Appendix

Chichester Wellbeing end of year summary 2014/15

Wellbeing Hub

The table below shows the number of new clients accessing the wellbeing service each quarter during the last three years for support and information. Clients are offered between one and three a 1 to 1 appointments or have had a 30 minute MOT appointment after this they are signposted to appropriate services which suit their needs.

Number of new clients	Q1	Q2	Q3	Q4	Total
2012/13	345	326	229	294	1,194
2013/14	580	396	268	336	1,580
2014/15	653	416	362	349	1,780
Total					4,554

Observations

The number of new clients has increased steadily during the last three years with consistent seasonal peaks and troughs.

We have seen a 49% increase in the number of new clients accessing the service between 2012/13 and 2014/15 our own target was to increase by 10% year on year.

We have recorded a steady increase in the number of referrals from GPs during the year with 107 direct from a GP and 77 indirectly through the practices. This is due to a variety of ways we have communicated with them eg postcard referral for GPs, letters GPs have sent to patients and from speaking at strategic Clinical Commissioning Group meetings attends by GPs.

Our target for 2014/15 was to increase the number of referrals from GPs by 10% which we have achieved.

We are pleased that this means the GPs are becoming more familiar with our service and trust it enough to recommend it to patients. We are continuing with regular drop in sessions at key surgeries outside of the city centre at Midhurst, Petworth and Selsey where we are building good working relationships.

The majority of clients are women 1,026, men 546 but we work hard to promote the service to men through workplaces and ensuring the later times are available.

Generally the ages ranges of clients we see most are 18-39 (546) and 40-54 (407). The numbers reduce with the older population. This is because there are other services better suited to this age group and many older people are referred directly into some of our commissioned projects.

Evaluation

Evaluation phone calls are carried out 3 months after the client has used the wellbeing service. To ensure the maximum number of clients are contacted we are required to three attempts to contact clients. (NB there are a significant proportion of clients who are not contacted because it is not appropriate to do so, who do not answer the phone after three attempts or whose telephone number is incorrect).

518 clients have been contacted during 2014/15 for evaluation.
90% of people said they found the service useful or very useful
82% of people said they found the advice useful or very useful
97% said they would recommend the service to a friend

83% of people have made positive changes as a result of their contact with the wellbeing service.

Positive changes include;
90 people took action to lose weight
78 people had started a form of physical activity

Wellbeing Hub case study.

This is a straight forward and really common example of the types of clients who use the service and how small changes can make a big difference to their health and wellbeing.

Referral: What were the reasons for it & where did it come from?

Referral by Diabetic nurse at Petworth Doctors Surgery

What was the intervention at first session? How long was session?

Client attended for 30 minute MOT and advice.

Client Stats: Weight 10st 10lbs BMI 30.3 (just in the obese category) non-smoker, inactive

Other emerging issues explored in session?

Mrs C was referred by the diabetic nurse who was concerned that she was gaining weight and not controlling her blood sugars very well. Mrs C is a really lovely 77 year old who lives with her husband and has as far as she is concerned always eaten a healthy diet. We discussed portion size, hidden sugars, how to read the information on packets, how much physical activity it actually takes to burn the calories we eat. She attended all her appointment with her husband who listens attentively, but made it clear this was not about him. She on the other hand was really focus and wanted to learn how to do it right, mainly because she feared, the diabetic consequences, if she stayed the same or got worse.

Were follow on sessions required? How many? How long?

Yes, Mrs C attended on a monthly basis at the Petworth surgery for a further 3 sessions and then attended just to get weighed for another two. She is now signed off but if at any time she wants to pop in for a weigh-in during my drop in sessions she would always be welcome.

Signposting / onward referral?

Sign posted to walking group in area.

What outcomes were met

Start Stats: Weight: 10st 10lbs Fat %: 38.7 Visceral fat: 12 BMI 30.3

End Stats: Weight 9st 1lbs Fat % 30.2 Visceral fat: 9 BMI 24.9

This represents a 15% weight loss, a healthy BMI/Fat %/visceral fat. A reduction in her risk of heart disease, diabetes, cancer etc

Her diabetes nurse is really happy with the results and reports that all her checks are now healthy.

Do you have quotes, comments or pictures from the customer about the service?

Quote ” I was really fearful about my future health and thought that at my age it would be impossible to change. Working together with the wellbeing service has shown me that it is never too late to make a change.”

Additional commissioned / in-house projects

Wellbeing weight loss workshops

We have delivered 18 weight loss programmes during 2014/15 and have reached our target for the year. The programmes are delivered over a 12 week period with a different topic each week. Whilst people do get weighed and we measure their weight loss over the 12 week period, the most important factor is the information they take away to ensure they can maintain a healthy diet over time. 300 people attended the weight loss workshops during 2014/15.

2014/15

261 clients attended a 12 week programme
123 (47%) of people taking part in the programme have reached the target of 5% weight loss (target 30%)
193 (74%) of people taking part in the programme have reached the target of 3% weight loss (target 60%)
95% report improved mental wellbeing. (Target 80%)
97% report increased physical activity levels. (Target 80%)
99% of clients are satisfied with the service. (Target 90%)

New for 2015/16 is a pre diabetes class for people who are at risk of developing type 2 diabetes. This is essential for supporting them to achieve a healthy weight and potentially stop the development of the disease.
The existing weight management classes will continue during the coming year as demand is always there.

