Enhance learning briefing 10

Stories from the front line

April 2023

Introduction:

This short report is based on monitoring returns from 14 Enhance delivery partners. Stories are grouped under each of the five outcomes of the Enhance programme for year one and all stories clearly show how timely interventions and a person-centred approach can help to prevent future difficulties or a deterioration in a person's health or wellbeing.

*Please note that all names have been changed in these stories

Outcome 1: Empower individuals to improve their own social connections, health, quality of life and/or wellbeing to prevent admission to, or following discharge from, hospital

Petra's* story

Petra recently had a heart attack while she was at her lunch group and was in hospital for a while. After discharge, the Enhance worker visited her home regularly as Petra doesn't have many family members around her. Petra told us that the two most important areas she needs help with are food shopping and help to manage her anxiety. She has been really anxious since the heart attack and doesn't feel confident enough to get back to her lunch clubs or other social groups, even though Petra is otherwise a very social person. The Enhance worker meets Petra once a week to help with her weekly grocery shopping, with chores around the house and to provide a befriending service. Petra's anxiety has reduced and she is feeling better about getting out and about as she accompanies the Enhance worker for shopping trips. Petra now visits her lunch groups - irregularly - but she hopes to resume her regular routine soon.

Earl's* story

Earl was referred to Enhance by ward staff in St James's Hospital. He was in hospital for over 6 weeks after going through multiple surgeries. The Enhance worker met Earl soon after discharge and together they identified areas where he might need support, prioritising help to clean up the house and access food immediately. Earl was worried that his sick pay wasn't enough to pay for his mortgage and we helped him to apply for benefits. Earl's health has improved and he is now doing well, he is out and about with work and is again able to clean and cook for himself. We'll soon be doing a second assessment as we believe we can sign him off from Enhance support soon.

Edna* and Billy's* story

Edna needed an operation for a broken hip after a fall and is a carer for her husband Billy who has very advanced dementia. Whilst Edna was in hospital the Enhance worker supported Billy at home by providing daily visits and multiple daily phone calls, arranged taxis for him to visit Edna every day, supported Billy with household tasks and took him to pay their bills. This prevented Billy needing emergency residential home care and gave Edna peace of mind so she could concentrate on her own recovery.

Faith's* story

Faith lives with COPD and multiple other health challenges, and Neighbourhood Team staff were very concerned that the effect of her cold, draughty home may cause a deterioration in her health. Through Enhance we addressed Faith's needs for financial support through benefits checks and Heating on Prescription from the Green Doctor service. We also provided practical items using the Household Support Fund to keep her warm whilst she awaits repairs and insulation upgrades on her council property.

Lucy's* story

Lucy has a number of health issues, including type one diabetes and dementia. After returning to Lucy's house after a quick errand, the Enhance worker noticed that Lucy had become vague looking, very hot and sweaty and unresponsive and so called 999. The ambulance arrived quickly and discovered Lucy was having a diabetic hypo and her blood sugars were down to 1.3 (should be between 4-6). Gradually Lucy responded to treatment and became more her usual self. Without Enhance intervention Lucy would have slipped into a diabetic coma, and with the nurses not due for another 4- 6 hours the outcome could have been very different.

Manny's* story

Manny recently lost his wife and was struggling to adjust. He attempted to take his own life, something which he now regrets. He was allocated a Community Mental Health Worker who referred him to Enhance. Manny felt he needed more social interaction and to feel more connected with people around him and to assuage his negative feelings. A joint visit was arranged with the Enhance worker and the Community Mental Health Worker and Manny's carer was also present at the meeting. Different options of support were discussed and he agreed that he would like to start attending a local Coffee Morning and also the Men's group. Taxis were arranged and Manny really enjoyed meeting people and said he would go again. Without this support and interaction there is a very good chance that Manny could have made another attempt on his life which could have resulted in further hospitalisation, or worse.

Clara's* story

Clara had not been out of the house without her daughters for a long while. She was experiencing fatigue and at times did not want to get out of bed. Clara felt it was time to start attending activities though did not feel confident to go to an activity on her own. The Enhance worker arranged to meet her at her home and to walk to a local activity with her. Clara felt her neighbours would be shocked to see her out. She was also apprehensive that she would not know anyone, nor would anyone be from the same ethnic background as her. She also felt that no one would be as visibly unwell as she felt she looked: she had tremors and was very self-conscious about it.

