Monitoring and Evaluating Enhance

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Outcomes for Enhance in Year 2

1. Take a person-centred approach by coproducing flexible, effective and tailored cross-sector wrap-around welfare support which leads to improved outcomes for individuals
2. Empower more individuals to manage their own health needs and improve their own social connections, quality of life and wellbeing
3. Reduce pressure (planned and unplanned) on NTs by investing in third sector services to complement clinical service provision
4. Develop stronger partnerships between third sector organisations and health and social care professionals in Leeds to support timely discharge from hospital and reduce pressure on the wider health system
5. Use a Test, Learn, Improve approach to build on our understanding of 'what works' in Leeds to develop partnership working with NTs, improve outcomes for individuals and to evaluate impact on individuals, NTs and the wider system

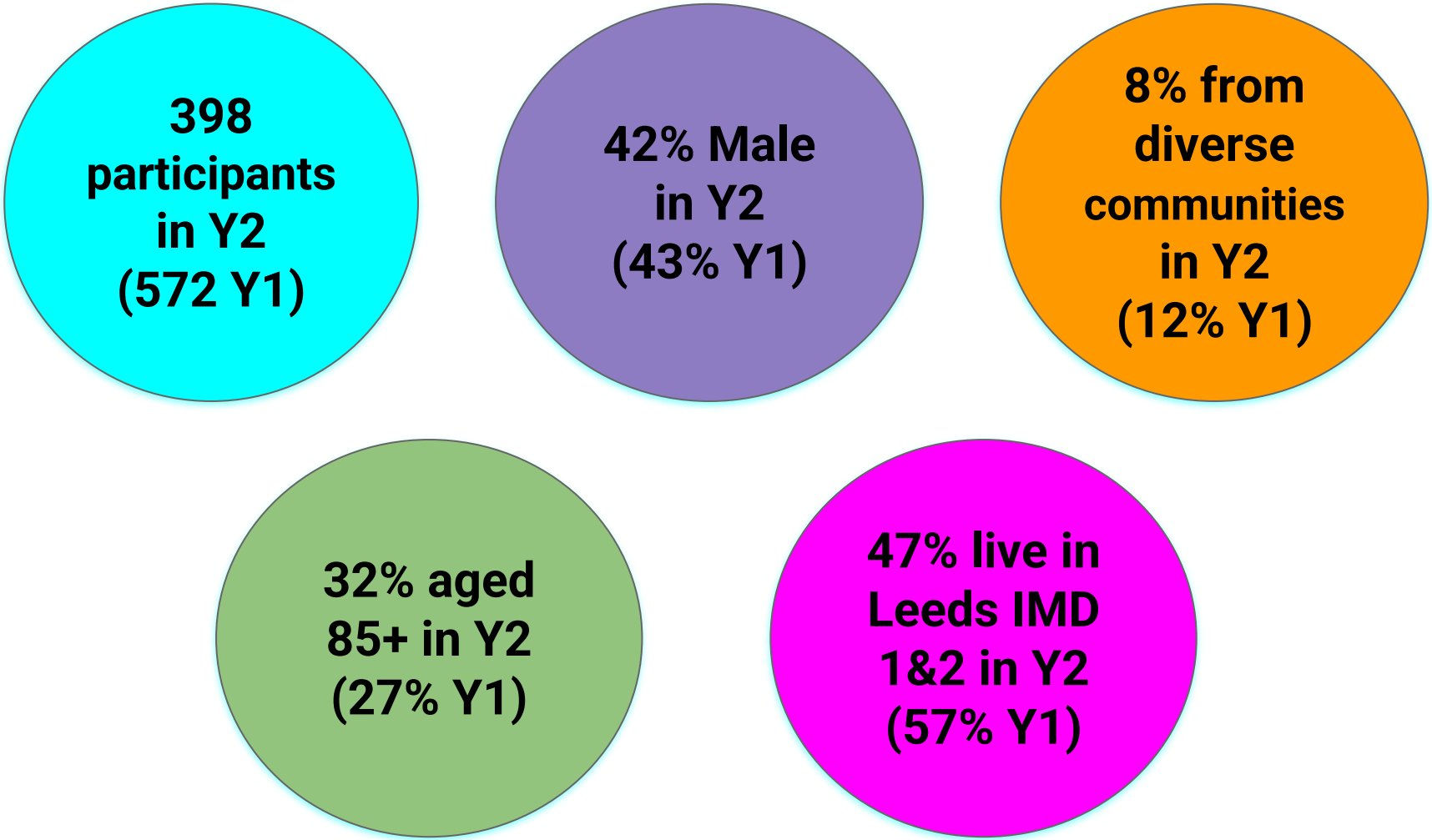
Overview - Monitoring and evaluation (M&E) for Enhance:

