**Enhance Year 3**

**Project Specification for Yeadon**

**Building on the Learning**

The Enhance Programme's initial aims were to support safe and sustainable discharge from hospital and neighbourhood teams into a secure home environment and to link neighbourhood teams with third sector organisations to avoid both delayed discharges and readmissions. After almost 2 years of programme delivery and looking forward to a third year, it is important that we take the learning that has been gathered so far, and work to apply that to our aims for year 3.

Years 1 and 2 saw our third sector delivery partners (TSDPs), Neighbourhood Teams (NTs) senior management at Leeds Community Healthcare Trust (LCHT) and the programme team at Leeds Older People's Forum (LOPF) work together to develop a cross sector partnership to maximise wrap around support and health outcomes for NT patients and for people referred to DPs from other sources.

As we move into year three there will be a greater emphasis on the Enhance Programme having an impact on LCH services particularly around time saved. The Enhance offer will also be made available to a wider range of LCH teams within the Adult Business Unit (ABU) and Specialist Business Unit (SBU).

***This service specification seeks to attract applications from potential delivery partners who are best placed to consider developing an Enhance project to cover the area covered by the Yeadon Neighbourhood Team***

**The 4 programme aims for year 3:**

1. Provide proactive and responsive person-centred support to people referred by LCH services to support recovery and rehabilitation, improve their health and quality of life, prevent deterioration and support wider health and wellbeing
2. Enhance capacity for LCH services by reducing time spent on clinical and non-clinical tasks & reducing clinical demand for LCH clinicians by improving health and wellbeing for people within prioritised LCH teams (NTs, ABU, SBU)
3. Link third sector organisations with LCH teams & other agencies to enable provision of joined up, appropriate, holistic care for people whilst on LCH (NTs/ABU & SBU) teams' caseload and to support safe and sustainable discharge from LCH services
4. Reduce pressure on the wider healthcare system including avoiding admission / readmission to hospital

**The 5 objectives for year 3:**

1. Establish good relationships and effective ways of working between delivery partners and all LCH referring services
2. Target Enhance support to LCH teams experiencing the greatest demand where time savings for LCH will be maximised
3. Develop a robust evaluation of impact for people (including reaching the most deprived supported by Enhance), LCH (in particular referral sources and time saving) and the wider system and demonstrating value for money
4. Develop a robust, sustainable case for a Business As Usual model for Enhance for the business case for future funding, using available data and building on the evaluations of years 1&2 and findings from year 3
5. Ensure reach in to communities experiencing health inequalities through weighted allocation of resource and funding

**The 4 outcomes for year 3:**

**Outcome 1 (Impact on the person):** Improve recovery and rehabilitation, quality of life and wider health and wellbeing and prevent deterioration

**Outcome 2 (Impact on LCH):** Reduce time spent by LCH services on non-clinical tasks & reduce clinical demand for LCH clinicians

**Outcome 3 (Impact on LCH):** Improve collaboration between LCH, partners and the third sector to improve provision of joined up, appropriate, holistic care supporting safe and sustainable access to and discharge from LCH services

**Outcome 4 (Impact on wider system):** Reduce pressure on the wider healthcare system, including preventing and reducing admission / readmission to hospital, to support the goals of the Healthy Leeds Plan

The successful applicant will need to commit to providing services that meet the core offer as follows:-

**Person-centred support to include:**

- Home visits
- Opportunities for social connection
- Support for setting up services to manage health (repeat prescriptions, dosette boxes, key safes etc)

**Information and advice to include:**

- Ensure home environment is safe including; a safe and well referral to Fire service and welfare benefits check
- Prompting exercise
- Support self-management
- Provision of regular contact/check-in for up to three months
- Support access to health appointments
- Ensure access to food

**Partnership work to include**-

- Joint visit and double up of visits when needed
- Regular communication - appropriate information sharing
- Agency advocacy, liaison and referrals
- Contributing to the test and learn ethos by sharing good practice etc
- Attending peer learning events facilitated by LOPF

The test, learn and develop ethos also allows a level of flexibility in how your project meets the targets and outcomes but potential applicants should be aware that the output and outcome targets negotiated at the outset won't change once the project delivery has started. All delivery partners are encouraged to share their learning on what has and has not worked as this helps to understand the complexities involved and test our assumptions.

Leeds Older People's Forum on behalf of the Forum Central partnership will continue to manage the Enhance programme and commission the delivery partner for the Pudsey area.

**You are being invited to apply to develop an Enhance project in the Yeadon area because you have already demonstrated:-**

- that you have a proven track record of working with individuals and groups in an empowering way.
- an understanding of how holistic support could have an impact on the people the project aims to reach.
- solid knowledge and experience of cross-sector partnership working, including integrated Neighbourhood Teams.

Within your application please tell us how you plan to manage this project including:-

- How you will meet the 4 outcomes of the Enhance Programme

- How you will structure your staff and volunteers to enable safe, timely and responsive support to the people referred in the Yeadon area.
- How your staff will work in a person centred/community centred way, linking with the Yeadon Neighbourhood Team, the West Triage hub and other health and social care services across the area.
- How you plan to provide the additional monitoring and evaluation of the project
- If you plan to involve the support of volunteers
- The project must consider transport needs as part of their planning and development.
- Staff and volunteers will be expected to take part in training provided by LCH and LOPF.

**1. Key Performance Indicators**

We expect the project to work towards specific targets as agreed as part of the contract negotiations and in advance of the project commencing. However, it is anticipated that the Key Performance Indicators are likely to include:

- Demographic data for people taking part in each project- i.e age, ethnicity, disability, sexualilty
- Quantitative data including, for example, the number of people supported, referrals received, referral sources, multi-disciplinary meetings attended, volunteers recruited etc
- Qualitative data including, for example, case studies, test and learn case studies, quotes
- Contribution to the test and learn ethos, for example by taking part in shared learning sessions and formal training

**2. Contract Management and Performance**

The project must:

- Work towards the Enhance Programme outcomes
- Comply with monitoring requirements set out by Leeds Older People's Forum, as outlined in previous sections
- Embrace a test, learn and develop ethos
- Work in a person-centred way
- Commit to partnership-working, collaboration and co-production
- Attend 6 weekly contract monitoring meetings with the programme manager

**3. Contract Value & Application Process**

Please make your application on no more than **4 sides of A4** via email to linda@opform.org.uk

The contract value for this work is **£40,000** for the Yeadon Neighbourhood Team area.

The contract duration is one year; May 2024 to April 2025. Funds should be spent by 30th April 2025

4. **Timescales**
    - Applications open: Monday 25th March 2024
    - Applications close: 5pm Friday 19th April 2024
    - Assessment Panel: Friday 26th April 2024
    - Applicants notified by: 1st May 2024
    - Funding released to successful applicants: w/c 6th May 2023
    - Projects start Immediately following notification

The assessment panel will consist of representatives from Leeds Community Health Care, LOPF/Forum Central and the Enhance steering group.

If you would like to discuss your application with a member of the LOPF team or you have any questions please contact linda@opforum.org.uk or 07944 635553.