Services provided ............................................................................ 20
    4.3 Contact with service users and other activities............................... 21
    4.4 Case status and closures .................................................................. 22
  5 Outcomes for service users ................................................................. 23
    5.1 Summary of findings ....................................................................... 23
    5.2 Supporting data and evidence ......................................................... 24
    5.3 Service user feedback .................................................................... 31
  6 Connectivity across the health and care system ...................................... 35
  7 Conclusions ........................................................................................... 36
  8 Considerations for further service development ...................................... 37

8.1 Routes into the service ...................................................................... 37
8.2 A greater presence in A&E .................................................................................................................. 37
8.3 Review the resourcing model .................................................................................................................. 37
8.4 Opportunities to link the support model across secondary care ..................................................... 37
8.5 Data collection and ongoing monitoring ................................................................................................. 38

Part 3: Appendices ....................................................................................................................................... 39

9 Organisations that users have been signposted to .............................................................................. 39
10 Service eligibility and triage criteria ........................................................................................................ 41
11 Outcome and measurement reference table ......................................................................................... 42
12 Summary of evidence against key outcomes ......................................................................................... 43
This report presents the findings of an independent evaluation of Family Action’s A&E WellFamily service in Hackney. The findings are based on analysis of service and outcome data collected by Family Action since the service began seeing clients in April 2016 (up to 24th November 2017), interviews with service staff and partner agencies, and in-depth interviews with a small sample of service users on two occasions over a three month period.

Family Action is a national charity that has provided support to children and families for almost 150 years. The organisation supports over 45,000 children and families each year through more than 135 local services. These services help people to tackle some of the most complex and difficult issues facing families today, including poverty, domestic abuse, mental illness, and substance misuse.

Family Action’s A&E WellFamily Service was developed to meet the needs of people who frequently or regularly attend Accident & Emergency departments (A&E) because they feel they have no (or limited) alternative support options. The support follows a similar design to the successful WellFamily service based in GP practices across Hackney, but with referrals received from A&E as well as GPs, and support aimed at a higher level of need. The A&E WellFamily service builds on the success of the WellFamily model, offering 1:1 emotional support, advice and practical assistance across a wide range of non-medical and social issues. The pilot is intended to test whether similar health and wellbeing outcomes achieved by the traditional WellFamily service can also be achieved:

- By targeting those who attend A&E frequently or regularly due to underlying stress, anxiety or other low level mental illness or non-medical issue(s)
- By providing an additional signposting presence in A&E to help generate self-referrals and encourage people to make use of more appropriate types of support.

This was a mixed-method evaluation, combining qualitative and quantitative data collection and analysis. The approach was based around a Theory of Change at the service level, with data collection and analysis aligned to those outputs, outcomes and impact that could be reasonably measured in the time available. The evaluation aimed to address three main focus areas:

1. **Outcomes for service users**, including awareness and access to alternative support services, improved mental health and wellbeing, greater resilience, and level of inappropriate use of A&E
2. **Connectivity**, including the extent of integration with other local health services, successes and challenges faced – and the impact on the service, and
3. **Coverage and local need**, including level of access by the target population and coverage across key demographic groups.

The A&E WellFamily service began with a set-up phase from February 2016. The following two months involved work to develop referral pathways in partnership with staff from Homerton University Hospital and local GP practices, and promoting the service across other care and support providers who might come into contact with potential service users. Direct client contact began in April 2016 and in total there have been 223 referrals. The
majority (54%) of referrals have been from a GP, with a further 14% being self-referrals. Nine percent were from a health practitioner (Homerton A&E department or Homerton Sickle Cell services).

A total of 90 new referrals have been received to date for year 2 (nearly 8 months), with 56 new clients becoming active during the same period. These figures include a general increase in both referrals and active clients throughout August, September and October, which if sustained, suggests that it is likely the service will exceed its current target of 100 active clients for year 2.

The A&E WellFamily service is targeted towards people ‘experiencing social issues and/or low to moderate mental health problems.’ This means that the service will engage with people experiencing a broad range of problems, with varying degrees of severity. The findings from this evaluation suggest that the service user profile is incredibly complex, and probably more so than the profile of users being referred to the traditional WellFamily service (although it was not within our scope to undertake any direct comparative analysis). This is important learning from this pilot phase and has implications for the design and resourcing of future service models that link into secondary care.

Complete outcome data was available for 94 clients who had received 1:1 support. This reveals that nearly half of these (47%) achieved the outcomes they identified at the beginning of their engagement with the service. This was despite some failing to continue their engagement with the service. Where service users did complete their interaction with the service and have a planned closure (38 people), 82% had achieved the outcomes they had intended, and the remainder had partially met their goals.

Key outcomes for the A&E WellFamily Service include:

- An average 66% reduction in inappropriate or frequent attendance at A&E for the based on service user interviews and GP data for this sample
- A 55% improvement in levels of anxiety and 59% improvement in levels of depression for service users
- An improvement of 0.3 to 0.53 (out of a score of 5) for all Wellbeing Star domains, with the biggest increases in ‘looking after yourself’ and ‘managing symptoms’
- Strong evidence of increased personal resilience from service user feedback and the Wellbeing Star
- Strong evidence of reduced social isolation from service user feedback

This evaluation has also shown that the service is effective at engaging people who have generally accessed little or no support in the past.

Based on this evaluation, we can also report with some confidence that these outcomes are likely to be sustained over a longer term for those clients who progress through to a planned closure. However, for some of these service users, a short, intense period of support will never be enough, given the complexity of the presenting issues. More data needs to be available about any ongoing support that A&E WellFamily clients are

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1 A&E WellFamily Big Lottery Fund Stage One application form, Family Action, 3/2/15.
supported to access in order to evaluate whether the current service model is the most effective option for this client group.

The evidence from this evaluation indicates that the A&E WellFamily service has made considerable progress towards being an effective link – or connector – between different parts of the health and care system in Hackney, however, there is more progress to be made. This is not the sole responsibility of Family Action, but requires a commitment from local partners (including the Homerton A&E department and other clinical teams) to work collaboratively together, identify opportunities, and support new ways of working for the ultimate benefit of local people.

Based on the findings from this evaluation, we recommend that the following points are considered by Family Action as part of its ongoing work to maximise the effectiveness and impact of A&E WellFamily within the context of the local care and support system:

- **Routes into the service**: continue to maintain and develop a range of different referral routes, to increase the reach of the service to the target population while maintaining a focus on those who use A&E because they don’t feel they have anywhere else to turn
- **A greater presence in A&E**: reconsider the possibility of establishing a greater physical presence in A&E, in line with the original service design and efforts from Family Action during the set-up phase. Based on learning from the traditional WellFamily model, this should make it easier for clinical staff to refer to the service, and increase the likelihood of effectively engaging with those potential service users and increasing the visibility of the service
- **Review the resourcing model**: Undertake a modelling exercise in collaboration with key partners to assess the current level of need within the local population, and consider developing a resourcing model for the service that will effectively meet that need over the longer term
- **Explore opportunities to link the support model across secondary care**: Explore opportunities to integrate A&E WellFamily within a wider social prescribing model in secondary care. This may generate efficiencies for both referring organisations and Family Action
- **Data collection and ongoing monitoring**: Refine data collection arrangements to improve ongoing monitoring and evaluation, including reviewing the number of tools used to gather outcome data and seeking a data sharing agreement with the NHS.
We are grateful for the support we received from Family Action staff, professionals from across the care and support system in Hackney, and those service users who gave up their time to take part in this evaluation. Your local knowledge, and your openness and willingness to tell us about your experiences of the A&E WellFamily service gave us important information and evidence for this evaluation.
1 Background

1.1 About this report

This report presents the findings of an independent evaluation of Family Action’s A&E WellFamily service in Hackney. The findings are based on analysis of service and outcome data collected by Family Action since the service began seeing clients in April 2016 (up to 24th November 2017), interviews with service staff and partner agencies, and in-depth interviews with a small sample of service users on two occasions over a three month period. The evaluation is primarily designed to assess the extent to which the A&E WellFamily service model can provide an additional and effective referral route for supporting people with multiple non-medical support needs.

1.2 About Family Action

Family Action is a national charity that has provided support to children and families for almost 150 years. The organisation supports over 45,000 children and families each year through more than 135 local services. These services help people to tackle some of the most complex and difficult issues facing families today, including poverty, domestic abuse, mental illness, and substance misuse. Through a strong belief in the strengths within people and families, and an approach to support that is grounded in evidence and achieving positive outcomes, Family Action seeks to empower people who are disadvantaged or socially isolated so that they can find the strength to overcome their difficulties, regardless of how complex those difficulties are.