- Is quite tricky
- Requires teamwork
- Uses multiple sources of data to build a full picture
- Has limitations

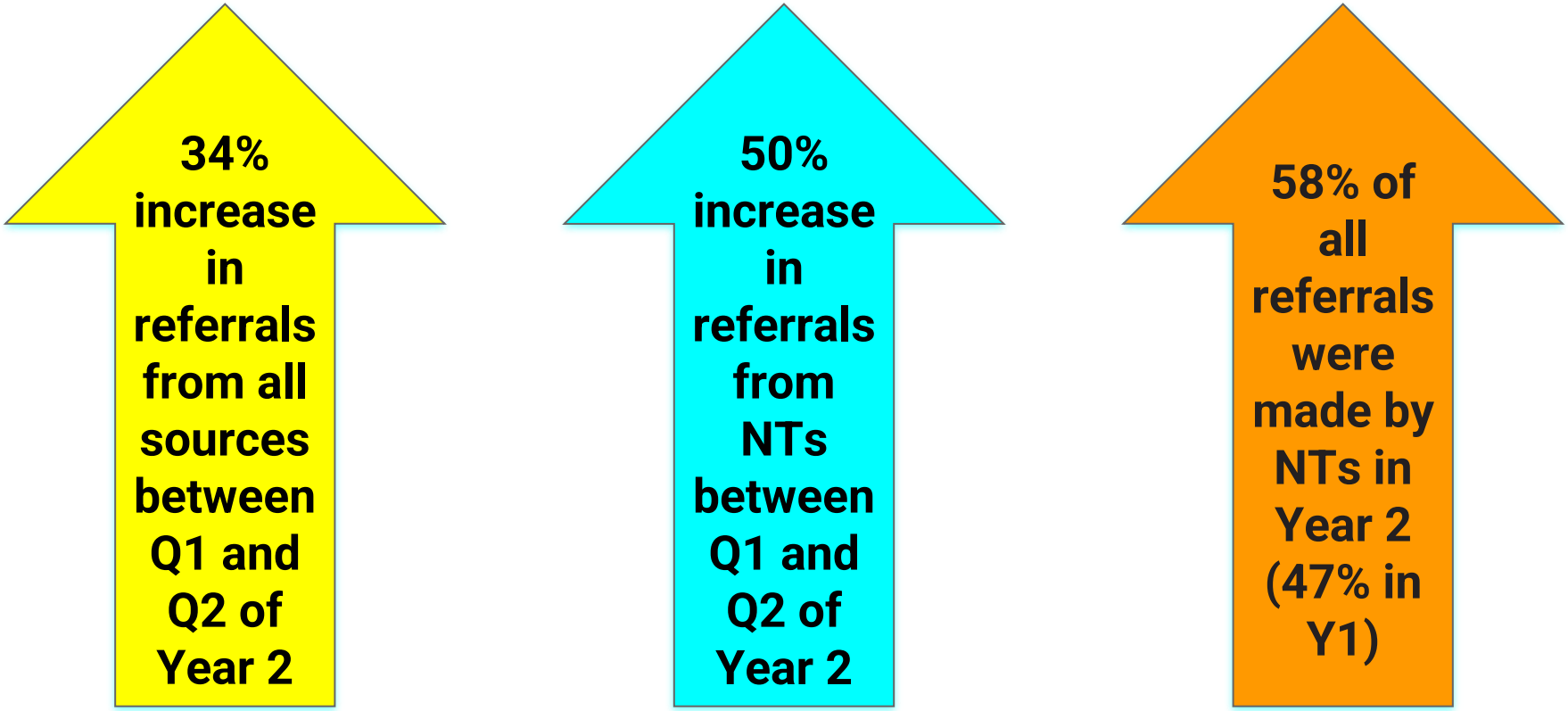
Data supplied by delivery partners each quarter includes:

