Enhance Learning Briefing 16

Stories from the frontline: holistic, person-centred support

January 2024

Introduction

This short report uses real-life stories provided by Enhance delivery partners as part of their quarterly monitoring. It focuses on how each of the 13 partners provide holistic, person-centred support - to help people get enough food, warmth, healthcare and other basic necessities, do exercises, tackle practical tasks and increase social connections - and the impact this has on a person's health and wellbeing. Health for All shared this photo after handing out Christmas presents from the team. *All names have been changed.

Enhance support helping people to get food, warmth and healthcare

OPAL: Ernie* was referred to Enhance as he had no food in the house. We used a £25 ASDA voucher (from our work with the household support fund through the Anchor Network) to do an ASDA shop for him. His house was also cold and dark. We referred him to Age UK Leeds for a benefits check and referred him to Adult Social Care. We also loaned Ernie an electric heater and gave him a warmth pack the fire service had given to us. Following the referral he had food and warmth immediately, and things have been put in place to help in the long term.

Action for Gipton Elderly: Ellie* a volunteer and previous Enhance participant, was diagnosed with terminal bowel cancer. Her only family were two adopted sons who work away but she wanted to be at home as long as possible and stay out of hospital. Enhance supported Ellie at home by taking food and shopping, driving her to appointments, providing home visits for social contact. She went into St Gemma's hospice for the last week of her life, the Enhance team visited daily and her sons came home to spend time with her at St. Gemma's. Ellie died with dignity and peace with her sons by her side.

Feel Good Factor: Sally* was referred by Adult Social Care. She is diabetic and lives alone in a large house. Sally also has dementia and would often mention that she had problems with her memory. She struggled with managing her property, her health, mobility and managing meals. She was being supported by a close friend and occasionally family members, particularly with managing her medication, shopping, meals and taking her out. Sally previously had not managed her diabetes and did not trust taking medication.

Enhance supported Sally with regular home visits and calls and provided food vouchers to help with buying food. I contacted her housing officer and we visited Sally together to provide support with issues she was having around the home, and I re-referred Sally back to Adult Social Care. I had noticed during a visit that Sally's feet appeared red and sore. I pointed out my concerns to Sally and her friend and, as Sally has diabetes, suggested she see a Doctor. Her friend agreed to take her to have her feet checked.

Sally is now on the waiting list for an assessment for her care needs and has been seen by a Doctor to check her feet, thus preventing it from becoming a serious health issue. Sally and her friend know her housing officer and me and will call if support is needed, however family members have said they will give more support.

Burmantofts Community Friends: Over the last 3 months Enhance staff have noticed that there has been an increase in the number of Enhance participants coming into the office to ask for support around accessing food. The reason this has happened is in response to the cost-of-living crisis and that members' health conditions are worsening.

Over the last quarter the Enhance team has given out 12 food vouchers to members who have been financially struggling. On home visits they have prepared sandwiches and small meals for members who have been physically struggling to make meals. They have signposted and referred members to meal delivery schemes such as Presto and Wiltshire Farm Foods. They have also hosted events such as Lunch clubs, afternoon teas, Christmas meals and a Christmas party where members have had access to low-cost quality food.

Enhance support helping people to do regular exercise

Cross Gates and District Good Neighbours' Scheme: Our Enhance led Moving On group is a weekly exercise group that is only accessed via a referral from Enhance workers. This group is solely to support frailer members who have lost muscle use, confidence and mobility. The exercises have enabled most of the participants to gain a much wider movement and flexibility range. It also addresses the social side of isolation as afterwards they enjoy refreshments and a chat. Feedback from participants is very positive:

"Well [the exercises] must be working as I don't need my walker now, I am just walking with a stick. I will continue with the classes in the hope I improve further"

"Really enjoyed the last few weeks. Feel like I have had a full head to toe workout and am more supple when I leave".

"I have really missed the classes and the people over the Christmas Period and am looking forward to getting back".

Leeds Irish Health and Homes: Wanda* was referred by a Community Physiotherapist for help accessing a fall prevention group with Leeds City Council. When I tried signing up to her local group we found there was a waiting list. Wanda and her family were concerned she isn't getting to do any exercise during the week and as such her mobility may decline whilst on the waiting list.

I contacted the Physiotherapist who made the original referral and arranged a joint visit with a Physio Assistant to run through some exercises with Wanda while she waits for a space to open up. I now call across every week and run through these exercises with Wanda ensuring she remains active and keeps her hip moving. Alongside this we go for a walk up and down the corridors - again working her hip. I've also found two local chair based exercises groups. Wanda now walks down with a carer to one group at the start of the week and is looking to try the other group in the new year. Longer term Wanda is hoping to attend the fall prevention group and continue to build strength in her hip.

Enhance support helping people to tackle practical tasks

Care and Repair: Mavis*, who lives alone and experiences severe anxiety, was referred to Care and Repair by another delivery partner, Leeds Irish Health and Homes, for a home assessment for rails. She was also having problems with her heating and hot water system. A home assessment was completed, and it was found that Mavis has had no heating or hot water for at least 2 weeks. The old, wooden rear door was letting draughts into the house and Mavis was having difficulties accessing parts of her property due to mobility issues since recently coming out of hospital.

Mavis was referred to Green Doctor for an Energy Performance Certificate assessment for a new boiler installation through Leeds City Council Warms Well Home Scheme. An internal referral was made to Care & Repair's technical team for a replacement door through the weatherproofing scheme. A job was also sent to a contractor for the fitting of stair rails and external grab rails.

