- each visit to clinic under Enhance support saved 15-30 minutes of band 6 staff time for 8 patients in 6 months.
- Over 1 year: 16 patients and a total of 4-8 hours at £24.34 saved per hour: **£195** per year
- If rolled out across all 18 clinics a conservative estimate is 16 x 9 patients: £1,750 saved per year

Costing the Impact of Prevention

Feedback from LCH clinicians, DPs and patients supported by Enhance consistently highlights that Enhance prevents deterioration, reducing future demand for LCH services and the wider system, as shown in the case studies of Mick and Joy, para 3.3.3 below. The ICB also recognises this: 'The need to proactively support vulnerable people at home either to avoid an admission or post admission set out in the LHCP priority programme HomeFirst will continue to be a priority over the next few years including building on the successes and learning from the Enhance programme'(Annual Position Statement October '24).

The LBU evaluation costed the savings to the wider NHS and LCH from Enhance preventing the following scenarios over the course of a year:

- 1 foot amputation

Cost to NHS: Elective inpatient stay = **£6256**
Cost to LCH: **£238.22**
3 visits per week @30 mins length of visits
1 x 30 min visits B5 and 2 x 30 min visit B3 per week.
6 weeks total duration

- 4 hospital admissions for uncontrolled diabetes

Cost to NHS: Attending major A&E dept by ambulance (£417) x4 with complex investigation and treatment: £137-£445 per visit x4; non-elective inpatient short stay @ £857 x2; non-elective inpatient long stay @ £4719 x 2 = £13,984
Cost to LCH: **£3766** (3 people for 4 weeks plus 1 person for a full year)
7 visits per week (daily to support insulin administration @15 mins length of visits
1 x 15 min visits B5 and 6 x 15 min visit B3 per week.
4 weeks total duration (or potential whole lifetime if they can't manage their own insulin.)

- 2 hospital admissions for chest infection

Cost to NHS: Attending major A&E department with complex investigation and treatment (£445), non-elective inpatient long stay (£4719) = £5164 x 2 = **£10,328**
Cost to LCH: **£363.70**
4 visits per week via Home ward @60 mins length of visits
4 x 60 min visits B8a (community Matron)
4 visit total duration

- 2 hospital admissions for severe respiratory disease exacerbation

Cost to NHS: Attending major A&E dept by ambulance (£417), with complex investigation and treatment (£445), non-elective inpatient long stay (£4719) = £5,581 x 2 = **£11,162**
Cost to LCH: **£363.70**
4 visits per week via Home ward @60 mins length of visits
4 x 60 min visits B8a (community Matron)
4 visit total duration

- 2 severe leg ulcers

Total cost (NHS & LCH) £6425 per person x2 = £12,850[1]
Cost to LCH: **£1,830.76**

[1] Based on cost in this paper https://bmjopen.bmj.com/content/12/1/e056790 with BoE inflation calculator

7 visits per week @60 mins length of visits
2 x 60 min visits B5 staff nurse and 5x 60 mins B3
6 weeks of visit total duration
Cost to NHS = £12,850 - £1830.76 = **£11,019.24**

- 1 broken hip as a result of a fall

Cost to NHS: Attending major A&E dept by ambulance (£417), with complex investigation and treatment (137-£445), non-elective inpatient long stay (£4719) = **£5427**
Cost to LCH: **£377.85**
2 visits per week @60 mins length of visits: 2 x 60 min visits B6 physio
6 weeks total duration

- 1 broken wrist as a result of a fall

Cost to NHS: Attending urgent care = **£91**
Cost to LCH: **£146.74**
1 visits per week @60 mins length of visits: 1 x 60 min visits B6 first week then B4 for the rest of the weeks 1x 60 mins
6 weeks total duration

- 15 A & E attendance

Attending major A&E dept by ambulance (£417), with complex investigation and treatment (137-£445) = **£10,620**

N.B. These do not include:

- time savings to LCH from Enhance preventing future referrals to LCH services where the person doesn't attend / isn't admitted to hospital
- salary oncosts or the costs of equipment and dressing in the community, so the savings would likely be higher.

Total cost saved to the wider NHS**: £68,887**
Savings to LCH: **£7,087** cost to LCH of prevention scenarios x2 to include non-clinical time = **£14,174**

Total estimated cost benefits to LCH in year 3 = AT LEAST (note the limitations flagged above):

- Cost savings from Enhance discharge survey plus Podiatry pilot: **£187,464** plus 28% oncosts = **£239,954**
- Costing impact of prevention scenarios: **£14,174**
- Cost savings from matched population analysis**: £32,658** to **£40,982**

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

3.3.2. Evaluation not included in the LBU evaluation

Referrer estimate of time saved and other positive impacts
The results in the table above were consistent with referrer estimates of impact at the time of referral. From July-September 2024, referrers were asked to estimate on the referral form how much time Enhance would save for the service by supporting the patient. 79 referrers completed this: 32 from SBU, 47 from ABU:

- Referrers estimated Enhance would save time for all 79 patients, a total of 207+ hours, an average of 2.6 hours per patient
- Referrers estimated Enhance enabled earlier discharge for 24 of the 79 patients, in total 64 to 80+ days, an average of 2.7 to 3.3+ days per patient

These results will be understated as the highest answer referrers could select was 5+ hours / days respectively.

