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The impact of Live Well Kent towards health-related outcomes and promoting self-management

A mixed-methods evaluation employing an implementation science approach

Live well Kent
Community wellbeing

On behalf of Kent County Council

NHS

by Shaw Trust

Porchlight

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PORCHLIGHT

Porchlight is a charity which helps people who have nowhere to go and no-one to turn to. It stops people from losing their homes and helps others to live safely and independently in communities across Kent.

It works with people on the streets, in its supported housing and in local communities. Porchlight helps people with their mental health, housing, education and employment so they can get where they want to be in life.

Porchlight is fighting for a fairer society where everybody has a safe place to call home and the chance to make a positive contribution.

BACKGROUND TO LIVE WELL KENT

In 2015 Kent County Council (KCC), Public Health and the Clinical Commissioning Groups reviewed and re-designed community mental health services, particularly those provided by the voluntary sector as part of the mental health pathway. This followed extensive consultation, competitive dialogue and a joint commissioning approach. Live Well Kent started delivering support in April 2016.

The development of an integrated mental health and wellbeing service was a response to existing delivery and behaviours prior to commissioning, which included:

- Services were not fully aligned to strategic outcomes or priorities
- Historic growth; there were different services in different areas, meaning inequity of access and a postcode lottery
- Services provided via a wide range of voluntary sector partners were not consistently networked together. This led to fragmentation and inconsistent pathways and the increased potential of duplication of services
- Those who used services had to tell their stories to multiple organisations leading to confusion about who was delivering which service
- Lack of impact information. The outcomes prior to integration were focused on the number of people using provision but did not include looking at the difference it was making.

Key principles of the new Live Kent approach are:

- Person centred, holistic and non-stigmatising – 'a life, not a service'
- Strength based, focusing on assets and improved self-management
- Community focused
- Prevention
- Targeted and focused on health inequalities
- Evidence based
- Maximise social value
- Co-production

The service focused on three areas of impact:

1. Personal outcomes

For individuals, Live Well Kent aims to improve wellbeing, reduce loneliness and isolation, stabilise accommodation, improve community connection, and economic wellbeing through financial stability.

It focuses on routes into and sustainment of employment, improved independence and social skills, and better management of mental health recovery. It enables individuals to have more control and influence in the services they use or are developed.

2. System outcomes

To improve and develop mental health pathways and their impact, Live Well Kent aims to reduce the uptake of statutory services including use of crisis and emergency services and secondary care. It aims to improve collaboration and partnership working, increase prevention and early intervention services, enable more people to be in employment and stable housing, increase peer support and reduce stigma and discrimination.

3. Strategic partner outcomes

To ensure that the Live Well Kent service and its network supports personal and system outcomes, and drives improvements in quality and insight.

The strategic partner's role is to provide leadership and vision for the service, support outcomes through operational delivery, proactively promote and market the service, ensure quality and performance (including managing risk and safeguarding), provide need insight and sustainability over time and innovation funding to diversify delivery.

Porchlight Live Well Kent

Following the KCC procurement process, Porchlight was successful as one of two Live Well Kent strategic partners. Porchlight delivers, commissions and manages a network of delivery partners across four clinical commissioning group areas which were divided into Lots during the procurement process:

- Dartford, Gravesham and Swanley (Lot 1)
- Swale (Lot 1)
- South Kent Coast (Lot 4)
- Thanet (Lot 4)

Porchlight was commissioned to target support in the most deprived communities due to evidence around mental health prevalence and social disadvantage.

From April 2016 to September 2019 78% (72% in Lot 1 and 83% in Lot 4) of the people Porchlight Live Well Kent has worked with are from the most deprived areas based on the national Indices of Deprivation. This figure has been consistently high across the three years of the service and above the baseline targets set by commissioners (48% in Lot 1 and 61% in Lot 4).

Porchlight's model of support focuses on three key areas of prevention within the mental health pathway to effectively support Live Well Kent outcomes:

Primary prevention; community conditions and factors such as social networks, housing, poverty, community assets; strengthening communities to improve wellbeing and mental health.

Secondary prevention; early intervention services.

Tertiary prevention; focused support to enable the best chance of sustainable recovery.

The Porchlight model delivers services and projects which support these three areas, using an evidence based approach and relevant outcome measures. See appendix for full details of the model and services.

The model reflects a more selective and targeted approach to prevention by working in the most deprived communities where risks around mental health issues are higher.

The people supported may show early indications of mental health issues which are a result of the impact of poverty or may have a diagnosed common mental illness (CMI) or severe mental illness (SMI).

Live Well Kent has a 'no wrong door' approach, placing the person's needs at the centre of support, so that people can access services as quickly as possible. This means that individuals can contact or make a referral through the Live Well Kent referral line or website, or they can go directly to delivery partners in their local community, such as North Kent Mind, Swale Your Way or SpeakUp CIC.

People can self-refer or others can refer on their behalf with their consent; this can include family members as well as other organisations and partner agencies. Once a referral has been made, the provider or the central referral team will look at which service is best able to meet the needs of the individual.

Commissioners set target times for referral responses, as well as sign ups to a service.

From 1 April 2016 to the end of September 2019, 95% of people were contacted within two days from referral and 70% started with the service within one week.

All referrals are recorded using Salesforce InForm which is Porchlight's data management system, and is used by services delivered and contracted by Porchlight. This is better for the individual as they experience one pathway of support (a key vision for Live Well Kent), particularly as providers can onward refer through the system. Having one database also supports effective service insight, development and performance management.

The Shortened Warwick & Edinburgh Mental Wellbeing Scale (SWEMWBS) was selected as the validated measurement tool by commissioners across all Live Well Kent services.

As a general wellbeing measure this provides a useful overview across a range of different services. The measure is a pre and post self-assessed service tool, with the second scale being collected after at least two weeks of support.

Changes to the external environment

Throughout the first three years of Live Well Kent external factors have impacted on the type and level of support provided. Key factors are:

Pressures within secondary care
Although historically around 75% of mental health commissioned funding in Kent is directed at secondary care services,[1] rising demand and workforce capacity has placed continuing pressure on secondary mental health services.

Live Well Kent has developed some effective working practices with secondary care services to ensure that people get the right support, but the transfer of people from secondary care into local care has put pressure on the service.

Porchlight has supported more than the double the number of people with SMI against the contractual target, with an average performance over the first three years of 211% over target. This trend continues.

As well as impacting on numbers, those people with severe mental illness (SMI) also need longer term support, affecting the capacity of the service to support all mental health needs, including common mental illness (CMI).

The service has, however, continued to over-achieve in supporting those with common mental illnesses as well; this has placed pressure on the service, and limited the scope of more preventative work.

Social determinants of mental health and wellbeing
Social and economic factors, including national government policy developments, have also impacted on mental health. A lack of affordable housing and increasing rents against a backdrop of frozen benefits has resulted in increasing demand on Live Well Kent around housing need – where housing issues are impacting on mental health.

The introduction of universal credits has also adversely affected people's mental health due to the change process and resulting debt experienced by individuals during the transition to the new benefit.

Changes to employment support
Live Well Kent was commissioned to provide a specific mental health employment approach for those with a severe mental illness – Individual Placement Support (IPS). This is a recognised employment model, with an associated fidelity scale, which supports those with SMI with rapid job search and employment.

Commissioners set targets for this service based on historical Department for Work and Pensions (DWP) employment targets. The DWP approach to mental health and wellbeing employment has considerably changed, with less focus on targets and a more supportive approach to wellbeing.

The DWP has commissioned a work and health service which also supports with those with mental health problems.

Health and care policy
Commitments made in the NHS Five Year Forward View for Mental Health and the recent NHS Long Term Plan have set the right direction for improving mental health services, as well as working towards a more integrated approach between health and social care.

These developments have started and will continue to pave the way for more collaborative partnerships and improved mental health pathways.

From 1 April 2016 to the end of September 2019, 95% of people were contacted within two days from referral and 70% started with the service within one week.

1. Kent County Council (2018)

The introduction of Integrated Care Systems and Primary Care Networks within the NHS will have an impact upon LWK. It is important that LWK continues to adapt to work successfully alongside these, ensuring that successes in reducing duplication and fragmentation of primary care mental health in Kent continue.

Service development

Since the service was initially commissioned, other areas have been added to the remit of the contract based on a contractual clause that additional services could be included where appropriate.

The largest of these is mental health housing related support which Porchlight and Shaw Trust, as strategic partners, have worked with commissioners to develop. This has included supporting existing providers of the service to develop a more cost effective approach to delivery which is better linked to the wider mental health pathways in Kent.

EVALUATION APPROACH

The overall research design has been drawn from implementation science. A robust approach that fosters stakeholder involvement, practical multi-method measurements and rapid transfer of knowledge into practice.

CHSS undertook a mixed-methods (quantitative and qualitative) evaluation to gather data from individuals, paid staff (i.e., employees across all Live Well services and network delivery partners) and wider stakeholders (i.e., CCG and LA commissioners, voluntary organisations).

Quantitative outcome data routinely collected by Porchlight was triangulated with the qualitative data generated from interviews with individuals and staff from Porchlight and wider stakeholder organisations.

Aim

Evaluate the impact of Live Well Kent (LWK) by exploring what works, for whom and in what circumstances to enable maximum impact on health and social care-related outcomes and use of health and social care.

Research questions

1. What is the impact of Live Well Kent on individual outcomes (e.g. mental health and wellbeing)?
2. What are the components of the model (or active/successful ingredients) that are contributing to the effectiveness of Live Well Kent (e.g. leadership qualities, collaboration, work force skills and knowledge, organisations involved, information sharing).
3. What is the impact of Live Well Kent on the wider voluntary sector in Kent?
4. How does Live Well Kent use community assets? Has knowledge and awareness of services available in the local communities changed?
5. What could be improved, replicated and sustained?

METHOD

Quantitative

The quantitative analysis uses data routinely gathered by Porchlight to explore impact. This database includes 7638 unique individuals from just over 3 years of service (1April 2016 until end September 2019)and includes data on demography, current mental health status, housing situation and employment.

Impact is measured by the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), captured at baseline (first appointment) and follow-up (exit appointment – no standard exit point, time period changes). This measure forms the main quantitative analysis alongside output and demographic data.

Qualitative

Interviews were conducted with 4 groups:

1. Individuals (SU)
2. Porchlight staff (PS)
3. Delivery partner staff (DS)
4. Wider stakeholders (e.g., commissioners, GP) (WS)

Across these four groups, 47 interviews were conducted in total (Porchlight staff n=14, Partner staff n=11, wider stakeholders n=3 and individuals n=19). All interviews were conducted either face-to-face or by telephone, and audio recorded with permission. Interviews typically lasted no more than 45 minutes.

Interviews were analysed according to its qualitative (thematic) requirements with the use of the relevant software. Transcribed interview data were analysed using the content analysis software NVivo, grouped into relevant themes aligned to research questions.

Once all data was analysed predominant themes were identified, guided by the initial research questions and findings summarised across the groups.

Main findings from the qualitative data are integrated into the analysis of the quantitative sections to further illustrate the impact on the individual and also discussed in a separate section that focuses on system outcomes.

Ethics

Ethical permission for the evaluation was granted by the Social Research Ethics Committee at the University of Kent (permission number: SRCEA id241) Before taking part in interviews individuals read information sheets and signed informed consent forms.

Porchlight has worked with commissioners to develop mental health housing related support.

WHO LIVE WELL KENT WORKS WITH

Individuals

Historically there was limited information about the demand and need within existing services being brought into the Live Well Kent network, and how this might influence services going forward.

Following conversations with key stakeholders through the co-design phase and engagement events, the model was developed to reflect improved approaches focused on mental health recovery and self-management as well as ensuring that those who needed support the most were being reached.

Porchlight is contracted to support 1623 people each year based on the expectations of commissioners, so for the first three and a half years this equates to a target of 5,681 individuals.

The largest proportion of individuals –27.6% (n=2019) resided in Thanet CCG, followed by South Kent Coast (SKC) at 26% (n=1983), Dartford, Gravesham and Swanley (DGS) 24% (n=1828) and Swale CCG at 19.5% (n=1485). There were some individuals from other CCG areas where there were boundary issues or where continuing to support an individual during a transition to a new area.

Of this population, 55.8% (n=4253) were female and 44.2% (n=3372) were male. This breakdown is broadly in line with the wider Kent demography of 51% female and 49% male (Census, 2011).

Age

Services are for those aged 17 and over; many of the providers within Live Well Kent are predominately adult focused, with other commissioned services focused on children and younger people's mental health.

However, over time and based on need, Porchlight Live Well Kent has commissioned services focused and more targeted at younger adults, particularly those making the transition from children and young people's services.

The Mean age of individuals accessing LWK was 42 years (range = 16 to 101 years, SD= 15.1). The majority-70% (n=5151) - were between 26-59 years old. 17.5% (n=1291) were between 17-25 years and 12.4% (n=915) over 60 years.[2]

2. 364 individuals did not provide age data

Services are for those aged 17 and over; many of the providers of Live Well Kent are predominantly adult focused, with other commissioned services focused on children and younger people's mental health.

Live well Kent
Community wellbeing

On behalf of

by

Porchlight

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Mental health: SMI/CMI

At the inception of Live Well Kent, definitions were agreed to ensure the service reached people with mental health needs in the community; this was defined using mental health diagnosis:

1. Common mental illness (CMI): those with a diagnosis of a common mental illness, most likely depression or anxiety.
2. Severe mental illness (SMI); those who had accessed secondary mental health support in the last five years.

Porchlight's targets for numbers supported each year are set at:

- 1260 CMI
- 363 SMI

Looking at mental health assessment on entry to LWK, the largest proportion of individuals over three years were categorised as presenting with a common mental illness (CMI) -57% (n=4349), followed by severe mental illness (SMI) at 31% (n=2365).

A relatively small proportion were identified as having 'prevention' needs (12%, n=912) where there was no diagnosis or it was not known.[3]

Looking at trends over the evaluation time period (April 2016 – September 2019) there is evidence of an upward trend for individuals accessing the service with a common mental illness, while the proportion who have a serious mental illness has decreased. Those with prevention needs have remained stable throughout. Figure 1 shows this trend.

Although CMI numbers has shown a steady increase, the proportion of those with SMI has continued to be much greater than anticipated numbers set for the service.

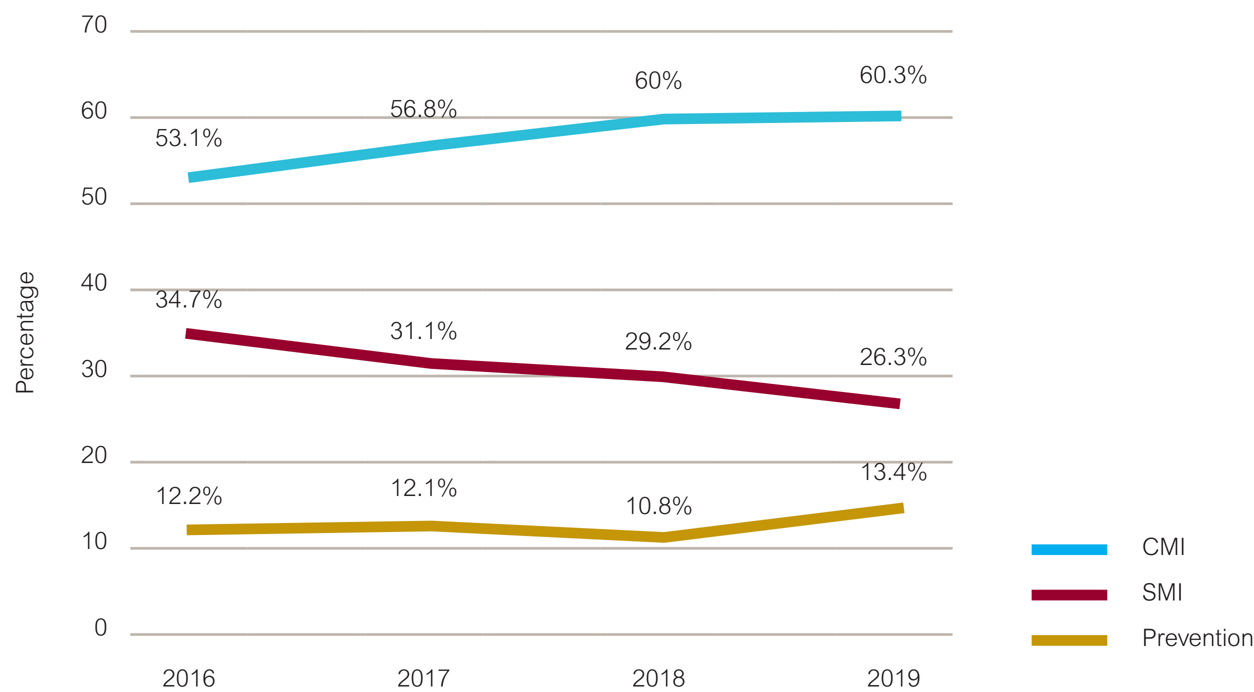
This has been influenced by limited historical data and insight into those using services, but also reflects pressures in secondary mental health services, with more people being supported within local care.

Kent County Council Public Health Observatory collates data to illustrate prevalence of SMI by CCG area. This provides a point of comparison for LWK to understand the reach of the programme.

Using the latest CCG population data provided by ONS (2017) it is possible to calculate a SMI prevalence estimate for the four key CCG areas covered by LWK (Dartford, Gravesham and Swanley (DGS), South Kent Coast, Swale, Thanet).[4]

The comparison of the two values (KCC and LWK prevalence) is illustrated in Figure 2 opposite.

Figure 1: Mental health on entry: Proportion in each group from 2016 to 2019



3. 12 individuals did not provide this data

4. www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/clinicalcommissioninggroupmidyearpopulationestimates

In Thanet the KCC prevalence estimate for SMI suggests that 1.1% of the population have a diagnosis associated with a SMI. Based on the data collected by Porchlight we can establish that LWK is accessing nearly half of this population (0.5%).

In SKC it is estimated 0.9% of the population have a SMI and LWK has accessed 0.4% of this group. Finally in DGS the estimate provided by KCC is 0.7%, with LWK providing support to nearly half of this population (0.3%).

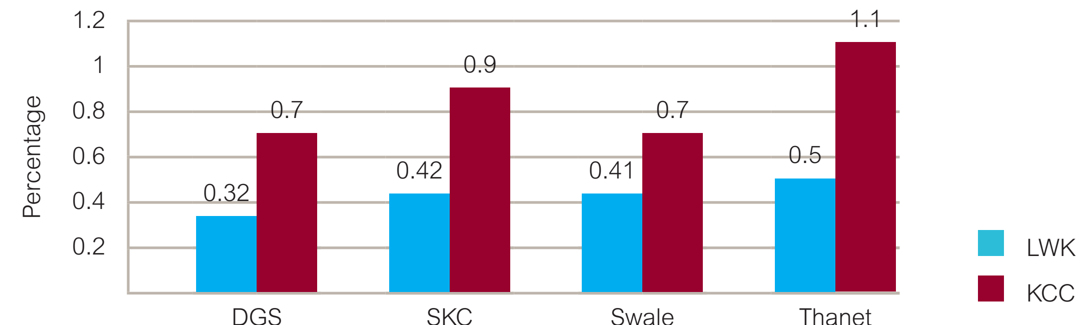
Overall, LWK is reaching a significant proportion of individuals with a SMI in each of the CCG areas. This reinforces the notion that LWK is providing support to individuals who might have historically accessed secondary mental health services.

> Porchlight has supported more than double the number of people with SMI against the contractual target, with an average performance over the first three years of 211% over target. This trend continues.

Mental health: level of need

Due to the limitations of the CMI and SMI diagnosis labels in providing insight about the needs of those presenting to Live Well Kent services, in April 2018 Porchlight introduced a high, medium and low rating of need for its own services (see table below).

Figure 2: SMI prevalence KCC population statistics vs. LWK statistics



High level of need	• Person is not managing to affect change in their situation • Person likely to be at or close to crisis situation • Multiple complex support needs • Immediate support is required • 8 weeks or above support predicted
Medium level of need	• Vulnerable – emerging problems requires appropriate support • Person presents more than one support need • Support will prevent escalation • 4 weeks or above support predicted
Low level of need	• Universal – general support • Signposting on needed only • Person able to follow-up independently following information/support • A single low level support need • 1 to 4 weeks support predicted

This identified 35.8% (n=729) of individuals with a low need, the largest proportion of 45.8% (n=932) with medium and 18.4% (n=375) with high.

