An evaluation of phase one of Enhance

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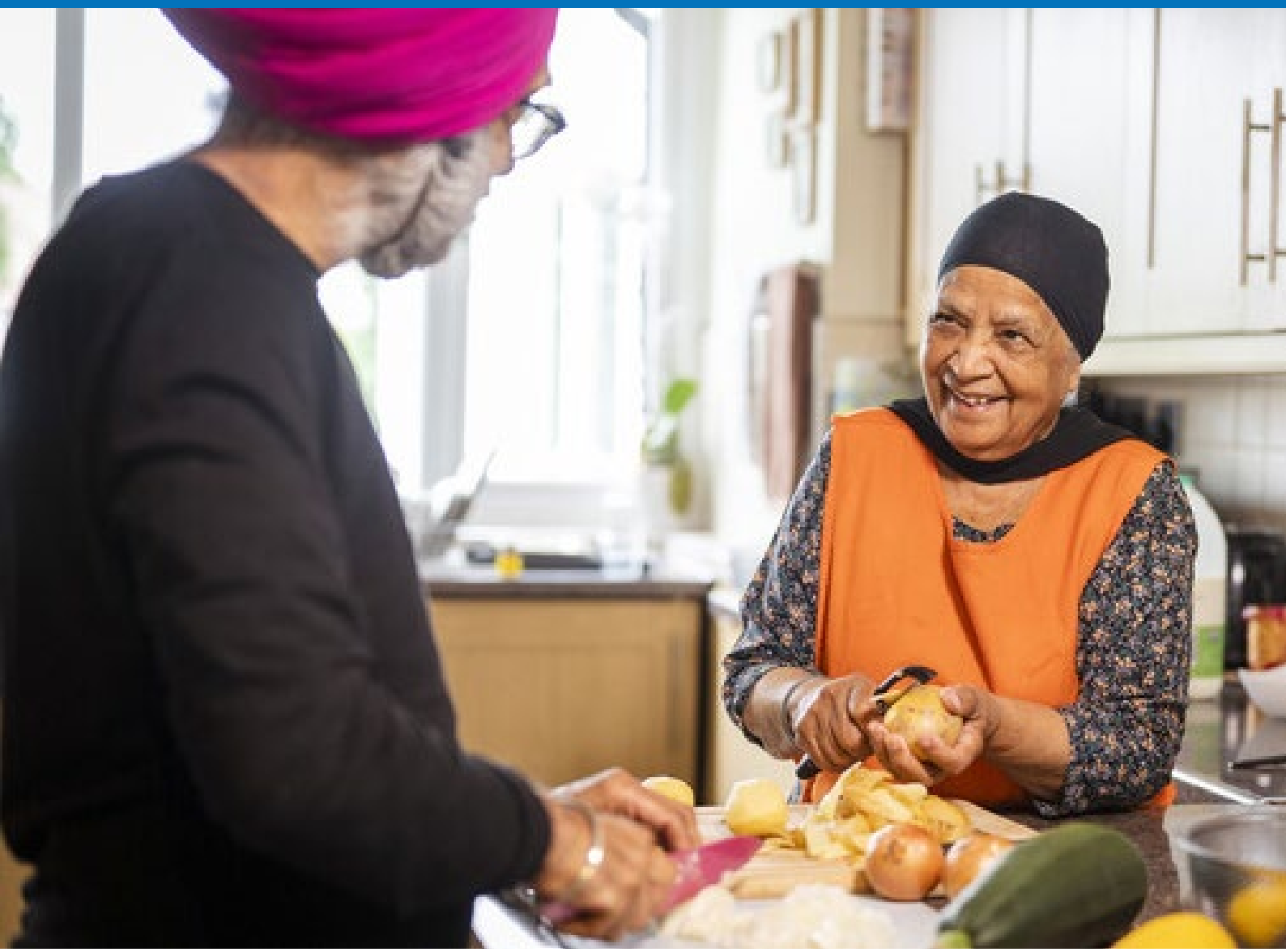

Enhance

Leeds Older People's Forum

Forum Central

Leeds City Council

NHS Leeds Community Healthcare NHS Trust

Introduction and overview

1. Background and the Enhance Model

The Enhance programme is managed by Leeds Older People's Forum (LOPF) on behalf of Forum Central, in partnership with Leeds Community Healthcare (LCH)[1]. It links LCH Neighbourhood Teams (NTs) with third sector organisations to enhance capacity in both sectors and avoid both delayed hospital discharges and readmissions. NTs provide care and support to ensure people can stay as well as possible for as long as possible in their own homes. The core team includes community nurses, community matrons, senior and district nurses, advanced nurse practitioners, clinical support workers for the elderly, social workers, physiotherapists, occupational therapists, clinical assistants, pharmacy technicians and self-management facilitators. NTs are based alongside Adult Social Care (ASC) and also work with GPs, the local council, hospitals and third sector organisations.

NTs receive a high volume of referrals (over 600 per week) and have limited capacity to support patients with non-clinical needs around managing their health and wellbeing. The Enhance programme was developed to ease capacity through providing holistic home-centred and coordinated support. Enhance works with people to empower them to increase independence and reduce dependency on health services, supporting safe and sustainable discharge from hospital and avoiding delayed discharges and readmissions.

Enhance aligns with the objectives of LCHs third sector strategy. Co-produced with Forum Central the strategy highlights the role of community-based third sector organisations in supporting a citywide health and social care system that is holistic, effective and improves health inequalities. Enhance also follows the principles of the current Frailty Outcomes Framework – which promotes a holistic approach and a system-level ambition to increase the proportion of people being cared for in the community (acknowledging that this will require increased expenditure on the third sector).

During the Enhance pilot phase (June 2022 to April 2023) 14 third sector delivery partners (DPs hereafter) have been working across 10 NT areas (this has recently increased to 11). Some partners work with more than one NT and some NTs are covered by more than one DP (two NT teams are not currently covered). As well as working with NTs to support their role, Enhance has a wider ambition of working toward a more integrated system.

The purpose of this mixed method evaluation is to report on project delivery and the progress toward achieving set outcomes. It finishes by offering some things to consider when designing the second phase of Enhance (which will continue to be funded by LCH until 2024). It is important to note that this is based on early reflections. Survey responses are highlighted throughout the report, where relevant – a fuller report of these findings can be found in Appendix One.

1 Forum Central is the collective voice for the health and care third sector in Leeds, delivered in partnership by Leeds Older People's Forum and Volition. LCH is responsible for providing community healthcare services for the people of Leeds

2. Evaluation methodology

This report is based on the following:

- Analysis of a two-phase questionnaire (using SPSS advanced statistical data analysis software) using the Patient-Reported Outcomes Measurement Information System (PROMIS) and Person Centred Coordinated Experience Questionnaire (P3C- EQ). 42% of Enhance clients completed an initial questionnaire, and 18% a follow-up questionnaire. The data provided by clients was compared to the 'living with frailty' cohort in the Leeds population survey – people who completed the same measures through a postal survey administered by Ipsos MORI which captured a snapshot of the Leeds population. A full analysis can be found in Appendix One.

- One-to-one interviews and focus groups with:
  - 15 Enhance clients supported across 10 Delivery Partners (11 women and 4 men, and where age was provided this ranged from 61 to 84)
  - 22 DP staff (11 Enhance frontline workers and 11 at strategic level) across the 14 Enhance service providers
  - 15 NT staff across 8 areas
  - 6 LOPF and 3 LCH staff

- Analysis of project documents including Monitoring and Evaluation returns submitted by DPs across all quarters, case studies and SystmOne data analysis. SystmOne is a central system used by NTs to record patient information.