Family Weight Management

- 14 families have engaged with the programme during 2014/15
- 75% children have stabilised their weight or lost weight. (Target 80%) the children that didn't lose weight have grown.
- 100% of children report improved self esteem / mental wellbeing. (Target 80%)
- 100% report increased physical activity levels. (Target 80%)
- 100% of the adult family members are engaged with other wellbeing services. (Target 50%)

The links with the Think Family programme are working well and consequently some of the families engaging with the service this year were highly complex cases. They required a lot of support to get to the point where they were able to put in place some of the changes required.

Healthy workplaces

13 new businesses have engaged with the programme during 2014/15
12 of these are based in our targeted areas / groups including Think Family Neighbourhoods.
44 businesses are working with the team to develop continued workplace health initiatives for their staff. These have engaged since the start of the project in 2012/13.

Employees are signposted to engage with other wellbeing services which support their goals to improve their health and wellbeing.

Wellbeing Home (joint with Arun DC)

(Target 250 home visits (total for Arun & Chichester – 50% in each) to home owners or private rented tenants are carried out and clients are supported to heat their homes in the most economical way)

93 households in the district have received information and advice about home energy during the year to date.

63 Referrals have been made to energy suppliers to help with changing tariffs or for funding to replace heating systems or boilers.

First Steps to Fitness

Target = to engage with 300 clients for an initial consultation and support to engage with the programme. (cumulative over the lifetime of the project 2012/13 – 2014/15)

- 426 clients have had an initial consultation since the scheme began in July 2013, 25% men and 75% women.
- 190 clients have completed the scheme, 63 are still engaged with the scheme. (Target 160 clients)
- Of the clients that have completed the course, 57 have increased their physical activity levels to the recommended level of at least moderately active 150 minutes per week. (target 60 clients)
- 124 have increased their activity levels to 180 minutes to the 'active' level.
- 96 have taken the subsidised membership and so far 50 have signed up for a full DD membership. (target 40 Clients)
- 99% of clients have reported improved mental and emotional wellbeing.

Active Older People

NB: all targets and number are cumulative across the life of the project from 2013/14- 2014/15

Targeting older people aged 65+ in areas of deprivation and where we know there are high numbers of older people living alone or are Carers. Clients are contacted via direct mail or can self refer to the programme. Once they sign up people are directed to local activity sessions that they have shown an interest in and are likely to sustain. There has been a good result from the targeted mail out so far.

357 people have registered with the programme and contacted for support to be more active. People registering are assessed using the GP Physical Activity Questionnaire for their current level of activity and the target is for 300 people to move from inactive to moderately active (150 mins per week)or active (180 mins per week).

53% of people accessing the service live in target areas including Think Family Neighbourhoods. (Target 50%)

Evaluation from 3 month follow up shows,

59% have increased activity levels by at least half an hour each week working towards 5 times a week at 3 months. Clients also report improved mental and emotional wellbeing and reduced isolation.

Case study 1

Female - Age 60 - 65

Ward: Chichester North

Activity level 1st sign up – 0 Activity level 3 months – 5 Activity level 6 months 5

Rating of service 3 months – 9

When this lady registered she wasn't doing any official activity and was looking for a strengthening activity like Tai Chi. She enjoyed her week's trial at the Leisure Centre, and attempted to do a different activity every day. She is now feeling a lot more active and is still more active at the 6 month mark. She walks most days of the week and at the moment she still works part-time. Her activity levels have increased from 0 to 5 sessions over 30 minutes per week, which is excellent.

WHO 5 mental wellbeing data indicates an improvement in most areas, as indicated with the responses below:

I have felt active and vigorous?

Sign up – Some of the time **3 months** – All of the time **6 months** – All of the time

I have felt calm and relaxed?

Sign up – Less than half of the time **3 months** – All of the time **6 months** – All of the time

Healthy Food for Life

Health Champions Training have delivered 13 cook and eat programmes and they are contracted to deliver 12.

Courses have been delivered at the Foyer Chichester, Selsey. Chichester Food Bank, Petworth and with people leaving inpatient mental health services to reintegrate into the community.

All participants are dependent on a low income and all have demonstrated an increased understanding of a healthy diet, how to prepare healthy food and how to shop for food on a budget.

Clients also report improved confidence and skills in food preparation, understanding food labels and making healthy choices in the supermarket.

Emotional Wellbeing workshops for Choose Work clients

Linked to the Choose work project a series of workshops have been delivered to support people looking for work with confidence and resilience in themselves to gain employment. Many people lack the basic confidence in themselves to apply for jobs and this course aims to build on that.

3 courses have been delivered in 2014/15 with 39 people attending. Often this client group can lead chaotic lives and find it difficult to attend regular appointment but 18 people completed the courses overall and others dipped in and out.

4 people found employment after doing the course and 1 applied for work experience. The others reported feeling more confident in applying for jobs.

Plans for 2015/16

The Wellbeing Hub will continue as it is in the coming year. We will continue to promote the service particularly to GPs and now Pharmacists. We have a marketing / campaign plan for the year to ensure we continue to engage with new clients and encourage professionals to make referrals.

The wrap around projects will continue for another year and will include a pre diabetes course and more focused weight management to target groups eg men and students.

We will be undertaking more evaluation of the projects we deliver in house so that we can demonstrate to WSX Public Health the positive outcomes we have achieved.

The funding under the current agreement comes to an end in March 2016. All the signs are that West Sussex County Council see the hubs as a key service to deliver a wide range of health improvement work and we are confident the funding will continue into the next funding period. We should have early indications in the summer with confirmation by autumn 2015.

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