Again looking at trends – displayed in Figure 3 – for the two years this measurement was used, individuals accessing LWK with low needs has remained constant (35%). The proportion with medium needs increased by 2.9% and with high needs decreased by 3.1%.

CCG and deprivation

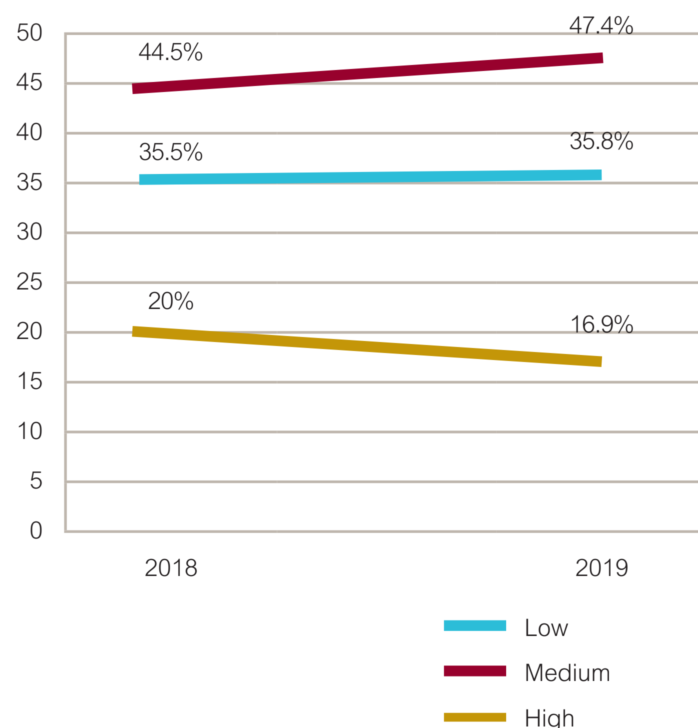
LWK funding allocations were proportioned according to need based on levels of deprivation. The largest proportion of individuals – 27.6% (n=2019) – resided in Thanet CCG, followed by South Kent Coast (SKC) at 26% (n=1983), Dartford, Gravesham and Swanley (DGS) 24% (n=1828) and Swale CCG at 19.5% (n=1485). There were small numbers of individuals in other CCG areas due to boundary issues and transition arrangements.

The majority of LWK clients – 57.1% (n=4282) – resided in the most socially and economically deprived areas in Kent (quintile 1).

Smaller proportions – 21.6% (n=1622) – were in quintile 2 and quintile 3 – 10.6% (n=791). Individuals in the least deprived areas (quintiles 4 & 5) represented the smallest proportions – 7.8% (n=584) and 2.9% (n=216) – respectively.

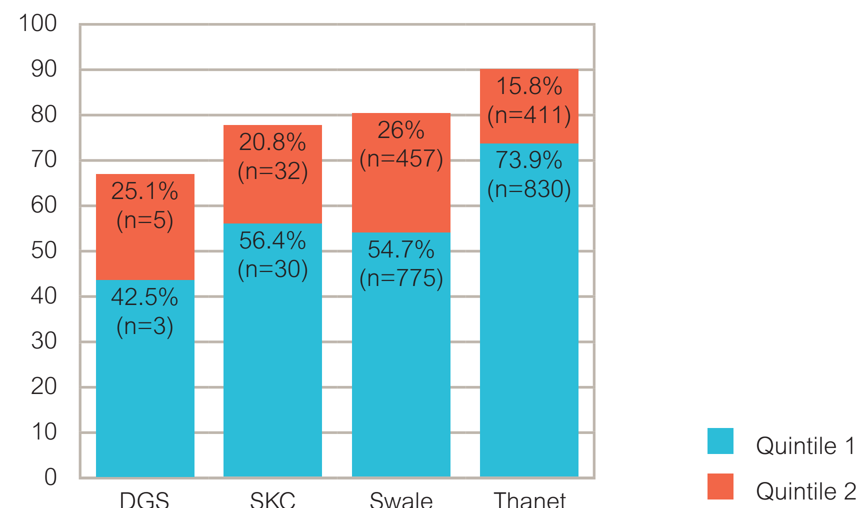
Deprivation breakdown by CCG is shown in Figure 4. With the exception of DGS, all of the LWK target areas (i.e. SKC, Swale, Thanet) over half of individuals accessing the service were from quintile 1.

Figure 3 Level of need on entry: Proportion in each group from 2018 and 2019



> The majority of Live Well Kent clients lived in the most socially and economically deprived areas in Kent.

Figure 4: Proportion of Individuals in quintile 1 and 2 per CCG area



Ethnicity

It is not possible to accurately compare Porchlight Live Well Kent reach to those from black and minority ethnic (BME) groups against up-to-date population figures as the data available is from the 2011 census.

However, Porchlight has developed local mapping analysis to try to better understand its reach within local communities and develop services and support within the resources available; this includes contracting specific BME services such as Rethink Sahayak in North Kent, as well as work with the Gurka community in Folkestone.

LWK was accessed by individuals from 17 different ethnic groups. The majority – 92% (n=6683) – identified as 'white' (i.e. white British, other or Irish). Asian Indian was the next largest group with 2% (n=150) followed by Black British African 1.1% (n=85). Full ethnicity breakdown is included in the appendix.

Housing status

Support with housing impacting on individuals' mental health is, and continues to be, a key need for people in areas of deprivation who are accessing Live Well Kent. Porchlight provides housing advice and support through two main services; Community Link, which helps people faced with a range of practical issues including housing, and its Community Housing service.

Community Housing works with people whose accommodation is unsettled or at risk due to their mental health and may need more intensive and urgent support.

The majority of those accessing LWK identified as being in settled housing (58.9%, n=3876). 39.1% (n=2573) reported themselves as being in an unsettled housing situation.

The largest proportion were living in private sector housing (28.5%, n=1537), followed by living with family (14.4%, n=777) and Housing Association (10.3%, n=556). The appendix shows full breakdown.

Referral

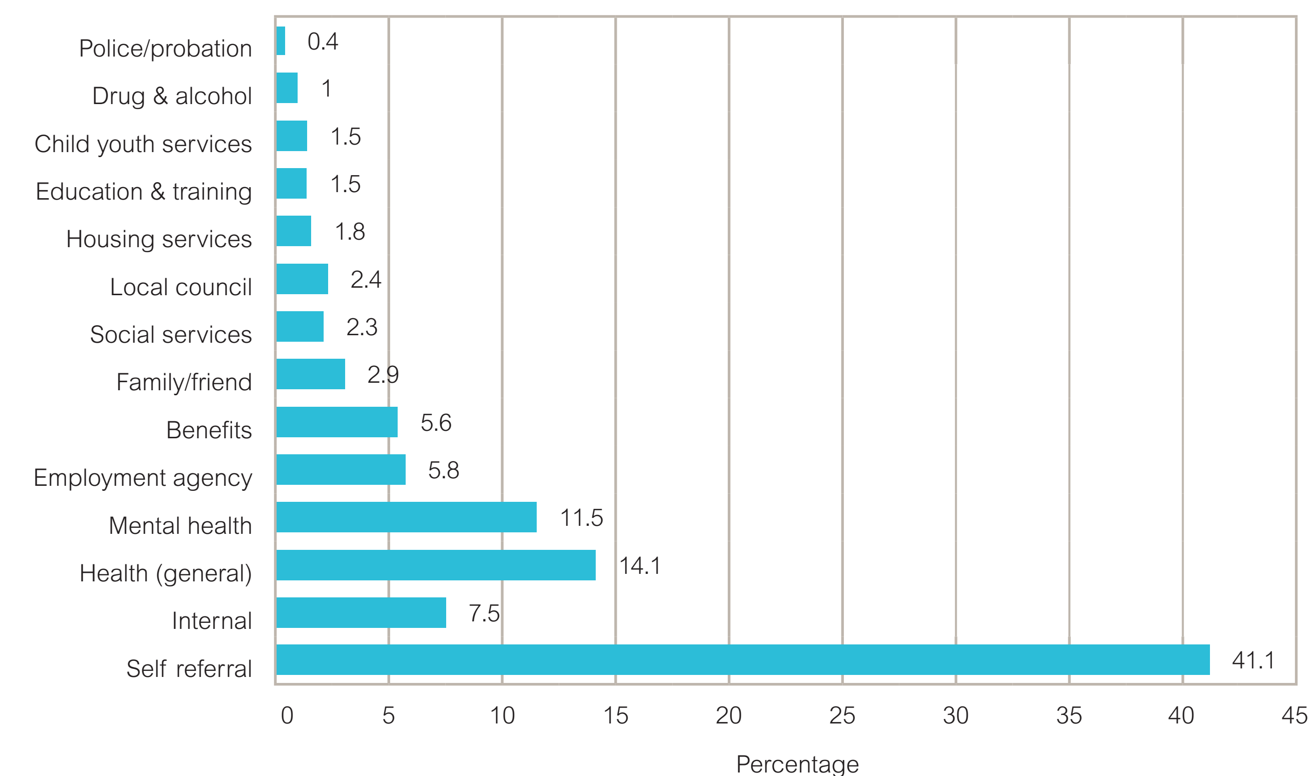
Referral routes into LWK covered a wide range of organisations in the statutory and voluntary sector, with 101 different referral pathways recorded.

The largest proportion of individuals came into LWK via self-referral – 37.4% (n=2849). To provide further insight into self-referrals Porchlight also asks how the person heard about Live Well Kent, as it knows anecdotally that health and social care professionals were signposting individuals to Live Well Kent. This was helpful to understand the system outcomes that Live Well Kent might be supporting.

The remaining LWK individuals were divided across a range of organisations. From these referral pathways, LWK Link Worker was the most frequently used route (4.5%, n=340), followed by GP (3.8%, n=288) and Job Centre Plus (3.5%, n=266).

Collapsing the different pathways in to 14 categories (see Figure 5), after self-referral the largest proportion of referrals came from health-related organisations/services (e.g. GPs, Health Trainers) – 14.1% (n=977) and 11.5% (n=798) from mental health (e.g. CMHT). Figure 5 shows full data.

Figure 5: Types of organisations: percentage referral for each category



IMPACT OF LIVE WELL KENT: INDIVIDUAL OUTCOMES

SWEMWBS

Outcome data for the Live Well Kent programme were collected using the Short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). This consists of 7 questions scored from 1 'none of the time' to 5 'all of the time'. The minimum score is 7 and the maximum score is 35. Higher scores indicate healthier mental wellbeing.

The 7 questions on the SWEMWBS scale are:

1. I've been feeling optimistic about the future
2. I've been feeling useful
3. I've been feeling relaxed
4. I've been dealing with problems well
5. I've been thinking clearly
6. I've been feeling close to other people
7. I've been able to make up my own mind about things

SWEMWBS data was collected on entry to LWK for all individuals except those who accessed a one-time service (e.g. North Kent Mind Coping with Life workshops),

Using the SWEMWBS data the following analyses are reported:

1. Descriptive statistics and frequency data for total SWEMWBS score
2. Inferential statistics (i.e. paired-sample t-tests) to compare mental health and wellbeing at the start (baseline) vs. end (follow-up of LWK service for both the total SWEMWBS score.
3. Percentage change score for both the total SWEMWBS score and for each of the 7 questions.

To explore the impact of LWK the three analyses were conducted on SWEMWBS data collected from the first service individuals accessed under LWK. A large proportion of LWK individuals access more than one programme which presents the challenge of double counting data for individuals. Considering this, for the impact analysis we needed to identify a single data point. In consultation with Porchlight it was decided the reliable and valid way forward would be to use the SWEMWBS data collected at the start (baseline) and end (follow-up) of the first service accessed by an individual.

Data were analysed using a number of statistical techniques to compare baseline responses to those collected at follow-up. Results from this analysis inform whether LWK has been successful in improving mental health and wellbeing (i.e., effectiveness).

Prior to analysis a number of data processing steps were completed. The degree of change score for each of the seven questions was inspected for distribution. From this it was established the range of changes for each question were normally distributed and hence parametric statistical tests could be used (i.e. paired sample t-tests).

Reliability statistics were also conducted for raw scores collected on SWEMWBS at baseline and follow-up. This analysis established that responses at both time points were highly reliable indicators of what the scale is intending to measure (Cronbach's alpha= .87 and .90 respectively).

Results from all inferential statistical analyses were tested at the standard level of significance ($p<.05$). If a result is statistically significant (i.e. demonstrates a 'p' value lower than .05), it is unlikely to have occurred by chance and we can assume that the variables are either related (correlation) or demonstrate differences between the groups (t-tests).

Where appropriate, bivariate correlations were also performed. This analysis explores whether the relationship between two variables (i.e. as one variable increases, the other also increases; or as one variable increases, the other variable decreases).

For correlations, alongside a 'p' value, the analyses also produce an 'r' value, which represents the magnitude of the correlation (i.e. the strength of the relationship between the two variables of interest). Standard levels against which the 'r' is judged are as follows: .10 'small'; .30 'moderate'; .50 'large' (Cohen, 1988). All analyses were conducted with SPSS (version 24).

OTHER MEASURES INTRODUCED BY PORCHLIGHT

SWEMWBS has been used as the validated measurement tool for Live Well Kent. However, due to the broad wellbeing nature of the SWEMWBS and its validation after two weeks of support, Porchlight has also introduced two other measures for key services.

Measure Yourself Concerns and Wellbeing (MYCAW) and De Jong Gierveld Loneliness measure are being used in response to logic models developed for Porchlight LWK services. These tools were deemed to be necessary to fully understand the impact services are making on an individual.

MYCAW was introduced within the Community Link Service and is a validated measure to better understand key concerns and worries for a person before and after support. It provides a much more tangible picture of what is important to the individual in relation to their mental health, and how services support improvement with these issues and feelings. As the measure was introduced recently as a pilot, data is currently limited. However, the use of the tool will be scaled up in 2020/21.

The De Jong Gierveld loneliness measure has been introduced to the Community Inclusion Service where there is a particularly strong focus on social isolation and loneliness. This measure is a self-assessed pre and post intervention. Having used the De Jong Gierveld loneliness measure over the past year, Porchlight will be moving to the new ONS loneliness measure. This will contribute to a national loneliness dataset; this is important for mental health insight, particularly as a lot of loneliness policy and research focus nationally is on older people.

As this is used for a small discrete service, the dataset is still relatively small. However, Porchlight is considering embedding the four ONS questions across their Live Well Kent services.

IMPACT ON PERSONAL OUTCOMES

Descriptive and inferential status

2782 individuals have returned SWEMWBS data for both baseline and follow-up time points and therefore are included in an impact analysis.

This is also limited to those who have been supported for more than two weeks due to SWEMWBS validity requirements, so for people using drop-ins in local communities for support with very time-limited advice and guidance and onward referral, they are not included.

It is also important to highlight that although improvement may be seen as aspirational for outcomes, for those individuals LWK are working with experiencing and living with mental health needs, sustainment of the wellbeing, with no escalation, is also important.

The target set by commissioners around wellbeing outcomes relates to those who have both sustained and improved their wellbeing.

The baseline average SWEMWBS score for this sample was 17.11. Published population norms for the scale indicate 23.61 as the 'population average', making the LWK sample below the norm for levels of mental health and wellbeing.

At follow-up, the level of mental health and wellbeing had increased to 19.79. Statistical tests revealed a significant difference between the two average scores ($p<.0001$), suggesting that mental health and wellbeing had improved after accessing support from LWK.

Percentage change ranged from a decrease of 55.81% to an increase of 400%, with an average uplift of 18.8% (SD=32.51). The majority of individuals reported an increase in mental health and wellbeing – 71.9% (n=2000), with 21.8% (n=606) observing no change and a small minority – 6.3% (n=176) a decrease.

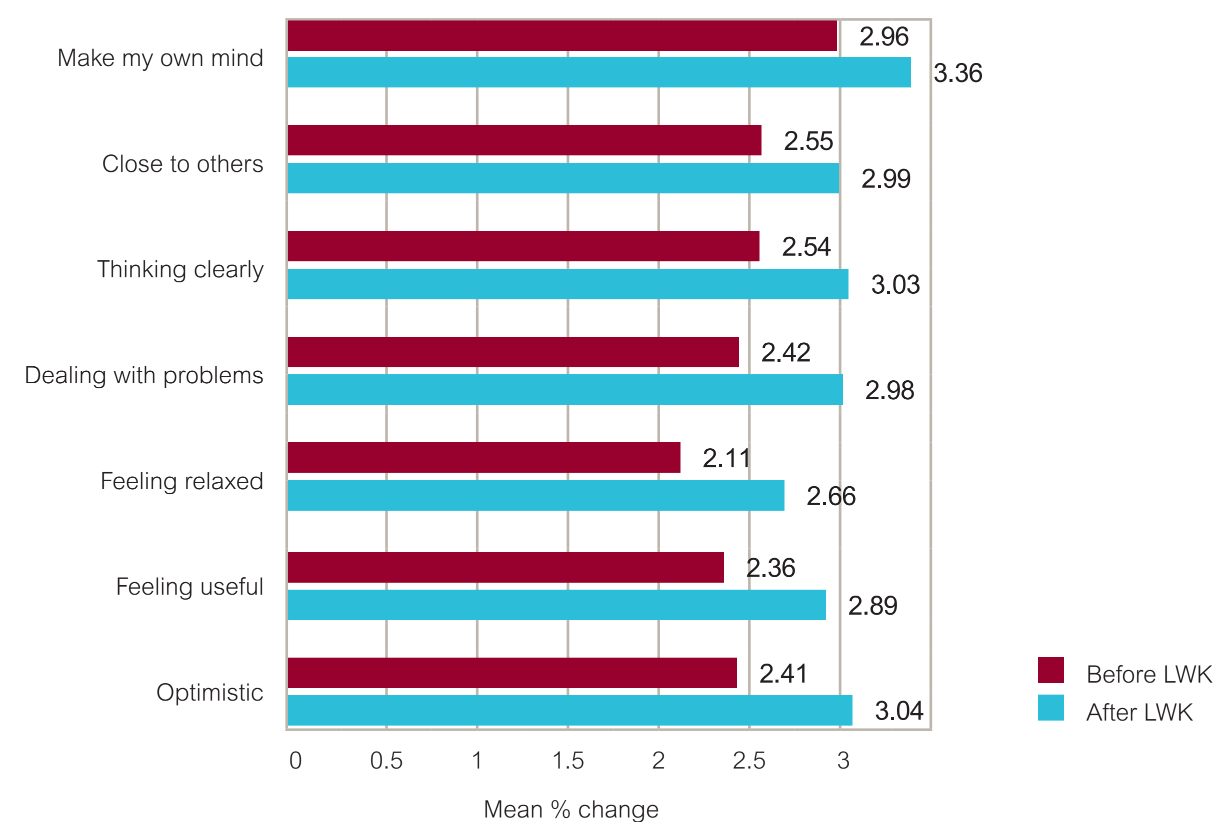
Looking at each of the seven questions in the SWEMWBS, improvements in average scores were noted across all the areas. The largest changes were observed for 'feeling optimistic about the future' (+.66) and 'dealing with problems well' (+.57). Smallest changes were observed for 'make up my own mind about things' (+.40) and 'feeling close to other people' (+.44). Full data are shown in Figure 6.

Paired-sample t-tests revealed statistically significant differences between scores at baseline and follow-up (all ps >.0001). These findings suggest that overall LWK is impacting on key personal outcomes the service was commissioned against.

Specifically it is enabling individuals to optimise their emotional wellbeing, feel more empowered over the choices in their life and improve social skills of individuals.

> The target set around wellbeing outcomes relates to those who have both sustained and improved their wellbeing

Figure 6: Mean score change for each of the seven SWEMWBS questions



Qualitative findings on personal outcomes

Before considering the qualitative information below, it is important to note the challenges of interviewing people with complex lives and support needs as well as fluctuating mental health. LWK is one element of their lives where there may be a number of different concerns or challenges affecting them. It may also be only part of the overall support they are receiving.

