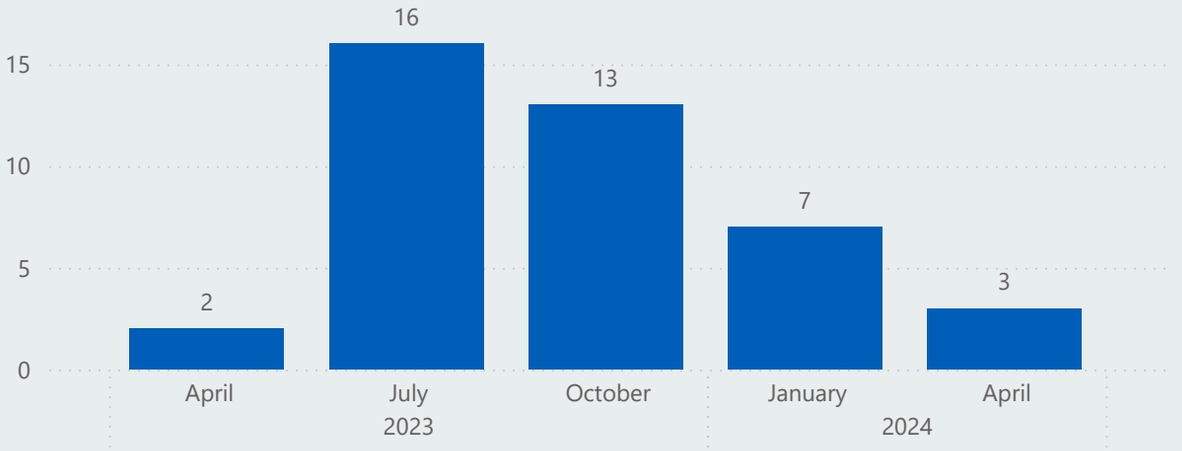
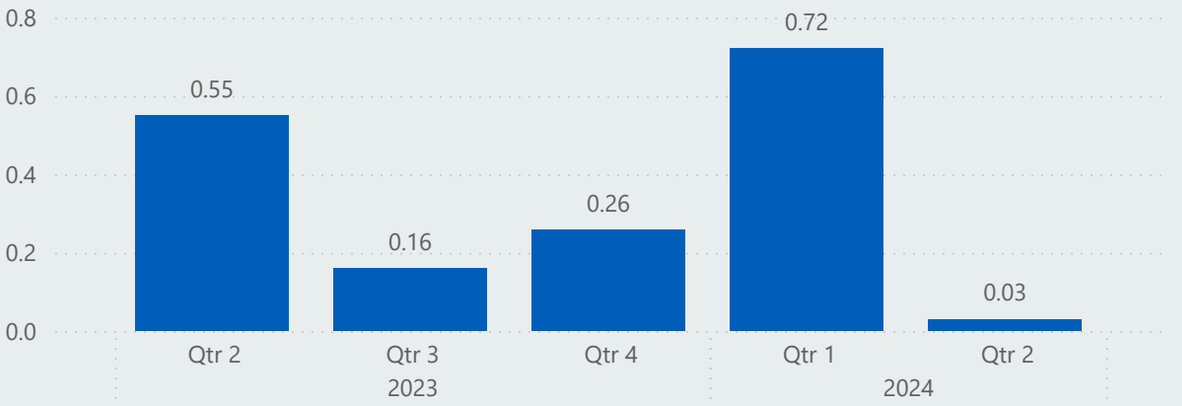
Effective - Audit

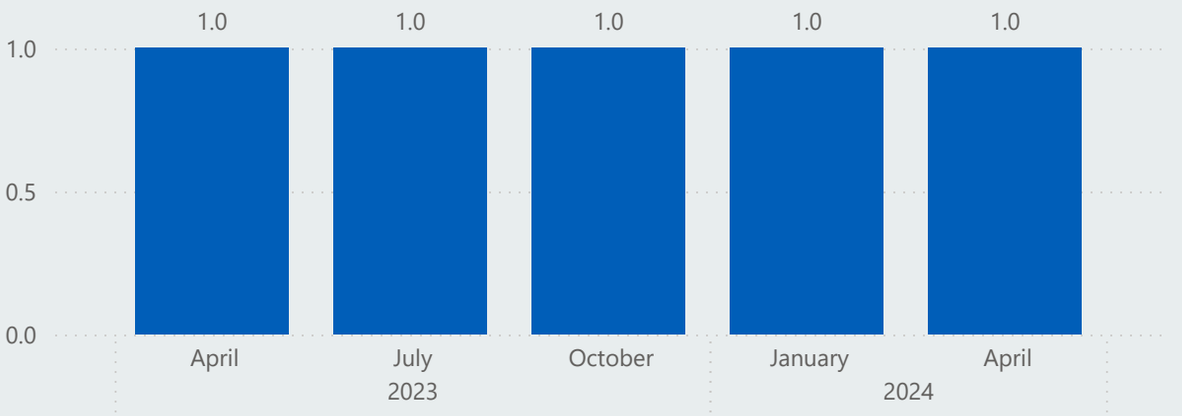
Total number of audits completed in quarter



Priority 2 audits: number completed year to date versus number expected to be completed in 2024/25

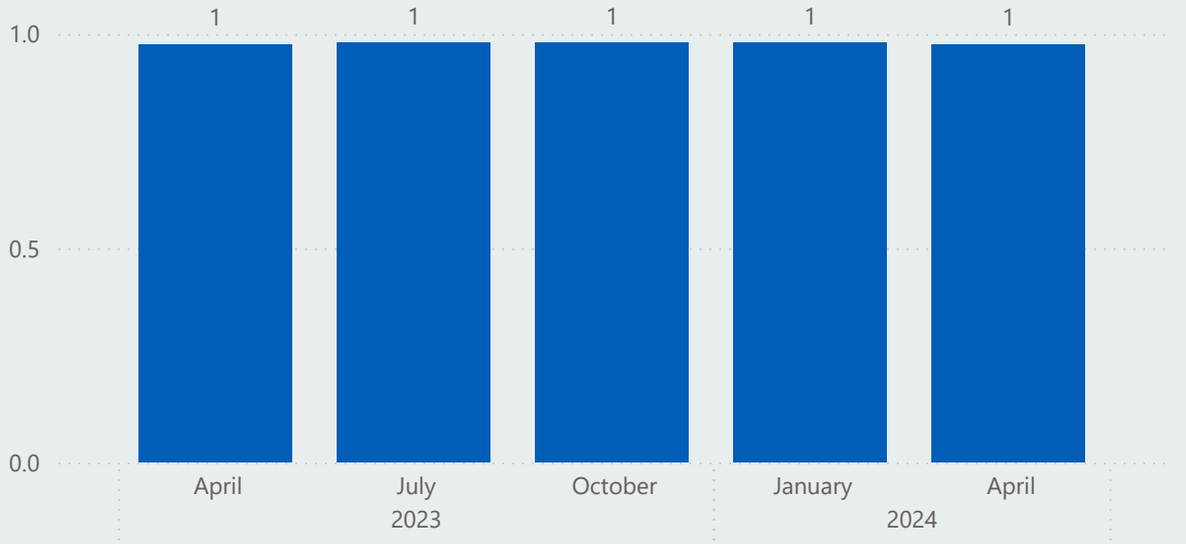


NCAPOP audits: number started year to date versus number applicable to LCH

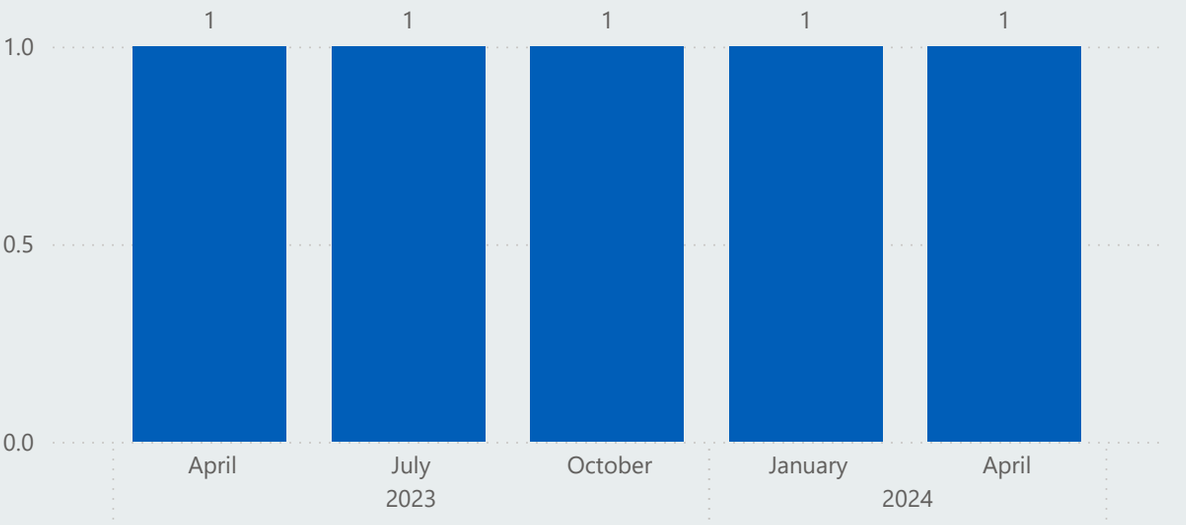


Effective - NICE Guidance

Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH



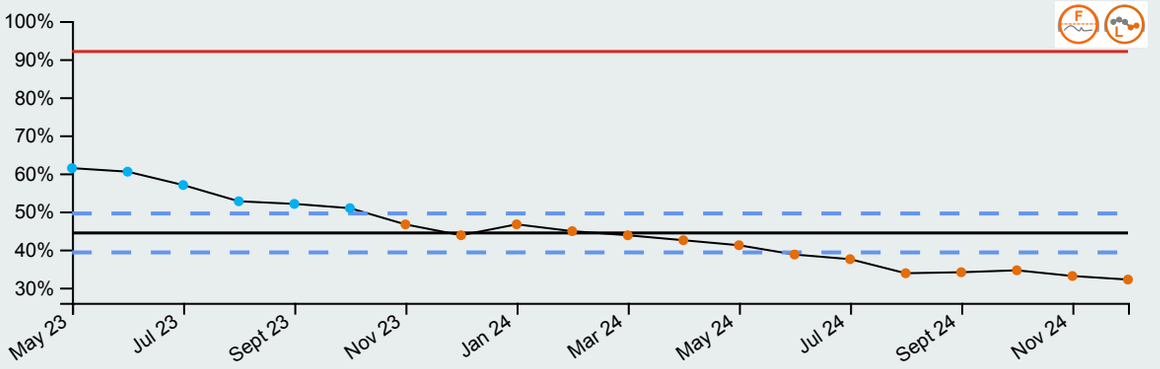
Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH



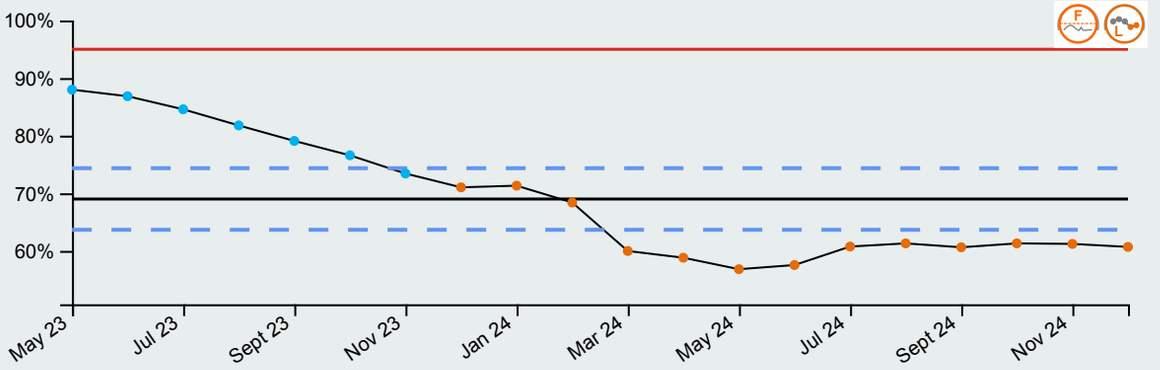
Responsive Domain

Leeds Community Healthcare NHS Trust

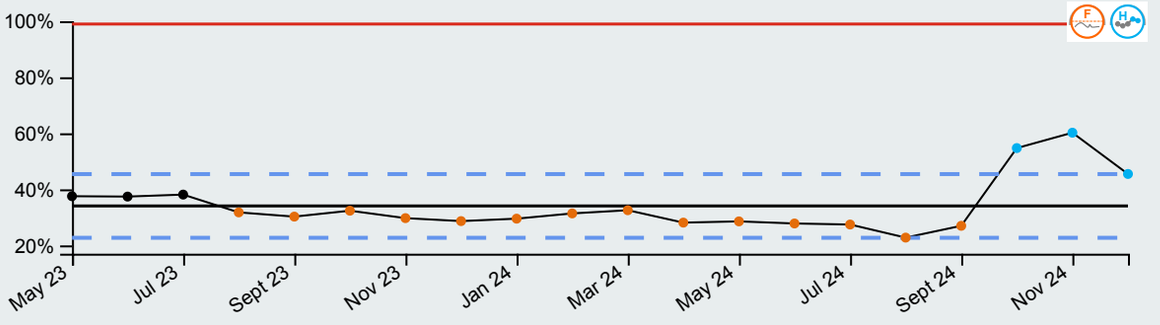
Percentage of patients currently waiting under 18 weeks (Consultant-Led)



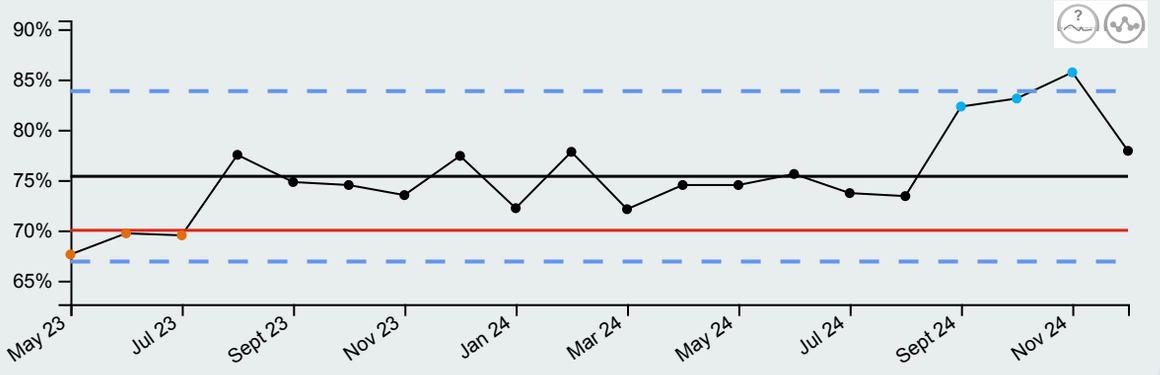
% Patients waiting under 18 weeks (non reportable)



Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)



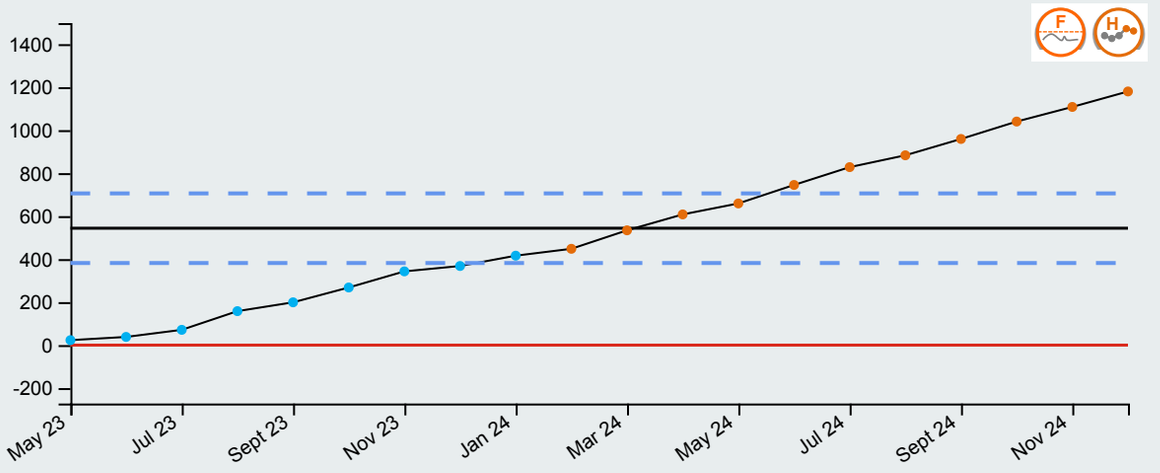
Community health services two-hour urgent response standard