Mavis is now accessing the parts of the property and all documentation required for the boiler and replacement door has been collected and the work is due to start soon. She was also provided with a pick up stick to assist her with reaching items at low levels and now feels less anxious, warmer and safer at home.

Seacroft Friends and Neighbours: Peter*lives alone in a first floor flat and has poor mobility. Through Enhance we supported Peter to get home adaptations and a key safe to keep him safe at home, and a cleaner as he was unable to manage. We helped Peter to successfully claim Attendance Allowance to help pay for the cleaning service. Peter has a poor memory so we make sure he has a calendar and we regularly encourage him to write dates down. We are liaising with Engage Leeds, who are looking for more suitable accommodation for him. Peter now attends social groups regularly and his mood has improved.

MAE Care: Kuljeet* was referred by a Self-Management Facilitator at Leeds Community Healthcare. She was learning to self-administer her insulin injections and learning to use her Libre sensor to monitor her sugar levels. These changes had consequently caused her to become overwhelmed with daily tasks. The main concern was that she was not managing her mail and as a result had missed some

medical appointments. Kuljeet was also experiencing loneliness and wanted to move to accommodation with communal living.

There was good collaboration with the Self-Management Facilitator and we completed a joint initial assessment which helped Kuljeet to engage with the Enhance service. Through regular home visits, we built a relationship with Kuljeet and identified her support network. With her permission we updated them about the recent issues she had faced with managing her mail so that they could also support her with this. Enhance also supported Kuljeet with a housing application. She has expressed her gratitude numerous times for the Enhance service. It has improved her confidence knowing that she has the service to fall back on and it has had a positive impact on her mental wellbeing.

Age UK Leeds: Jane* is a 67 year old woman who lives alone. Her home had become unkempt and cluttered after a period of poor physical health, in turn affecting her mental health and resulting in self-neglect. A serious flare up of her disorder had resulted in a 3-month stay in hospital followed by rehabilitation.

A deep clean and fumigation had been organised by her Occupational Therapist (OT) whilst she remained in the rehabilitation facility, and it was felt important that she have ongoing support following discharge, hence the referral to Enhance. Her mobility has been temporarily affected and she has been supplied with a hospital bed and commode as she is unable to access her upstairs bedroom and bathroom, though is expected to recover enough to be able to do so in a few weeks. The OT referred her to Enhance for provision of initial emotional support, and to arrange ongoing support with a regular cleaning service/gardening/companion service.

To date, the Enhance worker has visited her at home as well as making wellbeing phone calls and, following initial assessment, arranged for a regular service from Presto to provide a companion service, which will include light cleaning and support to reorganise her home. We continue to work together to explore whether Jane would like to have a befriender in due course, and a potential gardening service which could be provided by her local Neighbourhood Network.

Enhance support helping people to increase their social connections

Garforth NET: Kim* was referred to Garforth NET by the Self-Management Facilitator (SMF) at Leeds Community Healthcare. Kim used to come to the NET Leg Club where he could have his leg dressings changed and where he could socially interact with others. Unfortunately as his health deteriorated, he had to stop coming and the Nurses reverted back to house calls. Further deterioration in Kim's moods prompted the visiting Nurses to discuss Kim with the SMF who referred him to Enhance at NET.

We carried out a number of home visits to meet Kim. The second visit was a joint visit with the SMF and a joint plan was devised to enable Kim to come back to the Leg Club. Kim now has a commode and a wheeled walker and has been advised not to go upstairs. His son does the shopping, but there was very little food in the house and the SMF was concerned about Kim's blood sugar and thought his poor diet was contributing to falls/ill health, so this was discussed with Kim and his son.

After only a few weeks back at the Leg Club the Nurses could see a marked improvement in Kim's moods. Kim's son contacted NET directly to say he was really pleased with the change in his dad. His son felt his dad was giving up before and his social interaction at Leg Club has brought him back to life - Kim can't wait to come every week and has asked his son to get him some new trousers to come in. Previously Kim was becoming more and more withdrawn, but now he has started watching TV again and listening to music. As a result of NET working in collaboration with the Nurses Kim was able to come out and meet people and his confidence had increased. As a result we witnessed reduced pressure on the Nurses and reduced likelihood of hospital admission.

Armley Helping Hands: One of the Community Matrons in the Pudsey Neighbourhood Team referred Leslie* to Enhance as he was very socially isolated. We arranged a joint visit to see him. This was extremely helpful as it allowed a full and frank discussion with Leslie as he fully trusted the Matron which helped the meeting.

After discussing issues with Leslie he agreed to accompany me to an organisation in Pudsey which had a dedicated men's group. He was nervous at first but got talking to some of the members of the group and seemed to enjoy himself. He has been a

number of times since and at our last meeting he said he had made 2 friends there and was seeing them outside the group environment.

Health for All: Gemma* contacted Enhance to ask if she knew of any Christmas day events as she didn't want to be alone on Christmas day and her family situation is complicated. We looked at a local centre close to Gemma's home and made contact. It was then arranged that Gemma would be collected from home and taken for Christmas Dinner at her local centre. Gemma reported back she was made to feel very welcome and formed friendships there. She was very grateful for the quick response and arrangements.

We delivered Christmas presents to Enhance participants who we knew were alone and may not be receiving any. One of our volunteers made up some shoe box gift sets which were packed with lovely presents. It was lovely to see the smiles on their faces when they opened the boxes.