Further, many people may not be aware of LWK as a service in itself but instead recognise an individual provider – for example Porchlight or Speak Up. Often people accessing the service do not understand the limitations of LWK as part of wider systems that they are engaged with. It is important to recognise this context when evaluating these responses.

The positive impacts observed in the SWEMWBS analysis is supported by the interview data collected from individuals who received support from LWK interventions, alongside acknowledgement by staff and wider stakeholders. Three key themes emerged from these interviews when referring to impacts on individuals. First, across all groups, there was a common feeling that LWK interventions successfully focused on empowering individuals through improving their self-esteem and self-efficacy.

Porchlight staff, delivery partner staff and wider stakeholders all highlighted the key theme of empowerment when discussing the impact of LWK. This was frequently set within a wider conversation around the need for a recovery-based model.

The premise that individuals are supported to help themselves in the longer term appeared to be a main feature of the LWK programme and individuals gaining independence was repeatedly used as an example of the perceived success of the programme.

"One lady attended the open session with her mum at first. She got involved, made friends, and has now got a job and moved to the coast" (DP003)

A representative from one partner organisation provided the example below to illustrate how LWK has initiated, and then further supported, the empowering of individuals who access the service.

Reinforcing this view, staff from the community inclusion programme within Porchlight, in particular, noted the focus on building confidence within individuals, so that they would be able to attend groups and connect socially once the service ended.

Staff members of delivery partners displayed a focus on building confidence with courses, workshops and groups on offer that have been tailored specifically around this intended outcome. Importantly, those receiving support from LWK often recognised this focus and reflected on this benefit when interviewed:

"With the [IPS] service, it improved my confidence and self-esteem a bit because I was getting job interviews." (SU015)

"My confidence wasn't great, with speaking up and that. I found that my confidence was boosted through the coping with life course." (SU010)

"I've just gone to Folkestone for the day on public transport, by myself. I wouldn't have done that if it wasn't for them." (SU004)

The second key theme emerging from the interview data was the positive impact on mental health. Porchlight and the delivery partners commented upon the improvement they had witnessed amongst the individuals with whom they had worked.

"Chap who lived with very long-term depression and anxiety. Comes along to the music appreciation group. Now he's started to compile quizzes. He's met new people. He's travelling on public transport from […] to […]. And he's now delivering his own wellbeing course."(DP002)

Several individuals also remarked upon the improved mental health they had experienced through use of the programme.

"It helped me mentally." (SU009)

"It helped my mental health. Mindfulness content was a significant part of it. Mixing with a group who openly talked about their problems helped me to open up." (SU017)

When discussing this improvement it was noted by individuals that changes were often a result of having someone to talk to about their worries and concerns.

"I learnt a lot more about my health, so yeah it did help. Structuring and planning and that, a different way of looking at things…. I learnt not to be so negative about myself". (SU010)

"Having someone to talk to and listen really helped" (SU011)

"She (LWK member of staff) listened to me. She was with me. She was empathic" (SU18)

> "An individual who lived with very long term depression and anxiety comes to our group. He's met new people. He's travelling on public transport. He said that this time last year he would never have thought he'd be able to do that... he now develops and delivers his own workshops."

Overall there was less of a focus on how the LWK service impacted on physical health. Although mental health is a primary need for LWK, physical health needs are an important aspect of support. The Making Every Contact Count (MECC) Public Health approach is embedded throughout Porchlight services.

Only two of nineteen interviewees referred to this aspect when asked how LWK had affected their mental and physical health and neither mentioned a specific impact:

"My physical health issues are separate" (SU002)

The third and final theme focused on how LWK helped with reducing feelings of social isolation and loneliness. Interviewees from all four groups mentioned this as an impact of accessing LWK interventions.

Staff spoke about this in reference to discussions about the aims of LWK, with Porchlight staff and delivery partners in broad agreement that the support provided through the interventions has the potential to alleviate loneliness and enable people to feel part of their communities again.

Individuals tended not to explicitly describe the impact using the terms 'loneliness' or 'isolation' but instead made reference to LWK assisting them to become more involved in social groups and enabling them to build social connections.

"……But you feel like you're not alone. You're all sat around a table supporting each other. Everyone involved in the group, taking or leading the group, was supportive". (SU001)

"…Just learning from each other really… Learning how others dealt with things. I liked that there were men in the class. We bonded and it helped to open up". (SU010)

Although the predominant feedback from individuals was that LWK had benefited them in some way, there were differing voices. Some individuals felt that the service had little or no impact on them or their lives.

Of these individuals, there were some that couldn't get the help they needed from the service (e.g. help getting a home from the council). Some of the concerns expressed by people using the service are the result of a misunderstanding of the limitations of LWK services.

Two already had good support from other voluntary organisations. Several fell out of contact with LWK services, for a variety of reasons, and others found themselves in a similar position after the service provision had come to end as when it had started.

More flexibility around lengths of service provision and better closing processes after service withdrawal were suggested as solutions for these less favourable outcomes.

"Stay with people until things are resolved. This goes for all the organisations. Make sure people are okay before they're discharged."(SU006)

> Although mental health is a primary need for LWK, physical health needs are an important aspect of support.

LIVE WELL KENT AS A PREVENTION MODEL

It is also interesting to further break down this data to explore any potential differences in outcomes between two types of prevention approaches within Porchlight's LWK Prevention Model (see appendix):

Secondary prevention: Early intervention services that encompass all advice and guidance and housing programmes.

Tertiary prevention: Focused support to enable the best chance of sustainable recovery, covering the employment and recovery programmes.

Individuals who first accessed a secondary prevention service had, on average, lower levels of mental health and wellbeing (M=16.96, SD=5.48) on entry to LWK compared to tertiary (M=18.97, SD=5.42). As to be expected, based on the overall findings, individuals under both types of prevention observed statistically significant improvements in mental health and wellbeing.

Recalling the focus of this analysis is solely on data collected through the first service accessed, 1893 individuals were referred in to a secondary prevention programmes and 889 in to tertiary prevention. The mean percentage change for individuals in secondary prevention was 16.7% compared to 23.8% for tertiary.

> This difference was statistically significant suggesting the degree of impact on individuals was greater when receiving support from a tertiary prevention service compared to secondary prevention.

Considering the remit of tertiary prevention programmes to sustain recovery this findings is to be expected and would further suggest that LWK is appropriately supporting individuals to manage their recovery.

Qualitative findings on prevention

A theme arising often across all interview groups was the prevention of escalation. The idea of prevention was framed within either the context of intervening in the worsening of a negative environmental situation, such as financial difficulties or housing and its impact on mental health, or within the context of halting a deterioration in mental and physical health.

LWK is appropriately supporting individuals to manage their recovery.

"[Live Well Kent is] a preventative service supporting people to manage their mental health" (WS002)

"Without the courses, and that, you're left in a vicious cycle." (SU010)

To explicitly probe what LWK may have prevented, interviewees who received support were asked 'what would life be like if they had not been in contact with LWK'. Responses to this question were mixed. In some cases, people found this a difficult question to answer as they struggled to conceptualise what 'might have happened'.

Those individuals who did provide an answer suggested tangible changes that were facilitated by LWK, such as gaining employment, has provided a stable context for their continued recovery.

"I might have got extremely depressed. The job support maybe stopped a downward spiral." (SU015)

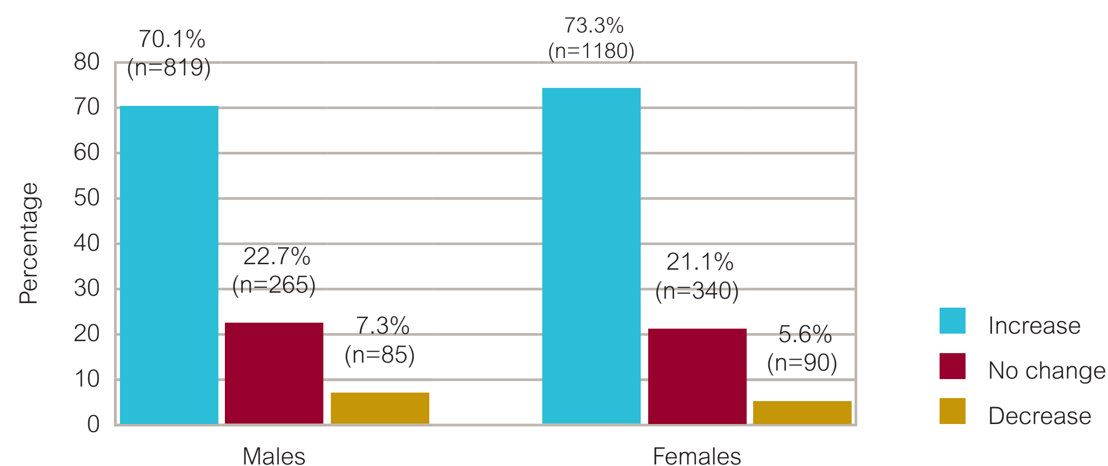
"I'd still be unemployed. Looking back. Things are looking a bit more positive." (SU011)

A number of other responses explicitly mentioned how LWK has prevented an escalation of poor mental health.

"I think my mental health would be really bad. It has helped me so much. Knowing that I can go to someone and get all that stress off my mind. I know I can always go there." (SU007)

"I wouldn't have made that move in the right direction without them." (SU009)

Figure 7: Direction of change in total SWEMWBS scores – gender



IMPACT AND DEMOGRAPHICS

Gender

Descriptive and inferential statistics

Males and females entered the LWK service with similar Mean scores on the SWEMWBS scale (Male = 17.56, Female=17.29).

Females reported a slightly larger Mean increase in mental health and wellbeing (+2.81) compared to males (+2.51). This difference was statistical significant ($p<.05$), thus suggesting gender influences the extent to which an individual's level of mental health and wellbeing was impacted on by the LWK service.

Percentage change analysis

For males, percentage change ranged from a decrease of 55.81% to an increase of 400% with the Mean increase at 17.79% (SD=33.43). For females, the average percentage increase was slightly larger at 19.17% (SD=31.85) and ranged from -50.28% to 365%.

As Figure 7 (below, left) shows, a slightly larger proportion of females observed a positive change in mental health and wellbeing compared to males (73.3% vs. 70.1%).

Looking at percentage change for each question by gender some clear trends emerge (Figure 8). Females report greater improvements across all areas on the scale, reaffirming the finding from the inferential statistics that the LWK service has a slightly larger impact on females versus males. The greatest difference was observed for 'being able to make my own mind up about things' (9.41%) while percentage change for 'feeling close to others' was most similar (2.05%).

Age

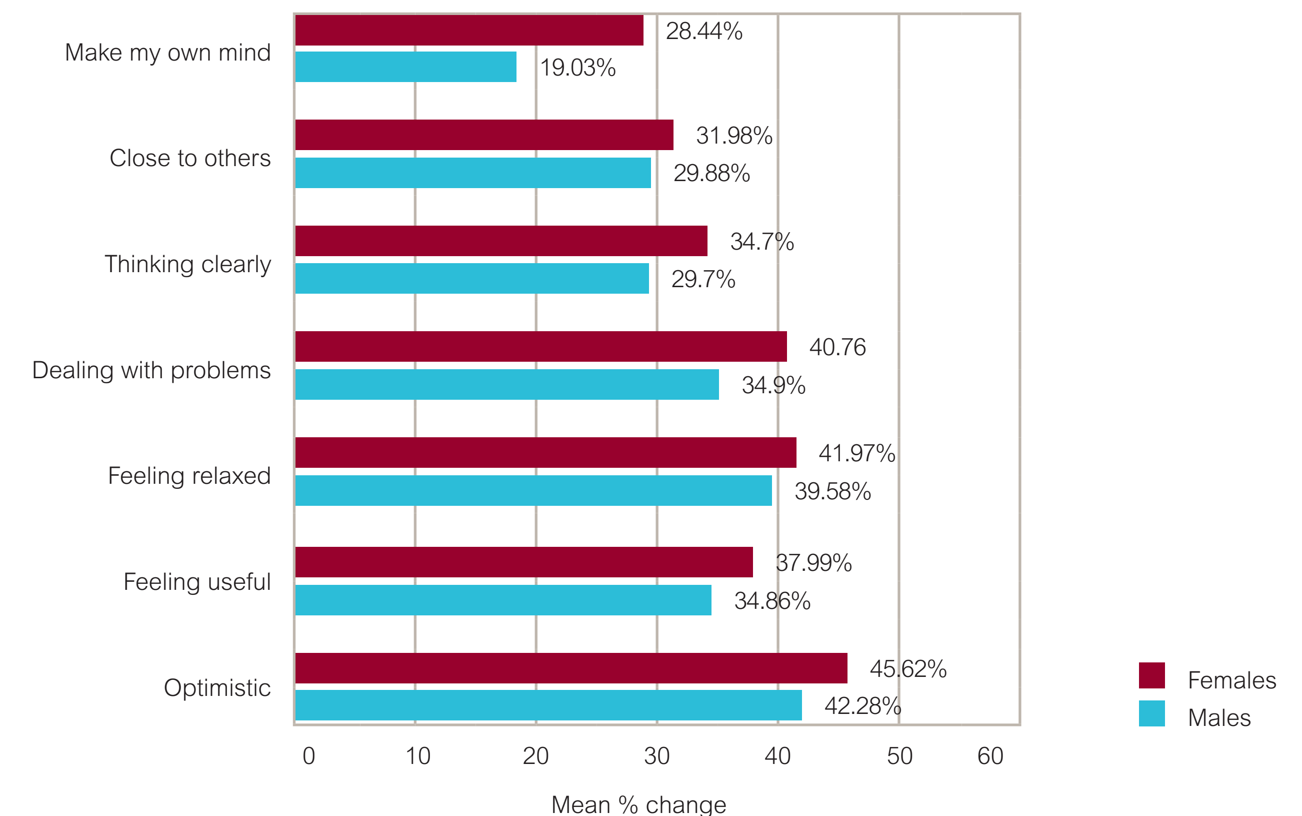
Descriptive and inferential statistics

Across the three age groups similar Mean scores on the SWEMWBS were observed on entry to LWK. The lowest score (poorest mental health) was noted in 26-50 years group (n=1979) at 17.19 (SD=4.21), followed by 17-25 years (n=414) at 17.89 (SD=3.64) and 60+ years at 18.01 (n=348) (SD=4.47).

A bivariate correlation explored the association between age and percentage of change in mental health and wellbeing. This analysis showed no significant relationship between the age of the individual and the impact of LWK ($r= -.04$, $p=.83$), suggesting that changes in mental health and wellbeing were not influenced by age.

Potential differences between the three age groups were also explored using t-tests. Improvements in SWEMWBS scores did not differ significantly for those aged 17-25 (M=2.67) and 26-50 (M=2.671 (p=.81) or between those aged 26-50 and 60+ (M=2.32) (p=0.7). There was also no significant difference between 17-25-year olds compared to 60+ group (p=.15).

Figure 8: Mean percentage change for each of the seven SWEMWBS questions by gender



Percentage change analysis

For the youngest group (17-25), percentage change ranged from a decrease of 31.23 % to an increase of 123.29%, with the Mean increase at 16.80% (SD=23.06).

Those individuals in the middle age group (26-59) observed the largest average percentage increase of 19.79% (SD=35.51), ranging from a decrease of 55.81% to an increase of 400%.

The smallest increase was noted in the oldest age group (60+) with a Mean of 15.69% (SD=23.87), ranging from a decrease of 54.31% to 156.86%.

As Figure 9 shows, the proportion in each age group reporting an increase in mental health and wellbeing was broadly consistent, with a slightly lower percentage in the 17-25 years group.

Looking at each SWEMWBS question separately, there are some interesting patterns between the age groups regards percentage change. For feeling optimistic, the largest percentage change was noted in 26-59 years, followed by 60+ years.

Regarding feeling useful there was a large difference between the youngest and oldest age groups, with a 38% average improvement for the 17-25 group compared to 31% for the 60+.

There was also a notable difference for 'dealing with problems' with greater improvement again in the younger age group – 40% vs. 29% for 60+. Overall the largest increases were observed for 'feeling relaxed' and 'feeling optimistic', both of which were in the 26-59 group. Full results are displayed in Figure 10.

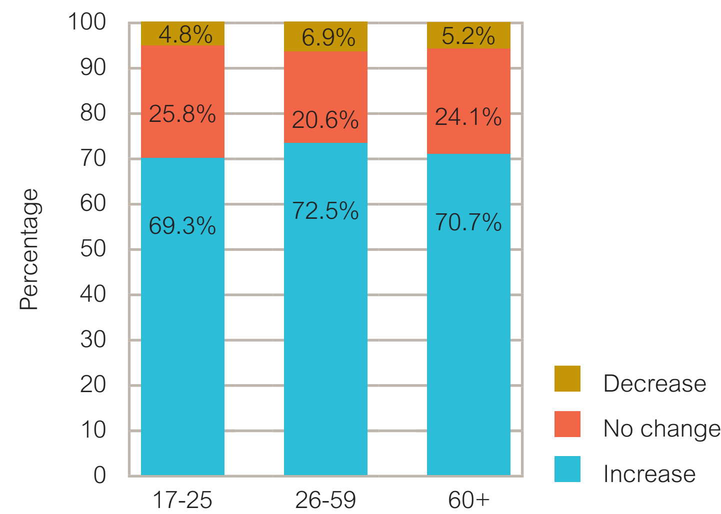
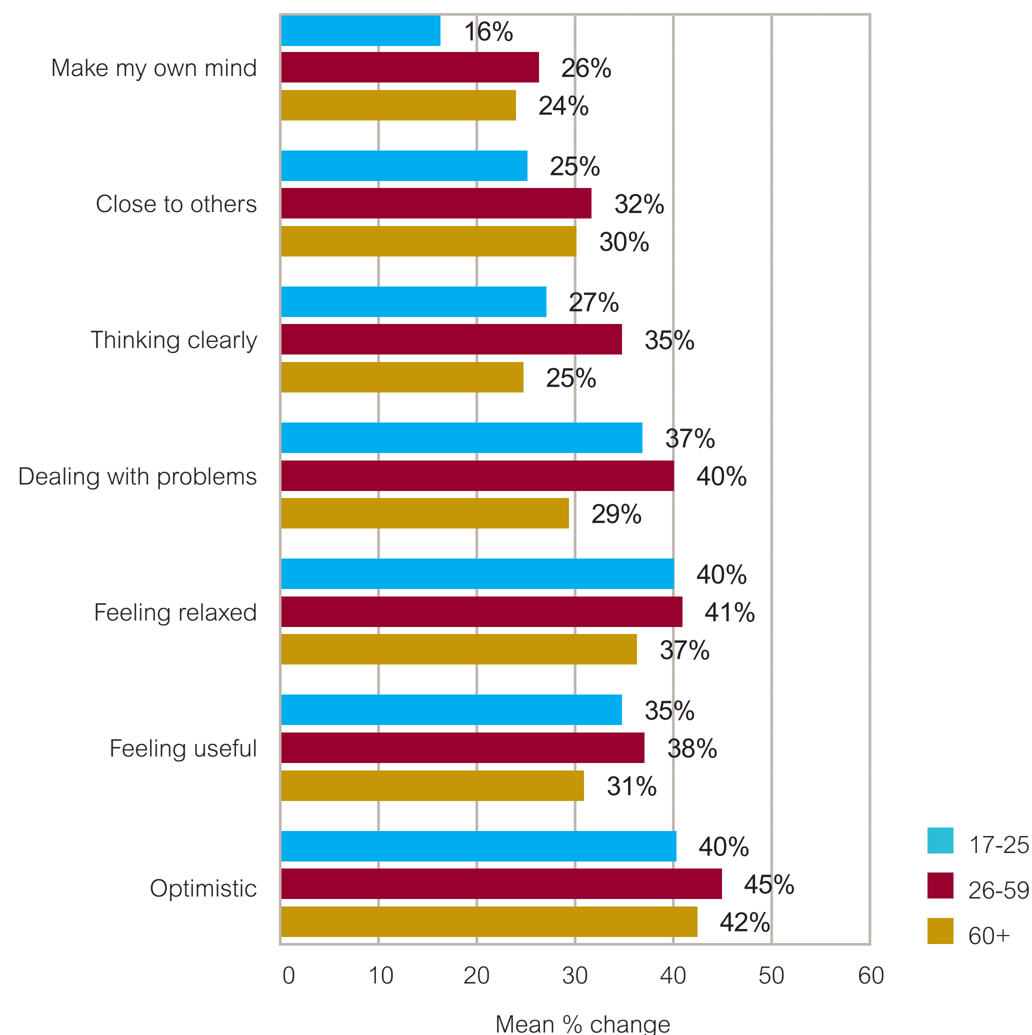


Figure 9: Direction of change in total SWEMWBS scores: Age group

Figure 10: Percentage change for each question by age group



Quintile

Descriptive and inferential statistics

On entering the LWK service Mean scores on the SWEMWBS scale were comparable across the five quintile groups, ranging from a low of 17.24 (most deprived areas) to 17.95 (quintile 4).