- The huge variety of tasks that contribute to person-centred support
- The benefits and challenges of partnership working
- Anonymous stories and quotes from participants
- Demographic data for ALL participants, regardless of referral source

Data from delivery partners for all referrals:



Referral sources as recorded by delivery partners:



Enhance

Leeds Older People's Forum

Forum Central

NHS Leeds Community Healthcare NHS Trust

Gemma Howorth

Information Analyst,
Health & Care Evaluation Service,
Office for Data Analytics, NHS

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Method for the quantitative evaluation

Leeds Community Healthcare Trust provided SystmOne data on the referrals made by the Neighbourhood Teams into the Enhance service.

This data was linked to wider health and care datasets held within the Leeds Data Model (LDM) using unique referral numbers and pseudonymised NHS numbers to gather demographic information and information about current medical conditions.

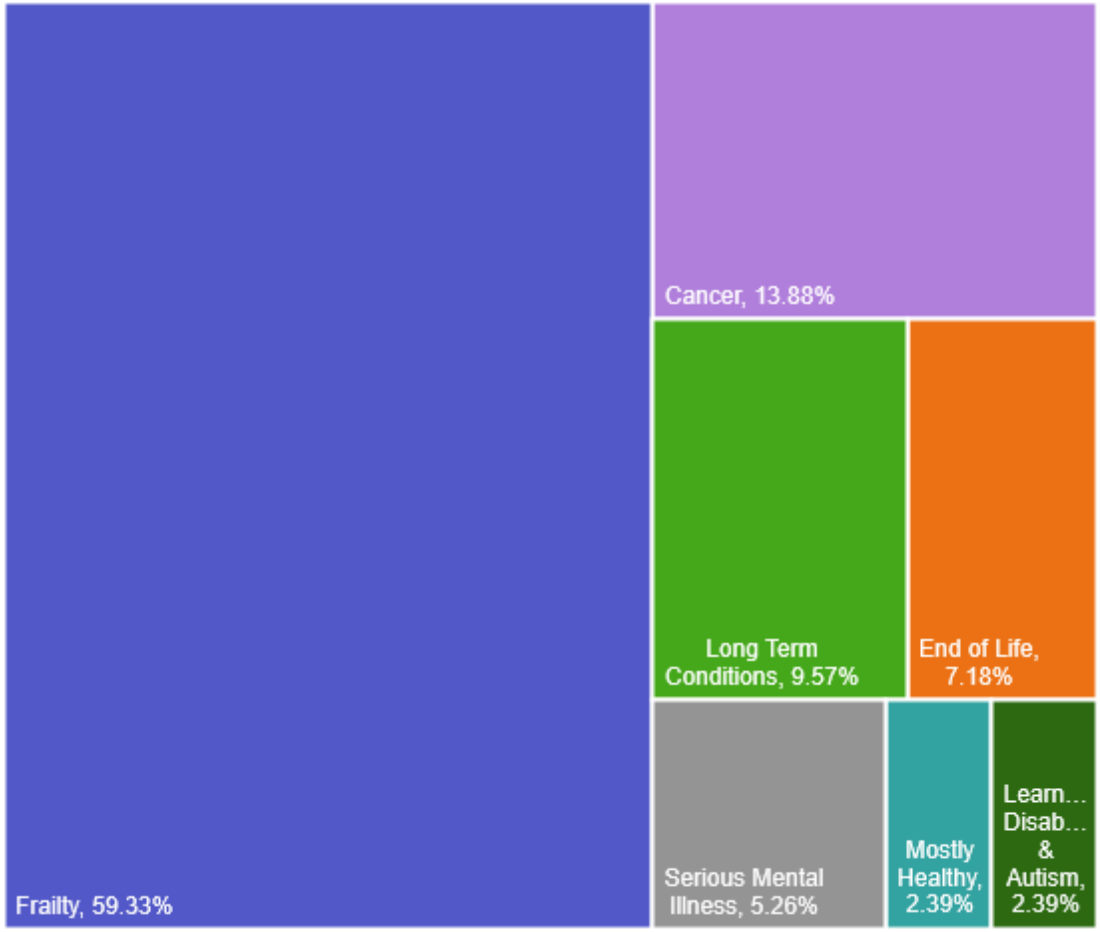
Referrals from Neighbourhood Teams

Source of Referral	Total	Q2 2022	Q3 2022	Q4 2022	Q1 2023	July & Aug 2023
All Referrals	249	64	42	38	67	38
Leeds Community Neighbourhood West 1- Armley	54	25	16	7	5	1