During our walk Clara waved at two of her neighbours and we chatted all the way there. Once inside the building she recognised one of her neighbours and talked with her. Her neighbour told Clara about the different groups she attends and that Clara would know some of the other attendees. Clara has arranged to join these groups, initially going with one of her daughters.

Sonny's* story

Sonny was admitted to hospital for around three weeks and on discharge we liaised with other services and Adult Social Care to put reablement and care teams in place. Consistent communication with services and Neighbourhood Teams resulted in the care being in place longer term. This supported Sonny to maintain their independence at home and also allowed consistent monitoring to watch for any further health concerns. We also supported Sonny to attend hospital appointments following on from discharge which allowed them to keep up to date with health checks and improved their confidence in engaging with appointments. It is likely that all this preventative work has an impact on hospital admission and readmission rates.

Anita's* story

Anita, aged 80, was not feeling safe driving. Her family was worried about her so they wanted her to stop driving. Anita also wanted to increase her social connection so an Enhance worker organised an access bus for her to go to different places. Now she goes shopping twice weekly and has made friends on the access bus. Anita feels much safer travelling by access bus than she did when driving and this has potentially reduced the likelihood of hospital admission following a car accident.

Farad's* story

Farad is 83 years old and frail and lives by himself in a council property. His electricity supply had cut out suddenly and he wasn't sure what to do, so he did nothing. When the frailty nurse made her scheduled appointment she noticed Farad didn't have the television turned on or any lights on and called the Enhance worker for assistance. The Enhance worker made many phone calls for Farad over a number of days until the situation was fully resolved and he had electricity again. This intervention is likely to have prevented hospital admission by reducing the likelihood of falls whilst the house was in darkness.

Outcome 2: Take a person-centred approach by coproducing flexible, effective and tailored cross-sector support to identify goals and improve outcomes for individuals

Jack's* story

Enhance staff worked in partnership with a Community Cancer Nurse and Occupational Therapist from the Neighbourhood Team to support Jack, a 92 year old man who is receiving palliative care and lives alone. Support started just before the Easter weekend and the Enhance worker took an Easter egg for Jack, who was over the moon with this kind gesture. Jack also received bedding, food, socks and underwear and laundry service. His bed was moved downstairs as previously he couldn't access it, and he now has regular wellbeing checks. He and his son now have information on sheltered accommodation which they are considering.

Tony's* story

89-year-old Tony was discharged from hospital with no care package or support at home. On returning home, he had a fall and was unable to contact anyone for help. Luckily our Enhance staff were able to gain entry to his home after being alerted by a neighbour that his curtains were still closed, and we were able to attend and call for medical support. During his subsequent hospital stay it was decided that he could no longer live independently as his care needs were too complex. The outcome for Tony, had we not attended with the neighbour, could have been so very different. Tony has now been moved into a care home.

Outcome 3: Enhance the NHS by investing in third sector services to complement clinical service provision and reduce delays in hospital discharges

Hari's* story

The Enhance worker was making regular befriending calls to Hari, aged 93. It was when a call was unanswered that we found out that Hari had been admitted into hospital due to being hit by a car. Hari was in hospital for a few weeks and once he was able to leave there were concerns as he had no food, drinks and no support system in place at home. The Enhance worker made sure that Hari had food in and, along with a colleague, cleaned the flat ready for his return. A fall pendant alarm and a key safe were also fitted. By the Enhance worker picking up these jobs, it allowed Hari to return home quicker without having to wait for a named social worker, and he has peace of mind knowing he has support in place if he needs it.

Anthony's* story

We accompanied Anthony to the hospital every week for his chemotherapy sessions as he had no family nearby and couldn't travel by himself. He's finished with his treatments and is now cured. We accompany him every month for follow up sessions to make sure he's still doing okay. Anthony said that knowing that he had access to constant support from Enhance has helped him with his mental and physical health and feels that Enhance was "god sent" in his life.

Shelly's* story

Shelly's mobility deteriorated due to arthritis. She is struggling to manage some activities of daily living at home, such as showering and cleaning, and getting out is becoming more difficult. An Enhance worker visited her at home and discussed what was important to her. As a result, we supported Shelly to apply for Attendance Allowance and referred her to an Occupational Therapist for an assessment of home adaptations for showering and a 'perching stool' for the kitchen so she can cook. Shelly now has some adaptations in place, helping her to remain independent at home. She is now in receipt of Attendance Allowance and is using it to employ a cleaner and for taxis so she can visit friends.