Looking at changes in mental health and wellbeing by quintile clusters, individuals in all five groups observed an improvement (see Figure 11). The largest improvement (+3.40) was noted in the least deprived group (quintile 5), followed by quintile 3 (+2.84). Paired-samples t-test showed statistically significant increases in mental health and wellbeing for all quintile groups.

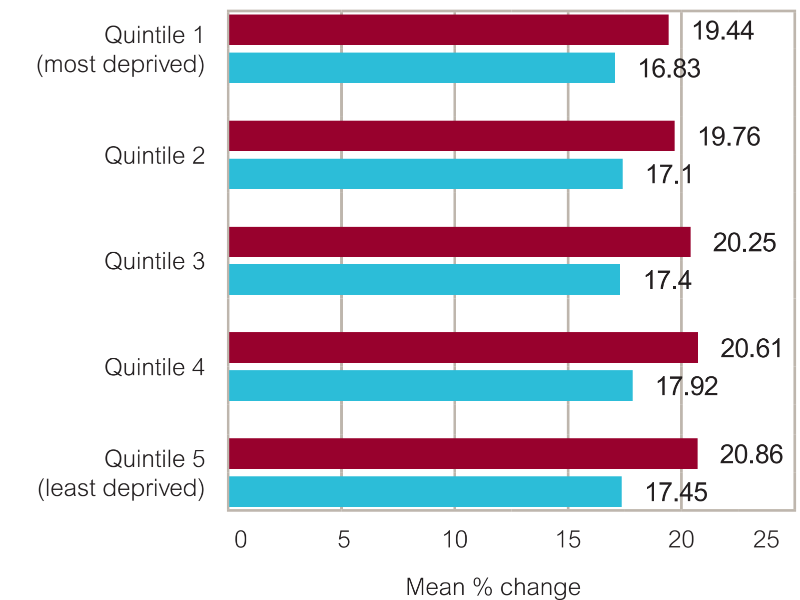
However, the overall statistical model was not significant suggesting that deprivation quintile was not an influencing factor on how the LWK service impacted on mental health and wellbeing. In principle, individuals in quintile 1 were just as likely to benefit from LWK as those in quintile 5.

Percentage change analysis

For individuals in the most deprived area (quintile 1), the percentage change ranged from a decrease of 55.81% to an increase of 319%, with the Mean increase at 18.58% (SD=31.43). For those in the least deprived (quintile 5), the Mean increase was slightly larger at 25.89% (SD=52.34) and ranged from -15.38% to 400%.

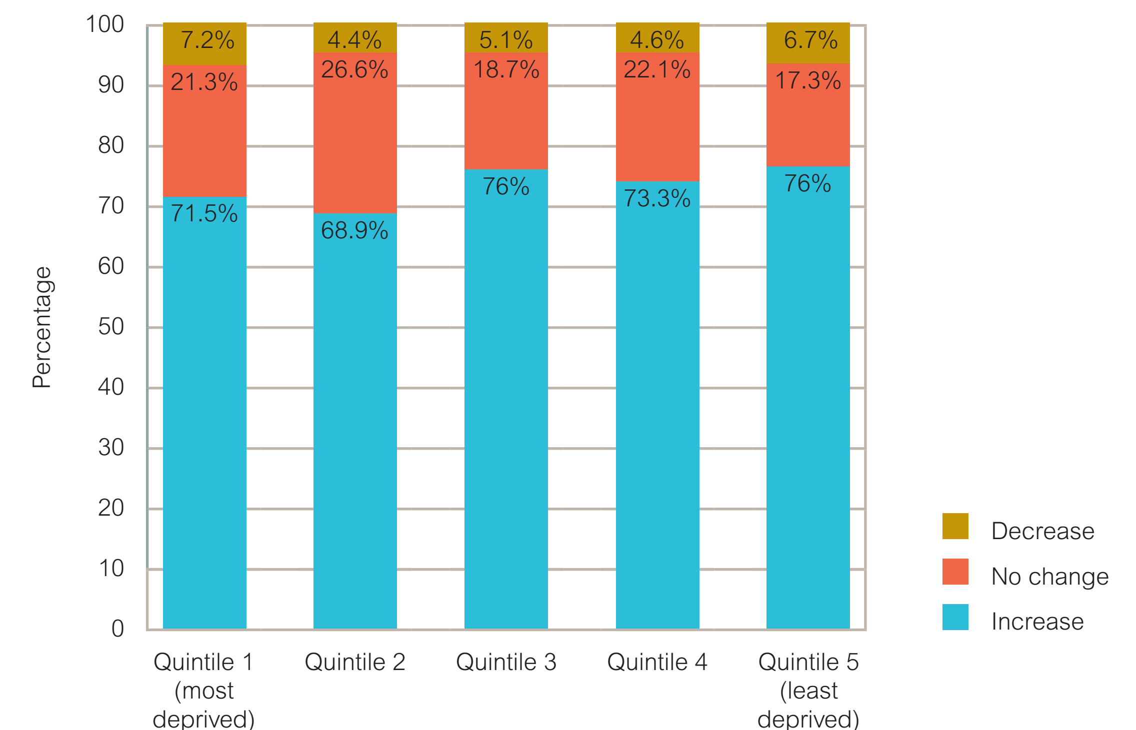
Figure 12 shows the proportion of individuals in each quintile group who observed an increase, decrease and no change in SWEMWBS scores. In all five groups, the majority of individuals within each cluster noted an increase in mental health. The proportion was highest (76%) in quintiles 3 and 5 (least deprived) and lowest in quintile 2 (68.9%).

Figure 11: Mean SWEMWBS scores at start and end of LWK service by quintile groupings



> In all five groups, the majority of individuals within each cluster noted an increase in mental health.

Figure 12: Proportion by quintile who reported an increase, decrease, no change in SWEMWBS scores



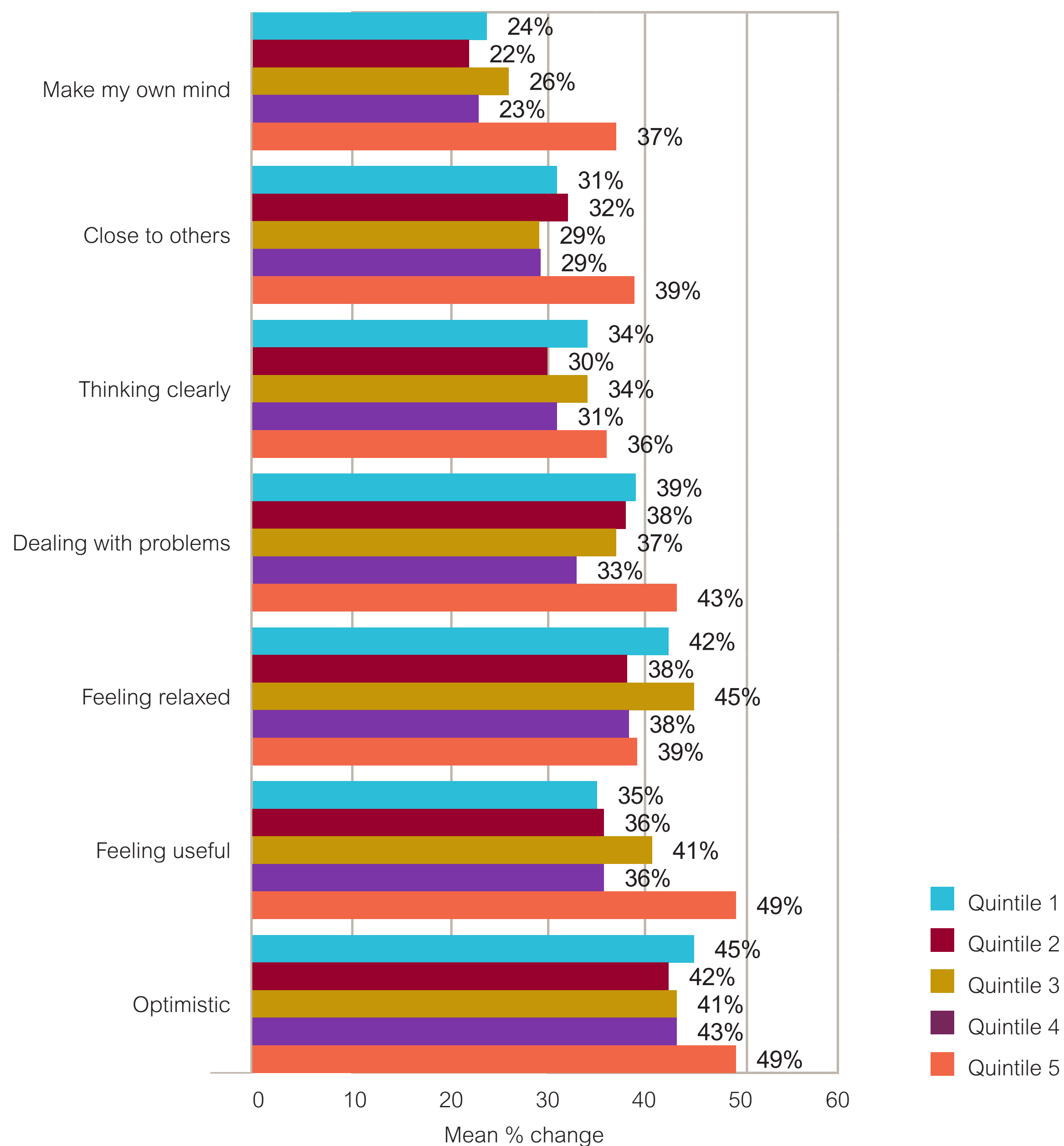
Breaking down each question by quintile, patterns start to emerge illustrating the difference in impact according to group.

For all questions, except 'feeling relaxed' individuals in the least deprived area (quintile 5) recorded the largest improvement.

For 'dealing with problems' those in quintile 1 and 5 noted the largest increases. Improvements in regards to 'thinking clearly' were broadly consistent across all quintiles. All data are shown in Figure 13.

Deprivation quintile was not an influencing factor on how LWK impacted on mental health and wellbeing.

Figure 13: Percentage change for each SWEMWBS question by quintile



Screening: common and severe mental health

Descriptive and inferential statistics

Those having 'prevention needs' came into LWK service with higher SWEMWBS scores (i.e. better mental health) (M=19.30, SD=4.35) compared to SMI (M=17.20, SD=4.26) and CMI who reported the lowest scores (M=17.13, SD=3.96).

Looking at changes in mental health and wellbeing, individuals in all three groups observed improvements (see Figure 14).

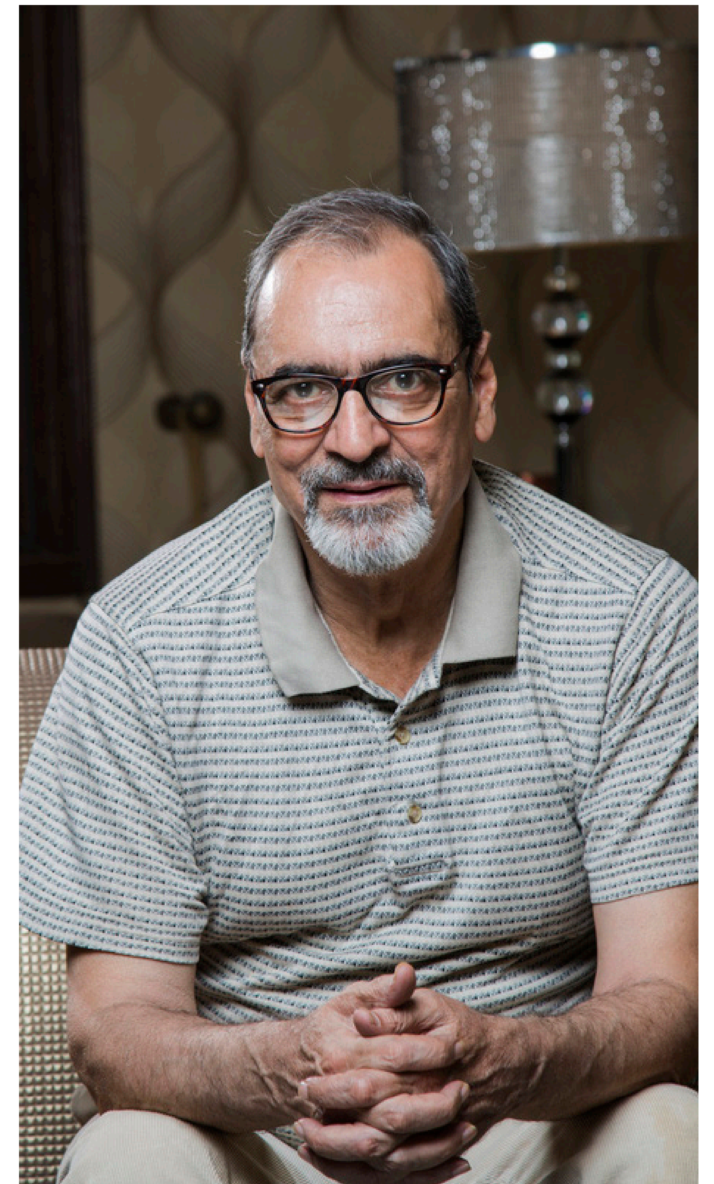
The largest average improvement (+2.83) was noted for individuals with a serious mental illness, followed by those assessed as having a common mental illness (+2.73). Those categorised as having prevention needs noted an increase on average of 1.87 on the SWEMWBS scale.

Paired-samples t-test showed statistically significant increases in mental health and wellbeing within each of the three groups (all ps<.001).

Focusing on whether the impact of LWK differed according to type of mental health diagnosis, the overall statistical model was significant (p<.01) suggesting this may be an influencing factor.

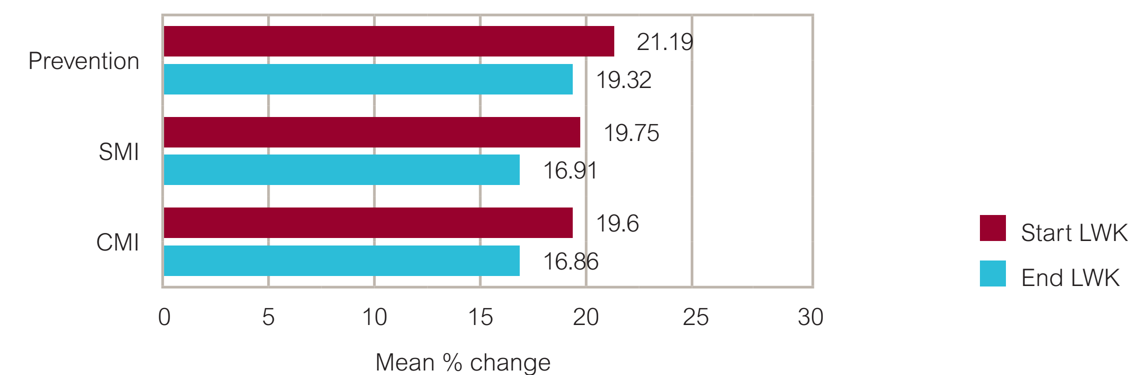
Potential differences between the three groups was explored using change scores in an independent sample t-tests. Improvements in mental health and wellbeing did not differ significantly between those with a severe (M=2.61, SD=3.69) and common mental health diagnosis (M=2.62, SD= 4.03) (p=.11).

This suggests LWK had an equitable impact on individuals in categorised in these two mental health diagnosis groups. There was a significant difference when comparing SMI with prevention (p<.01) and CMI with prevention (p=.01), with individuals in SMI and CMI groups reporting greater improvement.[5]



5. Caution should be applied when interpreting this results as there is a large difference in group sizes with prevention group including a relatively small group (n=267) compared to SMI and CMI.

Figure 14: Mean SWEMWBS scores at start and end of LWK service by serious/common mental illness grouping



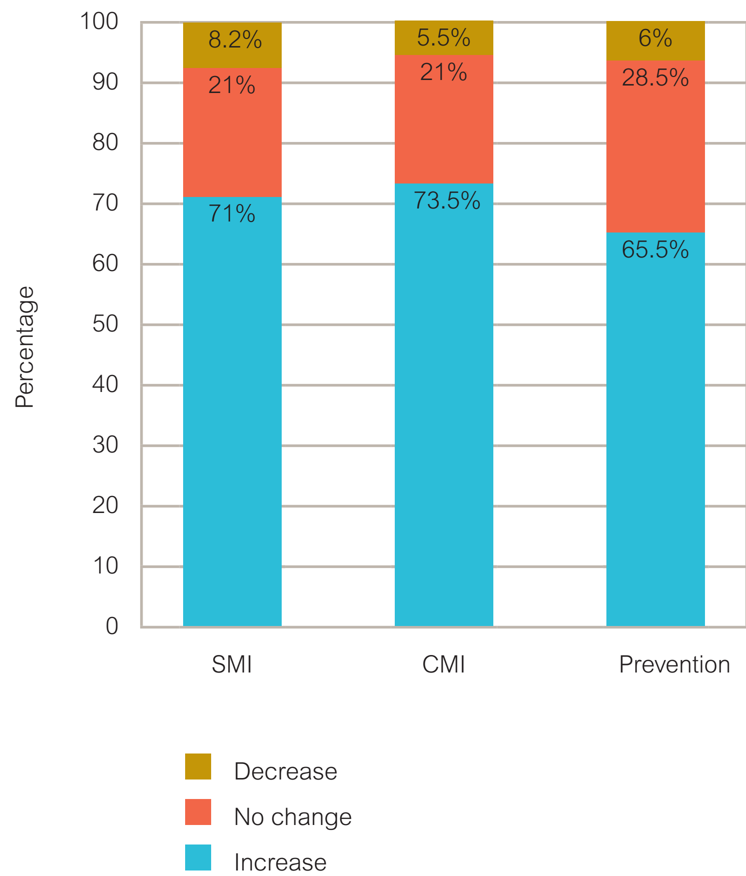


Figure 15: Proportion by SMI/CMI/prevention need who reported an increase, decrease, no change in SWEMWBS scores

Percentage change analysis

For individuals with a serious mental illness percentage change ranged from a decrease of 55.81% to an increase of 365%, with the largest mean change at 20.51% (SD=36.79).

Those individuals with a common mental illness ranged from a decrease of 54.31% to an increase of 400% (M=19.28%, SD=31.94). The smallest increase was noted in the prevention group with a Mean of 11.55% (SD=19.02), and ranging from a decrease of 26.02% to 175.00%.

As Figure 15 shows, the proportion in each diagnosis group reporting an increase in mental health and wellbeing was broadly similar for CMI and SMI, with a slightly lower percentage in the prevention group.

Breaking down each question by diagnosis group, patterns start to emerge illustrating the difference in impact according to how individuals were categorised. Across all three groups the greatest impact was reported for 'feeling optimistic about the future'.

Those with SMI reported large improvements in 'dealing with problems', 'feeling useful' and 'feeling relaxed'. Individuals with CMI noted particular improvements in 'dealing with problems' and 'feeling relaxed' and 'feeling optimistic'.

Across the majority of questions the largest percentage change was observed for individuals with a serious mental illness. The exceptions were 'thinking clearly' and 'feeling relaxed'. For all questions the smallest change was noted for those with prevention needs. Data are shown in Figure 16.