3. Enhance programme reach

To the end of December 2022 Enhance supported a total of 404 people (from 419 referrals). The majority are White UK (74%), heterosexual (all 254 who provided a response) and aged between 65 and 84 (58%). Just over a quarter (26%) are aged over 85; 52% are female.

Of those referred via SystmOne, nearly three fifths were living in deciles one and two on the indices of multiple deprivation, indicating high levels of poverty and disadvantage. 50% of patients referred to Enhance live in decile one (the most deprived areas) compared to 24% in the total NT caseload.

When compared to the Ipsos MORI Leeds population survey 'living with frailty' cohort Enhance clients show lower overall physical and mental health functioning. Of 169 clients who completed PROMIS questions on the initial evaluation questionnaire:

- 78% described their health as either fair or poor,
- 67% reported that they were only able to carry out every day physical activities either a little or not at all,
- 71% reported that their quality of life was either poor or fair.

These numbers are indicative of Enhance reaching a vulnerable population.

Delivering Enhance

This section considers the extent to which the Enhance model was delivered as intended, namely: adopting a person-centred approach, applying test, learn and improve principles and building relationships with NTs and other partners. Note that a fuller discussion of the wider delivery of Enhance through LOPF, including training and peer support, goes beyond the scope of this report – though overall feedback, where provided, was positive.

1. Delivering a person-centred service

Providing a tailored, holistic offer

Central to the Enhance service model is provision of holistic, person-centred and flexible support. This follows learning from an evaluation of SWIFt, which similarly established referral pathways through health and social care providers and highlighted that the person-centred approach was key to achieving positive outcomes.

All clients interviewed were very positive about their experience of the service, describing support which felt relational and where trust was built. Even in a case where the Enhance support was short, the interviewee referred to having an open, prompted discussion - where they felt able to explore their needs and aspirations. Interviewees valued workers advocating for them across a range of cross sector services.

Key to providing a person-centred service is ensuring the support is tailored to the needs of individuals. Enhance offers a wide scope of support, with signposting where necessary. This includes (though is not limited to): financial help, filling in forms, ensuring safety at home (aid, adaptations, safety checks etc.), attending appointments, arranging social events, attending social activities, shopping and food parcels, collecting prescriptions and encouraging people to exercise. Several specific examples were provided of how the support was responsive to what the individual needed, such as helping with cleaning and laundry whilst a worker supported a client to find a cleaner.

These qualitative findings are supported by the person-centred and coordinated survey measure. Of around 60 Enhance clients who responded to questions about their perception of person-centred care either after a period of around two months or at the end of the support:

- 87% felt that they had been considered a whole person, with only 1 feeling they had never been considered as a whole person,
- 68% reported that they felt their healthcare was joined up either ‘always’ or ‘some of the time’, with 20% agreeing that it was ‘to some extent’,
- 75% said they were either ‘always’ or ‘more often than not’ involved in decisions about their care,
- 70% responded that they either ‘always’ or ‘more often than not’ discussed what was important to them when managing their health and wellbeing (a further 21% responded either ‘to some extent’ or ‘not relevant’).

The high percentage of clients who described Enhance as feeling joined up and treating them as a whole person is positive, though giving and receiving information returned lower scores:

- 33% reported that they had to repeat information that should be in their care records either ‘always’ or ‘more often than not’.
- 28% reported that they ‘always’ receive enough information, the most frequent response was that useful information was provided ‘often’ (at 37%). 28% said they either ‘did not receive’, or only ‘sometimes received’ useful information.

P3C questions - the scale used to measure person-centred care - may have caused some confusion as it uses clinical-based language which clients reportedly struggled to link to the Enhance support. This issue has been recognised and, moving forward, the developers of P3C have agreed that questions can be re-designed to reflect specific elements of support linked to Enhance (see Appendix One).

Some NTs and clients referred to the limited operating hours around weekdays. Whilst a few DPs provide support at weekends where a client was felt to have needed it (such as a worker who phoned a client every Saturday as this was when the person was more likely to experience loneliness) – this is not offered as a rule. The reality is that a fully flexible 24-7 service is not feasible within the existing funding model. Similarly feedback suggested that the relatively short-term support offered through Enhance was less suitable for patients with longer term or progressive health issues. However, some DPs mitigated this through referring on to other support services, and/or introducing people to longer term support options through the organisation they are based at.

Supporting a coordinated approach

The survey responses highlighted that many Enhance clients were involved with more than one service (an average of 2.5 care services in the last month, with 10% reporting four or more). DPs worked to ensure clients had a consistent point of contact across health and social care services to ease navigation. Client interviewees referred to Enhance workers linking in with hospital staff and GPs, though also housing officers and social workers to deal with any issues. Some examples were provided of joint visits with Enhance and NT staff and social workers. This element of Enhance was key to supporting clients to manage their health and wellbeing, ensuring e.g., appointments were not missed, and housing was in good repair (this is considered later).

In some cases clients continued to struggle to recall which services were working with them, though this was often due to factors beyond Enhance, such as delays in accessing services once discharged from hospital, with one client paying for a private Occupational Therapist (OT) due to waiting times. Where clients reported a lack of coordination between NTs and Enhance, this was not necessarily perceived negatively, with one appreciating separation of practical and social from medical support, and another referring to: “*feeling more like a person than a patient”.*

2. Applying Test, Learn and Improve

As a project with long term ambitions around achieving system level change, it is important to ensure that ongoing learning from delivery is collected to inform Enhance as it moves into phase two. Enhance is picking up learning from DPs through monitoring and evaluation, one-to-one progress meetings and peer learning sessions and using this to shape future delivery. For example LOPF is taking steps to ensure all 13 NTs can benefit from Enhance after identifying gaps in need across the geographical areas which are not currently covered. There are also ongoing actions to clarify area boundaries due to feedback that lack of geographic alignment between NTs and DPs had caused confusion. Ongoing learning is also shaping Enhance 'in the moment', allowing DPs to be pragmatic and widen referral routes due to lower than expected referrals from NTs. Several partners have also been encouraged to try out different avenues for joint working (considered later).

The learning captured at LCH level feels more strategic (though LOPF programme managers also attend meetings where operational teams are present). Whilst LCH can feed back and inform learning – there is also a sense of disconnect around ensuring frontline NTs feed into phase two (though this evaluation spoke to 15 NTs, this should be further considered for phase two).

3. Setting up referral pathways

Neighbourhood Teams referral pathways

64% of Enhance referrals were recorded by NTs on SystmOne. Feedback suggests the overall proportion of NT referrals is in fact higher, with examples of NTs linking in with clients already known to DPs and a few DPs picking up verbal referrals which are not then added to SystmOne. Referrals also come through other sources, including social prescribers, GP, ASC, other third sector organisations and through self-referral.

Whilst the holistic support offered through Enhance was valued, it also reportedly hindered potential NT referrals due to confusion around what it could actually offer. One NT felt that their manager had misled them at the start through presenting the full suite of the Enhance offer (i.e., based on an aggregate across all areas) – and that staff had been disappointed when they realised they could not access particular things in their postcode area. Another NT felt that they were not using Enhance to its full potential:

"It's a bit grey as to what can be provided and some [NT] staff are confused – I asked about supporting a patient to keep exercising as she had lost confidence… the staff were unsure if they could help. Management sold it as something that would help with medication and making lunch but this isn't offered. So I just refer across for befriending or linking to community groups, which is what I used to do before [Enhance] to be honest." *(Occupational Therapist)*

DPs acknowledged this point and agreed that a clearer initial offer is needed to help NT navigation and present more of a consistent offer across areas.