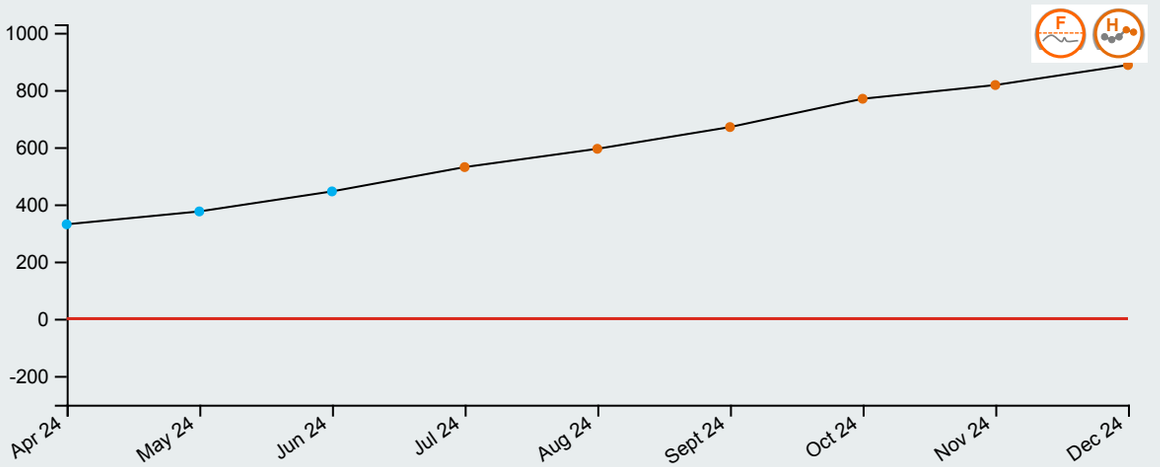
Responsive Domain

Leeds Community Healthcare NHS Trust

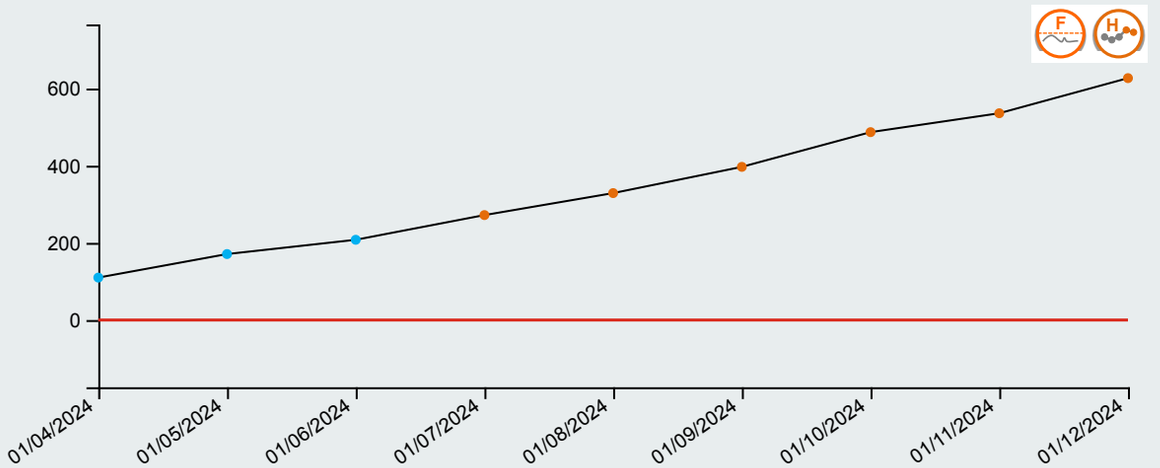
Number of patients waiting more than 52 Weeks (Consultant-Led)



Zero tolerance RTT waits over 65 weeks for incomplete pathways

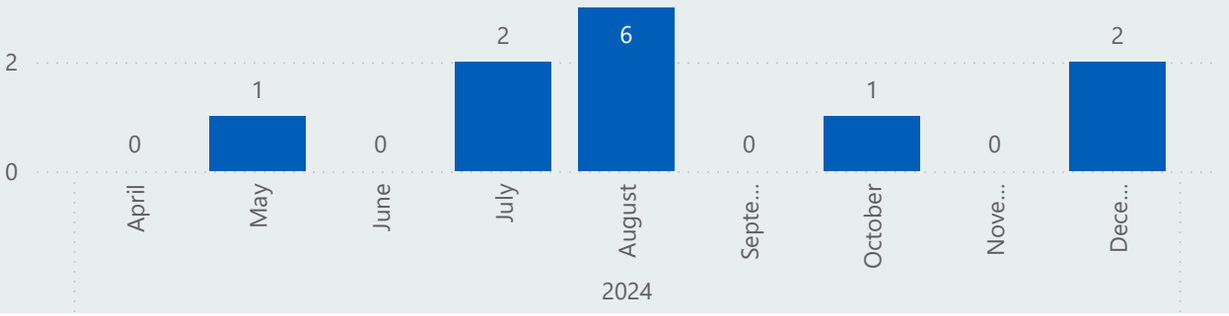


Zero tolerance RTT waits over 78 weeks for incomplete pathways

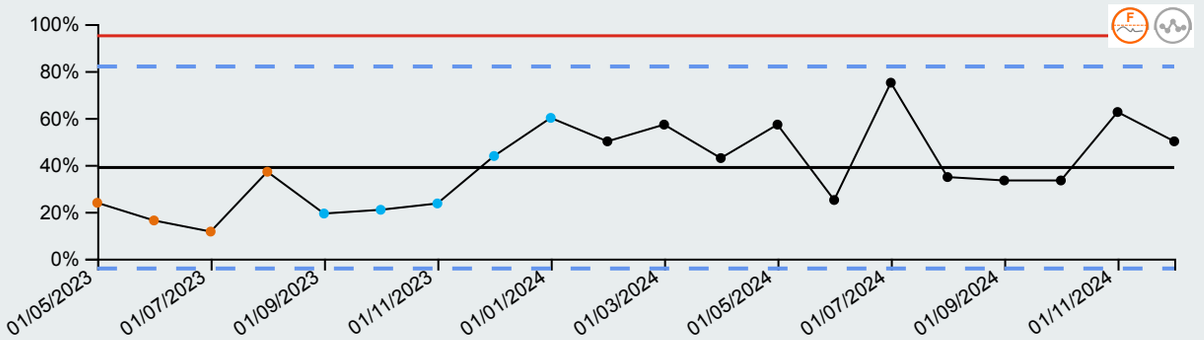


Responsive - CAMHS

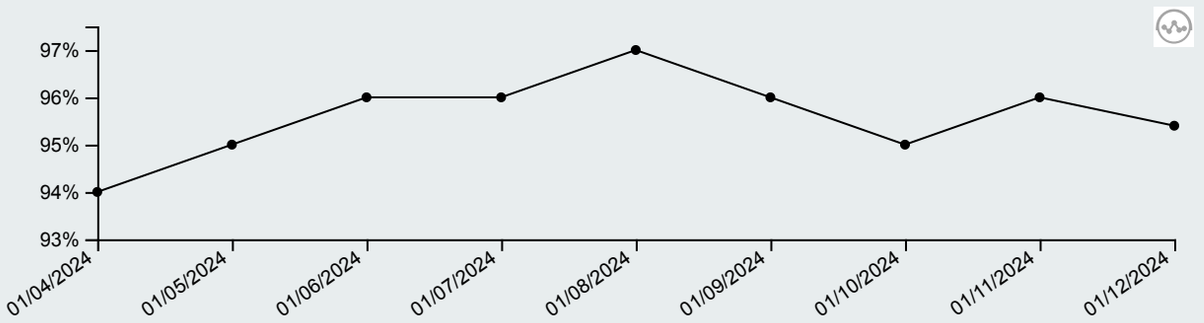
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care



% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment



Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment



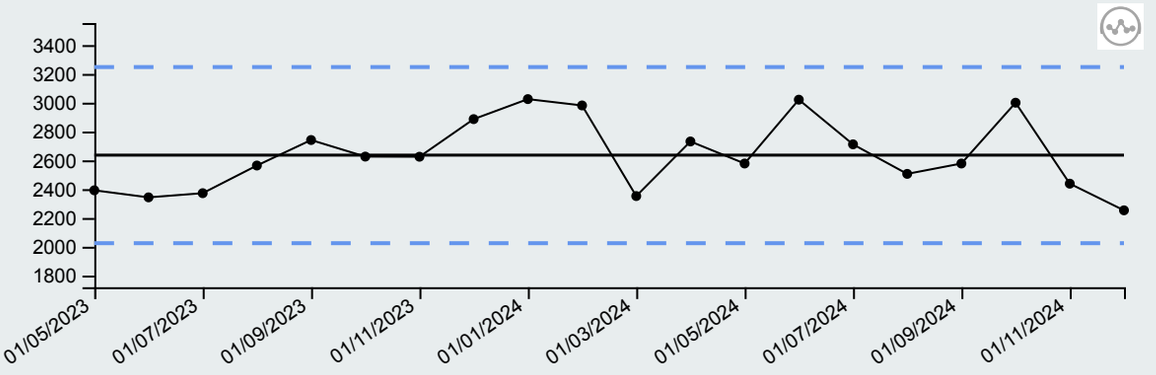
Number of children and young people accessing mental health services as a % of trajectory**

This measure is underdevelopment

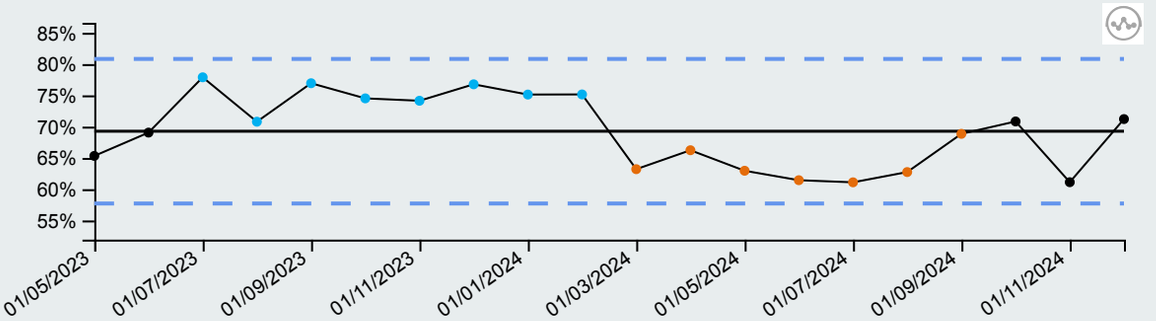
All dates/IDs are missing or null!

Responsive - LMWS

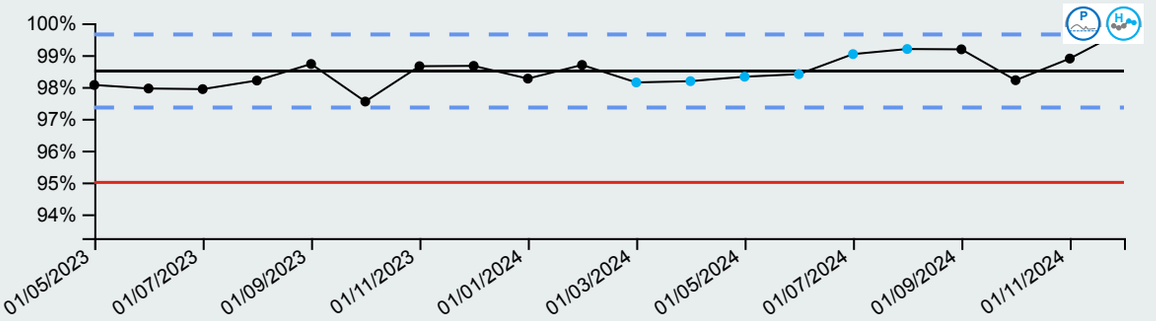
LMWS – Access Target; Local Measure (including PCMH)



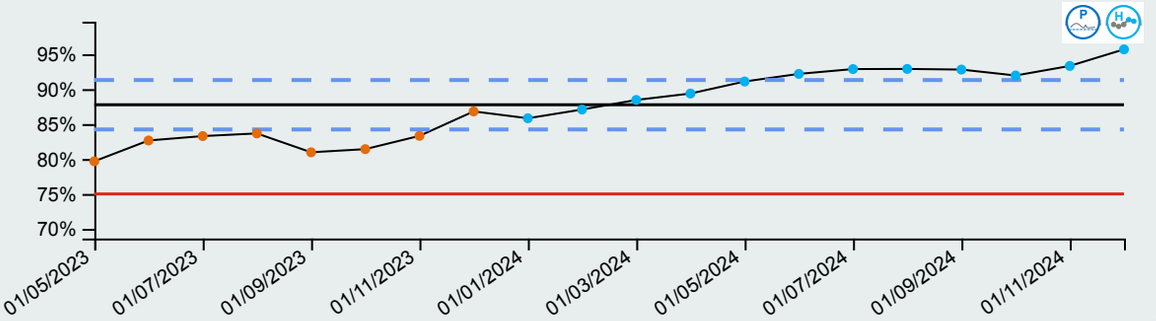
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral



IAPT - Percentage of people referred should begin treatment within 18 weeks of referral

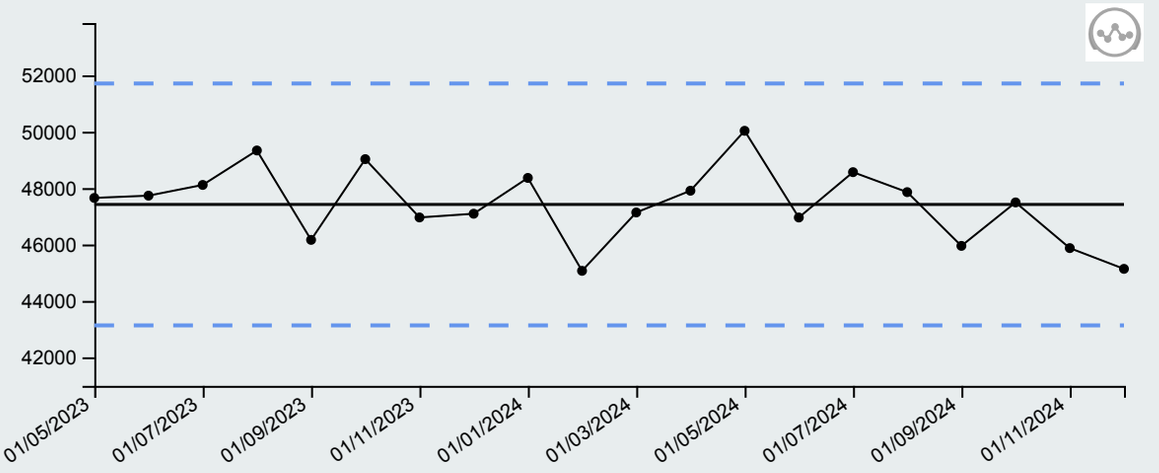


IAPT - Percentage of people referred should begin treatment within 6 weeks of referral