Leeds Community Neighbourhood North 1- Meanwood	52	7	4	16	17	8
Leeds Community Neighbourhood North 2- Seacroft	41	7	6	3	16	9
Leeds Community Neighbourhood North 2- Chapeltown	31	11	6	3	9	2
Leeds Community Neighbourhood South 2- Middleton	24	7	4	2	10	1
Leeds Community Neighbourhood South 1- Beeston	14	2	1	0	5	6
Leeds Community Neighbourhood West 2- Holt Park	10	1	3	4	1	1
Leeds Community Neighbourhood South 1- Morley	7	0	0	0	2	5
Leeds Community Neighbourhood North 1- Wetherby	6	0	0	1	2	3
Leeds Community Neighbourhood West 2- Yeadon	4	2	1	1	0	0
Leeds Community Neighbourhood West 1- Pudsey	3	0	1	0	0	2
Leeds Community Integrated Wound Management	1	1	0	0	0	0
Leeds Community Neighbourhood South 2- Kippax	1	1	0	0	0	0
Leeds Community Neighbourhood West 2- Woodsley	1	0	0	1	0	0

N.B. Morley and Pudsey Neighbourhood Teams were not included in Year 1 of the project

Population Segments

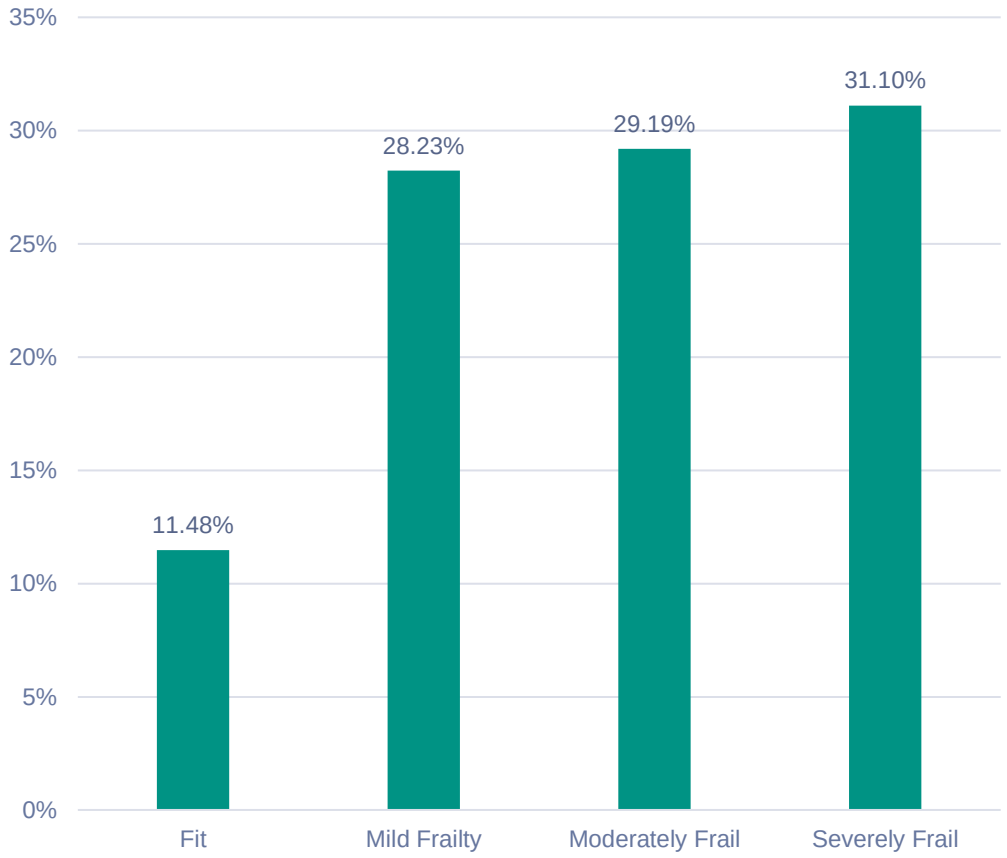
- Over half the of service users were in the frailty population cohort (59.33%)
- 13.88% were in the cancer population cohort
- 9.57% were in the long-term condition's population cohort
- 5.62% were in the serious mental illness cohort
- Less than 3% were in mostly healthy and learning disabilities & autism cohorts (2.39%)