Family Action delivers health and wellbeing services for adults in a variety of community settings, offering people a familiar and non-threatening environment in which to engage with highly skilled practitioners, volunteers, and peer support. This includes effective joint working with professionals across healthcare, social services, housing, the criminal justice system, and the wider voluntary sector.

1.3 A&E WellFamily in Hackney

Family Action’s A&E WellFamily Service was developed to meet the needs of frequent attenders to Accident & Emergency departments (A&E). The support follows a similar design to the successful WellFamily service based in GP practices across Hackney, but with referrals received from A&E as well as GPs, and support aimed at a higher level of need. The WellFamily service in Hackney is a community based, tailored support service for people whose social problems and complex needs underlie their use of medical services. It provides a service through direct contact with a support worker in community venues and GP practices.

The WellFamily service has a long history in Hackney – it was first established in 1996 and is now funded by City & Hackney Clinical Commissioning Group. Previous evaluations have shown that the service reduces unnecessary GP attendances and improves health
and wellbeing for people with multiple – and often complex – non-medical needs. These outcomes are achieved through a flexible and holistic approach that addresses both physical health and mental wellbeing. The service model is also designed to address the wider determinants of wellbeing, including participation in community life, financial stability, accommodation, and employment.

The service has been successfully adopted elsewhere in London, where it has been shown to deliver potential cost savings to the NHS by lowering the likelihood of individuals experiencing future crisis events. This is likely to be the result of greater confidence and personal resilience among service users, and improved awareness of, and ability to access, other support mechanisms (such as peer support or other community based interventions).

In 2016 Family Action was awarded three years of funding from the Big Lottery Reaching Communities Fund, to deliver an innovative pilot project in the London Borough of Hackney, adapting its successful WellFamily service model to be delivered through the Accident & Emergency department at the Homerton University Hospital. This was based on growing evidence of increasing demand on emergency services, driven in part by inappropriate A&E attendances by people experiencing underlying mental illness, stress, or anxiety.

1.4 Basis of the service model

The A&E WellFamily service builds on the success of the WellFamily model, offering 1:1 emotional support, advice and practical assistance across a wide range of non-medical and social issues. The pilot is intended to test whether similar health and wellbeing outcomes achieved by the traditional WellFamily service can also be achieved:

- By targeting those who attend A&E frequently or regularly due to underlying stress, anxiety or other low level mental illness or non-medical issue(s)
- By providing an additional signposting presence in A&E to help generate self-referrals and encourage people to make use of more appropriate types of support.

1.5 Overarching assumptions

The effectiveness and efficiency of the A&E WellFamily Service is based on a number of key assumptions:

- Demand for A&E services in Hackney is rising, and is being driven in part by inappropriate use of A&E by people who have underlying low level mental illness, anxiety or stress, in many cases due to non-medical / social issues
- Some of these attendances could be avoided by offering alternative emotional and practical support, which in turn will build longer term confidence and resilience and prevent more serious problems developing in the future

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2 Independent Evaluation of Hackney WellFamily Service, January 2014, Dr Alison Longwill
3 Evaluation of Wandsworth WellFamily, January 2016, Apteligen
- A&E could be an effective, additional point of contact to reach people who need emotional and practical support, and who would otherwise be unknown to, or not engage with, other support services
- For these people, emergency medical help is unlikely to resolve the root cause(s) of their regular or frequent attendances at A&E, and improved health and wellbeing is more likely to be achieved through a more tailored, holistic support service that addresses wider determinants of wellbeing.

These assumptions will be tested as part of this evaluation.

1.6 A&E WellFamily – evidence of need

Hackney’s population is estimated at 273,526 people, the third most densely populated borough in London and the 11th most deprived Local Authority in England in 2015. Life expectancy in Hackney is below the London average by a year and six months for women, and a year and seven months for men. It is estimated that 53,000 working aged people in Hackney are affected by a common mental health condition. Around half of these are affected by anxiety and depression.

The A&E WellFamily service was developed in response to growing demand on A&E services in the borough. Across England the total number of attendances to A&E increased by 4.4% in November 2017 compared to November 2016, with 26% of admissions listed as emergencies. A&E attendances increased by 0.6% in the year November 2016-17 in comparison to the year before, matching the trend for increasing A&E demand.

Local consultation undertaken by Family Action with local residents and delivery partners highlighted that a number of people attended A&E at the Homerton University Hospital because they felt that they had nowhere else to turn. Consultation with residents also showed that people experiencing stress or anxiety feel isolated, don’t know where to access support, or do not feel like there is adequate support available in the community. They therefore would rather go to A&E for support rather than seek alternatives. They also want someone to talk to on a 1:1 basis, who has the time to listen and understand the issues they are facing, and who they can build trust with. The consultation revealed that often there is no single reason for needing support, and multiple issues (most commonly debt, housing, domestic violence and bereavement) were triggers for stress and anxiety.

Healthcare professionals also reported increasing pressure on A&E from people with underlying social, emotional and mental well-being issues, and significant gaps in alternative provision available locally.

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4 A Profile of Hackney, its People and Place. Hackney Council January 2018
5 Index of Multiple Deprivation 2015
6 A Profile of Hackney, its People and Place. Hackney Council January 2018
7 Ibid
1.7 **A&E WellFamily – overview of the delivery model**

The A&E WellFamily service has two strands, the first of which forms the main body of support:

1. **1:1 client support** through a combination of direct 1:1 contact, support to access alternative services in the community and to engage in community activities, and advocacy and practical assistance with housing, benefits, and small grant funding.

2. **Information sharing** about support available as an alternative to A&E, via the weekly stall located in the Homerton A&E department.

1:1 sessions are provided face-to-face at a community centre in Hackney, or at the person’s GP practice. The service accepts anyone who has attended Homerton University Hospital A&E department on at least one occasion within the past 12 weeks, and who presents with support needs including housing, employment, finances, social isolation, mental ill-health (including low level depression, stress and anxiety), domestic violence, parenting issues, or help to manage long-term physical health conditions.

The Theory of Change assumes that a high number of referrals will come from A&E clinical staff, given that they are the main point of contact where frequent attenders are identified, and will also be in a position to identify the need for non-medical support. Referrals are also likely to come from GPs (who receive discharge summaries following each A&E attendance) and potential service users themselves following contact with an A&E WellFamily worker at the information stall.

Following a comprehensive assessment, clients are offered 6 to 8 1:1 sessions in the first instance. The baseline assessment includes the completion of the Wellbeing Star, which covers eight domains of subjective well-being. All clients are also assessed on the GAD-7 anxiety scale, PHQ-9 scale for depression, and the CORE 10 outcome measurement tool. Follow-up assessment is carried out at the end of the planned intervention.

Depending on the presenting issues, and those that may arise once a support plan is in place, clients will be provided with advice on alternative support available (other than A&E or other specialist medical services), emotional support, advocacy, and practical assistance.

The service is delivered by a Wellbeing Co-ordinator and a Wellbeing Worker. In addition to direct client engagement, staff spend time promoting the service, meeting with key partners, follow-up phone calls and emails on behalf of clients, and running a weekly ‘stall’ at the Homerton A&E department to encourage self-referral. Management and oversight is provided by the Hackney Services Manager and a Family Action Operations Manager.

1.8 **Intended outcomes and impact within the Theory of Change**

The ultimate goal of the A&E WellFamily service is that people with non-medical issues are more able to find the correct support for their needs, meaning they are likely to require less support in the future and reduce their inappropriate use of A&E services. This goal is
achieved through specialist emotional and practical support that meets the needs of individual service users. These needs are likely to be wide ranging and could include: mental health issues, domestic abuse, housing issues, parenting issues, substance misuse, long term physical health conditions, social isolation, or financial pressures.