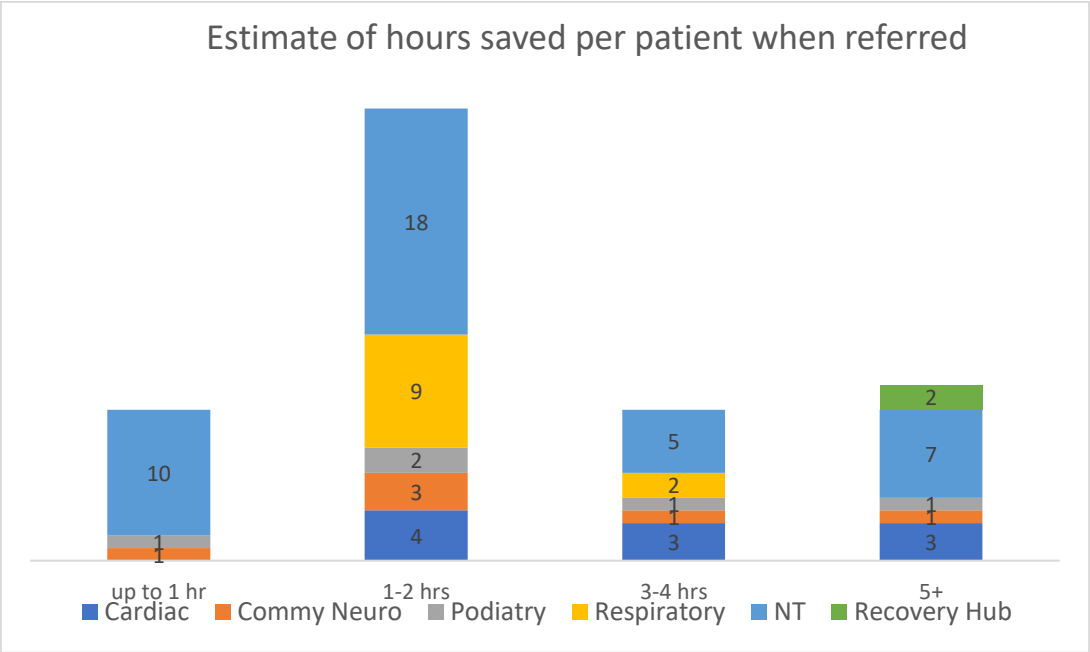


Fig. 6: Estimate of hours saved per patent

3.3.3. Quantified case studies

The following summarised costed case studies show that time savings for LCH services can be significantly higher than indicated in the 2 surveys referred to in para 3.3.2 above, both for actual time saved and preventing serious deterioration necessitating hospital admission and associated savings for LCH and the wider system. See **Appendix 6** to read the full case studies and breakdown of time and cost savings.

Case Study 1: *Tom **Annual time saving for LCH: 78 hours (£2340.52)**		
Referring service and reason	**Enhance support provided**	**Impact on LCH**
Referred by the NT for support with access to food Visits from NT carried out in pairs to ensure staff safety	Sourced a fridge for safe storage of medication, access to food, financial benefits, support with fuel payments	Clinicians no longer having to • collect insulin from pharmacy prior to visits. • do emergency food shopping • do repeat visits due to uncontrolled diabetes

Case Study 2: *Mick Weekly time saving for LCH: **1 hour 30 minutes (£12.50)** Likely additional time saving for LCH from preventing a wound infection: **56 hours 30 minutes (£909.82)** Total time saving in 12 months: **134 hours (1,559.82)**; ongoing annual saving: **78 hours (£650)**		
Referring service and reason	**Enhance support provided**	**Impact on LCH**
Referred by the NT for support with attending health appointments, access to food, social inclusion	Support to attend healthcare appointments, access to prescriptions, financial benefits, laundry facilities, a mattress, a heater, food	• Mick now attends Health Hub, saving time compared with home visits. • Potential prevention of a wound infection. • Enabling attendance at GP and hospital appointments and improved management of Mick's health conditions will have prevented significant deterioration and involvement by the NT. The DP consider Mick to be an exceptionally complex case that will require third sector support indefinitely due to his ongoing complex needs, and

		not being able to attend health appointments independently. This will not be able to continue if Enhance funding is no longer available.

Case Study 3: *Joy Total actual and predicted time saved for LCH**: 35 hours 45 mins (£547.41)**		
Referring service and reason	**Enhance support provided**	**Impact on LCH**
Referred by the NT for social support	Support with attending healthcare appointments, social support and home care, Podiatry care, access to food, access to benefits	• Assisted to two LCH Podiatry clinics preventing home visits. • Likely prevention of a foot ulcer and falls prevention.

Case Study 4: *Colin Total time saved for LCH: **12 hours (£292.08)**		
Referral source / reason	**Enhance support provided**	**Impact on LCH**
Referred by the Cardiac Service for support with home adaptations	Many hours of liaison with Colin and his wife, and other organisations, and facilitated installation of a stair lift	Reduction in clinician time spent liaising with other agencies

3.3.4 Collaborative social models

The value of time saved through the collaborative social models enabled by Enhance and for these models is not included in LBUs evaluation.

Self-Management Health Hubs are a very cost-effective delivery model, allowing 8 patients to be seen by two LCH clinicians in a two-hour timeframe in a third sector setting, generally 2 more than can be seen in Home Visits. Other benefits of this model include

- Quicker access to support and wrap around support that falls outside the scope of LCH, which ultimately avoids deterioration, call outs and admission to hospital.
- low DNA rate which saves resources, leads to better outcomes and improved quality of life for patients.
- The transport provided by Enhance means that all patients living within the locality can attend, unlike the standard clinic offer.
- Patients are mobilising outside the home which helps improve and maintain independence. There are multiple examples where patients' mobility has notably improved since attending the hubs.
- Introducing patients to their Enhance DP via the Health Hubs means patients are able to build relationships and re-engage with their community which has multiple mental health and physical health benefits, and very beneficial if they are in crisis.

The future plan, in line with the "proactive care approach" is for Enhance DPs to host LCH led education forums that educate and empower patients and their carers to lead their own healthcare and avoid deterioration.

Self-management team activity is not currently reported on System1. The service is working with BI to develop reporting that will enable robust reporting on activity and outcomes.

The weekly Integrated Clinic at OPAL in Holt Park often sees 8 patients in a 2 hour session, 2 more than in other clinics, has significantly lower DNAs and cancellations than clinics delivered in LCH and primary care premises and also brings considerable wider benefits for the patient through connecting with Enhance DPs.