Steve's* story

Steve was referred to Enhance for support with getting services in place such as cleaning and shopping due to physical impairments and also difficulties navigating services independently. He wanted to maintain his independence but struggled with where to find the right services to assist. Steve said he felt his visits from his Neighbourhood Team didn't allow enough time to help him resolve his issues. After an Enhance worker spent some time with Steve to discuss his priorities, he said he already felt relieved that he had more time to chat. During subsequent visits we were able to help Steve get some structure around his energy bills, prescription

deliveries and help him maintain his independence with light help around the house. He said he found it ‘so helpful and kind’ to have an Enhance worker who was able to provide more time with him during his recovery. Building rapport with Steve also allowed us to encourage him to attend medical appointments and engage with healthcare staff better as we were able to explain their roles and importance of these appointments in a way which worked for him.

Frida’s* story

Frida’s son lives a long way away and he had a high level of concern that he could not be with his mother to help with her illness management. Frida has hearing issues and anxiety when contacting the doctor's surgery. Our Enhance worker called round in person to help Frida arrange a doctor’s appointment and to explain to her that she would be accompanied to the doctors to try and help alleviate her anxiety. When we tried to contact the doctor the phone was cut off so Frida started to get agitated. To help reduce her stress levels the Enhance worker drove to the doctors to speak with them in person and to arrange an appointment for her face-to-face. Frida said this was a great help to both her and her family, and she is glad someone is coming with her to help reduce her anxiety.

Outcome 4: Enhance partnerships between third sector organisations, health professionals and individuals to improve efficiency, share up-to-date information, resolve challenges and evaluate impact

Joan’s* story

Joan was referred to Strength & Balance run by Active Leeds. Her mobility was poor with a limited range of movement. Jean completed their 8-week course and then joined our Enhance ‘Moving On’ sessions as she wanted to continue regular exercise. Joan would not have been able to continue had we not been able to provide transport to and from the sessions. Not only has Joan’s mobility vastly improved, but her confidence and social networks have too as she socialises with new friends she’s made at the class.

Satinder’s* story

Satinder was on the End of Life pathway and required support with shopping. After a holistic needs assessment we were able to provide her with all the necessary information and options for shopping and other tailored support such as sourcing and delivering a pressure cushion for her, liaising with the pharmacy about pain relief and making drinks for her. Satinder enjoyed bird watching and so we often supported her to take a walk in the garden where we also spotted some birds.

Sabina's* story

Sabina is currently undergoing several treatments including for cancer. She has extreme anxiety as she is currently in and out of hospitals almost every single day, and this has taken a huge toll on her mental health. Through Enhance we provide her with befriending services and help build her confidence. Sabina fears going out by herself and her Enhance worker has been accompanying her on walks and taking her out to reduce her fear and anxiety. We recently referred, then accompanied, Sabina to Maggie's Leeds where she was briefed on what kind of cancer support is available for her and this has really helped her. Enhance has helped Sabina with her anxiety which could have led to hospital admissions but also being part of the project has helped her with building her confidence as well.

Betty's* story

Betty, aged 64, has complex mental health issues. The flat in which she was living was not suitable to her needs as it was on the 4th floor. This caused access issues due to her poor mobility and she had lots of issues with antisocial behaviour from neighbours. Betty had problems sleeping because of these issues and she also struggled to leave her flat. As this affected her mental health she was ringing her GP surgery up to 4 times a week for support and she attended A&E a number of times. After some partnership working with Housing Leeds, the Enhance worker was able to support Betty to move flats and this has had a life-changing effect. Betty is now able to go out to see family and attend different social activities. In the last six weeks since the move Betty has not attended A&E once.

Outcome 5: Use a Test and Learn approach to build on our understanding of 'what works'

Kevin's* story

Kevin, aged 74, recently had a lower leg amputation and he was finding it hard to get around. He said he really missed being able to get around and do his own shopping or just go and visit his mates. We discussed mobility scooters and he loved the idea, so we tested the idea of lending him one that had been donated to our organisation, after having it serviced. Kevin knows he can borrow the scooter for as long as he needs to and is so pleased that he can access local facilities and services and, most importantly, it has given him back his independence and freedom.