The evidence underpinning this Theory of Change is drawn from the two previous evaluations of the WellFamily service model in Hackney, which demonstrated the effectiveness of the 1:1 sessions and the number of service users achieving these outcomes. The 2014 evaluation of the Hackney WellFamily Service found that it led to a statistically significant reduction in anxiety and depression. 81% of service users felt that the service had helped them achieve their goals in relation to community participation, social networks, employment and training opportunities, improved physical and mental wellbeing and independent living. One patient sample also showed a 70% reduction in unnecessary GP visits and estimated net cost savings to the health and care economy of £100,000 per annum.⁹

The Theory of Change for the A&E WellFamily service therefore assumes that the same support, delivered to those who also have non-medical needs, but who frequently attend A&E rather than their GP, will achieve similar outcomes. Indeed, the 2014 evaluation of the Hackney WellFamily Service recommended that a pilot service be delivered in an A&E setting to see if this was the case. The expected outcomes for the A&E WellFamily service are displayed in Figure 1 and include: improved wellbeing of service users, reduced anxiety and depression (and the associated negative impact on physical health), increased personal resilience and greater awareness of alternative support, and the development of stronger social networks. This should lead to less inappropriate use of healthcare services, including A&E, achieving subsequent cost benefits to the health and care system.

The Theory of Change assumes that the provision of an information stall in A&E will also help to deliver greater awareness of alternative support available, as well as encourage self-referrals to 1:1 support.

This current evaluation will help to provide evidence for the pilot model and test whether the A&E variant is an effective model for reaching this particular target population.

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⁹ Independent Evaluation of the Hackney WellFamily Service, Alison Longwill 2014
Figure 1: A&E WellFamily Theory of Change
1.9  **Experiences of the service to date**

In undertaking this evaluation, it is important that we recognise some of the challenges the service has faced to date and how it has responded to these challenges.

1.9.1  **The number of referrals from A&E**

The number of referrals directly from A&E has been lower than expected, which is likely to be the result of a number of factors. This is explored further in section 3.1. The service has worked hard to raise awareness within A&E, share case stories, and work with clinical and management staff to identify and refer potential clients. A considerable amount of work has also taken place to link with local GP practices and other agencies that may identify people who frequently attend A&E due to underlying mental ill-health or non-medical issues. Self-referrals have only been sought because the number of referrals received from A&E has been below that expected by Family Action.

1.9.2  **Complexity of service users**

Service users are presenting with high levels of complexity and risk – to themselves and others. This has required very detailed assessment and support planning, which has taken more staff time. It has also resulted in difficulty engaging clients through to a planned closure, because people’s lives may be chaotic, they are less likely to want to engage with communication, or their level of need can escalate quickly, leading to them no longer wishing to attend appointments with the service.

1.9.3  **Lack of complete outcome data**

As a result of people disengaging with the service, a number of clients do not have complete outcome data recorded. This may result in an under-representation of the outcomes and improvement seen in the data. For example, of the 95 active clients whose cases have been closed, there were only 59 clients who had a planned closure, or where a single episode was planned and therefore a full and final review was not undertaken.

2  **Methods**

2.1  **Objectives of this research**

This was a mixed-method evaluation, combining qualitative and quantitative data collection and analysis. The approach was based around a Theory of Change at the service level, with data collection and analysis aligned to those outputs, outcomes and impact that could be reasonably measured in the time available.

The evaluation aimed to address three main focus areas:
1. **Outcomes for service users**, including awareness and access to alternative support services, improved mental health and wellbeing, greater resilience, and level of inappropriate use of A&E

2. **Connectivity**, including the extent of integration with other local health services, successes and challenges faced – and the impact on the service, and

3. **Coverage and local need**, including level of access by the target population and coverage across key demographic groups.

The work was conducted in three phases as follows:

1. Phase 1: Evaluation design and development of the Theory of Change
2. Phase 2: Data collection and analysis, including interviews with service users and professionals
3. Phase 3: Final report

2.2 **Development of the Theory of Change**

The first task of the evaluation was to develop a Theory of Change for the A&E WellFamily service. A Theory of Change is a commonly used tool in evaluation that consists of a number of key components that together describe the changes a programme intends to achieve (the outcomes), for whom (the target population), and how (the inputs, processes and outputs). The Theory of Change for the A&E WellFamily service was developed through document reviews and consultation with Family Action staff.

2.3 **Interviews with key stakeholders**

A total of eight semi-structured interviews were undertaken with key stakeholders from partner agencies and Family Action staff. These are as follows:

- The Frequent Attenders List Manager at Homerton University Hospital
- Two senior A&E Nurses at Homerton University Hospital
- A solicitor who receives referrals from the service and provides legal advice in relation to housing issues
- The Deputy Service Manager from the Hackney Domestic Abuse Intervention Service
- A local GP Practice Manager (Kingsmead Practice)
- Family Action’s A&E WellFamily Support Co-ordinator and Hackney Services Manager.

We contacted an additional two GP Practice Managers, however, they were unavailable for interview.

The interviews explored the following topic areas:

- Experiences of the A&E WellFamily service to date, including what has worked especially well, the main challenges, and what could be improved in the future
• The profile of service beneficiaries, and any issues reaching the intended target population
• The main outcomes that the service has helped clients achieve
• How the service fits in with other support services available locally, and the potential benefits of offering this type of support through A&E, including where else clients would potentially seek help and receive support
• How the service has benefited partner agencies.

2.4 Service user interviews

In-depth interviews were completed with a total of eleven service users, and these took place during September and early October 2017 and then again in December 2017 (approximately two months apart). Six service users were interviewed on both occasions in order to understand the potential sustainability of outcomes achieved following their involvement with the service.

Of the eleven people interviewed, ten were female and one was male. The sample included a mix of ages and ethnic backgrounds. Five service users had completed (or were nearing completion of) their planned engagement with the Family Action worker, and six were currently undergoing support. All clients had received at least one face to face session with a Wellbeing Worker.

The interviews took place either face to face (at the Wally Foster Community Centre) or over the telephone. Written consent to participate in the research and to share personal information (name and telephone number) was obtained from service users by Family Action staff prior to contact from the evaluation team.

The service user interviews were undertaken as semi-structured discussions, covering the person’s history prior to engaging with A&E WellFamily, their use of services in the past and since receiving support from Family Action, the referral process, and the difference the service has made to their lives.

2.5 Analysis of service activity and outcome data

The data contained within this report is based on data provided by Family Action on 24th November 2017.

Analysis was largely undertaken on a question-by-question basis, with additional cross-tabulations and filtering undertaken to explore hypotheses raised by Family Action or to address queries raised by earlier rounds of analysis.
3 Service activity and reach to the target population

3.1 Number of referrals to the service

The A&E WellFamily service began with a set-up phase in February 2016. The following two months involved work to develop referral pathways in partnership with staff from Homerton University Hospital and local GP practices, and promoting the service across other care and support providers who might come into contact with potential service users. Direct client contact began in April 2016.

In total there have been 223 referrals since April 2016. Eight people were referred twice, and one person had been referred three times. Of the 223 referrals, 133 (60%) became active clients.

The chart below shows the number of new referrals and the number of newly active clients each month, between April 2016 and October 2017. Over this period there was an average of 10 new referrals and 6.7 new clients each month. However, 36 new clients became active in the most recent three months (an average of 12 per month), suggesting that the service has received an increased number of appropriate referrals.

![Referrals and new active clients over time](image)

**Figure 2: Number of new referrals and new active clients by month (April 2016 – October 2017)**

The design of the A&E WellFamily model involved detailed consultation with local residents and partner agencies prior to implementation. Based on the outcomes of this consultation exercise, and learning from the experiences of the WellFamily model already operating in GP practices in Hackney, Family Action anticipated that 300 people per year would receive 1:1 support from the service (900 people over three years). This was subsequently revised to 100 per year in receipt of direct 1:1 support in years two and three, in response to the lower than expected number of referrals directly from A&E in the first year, and evidence of a more complex service user profile compared with the traditional WellFamily service, which has required more staff time to maintain engagement.
At the same time, however, it was also clear that the service was able to support many more people through signposting and by providing information on alternatives to A&E. Where this report refers to the term ‘signposting’, this includes both information giving, and active liaison and direct referral to other relevant agencies. This was expected to be an additional 300 people in year two and 335 in year three, achieved via the weekly A&E stall, and working closely with staff in A&E triage and GP practices. Between January and October 2017 (10 months), approximately 240 people were provided with one-off support or advice and information through the A&E stall, or contact at a GP practice. However, it is not possible to know from the data collected whether these people go on to receive 1:1 support.

A total of 90 new referrals have been received to date for year two (nearly 8 months), with 56 new clients becoming active during the same period. These figures include a general increase in both referrals and active clients throughout August, September and October, which if they can be sustained, suggests that it is likely the service will exceed its current target of 100 active clients for year two.