Leeds Community Pain Service (LCPS) Pain Hub: the weekly Pain Hub pilot has seen 82 people since starting in April 2024, in partnership with the DP in the Burmantofts area.

- 13 patients (11%) were able to be discharged from the LCH Pain service with continued Enhance support.
- 22 patients (18%) are continuing with both Pain support and Enhance support.
- 7 people (6%) were discharged from the Pain Service due to the pain pathway not being suitable for them, and did not take up Enhance support.

The service is looking at ways to increase attendance at the two Pain Hub pilots, a key limiting factor being ability to travel independently, which Enhance DPs cannot always overcome e.g. if the person needs accompanying to appointments over more than 12 weeks.

LCPS also refers patients attending mainstream clinics to Enhance. The service DNA rate for August-October 2024 was 21.98%. Over this same timeframe there were 22 new appointments within LCPS for patients referred to Enhance. If the 21.98% DNA rate (5008 new appointments) was applied to this smaller cohort of 22 people, we would expect 4.8 people to DNA. The DNA rate for the Enhance cohort was 1, suggesting that Enhance support reduced DNA rates within LCPS. The Enhance programme team will work with the Pain Service (hub) and Podiatry Service pilot to explore increasing attendance / clinics.

3.3.5. Feedback from SBU referring services

In September all referring SBU services were asked to provide feedback on their experiences with Enhance since starting to refer in May. Please see **Appendix 7** for a summary of responses. All services indicated that they would like to continue referring to Enhance.

3.4. Impact on the wider health and social care system

Click on this link to hear about the impact of Enhance on the wider healthcare system (a 4 minute video) https://youtu.be/WDPtYakBroc

Leeds Beckett University's Evaluation Of Impact On The Wider Health Care System.

LBU also produced comparative analysis of wider health service use of the matched cohorts and Enhance cohort in relation to patients referred to Enhance September - December 2023: utilisation of Patient Transport Service (PTS), Urgent care calls to NHS 111 (UC111), Emergency calls to 999 (UC999), A&E attendances, Outpatient visits, elective spells (ES), non-elective spells (NES). Before and after values for each variable are presented as the Mean and the standard deviation of each mean is the figure in brackets. Statistically significant differences ($p<0.05$) between Enhance and comparison groups are denoted by an asterisk. Potential savings on GP appointment times and callouts were not included in this analysis as they are not available in either the ICB or the LCH SystemOne datasets.

Activity	Enhance	Matched cohort	Matched cohort subgroup	Potential savings for Enhance
UC111	N=214	N=89,582	N=7481	(i) 128.07 x £147 = £18,826
Before	0.43 (0.87)	1.40 (2.86)*	1.42 (1.05)*	(ii) 369.98 x £147 = £54,387
After	0.34 (0.81)	1.45 (4.18)*	1.59 (7.59)*	
Difference	0.09 (1.05)	-0.05	-0.17 (7.63)*	
UC999	N=214	N=89,574	N=7481	(i) 85.38 x £287 = £24,504
Before	0.91 (1.88)	1.63 (2.73)*	1.65 (2.00)*	(ii) 28.46 x £287 = £8,168
After	0.85 (1.81)	1.63 (4.99)*	1.60 (1.73)*	
Difference	0.06 (1.95)	0	0.04 (0.29)	
A&E	N=214	N=86,758	N=7483	(i) 199.22 x £445 = £88,653
Before	0.66 (1.16)	0.07 (0.31)*	0.76 (0.75)	(ii) n/a
After	0.52 (1.04)	0.07 (0.31)*	0.16 (0.53)*	

Activity	Enhance	Matched cohort	Matched cohort subgroup	Potential savings for Enhance
Difference	0.14 (1.25)	0	0.60 (0.82)*	
Outpatients *Before* *After* *Difference*	N=214 1.84 (2.26) 1.90 (2.47) -0.06 (2.65)	N=86,758 0.52 (1.25)* 0.54 (1.31)* -0.02	N=7483 0.97 (1.89)* 0.85 (1.78)* 0.12 (1.90)	(i) n/a (ii) n/a
NES *Before* *After* *Difference*	N=214 0.49 (0.86) 0.36 (0.76) 0.13 (1.02)	N=89,584 0.06 (0.31)* 0.06 (0.30)* 0	N=7483 0.76 (0.78)* 0.14 (0.47)* 0.61 (0.86)*	(i) 184.99 x £857 = £158,536 (ii) n/a
ES *Before* *After* *Difference*	N=214 0.20 (1.08) 0.11 (0.52) 0.09 (0.77)	N=89,584 0.11 (0.43)* 0.11 (0.45) 0	N=7,483 0.14 (0.55) 0.13 (0.66) 0.005 (0.72)	(i) 128.07 x £6256 = £801,206 (ii) 120.96 x £6256 = £756,694
PTS *Before* *After* *Difference*	N=214 1.14 (5.64) 1.24 (5.71) -0.10 (2.43)	N=89,580 6.16 (13.98)* 6.10 (13.55)* 0.06	N=7,482 5.94 (13.69)* 5.90 (13.28)* 0.04 (12.62)	(i) n/a (ii) n/a

Fig. 7: Matched comparison analysis

Summary of findings for matched comparison analysis:

- There was a statistically significant reduction in calls to 111 in the Enhance group, compared to the matched comparison subgroup, following referral to Enhance.
- Relative reductions in service use in the Enhance group compared to the matched comparison subgroup, although not statistically significant, were also seen for 999 calls and elective hospital stays
- The data suggest that referral to Enhance is associated with a reduction in visits to A&E and unplanned hospital stays, in the three months after referral compared to the three months before referral.
- The data suggest that the number of outpatient visits and use of the patient transport service increased slightly in the Enhance group following referral, compared to the matched comparison subgroup, which may indicate that Enhance clients are supported to access appropriate healthcare appointments.