It was fed back by some that the Enhance referral process was not well matched to the working environment of some NT teams, that it does not consider that they may have 15 minute visits across patients, with no time allocated to do referral admin at the office (some were able to ring a care coordinator, but not all). NT staff suggested they would just prefer to refer via a quick phone call or email when they got the chance.

Using SystmOne as a primary referral route was frequently referred to as a barrier, as some referrers outside of NTs did not have access to it, and NTs struggled to fit this into a working day which involved being on the move with limited access to a computer.

Widening referral pathways

In response to receiving lower than expected NT referrals DPs adopted a pragmatic approach to increasing these such as through accepting referrals from other health providers, identifying frailer clients already known to them who had recently been discharged from/at risk of being admitted to hospital, taking informal referrals from NT, working with legacy clients from SWIFt.

Hospital discharge routes were felt to be a key pathway to supporting the Enhance target client group when needed. NT and DP interviewees referred to the importance of working with clients as they leave hospital, to reduce re-admission through ensuring they can settle back home and avoid becoming housebound where possible. Leeds-based data suggests around 10% of frail older patients were sent home from hospital without the right support in 2022. Yet timely hospital discharge processes were highlighted as a system-level barrier, with NTs reporting that they were sometimes unaware of discharge up to 72 hours afterwards (it was also noted that Enhance workers are not informed when their clients are re-admitted to hospital). This led to some DPs tapping into existing assets, such as through other projects working across hospital discharge routes or identifying people known to them who had recently been discharged from hospital and

contacting them to see if they required more intensive support. As this is not set up as a formal referral route coverage has been patchy – with DPs acknowledging that clients who are being discharged from hospital and who would benefit from their help are being missed.

Regarding external NT referral routes, a common thread was that some clients referred to NTs through hospital discharge or primary care could potentially go through Enhance instead, and that referrals sometimes go through NTs due to a lack of awareness of what else is out there in the community (hospital staff do not work at locality level and have limited awareness of what is on offer across different Leeds wards). This highlights a need not just for ongoing awareness raising, but also how to embed Enhance within these referral pathway routes.

Social prescribers were referred to as potential referrers as some had a fairly long waiting list and Enhance could potentially jump in sooner and fill a capacity need (this approach was also referred to for physio assistants for when they were overstretched). Whilst Enhance can certainly play a role in supporting these services, it is important to ensure that it retains its identity and is not used as a plug for other under-resourced services.

4. Building a partnership with Neighbourhood Teams

Building relationships with Neighbourhood Team staff

A key objective of Enhance is to establish ways to work more closely with NTs. Developing seamless referral routes is necessary to achieve this although this alone will not be sufficient to achieve Enhance's wider ambition around integration.

Whilst some DPs felt that Enhance was raising their overall profile in the health sector, many reported that building up relationships with NTs had been more challenging than expected. Monitoring returns from January 2023 show that 11 out of 14 delivery partners scored the relationship with their NT as seven or less out of 10, with three scoring this a one. Some struggled to raise awareness and promote Enhance. The reasons for this, as reported by DPs and NT staff, was extreme workload pressures, high staff turnover (with referrals sometimes waning if a key staff member left) and the referral process not being tailored to the NT role. Interviewees also reported a lack of awareness about what each other's role entails. This reportedly made it harder to see the value of working closer together, as it was not always clear to NTs where Enhance could fit into the clinical side of things.

It is important to note that feedback tended to differ based on staff role, with some suggesting that embedding referrals will take far longer and require more input for say, district nurses – whose role can be more task-based and who may struggle to build a full picture as they do not consistently support the same patients. This was compared to NT staff who described their role as taking in "*the bigger picture*" around how to keep people out of hospital through e.g., ensuring the home environment is safe and/or being more accustomed to referring in to community-based services:

"The role of nursing staff can be task orientated and they may not get the time to consider the patient's wider needs. We look at the bigger picture around support to live in their own home and feeling safe, our role is to try to keep people out of hospital. I have always looked to the community to help support me with this." *(Matron)*

Based on feedback, Enhance referrals were more likely to come from: OTs, physios, re-ablement, self-management, older people and frailty teams, matrons, dementia and frailty nurses and memory support workers.

Embedding Enhance across NTs

DPs and NTs tended to report on Enhance more positively where workers had been able to establish a regular presence (e.g., through handovers, triage and case management meetings) rather than attending one-off meetings:

"We speak to the worker regularly and they come to our handovers – they have built up a picture of what we are up against and can tell us how they can potentially plug the gaps. They might not be able to solve the issue but they can refer to an appropriate service– as they have a good relationship with services across the area." *(Coordinator)*

"[The worker] pops in a lot to handovers and that is good – I might have someone in mind [to refer] but [I have] not got around to doing the form. Just seeing her face…jogs my memory. If she is working with someone it is good to hear what she has observed or seen – as this can help us." *(Matron)*

Ensuring the worker was perceived as offering something more than a referral route was viewed by a senior NT member as particularly important:

"It is good to build relationships and ensure the [Enhance worker] is included. I knew the key to success was working together and not being seen as separate." *(Operational Team Lead)*

That said, even Enhance workers who were more embedded in NTs reported that the majority of NT staff did not send across referrals. Some DPs attended meetings led by NT staff who were more likely to refer, such as monthly matron and self-management team meetings, which seems to be a good approach. An NT interviewee liked that Enhance would give them regular updates, which had not happened when they referred to a befriending service run by the same organisation.

Another reported way that DPs and NTs worked more closely together was through joint visits (of which 63 were recorded across the 14 areas by 31 December 2022) and in the case of a few areas, Enhance workers shadowing NT staff. Both NT and DPs referred to how joint visits worked particularly well for existing patients as it helped them to trust DPs from the outset. Others appreciated the opportunity to shadow NT staff, as it helped them understand the NT role and consider ways in which they could help to bridge the gaps. However, relatively few DPs carried out shadowing, and it did not necessarily lead to increased referrals (one DP who shadowed an NT staff member had not received any referrals from them afterward). Some DPs felt it would be useful if NTs shadowed their role. Whilst this had happened on one occasion, it may be less realistic due to NT time pressures (this would also engage relatively few staff members).

In an area where NT referrals are becoming oversubscribed, with an NT interviewee stating that the Enhance worker is "*a valuable part of the team*", the worker has a regular visible presence, carrying out joint visits and attending handovers a few times a week. There are plans for the worker to co-locate in phase two, which should produce some useful learning (with the caveat that this approach will not necessarily work in all areas).

Though capturing learning across different areas is to be encouraged, partnership development needs to be context specific, giving regard to an NTs make-up and culture. For example, some NT staff felt that Enhance staff attending handovers was inappropriate, as they are for "clinical" discussions, yet others felt this kind of setting was ideal to build a relationship through becoming a known face. Some felt that a "one-on-one" model (One DP attached to one NT) worked particularly well to support relationship building. The physical NT environment was also important. Interviewees provided examples of an NT with a large open plan room which provided more opportunities to talk to people – yet another had small rooms where people were "*squirreled away*"– which was less amenable to having those more relaxed conversations that can help build relationships and make personal connections.