### 3.2 Source of referral

While the early thinking around the design of the A&E WellFamily model did not include an assumption that A&E would be the only referral route into the service, there was an expectation that this would be one of the primary sources of referral:

> ‘Following discussions with the A&E team at the Homerton Hospital we have identified that piloting this innovative model will meet a significant gap in local provision and provide a referral route for A&E patients in need of tailored support to help prevent frequent and/or inappropriate attendance.’

However, since April 2016, the majority (54%) of referrals have been from a GP, with a further 14% being self-referrals. Nine percent were from a health practitioner (Homerton A&E or Homerton Sickle cell services).

Across the GP practices, Gadhvi Practice referred 15% of clients (34 people) and Lea Surgery referred 11% (24 people). A number of surgeries only referred one or two people. It is notable that most of the GPs with a higher level of referrals are ones in which the service has had a greater presence. For example, Cedar Practice, Gadhvi Practice, Kingsmead Health Centre and Lea Surgery all generate a report about the most frequent attenders and ask the service to distribute leaflets and information to these people directly as well as giving them a telephone call.

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10 A&E WellFamily Big Lottery Fund Stage One application form, Family Action, 3/2/15.
Figure 3: Referral origin for all referrals to November 2017

- **56%** from GPs
- **14%** from Self
- **9%** from Health Practitioner
- **8%** from Family Action
- **1%** from Children's Centre
- **1%** from Children's Services
- **1%** from CAMHS
- **1%** from Adult Mental Health
- **1%** from Statutory
- **0%** from Health Visitor
- **7%** from Other - please specify
This evaluation has identified a number of possible explanations for why direct A&E referrals have been fewer than the number expected from early discussions, and these provide valuable learning from this pilot:

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11 The referring agency is a free-text response and was not always captured within the relevant field within the data.
• Inability to base the service in the A&E department – it was expected during the design phase that the service would use space within the A&E department to engage with clients, both at the time of their attendance and as the place where the majority of 1:1 support sessions would take place. This arrangement could not be put in place and as a result, Family Action staff feel that this has extended the time needed to introduce new referral pathways and to effectively support busy clinical teams.

• Understanding of the service among A&E staff – this has taken time and involved ongoing support and engagement from Family Action staff. Sharing case studies of service users who have been supported by the A&E WellFamily service has helped to build greater understanding among clinical teams of who to refer and the potential outcomes that Family Action can achieve with those people.

• Widening referral criteria (service users only need to have attended A&E on one occasion in the past three months) – this was necessary in response to the lower than anticipated number of referrals from A&E. However, this also means that the referral data will now show a higher proportion of referrals from other routes (including self-referral).

• The time needed to introduce change – the time it takes to introduce new pathways of care, build trust between services, and develop strong and professional working relationships will obviously vary from service to service, and organisation to organisation. Health and care is a complex system of interactions and well-established practices and protocols, which take time to change. There also needs to be a commitment at all levels for change to happen.

Despite these challenges, there are promising signs that the new Social Prescribing in Secondary Care pilot, funded by Healthy London Partnership, that Family Action is delivering at Homerton University Hospital over the winter months of 2017/18, will provide an opportunity to engage the wider clinical teams at the Trust, re-establish a commitment to work collaboratively together, and learn more about how best to support people who present to A&E with complex social and non-medical needs. Family Action are already considering how the two services can be designed to best complement and integrate with one another within the secondary care setting.

3.3 Demographic profile

3.3.1 Gender

Analysis of the demographic data shows that nearly two-thirds (63%) of those referred to A&E WellFamily were female. In Hackney, 50.2% of the population are female and 49.8% are male12, so a slightly higher number of female service users would be expected. The target population for the A&E WellFamily service includes people with low to moderate mental health problems; a higher number of female service users is not inconsistent with what we know about the prevalence of mental illness across the UK and globally.

12 A Profile of Hackney, its People and Place. Hackney Council January 2018
The World Health Organisation (WHO) states that ‘overall rates of psychiatric disorder are almost identical for men and women but striking gender differences are found in the patterns of mental illness.’ For example, women are almost twice as likely as men to be diagnosed with anxiety disorders. Depression in women may also be more persistent than in men, as well as a diagnosis of Borderline Personality Disorder. However, according to WHO, ‘there are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect less than 2% of the population.’

It might therefore be expected from these global population estimates that the service would engage with a higher number of women than men, owing to the level of need supported. Local data also show that the estimated prevalence of common mental health disorders in women in Hackney is 19.7% of the population and 12.5% for men. However, it is impossible to know for sure how representative the actual service user profile is for the Hackney population without more detailed analysis.

When looking at the gender profile of those who became active clients, the gap between the proportion of males and females increased, with 74% female. This indicates that there may be more of a challenge in encouraging men to engage with the service than women.

### 3.3.2 Age

For those where age was known, the largest proportion was 31 – 40 years old (20%). This is to be expected given that the majority of residents in Hackney are aged 25-39.

There is limited data available about the prevalence of mental illness by age group, however, recorded depression in Hackney is highest in those people aged 50–64 and 40–49 (around 4.5% of the population). The next highest recorded prevalence is in the 25–39 age group (approximately 3%). However, these figures are based on recorded prevalence and do not necessarily represent the age profile among those not engaged with services, or those with unmet needs. Again, no modelling of need exists for us to compare the actual age profile with those who are accessing the service.

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16 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 2000
17 Ibid
18 City and Hackney Mental Health Needs Assessment, 2014, available at: [https://hackney.gov.uk/jsna](https://hackney.gov.uk/jsna)
19 A Profile of Hackney, its People and Place. Hackney Council, January 2018
3.3.3 Ethnicity

Service data shows that of those where the ethnicity was recorded\(^{21}\), 43% of those who referred to the service were white British/European and 35% were Black/Black British, with a further 10% from Asian backgrounds. When considering the proportion who became active clients, there are a higher proportion of Black/Black British clients (44%) than white (38%), and a similar proportion of Asian clients (7%) as were referred.

Hackney has a diverse population with two thirds of residents from a black or minority ethnic (BME) background.\(^{22}\) Mental health admissions in the borough are also particularly high among BME communities, often because of barriers to receiving support earlier, such as stigma and misunderstanding.\(^{23}\) It would appear that although there may be an under-representation of those from BME groups, these groups are accessing the service and there is unlikely to be any substantial under-representation when compared with the wider population.

4 Complexity of the user profile

The A&E WellFamily service is targeted towards people ‘experiencing social issues and/or low to moderate mental health problems.’\(^{24}\) This means that the service will engage with people experiencing a broad range of problems, and with varying degrees of severity. The

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\(^{21}\) It should be noted that there was a high proportion of individuals where their ethnicity was not recorded, particularly for those who were referred but did not progress to becoming active clients. Ethnicity is a voluntary category

\(^{22}\) Office for National Statistics, 2011 Census.

\(^{23}\) A&E WellFamily Big Lottery Fund Stage One application form, Family Action, 3/2/15

\(^{24}\) Ibid
findings from this evaluation suggest that the service user profile is incredibly complex, and probably more so than the profile of users being referred to the traditional WellFamily service (although it was not within our scope to undertake any direct comparative analysis). This is an important learning from this pilot phase and has implications for the design and resourcing of future service models that link into secondary care.

4.1 Reason for referral

In order to be eligible for 1:1 support from an A&E WellFamily worker, a person must have presented to Homerton University Hospital A&E department within the previous 12 weeks and need support in relation to issues such as one or more of the following:

- Destabilising events
- Social isolation
- Mental health issues, including emotional support needs, stress or anxiety, suicidal ideation, panic attacks, bereavement, or depression
- Managing long term physical health conditions
- Frequent inappropriate use of A&E
- Eating disorders
- Housing issues
- Domestic abuse
- Support needs as a carer
- Applying for financial assistance
- Parenting issues
- Immigration issues
- Substance misuse

This may be identified by A&E staff when the person attends A&E, GPs (by reviewing A&E attendance data, or following receipt of discharge summaries, or in direct discussion with a patient), or by a person presenting at the Family Action A&E stall.