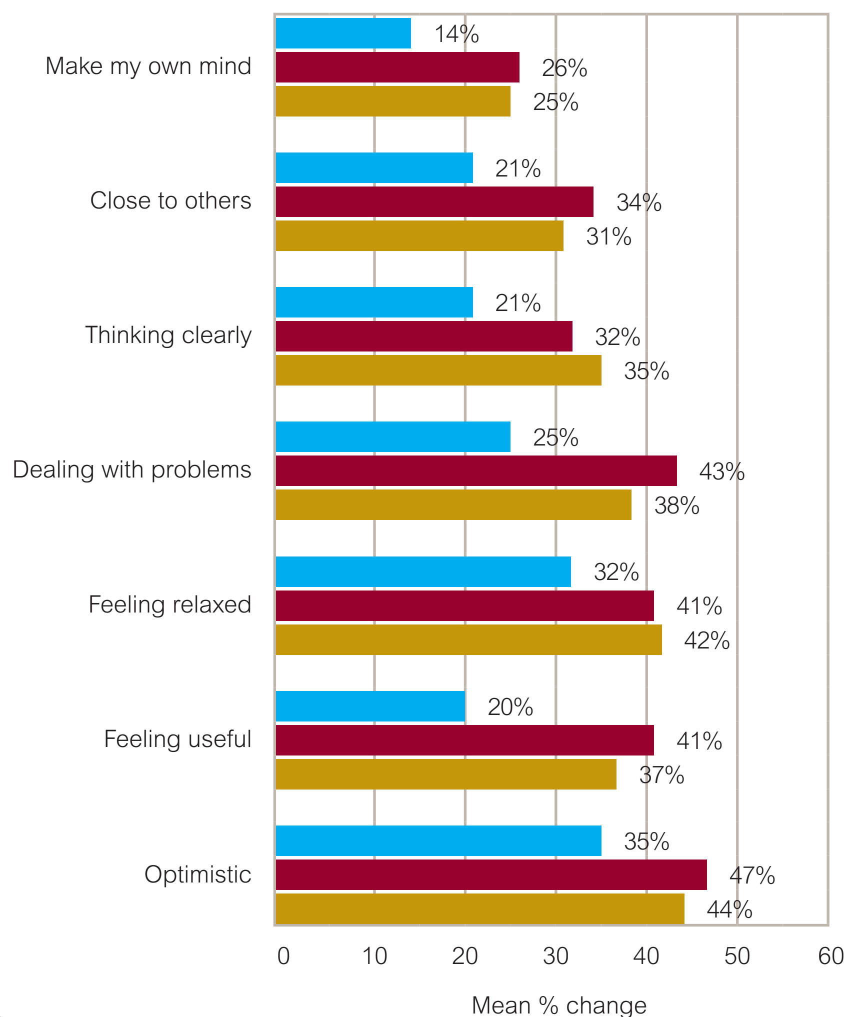


Figure 16: Percentage change for each SWEMWBS question by SMI/CMI/prevent needs

Screening: level of need

Descriptive and inferential statistics

As might be anticipated, individuals reporting relatively 'low need' came into LWK service with higher SWEMWBS scores (M=18.43, SD=4.36) compared to those with a 'medium need' (M=17.07, SD=3.66). Individuals with the highest needs had the lowest SWEMWBS scores on referral in to LWK (M=15.54, SD=4.19).

Looking at changes in mental health and wellbeing, individuals in all three groups observed improvements (see Figure 17).

The largest average improvement (+2.91) was noted for individuals with a high need, followed by those assessed as having a medium need (+2.79). Those categorised as having low need reported a Mean increase of 2.61 on the SWEMWBS scale.

Paired-samples t-test showed statistically significant increases in mental health and wellbeing within all three groups (all ps<.001).

However the overall statistical model was not significant (p=.71) suggesting that 'need' was not an influencing factor on how the LWK service impacted on mental health and wellbeing. Individuals with low need were just as likely to benefit from LWK as those with high.

Percentage change analysis

For individuals with low needs percentage change ranged from a decrease of 26.57% to an increase of 400% (M=17.47%, SD=31.10). Those individuals assessed as having medium needs ranged from a decrease of 37.43% to an increase of 244.43% (M=18.60%, SD=29.25). The largest increase was noted in the high needs group with a Mean of 24.51% (SD=47.28), and ranging from a decrease of 37.78% to 365%.

As Figure 18 shows, the proportion in each diagnosis group reporting an increase in mental health and wellbeing was consistent across the three groups, with a slightly lower percentage in the high need group.

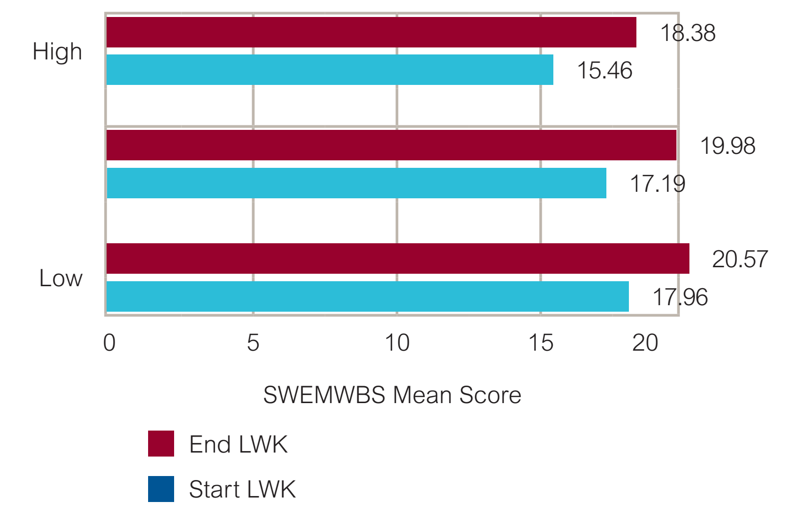


Figure 17: Mean SWEMWBS scores at start and end of LWK service by low, medium, high need

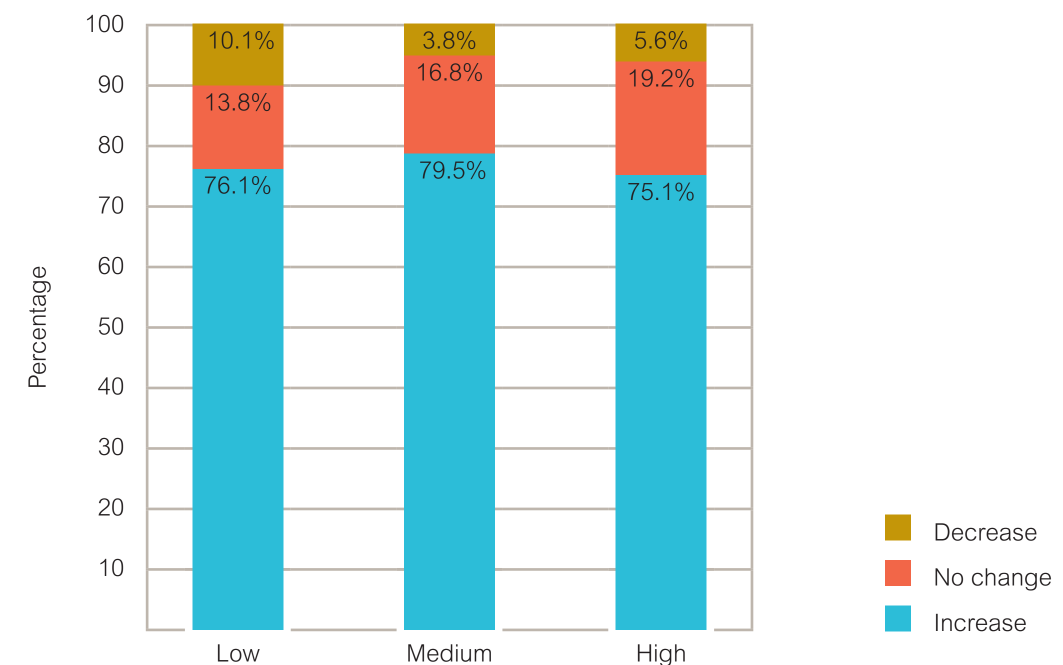


Figure 18: Proportion by high/medium/low need who reported an increase, decrease, no change in SWEMWBS scores

Looking at each question shows the relationship between levels of need and the different aspects of mental health and wellbeing measured by SWEMWBS.

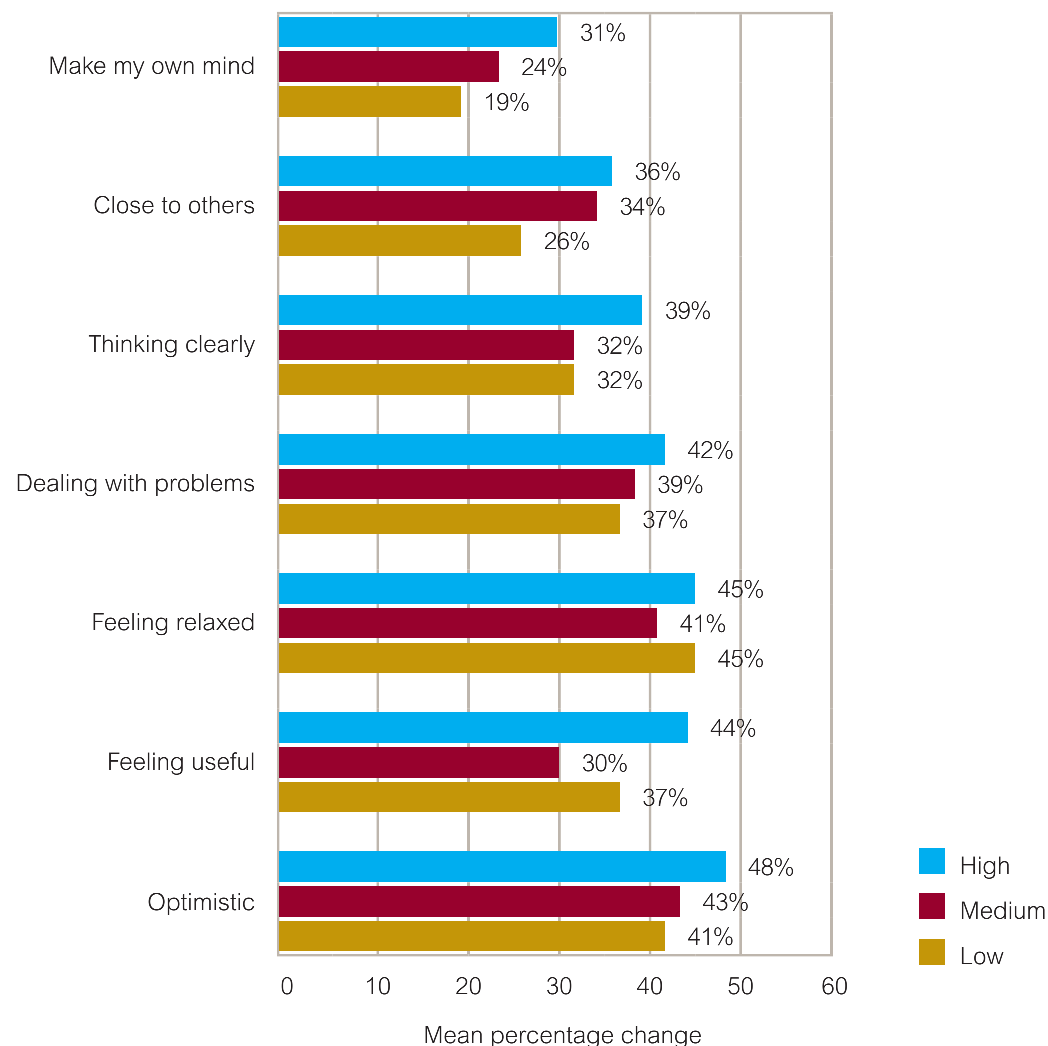
Replicating findings from SMI/CMI analysis, for all three groups the greatest impact was for 'feeling optimistic about the future'.

Those with high needs reported large improvements in 'feeling useful' and 'feeling relaxed'. Individuals with medium and low need noted particular improvements in 'dealing with problems' and 'feeling relaxed'.

The smallest impact in all three groups was for capacity to 'make up own mind'. All data are shown in Figure 19.

> Those with high needs reported large improvements in 'feeling useful' and 'feeling relaxed'.

Figure 19: Percentage change for each SWEMWBS question by high, medium, low need



EXPERIENCE OF SERVICE

Porchlight uses a number of approaches to gain feedback from people who have used LWK to help it better understand how well it is doing and where it can improve. Individuals are asked for feedback when they exit the service through standardised exit questions and through sampling follow up calls 6 months afterwards carried out by Porchlight's involvement team.

Asked if individuals would recommend LWK to family and friends, a large proportion – 92.9% (n=1914) – indicated they would. A minority – 6.0% (n=130) reported yes, but not directly. Less than 1% (n=15) would not recommend. This suggests the LWK service fulfils a key outcome by providing support that users are highly satisfied with.

PROFILES OF INDIVIDUALS ACCORDING TO IMPACT

When focused solely on the profile of individuals whose mental health and wellbeing increased, a number of key findings emerge and are summarised below:

- Overall 2000 LWK individuals (71.9%) reported an improvement in mental health and wellbeing (606 sustained their mental health/wellbeing, 176 reported a decrease).
- 1180 females reported an increase in mental health and wellbeing, constituting 73.3% of the total female sample who returned both baseline and follow-up data. 819 males or, 70.1% of the male sample, reported an increase. This pattern of results suggests LWK is slightly more effective in females, compared to males, regards improving mental health and wellbeing.
- There was an equitable impact across all age groups with 72.5% of 17-25-year olds, 69.3% of 26-59 year olds and 70.7% of 60+ group reporting a positive impact on mental health and wellbeing.
- Individuals from across all deprivation quintiles reported improvements in mental health and wellbeing. A slightly larger proportion of those living in the least deprived area reported a positive change (76%) compared to those living in the most deprived areas (71.5%). Reasons for this difference between most and least deprived areas cannot be reliably identified with the available data but with widely acknowledged health inequalities evident in deprived areas, it is reasonable to hypothesise that individuals in these areas would also be vulnerable to additional external factors that could affect the impact of LWK – for example, amount of disposable income, access to established networks of support, access to adequate health care and resources (i.e. time and money) to support a positive change. An absence of these 'protective' factors may influence effectiveness of any type of intervention aimed at improving health and social outcomes.
- There was equitable impact across individuals diagnosed with a SMI and CMI. 71% of those with a SMI and 73.5% with CMI benefited from increased mental health and wellbeing.
- The proportion of individuals with high mental health needs who reported an improvement was slightly lower at 76.1% compared to medium 79.5%.

It is also useful to identify trends for those individuals who sustained without an improvement in their mental health and wellbeing.

• This included 340 females or 21.1% of the total female sample who returned both baseline and follow-up data. 265 males or, 22.7% of the male sample, reporting sustainment. Reinforcing the conclusions made regards positive impacts and gender, this pattern suggests males have a slightly higher propensity to not record an improvement in mental health and wellbeing.

• Individuals aged 17-25 were most likely to report sustainment – 25.8% - followed by 60+ years (24.1%). Those in the between 26-59 years were least likely not to sustain- 20.6%.

• Individuals living in the most deprived areas of the county (quintile 1 and 2) were more likely to report sustainment (21.3% and 26.6% respectively) compared to those living in least deprived areas (17.3%).

• As you would expect based on the profile of those who reported a positive change, there was little difference in proportion of individuals diagnosed with a SMI and CMI who reported sustainment – both at 21%.

Total interventions experienced - outcomes and changes

A key vision for Live Well Kent was for individuals to have 'a life not a service', moving easily through the support they needed, when they needed it, and with a choice.

The first set of analyses in the report focus on data collected for only the first service accessed. In the interest of completeness, and to better understand how individuals move through the different programmes offered under LWK, analyses were also conducted on data collected from every intervention an individual received.

Descriptive and inferential statistics

Across all programmes data from 11,027 interventions were collected from a baseline (start of service) SWEMWBS data. The Mean score for this sample was 17.13 (range= 7-35, SD=4.11).

At follow-up data were collected from 4640 LWK interventions (42.1% of total sample) provided follow-up data at the end of the service. The Mean score for this group increased 2.62 to 19.76 (range= 7-35, SD=4.64).

Statistical tests comparing baseline and follow-up data revealed a significant difference between the two Mean scores, showing an overall improvement in mental health and wellbeing in individuals after accessing LWK interventions ($p<.001$). However, it should be noted that the Mean score at the end of the LWK service (19.76) is still below the population norm.

Looking at each question on the scale separately, statistically significant improvements were observed across all seven areas of mental health and wellbeing ($p<.001$). The largest improvement was for 'feeling optimistic about the future' (+.63), followed by 'dealing with problems well' (+.55).

The smallest increases were observed for 'being able to make my own mid up about things' (+.41). Figure 20 displays the Mean values for each question at baseline and follow-up.

> A key vision for Live Well Kent was for individuals to have 'a life not a service', moving easily through the support they needed.

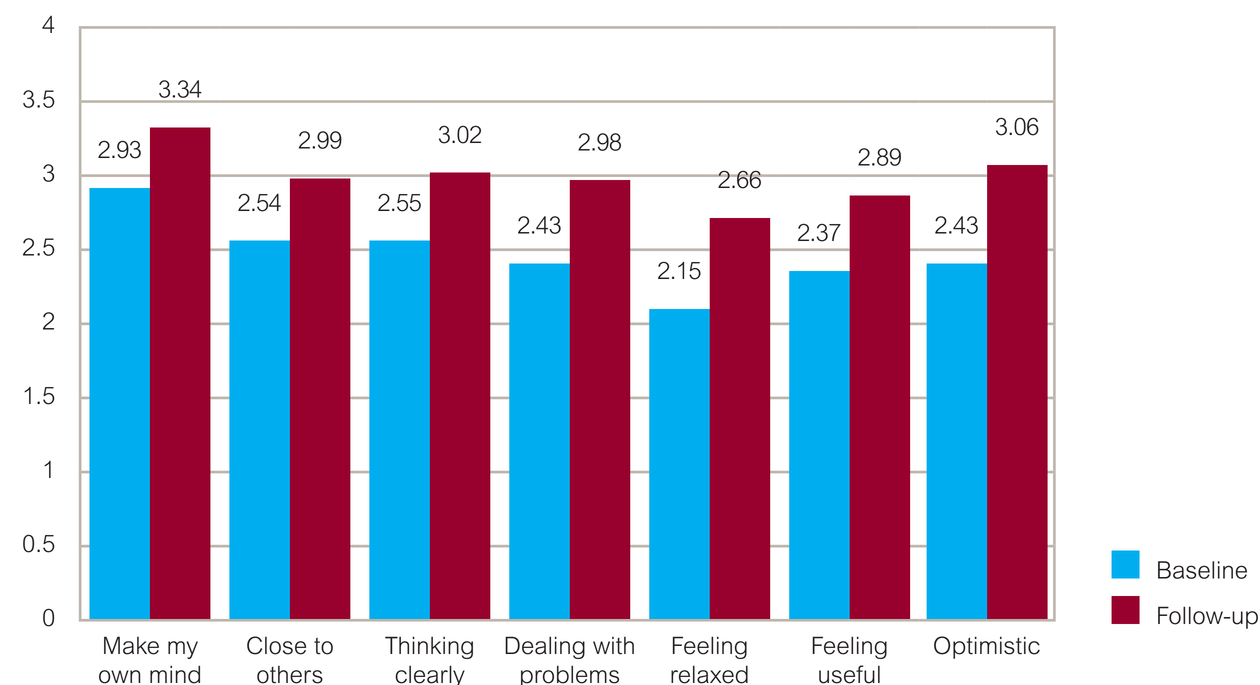


Figure 20: Mean scores for each of the seven SWEMWBS questions at start (baseline) and end (follow-up) of LWK service

Percentage change analysis

Percentage change ranged from a decrease of 63.34% to an increase of 400%, with the Mean increase at 18.5% (SD=32.21).

The majority of individuals – 71.7% (n=3326) – reported an increase in mental health and wellbeing, with 20.0% (n=930) observing no change, and 8.3% (n=384) a decrease. This result is displayed in Figure 21.

Looking at percentage change for each question on the SWEMWBS scale, all items observed a change from a decrease of 80% to an increase of 400%.

Figure 22 displays the Mean percentage change from baseline to follow-up for each question. As to be expected based on the total SWEMWBS analysis, an increase (i.e. improved outcomes) was noted across all areas.

