The Enhance Programme

Year 2 Conference
9th November 2023

People.
Prevention
Partnership

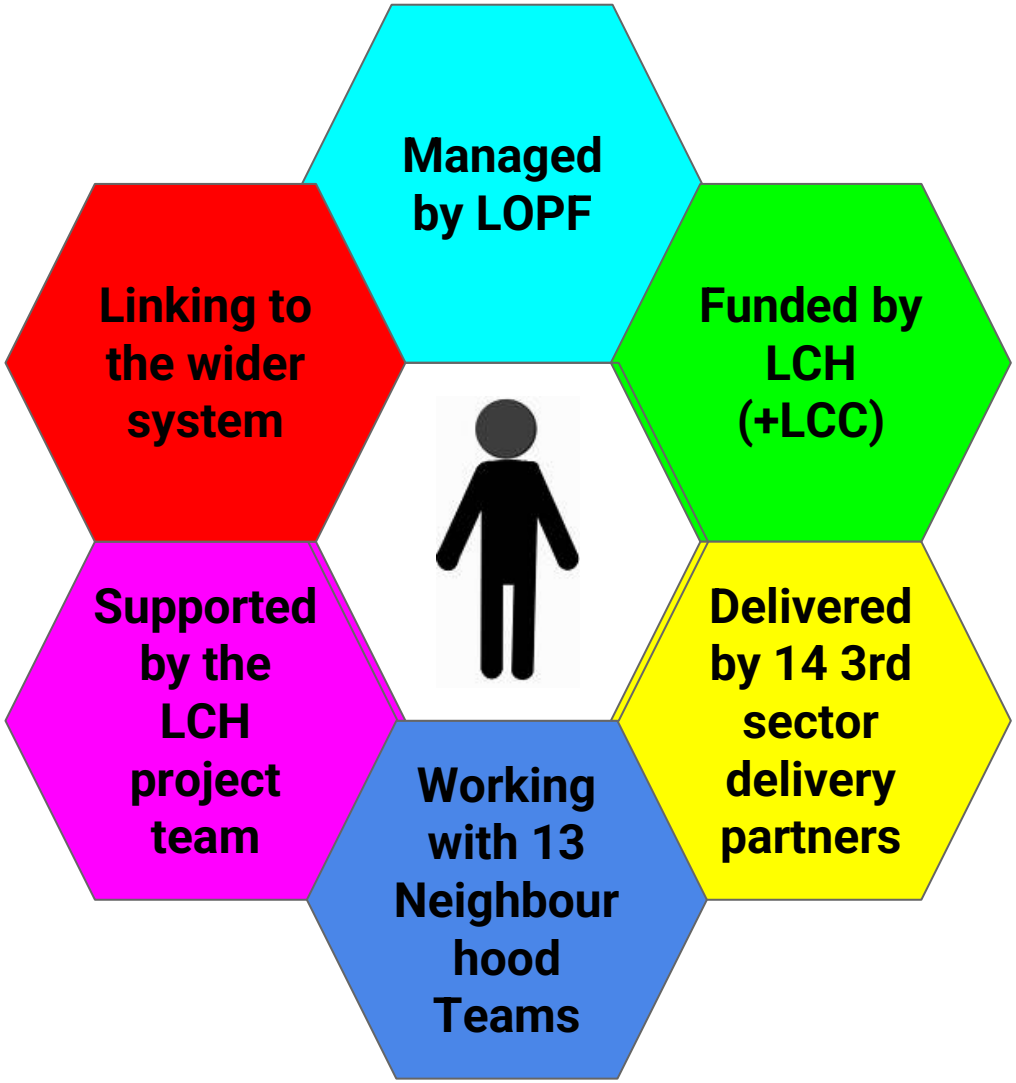
Enhance

Leeds Older People's Forum

Forum Central

NHS Leeds Community Healthcare NHS Trust

How does it work?



Is it working though?

I am delighted to have a service [Moving On] like this to refer into for low risk patients. It will save therapists time, reduce their waiting lists and caseloads

SNT Self Management Team (Cross Gate)

I'm not used to relying on anybody for anything, but you're really helping me sort out what it is that I want to do next. I hadn't realised that I had much choice in the matter."

83 year old person (Age UK Leeds)

Feel Good Factor

You've helped me a lot when I was released from my counselling. You help with resources such as food parcels. You checked up on me regularly. I was struggling at a lot, you helped me get my footing from where I was to where I am now

Thank you so much for helping our parents you have made us realise we are not on our own and can ask for help rather than just muddle on.

(Health for All)

Is it working though?

We've seen changes in patients that we didn't think would be possible before. With Enhance support they have so much more motivation and are doing things they never would have considered before

OT at Meanwood NT (Leeds Irish Health & Home)

thank you so much to the Enhance Team for the support you have given Arthur. The latest is wonderful news, you have restored his motivation and confidence, going forward the med prompts which were set in place, will no longer be required as of next week, this has been a marvellous outcome all round and the nursing team will be pulling out on Monday

Kippax NT

Participant (Armley Helping Hands)

Thanks for pushing me all the way around the hospital

Good luck with your continuing work with the lady we spoke about – don't underestimate how much you are offering by being alongside her and listening" (whilst she is on the waiting list for support)

Hospice support worker (Age UK Leeds

Impact on People

Outcome 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

Outcome 2: Empower more individuals to manage their own health needs and improve their own social connections, quality of life and/or wellbeing

Impact on People

Paula was referred by an occupational therapist for support with cooking and coping at home as Paula recently moved from supported accommodation to live independently. Paula is in her 50s and has learning difficulties, Cerebral Palsy with Spastic Diplegia and has recently had a stroke. She struggles with her mobility due to left calf spasticity. When the Enhance worker visited, Paula showed her around her kitchen. There was an air fryer - which Paula didn't know how to use - but no cooker. Paula's freezer was stocked with food but she had removed the packaging to be able to fit more in so there were no instructions or cooking times.

The Enhance worker showed Paula how to use the air fryer, printed off cooking guides for her, and explained how to test things that were cooked before eating them and talked about eating a balanced diet, eating fruit and cooking veg. On the next visit the Enhance worker gave Paula a folder with lots of beginner's air fryer/ slow cooker recipes for her to try, and they now speak weekly. Paula gives updates on the food she has cooked and new recipes she has tried, as cooking has become a hobby. Paula is really proud of herself and her achievements and has invited friends around for tea.

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Impact on LCH (& the wider system)

Outcome 3: Reduce pressure (planned and unplanned) on Neighbourhood Teams by investing in third sector services to complement clinical service provision

Outcome 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

Outcome 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

Impact on LCH (& the wider system

Peter's story

Peter is 70 years old, lives alone and presents as having a learning disability, though this is undiagnosed. He was a frequent falls risk, resulting in him calling the Neighbourhood Team (NT) for assistance. Peter would receive, on average, one 30 minute unplanned visit per week from the NT for help following a fall

Peter also a received a planned NT visit per week of about an hour for wound and leg care (Neighbourhood Clinical Assistant or Registered Nurse) and 1x 60 minute NT visit per week for management of long-term conditions (Community Matron).

Peter had also been hospitalised following a fall a number of times with minor injuries such as cuts and bruises and a broken rib.

Peter was referred to an Enhance Delivery Partner for social support, and for him to attend the Health Hub for his leg and wound care.

Impact on LCH (& the wider system

Enhance involvement with Peter

After spending time building a relationship with Peter, the Enhance worker established that Peter was not taking his antidepressant medication as prescribed. This contributed to Peter experiencing memory problems, confusion, and to him being unsteady on his feet. The Enhance worker worked with Peter to build trust, and encouraged him to use a dosset box for his medication. She also set up mobile phone alarms to prompt Peter to take his medication at the right time.

A referral was sent for a housing support worker, who arranged for Peter to move into sheltered accommodation as well as help to assess trip hazards. It was arranged for Peter to have a falls pendant, which alerts his sheltered housing staff if he has a fall. A key safe was also installed to improve Peter's security.

Impact on LCH (& the wider system

The Enhance worker supported Peter to attend the Health Hub, and he also now attends for social activities regularly. Staff at the Health Hub noticed a change in Peter's behaviour, and organised prompt emergency care for a suspected stroke.

The Enhance worker also worked with Peter around positive relationships to reduce the risk of financial abuse from a neighbour. Peter has received support with paying his bills by direct debit and the Enhance worker has supported him with reading letter and bills. The Enhance worker has supported Peter with access to benefits. Peter has also shown some interest in improving his appearance.

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Impact on LCH (& the wider system

Outcome for Peter

- Better management of Peter's overall health.
- Better compliance with medication, therefore reducing Peter's risk of falls.
- Peter is much happier and feels safe and secure.
- Peter is now coping better financially.
- Medical appointments are not missed due to better reading of letters and accompanying Peter to appointments due to his anxiety around authority figures.
- Improved confidence and self-esteem.
- Fully recovered from suspected stroke.
- Access to benefits and a fully funded care package.
- Access to a new mobility scooter and improved confidence in using it.
- Better food preparation skills and a healthier diet.

Impact on LCH (& the wider system

Value for the Neighbourhood Team

Clinical time

- Unplanned call outs for falls reduced: 1 x 30 mins per week (Band 5 Nurse or Band 3 NCA)
- Community Matron visits to manage LTCs reduced from 60 mins weekly to 60 mins fortnightly
- Peter has now been discharged from leg and wound care so no longer requires clinical care at the Health Hub
- Attending Health Hub 2 x per week saves 2 x 30 mins of weekly home visits by Band 3 NCA (Band 5 Nurse every 3rd visit)

Non-clinical time

- Community Matron is saved 60 mins of phone calls per week to Peter/other organisations
- Community Matron is saved 1 hour of non-clinical admin time per week (eg. organising key safe, hospital transport, housing, liaising with organisations etc.)
- Travel time saved 15 mins per visit x 2 = 30 mins

Total time saved for Community Matron = 2.5 hours weekly
Total time saved for Neighbourhood Clinical Assistant/Nurse = 1 hour weekly

Value for the wider system

Reduced stay in hospital following a stroke due to prompt care at the Health Hub

How has the programme developed in year 2

Review of DP provision resulting in dedicated DP for Pudsey and Morley aligned to NT boundaries
Strengthened Outcomes & Measures
Development of a Core Offer
Delivery Partner Rationale
Promotional Materials
Mapping and Postcode Finder
Widening Referral Sources

How has the programme developed in year 2

Strategic Engagement
Widening our Evaluation - Quantitative
Widening our Evaluation - Qualitative
Community Health Hubs
Neighbourhood Team Engagement

Our Intention for Years 3-5

- To seek a funding commitment for 3 years
- To cover all areas of Leeds
- To continue to work in close partnership with LCH to provide continuing development
- To deepen NT engagement and increase referrals
- To extend referral routes across LCH
- To continue to support the wider system with a third sector offer
- To target the reach into communities facing health inequalities
- To provide value for money

What if Enhance is not Continued?

Delivery partners would not be able to continue
Core Work vs Enhance Provision
Less Capacity for Partnership Work
Frailty & Complex Issues Harder to Support
Exit Strategy
Decision Process

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