InForm service data was analysed to explore the main reasons why people were referred to A&E WellFamily. The most commonly identified reasons were needs around:

- Isolation (22%)
- Information/advice (20%)
- Housing (16%)
- Mental health (11%)
- Domestic abuse/violence (8%)

However, as can be seen from the chart below, there were also a number of other reasons why individuals were referred. As there was more than one reason for some clients being referred to the service, the total percentage totals more than 100%. This is to be expected given the diverse needs of the target population.
Just under a third (32%, 72 people) of people referred had one of the issues listed, and 28% (62 people) who were referred presented with two or more issues from the list above. This gives some indication of the level of need and complexity of service users. Around 40% of referrals had no referral reason captured in this data field (the referral reason was captured in the InForm database within a free text field) and has therefore not been included in our analysis owing to the extra resource required to analyse free text.

However, this data is not consistent with the information obtained from our interviews with service users and we believe that it does not adequately reflect the complexity of the user profile. All of the people we interviewed stated that a recent traumatic event (typically a tenancy breakdown, domestic violence, bereavement, sudden illness or multiple long term conditions) was their main reason for needing support. Social isolation may have been a
factor affecting their ability to recover from that event, however, in the majority of cases service users reported uncontrolled levels of stress and anxiety as the issue they needed most help with. This is not represented in the data above.

In terms of practical assistance, service users most commonly cited help with accessing small grants or benefit entitlements as the main areas of support. Housing was an issue for two of the people we interviewed, however, the professional stakeholders we spoke to suggested that housing is likely to be a much more common issue among the target population, and one which drives high levels of stress and ill health.

These findings are supported by the service staff and management team, who report higher than expected levels of significant emotional trauma among service users (including childhood trauma, abusive relationships or bereavement), and often people who have received little or no support in the past (our impression is that these are not generally people who have been in and out of services over a long period of time, but are receiving this type of support for the first time). Staff also report a considerable amount of time assessing and managing risks and providing practical assistance due to low awareness among service users about the different types of support available to them.

4.2 Services provided

Analysis of the type of support people received shows that one of the most common services provided is signposting to other services, with 32% of all referrals signposted to other services. In some instances, these individuals did not become active clients but were signposted on to more appropriate services, although even where individuals did become active clients with the A&E WellFamily service, 30% were also referred to other services for additional support, from over 60 organisations (see Appendices).
The majority of support provided relates to individual work, with between a quarter and a third of clients requiring advocacy and/or counselling, or some other support not listed. Meanwhile, family related support and groupwork was less commonly provided. Consistent data on the ‘other’ services provided would be required to conclude anything further from this data. This was recorded as free text, and therefore not able to be analysed within the scope of this report.

Although the data indicates that individuals were signposted to other services, and the service has a list of over 60 organisations that have been signposted to (see Appendices), the way data is collected does not enable the service to identify the services that each individual was signposted to during/at the end of their support, and therefore what longer term support they are being linked in to.

4.3 Contact with service users and other activities

The service staff undertake a range of different activities as part of their work with service users, not all of which is client facing time. For example, for the average active client who completes their engagement with the service there are:

- 16.9 phone calls
- 8.5 emails
- 7.3 support sessions
- 1.4 letters

Additional time is also spent on activities such as third party liaison, text messaging, and meetings. Staff report a considerable amount of time spent on direct client contact outside
of face to face clinic time. A typical week for each of the WellFamily workers involves the following:

<table>
<thead>
<tr>
<th>Typical weekly activities</th>
<th>WellFamily Support Co-ordinator</th>
<th>WellFamily Support Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face to face clinic time</td>
<td>2 days</td>
<td>3.5 days</td>
</tr>
<tr>
<td>Follow-up client time (phone calls, letters, information gathering)</td>
<td>1 day</td>
<td>1 day</td>
</tr>
<tr>
<td>A&amp;E stall</td>
<td>0.5 days (every 2 weeks)</td>
<td>0.5 days (every 2 weeks)</td>
</tr>
<tr>
<td>Management and administration</td>
<td>1 day</td>
<td>0.5 days</td>
</tr>
<tr>
<td>Service promotion</td>
<td>0.5 – 1 day</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 1: Estimated breakdown of time spent on different activities

It is important to note these breakdowns are estimates only for a typical five day working week and may vary from week to week depending on workloads, staff absence, and other commitments. For example, the A&E WellFamily Support Worker occasionally helps with service promotion.

### 4.4 Case status and closures

At the time of the data extract (received 24th November 2017) there were 38 active clients, there had been 167 closed clients and there were 18 individuals at the referral stage.

Of the cases that had already closed, 41% were closed because there was no engagement from the service user, 26% were closures which were planned with the service user, and 17% began the service but disengaged at some point.

![Case closure type](image)

Figure 8: Case closure type (Based on all closed cases)
This data highlights the potentially complex nature of this service user population, many of whom have experienced trauma in the past and/or lack of support over a long period of time. The complexity of the service user population means it is unsurprising that over half of the case closures were due to lack of client engagement, as when people have chaotic lives maintaining appointments may not be prioritised. This is despite considerable effort on the part of the Family Action staff to engage clients once a referral is made, including:

- Using a range of mechanisms to reach clients, including by phone, text message and written communication
- Offering information and advice on alternative services
- Providing phone support outside of agreed appointment times, and
- Offering flexibility in the frequency of face to face sessions to suit individual circumstances

5 Outcomes for service users

5.1 Summary of findings

Data was available for 94 clients about whether their goals had been achieved. This reveals that nearly half of these (47%) achieved the outcomes they identified at the beginning of their engagement with the service. This was despite some failing to continue their engagement with the service for the expected length of support of 6-8 sessions. Where service users did complete their interaction with the service and have a planned closure, 82% had achieved the outcomes they had intended, and the remainder had partially met their goals.

Four different tools were used to access outcomes:

- CORE-10
- GAD-7
- PHQ-9
- Wellbeing Star.

The Wellbeing Star data is collected at 3 points during an individual’s interaction with the service. Not all domains were used for some clients at the midpoint, with more recent clients usually only using 4 of the 8 elements of the star. This change to the Wellbeing Star was agreed with Big Lottery as the time taken undertaking the tools to monitor progress was limiting the time staff could spend supporting the clients, and the elements not measured did not directly help inform decisions about the support the person was provided. There were 99 clients with completed before and after Wellbeing Star data.

For the CORE-10 scores the analysis looked at both the final score and the penultimate score (where there were at least 3 scores) as it is understood that the last session can result in less positive scoring due to anxiety associated with leaving the service. There were 67 clients for whom CORE-10 was considered appropriate to use owing to their psychological distress, and who had scores from at least 2 points in time.
Across all the tools above there have been improvements in the average scores for the wellbeing of service users before the client began their support, compared with at the end. The Wellbeing Star particularly shows improvements across all domains, and GAD-7 and PHQ-9 show improvements in anxiety and depression. While the changes are fairly modest at an average level, there have been some clients who have experienced a high level of improvement. Although there were a small number of clients where their final scores were not as positive as at the point at which they commenced the service, the number with a decline, and the scale of this, is much smaller than for those where there has been an improvement.

The CORE-10 measure, ‘I have someone for support’ and the Wellbeing Star measure in relation to Family and Friends, suggests that there has been an improvement in the degree of social isolation. Similarly, improvements in the CORE-10 measures ‘Felt tense, anxious or nervous’, ‘Images or memories cause distress’, ‘I have felt unhappy’, ‘I’ve felt despairing or hopeless’ and ‘I have difficulty sleeping’ suggest a reduction in the global distress of service users. Clients also appear to have more personal resilience, with improvements in the CORE-10 measure ‘Able to cope as things go wrong’, as well as wellbeing star scores showing an improvement in clients’ ability to manage their symptoms, look after themselves and ‘feeling positive’.

Although it is not possible to tell from Family Action’s case management data whether there has been a reduction in frequent attender/inappropriate A&E visits, and data from the A&E Department was not available, all the service users we interviewed reported a notable reduction in their need to attend A&E in the last three months (or since they started with the service). In most cases, any recent attendances were due to a new or unrelated medical issue. Of the nine users we interviewed and for whom prior A&E attendance data was available (provided by Family Action), the average number of attendances per person prior to engaging with the service was one per month. This was reduced to one per quarter or less in the majority of cases (an average reduction of 66%). Users also reported greater ability to deal with issues, greater confidence, and more awareness of alternative sources of support, which gives us confidence that the outcomes achieved are likely to be sustainable for a majority of service users who engage with the service.

5.2 Supporting data and evidence

5.2.1 Meeting outcomes

It can be seen from the chart below that for 47% of all closed cases, regardless of reason for closure, the outcome goals were fully met, whilst they were partly met for a further 24%. These figures include those who did not complete the service, including both those who do not engage at all (but may have been signposted elsewhere) and those who dis-engaged.