The Electronic Frailty Index is a tool that can be used to identify people as they progress through different levels of frailty

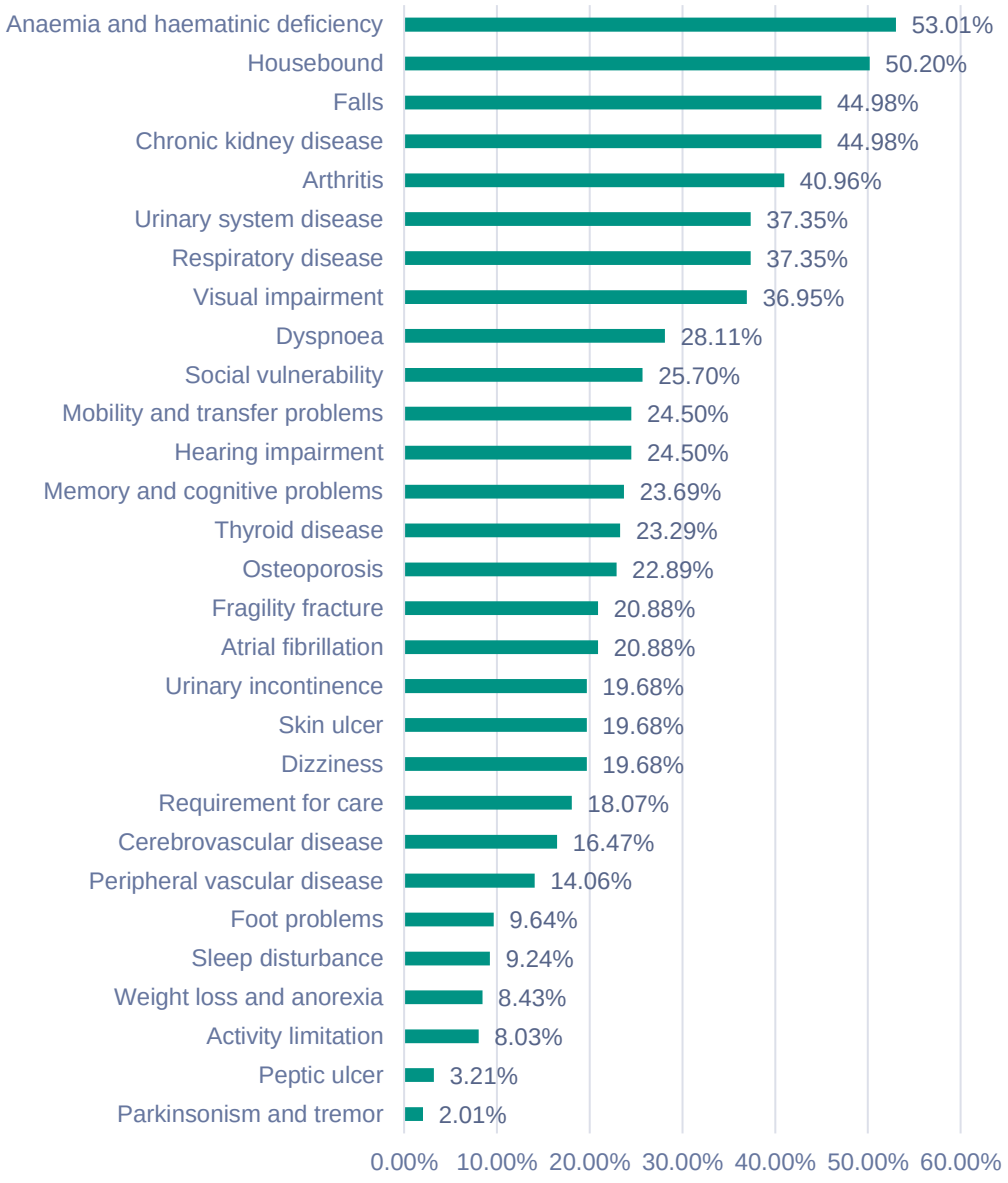
Frailty Indicators

- 88.51% of service users had some level of frailty
- 31.10% were considered severely frail



Frailty Indicators

- Over half of the service users were housebound (50.20%).
- 44.98% of service users had a history of falls
- 24.50% had mobility and transfer problems
- A quarter of service users were considered to be socially vulnerable (25.70%)



Dr Sarah Alden

Independent Social Researcher

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Building on evaluation findings from year one

Continues to achieve positive client outcomes around empowerment to improve health, wellbeing and independence and build evidence of this beyond the home

Building new, and embed existing relationships across Neighbourhood Teams to offer complementary support and reduce service pressures

Extends reach through opening additional referral pathways across the health and care system

Gathers learning to support achievement of a shift from organisational collaboration to effective systems working

Exploring longer term impact

Participants:

Extent to which assessed health and wellbeing outcomes have been maintained

Neighbourhood Team staff:

Ongoing referrals, partnership building and assessed impact on role

Key message: How does Enhance add value for NTs?

- Connecting patients to services and advocating for them when needed
- Applying a holistic (“whatever is needed”) approach
- Offering social support and building confidence for the most isolated patients
- Delivering responsive support to ensure a patient can stay safe at home
- Providing complementary support
- Added value where teams work together to deliver support, helps to build trust

Key message: reported NT staff outcomes

- Provides peace of mind, enhances role satisfaction
- Able to discharge long term patients due to Enhance meeting non-clinical and social needs
- Examples of saving time through delegating specific tasks (ASC referral, contacting services, apply for dosette boxes, exercise and medication prompts, buying essentials)
- Where Enhance support community hubs described as efficient and meeting clinical and social needs