Caveats / limitations

- Potential savings on GP appointment times and callouts and Adult Social Care were not included in this analysis as they were not available in either the ICB or the LCH SystemOne datasets.
- In the comparative study, the benefits observed are over a three month follow-up period, but it is likely that the benefits from being supported by Enhance would persist for longer than three months, so the financial impact to the NHS is likely underestimated. LBU and the ICB Data Analytics team planned to also analyse health service use data at 6 months post-referral but it was not possible to retrieve data beyond 3 months from the WYICB dataset, due to the short time between Enhance referral and data download.
- Although few of the differences in mean difference across groups are statistically significant, we (and the WYICB data controllers) consider that this is more likely to be due to issues with the data - particularly the differences in the size of groups, and lack of baseline equivalence between groups – rather than indicating that there is no real difference between groups. This is because the mean values indicate a consistent direction of effect for most health service use outcomes – that Enhance participants reduce their service use, while the matched comparison groups' service use either stays the same or increases.

- In the comparative study, the Enhance cohort is matched with a population cohort using covariates most similar to the Enhance cohort. 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 and it was not possible to identify an appropriate proxy measure for 'deterioration' in the matched cohort. Therefore, the cohorts are not an exact match despite scoring highly in the propensity score matching. A subgroup of the matched cohort was generated using only those cases with either an A&E visit or an unplanned hospital stay in the three months prior, to try to include some potential indicators of deterioration and get a closer match. However, this is still not a perfect match, as can be seen in the mean scores. It overstates the impact on A&E and non-elective stays in this comparison group, due to regression to the mean. 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.

Total potential savings to the wider NHS from Enhance support are indicated to be between (note the limitations flagged above):

- for each 'activity', the lower level of savings for each: i or ii : £18,826 + £8,168 + £88,653 + £158,536 + £756,694 + £32,658 = £**1,030,877**
- for each 'activity', the higher level of savings for each: i or ii: £54,387 + £24,504 + £88,653 + £158,536 + £801,206 + £40,982 = (highest) = **£1,127,376**
- In addition, potential savings from prevention scenarios: **£68,887.**

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

3.5. Return on investment

Total estimated cost benefits in year 3 = AT LEAST:

- **LCH savings: £286,786 to £295,110 (**bottom of para 3.3.1 above)
- **Wider NHS savings: £1,099,764 to £1,196,263**
-

TOTAL SAVINGS = £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. Additionally, we could confidently expect ROI for both LCH and the wider system to improve in year 4 as referrals are forecast to grow

The return on investment (ROI) is based on the money saved directly by saving clinical time and appointments to LCH and the wider NHS. ROI is calculated to be more than £1,386,550 and could be as much as, or even more than, £1,491,283. £1M was the investment for Year 3, so this return represents a ROI of between +38.7% and +49.1%. This is likely to be an underestimate given that there are significant gaps in the data available, a range of assumptions have been made and conservative estimates used throughout.

However, in a cost benefit analysis, the ROI isn't the only consideration to take into account, as this only tells us the direct financial savings associated with the investment. Other benefits, that are more difficult to place a financial value on, relate to improvements in the health, wellbeing and quality of life for people supported by the Enhance service described in this business case. There are also other benefits that we were not able to monetise, including reducing waiting times (and associated deterioration of health whilst waiting leading to greater treatment and care costs), reducing DNAs and cancellations, prevention of referrals to multiple other agencies,

While it is not possible to place a direct financial value on health and wellbeing benefits, the National Institute of Health and Care Excellence (NICE) considers an appropriate funding threshold to be £20,000 per quality-adjusted life-year (QALY)2. A QALY is a year of life lived in perfect health3. That is, if an intervention has

[2] https://remapconsulting.com/funding/how-does-nice-make-cost-effectiveness-decisions-on-medicines-and-what-are-modifiers/
[3] https://www.nice.org.uk/Glossary?letter=Q

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.

Therefore, Enhance, even at the most conservative estimate of cost vs benefit, represents value for money.

"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)

4. Proposal

This business case requests £902,416 funding p.a. for the 3 years (2025-28) to enable continuation and growth of Enhance support to people referred and LCH referring services as BAU, comprising:

- £805,000 to fund the thirteen third sector Delivery Partners to support limited further expansion of referrals in 25/26 as described in para 4.1 below – no change to funding in years 1-3
- £97,416 to LOPF to provide programme management – to be reviewed at the end of quarter 3, 2025/26. This is a 51% reduction from funding in years 1-3 and is enabled by development of robust processes and systems to date including a clear referral pathway and process, information for referrers about Enhance and robust engagement mechanisms between ABU services and DPs. In year 3 we have refined and further developed the monitoring and evaluation approach and reporting and are consequently able to reduce LOPF monitoring and evaluation resource from 2025/26.
    - Reporting on Enhance referrals is included in service monthly performance reports except for Self-Management Service and N, S and W Recovery Hubs as not currently reported on SystmOne.
    - LOPF will monitor performance data and provide performance reports to the Enhance steering group and quarterly contract management meetings as well as reporting routinely on risks, operational issues and expenditure against budget.
    - LOPF: DP contract management, co-ordination, support and regular cross sector / peer learning

In year 3 LOPF paid for 0.5wte LCH project management resource from their programme management budget. There will be no LCH project management from year 4 as the project will transition to BAU.

See **Appendix 7** for the LOPF programme management proposal and budget.

4.3. Referring Services

All ABU and SBU services that currently refer to Enhance would be able to refer – all SBU services have said that they want to continue referring in FY25/26.

4.4. Predicted growth in referrals

As mentioned in section 2.4 most DPs report generally having some capacity to take additional referrals. We anticipate further growth in referrals from:

- A small number of Neighbourhood Teams from developing awareness across the whole team of Enhance
- Planned expansions of Self-Management Health Hubs, increasing from 2 to 5 before the end of FY 24/25
- The Podiatry service pilot being extended city-wide to all 18 clinic bases
- SBU leadership is keen to explore the potential for Enhance supporting a wider range of services as they go through the Quality and Value programme.