Considering just those who completed their involvement with A&E WellFamily and had a planned closure, there were very positive outcomes with 82% of clients who ‘fully met’ their goals, and 18% who ‘partly met’ them.
5.2.2 CORE-10 score

Clients also complete CORE-10 as part of their engagement with the service. The CORE-10 is a shorter version of the CORE-OM tool which is widely used in the evaluation of counselling and in psychological therapies in the UK. The CORE-10 was developed as a more practical tool to be used in evaluation where there is not the time to work with clients to undertake the longer tool.

Overall, CORE-10 scores were on average 19.36 out of a maximum of 40 at the beginning for the clients for whom we have pre and post data. This puts clients at the upper end of the ‘Moderate distress’ category in the CORE-10 clinical assessment.

When filtering for those who completed a first and last score, the average score was 19.84 at the beginning, compared to 15.57 at the end. Although on average clients remain in the moderate distress category, as can be seen from the table below, there was a greater change for those who started with a higher level of distress. A lower score is desirable, so the more negative the score, the greater the improvement. There was a particularly notable improvement for the 10 clients who entered the service scoring as being in ‘Severe psychological distress’. Three clients who entered the service had a total CORE-10 score which put them in the ‘healthy’ band.

<table>
<thead>
<tr>
<th>Total score</th>
<th>Interpretation</th>
<th>Number at this level at first score (where at least 2 responses)</th>
<th>Average change for this group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Healthy</td>
<td>3</td>
<td>2.67</td>
</tr>
<tr>
<td>&gt;5 to 10</td>
<td>Low level problems</td>
<td>7</td>
<td>0.00</td>
</tr>
<tr>
<td>&gt;10 to 15</td>
<td>Mild psychological distress</td>
<td>14</td>
<td>-1.43</td>
</tr>
<tr>
<td>&gt;15 to 20</td>
<td>Moderate distress</td>
<td>17</td>
<td>-5.29</td>
</tr>
<tr>
<td>&gt;20 to 25</td>
<td>Moderately severe</td>
<td>16</td>
<td>-6.50</td>
</tr>
<tr>
<td>&gt;25 to 40</td>
<td>Sever psychological distress</td>
<td>10</td>
<td>-8.50</td>
</tr>
</tbody>
</table>

Table 2: Change in CORE-10 severity
The chart below shows the changes in CORE-10 for active clients, who had at least two CORE-10 assessments, against each of the individual dimensions.

The biggest average change for A&E WellFamily clients was in relation to feeling tense, anxious or nervous. However, clients also showed improvements in feeling they have someone for support and in relation to the extent they have ‘felt unhappy’.

![Figure 10: Average change between the first and last CORE-10 scores](chart)

The chart below shows the first and last scores for CORE-10 for active clients who had at least two CORE-10 assessments. Feeling tense, anxious or nervous was one of areas in which clients scored particularly highly on entering the A&E WellFamily service, but as noted above, this was particularly improved. Although the chart above showed little improvement in scores around ‘I have made plans to end my life’, it is clear from the chart below, that this was not particularly identified as a concern for WellFamily clients.
5.2.3 GAD-7 and PHQ-9

GAD-7 and PHQ-9 provide measures of anxiety and depression. There were 75 clients with a first and last score for at least one of these measures.

For GAD-7 respondents indicate a response of zero to three for seven different statements about problems that may have bothered them over the last two weeks, where one indicates not at all and three indicates ‘nearly every day’. These statements include ‘Feeling nervous, anxious or on edge; and ‘Feeling afraid as if something awful might happen’. The scores across all seven statements are added together to give a total GAD-7 score. As such the GAD-7 score ranges between zero and 21 and a reduction in the total GAD-7 score demonstrates an improvement in anxiety levels.

The average starting score for service users was 11.54 and the average final score was 9.41, suggesting that on average there was a slight improvement in the level of anxiety clients experienced. As can be seen in the chart below, there was however a range in the level of impact the service has had. In total, 55% of clients experienced an improvement in anxiety as measured by GAD-7, 11% did not have any change, whilst 34% experienced a worsening in their anxiety levels. When looking at the average profile, there was greater reduction in anxiety for those that experienced an improvement, than the increase in anxiety for those who felt things worsened. There were also some substantial improvements for a small number of clients. Unsurprisingly, those clients with the highest levels of improvement in their GAD-7 score, generally started with a higher first score.
PHQ-9 is based on a similar principle to GAD-7, but explores depression instead of anxiety. There are nine statements with a response ranging from ‘Not at all’ with a score of zero, to ‘Nearly every day’ with a score of three. The depression severity is then calculated as a total out of 27 with a score of -4 reflecting no depression, 5-9 mild, 10-14 moderate, 15-19 moderately severe and 20-27 severe depression.

The average starting PHQ-9 score was 13.67 compared to the average last score of 11.87. The chart below shows the PHQ-9 scores. Overall, 59% experienced an improvement, 7% saw no change in their depression scores, and 33% felt things were worse. However, as with GAD-7, it is notable that those who experienced an improvement generally saw a larger improvement than the scale of change for those who felt things worsened. As with GAD-7, those with the greatest improvement were those who started with a higher PHQ-9 score.
### 5.2.4 Wellbeing Star

The Wellbeing Star was developed by Triangle Consulting Social Enterprise Limited. It was designed for use with ‘people living with a long term health condition, to support and measure their progress in living as well as they can’. There are 8 domains in the Star which are:

- Lifestyle
- Looking after yourself
- Managing symptoms
- Work, volunteering and other activities
- Money
- Where you live
- Family and friends
- Feeling positive

The individual completing the star gives a response of 1 to 5 based on the categories below:

- 1 - Not thinking about it
- 2 - Finding out
- 3 - Making changes
- 4 - Getting there
- 5 - As good as it can be
The chart below shows the Wellbeing Star with the average change across all clients that completed the first and last assessment. Unlike the previous tools, a higher change score is a positive. As is demonstrated in the two charts below, the most notable changes were in ‘Looking after yourself’, ‘Managing symptoms’ and ‘Where you live’.

![Average change in Wellbeing Star score](image1)

**Figure 14: Average change in Wellbeing Star score**

Figure 15 shows the first and last Wellbeing Star scores. The scores across the domains are relatively consistent, demonstrating the ability of the A&E WellFamily model to support clients across a range of complex needs.

![Average first and last Wellbeing Star scores](image2)

**Figure 15: Average first and last Wellbeing Star score – for all Wellbeing Star domains**
5.3 Service user feedback

All the clients interviewed were extremely positive about the A&E WellFamily service. All clients reported lower levels of stress and anxiety, and more confidence in managing their wellbeing. This was most commonly due to a feeling that the Family Action worker showed empathy and was able to really listen to the issues the person was facing. Many said that this was the first time they felt someone from a support service had made an effort to properly understand their circumstances, and to offer both practical and emotional support across a range of issues.

“I have greater confidence - without Family Action I wouldn’t be where I am today” – Service user

The findings from the interviews evidence that it is this combination of practical assistance and emotional support that helps to achieve positive outcomes, and something which is not typically available through statutory – or indeed some other voluntary sector – services.

Many had also never been in contact with a service like WellFamily in the past, although they had typically been in contact with mental health services.

“I’ve never had anything like this before” – Service user

All the clients we interviewed experienced some combination of mental health and physical health issues, which had not been addressed holistically in the past. Our initial findings show that the A&E WellFamily service is successful in taking a whole person approach, especially for people with mild to moderate needs who fall below the threshold for more specialist health and social care services.

The interviews also demonstrate that the service effectively signposts people to alternative sources of support in their community. However, with more resources and greater capacity within the service to recruit and train volunteers, additional efforts could then be made to support people to actively engage with those alternative sources of support, as a means to build their support networks and to engage in more active and fulfilling lives over the longer term. This could be achieved through more use of volunteer befrienders and peer support groups, for example. However, it is important to recognise the challenges associated with this client group (this is the first time many of these people have engaged in any type of non-medical support) and the extent to which longer term, sustainable behaviour change is achievable within the timeframe of this intervention.

“[The Family Action worker] is very, very good. I know much more about where to go to for help now.” – Service user
Case example – Jennifer

Jennifer was referred to the A&E WellFamily Service following her frequent attendances to the Homerton University Hospital A&E department with her baby son. She was typically attending A&E once a month. Often the visits to A&E would be unnecessary and could have been managed by her GP. The referring practitioner asked that Jennifer be given some education around more appropriate services to use, and support for her anxiety.