- Some patients more willing to carry out clinical tasks independently through building confidence and community integration

Key message: reported outcomes and impact around increased independence for participants

- Provided a springboard to improving mental health and wellbeing through building social engagement
- Continue to benefit from financial and practical help
- Retain a safer home environment
- Those linked to community hubs positive about its social benefits and convenience
- Those who received ongoing light touch support or attend follow-on activities reported more positive impact

Some early reflections

- 12 week offer works well for some, though less so for those with more complex or entrenched needs
- Holistic support valued, though for some a more goal-oriented approach may be more effective
- Building on positive learning around working together to meet the needs of the most complex clients
- Exploring ways to further embed Enhance support across LCH led activities (e.g., community hubs)

Next steps for the evaluation

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Next Steps for Year 2 - Gemma's quantitative evaluation:

- A new dataset using NHS numbers will extend demographic analysis to include ALL referrals

- Further analysis on all referrals will assess the extent to which the activities of Enhance are helping to support vulnerable people and to alleviate the pressure faced by health and social care partners

Next Steps for Year 2 - Sarah's qualitative evaluation:

- More interviews with participants and operational and statutory stakeholders
- Face-to-face observation across different settings, such as the community hubs
- Case studies
- Analysis of Enhance two-phase evaluation questionnaires completed by participants

Both strands of the evaluation will combine into a single Year 2 evaluation report, due in Spring 2024

Future plans for Leeds Older People's Forum

- It's our ambition to continue Enhance and its evaluation
- Review / refresh the 5 Enhance outcomes
- Use the evaluation report and delivery partner insight to develop Enhance, building on the Test, Learn, Improve approach
- Find better ways to evidence the impact of third sector collaboration, cost savings and value for money