- The ABU Quality and Value Programme will develop therapy clinics in 2025 which would refer to Enhance given NT physios and OTs positive experience of referring to Enhance for support with exercise and mobility as well as wider support.

DPs work cohesively, supporting each other around capacity with flexibility across postcode borders where possible. The allocation of funding to DPs would be reviewed in quarter 4 to align capacity with predicted demand. LOPF will continue to monitor DP capacity through the DP capacity tracker tool and 6 weekly review meetings with each DP. LOPF will ensure there is reasonable consistency in intensity of DP support. If demand does exceed DP capacity LOPF would escalate this to SBU and ABU leadership through the Enhance Steering Group to agree prioritisation of referrals or changes in services able to refer to Enhance.

4.5. A citywide model

We propose that Enhance continue to be a city-wide offer, available to support people living in all Leeds postcodes. In year 3 there have been some small gaps in provision in a couple of areas which will be addressed in year 4. We expect to see continued reach to people living in the most deprived areas.

4.6. Age Criteria

The focus of Enhance was originally to support patients referred by NTs. Consequently, Enhance DPs were selected because of their expertise in working with older people, networks and core offer which add considerable value to the work and time saved for LCH. DPs have a range of age criteria: 8 of the DPs are Neighbourhood Networks and offer services and support for people aged 60+. Enhance now takes referrals from a wider range of services and whilst the Enhance cohort are largely older people (90% are aged 60+, and 7% are aged 50-60) we recognise that those living with multiple long term conditions age and develop frailty faster added to which some SBU services who refer to Enhance have a wider age range of patients who would benefit from Enhance support, in particular Community Neuro, CIVAS and the Diabetes service. It is proposed that the age criteria be standardised at 50+ to maintain the level of expertise and to provide clarity for LCH referring services. For any referrals made for people under the age of 50, LOPF will source appropriate support for the person from the wider 3rd sector network if not supported by either of the 2 DPs who accept referrals for people aged 18+.

4.7. Transport

There is variation in what support the DPs can currently offer regarding transport. 5 DPs have minibuses which are used to transport Enhance participants to healthcare appointments and OPAL and Armley Helping Hands also transport Enhance participants to health hubs and Integrated Clinics that they host. Some DPs are also able to accompany participants to LCH and other healthcare appointments using taxis, public transport, or their own vehicles. All DPs support participants with accessing attendance allowance and other financial benefits, building confidence to use taxis / public transport, putting in place systems to remind people about appointments, physical mobility etc.

4.8. Governance

The LOPF Programme Manager will liaise directly with service Enhance Champions, NT Co-ordinator Enhance lead, service leads and ABU and SBU leadership as necessary on day to day operational issues: currently done by, or jointly with, the LCH project manager.

Operational issues, performance monitoring, risk management and future planning will be managed through an Enhance Steering Group which will be chaired by LCH, with representation from LOPF, all referring SBU and ABU services, and the LCH Partnership Development Manager – frequency to be agreed with ABU and SBU senior leadership. This is a change in remit and membership from the current Steering Group. The Steering Group will escalate issues and risks via ABU Change Forum and SBU senior leadership team.

LCH quarterly contract management meetings provide oversight and assurance about delivery of the contract and associated requirements. These meetings are chaired by the ABU Business Manager with representation from ABU and SBU leadership, the Partnership Development Manager, LOPF Programme Manager and Chief Exec.

5. Options appraisal

a) Critical success factors

The options appraisal needs to consider the following critical success factors:

- Patient quality / safety – the EQIA Panel endorsed the very significant positive impact on quality of care – access, experience and outcomes in both the short and longer term as a direct result of the support provided by / arranged by Enhance DPs and its preventative impact, as well as positive impact resulting from releasing time for clinicians to provide clinical care. No adverse impacts were identified.
- Delivering benefit to LCH services, in particular time saved and providing value for money – evidence of time saved and other positive impacts for services and staff is set out in section 3.2. The EQIA Panel asked that concern be noted about the impact on LCH services if Enhance funding were discontinued – an increase in non-clinical and clinical demand within LCH referring services leading to additional pressures on clinical caseloads as well as increased risk of deteriorating health for patients, further adding to the burden of capacity and demand.
- Support improvement in Health Equity - the EQIA Panel recognised the very positive impact of Enhance on reaching and supporting vulnerable and disadvantaged populations to access health care, better self-manage their health and conditions and support their wider health and well-being. See para 3.1.1
- Improve patient outcomes, prevent deterioration and maintain independence – feedback from patients and staff reflects a very positive, at times truly transformational impact on health as well as quality of life and well-being. See section 3.1. The EQIA Panel asked that concern be noted about the detrimental impact on patient health in both the short and long term if Enhance is not funded beyond the end of FY 24/25 by LCH or other Leeds healthcare system partners
- Develop integrated collaborative working with the Third Sector – this is central to Enhance and is supported through engagement mechanisms. Discontinued funding would negatively impact the ability for LCH to provide Self-Management and Pain Hubs.

b) Options appraisal

The below table describes four possible options with **our recommended option being Option 3**

Option	Description	Cost	Pros/ benefits	Cons/ disbenefits	Risks
Option1	• Funding is discontinued beyond year 3. • Demobilisation of Enhance.	£0	• Cost saving for LCH	• Increased demand on LCH services and wider healthcare partners in the short and longer term • Caseloads and waiting times increase • Deterioration of health for patients and well-being	• People currently being supported would no longer receive the level of support in place, increasing demand on LCH and wider system
Option 2	• 3 years of funding. • BAU model. 50% level of funding to Delivery Partners. Would need to target Enhance support e.g. ○ reduce the number of services able to refer e.g. based on maximising time saved for clinicians ○ by patient cohort e.g. people with multiple and complex needs or reduce the Enhance offer e.g. reduce input to 6 weeks • Reduced LOPF programme management resource. • No LCH project management resource.	DPs £402,500 LOPF £75,000 Total £477,500	• Cost saving for LCH (DP and programme & project management) • Services continuing to refer would derive the benefits of Enhance - time saved for clinicians • People supported would gain benefits to date of Enhance - impact on health, well-being, maintaining independence	• Reduced level of Enhance provision • Increased demand on services in the short, medium and longer term resulting in increase in caseloads and waiting times • Reduction in number of patients who can be supported with corresponding adverse impact for their health, ability to maintain independence and wider well-being • Business units to commit resource to ensure continued engagement and successful collaborative working with Enhance DPs and LOPF • Business unit monitoring of referrals and contract management as BAU • Reducing the offer to a shorter time period would, for patients with complex needs, compromise significantly time savings for referring services and benefit to the person supported	• Some DPs may not be able to continue with reduced funding, potentially leaving large areas of the city not covered