Over a period of around 10 months, the A&E WellFamily worker, Sam, provided emotional support and advice on alternative support services. – This was provided against a background of domestic violence and relationship breakdown that emerged during the initial assessment. – The A&E WellFamily Service gave Jennifer a safe place to discuss her concerns, to set goals for her future, and provided support for Jennifer’s anxiety through referral to the Hackney Wellbeing Network.

Jennifer’s relationship difficulties and associated stress were also having a negative impact on the behaviour of her children, so Sam supported her to access appropriate support for them. Jennifer was also supported to access counselling and a support group for women who have experienced domestic violence.

In order to ensure Jennifer would be well supported over the longer term, Sam provided information about Children’s Centres and activity groups in her local area that she could attend with her children. This would help Jennifer meet new people, form positive relationships, and provide additional avenues for support.

Jennifer was also provided with practical support, including:

- An application to move to more suitable housing
- A £300 Family Action grant towards a holiday for her and her children following a number of upsetting incidents for the family
- Support to apply for a grant towards the cost of necessary home items
- Food Bank vouchers to support her and her children
- Referral to organisations that could provide her with legal advice around an upcoming Family Court hearing with her ex-partner, and
- Support with filling out forms and letter writing to a number of organisations.

Jennifer attended A&E only twice over the 10-month period she was supported by Family Action.

“When I am with you I feel I have more power and I am not afraid to say how I feel. Thank you for everything.”
The advocacy role of the service is also a key driver of positive outcomes. All the service users we spoke to reported that the Family Action worker had made contact with other agencies on their behalf, and that this had made a huge difference to their stress and anxiety. This included social services, community health services, housing and benefits, and local community groups.

“I’ve never seen anything happen so quickly” – Service user

All the service users interviewed were able to articulate some form of emotional support received, whether that be through listening, goal setting, confidence building, and/or referral to more specialist psychological support, such as cognitive behavioural therapy.

“I’m feeling much better and I have my confidence back now. [The support worker] has given me the details of lots of groups to contact and I have already followed up one of them and I’m really looking forward to getting started.”

These improvements have also led to a reduction in A&E attendances. Data was available for nine service users on their level of attendance prior to their engagement with A&E WellFamily (provided to Family Action by GP practices) and since their engagement with the service (obtained in service user interviews). The average change for these service users was a reduction of 66%, from an average of 1 attendance per month to 1 attendance per quarter.
Case example – Samira

Samira is a young adult who lives in Hackney. She has a number of physical health problems, including epilepsy and lower back pain, which have troubled her for many years. She has been in and out of hospital regularly over this time and has received counselling in the past to help cope with daily life, low mood and periods of depression.

Samira’s physical and mental health began deteriorating, and she had attended A&E six times in three months. She didn’t know where else to turn for help. Samira lives on her own in temporary accommodation and is studying part-time at university. She has some family nearby and often stays with her mum, who lives outside of London, on weekends.

Samira became aware of the A&E WellFamily Service during one of her visits to the A&E department at the Homerton University Hospital, and made an appointment to see an A&E WellFamily worker, Jane, at the local Community Centre. Jane talked to Samira about everything going on in her life, what she wanted to achieve, and what help she felt she needed to take more control over her health and wellbeing. This included exploring with Samira the different types of help and support available through family, friends, and her community.

Over six 1:1 sessions Jane was able to provide Samira with emotional support, through listening and helping to set realistic goals, offer advice and practical support around benefit entitlements and housing options, and talk to Samira’s GP about the ongoing management of her physical and mental wellbeing.

Although Samira continues to experience ongoing health problems, she now feels in a much better position to cope with anything that comes along, is more confident, and knows where to go to for more appropriate support. She has not attended A&E in the past three months.

“The support from Family Action has been excellent. They’ve helped me with whatever I needed and have been able to point me in the right direction for help and support.”
6 Connectivity across the health and care system

Effective service integration is a key requirement for effectively supporting people who have complex and wide-ranging support needs. The evidence from this evaluation indicates that the A&E WellFamily service has made considerable progress towards being an effective link – or connector – between different parts of the health and care system in Hackney, however, there is more progress to be made. This is not the sole responsibility of Family Action, but requires a commitment from local partners (including the Homerton A&E department and other clinical teams) to work collaboratively together, identify opportunities, and support new ways of working for the ultimate benefit of local people.

The Family Action team have spent time over the past two years (and prior to this as part of the design phase), building relationships and meeting with City and Hackney Clinical Commissioning Group, the GP Confederation, Hackney Council for Voluntary Services, the Hackney Safeguarding Board, the Child and Adolescent Mental Health Alliance, and others across the local health and care system. Strong working relationships have been developed between the A&E WellFamily Service and the Hackney Domestic Abuse Intervention Service, where there is sharing of information and care co-ordination arrangements in place between the two services for people who have experienced domestic violence. This could be extended to other statutory services, such as inpatient and/or community mental health teams.

The service has also established close working relationships with a number of GP practices, and there is evidence that this effort is starting to pay off, with a noticeably higher number of referrals from those practices compared to those where a Family Action worker is not present.

We received a number of positive comments from local stakeholders about the value of the A&E WellFamily service, and the outcomes it achieves for clients. In particular, the professionalism and expertise of Family Action staff, the quality and consistency of communication, and the approach to collaboration and joint working were all highlighted. All the stakeholders we interviewed felt that the service fills a much needed gap in local service provision – for people with multiple low to moderate non-medical needs.

However, raising awareness and relationship building needs to be properly resourced in any future funding model. Despite Family Action’s existing presence in Hackney, through its traditional WellFamily model, raising awareness of this new service, and influencing referral pathways and behaviours, has required a huge amount of time and effort. This will need to continue if the A&E WellFamily service is to provide an effective link service for this user population.

There are now new opportunities to extend the reach of this pilot project through a Social Prescribing in Secondary Care ‘Winter Pressures’ pilot project that Family Action is also running in partnership with Homerton University Hospital from December 2017 to March 2018. This will engage with other clinical teams in secondary care and provide additional capacity to link into other care and support services throughout the local community.
Conclusions

A key challenge for this evaluation has been the developing nature of the service model since the service began nearly two years ago. In response to lower than expected referral numbers from A&E early on, the service has opened up additional referral pathways and made changes to the referral criteria in an effort to meet a demonstrable need within the local community. This means that we cannot draw firm conclusions about the viability or effectiveness of the service from the perspective of the original design.

However, the evidence from this evaluation demonstrates that the A&E WellFamily service is an effective service model for people with non-medical support needs. However, any future delivery model needs to recognise that the service user profile is likely to be more complex than the traditional WellFamily service, and a physical presence in the acute hospital setting (ideally within A&E) is likely to enable more direct referrals and potentially result in a higher level of engagement with the service. It is also clear that offering a number of different referral routes (including self-referral and direct referral via GP practices) will help to increase the reach of the service to the target population.

Despite this, the evaluation has shown that the service is effective at engaging people who have generally received little or no support in the past, and supporting people to achieve notable improvements in mental and physical wellbeing. This has resulted in at least a 66% reduction in A&E attendances among the sample of service users who took part in the evaluation.

We can also report with some confidence that these outcomes are likely to be sustained over a longer term for those clients who progress through to a planned closure. However, for some of these service users, a short, intense period of support will never be enough, given the complexity of the presenting issues. More data needs to be available about any ongoing support that A&E WellFamily clients are supported to access, in order to evaluate whether the current service model is the most effective option for this client group. For example, a future delivery model could include some provision for social prescribing to provide direct support for people to attend local groups or other community support services for a period of time beyond the period of the intervention.

The evidence from this evaluation indicates that the A&E WellFamily service does help to fill an important gap in local support for people who are experiencing low to moderate mental ill-health, and the service has made considerable progress towards being an effective link – or connector – between different parts of the health and care system in Hackney. However, there are now new opportunities to engage with clinical teams across secondary care, and to establish new referral pathways and connections with other care and support services as part of the social prescribing pilot being launched with the Homerton University Hospital.
8 Considerations for further service development

Based on the findings from this evaluation, we recommend that the following points be considered by Family Action as part of its ongoing work to maximise the effectiveness and impact of A&E WellFamily within the context of the local care and support system:

8.1 Routes into the service

Continue to maintain and develop a range of different referral routes, including developing pathways with acute mental health teams and other local services, and continuing to work with the A&E Frequent Attenders List Manager at the Homerton University Hospital. This will increase the reach of the service to the target population while maintaining a focus on those who use A&E because they do not feel they have anywhere else to turn.