The largest increase was seen for how optimistic people felt about the future (42.09%) and the smallest for being able to make their own minds up about things (24.74%).

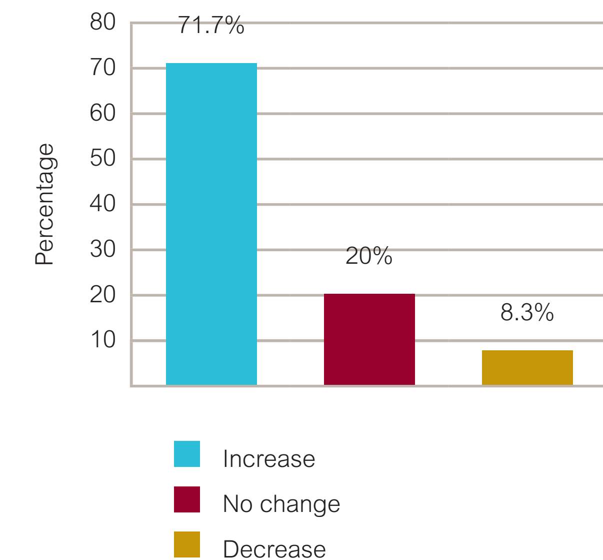


Figure 21: Direction of change in total SWEMWBS scores

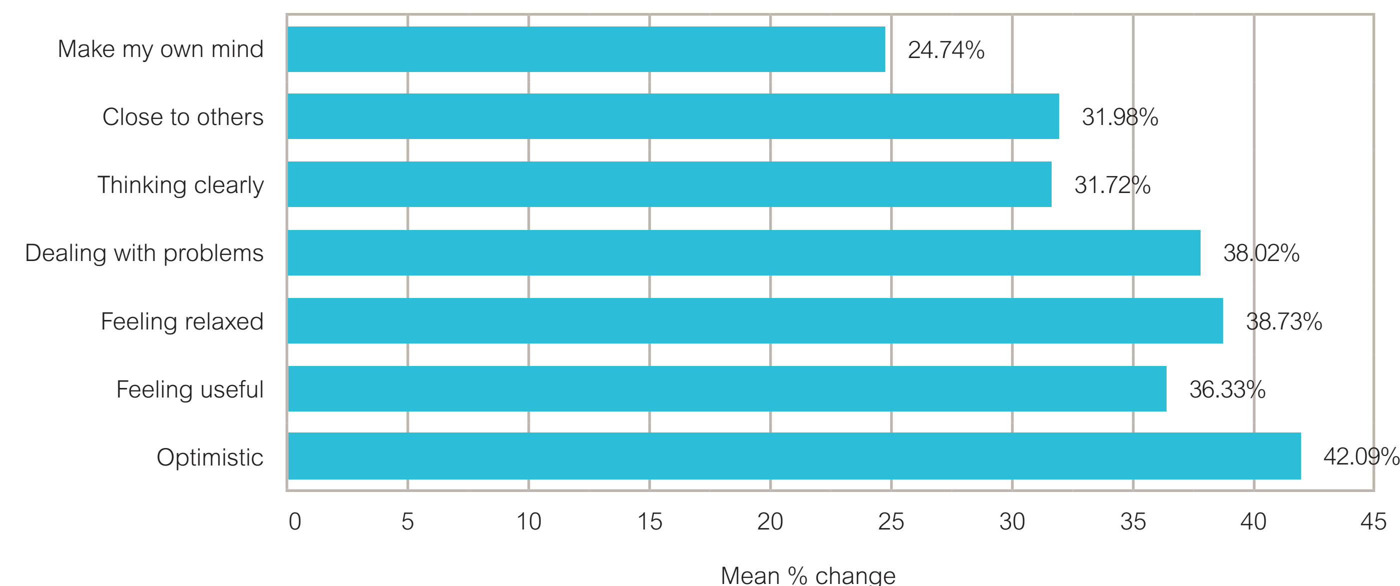


Figure 22 Mean percentage change for each of the seven SWEMWBS questions

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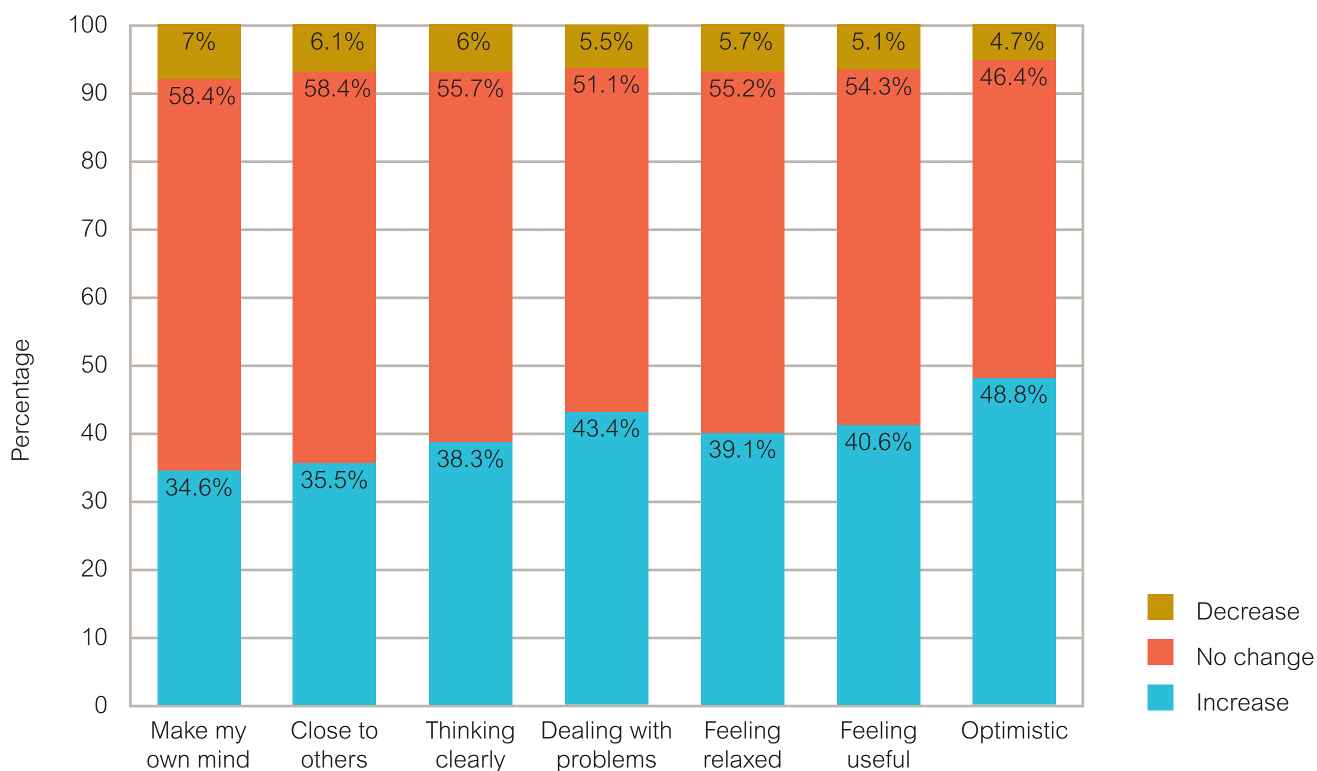
Looking at the direction of change for each question, the proportion of individuals who reported an increase ranged from 34.6% (make up my own mind) 48.8% (feeling optimistic about the future).

For six of the seven questions, the largest proportion of individuals observed no change from baseline to follow-up. The exception to this was feeling optimistic about the future. Full results are displayed in Figure 23.

> Over 71% of individuals reported an increase in their mental health and wellbeing.

Figure 23: Direction of percentage change for each SWEMWBS question



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TYPE AND USAGE OF INTERVENTIONS

Live Well Kent was primarily commissioned as a shorter-term service. Historically many of the services delivered had provided longer term support, with very limited data to help understand whether length of support had an impact on outcomes. There was also concern through the review of services as part of the original commissioning that many services created a dependency for individuals, with limited progress or recovery.

Length of support through Live Well Kent ranges from short term interventions, such as Community Link providing practical advice and information (secondary prevention), to longer term recovery services through peer support, self-management programmes and community inclusion work (tertiary prevention).

TYPE OF SUPPORT

The 47 LWK services can be categorised into four broad types based on the overall aim of the service: advice and guidance (e.g. Porchlight Community Link); housing (e.g. Porchlight Community Housing Support); employment IPS (e.g., Rethink Thanet Way Project IPS); recovery (e.g., Mind programmes).

Figure 24 displays the Mean percentage change in SWEMWBS scores under in each of these types of service. The largest change is observed in the specialist housing service, with an average improvement of 30.9% (n=461, range = -63.64% to 365%), followed by IPS employment at 23.4% (n=642, range= -40.18 to 400%).

These four service types fit under different areas of prevention as described in the LWK model:

Secondary prevention: Early intervention services that encompasses all advice and guidance and housing programmes.

Tertiary prevention: Focused support to enable the best chance of sustainable recovery, covering the employment and recovery programmes.

Collapsing data across these two prevention groups, percentage improvement in SWEMWBS scores was higher for tertiary services (M=21.42%, SD=32.32, range= -60.6% to 400%) compared to secondary prevention (M= 16.71%, SD=32.02, range= -63.64% to 365%). This difference was statistically significant ($p<.001$) suggesting the degree of improvement in mental health and wellbeing was greater for those individuals accessing tertiary prevention services.

To explore what might be a 'typical' pathway for individuals once referred in to LWK, frequency data were analysed to illustrate what services were individuals most likely to access first, second, third and last.

First contact

The most popular option for individuals to access first is advice and guidance services, with just over half of referrals (55.6%, n=4247) falling into this category.

Within this type the overwhelming majority came from the Porchlight Community Link service (n=3783, 89.1%), followed by Porchlight Thanet Health Inclusion (n=449, 10.6%).

The second type were recovery services, with 27.4% (n=2094) of referrals being directed here first. As 34 different services sit within this type the spread of referrals was of a more even spread with Together UK (21.3%, n=447), all interventions provided by North Kent Mind (21.3%, n=445) and Folkestone & District Mind (16.9%, n=353) being the most common options.

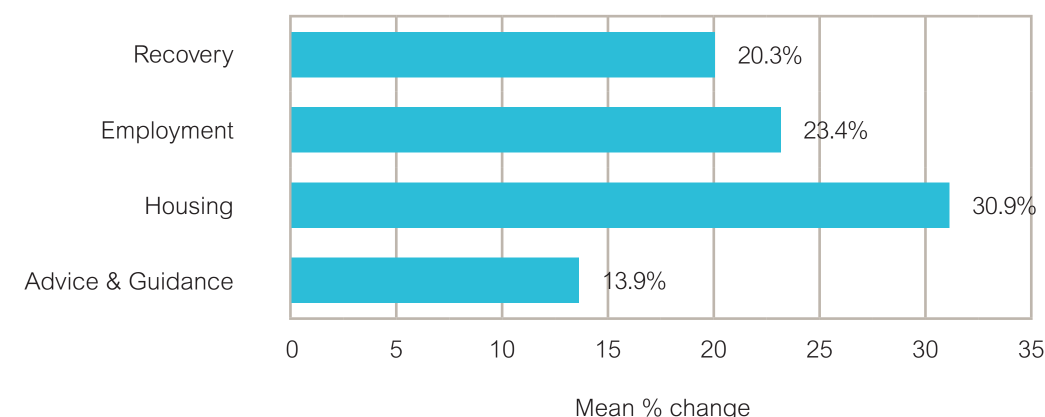
Services under employment accounted for 13.7% (n=1047) of first referrals, with the largest proportions of these going to either North Kent Mind Springboard (28.8%, n=302) and Rethink Thanet Way (20.0%, n=209).

This data relates to the IPS employment services only, and not general advice and guidance around employment issues. For specific data related to IPS employment outcomes see the appendix.

Housing represented the smallest proportion at 3.2% (n=244), with all referrals accessing the only housing specific service – Porchlight Community Housing. This is a specialist housing service where the person's mental health is impacting on housing stability.

More general housing advice related to mental health need or impacting on mental health is also part of the advice and guidance provided by the Community Link Service.

Figure 24: Mean percentage change in SWEMWBS scores according to service type



Subsequent contacts

2041 individuals were referred to a second service under LWK. The largest proportion of these – 40% (n=816) - went into recovery services, followed by advice – 27.7% (n=566) and then housing – 18.9% (n=386). The smallest proportion were referred into employment services – 13.4% (n=273).

650 individuals went on to receive support from a third service. Again, the largest proportion of which were referred to recovery programmes – 50.3% (n=327), followed by advice – 24.2% (n=157). Relatively small proportions accessed employment (15.1%, n=98) and housing (10.5%, n=68) at this point.

Individuals who accessed 4 or more different services (n=324), again the most frequently used services were those categorised as recovery with 62% of individuals being referred in. For those individuals who accessed multiple services, the final referral was most likely in to a recovery programme (42.3%, n=863), followed by advice (27.2%, n=555), housing (17.7%, n=362) then employment (12.8%, n=261).

USAGE OF SUPPORT

To explore the relationship between duration of time spent under LWK service(s) and outcomes in health and wellbeing, two types of analysis were conducted.

First, length of time as a continuous variable was used in a bivariate correlation in which number of days for each timeline was correlated with percentage change in SWEMWBS scores.

A variable was created for each individual that provided the average number of days they received support from LWK. For those individuals who accessed multiple interventions the data were collapsed across all interventions and an average number of days obtained from this.

Using this data it was observed that the mean number of days accessing support from LWK was 124 (SD=147 days) and ranged from 1 to 1464 days. To ensure reliability of the correlation analysis outliers were removed (3+ SD from mean: ≥566 days).

Number of days was positively skewed (majority of data on lower end of scale) hence a non-parametric correlation was employed (Spearman's Rho). Results from this analysis suggest a significant but small positive correlation between number of days and percentage change ($r=.16$, $p<.01$).

This result suggests there may be a relationship between the amount of days receiving support from LWK interventions and wellbeing outcomes; however the correlation is relatively small and likely significant as a consequence of the large sample. This conclusion is reinforced when looking at a plot of the data points.

As shown in Figure 25, higher percentage change values (i.e. largest improvements in wellbeing) are observed in the first 100 days of support, after which the degree of change is concentrated under 100%.

This suggests that longer support does not necessarily equate to larger improvements in outcomes and there is a likely threshold where any progress plateaus once an individual is stable. Importantly there is little evidence of reduction in mental health and wellbeing over time (i.e. negative scores on the scatter plot), with nearly all individuals reporting an increase in wellbeing or remaining stable.

This is an important observation as it indicates that, over time, LWK can act as a preventative service, supporting individuals and averting escalation of problems that impact on mental health and wellbeing.

Individuals identified as having a SMI tended to access LWK interventions for longer (M=110 days) compared to those with CMI (73 days) and prevention needs (58 days). Observations for level of need data reiterated this with those categorised as high needs spending the most time receiving support from interventions – 62 days, compared to 59 days for medium needs and 53 days for low need.

> Over time, LWK can act as a preventative service, supporting individuals and averting escalation of problems that impact on mental health and wellbeing.

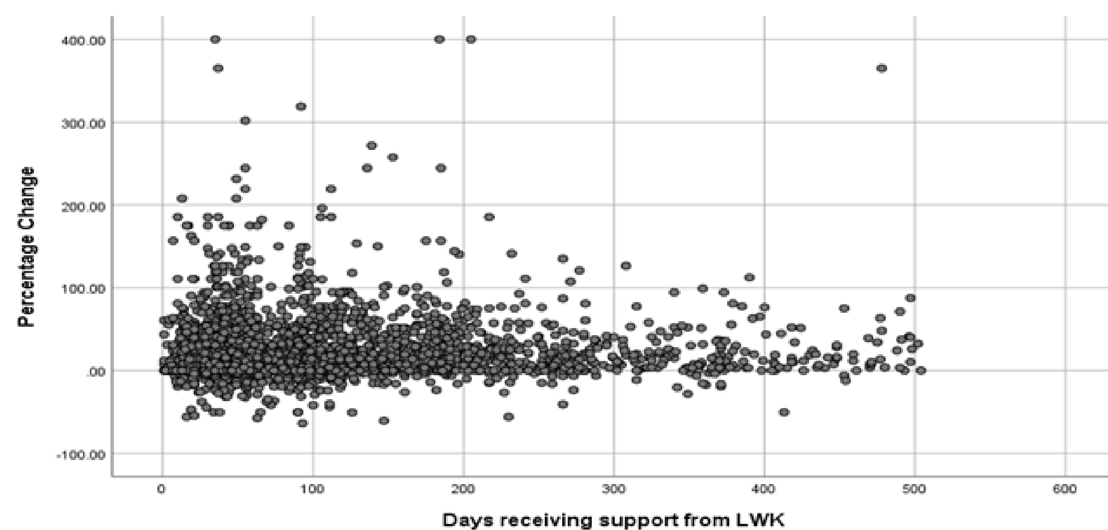


Figure 25: Box plot of percentage change in SWEMWBS scores by number of days in LWK service

The second analysis used categories, collapsing length of time in to four groups: up to 8 weeks (up to 56 days); up to 12 weeks (57-84 days); 13-16 weeks (85-112 days); ≥4 months (113+ days).[6] The Mean percentage change observed in each of these categories is displayed in Figure 26.

As is clear from the figure, the largest improvement is observed for individuals who spend 4 months or longer receiving support from LWK (M=27.02%, range= -60% to 400%), followed by 13-16 weeks (M=23.73%, range=-63%- 318.71). The two categories covering the briefer services had comparable impact in terms of SWEMWBS outcomes (both with a Mean of 15.4%)

Return individuals

A small proportion of LWK interventions – 13.9% (n=1549) – included where individuals were at some point referred back in to the same service. Focusing specifically on individuals who returned to identify any common patterns data suggests gender was not an influencing factor as the spilt was 54% female vs. 46% male which is broadly in line with the overall divide.

Regards age, the largest group who returned to the same service were in the 26-50 years group (76.1%, n=1158), but again this mirrors the demography for the whole population of LWK users (71.1%, n=6589).

Individuals in the lowest two deprivation quintiles were more likely to return and formed 82.5% (n=1258) of individuals who accessed a service multiple times.

For level of need, 19% (n=109) of those with high needs returned to the service. This is a larger percentage than for individuals with low (14%, n=137) and medium needs (17%, n=237). This suggests that individuals with complex mental health needs are more likely to return to the service compared to those with less serious mental illnesses.

Focusing on deprivation, 15% (n=955) from quintile 1 and 13% (n=303) from quintile 2 returned to the service. This compares with a return rate of 10.6 (n=85) and 9.8% (n=32) for quintiles 4 and 5 respectively.

This illustrates that individuals living in the most deprived areas were more likely to access LWK services multiple times, compared to those living in more affluent areas.

Looking at patterns across the six CCGs, individuals living in Thanet CCG were most likely to return with 19.7% (n=554) of individuals from that area accessing the service multiple times. This was followed by South Kent Coast with 14.1% (n=338) of individuals in this area returning.

SROI ANALYSIS

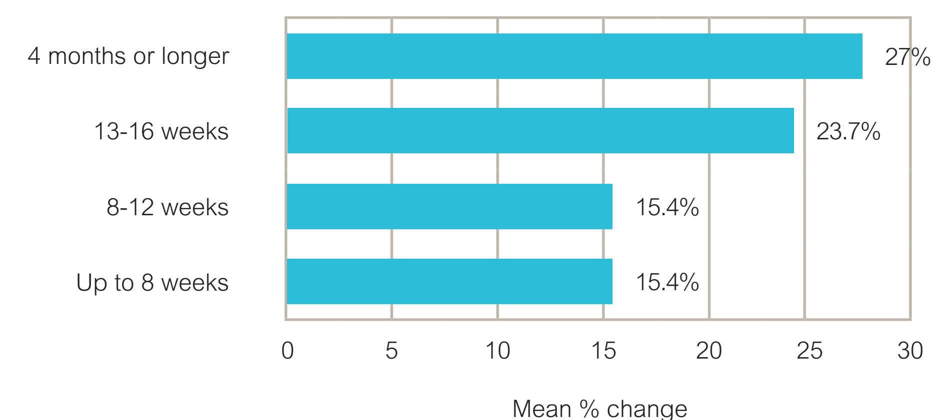
A Social Return on Investment (SROI) calculation was conducted to gather preliminary understanding on the potential social value of LWK.