Option 3	• 3 years of funding. • BAU model. • 100% level of funding to Delivery Partners. • Reduced LOPF programme management resource. • No LCH project management resource.	DPs £805,000 LOPF £97,416 Total £902,416	• Cost saving for LCH (programme & project management) • Increase in time savings for LCH services as Enhance is further embedded, some services implement plans for pilots and expansion, if Enhance extended to new services • Enables continuation, expansion and development of collaborative social models • Continued level of DP provision	• Demand on business units to ensure necessary commitment of resource to ensure continued engagement and successful collaborative working with Enhance DPs and LOPF • Business unit monitoring of referrals and contract management as BAU	• Insufficient referral numbers
Option 4	• Continue with current funding. • 100% level of funding to Delivery Partners. • Full LOPF programme management resource. • Full LCH project management resource funded from LOPF programme management budget (2.5 WTE)	DPs £805,000 LOPF £200,000 Total £1,005,000	• As for 3 above	• Cost for LCH • Requires capacity from BCDS (Project Manager) • Continued commitment to established monitoring, governance and engagement arrangements • Continued business unit monitoring of referrals and contract management as BAU	• Insufficient referral numbers

6. Implementation

If this business case is approved, Enhance processes currently in place will largely continue. SBU and ABU will be required to consider the impact of Enhance for current referring services and may choose to amend the agreed services included in Enhance. SBU and ABU are committing to supporting the BAU model, including providing leadership to ensure referring services:

- engage positively with DPs and LOPF to support operational management, resolution of issues and sharing of learning
- maintain staff awareness about and promote the Enhance offer, encourage referrals
- monitor referrals through service and BU performance review
- attend and participate constructively in regular NT and SBU review meetings and the steering group
- escalate issues and risks as necessary to BU leadership

If future funding is not approved, we will work towards demobilising Enhance by March 2025. We will develop an exit strategy that will initiate in January 2025. Alongside this, LOPF will develop a legacy plan that will highlight the legacy that Enhance will leave behind, lessons learnt, ways in which organisations have changed as a result, and any other funds secured on the strength of the evidence.

7. Recommendation

We request that TLT 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.

Internal Use Only

Sign off Checklist
Before the business case can leave the organisation please check the following:

	All costings have been completed by the finance team
	The appropriate Standing Financial Instructions (SFIs) have been followed for sign off (see table below)
	The commissioners/ other stakeholders who are involved in this opportunity or who may be impacted by it are aware of the business case
	Opportunity has been logged on the Business Development Log
	Bid no Bid and Equity and Quality Impact Assessment has been completed

A note on sign off – the value of the opportunity will dictate the level of sign off required as follows:

- Over £500k – signed off by LCH Board
- £250k to £500k - signed off by LCH Business Committee
- £100k to £250k - signed off by LCH SMT
- £25k to £100k - signed off by CEO and 1 x Director
- £25k and below – signed off by 1 x Director

Standing Financial Instructions (SFIs)

Scheme	Delegated matter	Authority delegated to (lowest level)
Capital schemes		
	Taking on or termination of leases	Executive Director of Finance and Resources
	Approval of schemes within the capital programme (in accordance with Business Case procedure):	
	Up to £500,000	Executive Director of Finance and Resources
	Above £500,000	Trust Board
Quotation, Tendering and Contract Procedures		
Competition requirements	Obtaining a minimum of 3 formal written quotations on a competitive basis for goods and services between £5,000 and £30,000, on a whole-life basis for expenditure or income	Budget Holder, General manager (within delegated limit)
	Obtaining formal written competitive tenders for goods or services above £30,000	Executive Director (or Deputy Director of Finance and Resources in their absence)
Waiving competition requirements	Up to £50,000	Executive Director of Finance & Resources
	From £50,000 to £250,000	Chief Executive, Executive Director of Finance and Resources
	Over £250,000	Trust Board
Acceptance of tenders and quotes	Up to £50,000	General Managers
	From £50,000 to £250,000	2 x Executive Directors
	From £250,000 to £500,000	Chief Executive, Executive Director of Finance and Resources
	From £500,000 to £1,000,000	Chief Executive and Executive Director of Finance & Resources. Or in the absence of one of the above, Chairman
	Over £1,000,000	Trust Board (or, if urgent, Chairman and Chief Executive, reported at the next Trust Board)
Investment Decisions		

Capital investments	Up to £50,000	Executive Director of Finance & Resources or Chief Executive plus 1 other Director
	£50,000 to £100,000	Quorate Trust Leadership Team
	£100,000 to £500,000	Business Committee (and Quality Committee for revenue investments in clinical services or new / discontinued clinical service)
	£500,000 and above	Trust Board
Introduction of a new operation or activity or discontinuation of a current one	Up to £25,000	Executive Director of Finance & Resources or Chief Executive plus 1 other Director
	£25,000 to £100,000	Quorate Trust Leadership Team
	£100,000 to £250,000	Business Committee (and Quality Committee for revenue investments in clinical services or new / discontinued clinical service)
	£250,000 and above	Trust Board

Authors:
Date:

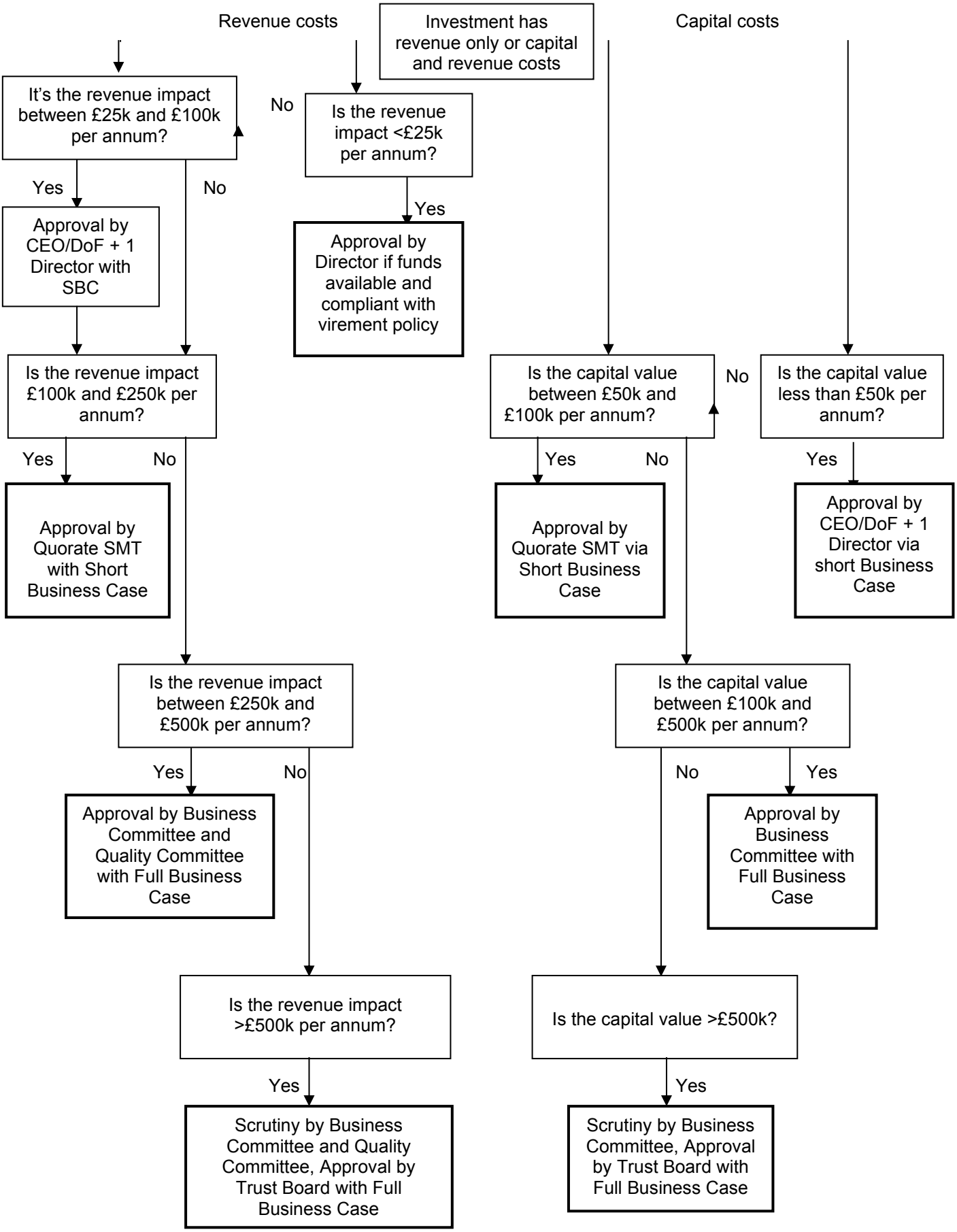
VERSION CONTROL

Version no.	Revision date	Summary of changes	Owner
0.1			

Approvals	**This document requires the following approvals:**			
Name	**Status**	**Title**	**Date**	**Version**

Distribution	**This document has been distributed to:**		
Name	**Title**	**Issue date**	**Version**

The Business Case Production and Approval Process – Decision Tree



Leeds Community Healthcare NHS Trust

Agenda item
2024-25
(129)