8.2 A greater presence in A&E

Given the findings about referral routes and numbers, reconsider with Homerton University Hospital the option of establishing a greater physical presence in A&E, in line with the original service design. This will make it easier for clinical staff to refer to the service, and increase the likelihood of effectively engaging with those potential service users. However, this will be reliant on available space within the hospital.

8.3 Review the resourcing model

The learning from the service to date, and the findings from this evaluation, should be used to undertake a more detailed modelling exercise to assess need within the local population, and develop a resourcing model for the service that will best meet this need. This should be done in collaboration with the Homerton University Hospital, City & Hackney CCG and the London Borough of Hackney Public Health team, in order to understand more fully the current need for the service and the likely service user profile (including the demographic profile and complexity).

8.4 Opportunities to link the support model across secondary care

Family Action should explore opportunities to integrate A&E WellFamily within a wider social prescribing model in secondary care, using the learning from the forthcoming pilot project and the evaluation being planned for that new service. This may generate efficiencies for both referring organisations and Family Action, and could include, for example, a single point of referral and triage service that would effectively signpost and/or link people into appropriate support (whether that be the A&E WellFamily service or elsewhere).
8.5 Data collection and ongoing monitoring

Refine data collection arrangements to improve ongoing monitoring and evaluation, including:

- Reviewing the number of tools used to gather data on wellbeing and impact of the service. It would be valuable to focus the use of tools around those where there is a clear benefit to improving the service for the client from using the tool, such as the CORE-10 where it has been shown to be a useful way of uncovering issues with clients. It is likely that PHQ-9 and GAD-7 are the best candidates for being removed, or at least the frequency with which they are undertaken being reduced to just the first and last interactions with the client. This will free up valuable direct contact time with service users. It is understood that all elements of the Wellbeing Star are now being used at all data collection points, and the extra resource required for this should be considered alongside this review.

- Limit the use of open text fields in the data system, as this makes analysis and reporting more time consuming and reduces the ability to identify trends and issues. It is understood that this is already being undertaken by Family Action, with a character limit to the field and clear guidance on its use, including anonymisation, provided alongside the field within the system.

- Seek data sharing agreements with the NHS to enable the service to more easily track the impact of key activities on attendance at A&E and shape service delivery as a result.
9 Organisations that users have been signposted to

- Homeless Shelters which do not require recourse to public funds and a list of places in Hackney which provide free hot food to the homeless
- WellFamily Plus
- Social Prescribing
- Hackney Migrant Centre
- Hackney Citizens Advice Bureau
- CHYPS Plus
- Street Link
- Hackney volunteers centre
- Homerton Perinatal services
- Environmental health
- The Hackney Wellbeing Network
- Children’s social services
- Adult social care
- Psychology services (IAPT, Tavistock and Portman)
- The Sun project
- Crisis helplines, such as Bikur, Hackney crisis service
- Community physical activities, such as Core Sports
- Community support groups, such as the MS Society or the Sickle Cell Support Group
- Occupational therapy
- Housing support services such as Shelter, housing solicitors
- The Learning Trust
- Cultural specific support services, such as Derman, Imice
- Singing groups/art groups such as CORE Arts
- Free meditation classes
- Hackney advice service
- Domestic abuse services, such as NIA
- Rape support services, such as the East London Rape Crisis line
- MARAC (DV related investigation services)
- Metropolitan police
- Kids Time
- Rethink
- Pause (a service for parents who have had children taken in to care)
- Adoption advice services for birth parents
- Citizens Advice Bureau
- Caribbean Elder Community organisation
- The Job Centre
- Hands Inc
- Children’s Centres in Hackney
- Carers support services
- Cooking classes, such as Made in Hackney
- Gardening groups
- Hackney volunteers centre
• Step Change (debt advice)
• The Learning Disabilities Team
• The Multiple Needs Service
• The Drugs and Alcohol service
• Hackney City Farm (volunteering opportunities)
• Parents as Partners
• MRS Independent Living
• Advocacy services in Hackney
• ACAS- job advice
• The Union- job advice
• Praxis
• Project 17
• Hackney Law Centre
• Off Centre
• Charities which provide grants, such as Skinners Benevolent Trust, The Talisman, Hackney Parochial charities
10 Service eligibility and triage criteria

Eligibility/referral criteria:
Have presented at Homerton University Hospital A&E department within last 12 weeks and need support with:

- Destabilising events
- Social isolation, social support
- Mental health issues (various diagnoses), emotional support, stress-related illness, anxiety, suicidal ideation (on discharge back to GP), panic attacks, bereavement, depression
- Managing long term physical health conditions
- Frequent inappropriate use of A&E – information on how/when to access health services
- Eating disorders
- Housing issues
- Domestic abuse
- Support for carers
- Applying for financial aid
- Parenting issues
- Immigration and housing issues
- Substance misuse

Triage:

- Signposting to Family Action A&E WellFamily Service/A&E stall
- Self-referral
- Referred to service by A&E nurse in charge following A&E attendance
- Identification from GP discharge summaries
- Identification through Homerton Frequent Attenders Manager
11 Outcome and measurement reference table

The following table sets out the outcomes that were within the scope of this evaluation and the measurement tools used.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measurement tool(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduction in frequent attender/inappropriate A&amp;E visits</td>
<td>• Self-reporting from clients</td>
</tr>
<tr>
<td></td>
<td>• Frequent attenders list</td>
</tr>
<tr>
<td></td>
<td>• GP data</td>
</tr>
<tr>
<td>• Improved wellbeing of service users</td>
<td>• Wellbeing Star</td>
</tr>
<tr>
<td></td>
<td>• Self-reporting from clients</td>
</tr>
<tr>
<td>• Reduction in anxiety and depression of service users</td>
<td>• PHQ9</td>
</tr>
<tr>
<td></td>
<td>• GAD7</td>
</tr>
<tr>
<td>• Increase in personal resilience of service users</td>
<td>• Self-reporting from clients</td>
</tr>
<tr>
<td></td>
<td>• Wellbeing Star</td>
</tr>
<tr>
<td>• Reduction in Global Distress of service users</td>
<td>• CORE10</td>
</tr>
<tr>
<td>• Reduction in social isolation of service users</td>
<td>• Self-reporting from clients</td>
</tr>
<tr>
<td></td>
<td>• Some data on referrals to community groups</td>
</tr>
<tr>
<td>• Greater awareness among service users of appropriate alternative support and increased ability to access this support</td>
<td>• Signposting data</td>
</tr>
<tr>
<td></td>
<td>• Self-reporting from clients</td>
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</tbody>
</table>
## Summary of evidence against key outcomes

A summary of the evidence from this evaluation is set out in the table below.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Strength of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in frequent attender/inappropriate A&amp;E visits</td>
<td>Strong evidence from a sample of users, which showed at least a 66% reduction in A&amp;E attendances following their engagement with the service.</td>
</tr>
<tr>
<td>Improved wellbeing of service users</td>
<td>Strong evidence. Consistent improvements in all wellbeing measures for the majority of clients. However, difficulties engaging with some clients through to planned completion means that this may actually be understated in the data.</td>
</tr>
<tr>
<td>Reduction in anxiety and depression of service users</td>
<td>Some evidence. Consistent improvements in the majority of clients on the GAD-7 and PHQ-9 scales, although around a third of clients did show higher levels of anxiety and depression at the end of their engagement with the service. We were not able to determine from the data whether or not clients reported higher levels of anxiety because they knew their planned support was coming to an end. All the service users interviewed reported lower anxiety as a result of the support they had received.</td>
</tr>
<tr>
<td>Increase in personal resilience of service users</td>
<td>Strong evidence. Consistent improvements in relevant outcome measures and also self-reported feedback from a small sample of clients.</td>
</tr>
<tr>
<td>Reduction in Global Distress of service users</td>
<td>Some evidence. Consistent improvements across most CORE 10 domains.</td>
</tr>
<tr>
<td>Reduction in social isolation of service users</td>
<td>Strong evidence. Consistently reported by clients in interviews.</td>
</tr>
<tr>
<td>Greater awareness of service users of appropriate alternative support and increased ability to access this</td>
<td>Some evidence from self-reported feedback from service users.</td>
</tr>
</tbody>
</table>