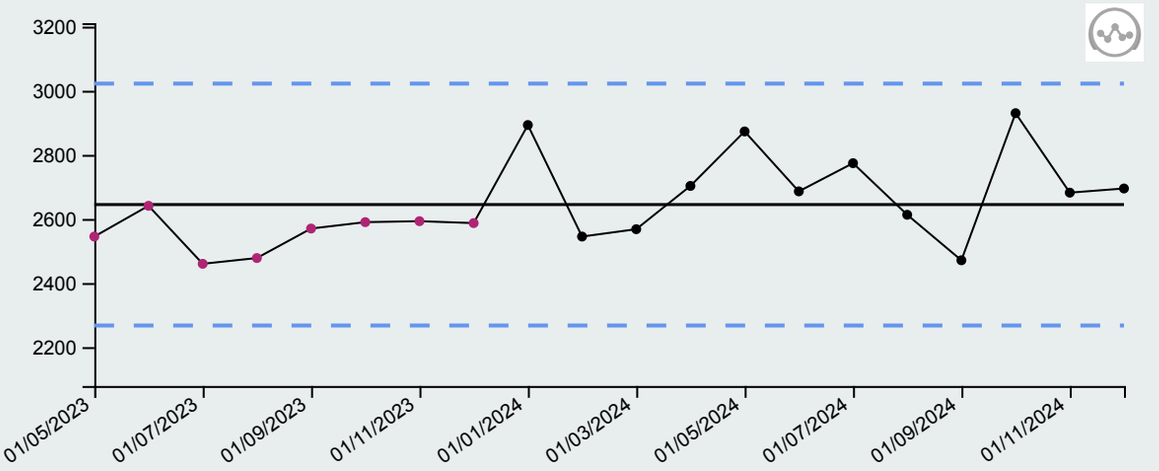


Responsive - NTs

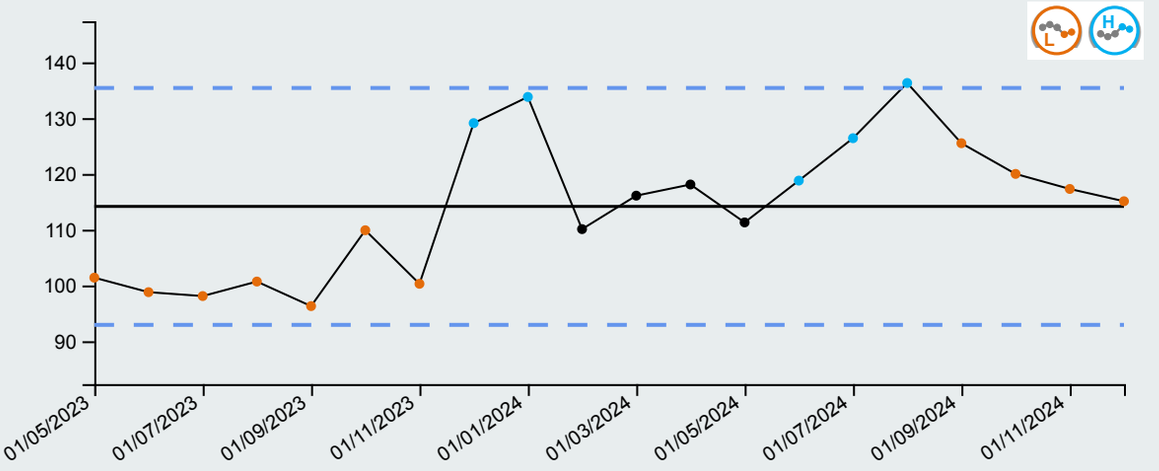
Neighbourhood Team Face to Face Contacts



Neighbourhood Team Referrals (SystmOne only)

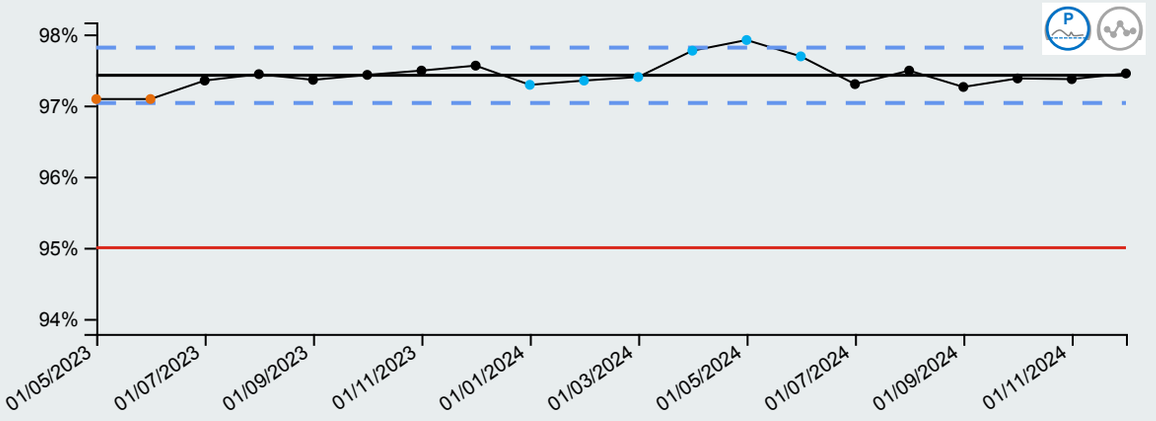


Neighbourhood Team Productivity (Contacts per Utilised WTE)



Responsive - Other

Percentage of patient contacts where an ethnicity code is present in the record



Responsive - Other

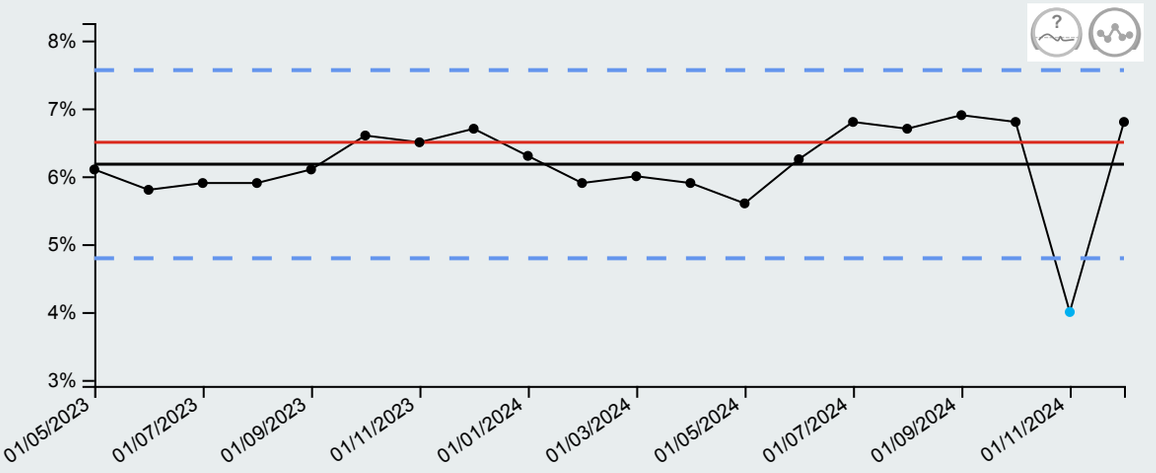
Number of children and young people accessing mental health services as a % of trajectory

Available virtual ward capacity per 100k head of population

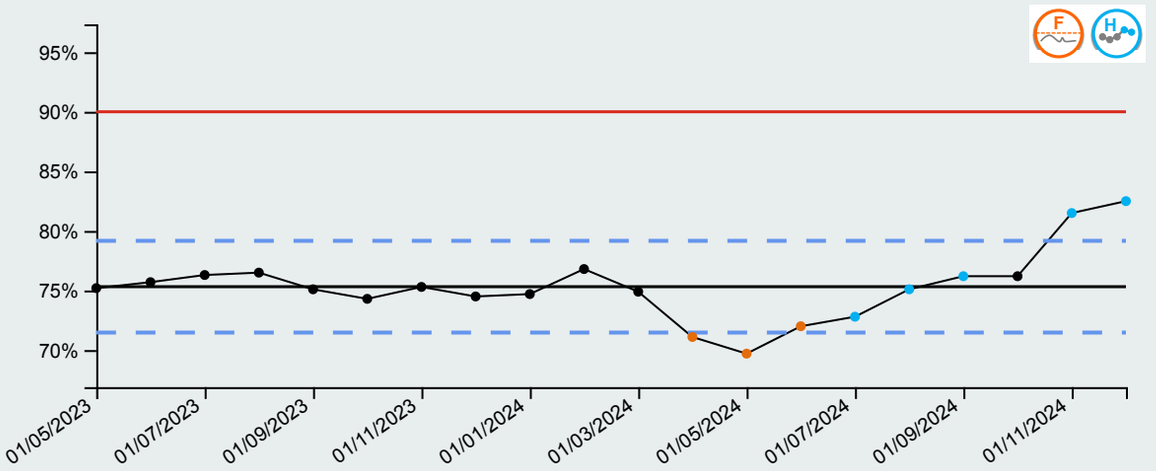
Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted

Well Led - Workforce

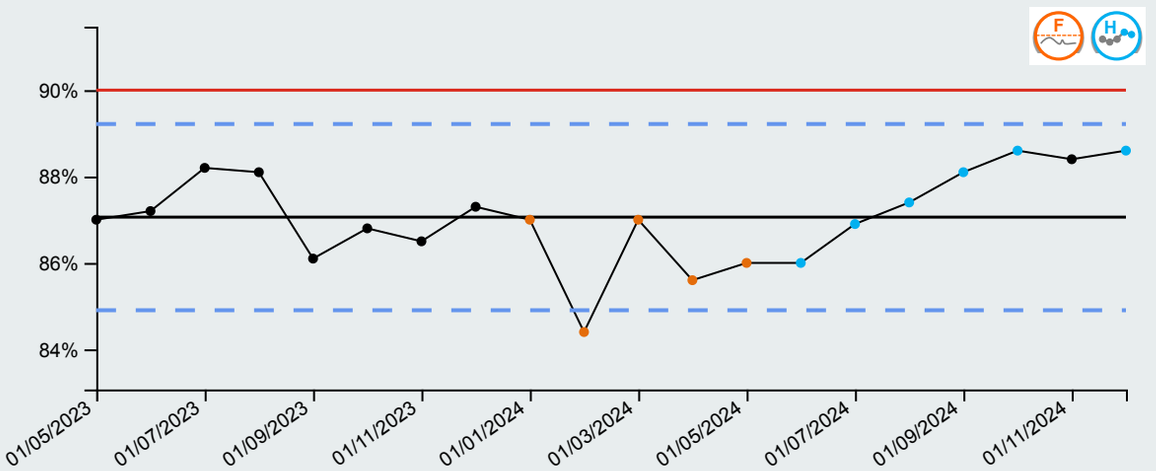
Total sickness absence rate (Monthly) (%)



AfC Staff Appraisal Rate

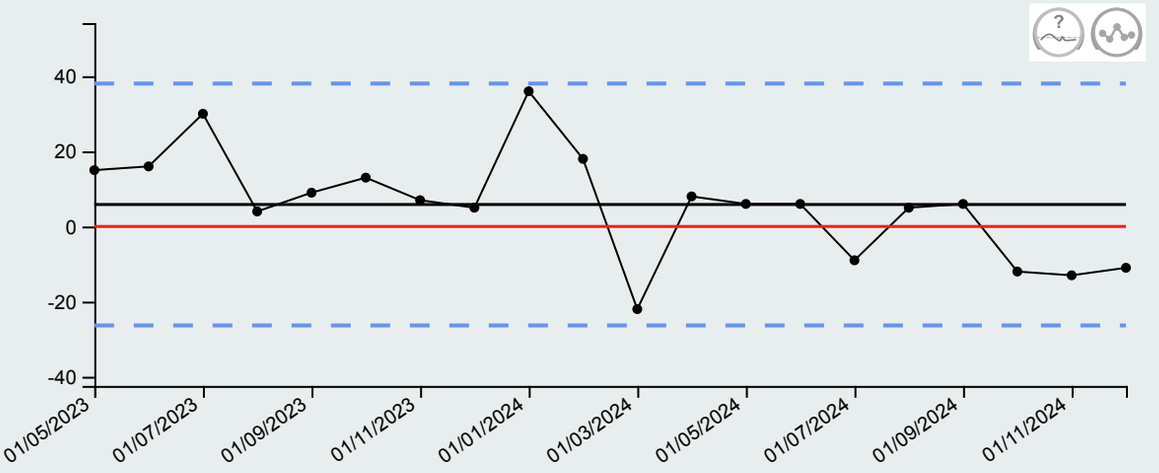


Statutory and Mandatory Training Compliance

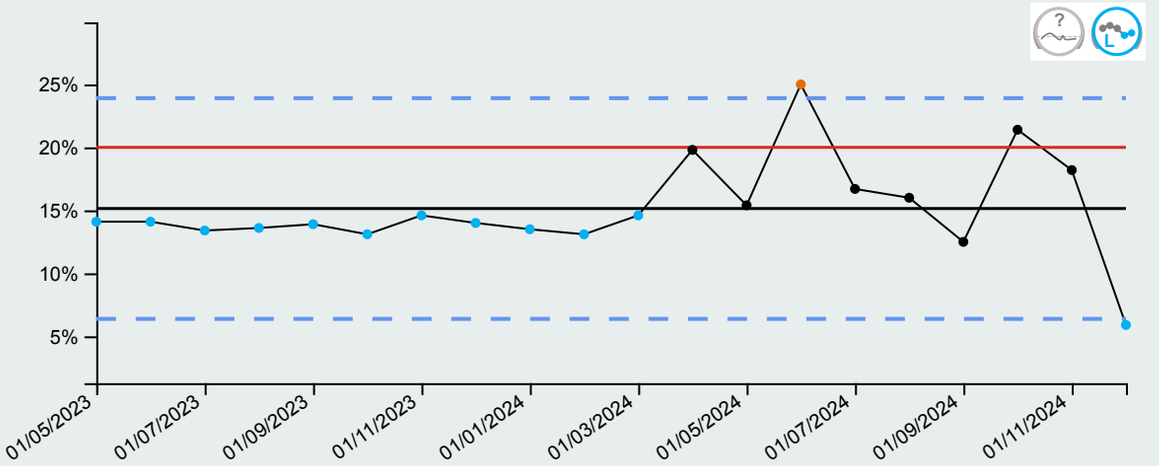


Well Led - Workforce

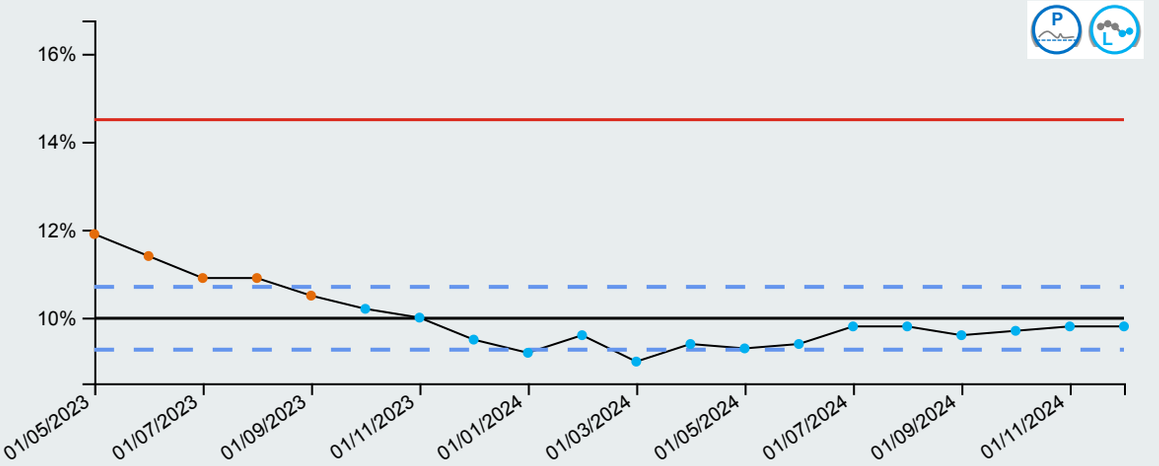
Starters / leavers net movement



Reduce the number of staff leaving the organisation within 12 months

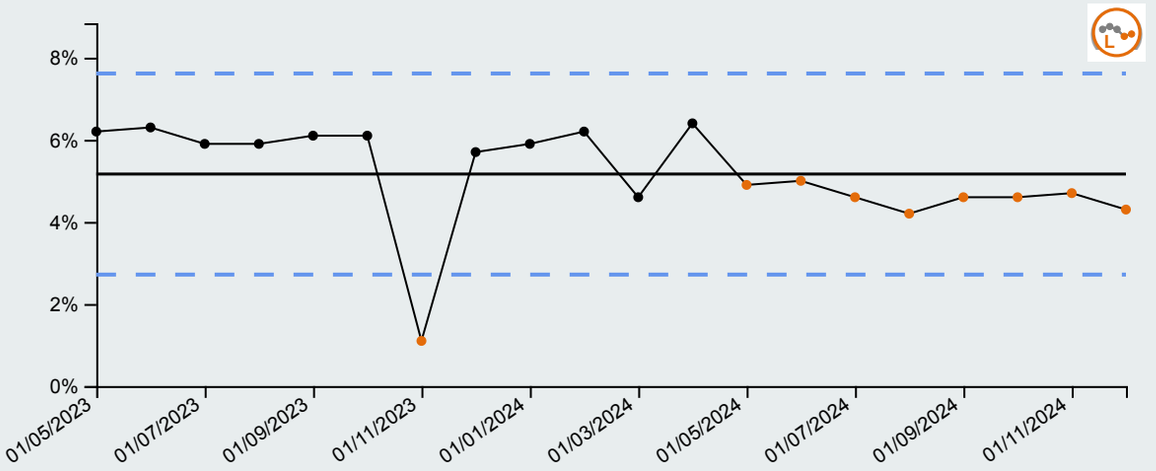


Staff Turnover

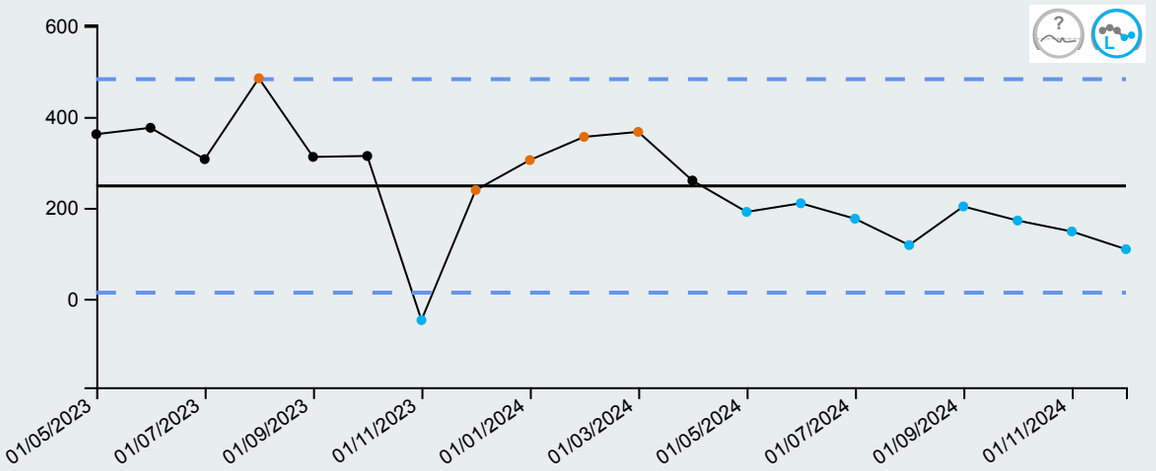


Well Led - Workforce

Percentage Spend on Temporary Staff



Total agency cap (£k)



Well Led - Other

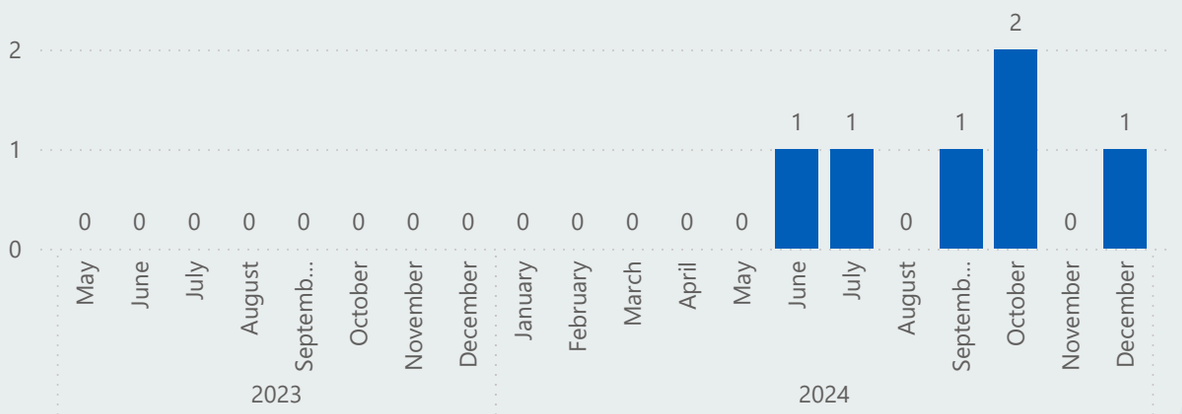
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)

This chart is under development

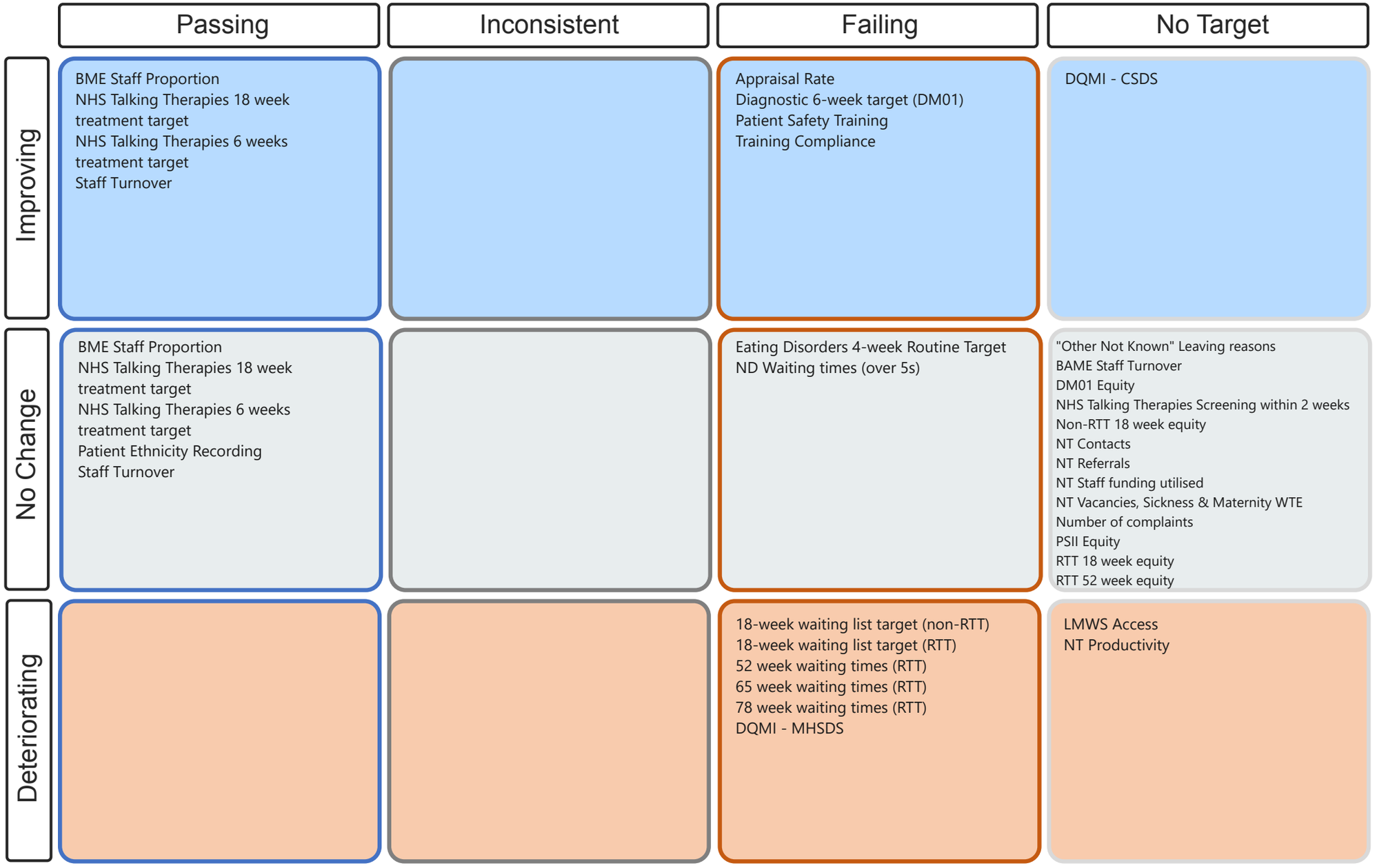
Percentage of staff who are satisfied with the support they received from their immediate line manager

This chart is under development

'RIDDOR' incidents reported to Health and Safety Executive



Categorisation of SPC Indicators



Categorisation of Non-SPC Indicators

No Concern

cDiff Infections
Deteriorating Patient Incidents
Fall Incidents
Meatal Tear Incidents
Medicines Code Assurance Checks
MRSA Infections
MSA Breaches
NCAPOP Audits
Never Events
NICE implemented from 2019
NICE implemented from 2020
NT Clinical Triage Incidents
Overdue PSII Actions
Presure Ulcers Incidents
Priority 2 Audits
Total Audits completed

Concern

CAS Alerts Outstanding
Eating Disorders 1-week Urgent Target
Number of PSIIs
RIDDOR incidents

Appendix II – High level Indicator Development

Overview

This report gives a summary of the progress to-date and upcoming planned work to improve and develop the assurance given to the Board and Committees through the Performance Brief.

In 2024, plans were developed to use Statistical Process Control (SPC) methodologies as the analytical foundation for the Performance Brief, and eventually as the foundation for all Performance monitoring and management across the Trust.

High Level Indicator Development

Each year, the Board and Committees specify the High-Level Indicators (HLIs) to be selected for the Performance Brief to give assurance on key strategic and operational priorities. The table below gives a summary of the work underway to migrate to SPC approaches.

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Caring	Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Positive Patient Feedback	Complete	N/A	SPC
Caring	Total Number of Formal Complaints Received	Number of complaints	Complete	N/A	SPC
Caring	Differences in the number of Patient Safety Incident Investigations (PSII) for patients living in IMD1 vs IMD2-10	PSII Equity	Complete	N/A	SPC
Caring	Mixed Sex Accommodation Breaches**	MSA Breaches	Complete	N/A	Column Chart
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	RTT 18 week equity	Complete	N/A	SPC
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	RTT 52 week equity	Complete	N/A	SPC

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - DM01 Services	DM01 Equity	Complete	N/A	SPC
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	Non-RTT 18 week equity	Complete	N/A	SPC
Effective	Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	NICE implemented from 2019	Complete	N/A	Column Chart
Effective	Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH	NICE implemented from 2020	Complete	N/A	Column Chart
Effective	NCAPOP audits: number started year to date versus number applicable to LCH	NCAPOP Audits	Complete	N/A	Column Chart
Effective	Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	Priority 2 Audits	Complete	N/A	Column Chart
Effective	Total number of audits completed in quarter	Total Audits completed	Complete	N/A	Column Chart
Responsive	Percentage of patients currently waiting under 18 weeks (Consultant-Led)	18-week waiting list target (RTT)	Complete	N/A	SPC
Responsive	Number of patients waiting more than 52 Weeks (Consultant-Led)	52 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Zero tolerance RTT waits over 78 weeks for incomplete pathways	78 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Zero tolerance RTT waits over 65 weeks for incomplete pathways	65 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Number of children and young people accessing mental health services as a % of trajectory**	CAMHS Accessing Treatment	Under Development	Jan-25	
Responsive	Available virtual ward capacity per 100k head of population	Virtual Ward capacity per 100k Population	Under Development	Mar-25	

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Responsive	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Units of Dental Activity	Under Development	Mar-25	
Responsive	Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	Eating Disorders 1-week Urgent Target	Complete	N/A	Column Chart
Responsive	Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	ND Waiting times (over 5s)	Complete	N/A	SPC
Responsive	Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	Diagnostic 6-week target (DM01)	Complete	N/A	SPC
Responsive	% Patients waiting under 18 weeks (non reportable)	18-week waiting list target (non-RTT)	Complete	N/A	SPC
Responsive	LMWS – Access Target; Local Measure (including PCMH)	LMWS Access	Complete	N/A	SPC
Responsive	IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	NHS Talking Therapies Screening within 2 weeks	Complete	N/A	SPC
Responsive	IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	NHS Talking Therapies 18 week treatment target	Complete	N/A	SPC
Responsive	IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	NHS Talking Therapies 6 weeks treatment target	Complete	N/A	SPC
Responsive	% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	Eating Disorders 4-week Routine Target	Complete	N/A	SPC
Responsive	Neighbourhood Team Face to Face Contacts	NT Contacts	Complete	N/A	SPC
Responsive	Community health services two-hour urgent response standard	UCR 2hour Performance	Complete	N/A	SPC

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Responsive	Percentage of patient contacts where an ethnicity code is present in the record	Patient Ethnicity Recording	Complete	N/A	SPC
Responsive	Neighbourhood Team Referrals (SystmOne only)	NT Referrals	Complete	N/A	SPC
Responsive	Neighbourhood Team Productivity (Contacts per Utilised WTE)	NT Productivity	Complete	N/A	SPC
Safe	Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	Medicines Code Assurance Checks	Complete	N/A	Column Chart
Safe	Safer Staffing – Inpatient Services	Safer Staffing - Inpatients	Under Development	TBC	
Safe	Attributed MRSA Bacteraemia - infection rate**	MRSA Infections	Complete	N/A	Column Chart
Safe	Clostridium Difficule - infection rate**	cDiff Infections	Complete	N/A	Column Chart
Safe	Never Event Incidence**	Never Events	Complete	N/A	Column Chart
Safe	CAS Alerts Outstanding**	CAS Alerts Outstanding	Complete	N/A	Column Chart
Safe	Data Quality Maturity Index (DQMI) - CSDS dataset score**	DQMI - CSDS	Complete	N/A	SPC
Safe	Data Quality Maturity Index (DQMI) - IAPT dataset score**	DQMI - IAPT	Complete	N/A	SPC
Safe	Data Quality Maturity Index (DQMI) - MHSDS dataset score**	DQMI - MHSDS	Complete	N/A	SPC
Safe	Compliance in Level 1 and 2 Patient Safety Training	Patient Safety Training	Complete	N/A	SPC
Safe	Number of Patient Safety Incident Investigations (PSII)	Number of PSIIs	Complete	N/A	Column Chart

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Safe	Number of overdue PSII actions	Overdue PSII Actions	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Pressure Ulcers	Presure Ulcers Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Falls	Fall Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Deteriorating Patient	Deteriorating Patient Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Meatal Tear	Meatal Tear Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Clinical Triage in Neighbourhood Teams	NT Clinical Triage Incidents	Complete	N/A	Column Chart
Safe	Compliance with statutory Duty of Candour	Duty of Candour	Complete	N/A	SPC
Safe	Incidents of E.Coli, bacteraemia**	E.Coli Infections	Under Development	Jan-25	
Well-led	Staff turnover amongst staff from a minoritised ethnic group	BAME Staff Turnover	Complete	N/A	SPC
Well-led	Reduce the number of “other not known” reasons for leaving	"Other Not Known" Leaving reasons	Complete	N/A	SPC
Well-led	The overall percentage of staff who have identified as BME (including exec. board members)	BME Staff Proportion	Complete	N/A	SPC
Well-led	Proportion of staff in senior leadership roles (8a and above) filled by staff who have identified as BME	BME Proportion (8A+)	Under Development	TBC	
Well-led	Proportion of staff in senior leadership roles (8a and above) who are women	Female Proportion (8A+)	Under Development	TBC	
Well-led	Proportion of staff in senior leadership roles (8a and above) who have a disability	Disability Proportion (8A+)	Under Development	TBC	

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Well-led	Proportion of staff in senior leadership roles (8a and above) who have identified as LGBTQIA+	LGBTQIA+ Proportion (8A+)	Under Development	TBC	
Well-led	Staff Turnover	Staff Turnover	Complete	N/A	SPC
Well-led	Reduce the number of staff leaving the organisation within 12 months	Leavers within 12 months	Complete	N/A	SPC
Well-led	Total sickness absence rate (Monthly) (%)	Sickness Absence	Complete	N/A	SPC
Well-led	AfC Staff Appraisal Rate	Appraisal Rate	Complete	N/A	SPC
Well-led	Statutory and Mandatory Training Compliance	Training Compliance	Complete	N/A	SPC
Well-led	Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	Staff that would recommend LCH	Under Development	Mar-25	
Well-led	Percentage of staff who are satisfied with the support they received from their immediate line manager	Staff satisfied with line manager support	Under Development	Mar-25	
Well-led	'RIDDOR' incidents reported to Health and Safety Executive	RIDDOR incidents	Complete	N/A	Column Chart
Well-led	Total agency cap (£k)	Agency Spend (£k)	Complete	N/A	SPC
Well-led	Neighbourhood Team Vacancies, Sickness & Maternity WTE	NT Vacancies, Sickness & Maternity WTE	Complete	N/A	SPC
Well-led	Neighbourhood Team Percentage of Funded Posts Utilised	NT Staff funding utilised	Complete	N/A	SPC
Well-led	Starters / leavers net movement	Starters and Leaver Net Movement	Complete	N/A	SPC
Well-led	Percentage Spend on Temporary Staff		Complete	N/A	SPC

Agenda item:	2024-25 (123)

Title of report:	Freedom To Speak Up Guardian Report February 2025

Meeting:	Trust Board Meeting Held in Public
Date:	6 February 2025

Presented by:	Selina Douglas Chief Executive					
Prepared by:	John Walsh Freedom to Speak Up Guardian					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This report covers the period of 3 September 2024 to 6 February 2025. It offers a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system. There were sixty- two concerns overall. Sixteen concerns were raised formally by LCH staff members concerning LCH or LCH services through the Freedom To Speak Up Guardian (FTSUG). Forty-five concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns (two of which came to the FTSUG).

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	N/A	What does it tell us?	
	No	N/A	Why not/what future plans are there to include this information?	

Recommendation(s)	The Board is recommended to note the report and continue to enable the embedding of this work across the Trust.

List of Appendices:	N/A

Executive summary

This report covers the period of 3rd September 2024 to 6th February 2025. It offers a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system.

There were sixty- two concerns overall. Sixteen concerns were raised formally by LCH staff members concerning LCH or LCH services through the Freedom To Speak Up Guardian (FTSUG). Forty-five concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns (two of which came to the FTSUG).

An external audit of the FTSUG service has offered us a positive assurance of the work.

The Freedom To Speak Up Guardian service has:

- Worked across the trust with key partners to share and embed the work.
- Worked with existing trust priorities such as the Quality and Value programme and the Patient Safety Incident Response Framework (PSIRF).
- Offered to all staff who approach the FTSUG a programme of pastoral support whether they wish to raise a concern or not at the time.
- Sought to ensure we align with all national work, learning and guidelines.

Recommendations

The Board is recommended to note the report and continue to enable the embedding of this work across the Trust.

1 Introduction

1.1 This paper provides an overview of the work of the Freedom To Speak Up Guardian (FTSUG), basic activity data and recommendations on the role and its development from September 3rd 2024 to February 6th 2025.

2 Background

2.1 The recommendation that trusts should have an agreed approach and a policy to support how organisations respond to concerns was one of the recommendations from the review by Sir Robert Francis into whistleblowing in the NHS.

2.2 CQC guidance published in March 2016, in response to the Francis recommendations, indicated that trusts should identify or appoint a Freedom to Speak Up Guardian in 2016/17. The NHS contract for 2016/17, accelerated this process and trusts were required to have made an appointment by October 2016.

2.3 The trust has created a form of work to enable staff to speak up and be heard. The work has been recognised nationally and locally as a respected service for our staff.

3 Current position

3.1 The FTSUG work receives strong ongoing support from the Chief Executive, the executive and non-executive directors, the Chair, the Non-Executive Director with responsibility for speaking up work, the trust's networks, trade unions and the wider Trust. A clear form of work has been established and operates well. This work has several forms principally where staff approach the FTSUG and the Race Equality Network Speaking Up Champions to discuss concerns. Other forms include managers inviting the FTSUG to work with their teams so staff voices can be heard to enable better team cultures, conversations, and change.

3.2 Work with the Race Equality Network the Disability, Neurodiversity and Long-Term Condition Network and LGBTQ plus Network is ongoing. Career development work is offered to any staff member from an ethnic minority community who contacts the FTSUG. This is a plan around their career development linking the staff to support mechanisms in the wider organisation such as mentoring, coaching, interview support and leadership courses. This career development offer now extends to staff who have a long term condition or have a disability.

3.3 The FTSUG works at local, regional, and national levels. The local work at LCH continues to develop and evolve. The learning and outcomes include work linking to the WRES, initiatives around mental health, leadership development, staff health and wellbeing and organisational processes. The FTSUG works regionally through the Regional Freedom To Speak Up Network for Yorkshire and the Humber and nationally with the National Guardian Office and NHS England in developing speaking up in the wider health and care system. We have recently supported a national NHS organisation recruit FTSUG's for their organisation.

3.4 Different NHS Trusts and national NHS bodies have had consultations and conversations with LCH about our work and approach to speaking up in the period covered in this report. The FTSUG has offered support to guardians at different NHS trusts. The FTSUG also supports the national NHS Confederation Race and Health Observatory Stakeholder Engagement Group and the national NHS Employers Staff Experience Steering Group to support their work and thinking and share the LCH work and approaches.

3.5 The FTSUG attends the New Starters Forum with the Chief Executive and Director of Workforce to hear and support those new to the trust. The work continues supporting the Clinical Education Team facilitating a forum for our clinical students which has a special focus on wellbeing support and students being able to raise concerns. Attendance and presentation at Preceptorship is a key part of the work. The first Clinical Concerns meeting has happened and themes, areas for work and learning were discussed. A monthly meeting with the chair of Staffside has also started.

3.6 Work supporting speaking up as a key aspect of the Quality and Value work of the trust is ongoing. Staff and managers' report this to be helpful.

3.7 The work supporting Leeds City Council (LCC) and its Freedom To Speak Up work continues as does the FTSUG work at Leeds GP Confederation. Work with the Third Sector in Leeds has started around FTSU routes for Third Sector staff. .

3.8 There has been an external audit of the service involving the Chief Executive, the Director of Workforce, the NED for speaking up and the FTSUG. We have the draft report and there is significant assurance for the service and recommendations for development.

4 Activity data

4.1 The table below shows the volume and type of activity with which the FTSUG has been engaged between September 3rd, 2024, and February 6th, 2025. The table also indicates the nature of the issues raised with the FTSUG.

4.2 The table below details speaking up concerns formally raised about LCH services.

Business Unit	Numbers of concerns formally raised	Issues
Adult Business Unit	4	Culture, leadership, patient care
Children and Families Business Unit	4	Changes in service, leadership
Corporate Services	2	Organisational support around protected characteristics, recruitment
Specialist Business Unit	4	Patient care, staffing, leadership, recruitment issues

4.2 Fourteen concerns were raised formally by LCH staff members concerning LCH and LCH services through the FTSUG. Two concerns were for LCH as an organisation.

Forty-five issues were informally discussed or resolved through the FTSUG.

The Speaking Up Champions had three issues raised with them (two of which came to the FTSUG).

This brings the overall concerns raised to sixty-two in the period this report covers.

4.3 Eight staff colleagues who informally discussed concerns with the FTSUG are from Black, Asian and minority ethnic communities and of these none were related to issues of race. Two issues concerning religion / faith were raised. There were two formal concerns raised by staff from Black, Asian and minority ethnic communities and one involved race. There were ten informal and six formal concerns concerning physical and mental health issues.

5 Themes

The section below outlines the themes that have emerged from the work.

5.1 We see a significant number of staff using the FTSU mechanism in the last period. Staff report being supported and heard.

5.2 We are seeing more cases resolved or supported informally which fits with our ambition that concerns are addressed via local conversations and team / service changes.

5.3. Leadership, culture, and behaviours in teams are ongoing key factors that have featured historically. Health and wellbeing, ways of working, organisational changes are areas mentioned in recent concerns. Race, disability, and health issues are featuring in the concerns.

5.4 Staff with formal and informal concerns report the FTSUG work as supportive and responsive. The highest rate of new referrals is still from staff who are advised to contact the FTSUG service by staff who have already used the service.

5.5 The model we have created shows itself to easily apply to a wide range of work and needs. The trust has supported the work to flow into many organisational terrains which have had positive results for staff and services.

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6 Assurances and Future Work

6.1 **T**he assurances given to the organisation with the role are threefold – national engagement, organisational spread, and local comparison.

We are reporting quarterly to the National Guardian Office. The FTSUG is meeting staff from across all business units of the trust and at different roles and levels. In terms of local comparison with neighbouring NHS trusts, we evaluate well in terms of staff who speak up.

6.2 The following are ongoing and future work and plans.

- To review and implement where needed the recommendations of the external audit report
- To review the FTSUG service in the light of the recent Staff Survey results. To reach out to services on the basis of the survey.
- To develop the clinical and workforce concerns meetings to enable best triangulation and understanding
- To support the Sexual Safety work for staff, the PSIRF work and Quality and Value meetings.
- To continue to focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed.

7

8 Conclusions

7.1 The FTSUG work continues to receive positive support from the trust and its leadership. LCH staff welcome the work and the forms we use.

7.2 The FTSUG role allows staff voices to be heard in the trust. The role continues to illustrate the importance of workplace culture and leadership. It also has a strong focus on psychological and emotional support for staff and seeks to promote inclusion and equity.

7.3 The FTSUG work supports the work of building new ways of working and our commitment and behaviours for excellent clinical care and compassionate culture. It actively supports the ongoing trust initiatives and work.

9 Recommendations

The Board is recommended to accept the report and continue its support to embed our speaking up work.

Agenda item:	2024-25 (124)

Title of report:	Safe Staffing Report

Meeting:	Trust Board Meeting Held in Public
Date:	6 February 2025

Presented by:	Executive Director of Nursing and AHP's					
Prepared by:	Clinical Leads ABU and CBU					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	The paper describes the background to the expectations of boards in relation to safe staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report sets out progress in relation to maintaining safe staffing over the last six months. It covers the mandated in-patient areas only and for LCH these are Hannah House and Wharfedale Recovery Hub. Safe staffing has been maintained across both inpatient units for the time period.

Previously considered by:	Quality Committee and Business Committees January 2025

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	√
	Use our resources wisely and efficiently	√
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	√
	Embed equity in all that we do	√

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	N/A	What does it tell us?	
	No		Why not/what future plans are there to	

			include this information?	

Recommendation(s)	• Receive the report. • Agree the level of assurance provided.

List of Appendices:	None

Safe Staffing Report

Introduction

In line with the NHS England requirements and the National Quality Board (NQB) recommendations, this paper presents the six-monthly nursing establishment's workforce review, alongside other staffing data.

This report will just report on the two in-patient areas which is what is mandated by the NQB for the last 6 months 1 July 2024 to 30 December 2024.

Background

We continue to use a set of principles to monitor safe staffing in our in-patient beds.

Children's Business Unit (CBU)

Hannah House is an inpatient unit within the Children's Business Unit. There are currently 2 Band 5 vacancies within the team. There has been some use of bank staffing during this period. The bank hours utilised in the last 6 month are outlined below. Safe staffing levels have been maintained at all times.

Band 2 = 89 hours (x 8 shifts)
Band 3 = 62.5 hours (x 6 shifts)
Band 5 = 21.5 hours (x 3 shifts)

Total Bank = 173 hours (almost three times greater than the last reporting period January – July 24).

There have been no complaints or incidents recorded with safe staffing as a factor. Three nights was cancelled in total during the 6-month period relating to not having safe levels of staffing. This affected two children, and two nights were consecutive for the second child. All nights have been re-booked for the two children affected. Sickness in the team rose to 24.2% at the end of November 24.

Adult Business Unit (ABU)

Wharfedale Recovery Hub is the inpatient unit in ABU. From June 2024 to December 2024 agency and bank continued to be used but at a much reduced need from the previous 6 months.This is due to vacancies for **unregistered** staff.

Vacancies have been recruited to 3 WTE in the last 6 weeks and there is currently an advertisement out to cover further gaps which we anticipate will be filled before the end of March. In the last 6 months, 154 carers' shifts have been covered by bank and agency and we anticipate this cost will continue to be reduced. There has been some use of bank for AHPs (OT), and recruitment is ongoing.

Safe staffing levels have always been maintained during the reporting period and there have been no incidents or complaints concerning staffing levels. The resource has been used effectively. The nursing staff at Wharfedale have now reached a level of stability. Retention is excellent with little movement in the workforce.

Conclusion

This paper provides assurance to Quality Committee and Board in relation to safe staffing levels and that these have been maintained in the inpatient units during the last 6 months.

Recommendation

Board is asked to receive this report and agree the level of assurance provided.

Agenda item:	2024-25 (125)

Title of report:	Significant Risks and Risk Assurance Report

Meeting:	Trust Board Held in Public
Date:	6 February 2025

Presented by:	Lynsey Yeomans, Executive Director of Nursing, Quality and AHPS					
Prepared by:	Anne Ellis, Risk Manager					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks. There are three risks on the Trust risk register that have a score of 15 or more (extreme). There are a total of eight risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team 22 January 2025

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	✓
	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	✓
	Collaborating with partners to enable people to live better lives	✓
	Embed equity in all that we do	✓

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to include this information?	N/A

Recommendation(s)	• Note the changes to the significant risks since the last risk report was presented to the Board; and • Consider whether the Board is assured that planned mitigating actions will reduce the risks.

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures. It describes and analyses all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (December 2024).

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks).

1.3 The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Themes identified from the risk register have been aligned with BAF strategic risks to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

2. Risk register movement

2.1 The table below summarises the movement of risk since the last risk register report.

	Current	Previous (December)
Total Open Risks	68	70
Risks Scoring 15 or above	3	3
New Risks	4	3
Closed Risks	7	3
Risk Score Increasing	2	3
Risk Score Decreasing	5	5

2.2 The following updates have been provided for risks scoring 15 (extreme) or above since the last risk register report.

Risk	Risk Type	Current Score	Previous Score (December 2024)
1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure	**Operational**	**16**	**16**
Implementation of recommendations from the THIS review continues with actions being led by the Head of IT, Helpdesk Manager and Associate Director of BI.			

Risk	Risk Type	Current Score	Previous Score (December 2024)
Recruitment to third line (Network Administrator) position to provide increased permanent support, successfully concluded 1st November 2024 through internal appointment. Recruitment to post vacated approved by Q&V Panel 6th January 2025. Following recruitment to this post, the risk rating will be reviewed. Additional temporary contractor resource in place to enhance RPA / SQL Connections for Azure, expertise commenced 06/01/25. (update 10/1/25). The aim is to reduce this risk to 4 by 31/12/25 Next review is due 31/1/25			
1048: Mind Mate SPA increasing backlog of referrals (system-wide risk).	**Operational**	**15**	**15**
The Mind Mate Spa review (led by the ICB) is in the process of drawing up conclusions and options following conclusion of the Integrated Design Office workshops. These should be available by the end of December/beginning of January 2025. In the meantime, safeguards remain in place to ensure all referrals are risk assessed and escalated clinically as appropriate. (updated 10/12/24) The aim is to reduce the risk to 12 by 31/3/25 and then reduce further in 2025. Next review is due 31/1/25			
1179: Impact/Management of Neurodevelopmental Assessment Waiting List.	**Operational**	**15**	**15**
Preschool neurodevelopmental (ND) assessments have re-started with a focus on only offering "enhanced" assessments so that those children with additional complexity (such as safeguarding, co-morbidity etc) will be seen by a paediatrician. The remaining preschool children on the waiting list will receive a needs-led offer only with no diagnostic assessment. School age ND children and young people (CYP) continue to be prioritised in a similar way with CYPMHS capacity focusing on those CYP with most risk and complexity. The remaining CYP continue to wait on the waiting list. The business case has been delayed due to BI capacity. (updated 10/12/24) The aim is to reduce the risk to 12 by 31/3/25 and then reduce further in 2025. Next review is due during January 2025.			

3. Summary of risks scoring 12 (high)

3.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not limited to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks

recorded as 'high' and particularly those scored at 12. The Quality and Business Committees have oversight of risks categorised as 'high' (risks scored at 8 – 12).

3.2 The table below details risks currently scoring 12 (high risks)

ID	Description	Rating (current)	Rating (previous)	Status
877	Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	12	Unchanged
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	12	Unchanged
1198	Impact of ADHD medication waiting list	12	12	Unchanged
1199	The impact and management of the CYPMHS Therapies waiting list	12	12	Unchanged
1217	Digital and BI teams have insufficient capacity	12	12	Unchanged
1218	Lack of capacity in services to engage with digital transformation projects	12	12	Unchanged
1221	Likelihood of a cyber attack	12	8	Increased
1230	Non-compliance with NHSE EPRR Annual Assurance process	12	12	Unchanged

Seven of the risks scoring 12 have not changed since the last report (static), these risks have been reviewed and the target dates to reduce the risks are not yet due. When risk scores have been static for over 12 months, they are flagged to SLT and the Quality and Business Committees, none of the risks listed above have been static for over 12 months.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 68. Of these there are 21 clinical risks and 47 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	1	1	0	0	2
4 - Major	0	7	5	1	0	13
3 - Moderate	1	13	23	4	1	42
2 - Minor	0	2	4	1	0	7
1 - Negligible	1	0	1	1	1	4
Total	2	23	34	7	2	68

5. Risks by theme and correlation with BAF strategic risks

5.1 For this report the high risks (scoring 8 and above) on the risk register have been themed where possible according to the nature of the hazard and the effect of

the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

5.2 Themes within the current risk register are as follows:

Theme One: Demand for Services	
The strongest theme across the whole risk register is demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals Specifically, thirteen risks relate to an increase in referrals and service demand[1]	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to manage demand for services BAF Risk 8 Failure to have suitable and sufficient staff resource (including leadership) BAF Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients.
Theme Two: Patient Safety	
The second strongest risk theme is patient safety due to staff working outside their role, lack of incident management, workload pressures, capacity to complete clinical supervision, clinically essential training, and safe operation of medical devices [2].	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to manage demand for services BAF Risk 4 Failure to be compliant with legislation and regulatory requirements
Theme Three: Compliance with Standards/Legislation	
There is also a risk theme relating to compliance with standards/ legislation[3] This includes health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	The BAF strategic risks directly linked to compliance with standards / legislation is: BAF Risk 4 Failure to be compliant with legislation and regulatory requirements BAF Risk 7 Failure to maintain business continuity (including response to cyber security)
Theme Four: Quality and Value Programme	
Four risks relate to the Quality and Value programme and concern the impact on staff and patients and the risk that financial balance is not achieved.[4]	The BAF strategic risks directly linked to the Quality and Value programme are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 5 Failure to deliver financial sustainability

[1] Risks: 772, 874, 913, 954, 957, 994, 1015, 1042, 1048, 1112, 1179, 1198, 1199
[2] Risks: 877, 1109, 1139, 1168, 1187, 1196, 1231, 1125, 1169, 1241, 1278, 1283
[3] Risks: 902, 1089, 1178, 1204, 1206, 1221, 1223, 1230, 1240, 1242, 1243
[4] Risks: 1226, 1227, 1228, 1229

	BAF Risk 6 Failure to have sufficient resource for transformation programmes
Theme Five: Digital Transformation	
Four risks relate to digital transformation, including capacity to deliver transformation[5]	The BAF strategic risk directly linked to digital transformation are: BAF Risk 3 Failure to implement the digital strategy BAF Risk 6 Failure to have sufficient resource for transformation programmes

6. Impact

6.1 Risk and assurance

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

7. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure and the Board will receive an update report at the meeting to be held on 1st April 2025.

8. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board; and
- Consider whether the Board is assured that planned mitigating actions will reduce the risks.

Author: Anne Ellis, Risk Manager
Date written: 22 January 2025

[5] Risks: 1217, 1218, 1220, 1224

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (126)

Title of report:	Register of Sealings April 2024-February 2025

Meeting:	Trust Board meeting Held in Public
Date:	6 February 2025

Presented by:	Selina Douglas, Chief Executive					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	x	Discussion		Approval	

Executive Summary:	In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. The corporate seal had been used once in January 2025 and a copy of a section of the register is presented to the Board.

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	N/A	Why not/what future plans are there to include this information?	

Recommendation(s)	The Board is asked to note the use of the corporate seal.

List of Appendices:	N/A

Register of affixing of corporate seal and signatories to legal documents

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
Dilapidations Settlement Agreement: Merrion Centre and Wade House	Leeds Community Healthcare TCS Holdings Limited	Executive Director of Operations and Executive Director of Nursing and AHPs	08.01.2025

Agenda item:	2024-25	(127)

Title of report:	**Future Funding of the Enhance**

Meeting:	Trust Board Meeting Held in Public					
Date:	6 February 2025					
Presented by:	Sam Prince, Executive Director of Operations					
Prepared by:	Caroline Schonrock, Partnership Development Manager					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	✓

Executive Summary:	The Enhance programme is a partnership development by LCH and Leeds Older People's Forum (LOPF) to release capacity in LCH services by investing in third sector capacity to work collaboratively with LCH services and provide personalised care and support to patients' physical and mental health and wider well-being, aiding recovery, preventing deterioration and maintaining independence. The programme is now in its third year. During the current year a full evaluation was completed which demonstrated the return on investment both for LCH and the wider system This paper details the findings of the evaluation and makes a recommendation on next steps

Previously considered by:	Trust Leadership Team – 24 November 2024; 15 January 2025 Business Committee – 29 January 2025

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	✓
	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	✓
	Collaborating with partners to enable people to live better lives	✓
	Embed equity in all that we do	✓

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	✓	What does it tell us?	Enhance has better engagement with patients in IMD1/2 than NTs 97% of Enhance patients have at least 1 long-term condition, 88% live with 3 or more, and 75% with 4 or more. 88% of Enhance participants have a frailty risk
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	The Board is asked to support the Business Committee/TLT recommendation to provide £300k funding for the financial year 2025-2026 and to retain elements of the service within five neighbourhoods with a view to maximising impact and return on investment for LCH.

List of Appendices:	Enhance Business Case (for information only)

Future Funding of the Enhance

1 Introduction

The Enhance programme is a partnership development by LCH and Leeds Older People's Forum (LOPF) to release capacity in LCH services by investing in third sector capacity to work collaboratively with LCH services and provide personalised care and support to patients' physical and mental health and wider well-being, aiding recovery, preventing deterioration and maintaining independence. The programme is now in its third year.

LCH has provided £1,005,000 funding p.a. from ABU staffing underspend to Leeds Older People's Forum (LOPF): £805,000 for 3rd sector Delivery Partners (DPs) and £200,000 to LOPF to provide programme management. In approving funding for the current financial year the Trust Board asked for a business case of a BAU model to be developed underpinned by academic evaluation of time saved and value for money for LCH, as well as the wider healthcare system. Leeds Beckett University led this evaluation working closely with Leeds Office of Data Analytics and a Steering Group sub-group which also included ABU and SBU senior managers, LCH BI, Public Health and the LCH and LOPF programme team.

As requested by LCH Board in approving Enhance funding for FY 24/25, in year 3 Enhance has only accepted referrals from LCH services and widened the portfolio of referring services to ABU and SBU services where there was considered to be the greatest potential to save time for services. Referrals have continued to grow: forecast to increase 140% in year 3, from 423 in year 2 to 1066 in year 3 with 71% of referrals from Neighbourhood Teams(NTs) and 29% from SBU services (started May '24).

Enhance has enabled testing and delivery of innovative collaborative service models such as ABU Self-Management Health Hubs and a NT Integrated Clinic hosted in DP premises which are highly efficient and enable patients' wider well-being needs to be supported on an ongoing basis through connecting with Enhance DPs and accessing their core offer.

Enhance has evidenced reach to a particularly vulnerable population who are at risk of being higher users of LCH and wider healthcare services in the short and medium term:

- 41% of the Enhance cohort live in IMD 1 and 2 compared to 33% of the NT total caseload, 23.9% of the >65 GP population. LCH staff highlight the role of Enhance in supporting patients from deprived areas where social and financial challenges are felt to impede recovery and lead to patients staying on LCH caseloads for longer e.g. through facilitating access to essential items such as food, hygiene items and equipment, heating, help to avoid trip hazards and accessing financial benefits to help people afford what they need to keep well, travel to appointments, pay for cleaners. In the 1st 7 months of FY24/25

Enhance supported 67 successful benefit claims which equates to £635k in annual financial benefits.

- Key findings from 2-phase validated participant surveys which assess frailty risk (PRISMA-7) and physical and mental health related quality of life (PROMIS) include;
    - PRISMA-7: 97% have at least one long term condition, 88% live with 3 or more, and 75% with 4 or more. 88% of Enhance participants have a frailty risk.
    - PROMIS: improved scores for all responses which suggests mental and physical health functioning improved whilst receiving support through Enhance.

More detail of this and the evaluation available on request.

Patient videos: https://youtu.be/tsJLBIcg0Xk, feedback, case studies and stories reflect the significant, and at times life changing impact of Enhance on health, quality of life and well-being.

2 Leeds Beckett University (LBU) Evaluation

Annual time savings for LCH:
Total savings: at least **£286,786 to £295,110.** This is an under-estimate and does not include a financial value for:

- reducing DNA's, positive impact on waiting list / times reported on discharge surveys:
- efficiencies derived from more productive collaborative social delivery models: self-management health hubs, an Integrated Clinic – can see 2 more patients than if visiting at home
- Enhance preventing future referrals to LCH services where the person doesn't attend / isn't admitted to hospital

Costed case studies show significantly higher time savings for some patients who have complex clinical and social needs and receive regular visits over an extended period of time.

Annual time savings for the wider system – secondary and urgent care:

LBU comparative analysis of time savings for the wider system compare resource use for Patient Transport Service, calls to NHS 111 and 999, A&E attendances, Outpatient visits, elective and non-elective spells. It does not include use of Adult Social Care or Primary Care. The business case (Appendix 1, para 3.4) indicates data limitations and challenges specific to this analysis.
Total savings for secondary and urgent care: **£1,099,764** to **£1,196,263**

TOTAL SAVINGS for LCH plus parts of the wider system: at least £1,386,550 (ROI + 38.7%) to £1,491,283 (ROI +49.1%). This will be an under-estimate, in particular for LCH, due to the data limitations and challenges in evaluating time saved flagged above. ROI for both LCH and the wider system would improve in year 4 as referrals are forecast to grow.

Value for Money - LBU highlighted that cost benefit analysis should, in addition to direct financial savings associated with the investment, also reflect other benefits that relate to improvements in health, wellbeing and quality of life which are more difficult to place a financial value on. NICE considers an appropriate funding threshold to be £20,000 per quality-adjusted life year (QALY). If an intervention has an impact of supporting one person to have a year of perfect health or quality of life, that is worth £20,000. For Enhance participants, a more realistic estimate of their best achievable quality of life might be 0.5 of perfect health (on a scale of 0 to 1), representing £10,000. With more than 1000 referrals per year, even if only 5% of Enhance clients benefited in terms of improved health or quality of life for one year, this would represent additional value of £500,000 to NICE. It is also likely to be reflected in longer term savings to the NHS and LCH as people will stay healthier for longer and need less care.

The evaluation concluded therefore that Enhance, even at the most conservative estimate of cost versus benefit, represents a good return on investment and good value for money.

Strategic alignment with city and national priorities: the ICB has consistently cited Enhance as a really strong example of collaborative working across statutory healthcare and the third sector to deliver on the Healthy Leeds Plan prevention ambitions and HomeFirst. Enhance reflects the ethos of what is expected in the 10-year plan and Lord Darzi's report: the need to re-empower patients, shift care closer to home and from treatment to prevention, through innovating care delivery to create a Neighbourhood NHS.

3 Business Case Proposal and TLT Decision

In November 2024, TLT considered the business case which requested £902,416 funding p.a. for the 3 years 2025-28 to enable continuation and growth of Enhance as a city-wide offer with 'no wrong door'.

TLT felt that the evaluation evidenced well a service that demonstrates tangible, positive outcomes for service users and adding value to the Leeds system. However, TLT felt that a better return on investment for LCH would need to be evidenced to secure full future funding for Enhance and that Enhance would be better resourced from elsewhere in the system, as this is where the return on investment is so strongly evidenced.

TLT did not want to risk losing the years of knowledge and expertise that have gone into developing Enhance, therefore proposed:

- providing £300k funding for FY 2025-2026 to retain elements of the service which will enable future scaling up if funding from elsewhere is secured
- seeking support from system partners for wider system funding, and LCH, LOPF, and Delivery Partners to work together with the Leeds system to create a viable proposition and obtain system support for resourcing this from elsewhere

TLT requested options that would maximise impact and return on investment for LCH to be scoped and recommended in January that the reduced Enhance offer

should focus on five Neighbourhoods – Armley, Beeston, Middleton, Chapeltown and Seacroft

As the Enhance contract expires at the end of April 2025 and a decision about future funding of Enhance wont be approved until 6 February Board, TLT has given a commitment to provide 3 months notice to Delivery Partners, extending contracts by 5-weeks till 6 May. LOPF and Enhance Delivery Partners have been asked to pause recruitment into any Enhance vacancies until we are clearer on the new short-term model and any underspend will contribute towards the cost of the 5-week extension with LCH only providing additional funds to cover a gap, if any.

4 Recommendation

The Board is asked to support the Business Committee/TLT recommendation to provide £300k funding for the financial year 2025-2026 and to retain elements of the service within five neighbourhoods with a view to maximising impact and return on investment for LCH.

Sam Prince/Caroline Schonrock
22 January 2024

Title: Enhance Years 4-6: A Business as Usual Model

Category of paper: Approval

History:
Reviewed by:
Enhance Steering Group
ABU & SBU General Managers

Responsible director: Director of Operations

Report author: LCH Enhance Project Manager, LCH Partnership Development Manager, LCH Business Manager

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Business case type: (tick all that apply)

- Other (please state)
  Shift from project to business-as-usual funding

Business case checklist: (tick all that apply)

- Does the proposal align with the LCH strategic goals 24/25?
  - ✓ Work with communities to deliver personalised care
  - ✓ Enable our workforce to thrive and deliver the best possible care
  - ✓ To embed equity in all that we do
  - ✓ Use our resources wisely and efficiently in both the short and the longer term
  - ✓ Collaborating with partners to enable people to live better lives
- ✓ Is the proposal contained within the appropriate business plan?
- ✓ Does the business case improve quality and/ or patient safety?
- ✓ Does the business case identify a more efficient way of service delivery?

Total value of business case:

Governance route for sign off:

27/11/24 LCH Trust Leadership Team
27/11/24 LCH Business Committee – requested extraordinary meeting be convened to enable business case to go to 6 December Board for decision
06/12/24 LCH Board

Enhance Years 4-6: A Business as Usual Model

Executive Summary

Enhance is a collaboration between LCH and the third sector that aims to free up clinicians to provide clinical care and enable earlier discharge by investing in third sector capacity to support patients with non-clinical needs. Initially set up to support NTs, in its current third year of funding, Enhance has expanded to include other ABU services and a range of SBU services. Enhance has been recognised by the ICB as a really good example of collaborative working with the third sector to deliver on the Home First and Healthy Leeds Plan Prevention ambitions. It supports the key focuses of Lord Darzi's report and what is expected in the NHS Ten Year Plan: re-empowering patients, shifting care closer to home and from treatment to prevention, innovating care delivery to create an Neighbourhood NHS.

This business case requests £903,416 funding p.a. for a further 3 years (2025-28) to enable continuation and growth of Enhance as BAU:

- £805,000 to fund third sector Delivery Partners (DP)
- £97,416 to LOPF to provide programme management – 51% reduction from funding in years 1-3 (to be reviewed quarter 3, 2025/26)

There has been significant growth of LCH referrals throughout years 1-3 with further growth forecast over the remainder of the current FY. Evaluation in years 1 and 2 evidenced strong impact on people's health and wellbeing and reach to people living in disadvantaged areas. In year 3 a key focus has been developing robust evaluation of the impact on LCH services, particularly time savings and value for money.

Impact on People

Enhance is reaching a particularly vulnerable population who are at risk of accessing LCH and wider healthcare services in the short and medium term: 88% are classed as having a frailty risk, 88% live with 3 or more long-term conditions. In year 3, 41% of Enhance participants live in the most deprived areas: IMD 1 & 2 and 74% are over 70 years old, 16% are 60-70.

As the patient video and case studies show, Enhance can transform people's health and quality of life. A validated patient survey gave improved scores for all responses which suggests mental and physical health functioning improved whilst receiving support through Enhance.

Impact on LCH

Interviews with 29 LCH staff clearly showed how much staff value Enhance - supporting rehabilitation and enabling earlier discharge by supporting mobility and compliance with prescribed exercises diet, hydration and medication, liaising with and making referrals to other agencies and financial benefits applications, creating a safe living environment, supporting people to attend health appointments, better engage with services and enabling social connections.

Leeds Beckett University in conjunction with Leeds Office of Data Analytics led an academic evaluation of annual time savings for LCH and return on investment comprising:

- comparing NT resource utilisation for patients referred to Enhance for 3 months before and post referral to Enhance against matched cohorts: **£32,658 - £40,982** savings. LBU and Leeds Office of Data Analytics noted that this is likely to be a significant under-estimate principally because:
    - much non-clinical support activity is not reportable on S1 and Leeds Data Model (LDM), so significant non-clinical time savings to clinicians are not reflected, nor time-savings for NT Co-ordinators
    - the analysis only compares impact for 3 months pre and post referral
    - the analysis is based on the number of visits, assuming visits by Band 5 clinicians with a 'standard' visit length of 15 minutes.

There are also limitations resulting from difficulties in creating robust matched population cohorts for comparison. LBU noted that this will be an under-estimate due to significant challenges in evaluating time-savings and limitations with the data, most importantly that and not evaluating positive impact beyond 3 months. Because of these data limitations, the analysis of time savings for LCH also includes:

- calculating cost savings from an Enhance discharge survey plus a Podiatry pilot: **£187,464** plus 28% oncosts = **£239,954**
- costing impact of prevention scenarios: **£7,087** cost to LCH of prevention scenarios (x2 for non-clinical time = **£14,174)**

Total savings: at least **£286,786 to £295,110**

This will be an under-estimate for the reasons stated above and because it does not include a financial value for:

- other positive impacts reported on discharge surveys: supporting earlier discharge, reducing DNA's, positive impact on waiting list / times
- efficiencies derived from more productive collaborative social delivery models: self-management health hubs, an Integrated Clinic
- Enhance preventing future referrals to LCH services where the person doesn't attend / isn't admitted to hospital

Impact on Wider Health and Social Care System

Enhance also benefits the wider health and social care system, reducing pressure on primary care, ambulance, hospital services and adult social care in the short and longer term. LBU produced comparative analysis for an Enhance and matched cohorts of use of Patient Transport Service, calls to NHS 111 and 999, A&E attendances, Outpatient visits, elective and non-elective spells.