Public Board workplan 2024-26
Version 8: 28 01 2025

TOPIC	Frequency	Lead officer	BAF Strategic Risk	7 June 2024	19 June 2024- Annual Report and Accounts only	3 September 2024	4 October 2024	6 December 2024	6 February 2025	1 April 2025	5 June 2025	25 June 2025- Annual Report and Accounts only	4 September 2025	2 October 2025	4 December 2025	5 February 2026
STANDING ITEMS																
Declaration of interests (table from Declare)	every meeting (from April 2024)	cs	N/A	X	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of previous meeting	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Action log	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Board workplan	every meeting	CS	N/A	X		X	X	X	X	X	X	X	X	X	X	X
Patient story	every meeting	EDN&AHPS	N/A	X		X	X	X	X	X	X		X	X	X	X
STRATEGY AND PARTNERSHIPS																
Chief Executive's report	every meeting	CE	All	X		X	X	X	X	X	X		X	X	X	X
System flow (part of CE report from Sept 2024)	every meeting	EDO	SR 10	X												
Operational Plan (Trust) priorities (for the coming year) for approval	Annual April	EDFR	SR 6,8							Final X						
Operational Pan (Trust priorities) update	3x year (Feb, June and Oct)	EDFR/EDN&AHPS	SR 6,8	X			Deferred to December 2024 X	X	Deferred June end of year update X		X			X		X
Third Sector Strategy	2x year (Feb and Sept)	EDO	SR 10			X			Deferred for this meeting				X			X
Estate Strategy	2xyear (April and Oct)	EDFR	SR 6				X -Blue box Deferred			X -Blue box				X -Blue box		
Digital, Data and Technology Strategy	2x year (April and October)	EDFR	SR 3,6	Deferred to Oct 2024			X	X		X				X		
Business Development Strategy	2xyear (April and Oct)	EDO				X -Blue box Deferred				X -Blue box						
Business Intelligence Strategy -part of Digital Strategy September 2024	2x year (Feb and Sept)	EDFR				X -Blue box Deferred										
Learning and Developement Strategy	annual	EDN&AHPS	SR 1							X -Blue box						
Patient Safety Strategy Implementation Update	Final report to Board Dec 24	EDN&AHPS	SR 1,2,4				X Deferred to December 2024	X Final update report								
Health Equity Strategy	Annual (Sept)	EMD	SR1,9			X							X			
Quality Strategy	2xyear(June and December)	EDN&AHPS	SR 1,4	X - Blue box item				X - Blue box item			X - Blue box item				X - Blue box item	
Workforce Headlines and Strategy update	3x year (Feb, June and Oct)	DW	SR 4,8	X			X		X		X			X		X
Research and Development Strategy	annual	EMD				X										
Research and Development Strategy	annual	EMD				X										
QUALITY AND SAFETY																
Quality Committee Chair's Assurance Report	every meeting	CS	SR 1,2,3,4	X		X	X	X	X	X	X	X	X	X	X	X
Quality account	annual	EDN&AHPS	SR 1	X							X					
Mortality reports	4x year (June plus annual report, September, December and February)	EMD	SR 1,4	X				X -Blue box	X		X -Blue box		X -Blue box		X -Blue box	X -Blue box
Patient safety (including patient safety incident investigations) update report	2 x year (April and October)	EDN&AHPS	SR 2,4				X -Blue box			X -Blue box				X -Blue box		
Patient experience: complaints and concerns report	2 x year (Feb and Sept)	EDN&AHPS	SR 1,2			X			X				X			X
Infection prevention control assurance framework	2x year(April and October)	EDN&AHPS	SR 1,4				X -Blue box			X -Blue box				X -Blue box		
Infection prevention control annual report	annual (Sept)	EDN&AHPS	SR 1			X							X			
Care Quality Commission inspection reports	as required	EMD	All													
Safeguarding -annual report	annual	EDN&AHPS	SR 1,4			X							X			
FINANCE PERFORMANCE AND SUSTAINABILITY																
Business Committee Chair's Assurance Report	every meeting	CS	SR 2,3,4,5,6,7,8	X		X	X	X	X	X	X		X	X	X	X
Audit Committee Chair's Assurance Report	as required	CS	SR7	X		X		X	X	X	X		X		X	X
Charitable Funds Committee Update Report	2x year (April and Oct)	EDN&AHPS	N/A							X				X		
Emergency Preparedness, Resilience & Response Statement of Compliance	Annual	EDO	SR2,7					X							X	
Emergency Preparedness, Resilience & Response Policies	Annual	EDO	SR2,7					X							X	
Charitable Funds Committee Chair's Assurance Report	4 x year (April, Sept, Oct and Feb)	EDN&AHPS	N/A			X	X		X							X
Performance Brief	every meeting	EDFR	SR 1,2,3,4,7,8,10	X		X	X	X	X	X	X		X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	annual	EDFR	SR 1,2,3,4,7,8,10							X						
Annual report	annual	EDFR	All		X							X				
Annual accounts	annual	EDFR	SR 5		X							X				
Letter of representation (ISA 260)	annual	EDFR	N/A		X							X				
Audit opinion (Internal)	annual	EDFR	N/A		X							X				
Green Plan	2x year (June and Dec)	EDO	SR 4,6	x				X -Blue box			x			X		
WORFORCE																
Staff survey	annual	DW	SR 8							X						
Safe staffing report	2 x year (Feb and Sept)	EDN&AHPS	SR 2,8			X			X				X			X
Freedom to speak up report	2 x year (Feb and Sept)	FTSUG	SR 8			X +Annual Report			X				X Annual report			X
Guardian for safe working hours report	4 x year (April, June, Sept, Dec)	GoSWH	SR 8	X + Annual Report		X		X		X	X Plus Annual report		X		X	
Medical Director's annual report	annual	EMD	SR 4			X -deferred to Oct 2024	X						X			
Professional registration: Nursing and Allied Health Professions	annual	EDN&AHPS	SR 4			X							X			
WDES and WRES -annual report and action plan	annual	DW	SR 8,9				X							X		
GOVERNANCE AND WELL LED																
Well-led framework	as required	CS	N/A													
Audit Committee annual report	annual	CS	N/A	X							X					
Standing orders/standing financial instruction	annual (Dec)	CS	N/A					Deferrred to be reviewed by Audit Committee March 2025 following well led review		X					X	
Going concern statement	annual	EDFR	N/A							X						
Code of Governance compliance	annual	CS	SR 4							X						
Committee terms of reference review	annual	CS	N/A	X						X	X					
Register of sealings	As required (from February 2025)	CS	SR 5	X None for this meeting		X None for this meeting		X None for this meeting	X							
Significant risks and risk assurance report	every meeting	CS	All	X		X	X	X	X		X		X	X	X	X
Board Assurance Framework -quarterly update report	Apr, June,Sept and Dec	CS	All	X			X	X		X	X		X		X	X
Board Assurance Framework -process update (July Audit Committee)	annual	CS	All			X - Blue box item							X - Blue box item			
Risk appetite statement (part of corporate governance report March)	annual	CS	All							X						
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Oct 2025)	CS	All													
Declarations of interest/fit and proper persons test (part of corporate governance report March)	annual	CS	N/A							X						
Board Members Service Visits Report	3xyear (June, October,February) from June 2024	CE	N/A	x First Report			X		Deferred		X			X		X
Business Continuity Management Policy	as required	EDO	SR 2,7													
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Jan 2026)	EDN&AHPS	N/A													
Health and Safety Annual Plan	annual	EDFR	SR 4			X - Blue box item							X - Blue box item			
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR	SR 4													
Senior Information Risk Officer - Annual Report	annual	EDFR	SR 4,7							X						X
FOR INFORMATION																

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary