mPower
Healthy & Connected Communities

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Evaluation of the mPower Project 2017-2022

Executive Summary

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Introduction

This report presents the findings from the evaluation of the mPower project. The project aimed to deliver social prescribing and eHealth interventions within deployment sites in Scotland, Northern Ireland and Ireland.

Social prescribing is any activity in which a non-pharmaceutical intervention is recommended or provided to people with a non-clinical need such as loneliness, social isolation or low-level depression. eHealth interventions are any use of digital technology to promote health, wellbeing, self-management or efficient and appropriate use of statutory or private healthcare services.

This report examines the outcomes from the mPower project as evidenced through qualitative and quantitative work, as well as the differences and similarities between mPower deployment sites. Our evidence mainly consists of interview data gathered from a range of stakeholders including beneficiaries, local staff, mPower Project Board members, primary care representatives and third sector representatives, as well as questionnaire data collected by Community Navigators.

Social Prescribing and eHealth – the Policy Context

The health, care and wider ageing and community policy contexts within each of the mPower partner areas appear to be conducive to supporting both eHealth and social prescribing implementation. Scottish health policy indicates digital technology will play an important part in achieving the Government's person-centred vision for health. Social prescribing is also central to the Government's strategy on self-management of long-term conditions. In the face of an ageing population and limited funding, Northern Ireland is seeking to maximise the potential of technology to develop and modernise its health and care system to make it more responsive and better focused on the people it serves. According to the eHealth Strategy for Ireland, eHealth is a critical enabler of best-practice health systems and optimum healthcare delivery, and the ROI has a framework that aims to mainstream social prescribing.

Existing Evidence on Social Prescribing and eHealth

Common positive outcomes from social prescribing identified in the existing evidence base include increases in self-esteem and confidence; improvements in mental wellbeing; reductions in anxiety and depression; and reductions in social isolation. However, there is a lack of evidence on whether social prescribing decreases non-clinical primary care usage.

Several eHealth interventions were more numerous within the mPower deployment sites: home alarms (pendants and wristbands); Florence (text-based medication reminders) and video conferencing (VC) through the NHS Attend Anywhere system, known as NHS Near Me in Scotland. Home alarms have been shown in the existing evidence base to contribute to enabling older people to live at home, and as independently a

possible, for as long as possible. As a text-based reminder system, Florence has been shown to have a positive impact on self-management. Video conferencing has also shown positive outcomes when it is used in clinically appropriate situations. In addition, communications technology has been shown to reduce social isolation of older people. The use of technology has rapidly become more widespread since the beginning of the COVID-19 pandemic.

Methodology

Our evaluation of the mPower project took a realist approach (Pawson and Tilley, 1997). Its key principle is that the context in which an intervention takes place determines whether the intended outcomes are achieved. Realist evaluation aims to identify the underlying generative mechanisms that explain 'how' the outcomes were caused and the influence of context.

Multiple data sources have been used in our evaluation, including eHealth readiness questionnaires; baseline deployment site data; beneficiary questionnaire data; qualitative interviews; and observational notes. Interviews have been undertaken with mPower project beneficiaries (56); Community Navigators (20); Implementation Leads (12); primary care staff (14); third sector staff (14); mPower Business Leads (1); mPower Programme Manager (1) and mPower Project Board members (18). Participant observation has also been carried out at three deployment sites. Interview transcripts and observational fieldnotes were analysed within the NVivo software package, using thematic analysis.

As interview participants were recruited through local mPower teams, the sampling may not provide a holistic picture of the range of beneficiaries and other stakeholders involved in the mPower project.

Quantitative beneficiary data was collected between May 2018 and May 2022 through baseline and follow-up questionnaires which were administered by project Community Navigators.

Overall Project Targets

mPower has achieved its target number of digital health interventions and Wellbeing Plans. Just over half of the digital health interventions and Wellbeing Plans have taken place within the Scottish deployment sites.

Our evaluation has shown that context and approach to service delivery are central to understanding the generation of outcomes within each deployment site and for the mPower project as a whole. The Scottish sites, for example, have benefited from having mPower staff in post quicker and employing staff already familiar with the landscape of their local areas. Their work has been aided by embeddedness within multi-disciplinary teams (MDTs). In addition, their eHealth readiness assessments generally show environments more conducive to the use of (innovative) technology.

The highest overall numbers of both eHealth beneficiaries (1,722) and Wellbeing Plans (762) were reported by NHS Ayrshire and Arran. The beneficiary figures for NHS Dumfries and Galloway are the second highest within the project and they have the greatest reach of

any of the deployment sites – equating to reaching approximately 20% of their over 65s population. Relatively high numbers of beneficiaries were also reported for the Southern Trust (929 eHealth and 427 Wellbeing Plans).

Local Identity

Areas in which higher numbers of Wellbeing Plans have been completed, tended to have fairly well-developed identities as 'specialist' social prescribing providers for older people. Areas in which staff reported feeling unsure about mPower's role in eHealth service provision tended to have lower numbers of eHealth beneficiaries.

Connections to Primary Care and the Third Sector

Evidence shows that Community Navigators and Implementation Leads have put a lot of time and effort into establishing connections to primary care and local third sector organisations. The amount of effort was sometimes greater for those staff who had not previously worked or lived within their deployment site. We have seen evidence that effective social prescribing requires good links to both primary care and the local third sector. It was a difficult task for Community Navigators to both build these links and to carry out the Wellbeing Plans/ interactions with beneficiaries. Community Navigators and Implementation Leads being physically based within the same space as multidisciplinary teams/primary care, and being embedded within the broader health service or third sector, were seen as facilitators of success.

The Relationship between Community Navigator and Beneficiary

Across all deployment sites, the relationship between Community Navigator and beneficiary was central to the generation of outcomes. Beneficiaries highlighted, for example, that they were able to engage with the project and achieve health and wellbeing outcomes because Community Navigators visited them in their own home, spent an adequate amount of time with them on each visit, and demonstrated genuine engagement and caring in interactions with them. Community Navigators were shown to be flexible, adaptable and in possession of a considerable skill set. This was also evident in the ways in which they adapted to keep the service going through the COVID-19 pandemic.

The Community Navigators have been shown to have the power to act on the social determinants of health. The importance of the human contact that they provided for older people, who may be experiencing loneliness and isolation, is hard to overemphasize. It is the relationship between Community Navigator and beneficiary that is the foundation of much of the generation of positive outcomes within the mPower project. However, this role carries with it a not inconsiderable burden in emotional terms. Evidence suggests that Community Navigators could be further supported through more formal debriefing processes and peer support.

A Broad Approach to eHealth

Numbers of eHealth beneficiaries are higher in the Scottish sites that report the adoption of a broad conceptualisation of eHealth. For example, the use of video conferencing software for social interaction (rather than just interaction with a healthcare professional) supports older people's self-esteem and wellbeing. Supporting the use of technology for increased social connection has the potential to increase self-esteem, reduce depression and alleviate anxiety.

Increasing Beneficiaries' Confidence and Empowerment

There is evidence that engagement with the mPower project increased beneficiaries' confidence and sense of empowerment – this is largely through their interactions with Community Navigators and the completion of Wellbeing Plans. We have seen how the process of a guided conversation and goal setting with a Community Navigator is particularly important in generating confidence and empowerment for the beneficiaries.

Reducing Loneliness and Social Isolation

There is evidence that interaction with mPower led to reductions in loneliness and social isolation. This is the outcome most frequently discussed by beneficiaries, staff, third sector representatives and interviewees working in primary care. Group activities, in particular, were considered to contribute to the realisation of this outcome. From the overall quantitative sample of beneficiaries, 20% reported reductions in loneliness on the measurement scale between baseline and follow-on. However, the proportions experiencing decreases were much higher within deployment sites Western Trust (52%) and HSE CHO1 (48%) and much lower in Ayrshire and Arran (8%). The positive changes were statistically significant for those with depression.

Enhancing Mental Wellbeing

Evidence suggests that interaction with mPower contributed to maintaining or enhancing older peoples' mental wellbeing. Our analysis suggests that it is social prescribing, and in particular, the nature of the contact with the Community Navigator, that generated a positive impact on mental wellbeing. However, there are also examples of eHealth and technology solutions contributing to the enhancement of mental wellbeing. From the overall quantitative sample of beneficiaries, 18% reported an improvement in life satisfaction between baseline and follow-on. However, proportions were much higher in deployment site HSE CHO1 (42%) and the Western Trust (40%). Proportions were also higher for those with depression (48%), chronic pain (39%) and chronic kidney disease (31%).

Facilitating Self-Management

There is some evidence from the analysis of our qualitative material that mPower encouraged older people to engage with self-management behaviours. This was most often seen as a result of an interaction with a Community Navigator that kick-started a change in behaviours. In our quantitative sample, 72% of respondents said they felt more confident managing their long-term conditions on a daily basis after their interaction with mPower. Again, this was higher for those living with depression (44%), chronic kidney disease (40%) and chronic pain (33%).

Safety of the mPower Approach

Generally, mPower stakeholders felt that social prescribing and eHealth are both acceptable and appropriate ways to facilitate self-management and to improve physical and mental health, and that safety issues do not outweigh the positive outcomes that can be achieved.

Impacts on Primary Care

Interviews with beneficiaries do not suggest that interaction with mPower affected their level of primary care attendance. This may indicate that 'frequent flyers' were not always targeted for referrals. For beneficiaries who were referred for social prescribing and completed their follow-up questionnaires before the COVID-19 pandemic, there was no statistically significant difference between the number of primary care appointments attended before mPower and during participation in mPower (n=305).

Benefits of the mPower Project-Level Approach

Many of the local staff cited a key benefit of the mPower project-level approach being that it gave them the ability to 'pick up the phone' and speak to local staff in other sites if they had a problem or concern they wanted to discuss. The presence of the central operational service spanning the deployment sites took some of the pressure off project leads once this central team had been established.

Challenges with the mPower Project-Level Approach

The main challenges discussed by interviewees surrounded the non-realisation of their expectations of mPower prior to starting in their project posts. Commonly, they had the expectation that there were joining a team to implement a specific service and eHealth solutions, that would be centrally provided by mPower. Participants expresses disappointment that these expectations were not realised.

Cross-Border Knowledge Exchange

Interview participants sometimes struggled to describe ways in which effective shared learning had taken place, although many accepted it did occur. Even when opportunities for shared learning were available, the cross-border aspect of the project meant that learning was not always easy to transfer across areas. However, not all shared learning was formal e.g. workshops or classroom settings. Many effective instances of shared learning occurred on a 1:1 basis between professionals introduced in mPower where exploring the different contexts was instructive. Furthermore, the introduction of case studies to project assemblies was broadly welcomed by local staff as it provided a good platform to communicate about challenges and approaches to service delivery across deployment sites. The introduction of ECHO sessions was also viewed as making a positive contribution towards knowledge exchange.

Project Legacy

A concern often raised by local mPower teams and Project Board members alike was whether mPower would have a meaningful legacy. In particular, they raised concerns about the ability to embed Community Navigator posts within their local systems. It is important to build in an understanding of the potential legacy of short-term projects from the outset.

Relationships between mPower and community organisations were considered key to creating a legacy from mPower; as was alignment with national strategy and policy. mPower has built pathways that can be sustained longer term, provided the networks built are strong enough. Again, this is dependent on how embedded mPower was in the local health and social care structures, as well as the third sector. Several deployment sites have set up Community Digital Hubs which will ensure legacy.

Implications and Conclusions

Whilst work has been done to ensure the legacy of mPower, fully embedding and mainstreaming the type of services started during the project requires consideration of the lessons learned from mPower for wider technology enabled social prescribing and eHealth interventions.

- **Highlight and disseminate the good work of the Community Navigators as without them outcomes would not have been achieved.**

- **Three elements have been shown to be key to the realisation of benefits from Community Navigators' work: the time spent with the beneficiary, the visit to their home space and the manner in which the Navigator engages in a person-centred approach.**

- **Recognise the benefit of the physical location (base) of Community Navigator or Implementation Lead type posts as we have seen the benefits of sitting within the same space as MDTs and/or primary care staff, or the third sector.**

- Where possible, Community Navigators and social prescribing services within a locality should work together, understanding the specialist nature of each one.

- The tasks of local project promotion, asset mapping and relationship brokering were time consuming for Community Navigators and Implementation Leads within mPower.

- It is important to consider the staffing resource level of Community Navigators relative to the area and the population to be covered at the planning stage.

- Several staff talked about capacity issues within the local third sector.

- Transport was also a much-cited challenge in terms of remote and rural beneficiaries being unable to easily access services.

- Another key challenge was liaison with primary care.

- Basic financial analysis suggests that a project like mPower can cost less than GP time, SSRI mediation and psychological support.

- In relation to eHealth, mPower has shown the potential of 'low level' and 'off the shelf' technological solutions.

- Evidence suggests that health/care technology is not the only avenue to achieving the mPower outcomes – wellbeing and self-management can be promoted through things as simple as supporting someone to use a smart phone that they already own.

- Through guided, person-centred conversation, those in Community Navigator roles can also support the identification of appropriate eHealth and technological solutions for individual beneficiaries.

- Several deployment sites also set up Community Digital Hubs. The hubs continued to run beyond the mPower project, thus contributing to its legacy

- Some sites felt having Community Navigators specifically focussing on digital support to be beneficial.

- The ECHO format has been a successful vehicle for sharing learning and peer support/safe debriefing opportunities.

In order to focus future activity on areas of greatest benefit to both patients and providers, integrated eHealth and social prescribing systems may profit from identifying and targeting frequent primary care users or those with particular conditions such as depression, which was the one long-term condition within the mPower quantitative sample that showed statistically significant improvements in health and wellbeing measures.

Notes

A project supported by the European Union's INTERREG VA Programme, managed by the Special EU Programmes Body (SEUPB)

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