- Potential savings were calculated to be between **£1,030,877 - £1,127,376**
- In addition, potential savings from prevention scenarios: **£68,887.**

Total: **£1,099,764** to **£1,196,263**

TOTAL SAVINGS for LCH plus parts of the wider system: £1,386,550 (ROI + 38.7%) to £1,491,283 (ROI +49.1%). It is important to note that this will be an under-estimate of time savings and ROI, in particular for LCH, due to the limitations of the data and multiple challenges in evaluating time saved flagged above. We could confidently expect ROI for both LCH and the wider system to improve in year 4 as referrals are forecast to grow.

Value for Money LBU highlights that cost benefit analysis should, in addition to direct financial savings associated with the investment, also reflect other benefits that relate to improvements in health, wellbeing and quality of life which are more difficult to place a financial value on. The National Institute of Health and Care Excellence considers an appropriate funding threshold to be £20,000 per quality-adjusted life year (QALY). A QALY is a year of life lived in perfect health. If an intervention has an impact of supporting one person to have a year of perfect health or quality of life, that is worth £20,000. For Enhance participants, a more realistic estimate of their best achievable quality of life might be 0.5 of perfect health (on a scale of 0 to 1), representing £10,000. With more than 1000 referrals per year, even if only 5% of Enhance clients benefited in terms of improved health or quality of life for one year, this would represent additional value of £500,000 to NICE. It is also likely to be reflected in longer term savings to the NHS and LCH as people will stay healthier for longer and need less care.

The evaluation concluded therefore that Enhance, even at the most conservative estimate of cost vs benefit, represents a good return on investment and good value for money.

The proposed model

- To continue providing a city-wide offer

- Provide a 'no wrong door' offer – all DPs to take referrals for people aged 50+. LOPF to identify third sector support for the small number of referrals for people under 50
- ABU and SBU to review referring services as part of 24/25 business planning considering potential for Enhance supporting the Quality and Value programme
- Align DP capacity and forecast demand
- Embed performance monitoring, risk and issue escalation in ABU and SBU BAU processes. Operational management and future planning managed by an Enhance Steering Group with appropriate representation from BUs.

Recommendation

We request that TLT/ Business Committee provide a decision around our recommended option;

- Option 3 – for LCH to provide £902,416–funding per year for years 4-6 of the Enhance programme

1. Background and Context

Enhance is a partnership initiative between LCH and the third sector, aiming to reduce pressure on referring services by investing in third sector capacity to support patients with non-clinical needs. Leeds Older People's Forum (LOPF) are funded by LCH to provide programme management, and LCH services and Enhance Delivery Partners (DPs) work collaboratively to provide person-centred, holistic support to promote recovery and rehabilitation, prevent deterioration and support people to stay well, connected to their community and independently manage their health. Enhance also eases demand on wider health and social care systems, including hospital discharge/readmission.

Enhance was a response to recognition that Neighbourhood Team (NT) clinicians were spending time supporting patients with non-clinical needs (especially when there weren't family or carers able to provide that support) and keeping patients on caseloads longer than clinically necessary because of concern about the patient deteriorating in the absence of other support. Enhance recognises the strengths of Leeds third sector in supporting behaviour change working with a strengths-based approach and supporting disadvantaged vulnerable people including those with complex needs.

In years 1-3 LCH provided:

- £200k per annum to LOPF to provide programme management
- £805k to fund additional capacity in third sector organisations to work with people intensively for up to 12 weeks to improve health outcomes
- There are thirteen Enhance Delivery Partners (DPs) aligned to NTs - all have a strong track record in providing support for older people – see **Appendix 1**

In years 1 and 2 LCC provided £98k funding.

In year 1 Enhance focussed on NTs, widening in year 2 to include referrals from several other ABU services and hospital discharge teams. In years 1 and 2, because DP capacity wasn't fully utilised, referrals were accepted from Adult Social Care (ASC), Primary Care and DPs - LCH referrals had priority.

Enhance aligns with all 5 LCH strategic objectives,

- **enabling our workforce to thrive and deliver the best possible care** by releasing time for clinical care, and providing staff with assurance that patients are receiving the support they need to stay safe and prevent deterioration.
- **working with communities to deliver personalised care** – the investment in third sector capacity enables DPs to provide personalised care - aiding rehabilitation and recovery, preventing deterioration and potentially crisis by supporting compliance with medication, exercise, nutrition and hydration,

creating a safe environment and supporting people to attend LCH and other healthcare appointments working intensively where needed. DPs support wider needs including tackling financial inequality, social isolation and digital exclusion.

- **collaborating with partners to enable people to live better lives** – Enhance has enabled development and testing of collaborative social models of provision delivered in Enhance DPs premises, including self-management hubs.
- **embedding equity in all that we do** – Enhance DPs are skilled in, and have considerable experience of supporting disadvantaged and vulnerable communities and populations. DPs are trusted by communities and have strong networks so are able to reach people who are reluctant to engage with statutory healthcare services. Analysis shows that Enhance reaches those who are vulnerable and have complex needs.
- **use our resources wisely and efficiently in both the short and the longer term** – Enhance enables resource to be used more effectively in the short-term through freeing up clinicians to focus on clinical care, improving attendance and enabling more efficient collaborative service delivery models. Both ABU and SBU are keen to develop collaboration with Enhance as part of their Quality and Value programme. The ICB highlights Enhance as a really good example of collaborative working to deliver on the HomeFirst and Healthy Leeds Plan Prevention ambitions. Through providing strengths based support and creating the conditions to enable people to stay well, maintain independence and health and well-being, Enhance supports reduction in demand for both LCH and wider healthcare services in the longer term.

"We had a gentleman with leg ulcers who was struggling to leave the house…[Enhance] helped him build his confidence to walk, and now he's able to get out to the hub for his leg dressings. This means we no longer need to visit him every other day, which frees up our time to see other patients. It's been a huge time-saver."
(District Nurse)

2. Year 3 Delivery

2.1. Referring services

As requested by TLT and LCH Board when approving Enhance funding for FY 24/25, in year 3 Enhance has:

- Only accepted referrals from LCH services.
- Widened the portfolio of referring services; ABU and SBU services were selected based on assessment of impact in terms of reducing time spent on non-clinical and clinical tasks, reducing clinical demand and enhancing capacity.
- Enhance has continued to take referrals from NTs (including Triage Hubs, Response Teams, Active Recovery and ABU Self-Management Service), Palliative Care, Recovery Hubs, Integrated Clinics and CUCS, and now also accepts referrals from the following SBU services: Respiratory, Cardiac, Community Neurology, Community Pain Service (including Pain Hub pilot), Falls, CIVAS, and Podiatry pilot.

Enhance enables testing and delivery of innovative collaborative service models such as ABU Self-Management Health Hubs, SBU Pain Hubs and a NT Integrated Clinic. These are all hosted in Enhance Delivery Partner premises with Enhance DPs working alongside LCH clinicians providing support to patients to attend, including some DPs providing transport, involving patients in social activities on the day, supporting with non-clinical needs and often creating a longer term connection between the patient and DP enabling ongoing identification and support with health needs. The cost of providing the premises is covered from DPs Enhance funding. Were they not funded by Enhance these models could not continue.

"The whole [working collaboratively in the community] saves loads of time for us, the appointment times are shorter, and we don't have to carry out so many home visits…without the social stuff being supported [through Enhance] I don't think as many people would come" (Self-Management Team)

2.2. Engagement

During year three we have established a number of initiatives and developments which will support effective ongoing partnership working and relationships between LCH referring services and Enhance DPs. This will enable a business-as-usual model moving forwards and enable a significant reduction in programme management capacity.

These initiatives include;

- Establishing Enhance champions within all referring services to maintain awareness of and promote Enhance across their teams and support positive relationships with DPs.
- Promoting good practice that supports development of strong relationships, awareness of Enhance across teams and referrals e.g. joint visits, regular DP presence in NT bases and attending handover or case management meetings
- Implementing 6-weekly review meetings for each Neighbourhood Team area (North, South, West), with respective DPs, NT Operational or Clinical Manager, NT Co-ordinator and NT Enhance Champions to monitor and maintain relationships, engagement and referral numbers.
- SBU Enhance Champrions and NT Co-ordinator lead for Enhance routinely attending Implementation Group meetings.
- Establishing regular Enhance Champions share and learn sessions.
- Improving the referral process, including providing NHS Mail addresses for all DPs, which strengthens information governance and streamlines the process.
- A discharge feedback process: DPs complete a 'part 2' referral form to provide information for referring services about support provided and outcomes for the patient. Now implementing DPs additionally routinely providing feedback about support being provided once plan agreed with patients
- Communication of DPs expected response times on a weekly basis: 51% of DPs are responding within 1-2 days, and 96% within 7 days.
- Service information: patient leaflets, posters for bases and the Enhance intranet page updated

2.3. Referrals

SBU services started referring to Enhance in May 2024. As shown in Table 1 below, there has been significant further growth in LCH referrals in year 3: 622 referrals have been recorded on SystmOne (S1) in the first 7 months of year 3, compared with 618 for the whole of year 2, which if extrapolated, equates to 1,066 referrals. We anticipate a continued 5% increase in referrals for the remainder of year 3 which would result in 1,423 referrals in year 3 from increased referrals from Recovery Hubs, some NTs and 3 additional self-management Health Hubs - an 129% increase from year 2. The total number of Enhance participants since the programme began is 2,130.

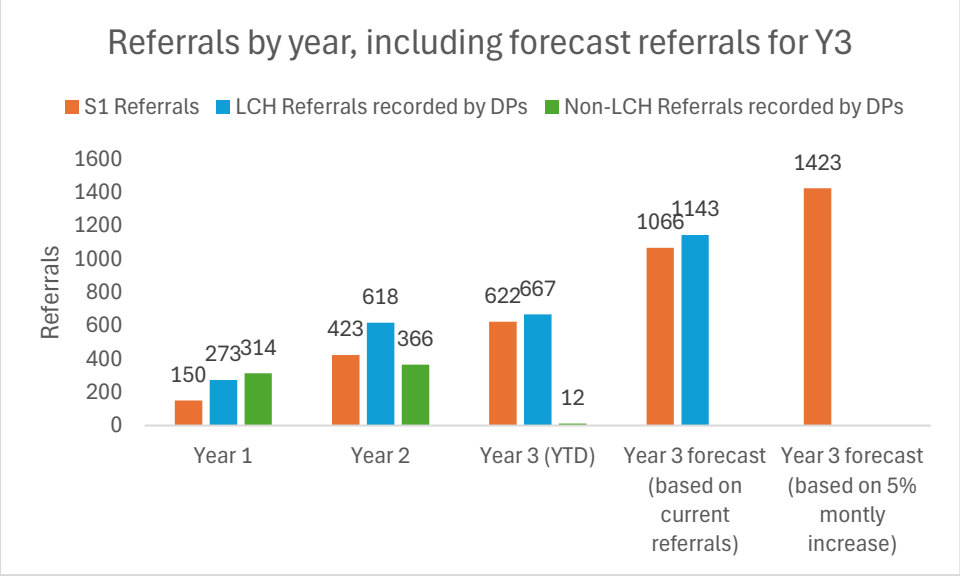

Fig. 1: Enhance referrals from year 1 to 3

"One lady was calling an ambulance and us every week due to loneliness. By introducing her to [Enhance], we got her to leave the house and attend classes… It's made a real difference to her and she has stopped calling." (NTC)

Fig. 1 shows that the disparity between referrals captured on S1 and reported by DPs has reduced significantly in year 3 and is now relatively small. This is due principally to referrers being able to make referrals via NHS mail since August 2024, and further comms and engagement with referrers and DPs to ensure the correct process is followed. We are confident of further improvement as a result of work this quarter to address remaining issues.

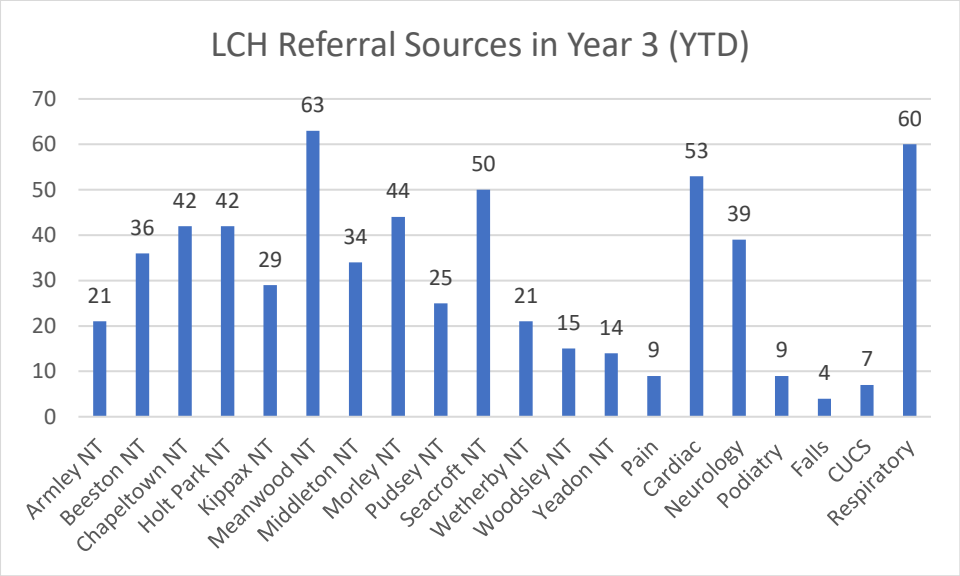

Fig. 2: LCH Enhance Referral Sources in Year 3

"Giving people confidence to get outside, get walking after a heart attack [Enhance] allows patients to continue their recovery while reducing the frequency of follow-ups by keeping them active." (Physiotherapist)

There have been some issues with referrals from Yeadon and Middleton NTs not all showing on S1, so referrals are higher than shown in the graph above. Work is underway to resolve these issues.

2.4. DP Capacity

Most DPs report that they generally have some capacity to take additional referrals although capacity fluctuates as every referral differs in terms of the demands on DP time and resources. Some cases can be accepted and closed in a few days - others will need to have support in place for the full 12 weeks and beyond. Some only need a single visit in any given week and others will need several. A single case can shift through all levels of need during their time of being involved in Enhance so may start out as a simple case, have peaks of complexity and then settle back to low level of need.

All DPs were asked to provide a snapshot of how many additional referrals they could accept (22 October 2024). On average DPs reported that they could accept around 11 additional referrals that week, with two DPs reporting being at full capacity, one being Health for All, the sole DP in 3 NT areas which is largely due to developing very good working relationships with those NTs over recent months resulting in increased referrals.

"We're often focused on the clinical side, but Enhance helps with the social side, which is so important for preventing patients from deteriorating…It's all about prevention rather than cure, and that makes a big difference in keeping patients healthy and out of the system." (NTC)

2.5. Monitoring and Evaluation

As requested by TLT, LCH Business Committee and Board, a key focus in year three has been ensuring robust evaluation of the impact of Enhance on time saved and value for money provided. Because of the limitations in reporting on non-clinical activity on S1, the LOPF and LCH project team in liaison with services developed additional mechanisms for evidencing time saved and other positive impacts for services. A sub-group comprising colleagues from Leeds Beckett University and Leeds Office of Data Analytics who led the

academic evaluation, LCH BI team, ABU senior managers and Business Manager, LOPF and LCH programme team developed the evaluation approach which comprises:

- Academic evaluation of
  - the impact on LCH, in particular time saved for services
  - value for money for LCH
  - impact on the wider health system: LTHT, the ambulance service and primary care
- Referrers' estimate of impact of Enhance for LCH services
- Service specific analysis of time saved for LCH services and other positive impact
- Costed case studies assessing time saved for LCH services
- Qualitative evaluation, building on evaluation done in years 1 and 2:
  - LCH staff views about the impact and benefits of Enhance on themselves, their service and for patients
  - Demographic and health profile of Enhance participants
  - Participant reported impact on physical and mental health and frailty through use of two validated surveys

"A [patient] referred to Enhance who I had been visiting at home came to clinic a couple of weeks ago with the worker….he wouldn't have been confident coming on his own… he has no family and [Enhance] are working to build up his confidence. He also walked to his GP surgery, he hadn't done this walk in years…I don't know if this patient will revert back to wanting a home visit when the 12 week support ends, but this progress feels positive (Podiatrist)

"We have patients who say they don't need to socialise, but they're lonely and need someone to talk to…so I end up spending longer with these patients during visits. When Enhance steps in and helps them get out into the community, it reduces that need for us check in so often." (OT)

3. Impact / Evaluation to Date

3.1. Impact on people

Click on this four minute video to hear from Enhance participants about their experience of Enhance and the impact on their health and lives. https://youtu.be/tsJLBIcg0Xk

3.1.1. Demographic profile of participants and reducing health inequalities

Data has shown that 90% of people supported by Enhance are aged 60+ with 16% aged 60-70, 24% aged 70-80, and 50% aged 80+.