The values used in this calculation were decided in collaboration with Porchlight and considered previous SROI work completed on similar projects.

However, it is important to note the SROI calculation detailed in this report is the first attempt at providing a value for a programme with the complexity of LWK and as such we have been cautious with discounts applied and mindful that these will need refining for future SROI calculations.

> It is also important to note that this SROI analysis has been calculated on SWEMWBS progress only. There are opportunities to develop this further in the future to include other key outcomes, such as housing and employment, which have a significant impact upon SROI.

Figure 26: Mean percentage change for length of support by category



6. Individuals also receive support in one day from drop-in service but SWEMBS measures are not completed for this group so excluded from this analysis.

LWK is a service that constitutes multiple different interventions, of varying lengths, targeted at a range of individual groups and delivered by a diverse workforce. All these factors influence the estimates made for the four discounts considered in a SROI: deadweight, attribution, displacement, duration and drop-off.

Deadweight: What would have happened without the support of LWK?

Deadweight allows us to consider what would happen if the LWK service was unavailable. It attempts to account for the possibility that individuals could have received the same outcomes through another activity or receiving support elsewhere from a similar service.

The Homes and Community Agency in the Additionally Guide (2014) provide guidance on deadweight when considering improvements in mental health.

It states that 27% of people experiencing an improvement would have achieved this anyway. In line with this recommendation the SROI calculation for LWK will use this value.

Attribution: Who/what else would contribute to impact on individuals?

With community-based interventions there is always a possibility that others will contribute towards any changes in people's lives such as family members or other organisations. Attribution allows us to recognise the contribution of other organisations (statutory and voluntary) and individuals towards achieving these outcomes.

This discount allows for a robust estimate regarding the extent to which any change reported by individuals is a consequence of the support provided by LWK. Considering LWK has extensive reach in to the most deprived areas in Kent, where there is often an absence of additional support.

Alongside LWK is supporting individuals while they wait to access community mental health services and adult social care, as such LWK interventions are frequently the only consistent support available.

Furthermore, individuals who receive support from LWK can access multiple interventions targeted at different levels of prevention (i.e. secondary and tertiary) and a range of problems (i.e. housing, employment, mental health). In consideration of these factors we estimate that 30% of any changes can be attributed to LWK.

Displacement: What activity would/will be displaced?

For the calculation we also need to consider if the outcomes achieved in LWK displace other outcomes elsewhere. In calculating this value a number of important considerations regards the design and commissioning of LWK were taken in to account.

First, LWK was commissioned by KCC on the basis that there was a gap in current services and an unmet need in the target areas, hence it is unlikely that any activity has been displaced. Furthermore LWK, and the interventions offered as part of the service, have been built on local knowledge and expertise; developed to fill specific gaps in provision.

Finally, recognising that a strategic aim of the commissioned model was to build links between voluntary sector and statutory organisations, LWK was designed to integrate and collaborate with wider services, not replace or displace outcomes. Planning for displacement was also integral to the discussions with commissioners and providers when designing the LWK model. Considering all the factors it was decided there would be no displacement due to LWK (0%).

Duration: Will the impact drop off in future years?

There is currently no scope in LWK to collect longitudinal outcomes but based on the extent of the impact in individuals (as evidenced by the quantitative analysis) the drop-off figures have been estimated at a rate of 25% per year over 3 years.

Calculation

The social return is expressed as a ratio of present value divided by value of inputs. Although there are likely to be impacts of the programme over many years, we calculated the value of the impacts only up to three years.

The proxies used in the calculation were generated from each of the seven questions from the SWEMWBS, the total SWEMWBS scores and an assessment based on avoiding depression.[7]

> The total financial value of the inputs for the two Lots co-ordinated by Porchlight from 2016-2019 was £7,321,887. This provided a SROI ratio of £4.55 of social value created for every £1 of investment.

7. Full QALY National Institute of Health and Clinical Excellence, and British Medical Association, Exploring the cost effectiveness of early intervention and prevention (2017)

IMPACT OF LIVE WELL KENT: SYSTEM OUTCOMES

Below outlines the impact that LWK has had on wider health and social care systems, where there were high aspirations for LWK to support improvements. Achievement in this area has been very limited due to LWK being unable to be part of shared data systems, primarily the Kent Integrated Dataset (KID), now Optum.

Further, during delivery of LWK General Data Protection Regulation (GDPR) has been introduced which has increased the challenge of data sharing amongst organisations. LWK aims to continue to work with commissioners and partner organisations to identify ways in which data sharing can be better used to improve services for individuals. There are indicators that this will be possible going forward.

GP usage

The impact on wider usage of healthcare services was captured through data collected by Porchlight and further explored in individual interviews.

Self-reported use of GPs was collected at the exit of LWK service. A large proportion – 67.5% (n=5155) did not provide an answer. From those who did, 33.1% (n=823) indicated it has reduce their need to visit a GP, while 17.5% (n=435) did not feel it had impacted on this. A large proportion – 47.5% (n=1180) – did not feel visiting the GP was support they required and as such the question on reduced need was not relevant.

The mixed results from this data is reiterated in the interviewees' responses.

When asked if LWK had affected their use of GPs a small number of individuals responded that it had increased usage. Reasons for this were varied. One individual spoke about how LWK had helped them recognising the importance of staying healthy:

"A little – in the sense that because I had that hope for the future and people to talk to I maybe used the health services more and took care of myself." (SU003)

While another interviewee simply stated they needed to increase GP usage as their mental health diagnosis had changed:

"They have increased as my mental health deteriorated and I needed medication review and assessment." (SU012)

Again, reiterating the survey data, the majority of interviewees shared that either there was no effect or they didn't regularly use GP services, hence no scope for impact.

> A strategic aim of the commissioned model was to build link between voluntary sector and statutory organisations.

Components of the LWK model that are contributing to the effectiveness: Identifying the 'active ingredients'

As noted throughout the report and evidenced in both the quantitative and qualitative data, interventions provided as a part of LWK had a positive impact on those who accessed the service.

A key purpose of the interviews with all groups (i.e. individuals, Porchlight staff, delivery staff and wider stakeholders) was to identify the 'active ingredients' that contributed to this success.

From across all interviews a predominant theme that emerged was how the relationship between staff (Porchlight and delivery partners) and the individual was a key determinant for positive outcomes. The positive impacts were discussed in a number of different ways.

First, an aspect of the service that both Porchlight staff and delivery partner staff felt had a major impact on individuals, and individuals said they were grateful for, and in need of, was the provision of practical help.

Tasks such as form filling, PIP assessment support, telephoning other services on the service-user's behalf, attending appointments and job coaching were deemed a great help.

"…..if you're very upset or you're bereaved or you've got mental health problems and then for someone to actually be able to solve the practical side of their issues is kind of everything to those people" (PS003)

"I helped an individual with a PIP assessment. I prepared him, giving him confidence, and advised on how to answer the questions in the best way" (PS009)

From an individual's perspective there were mixed feelings on this type of support. When received they were appreciative of the input.

"….What was good, they had people that can help find jobs. Helped with my CV. Put me in touch with probation services in case I could volunteer. I got work through an employment agency." (SU016)

"I needed help with finances. Practical help. (They) Helped me with direct debits, housing benefit and transferring money into a bank account." (SU007)

When individuals expressed dissatisfaction with the service, it was generally because they would have liked more help with these tasks.

"I have anxiety and have difficulty filling out forms and chasing things up. They offered some help, but I could have done with more." (SU003)

Leading on from the aspect of practical help, Porchlight and delivery partner staff often described, directly or indirectly, advocating on behalf of the LWK individuals.

This was particularly true when discussing partnerships with the statutory services, such as GP surgeries, mental health and social services teams.

"With one individual I had to liaise with statutory teams constantly. I had to update them on how she was presenting and her social and personal care needs, in order to evidence to them that she was constantly in need. Initially, they wouldn't even give her a psychiatrist appointment. It was like a fight." (PS008)

Individuals seemed grateful for this help, particularly when also describing anxiety.

"Honestly, I said it about five times, and I was going to lose it… She just took over. She said 'I think […] has explained enough to you. She's made it quite clear' I was like 'go on girl." (SU018)

Feeding into the theme of empowerment discussed in impact on personal outcomes, both Porchlight and partner staff spoke of the ability of the service to equip individuals with tools and resources which may help them to deal with problems better in the future.

Two individuals spoke of their experience of groups having a lasting effect on their mental wellbeing. One described a mindfulness-based course which gave out resources to use at home, and one described the impact of attending a talking group with males and the resulting change of personal perspective after hearing other men sharing their feelings.

".. (From the group I was referred to by LWK) I learnt a lot more about my health, so yeah it did help. Structuring and planning and that, a different way of looking at things." (SU010)

A strong theme that emerged from individuals as to why and how the LWK programme had benefited emphasised the importance of feeling listened to for their mental wellbeing, even when they felt no long-term help had been offered. Many cited talking about their problems with somebody face-to-face as a helpful activity.

"I felt that the people from the courses listened." (SU001)

"It was nice knowing that someone was trying to help, even if they couldn't."(SU003)

"She put me at ease, she was easy to talk to, she didn't push me too hard. She was just full of encouragement." (SU012)

Staff from Porchlight and delivery partners described listening to individuals as a priority of Live Well Kent.

"Being there to listen to people." (PS002)

This feedback from individuals and staff reiterates the underlying importance in the LWK model that the support provided is patient-centred, with staff guided by individuals as to how the service can provide support.

The active ingredients of the model from a service perspective were identified through interviews with Porchlight staff, delivery partners and wider stakeholders.

Five main themes emerged from this data as key contributing factors to the success of the model:

1. Accessibility

The term "no wrong door" was used repeatedly within all three professional groups of interview individuals as a major strength of LWK. One of the founding concepts for LWK, that individuals can access the same level of help regardless of entry method into the service, appears to be holding its pivotal position as one of its strongest assets.

The integrated data system for inputting referrals was seen to aid in accessibility, as details could be shared across partners, reducing the need for individuals to repeat their story every time they saw somebody from a new partnership organisation.

2. Role of the strategic partner

Many staff were supportive of Porchlight as strategic lead of the LWK service. They felt that a singular mouthpiece for a wide group of voluntary organisations was helpful in the time pressured areas of health and social care, particularly when working with statutory organisations.

Porchlight themselves were described as responsive and open to change, with several staff members describing issues that had arisen within LWK and their satisfaction at the way Porchlight had handled the issues, whether able to accommodate a solution or not.

"We're really pleased [with Porchlight], and we're pleased that they're pleased with what we've done." (DP002)

"Porchlight is always willing to listen to feedback and will give feedback in return." (DP006)

Several staff from partnership organisations discussed an appreciation for the lack of hierarchical structure within the LWK service. Some spoke of an initial apprehension with concern mainly focused on additional work or changes in existing systems that were needed, but most felt that mutually beneficial relationships had been forged, with Porchlight fully utilising the knowledge and experience offered by other organisations.

"The process is lengthier, but we adapted. We needed more resource to hit the performance indicators, but apart from that, nothing too radical." (DP001)

3. Partnership working

Staff from various organisations felt that partnership working amongst voluntary organisations has been nurtured by the LWK programme. When asked directly whether LWK has had an effect on partnership working, many staff spoke

One of the founding concepts for LWK, that individuals can access the same level of help regardless of entry method into the service, appears to be holding its pivotal position as one of its strongest assets.

highly about the quality of key partner organisations that they feel they are working well with.

"We're all coming from different places, different organisations, but what we have in common is that we're all there for individuals […]. We're all there to help their mental health and wellbeing, so by working together we're going to […] achieve more."(PS011)

It was also noted that this collaborative working has promoted person-centred working.

"Working in partnership means we can discuss the individual and find out what's right for them and help them move forward. LWK has helped put the individual at the centre of what we all do." (DP001)

A number of interviewees also mentioned how partnership working has been facilitated by holding regular meetings for delivery partners or attending networking events.

"We attend the LWK focus group and always referring to each other." (DP003)

"We attend focus group meetings, every couple of months. One in Thanet and one in the South East Coast. Take along a couple of peer support/ volunteers which helps with exchanging referrals." (DP002)

Those who did not feel they had gained in term of partnership were, in most cases, already working closely with these other organisations before the implementation of the LWK service.

"LWK hasn't made a huge difference. Not a failing of LWK, we've been around for 30 years so we're already well known. Historically we've done a lot of relationship building." (DP005)

Although the feedback on partnership was predominately positive across both Porchlight staff and delivery partners, a minority of interviewees felt there was still room for improvements across the partnership.

For example, an interviewee described experiences of meeting individuals at delivery partner organised groups and meetings and questioned why the delivery partners had not referred to the Porchlight service when encountering a need they felt their service could meet perfectly.

"I spoke to a woman and asked if she'd like to self-refer to us. Why wasn't she referred to us?" (PS007)

A minority of individuals felt that partnership working with statutory organisations had improved, although these individuals also felt these relationships would have been in place regardless of LWK.

"We had good connections anyway but it has improved." (DP002)

"Slightly. GP surgeries go to a lot of the meetings. LWK networking events help the working relationships as we can talk with potential referrers. Good working relationship but (feel) we would have had that anyway." (DP006)

"Working quite well with them (statutory services) currently. I don't know if that's to do with LWK or not. We've been around a long time so have built up good relations anyway. Used to share a building." (DP010)

4. Staff knowledge and experience

Some interviewees acknowledged the high level of staff knowledge and experience. Many of those participating in the interviews had worked in similar areas for many years and spoke of the knowledge and experience that they and their colleagues held in their chosen areas of work, and the usefulness of sharing this knowledge and experience with partners within LWK for the benefit of the individual.

5. Communication

Staff and wider stakeholder interviewees spoke positively about communication within LWK. It was said that feedback is given regularly, and good performance is acknowledged and praised. Staff from various organisations felt that they were kept up to date with any changes within LWK, and most seemed confident in feeding any issues which have arisen or may arise in the future back to senior staff within Porchlight. Staff were complimentary in their discussion of the regular LWK meetings hosted by Porchlight.

Problems with internal communication within Porchlight were raised by two interviewees from partner organisations. One said they had had problems connecting with the IT team in the past.

Several individuals stated that they would like to see an improvement in communication. More than one had 'lost contact' with the LWK service, and others were unaware that they had been discharged and had been expecting a letter with a summary of their use of the service.

Impact of Live Well Kent on the wider voluntary sector

A specific question was included in the interview guide to capture thoughts on this topic as the original vision of LWK was centred on building networks between voluntary sector organisations and collaborating to ensure the delivery of person-centred care. With this in mind it was important to explore this aspect in more detail.

In response to this question staff across the interview groups expressed a keenness to continue to work on partnerships, with many sharing the opinion that there is potential for LWK to continue to develop and improve services offered to individuals.

Most of the staff interviewed listed specific organisations within the LWK programme with whom they work well. However, when questioned further, it appeared that many of these were not partnerships gained since the implementation of LWK. Staff were clear that this was not a criticism of LWK; but rather an indication of how well they were already working in partnerships before its implementation.

Delivery partners find the LWK collaboration helpful. Overall, partner staff spoke positively of the programme, describing how closely they work with various organisations and how this benefits the individual. Cross-referring was highlighted as a key beneficial feature of LWK. A shared knowledge base and the opportunity to face challenges and issues together were considered strong assets of LWK partnership working.

"Working in partnership means we can discuss the individual. LWK has helped put the individual at the centre of what we all do." (DP001)

There was also a sense from interviewees that LWK had overall improved access to services. Staff from Porchlight and partnership organisations appeared pleased to be able to offer individuals a wide range of services. Those that had been working in their roles for longest spoke of their usage of other services frequently, and easily described positive outcomes for the individual as a result of these links.

"In DGS and Swale there are 16 funded services, but they network with over 100 voluntary sector organisations. There's nothing else like that."(WS003)

Sharing physical space was discussed as a facilitator of closer partnership working with several members of staff. Shared office buildings and events where various organisations attend together were both mentioned as useful tools for bringing partner organisations closer. One staff member spoke about the perceived comparative ease of referring an individual with a staff member that they had already built a rapport with in person.

"I go to a lot of networking events, so you don't feel bad about calling people up and. It's a warmer handover." (DP001)

Impact on knowledge and awareness of services available in the local communities changed

"[Live Well Kent] promotes the knowledge of local communities; of what's available to access" (DP001)

As mentioned previously, some staff discussed an improvement in local service availability as a result of LWK implementation. This was especially true within certain, more rural, areas. Churches were particularly valued in smaller communities. Other staff talked about their discovery of community assets which already existed but had a low profile within the community and to health and social care staff. The aim of tailoring care around an individual's particular needs, and a willingness to help however possible, leads staff to make enquiries and utilise a broad range of groups and settings with both referrals and signposting.

"Refer to health trainers; anything that's going to help people live better." (PS002)

"We have no issue referring to any service that fits an individual." (PS009)

Workers from Porchlight and partners repeatedly told of how they do not feel confined to the LWK network; feeling they can approach any organisation. Porchlight staff, in particular, made it clear that they were used to meeting individuals within a broad variety of community settings including libraries, community hubs, GP surgeries, cafés and job centres. They spoke positively about their use of these settings, especially in relation to the rapport they build with establishment staff. They appear to prioritise flexibility for the individual, wherever possible, and have constructed good local knowledge bases from this way of working.

> "We're all coming from different places, different organisations, but what we have in common is that we're all there for individuals... by working together we're going to achieve more."

Porchlight and partner staff discussed the creation of "drop-in" services in collaboration with both statutory and voluntary organisations and felt individuals benefited from the ease of access and joint working. Other useful assets mentioned include leisure centres, theatres and allotments.

What could be improved, replicated and sustained?

Using feedback from the qualitative and quantitative data collected throughout this evaluation, the below recommendations are made on areas for improvement or future consideration for LWK. These are focused on what has worked, what there could be more or less of and where there may be gaps in provision that LWK or others could address.

Overall, members of all four interview groups expressed a hope for LWK funding to be continued for as long as possible. Some individuals envisioned more funding for a larger, broader LWK workforce to meet demand.

1. Responding to changing mental health need within primary/local care

Since LWK was introduced the level of need for mental health services in Kent has changed significantly, or at least is different from the anticipated need. As can be seen from this evaluation, the proportion of people entering LWK with SMI compared to CMI is much higher than initially intended when the service was commissioned (30.7% compared to a target of 22.4%). This may be due to underestimating this demand based on information available at the time. However, a key contributing factor has been the ability of secondary mental health services to support those individuals as a result of differing eligibility criteria as well as workforce challenges. LWK, as a universal service, is an obvious choice for people to refer to when they are unable to access secondary care.

Interviews with individuals from Porchlight and partnership organisations also perceived a need for further assistance in working with individuals presenting with complex issues such as suicidal ideation and self-harm.

It can be seen through the referrals into LWK that there is a growing gap in provision for people who do not meet the new threshold for secondary care and where LWK is not currently designed to meet their needs.

There is therefore a need to ensure that the LWK workforce is suitably trained and supported to effectively work with people with SMI, as well as recognising when more specialist mental health support is needed. While LWK is able to support people with SMI, this is not the focus of the service and it has not been designed to allocate as much resource on this group as could be needed. This includes having the flexibility and specialist support available to work with people with more complex needs.

Porchlight have taken a number of actions to more effectively support people with higher/more complex needs within LWK. These include improving training, pathways for support and risk management processes. It will be important to continue to develop these areas as well as exploring opportunities to better meet the need of those individuals unable to access secondary care.

2. Supporting the development of a better integrated mental health sector in Kent

Through LWK, major gains have been made in reducing fragmentation and duplication of primary care mental health services in Kent. This is in line with the aims of the Community Mental Health Framework for Adults and Older Adults and it will be important for LWK to continue to align with these plans along with the NHS Mental Health Implementation Plan 2019/20 – 2023/24 and the NHS Long Term Plan.

Despite much progress being made to ensure more effective pathways, there remain a number of challenges to be addressed as the LWK services continues. Some of these are beyond the scope of LWK but many are areas where LWK can play a role in creating a more streamlined local health sector.

The key challenges relate to individuals' journeys through services. The acceptance criteria used by all involved organisations could benefit from clarity. Several staff members described uncertainty as to whether referrals to certain agencies were likely to be accepted and this was reflected in interviews when some individuals described being signposted to organisations which were not, ultimately, able to help.

"The biggest barrier is communication but there are also some really hard to access services." (PS005)

It would be useful for LWK staff to receive clear and consistent feedback on the reasoning behind acceptance or rejection of referrals to differing organisations, such as the Community Mental Health Teams and IAPT, to create a more consistent picture of the intended role of LWK within the wider health and social care service. There currently appear to be large differences in expectations placed upon statutory services. LWK would therefore benefit from clearer messaging, particularly for people who receive support, to help manage their expectations around the parameters of the service.

Some staff raised concerns over the potential for duplication with similar initiatives within Kent (e.g. social prescribers and care navigators). A desire for close working with the staff of these initiatives were shown by staff with either opinion.

"It's important that we engage and cross-refer with partnership working and an understanding of each other." (PS012)

> Staff appear to prioritise flexibility for the individual clients, wherever possible, and have constructed good local knowledge bases from this way of working.

To better reduce duplication and move towards a place-based model of mental health as LWK intends, it is important to continue to explore gaps in provision including the achievement of systems outcomes and how these can be managed. Greater access to data systems to understand individual's journeys would be beneficial.

3. Outcome measures and data

A large amount of data is collected within LWK and this is a resource intensive process so it's important that the data collected is relevant and allows effective analysis. The quantity of measures used and the administration of recording these raised questions amongst both Porchlight and delivery partner staff. It is important for staff to understand why they are collecting information so that they can communicate this to people accessing services.

Concerns were raised regarding the capabilities of the measures to capture a faithful representation when faced with the fluctuations associated with mental ill health, particularly for those with SMI. Another potential problem raised is that the categories of CMI and SMI are sometimes self-reported by individuals, potentially providing a barrier to the accurate image portrayed by individual statistics.

Much of the data collected is a requirement of commissioners and therefore must be included. Porchlight has begun the process of using logic models to improve understanding of how services operate and their impact. These are useful for guiding the types of measures that a service uses to evidence achievement of goals.

Evaluations can also highlight additional areas to explore and this may mean a reassessment of data collection methods. For example, this evaluation has highlighted that some of the greatest improvements on SWEMWBS are in relation to people feeling more optimistic about the future and this may be an area for greater exploration.

This evaluation has also highlighted the limitations of some measures, in particular SWEMWBS. To gain a fuller and more insightful understanding of service performance, a number of other measures have been introduced – for example MYCAW and De Jong Gierveld loneliness measure. Work still needs to be done to refine the use of them within LWK but it is important to continue to develop these measures to ensure an understanding of performance in relation to the LWK model of primary, secondary and tertiary prevention. In particular, the development of measures appropriate for tertiary prevention support will be useful to LWK.

4. More flexible time constraints

This evaluation has indicated that many people plateau in terms of the length of support they receive and that after a time LWK is limited in how much it can achieve with an individual. Porchlight and delivery partner staff also emphasised the importance of reducing individuals' dependency on services by setting time limits to create beneficial boundaries.

However, for some people there can be seen to be need for longer term services to achieve lasting outcomes and truly deliver a prevention service. This is highlighted by the largest improvements being made by people who have been supported for over 4 months and that most people returning to LWK access recovery services - 40% for second service and 50% for third service accessed.

Some staff highlighted that it would be useful to have the flexibility to support individuals for longer where this was needed.

Those returning to LWK – indicating a need for longer term support – are more likely to come from areas of deprivation and experience greater complexity of need. As people re-enter LWK they are more likely to access recovery services where there is a longer-term focus. This indicates that to achieve the tertiary prevention aims of the LWK model – including those services where SWEMWBS improvement is highest – it may be necessary to make more longer-term services available. This is reinforced by the higher proportion of SMI individuals accessing the service than expected and the need for LWK to adapt to meet this need.

It will be important for LWK to continue to review, with commissioners, the opportunities for longer term support available for people where a need is identified.

5. Improved working with statutory services

Similarly to the recommendation for LWK to continue supporting the development of a better integrated mental health sector in Kent, it is important for LWK to continue to improve the way in which it works with statutory services. These working relationships and pathways make a significant difference in the quality of service provision and outcomes for the people LWK supports.

As highlighted in discussions on working with statutory services, interviewees felt there were some scope for improved working practices. When asked how this could be achieved the following suggestions were put forward:

- More meetings between the sectors with relevant individuals
- Better communication between the sectors
- Smoother referrals process
- More appropriate referrals to LWK from statutory services. Recognised this may be in part due to a lack of knowledge and understanding of LWK
- More information about risk management for highly vulnerable individuals
- Named contacts in statutory services for LWK staff
- Appoint an individual whose remit is to act as link between the sectors – for example, a liaison post or a lead voluntary partnerships nurse

There may be opportunities in the future for LWK to demonstrate the ability of community services to help statutory services address their workforce challenges.

Through continued developments of LWK staff in response to a changing mental health arena and by utilising more creative approaches from the voluntary sector, there is likely to be further scope for LWK to help statutory services meet the demand.

A more strategic approach to working with commissioners to achieve this could have significant benefits throughout the health and social care pathways.

SUMMARY

This mixed-method evaluation of Live Well Kent explored the impact on both the individuals who accessed the interventions and the wider system changes stimulated by LWK.

The service had wide reach into target areas of high deprivation, providing support to individuals with a range of mental health needs – including people with more complex needs than the service was initially designed for.

Overall, data suggests that LWK had a positive impact on people's mental health and wellbeing. This improvement remained stable across gender, age, mental health diagnosis/need, length and type of service.

The LWK model can also be seen to be a cost-effective means of meeting primary care healthcare needs. The SROI analysis indicates a SROI ratio of £4.55 of social value created for every £1 of investment. This has the potential to be higher if wider benefits of LWK, such as housing and employment, are included in future calculations.

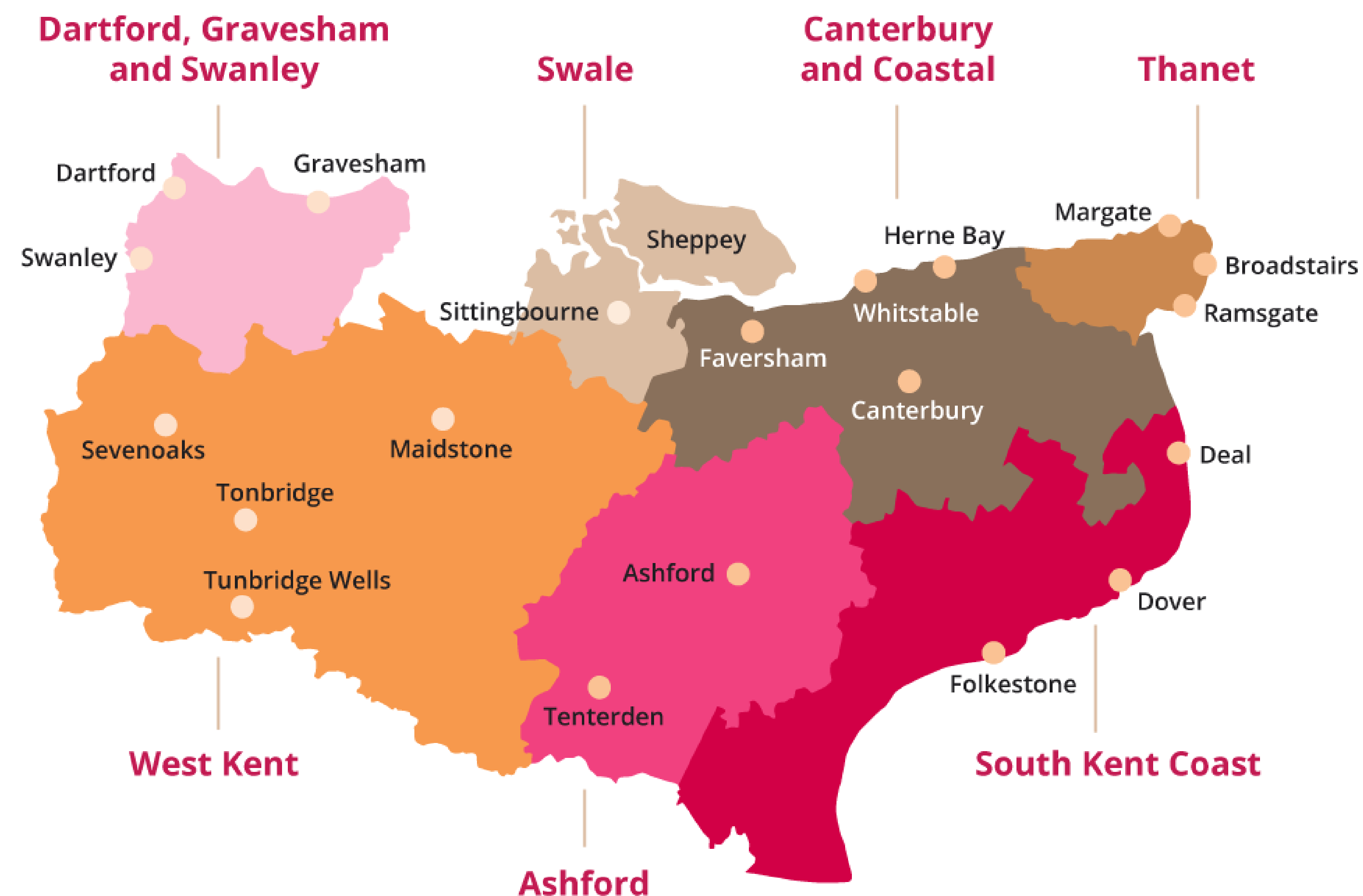
Some services or elements of LWK can be seen to achieve greater improvements with individuals and the reasons for this should be explored further. This includes housing support services and those services focused on the tertiary prevention element of the model. There is also a suggestion that the availability of longer-term services within LWK could have a significant impact on the improvements made with some individuals, including those from areas of deprivation and people with SMI.

In addition, interviews illustrated that partnership working is a strong element of LWK, enabling a person-centred approach. The no wrong door approach taken by the service is also positive with Porchlight staff in particular focused on ensuring that individuals are never turned away without receiving some form of support. This often requires a flexible approach.

The impact of LWK on the voluntary sector was felt by Porchlight staff, delivery partners and wider stakeholders to have been generally positive. Advantages such as cross referring between services, a shared knowledge base and opportunity to face challenges together were identified during interviews. It was also felt that LWK has enabled, to an extent, greater access to services and closer working of the voluntary sector as well as greater use of assets already existing within the communities it serves.

There are a number of key areas where there will be opportunities for LWK to improve performance in the future. These include:

- Exploring opportunities to better support those people who do not meet the threshold for secondary mental health care but need more intensive support than LWK is currently designed to provide;
- Continuing to support a more integrated mental health sector in Kent – including attempting to gain access to data systems which would enable better systems outcomes;
- Review outcome measures to ensure that LWK is utilising those best able to provide effective insight into the services provided;
- Explore the potential to increase flexibility of time that people can be supported for, enabling greater achievement in tertiary prevention;
- Work with commissioners to explore areas where LWK has the potential to help address statutory workforce challenges.



APPENDIX A

Porchlight's delivery network

As a strategic partner for Live Well Kent, Porchlight is contracted to commission and manage a network of delivery partners and build links to wider services.

Porchlight has positive working relationships with its delivery partners, with a focus on working together for the good of those who need to access the services. Delivery partners make referrals to each other, ensuring a smooth pathway for clients.

Porchlight values and respects the breadth of experience within the Live Well Kent network and has worked with partners to provide more recovery focused services. The peer support offer has been increased and outreach to under-represented or at risk groups has been commissioned including to BME communities, young people and the LGBT+ community.

Performance has been maintained or improved through detailed service specifications, comprehensive reporting and accountability and close monitoring of services. Payment by results has been linked to key targets for each delivery partner and where poor performance has not improved, partners have had their contracts reduced or ended.

Porchlight has helped organisations to build capacity by sharing best practice and training, auditing and giving opportunity for innovation through specific funding. Delivery partners have access to detailed management reports on the Live Well Kent database and have been able to use the information for other funding applications.

A survey of delivery partners shows 100% satisfaction rate with Porchlight as strategic partner. Partners have described equal commitment to improving the quality of life for people living with mental health illness.

> A survey of delivery partners shows 100% satisfaction rate with Porchlight as a strategic partner.

APPENDIX B

Ethnicity breakdown

		Frequency	Percent
Valid	White British	6613	88.4
	White other	209	2.8
	White Irish	61	.8
	Mixed White Black	57	.8
	Mixed White Black African	18	.2
	Mixed White Asian	17	.2
	Mixed other	55	.7
	Gypsy	15	.2
	Chinese	21	.3
	Black/British other	20	.3
	Black British Caribbean	47	.6
	Black British African	85	1.1
	Asian Pakistani	11	.1
	Asian other	37	.5
	Asian Indian	150	2.0
	Asian Bangladesh	10	.1
	Arab	7	.1
	Not disclosed	51	.7
Missing	Total	7484	100.0
	System	154	
Total		7638	

APPENDIX C

Housing breakdown

		Frequency	Percent
Valid	Any other temporary accommodation	160	3.0
	B&B	60	1.1
	Children's home	4	.1
	Direct access hostel	11	.2
	Foyer	2	.0
	HA general needs tenancy	556	10.3
	Approved probation hostel	5	.1
	HO asylum	1	.0
	Hospital	2	.0
	Housing for older adults	30	.6
	Living with family	777	14.4
	Living with friends	83	1.5
	LA general need tenancy	528	9.8
	Losing tenancy arrears	12	.2
	Losing tenancy court order	2	.0
	Losing tenancy landlord no benefits	1	.0
	Losing tenancy selling	12	.2
	Mobile home	60	1.1
	Other	152	2.8
	Owner private	536	9.9
	Owner low cost	31	.6
	Prison	2	.0
	Private sector	1537	28.5
	Private sector shared	78	1.4
	Residential care home	11	.2
	Rough sleeping	137	2.5
	Short life housing	10	.2
	Sofa surfing	490	9.1
	Squat	2	.0
	Supported housing	95	1.8
	Rented with job	2	.0
	Winter shelter	1	.0
	Women's refuge	7	.1
	Total	5397	100.0
Missing	System	2241	
Total		7638	

APPENDIX D
(SEE TABLES OPPOSITE AND OVER PAGE)

Live Well Kent pathway to independence model

The Live Well Kent model of support focuses on three key areas of prevention within the mental health pathway:

1. **Primary prevention**; community conditions and factors such as social networks, housing, crime, community assets; strengthening communities to improve wellbeing and mental health.
2. **Secondary prevention**; Early intervention services.
3. **Tertiary prevention**; focused support to enable the best chance of sustainable recovery.

The model delivers services and projects which support these three areas, using an evidence based approach and relevant outcome measures. The model reflects a more selective and targeted approach to prevention through LWK's work in the most deprived communities as it is known this increases risks around mental health issues, with many of the people supported already showing early indications of mental health issues, including diagnosed mental illnesses.

PRIMARY PREVENTION

Evidence base
- Local needs mapping for each CCG area, working with colleagues in Public Health Observatory, identifying risk factors for loneliness, including mental health prevalence
- Live Well Kent data
- Indices of social deprivation
- JSNA
- Marmot Review 2010
- Joseph Rowntree research and guidance on poverty interventions

Offer
- Community Asset Development
- Capacity building smaller community organisations
- Partnership work
- Innovation Funding

Service and project examples
- Community asset database
- Dartford & Gravesend wellbeing network
- Eastern Sheppey mental health project
- Innovation projects

Outcome measurement
- Shortened Warwick Edinburgh Mental Wellbeing Scale (where the individual's
- Involvement supports their wellbeing)
- Community surveys (pre and post intervention)

SECONDARY PREVENTION

Evidence base
- Local needs mapping for each CCG area, working with colleagues in Public Health Observatory, identifying risk factors and mental health prevalence
- Live Well Kent data
- Indices of social deprivation
- Kent Housing Group
- JSNAs
- CCG local plans
- National Housing Federation data and reports
- Crisis Homelessness Monitor 2018

Offer
- One-to-one staff support sessions in community settings, GP practices and drop-ins
- Pathways to specialist support services and advice as needed
- Making Every Contact Count approach
- Workshops
- Case management
- Access to pro bono legal advice
- Local authority working partnerships
- Referral into other Live Well Kent services as appropriate
- Referral to increased mental health support alongside housing intervention as needed

Service and project examples
- Porchlight community link service
- Porchlight community housing service
- Christians Against Poverty
- Rethink Asian helpline

Skills, training and resources
- Motivational interviewing
- Local asset mapping and database of services
- Community advice drop-ins
- Housing law training and updates (NHAS)
- Hodge Jones & Allan housing solicitors (pro bono support)
- Local partnerships for specialist support as needed

Outcome measurement
- Shortened Warwick Edinburgh Mental Wellbeing Scale
- Measure Yourself Concerns & Wellbeing (MYCAW)

TERTIARY PREVENTION

Evidence base

- Local needs mapping for each CCG area, working with colleagues in Public Health Observatory, identifying risks and mental health prevalence
- Live Well Kent data
- Analysis in Live Well Kent focus groups with service users and delivery partners
- ImRoc resources
- What Works Well Loneliness Practice Guidance
- Campaign to End Loneliness research and guidance
- Individual Placement & Support (IPS) Mental Health Employment model

Offer

- Community engagement services – one to one support with staff, leading to support from a volunteer to develop social skills and confidence
- Peer led recovery groups; one-to-one, online communities; pathways which can lead to training to become a peer worker
- Group recovery activities focused on shared interests – allotment, cookery, football, drama, arts, photography
- Group support shared experiences – personality disorder, LGBT+, anxiety and depression, bipolar
- Courses – Mindfulness, Coping with Life, Coping with Depression, Recovery
- Primary Care mental health clinical support
- IPS employment services; one to one work, employer engagement, group work sessions, CVs, interview practice
- Pathway to Porchlight's Aspirations service for those furthest from work

Skills, training and resources

- Recovery practice
- Motivational interviewing
- Coaching techniques
- Group facilitation
- Volunteer management
- Peer support training programmes
- IPS employment services
- Fidelity Scale training (managers)
- Local employer relationships and networks
- Royal Society for Public Health Connect 5 training
- Royal Society for Public Health Connect 5 training for employers
- Clinical governance

Service and project examples

- Porchlight community inclusion service
- IPS employment services (Rethink, North Kent Mind Springboard, Shaw Trust, Porchlight)
- Swale Your Way health & wellbeing services (includes one-to-one support, shed and allotment groups, creative writing, football therapy)
- North Kent Mind wellbeing services (including coping with life courses, mindfulness sessions, and a recovery group)
- East Kent Mind wellbeing services (includes support for coping with depression, anxiety & depression, and confidence & self-esteem)
- South Kent Mind wellbeing services (includes arts & crafts projects, mindfulness, SELF course, BME and young people's projects)
- Rethink peer support group
- Rethink Sahayak (BME specialist service)
- Richmond Fellowship (recovery workshops, peer leadership course)
- Take Off peer support (includes managing depression, creative sessions and cooking)
- Speak Up CIC peer support and social groups (including SpAce art group, LGBT+ group, weekend group and Night Owls online group)
- MEGAN CIC (personality disorder peer support)
- Invicta Health Primary Care Mental Health Specialist Service

Outcome measurement

- Shortened Warwick Edinburgh Mental Wellbeing Scale
- De Jong Gierveld Loneliness Scale
- IPS employment services fidelity scale
- Employment-based outcomes (work readiness, training, CV support)
- Job outcomes
- Job sustainment outcomes

APPENDIX E

Live Well Kent employment service for people with SMI

	Sign ups		Achieved 16+ hours employment		Sustained 13+ weeks 16+ hours		Sustained 6+ months 16+ hours	
2016	29		16		7			
	58		14		15		5	
	72		13		11		13	
	78	237	15	58	13	46	8	26
2017	68		32		11		11	
	103		18		26		10	
	60		20		16		25	
	67	298	25	95	17	70	10	56
2018	104		41		20		12	
	56		22		34		18	
	68		33		17		27	
	65	293	34	130	21	92	10	67
		828		283		208		149

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On behalf of

by