One NT felt that whilst some see how Enhance can benefit the NT service overall, they referred to staff who keep their head down, this was felt to be particularly so when the benefits may not be felt in the short term. Guidance from a senior clinician or peers may offer some support here.

In areas where there have been frustrations, meaningful relationships are beginning to build with an overall sense of optimism and plans to embed more joint working in year two, making better use of existing assets to offer joint spaces. Staff across NT and DPs referred to the value of informal cross-sector, face-to-face learning. A round table event in February 2023 to share Enhance findings for phase one led to staff sharing contact details and agreeing to make introductions across different teams.

Two DPs reported that they were exploring co-location options, a few others are working with self-management teams to set up joint spaces via community health hubs, yet others are looking to link in more closely with recovery or social services. Other planned activities included joint community wellbeing clinics (where people can have blood pressure checked and flu jabs alongside attending

a coffee morning). A DP which runs a social worker drop-in is exploring how to widen referral routes through this. Together, these can start to support a longer-term cultural shift. In the shorter term, these types of activities can move the relationship beyond a one way referral route to a more integrated approach:

"We have recently started running a weekly community health hub. the [NT] nurses come to our building and see patients here – they can do catheter and dressings – we had a meeting to identify people that nurses were carrying out home visits to see if any were our members [11 out of 60 were]. If people who need visits come to the hub – this can save NTs going carrying out that visit. We provide transport and refreshments – it is more social for clients too who can get out and meet other people." *(Delivery Partner)*

"We met with the self-management team and agreed that to make Enhance a success we need to work closer together, we feel establishing a hub can help achieve this – this will be located at one of our bases. [NT] staff can attend and meet clinical needs and we will identify all the other needs. Alongside that we are considering running a dementia support group once a month and we can work with NT staff here too." *(Delivery Partner)*

We are discussing with the NT the possibility of me basing myself within the NT rather than just going to meetings – I am looking to regularly spend the whole day there – take my laptop and get on with things even if a handover doesn't happen." *(Delivery Partner)*

Achieving outcomes

1. Achieving outcomes for clients

This section considers the extent to which Enhance has achieved or looks on track to achieve outcomes around empowering people to improve their health, wellbeing and social integration. For discussions based on qualitative data, findings should be treated as being indicative of promising emerging findings. The programme team are considering additional data collation in phase two to potentially quantify some of these.

The main themes which emerged as leading to improved health and wellbeing and potentially reducing use of NHS services include: supporting a safe home environment, offering non-clinical complementary support, advocacy and coordinating care, attending appointments, reducing the impact of poverty, supporting emotional wellbeing and social integration. Clients who completed the survey across two timepoints returned an increased average score across physical, mental, and social health, as well as improvement to overall quality of life and reduced fatigue. This indicates that the support had led to some improvement across these areas, with two thirds reported that they felt ‘somewhat’ or ‘very’ confident managing their own health and wellbeing (Appendix One).

Across all outcomes the person-centred, holistic support offered through Enhance was assessed as key – with many suggesting that without the Enhance offer, clients would have fallen through gaps and not received the help they needed (e.g., repairs would remain outstanding, income remain unclaimed, prescribed exercise would not be maintained). This was particularly so for isolated clients with limited family support.

As most clients had a range of related issues which impacted on their ability to live well at home, the themes considered in this section should not be taken in isolation – through rather, as different elements that worked together to contribute toward achieving intended outcomes (with workers often supporting clients over more than one of these).

Maintaining independence

Contributing to improved health and wellbeing is at the core of Enhance and it sets out to empower clients to maintain these independently where possible. A key asset to Enhance is that DPs generally have a number of existing services that clients can be referred into (balance classes, falls services, digital support, benefits advice, aids and adaptations, social activities and outings, befrienders etc.) as well as access to pots of funding which were sometimes used to pay for items which supported someone to remain independent. DPs also have wider connections across the community, meaning they are able to identify appropriate referrals where a service could not be offered directly.

DPs reported that for clients who are frail, housebound or living with progressive or limiting conditions (with many experiencing poor mental wellbeing), achieving independence was a challenge. Where this was the case workers ensured longer-term support was put in place:

"It is not always realistic to support people to full independence in three months – so I always ensure where this is the case things are in place to support that person when I need to take a step back. This might be referring to Adult Social Care, long term support workers or befrienders…The [NT] staff and people we support don't always realise what support is out there – so this can be very beneficial." *(Delivery Partner)*

An important and cross cutting area for consideration is transport, as transport issues can hinder independence and social integration – especially for those not on a public transport route. Clients talked about ongoing struggles to access affordable and suitable transport; one couldn't find a carer to support her to get outside safely, another couldn't afford a taxi to attend social groups. Self-management team members who took part in a focus group referred to being disappointed that some DPs were unable to offer help to meet transport needs. Whilst in some cases DPs were able to meet transport needs, this was patchy. It also causes a question as to how clients will manage beyond the period of Enhance support.

Maintaining a safe home environment

NT, DP and client interviewees all referred to examples of how Enhance helped tackle a poor or unsuitable home environment, highlighting how even small issues can escalate and impact on someone being able to remain independent at home. As a holistic service, there were several examples of how workers supported this, including fitting alarms, aids, adaptations, replacing furniture and appliances, sorting out essential repairs, telecare, carrying out shopping, arranging delivery of hot meals and helping clients to tackle a dirty and cluttered environment. The client examples below show how the type of support was person-centred and guided by the whole needs of the person:

"The worker looked at my home and asked me what could help me feel safer, they looked at my appliances and helped me get a handrail for the bathroom…My old Zimmer frame kept dragging and ripping up the carpet so they helped me to get a new one. I have been pretty well for the last year – I am not falling over anymore and all these things help. The worker is also helping me to find a cleaner to help with things I struggle with."

"My OT said there were a lot of things in my front room that may make it difficult for me to get around. It was cluttered but I struggle with my mental health and was putting up barriers as I didn't know where to start. The worker has really helped, she came in and said to tidy this bit up today – do that tomorrow. She also helped me get someone in to do a bit of cleaning. I am starting to do this a bit at a time rather than let it build up until it is undoable…she inspired me to get over the hurdles and want to do more."

Linked to ensuring a person's home environment is safe, some clients referred to their health being adversely affected by poor living conditions as they struggled to get essential repairs carried out by the council. In these cases workers had advocated for clients to ensure they could keep warm and ventilated – in the second example the support was felt to have reduced potential unplanned hospital admissions:

"I was having problems with the council – I had been waiting over a year for them to sort out a cracked window... The wind was blowing through and it was so cold. The worker stepped in and worked with the housing officer and within weeks got me a new window in. It's brilliant - the house is keeping heat in and there are no drafts now – I can keep warm."

"My flat is near a bin store which wasn't being emptied for months, I was worried that I would get an infection as I have acute asthma and have been rushed into hospital with breathing issues. I called my housing officer but they weren't listening – she knew I was poorly and needed help. I couldn't open windows or ventilate my home and was scared to go out – once the worker got involved with the council it was cleared up in a week, now I can get outside."

A few DPs have also supported clients who were struggling to manage with a move into more appropriate accommodation (such as a ground floor flat or bungalow) to support future independence.

Offering non-clinical complementary support

NTs reported particularly valuing the complementary non-clinical support offered to clients through Enhance, including attending cross sector appointments, supporting walking outdoors and exercise (e.g., a balance class to help prevent falling), offering 'light touch' medical support (such as picking up prescriptions) and preparing food. DPs also supported social care needs, referring across to ASC and/or helping clients access support around personal care (which meant clients felt better able to manage other areas in their lives, such as meeting social needs).

One NT described how carrying out a joint visit with a worker had saved them time and reassured them that the patient was getting the support they needed through passing on non-clinical tasks. These included applying for a dosette box and falls alarm and making a referral to Adult Social Care. OTs made referrals for clients who had limited family support to offer encouragement around continuation of prescribed exercise – some DPs referred to home exercise support and/or balance classes (note not all DPs offered this).

"I have been getting physio to improve my physical fitness and though I am getting slowly better I am frightened of falling. I told the worker this and she has organised a balance class for me – I have struggled to get out due to lacking confidence – so this should help."

The below quote offers a good example of the flexibility of Enhance to tap into different non-clinical tasks to support someone to manage their health condition(s):

"I got a broken tooth – the [worker] told me not to worry and took me to the dentist…Last week I had forgotten to pick up my prescription, I rang him up and he picked it up and brought it to me…I am on an insulin pump and keep going hypo, the worker helps – he runs to the kitchen and gives me jelly babies and stays with me until I am right. He got me a walking frame; this means I can get into the garden and I don't have to worry about falling – as I am not steady on my feet."

The emotional support and encouragement offered by Enhance workers was frequently referred to by clients as helping them to better manage their medical needs. In the below example this had reduced the number of times a client with breathing difficulties called A&E:

"I call her when my breathing is poor as I get scared – she comes around or speaks on the phone to reassure and calm me down, she will ask what she can do, and will remind me to take my nebuliser – she knows if I use this it makes my breathing better. I don't want to go to hospital – so it helps me avoid it as I feel more comfortable…She cares – I appreciate her."

Enhance workers also reported referring across to health services including NTs, chiropodists, sensory support and the Active Leeds falls prevention service.

Advocacy and coordinating care

As highlighted earlier, clients tend to be involved with a number of services and Enhance was viewed as a way of supporting clients to navigate this. While system-level barriers could sometimes get in the way of offering a fully coordinated service, clients provided a number of examples of workers communicating with services on their behalf, leading to them being able to better manage their health:

"I felt suicidal one day, I rang the doctor but struggled to put things into words, I gave the [worker] the phone and she explained that I was distressed and why I needed help…They were a lot better then – and offered to give me an appointment the following morning. She came back later that day to check I was okay and could attend."

"I have fallen a few times the past few months – my legs are so weak. The [worker] is working with social services to organise things to help me. [I have now] got a chair for the kitchen as I can't stand up – I can now sit down when washing and shaving and can prepare something to eat."

Other examples included liaising with the hospital dispatch team to set up a care package, liaising with the pharmacy to set up repeat medication/dosette boxes and carrying out a joint visit with a GP who carried out a check-up.

Attending health appointments

NTs and clients were very positive about the Enhance offer where it included accompanying people to health appointments (including with GPs, wound clinics, dentists, pharmacies, hospital), to ensure they could do so safely and ensure they were keeping appointments to better manage their health:

"I have blood cancer, the worker takes me to my chemo appointments, she does this with so much care – helping me into my wheelchair as I can't walk very far. She stays with me at the hospital and takes me back home…she rings all the time to see how I am doing. She has helped me apply for an electric chair to help me get around easier."

An NT referred to a client who would not attend hospital appointments due to feeling anxious, and how an Enhance worker had helped the client to build up confidence over time to go alone through accompanying them to appointments. The NT reported that this had eased her concern, as she did not have the capacity to take the person to appointments herself.

Reducing the impact of poverty

Reducing the impact of poverty is assessed as particularly important, as this can help prevent health conditions from developing or worsening through ensuring people can heat their homes and eat well (with workers bringing groceries or visiting a food bank for those who struggled to pay for food):

"I hadn't been eating properly, my physical and mental health is a double whammy – I struggle to find energy to peel veg and everything has gone up in price. Having the [worker] bring me food has really helped. She is also helping me to apply for [benefits], getting supporting letters from the nurse and my GP – which will increase my income if it goes through."

"I had been struggling to pay my bills – I am on pension credit and struggling to survive on this… the [worker] rang up JSA as I had problems with them – she helped me to apply for PIP and she contacted gas and electric…[she] sorted out my discount and has arranged for someone to visit and help me maximise my income. This has really helped and I feel able to turn my gas on now, I need to keep warm."

Enhance workers also liaised with phone providers, supported people to check their bank statement/credit cards to limit overdrafts/overpayments, and worked with energy providers to set up affordable repayment plans.

Supporting emotional wellbeing

A frequent theme through the fieldwork was the role that Enhance play in supporting a client's mental wellbeing, particularly for those with limited family support. Over three quarters of the 169 survey respondents reported that they were at least 'sometimes' bothered by emotional problems, with 47% experiencing this 'often' or 'always' (this compares to 26% of the 'living with frailty' population who completed the same measures through a postal survey administered by Ipsos MORI). Of the 70 who completed a follow up the average score for mental health functioning had improved (see Appendix One).

NTs were positive about the emotional support provided through Enhance, recognising that they did not have the time to offer this and that it gave them reassurance to know patients were being supported. A few noticed an improvement in their client's wellbeing.

The quotes covered in previous subsections often refer to how workers reduced stress and anxiety, with some attributing support around their mental health to tackling other areas of their life which were impacting on their physical health and wellbeing (such as feeling able to tackle clutter so the person could move around more safely). Clients reported that their mental health had improved through receiving Enhance support by, for example, cheering them up and helping them forget about their medical needs for a while:

"*I look forward to [the worker] coming – we have a laugh, it's not all about treatment and cancer… this helps with my mental health - which does as much good for me as any of the nurses with treatments and pills – it's about your morale too."*

"I suffer from depression which has worsened because of my [physical health] problems…The [worker] has been really supportive, the depression can get unbearable and its good knowing someone is there – talking through things with her helps – it takes my mind off of it. She has put me in touch with a few things I can join and I am looking at this, as it will be good to speak to other people."

While the emotional support is positive, in a few cases clients would have benefitted from clinical mental health support, such as where mental health support had broken down due to a client spending an extended spell in hospital - another referred to delays waiting for an assessment. These wider level issues are to a large extent outside of the control of Enhance and are noted here as it offers potential ideas around advocating more closely with these services in the future. Another issue to consider is that as with clients who experience loneliness (considered in the next subsection) clients may come to rely on the Enhance worker – with some requesting long term support.

Increasing social integration and reducing loneliness

The social aspect of Enhance was often cited by NTs as the main reason for referring to Enhance, particularly for clients who had limited family support and were at risk of loneliness and social isolation. A high number of survey respondents rated their ability to carry out, and their satisfaction with, social activities as 'fair' or 'poor' (83% and 79% respectively). These figures were much higher than for the 'living with frailty' cohort in the Leeds population survey, where 57% rated this item as fair or poor. Of the 70 clients who completed an initial and follow-up survey, an improved average score was recorded across both of these – which suggests that Enhance had led to improvements in reported social health. Though there is limited robust evidence in this area, the Local Government Association suggested that initiatives which tackle loneliness can cut emergency hospital admissions by up to 20 per cent, so this is an encouraging finding.

Of the 404 Enhance clients to date, just over a quarter have started to attend additional groups or activities offered by the third sector. Client interviewees talked about how Enhance workers had helped to reduce their loneliness in different ways, including referring to befrienders, groups, and sorting out a housing related need:

"I lost my partner earlier this year to cancer, I nursed him – I was so lonely and the [worker] has been someone to talk to about it… I wish I knew about her months ago…I am now looking to get out and meet people once the weather is a little better. And she referred me to a befriender…If I have got a problem I ring her – before this I didn't know where to turn."

"The worker helped me get somewhere else to live – where I lived neighbours were selling drugs and knocking on my door at night – the new place is beautiful – safe and I can get around. I was isolated but this has reduced…I have nice neighbours and am able to get out and about – I can go in the garden. Without her I don't think I would have got this housing."

For a few clients who experienced loneliness or struggled to get outside, there was a sense that the Enhance worker took on elements of a befriender role – with less evidence of these clients taking steps to manage social isolation beyond the project support period.

2. Outcomes at the NHS and NT partnership level

Whilst Enhance has led to positive outcomes for clients - partnership and wider system ambitions are still in development, with an acknowledgement that the NHS and partnership-level outcomes created in phase one relate to long term goals. This section considers early findings on the impact Enhance can potentially have around hospital discharge and admissions, improving health and easing pressure on NT services.

Reducing unplanned hospital admissions

Research carried out in Leeds showed the role that the third sector can play in reducing pressure on hospital services – with monitoring data on Neighbourhood Networks recording 1,031 instances of reduced hospital admissions. The interviews and monitoring returns picked up on several examples of where Enhance had potentially contributed to delaying, preventing or reducing hospital and A&E admissions / readmissions and these are listed in Table One.

Table One: Reported ways Enhance has reduced unplanned hospital admissions

- Carrying out an assessment for aids and adaptations to reduce risk of falls
- Supporting clients to declutter their home so they can move around more safely
- Encouraging clients to continue prescribed exercises, offer support around exercise/balance to support recovery and reduce risk of falls
- Ensuring clients can eat and keep warm through maximising income, liaising with services, providing food parcels
- Offering emotional and social engagement support, leading to a client no longer calling an ambulance at the weekend
- Reducing loneliness through befrienders and social integration – reported as reducing likelihood of calling emergency services
- Encouraging/reminding someone to take medication/manage a health condition
- Accompanying to health appointments to manage health conditions
- Attending a health hub in place of visiting hospital/GP
- Preventing overdose through liaising with primary care crisis team
- Ensuring a client keeps wounds clean (accessing new washing machine, personal care support, linking in with NT to report unchanged bandage)
- Ensuring medication is re-ordered
- Arranging an urgent care package
- Offer service as point of contact for any possible health and wellbeing concerns

Wider research identifies falls as one of the main reasons for unplanned hospital admission for older people (data from Emergency Hospital Admissions for Falls (Age 65 and over) on gov.uk). Many of the quotes referred to in the client outcome section allude to reducing the risk of falls, particularly through support around the home environment and with exercise and balance. Based on the monitoring data, DPs provided several examples of reducing falls.

A few NTs recognised the role Enhance can play in reducing falls, with a matron for example doing a referral to support a client who lived in a home with poor cleanliness and clutter – with concern that this represented a falls hazard. The matron reported that the help from the worker had led to the client hiring a cleaner and becoming more houseproud.

Enabling timely hospital discharge

Though less commonly reported, examples were provided of where Enhance had supported more timely hospital discharge, through ensuring people could return home safely, or offering practical help for those with limited family connections (see Table Two). As highlighted earlier – supporting patients as soon as they are ready to be discharged from hospital was viewed as key to increasing the likelihood of supporting patients to maintain independence and reduce the likelihood of re-admission.

Table Two: Enabling timely hospital discharge

• Visiting client in hospital and liaising with the hospital dispatch team to set up a care package • Setting up an action plan for practical and emotional support – including provision of hot, nutritious meals and topping up electricity • Carrying out regular (sometimes daily) wellbeing calls • Arranging transport to help someone get home

Improving health outcomes

Some NTs identified how the non-clinical elements of the support offered through Enhance led to better health outcomes, which in turn could help maintain independence and reduce the likelihood of health conditions prematurely deteriorating:

"[Enhance workers] are there for people…When people don't have family or anyone to lean on – little things become big things – [and the] wound can hurt a bit more." (Matron)

"Someone's health can deteriorate because their washing machine breaks down and they might not wash sheets or keep a wound clean –it has a knock-on effect. [The worker] sorted out a cleaner and washing machine – sorting these things out aren't top of the list for other services but it can be so important." (Coordinator)

Easing pressure on NT services

Some NTs reported ways in which Enhance was felt to ease pressure on their workload, such as reducing the likelihood of clients ringing into NTs, carrying out social care referrals and sorting out practical things such as ensuring there is food in the house. Enhance was referred to by one NT as *"bridging a gap"* where patients had progressed toward independence - yet may be at risk of things deteriorating - particularly for those without family support. The comments below are from NTs working across three DP areas:

"[Enhance] does relieve pressure – I have repeat callers – it's loneliness and [the patient] has a relationship with us – the worker has the time we don't to sit with the patient. One patient with mental health illness was ringing our office every other day, they were worried about PIP and other things and wanted a nurse to help. The worker went out and sorted it all out, and the patient doesn't really call us anymore". (Coordinator)

"[Enhance] supports my role. A big part of our service is making it accessible – perhaps going out with someone to encourage them to try something new. They can spend time on building relationships…breaking down barriers with patients – leaving a leaflet is not sufficient. The more intensive work from Enhance is invaluable for those with no family and who are isolated. I have 30 people on my caseload which limits how far I can stretch." (Memory Support Worker)

"[Enhance] means there is someone there to help that person – support their wellbeing when there is not really anyone who can help do some of these things, sorting out benefits or food parcels or going to the supermarket with someone. I don't really have time to do shopping – but I would worry about [the patient]. I saw a patient once and looked in the fridge and there was no milk – I went to the shops. I don't get the milk anymore – it's these little things." *(Clinical Support Worker for the Elderly)*

Whilst easing pressure around the needs of current patients was important, Enhance was also felt to have a role in managing caseloads through reducing the likelihood of a patient deteriorating and coming back through once NT support has ended. Again, this was particularly so for patients with limited family support:

"[When] patients no longer meet our service criteria and we cannot justify keeping them on our caseload just for confidence building…but we know they will benefit from extra sessions to build their confidence…This is where the Enhance service has been really useful to bridge that gap, I feel it makes it more likely for the patient to continue working towards their goals once discharged from the neighbourhood team and less likely to come back on the service in the future." *(Physio)*

A business intelligence analyst from LCH extracted data from SystmOne to explore evidence from phase one around whether Enhance had saved time for NT staff who had referred into it, by comparing data for 151 Enhance patients against 10,793 NT referrals over the period 13/07/22 – 08/02/23. The data analysed was informed by what NTs reported as having saved time for them, including: reduction in length of time on the caseload; shorter duration due of the initial Enhance assessment; reduction in the number of non-clinical phone calls to and from NTs.

The data at this stage did not show any reductions across any of the metrics. Whilst we cannot say for sure, it may be that the Enhance cohort is assessed as more complex than the average NT patient groups (i.e., more deprived, from a more ethnically diverse group – which potentially would have resulted in increased use across the three metrics). The relatively small number of Enhance clients, with some being involved for a short period of time, may also be factors here. Finally, due to the single referral model used by NTs a patient may be discharged from one type of care but if they are still on the NT caseload for another reason then their length of stay will continue to increase.

It is important to add that whilst the aim of easing the workload of NTs no doubt has merit, this should be considered alongside the potential of Enhance to ensure patients receive a more person-centred approach, which will not be picked up using metrics such as this:

"I get a lot of lovely feedback from patients – they say it has really made a difference and they really look forward to the visit. It is changing their life as they were isolated and secluded at home– it opens lots of doors and makes a massive difference." *(Clinical Support Worker for Elderly)*

"A lady was really anxious about her physical health and needed support to attend hospital – the worker accompanied her and the patient was so grateful and happy – it made a huge difference and she is now going to the appointments willingly – this is really reassuring." *(Self-Management)*

A few NT interviewees believed that Enhance was not meeting its full potential around easing workload - whilst busy NT staff was acknowledged, other areas were also highlighted. One NT suggested that it was overambitious to target all NT teams – and that instead, the project should consider working with those more aligned to the holistic ambitions of Enhance. Interviewees from NT staffing teams identified the potential for Enhance to ease pressure through diverting some inter-referral pathways – as NTs tended to be a default option in the absence of other options. Suggested routes where NTs felt this would work particularly well included: PCN paramedics (who carry out home visits to frailer GP patients) and district nurses referring patients with non-clinical need to Enhance rather than e.g., to matron or self-management teams.

Health hubs were identified as a good approach to show NTs how a model such as Enhance can offer tangible ways of reducing their workload, as it can save them carrying out single home visits.

Feedback from NT staff

It is worth giving regard to the elements of Enhance that NT referred most positively to and those which they felt could be improved so that it better complemented the needs of teams (Table Three), as this offers a useful starting point when considering the offer moving forward (these are incorporated into the “Considerations and recommendations for phase two” section). As noted earlier, though some DPs offer some of the services referred to in the right-hand column, this is not the case for all.

Table Three: Feedback from NT staff about Enhance

Positive elements of Enhance	Suggested improvements
• Having a dedicated worker who can provide a rapid response • An advocacy approach across services to resolve outstanding issues and system-level gaps and delays • Knowledge of the local community • Linking in to a wider offer such as digital inclusion, exercise and balance, group activities, adaptations support • Complementary work (e.g. applying for ASC, dosette boxes) • Providing support that family may traditionally offer (e.g., accompanying to hospital visits, 'checking in') • Having the time to provide relational support to patients, identifying additional needs across time • Accompanying to appointments • Reducing social isolation and loneliness (through holistic support and referrals to group sessions/ befriending) • Feeling reassured that the patient is receiving a person-centred service • Bridging gap for patients with no clinical need, but who lack confidence to carry out daily tasks • Good model for people affected by dementia – as can build relationship and trust over time, signposting not sufficient	• Enhance staff could take on less intense tasks where a patient is ready to be closed e.g. weekly stocking change or medication tracking • Increase transport options to support patients to get to groups/ appointments • Support prescribed exercises/ encourage walking where confidence is the main barrier • More consistent support around meal preparation • Offering long term support for patient with progressive health conditions • Carry out communal activities to identify referrals in sheltered housing settings

Considerations and recommendations for phase two

Enhance forms part of an ambition to achieve a more integrated and collaborative cross sector approach. Whilst it may not be realistic to achieve system-level change in the short term, this should be kept in mind throughout ongoing delivery of Enhance as phase two looks to further strengthen relationships and try out new joint working approaches.

When planning phase two of Enhance, phase one research has highlighted the following recommendations, all of which are grouped into three themes – Referral routes and pathways, building partnerships with NTs and measuring outcomes and impact.

Referral routes and pathways

Encourage joint working models

Enhance could encourage and seek to gather learning around the co-working models being developed across phase two, particularly where community spaces are being utilised and colocation is being put in place – alongside continuing to learn from DPs who have already built effective referral routes. This will provide an opportunity to consider approaches that work well or less well, giving regard to the need to tailor activities to the make-up of different areas. Where possible it would be good to continue to allow partners to be flexible and try out different ways of nurturing health-based relationships as they emerge, which was enabled during phase one. Enhance could also look to run more informal cross sector learning sessions, with staff who attended the end of year session suggesting this was a useful way to meet face-to-face and make connections.

Widen referral routes

Phase two is looking to develop a more proactive, preventative approach with individuals at risk of hospital re/admissions. This is positive as feedback pointed out that relatively minor things can delay discharge and if a pathway with Enhance could be set up, it could potentially contribute to pre-discharge care plans. It was identified that senior-level input would be needed to work to embed Enhance as part of an informal pathway route and as highlighted earlier – there are challenges to this (e.g., citywide focus of discharge staff, lack of access to SystmOne).

Other potential opportunities to further embed Enhance across wider health and social care pathways include through: Active Recovery and Intermediate Care, the Transfer of Care Team, GPs and social prescribers, community falls service and any teams responsible for putting discharge care packages together.

Embed Enhance across established referral pathways

Much of the feedback alluded to ensuring referral pathways get to the heart of the intended outcomes of Enhance to both reduce pressure on NT workloads and support hospital discharge. This has been picked up by the LOPF team who are working with LCH and looking at ways to do so.

Health-led initiatives which are modelled around a single point of access were identified as particularly suitable to partnership working, such as the forthcoming Active Recovery Model (LCH NTs and LCC Skills Reablement) and recently developed triage hubs. When discussed, NT staff suggested Enhance could be introduced as a non-clinical referral route.

NT staff teams also made suggestions as to how Enhance could potentially offer a “step down” referral, allowing NTs to close cases earlier. An example of this would be self-management doing a handover to Enhance where need is identified as non-clinical but who would benefit from prompts/ social integration.

Explore ways to simplify and flex referral routes

Referral pathways could be set up with the working environments of staff in mind – giving regard to NTs who may have limited time during or after appointments and who may struggle to access a digital device – with expressed preference to refer via a phone call.

There are ongoing actions to enable DPs to access SystmOne and though this can support system-level ambitions through ensuring data sharing is more embedded, the fact remains that other services in the system do not have access to it. If hospital discharge gets on board - for example with a focus on wards rather than localities and a limited understanding of referral pathways into community-led services - they may respond better if the initial way in is citywide. Though dependent on resource, one NT suggested that LOPF could host a central care coordinator type role.

Cross DP referrals may also benefit from more flexibility, with citywide DPs in particular batting back referrals that did not cover their area. Another issue related to this is that if NTs experience push back from referrals, it may discourage them from referring into Enhance in the future.

Due to the nature of the client group, some clients required a longer period of time to help them gain some independence, or to make outside referrals if this was not possible. Feedback suggests flexibility was already built in to allow for this – so no specific actions around length of support are suggested (indeed, the aim of Enhance to empower and increase independence will be impacted if the model changes to one which provides long term support).

Building partnerships with Neighbourhood Teams

Link in with specific Neighbourhood Teams staff teams

Some interviewees felt that it was overambitious to target NTs as a whole cohort, and that during earlier phases it would work more effectively if Enhance built closer relationships across specific pathways/staff teams within NTs. This included a "step down" from re-enablement, self-management or OT/physio. As highlighted earlier, interviewees referred to NTs who build a consistent overview of the patient and were therefore more likely to link in with community-based support. It was suggested that this could be taken as an approach initially, and then involved staff could promote and cascade the benefits of Enhance to NT colleagues.

Build meaningful relationships at system level

LOPF is starting to make inroads more widely across the Leeds Health and Care system. It has identified a need to work more closely with key health and social care partners across the Integrated Care Board and Integrated Care System, to help raise the profile of Enhance though also the third sector more generally. There are some positive examples of this starting to happen, with Enhance being referenced in the re-design of intermediate care. LOPF is also representing the third sector more broadly through third sector strategies developed/being developed with the LCH and Frailty Board.

As it goes into phase two Enhance offers opportunities to continue building these strategic-level relationships. The Enhance steering group (which contains representatives across the local authority, health and third sectors) is a key resource to help push this wider agenda and ensure there is ownership of the ambitions of Enhance at wider system level.

Whilst it goes beyond the scope of the first phase evaluation, many clients interviewed reported struggling to communicate with the local authority around housing repairs, waste disposal, dangerous pavements – which Enhance workers were able to step in and resolve quickly once they got involved. It is therefore recommended that housing-related providers are linked into wider system-level priorities.

Ensure buy-in from senior clinicians

Strategic LCH staff and operational NTs suggested that a senior clinician or similar is necessary (though by no means sufficient) to give permission to busy NT staff to consider Enhance as an option. A senior clinician could work to ensure Enhance is discussed beyond a few staff at NTs, encouraging staff to focus on wellbeing aspects and alternative referral routes where their capacity is full during handovers and to take the time to refer to community-led initiatives such as Enhance. Alongside this NTs suggested that the operational management team could provide regular reminders about the project, how it works and its benefits. The assessed challenge here was that it will take time for this to make an impact on workloads – and for some NT staff to step away and acknowledge that they do not need to do everything themselves. Again, this is why it may be more beneficial to initially focus on NT staff who are more inclined to use Enhance.

Identify Neighbourhood Teams 'ambassadors'

Peer approaches are identified in wider research as an effective way to raise the profile of and highlight the value of services. A few NTs interviewed suggested they would be willing to 'sell' Enhance across their teams – in two cases the motivation was to ensure that Enhance would keep running. Other NT staff reported being pleasantly surprised by the breadth of support on offer, that it had a positive impact on their patients and reduced pressure on their workload. This feels like a good opportunity to demonstrate the value of Enhance and what it can do through peers talking about what it has done for them.

Other suggestions around promoting Enhance to staff included recording testimonies, and showing visual journeys of patient care at key touchpoints which show where NT and DPs worked together to improve patient outcomes.

Develop a standardised core offer

Though interviewees across both sectors agreed that the holistic element of Enhance no doubt benefitted patients, it also limited NT referrals due to a lack of clarity around the main offer. LOPF is currently exploring what a core offer might look like, this will ideally overlay feedback from NTs about what they valued or would like to see included as part of Enhance. The current challenge here is that some DPs are providing services that some NT areas would like to receive but they cannot refer due to it being outside of their postcode.

Some suggestions, based on feedback provided and discussed earlier include: ensuring the home environment is safe, community integration for socially-isolated patients (particularly patients with limited family support – reported as a key referral nudge by some NTs), agency advocacy (working across housing, primary and secondary health, benefits etc.), setting up services to manage health and care (e.g., keysafes, repeat prescriptions, dosette boxes, attending health appointments, referrals to ASC, encouraging walking and exercise etc.) and financial support. Some suggestions will have implications for DPs that do not currently offer elements of these services - perhaps in these cases a signposting element could be considered. Some NTs felt greater transport options would be valuable – though including this as a core offer is perhaps not realistic without identifying additional resource, at least for some DPs.

It is important to ensure that the core offer is clear and avoids ambiguity. In this vein, as well as gaining feedback from strategic partners across LCH, the core offer should also be shared across NTs too if it is clear and it is what NTs want and need. NT and DP staff also iterated the need to ensure any materials are 'pithy', where the offer can be gleaned at a glance.

Measuring outcomes and impact

There are Leeds-level programme evaluations which show what the third sector can do to improve health and wellbeing, but robust evidence around how this eases service pressures or shows how the third sector fits into the system is limited. This section offers some suggestions for consideration when monitoring and evaluating Enhance moving forward.

Reframe outcomes so they are specific and targeted

In the context of Enhance, it is suggested that for phase two intended outcomes are developed which are more specific and targeted – and ideally can be directly measured in the timeframe

available. For partnership building, outcomes may refer to more tangible activities which demonstrate that Enhance is moving in the right direction, such as establishing a joint initiative/ number of joint visits etc. This may also link into longer term ambitions that go beyond Enhance – such as ways to secure system-wide funding. For clients the focus should remain on the extent to which they are empowered to manage their health and wellbeing within these wider developments (e.g., how attending hubs or joint activities link to these outcomes).

Continue qualitative data capture

The qualitative data collected in phase one has provided valuable learning around the delivery processes that work well and less well. As Enhance moves into phase two and starts to widen referral routes and try out new joint working ventures – continuing a more in-depth approach to capturing process-level and partnership-level learning will remain important – as will understanding the impact on clients who attend hubs and similar community-led cross-sector services.

Amend quantitative outcome measures

The first phase used an initial and follow-up surveys to identify impact using PROMIS and P3C, which measured patient reported health and wellbeing and person-centred coordinated experience respectively. Feedback from Enhance workers suggested that they struggled with the surveys – this may be due to P3C in particular being less suited to measuring third sector led interventions. Following discussion with Professor Helen Lloyd, who was involved in creating the measure, if P3C is used moving forward it should be tailored to ensure question wording is more explicitly linked to the Enhance offer. This in turn may make it easier for Enhance workers to complete, and clients should be better able to link the questions explicitly to the Enhance experience. It may also be worth including a question that links explicitly to risk of falls – as this was a consistent theme across the fieldwork.

Identify avenues to collate NHS evidence

No doubt the numerous case studies and stories which show the positive impact that Enhance has had for clients is powerful and shows why this type of service is needed. Despite this some strategic LCH and LOPF staff felt that ultimately, commissioners are “following the data”. Ideally, Enhance will gather NHS-led data to trace impact, such as exploring changes to flow through a particular system. Whilst this evaluation would suggest it is difficult to measure a reduction in NT workload, at least in the short term (and as evidenced in the analysis of three metrics using SystmOne) – this approach may have more success if data can be matched to frequent NT referrers – so that their individual role is tracked, rather than across NTs as a whole. Other options for improving data analysis for phase two include: enabling DPs access to SystmOne to record more complete information;
use the Leeds Data Model to provide a system-wide cohort matching analysis. Another suggestion put forward is to carry out an audit in which NT staff are asked to answer a list of set questions, but this would need to be considered carefully and perhaps only include regular referrers. Moving forward Enhance can also look to measure quicker discharge or less frequent admission into hospital.

Conclusion

During phase one Enhance has achieved positive health and wellbeing outcomes for clients, with promising examples provided of the potential of Enhance to reduce pressure on NTs and other NHS services through embedding a strength-based holistic approach. While partnership building ambitions are perhaps progressing a little slower than hoped – there is optimism as these continue to build as Enhance moves toward phase two.

The third sector in Leeds has long contributed to supporting the health and care system. There is a sense that the third sector is valued in and of itself, but that its role can be taken for granted by clinical providers, with limited awareness of its crucial role in improving health outcomes and of the precarious and often short-term nature of third sector funding models.

Enhance provides an opportunity to evidence more explicitly the importance of more formally linking the sectors to achieve common aims. This will become ever more important as we witness increasing patient complexity and a drive toward supporting people to age in place.