Enhance continues to support with reducing health inequalities through its reach to people living in the most deprived areas of Leeds and diverse communities, as shown in the table below, and having the capacity, skills, knowledge and networks to tailor support to individuals needs. People supported by Enhance are more likely to live in IMD 1 & 2 areas and be more ethnically diverse than the NT cohort as a whole. This has been consistent since the start of Enhance.

% IMD 1 & 2	Enhance cohort: 41%	NT total caseload: 33%	Leeds >65 population: 23.9% *
% Non white **	Enhance cohort: 15.3%	NT total caseload: 11.1%	Leeds population: 21%

Fig. 3: Enhance cohort reach – reducing inequalities

** GP Registered Population who are 65 and over and who live in IMD 1 and 2*
*** Excludes Irish, Roma, Gypsy or Irish Traveller.Leeds population data – source Leeds Observatory 2021 Census*

Staff highlight the role of Enhance in supporting patients from deprived areas, where social and financial challenges were felt to impede recovery and lead to patients staying on LCH caseloads for longer. Examples were provided of Enhance facilitating access to essential resources such as food, heating, and financial support to help people afford what they need to keep well as well as paying for cleaners, helping to avoid trip hazards. Both LCH staff and Enhance DPs have fed back that some Enhance participants have very complex needs and would ideally be better supported by Adult Social Care. DP experience of referring to ASC varies. Some have experienced little delay and others 3-4 months waiting time which can extend the period of DP support

"There's one guy who's house was in a terrible condition—no fire alarms, unsafe kitchen, living room falling apart. He had no idea where to turn we got [Enhance] in, they got the fire service in and helped him get benefits that he was entitled to. This is what is needed to stop people needing more medical care down the line." (Clinical Nurse Specialist)

3.1.2. Frailty Risk and Quality of Life

Previous analysis of responses to validated participant surveys that assess frailty risk (PRISMA-7) and physical and mental health related quality of life (PROMIS) was extended to include surveys completed in quarter 3 of 2023. PROMIS comprises a baseline questionnaire completed soon after referral to Enhance, and a follow up whilst receiving support from Enhance or following discharge. 503 baseline surveys were completed and 248 follow ups, between June 2022 and December 2023.

Key findings include;

- Enhance is reaching a particularly vulnerable population: 97% have at least one long term condition, 88% living with 3 or more, and 75% with 4 or more. 88% of Enhance participants having a frailty risk.
- PROMIS follow up responses gave improved scores for all responses which suggests mental and physical health functioning improved whilst receiving support through Enhance. Measures based on social health show the most significant improvement – suggesting Enhance is particularly effective at tackling isolation through increased social interaction.
    - General health boost: Participants were 18% less likely to rate their health as "poor," and over a third more likely to rate it as "good" to "excellent"
    - Participants were a quarter less likely to rate quality of life as "poor" and 13% more likely to rate it as "good" to "excellent"
    - Reports of severe fatigue decreased by 28%
    - Mental health functioning saw a 9.6% improvement, with a 30% reduction in respondents reporting "poor" mental health.
    - Respondents were 35% less likely to be "always" bothered by emotional problems
    - Satisfaction with social activities jumped by 19.4%, with 57.5% more participants reporting "good to excellent" satisfaction levels.
    - Improvement in social health scores improved by 13.7%.

See **Appendix 2** for full report

3.1.3. Participants' experiences

Enhance participants benefit hugely from Enhance support. See **Appendix 3** for a selection of general short stories outlining benefits of Enhance for the person.

"J has just phoned to absolutely sing our praises for helping him with the Dentist appointment last week. He has been working with the physio to practice walking up the slight hill to the bus stop and he did it on his own this morning to attend his filling appointment. He was very emotional and said it was the first time he has been out on his own in over 40 weeks and couldn't have done it without the support of AVSED taking him out first. He now wants to try and attend a group. he can't wait to start his life again" (Enhance DP)

Examples of benefits described include:

- Better access to food, improved living conditions, improved social connections, support to attend health appointments, support with physical activity and prescribed exercises, onward referrals and liaison with other organisations.
- Support to access financial benefits - Enhance supports people to stay safe and well at home and improve their quality of life, including by supporting people to access financial benefits. Since April 2023 as a result of Enhance DP support there have been 67 successful benefit claims awarded, resulting in a yearly-equivalent amount of just over £635,121 in additional financial benefits for Enhance participants. Most of the year 3 applications were for attendance allowance most of the additional income spent on transport costs to access health appointments, social activities, carers and help in the home. Participants also refer to the additional income being used for food, daily living costs, medication and rent.

"I find that claims for attendance allowance take a lot of time and can be daunting…I have started to pass these on [to Enhance]. They know how to complete the forms efficiently…they know the buzzwords and what to include, which not only saves my time but also ensures patients get the support they need." (Self-Management)

- Supporting Enhance participant carers - often Enhance DPs find that to support the person referred they also need to provide support for a carer (often a spouse) who lives in the same home but who has their own health and social care needs. Being able to support both people can help prevent carers fatigue, help couples to stay together in their own home and prevent health deterioration for both the patient and their carer. The impact of this is difficult to quantify and not included in the evaluation. See **Appendix 4** for some short stories about couples supported by Enhance.

"You have been an ear to listen at one of the hardest times of our lives, and knew what to do when we didn't know where to start". (Enhance participant)

"I didn't have anyone to help me, I felt abandoned. But then I was referred to Enhance and everything changed for me. I was able to get my finance in order and enjoyed meeting new people at Tuesday lunch club. I don't think I would have survived without [the DP] being there for me." (Enhance participant)

3.2. Impact on LCH

3.2.1. Staff views about the impact of Enhance on services

Click on this link to hear from LCH staff about their experience of Enhance and the impact on their service (a 4 minute video) https://youtu.be/xo4a6v-2qdk

Group and one-to-one interviews with 36 staff members were undertaken by an external evaluator: 21 from ABU; 10 from SBU; 4 Leeds City Council. In addition, questionnaires were completed by 29 LCH staff referrers across 9 NTs and 3 SBU services

Key themes include;

- Therapy staff particularly valued Enhance's role in offering ongoing encouragement and reminders to keep to prescribed exercises and recommended movement. This was felt to both reduce visits and help accelerate recovery enabling quicker discharge.
- Enhance support at times enables patients to be removed from waiting lists, as it's identified that there is no clinical need.
- Enhance's role in encouraging patients to go outside and engage in the community (e.g., walking groups, social hubs) helps patients gain a sense of purpose and motivation, which contributes to their overall health and means long term cases in particular could be closed.
- Handling those "small tasks" that, while not always recorded, add up over time. Others offered specific details, noting time savings from 30 minutes for arranging a key safe to over an hour for processing disability benefit claims or referring patients to Adult Social Care. Staff also emphasised the additional time spent following up on these referrals.

- Facilitating access to services and the convenience of having Enhance as a single point of referral, saving staff the effort of searching for local services.
- Enhance helping patients access essential items - which in turn helped patients to maintain their hygiene and reduce the chance of complications such as pressure sores or re-infection which could lead to more visits or spending longer with a patient during a visit.
- Staff reported that they often did extra things for patients on a low income as part of their duty of care as the consequence of not doing so could put the patient at risk, particularly if the patient struggled to keep warm or eat. Clinicians recognised that Enhance enables them to concentrate on clinical need

"When I had to go on a six-week placement, I felt confident leaving the patient with [Enhance worker]. His proactive approach and understanding of [the patient's] mental health challenges made a real difference. He not only took the time to go over exercises but was supportive throughout... It was a relief knowing I could trust him to keep things moving in my absence, allowing me to discharge the patient without needing additional input from the Neighbourhood Team." (OT Assistant)

3.3. Time savings for LCH services

3.3.1 Leeds Beckett University academic evaluation - see Appendix 5 for more report detail

Analysis Of Time Saved
The LBU evaluation produced a secondary cost benefit analysis of existing data in the Leeds Data Model, comparing NT, including Palliative Care Team, service use data collected for people referred to the Enhance programme September - December 2023 with a matched cohort from similar populations in Leeds, for 3 months before and after their first Enhance referral (or equivalent date for matched cohort). Before and after values are presented as Mean with the standard deviation in brackets. Statistically significant differences ($p<0.05$) between Enhance and comparison groups are denoted by an asterisk.

Time-frames did not permit data for year 3 referrals to be used in the analysis as Enhance's core offer provides support for up to 12 weeks, it takes 6-7 weeks for data to be cleared through the Leeds Data Model, Leeds Office of Data Analytics then had to develop matched population cohorts before producing data reports for LBU to undertake their analysis.

Event / Activity	Enhance	Matched cohort	Matched cohort subgroup	Potential savings for Enhance
CN	N=214	N=89,584	N=7,481	(i) 2177.19 x £15 = £32,658
Before	24.59 (40.45)	6.12 (16.29)*	7.64 (17.69)*	(ii) 2732.16 x £15 = £40,982
After	23.06 (40.53)	6.26 (16.85)*	8.03 (19.78)*	
Difference	1.53 (42.5)	-0.14	-0.39 (17.9)	

Fig. 4: Matched cohort data

Potential savings from reduction in NT nursing face to face and non face to face activity have been calculated based on the predicted total Enhance referrals for year 3 (n=1423), NT visits being 15 minutes duration by Band 5 clinicians, multiplied by:
(i) the difference in means before and after in the Enhance cohort, where this is a reduction in service use.
(ii) the difference in mean differences between the Enhance and the matched cohort subgroup, where this indicates a relative reduction in service use for the Enhance groups.

The analysis indicates that the Enhance cohort had a much higher number of contacts with NTs, both before and after referral, than either of the matched comparison groups, as would be expected, but the number of community care clinical contacts for people in the Enhance cohort reduced after referral to Enhance by an average of 1.53 per person, while the number of community care contacts in the matched comparison subgroup increased by an average of 0.39 per person. The difference between groups was not statistically significant however, due to a large amount of variation (a high SD) across both groups. Savings to LCH from Enhance support between £26,714 and £33,523

Caveats/ limitations/ sensitivity analysis - there are significant data limitations which will result in the calculation of time saved and associated savings being understated:

- The analysis only calculates time saved for up to 3 months beyond referral
- A significant proportion of clinicians' non-clinical time e.g. liaising with and making referrals to other agencies and benefit applications, will not be recorded in SystemOne in a way that the data could be shared for this analysis, so the time saved by LCH staff and potential cost savings is also likely an underestimate.
- The financial value of time saved by Enhance for LCH activity is likely to be an underestimate, as what is recorded in the dataset is the number of visits. A 'standard' visit length of 15 minutes at band 5 was applied using the PSSRU unit cost resource. In practice, visits may last up to an hour and may be undertaken by bands 3-8.
- NT clinicians often delegate non-clinical support to NT Coordinators who provide administrative support to the Neighbourhood Teams. So by referring to Enhance it will often / quite often be a time saving for Neighbourhood Team Co-ordinators (NTCs), however, NTCs don't consistently record that activity on Systm1 in a way that data can be reported, so associated time savings for the NTCs are not reflected in either the LCH or the LDM datasets.
- the self-management team does not report activity on S1 so not included: being developed
- The Enhance cohort is matched with a population cohort using covariates most similar to the Enhance cohort: age, gender, frailty level, IMD decile, ethnic group, population segment, however, one covariate that could not be matched was the trigger for the Enhance referral: only 60% of the Enhance cohort had a hospital discharge date close to their referral date, an appropriate proxy measure for 'deterioration' in the matched cohort could not be identified. Therefore, it is possible that the cohorts are not an exact match despite scoring highly in the propensity score matching. The only rigorous way to overcome this limitation would be to undertake a randomised controlled trial, meaning that participants would be matched for both known and unknown characteristics. We have however generated a subgroup of the matched cohort using only those cases with either an A&E visit or an unplanned hospital stay in the 3 months prior, to try to include some potential indicators of deterioration and get a closer match.

Because of the significant challenges and limitations in creating reliable reporting through Systm1 on non-clinical time saved and other positive impacts for services, the LCH and LOPF project team worked with services, the Business Intelligence and Clinical Systems Teams to develop a range of additional methods for assessing time saved and other positive impacts for services.

Enhance Discharge Surveys - from August to October 2024 referrers were asked to also complete a 'part 2' referral form outlining the value for their service of Enhance following Delivery Partners discharging patients and returning the form outlining support provided and outcomes. 33 ABU and SBU clinicians completed the surveys.

- 27 (82%) said Enhance had saved time for their team / service
- 25 (76%) said between 46 – 98 visits were saved, an average of 1.8 – 3.9 visits per person
- 20 (60%) said Enhance enabled shorter visits / appointments
- * 25 (76%) said between approximately 36 – 59+ hours of non-clinical time saved, an average of approximately 1.4 – 2.4+ hours per person
- 9 (27%) said that Enhance enabled fewer and / or lower band staff to support the person clinically
- * 17 (51%) said earlier discharge was enabled, saving between 53 – 62+ days on the caseload, an average of 3.1 – 3.6+ days per person
- 4 (12%) said Enhance reduced the person's DNA's / cancellations
- 9 (27%) said Enhance had a positive impact on waiting list / waiting times
- 8 (24%) said a referral to the Neighbourhood Team or other LCH service was prevented
- 8 (24%) said Enhance enabled access to an LCH clinic or health hub

* It is important to note that results will be understated for non clinical time and enabling earlier discharge as the maximum response was 5 days+:

> *"We can't discharge a patient into an unsafe environment, or where there is a fall or fire risk, or they don't have access to food. We have to make attempts to sort things out, or wait until it is…as Enhance can take this on… it helps us get to a place where we can discharge patients" (Nurse)*

LBU assessed:

i. value of time savings in clinical visits and non-clinical time to LCH. As surveys were completed by LCH staff ranging from Band 3 to Band 8a, an average cost per hour was modelled across all bands (£23.58), two scenarios based on most and least time saved were modelled to come up with predicted potential savings for year 3, year 4 and year 5, as indicated in the table below:

Lowest time saved scenario						
	Clinical visit saved per person	Clinical time saved per visit	Non clinical time saved per person	Total predicted LCH referrals	Number affected (76%)	Total amount predicted to be saved
Year 3	1.8	15min	1.4 hours	1423	1081	£47,157
Years 4 & 5/ Projected	1.8	15 min	1.4 hours	1779	1352	£58,692
Highest time saved scenario						
Year 3	3.9	60 min	2.4 hours	1423	1081	**£160,587**
Years 4 & 5/ Projected	3.9	60 min	2.4 hours	1779	1352	£200,845

Fig. 5 : Value of time savings in clinical visits and non-clinical time to LCH staff

The results show that non-clinical time savings are likely to be significantly higher than clinical time saved, consistent with the original assumptions around Enhance releasing non-clinical time.

ii. 20 (60%) said Enhance enabled shorter visits / appointments – a conservative assumption is that 30 minutes are saved per visit – assuming only one visit per person @£23.58 per hour x 854 (60% of 1423) = **£10,069**

iii. 17 (51%) said earlier discharge was enabled, saving between 53 – 62+ days on the caseload – an average of 3.1 – 3.6+ days per person. A conservative estimate is that this might save an average of one 30 minute visit per person for 726 people (51% of 1423) @£23.58 per hour = **£8,560**

iv. 8 (24%) said a referral to the Neighbourhood Team or other LCH service was prevented – a conservative assumption would be to assume each referral avoided saves a minimum of 2 visits (total 90 minutes) per person @ £23.58 per hour for 342 people (24% of 1423) = **£8,053**

Total Year 3 savings: £187,269

Other analysis included in the LBU evaluation

v. Podiatry Enhance pilot - since August 2024 the Podiatry service has piloted referring patients from 2 clinic areas to explore the potential for Enhance supporting people to attend Podiatry clinics, thereby reducing the Podiatry domiciliary caseload, working with three DPs. 12 people declined Enhance support. Of the eight referrals supported,3 were supported to attend podiatry clinic long-term and 1 has been discharged from the Podiatry caseload so 4 patients will no longer receive podiatry home visit saving staff time and associated costs: