Leeds CITY COUNCIL

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Report of **Director of Adults & Health**

Report to **Executive Board**

Date: **19Th December 2018**

Subject: **Leeds Recovery Service**

Are specific electoral wards affected? If yes, name(s) of ward(s):	☐ Yes ☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes ☒ No
Is the decision eligible for call-in?	☒ Yes ☐ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes ☒ No

Summary of main issues

1. The Leeds Recovery Service plays a key strategic role in meeting the city's ambition to maintain people in their homes for as long as possible, promoting their independence, delaying and reducing the need for on-going long term care services. These services represent a critical element of the Leeds Health and Care Plan to ensure people get timely community-based support to recover and also enable people to leave hospital in a timely way, reducing delayed transfers of care (DTOC).

2. The city has a long tradition of applying asset-based or strengths-based approaches to public services and the purpose of this report is to inform Executive Board of the achievements of the Leeds Recovery one year on from the opening of the three Recovery Hubs which details the way in which a strengths-based approach to social care has been applied. Customers are supported in utilising their independence skills through identifying what they can do for themselves, rather than a traditional deficit model of what services can do for the individual. The strengths-based approach has, as its starting point, the firm belief that people have strengths as well as support needs and that by facilitating better links with the natural support assets in our communities, people will need to make less call on

formal services. (Please see case studies on page 10 that supports this approach and has ensured that these individuals have met their goal of returning home)

3. One of the examples where this way of working has been applied is within the Leeds Recovery Service which comprises of four key components that support recovery and rehabilitation:
   - Three Recovery Hubs offering short term beds in the East, South and North West of the city (two of which are provided in partnership with Leeds Community Healthcare Trust)
   - The Skills for Independent Living Service (SkILS) – a seven day a week reablement service which supports recovery in people's own home
   - A seven day a week 8am to 8pm Occupational Therapy Service
   - Assisted Living Leeds: offering a range of assistive technology

Recommendations

1. Executive Board are asked to note the strategic significance of the Leeds Recovery Service to the Leeds system.
2. Executive Board are asked to note progress within the Leeds Recovery Service and the positive outcomes for customers and family carers that have been achieved through the service changes that have been made.
3. Executive Board to note that the Director of Adults and Health is responsible for the implementation of the services outlined in this report.

1. Purpose of this report

1.1 This report provides an update on each element of the Leeds Recovery Service and describes how they work together to provide a co-ordinated offer to people who need a short term intervention to support their recovery after an admission to hospital, a health issue or a significant change in their social circumstances.

1.2 The Recovery Service comprises a number of Council run and jointly provided services which sit within the range of services that are commissioned and delivered across the city to support discharge from hospital, the maintenance of system flow and support to live at home for adults over 65.

1.3 This report outlines plans for the continued development of the Recovery Service and its links with partners.

2. Background information

2.1 Recovery Hubs

2.1.1 In May 2017 Leeds City Council, formed an Alliance with Leeds Teaching Hospital NHS Trust (LTHT) and Leeds Community Healthcare NHS Trust (LCHT) in preparation to bid for the provision of a Community Beds Service commissioned on behalf of the NHS Leeds South & East Clinical Commissioning Group (CCG).

2.1.2 Following the submission of the Alliance's response to this procurement and the conclusion of the evaluation process, the Alliance was successful in the bid to provide 72 nursing beds across two sites.

2.1.3 As part of a whole system approach to the delivery of health and social care to older people the CCGs committed to supporting and funding 32 nursing beds at the RecoveryHub@NorthWestLeeds (formally known as Suffolk Court) and 40 nursing beds at the RecoveryHub@SouthLeeds (formally known as the South Leeds Independence Centre) commencing service delivery from 1st November 2017.

2.1.4 It was also agreed that the Council, on behalf of Health & Social Care Commissioners, would commission 37 beds at the RecoveryHub@EastLeeds (formally known as The Green) as residential community beds through existing funding available within the Better Care Fund. This was delivered through the existing Better Care Fund Section 75 agreement.

2.1.5 Everyone who is admitted works with the staff and their families to develop their own support/recovery plan. Customers are supported to identify their strengths, working towards building resilience and a fulfilling life, taking into account their wishes, aspirations and goals. In addition, the service focuses on promoting independence by offering nursing and therapeutic interventions to support each person to fulfil their maximum potential. This has been successful in reducing admissions to long term residential/nursing care and/or unnecessary hospital admissions and supports people to live at home longer. Leeds has seen a reduction in admissions to long term homes over the last three years, maintaining a positive

trajectory The aim is for a 3 - 4 week stay within the homes, sufficient to support recovery, but not sufficient to create a dependence on the level of support that is provided.

2.1.6 Over and above the care home with nursing/therapy offer, there is also a range of other services on each site which include:

- Information and Signposting Service
- Carer support
- Support for people in maintaining links with their local community and to foster development of new social networks
- Assistive and Health technology demonstrator/smart room where environmental assessments can determine if any equipment and/or adaptations are required
- Community space/multi-functional rooms

The Recovery Hubs aim to:

- Offer the opportunity to recover from a spell in hospital or avoid an admission to hospital
- Offer recovery opportunities on a day basis, e.g. chair-based exercise, Thai Chi and other activities

2.1.7 In addition to responding to the older person's immediate situation, the Hubs offer a full well-being "MOT" that looks at how someone might improve their health and wellbeing and address any issues of loneliness and isolation. This includes consideration of how assistive technology and citizen driven health technology may improve their health, safety and wellbeing.

2.1.8 The buildings offer a Resource Hub for older people to self-organise to hold social gatherings/ improve social interaction and link closely with the relevant Neighbourhood Networks and other voluntary sector partners.

2.2 <u>Skills for Independent Living Service</u>

2.2.1 The Skills for Independent Living service is the Council's home care reablement service which has delivered a city wide service since 2012.

2.2.2 The service provides short term home care support to adults who have experienced a change in their health or social situation which means they are at risk of needing long term social care support at home, or of needing to move into a care home.

2.2.3 The purpose of the service is to support the person to regain their daily living skills and to re-engage in the activities that they enjoy. Over the period of the support, which is an average of 3 weeks, the level of support is reduced as appropriate. At the end of the service the person will either need no social care service or the amount of support they need will have been established at a level that allows the

person to be as independent as possible in their daily activities which, in turn, maximises their day to day choice and control.

2.3 Occupational Therapy Recovery Team

2.3.1 Occupational Therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation.

2.3.2 Unlike the other Council Occupational Therapy Services in the Adults and Health, Resources and Housing and Children's Directorates, the Recovery Occupational Therapy Team operate 7 days a week from 8am to 8pm. These Occupational Therapists are based in the Recovery Hubs and assess people's needs on entering the Hub, agree goals with the person and lead on planning for their discharge, to their own home wherever possible.

2.3.4 The Occupational Therapists support the care staff in the hub to maximise people's independence and also identify the right equipment for people, in the Hub and for when they go home. They make onward referrals to reablement where needed and provide out of hours support to the reablement service, so the links are very strong.

2.3.5 The Recovery Occupational Therapy Team also make links with community health staff where required for people going home from the Recovery Hubs.

2.4 Assistive Technology

2.4.1 Leeds Community Equipment Service and the Tele Care Service are jointly commissioned by the Council and the CCG and are co-located at Assisted Living Leeds and under a single management structure.

2.4.2 These are well established services that are used by 2,000 health and care assessors across the city. Community equipment and telecare are used to support people to be safe and independent at home and are often used where an older or disabled person has lower levels of impairment so that they can maintain their daily living activities without support from other people, so they are an essential part of a recovery approach. However, people who rely on paid or unpaid carers for physical assistance also benefit from community equipment and telecare including so that the person providing physical care can do so safely.

2.4.3 In this short video staff and customers talk about the South Recovery Hub and how it works as part of the Recovery Service.

https://youtu.be/OiZlkgqTDx8

3 Main issues

3.1 Recovery Hubs – Update on the last year

3.1.1 The RecoveryHub@SouthLeeds and RecoveryHub@NorthWestLeeds are registered with the Care Quality Commission as registered care homes with nursing

and the RecoveryHub@EastLeeds is a care home. Each of the services has a registered manager on site. The service is committed to working within a recovery framework that builds on the personal strengths and resilience of the individual and supports them to return home as quickly and safely as possible.

3.1.2 During the last 12 months the 3 Hubs have supported a total of 793 people, supporting on average 65% of these people back their own home.

3.1.3 All three Recovery Hubs have received significant investment to meet health and safety and infection control standards in addition to making the environments homely and fit for meeting the requirements of supporting the Community Beds Service.

3.1.4 These proposals are provided in line with the Service Specification for the Community Beds Service for the city which offer an excellent experience for people by supporting them to achieve their independence and potential so that they can return to their own home as soon as possible.

3.1.5 The Hubs provide a warm and homely environment which promotes recovery and offer a lovely space for people to get well. Space is also available for relatives with a comfortable visitors room located at each site as well as a contemplation room. There is a touchdown space for staff which has modern technologies and maximises the business benefits and supports the digital inclusion agenda. It also supports the completion and review of recovery plans and for other staff such as the Skills for Independent Living team to touch down and work from.

3.1.6 The internal refurbishment and decoration have taken into account the needs of older people; best practice in dementia friendly design has been incorporated. This includes consideration of colours, textures, signage, flooring and lighting.

3.1.7 Both building bases are currently fully accessible and have facilities where assessments can be undertaken to identify areas of development in addition to equipment and adaptations. The services also provide space for the nursing and therapy staff who support the nursing bed service 24 hours a day.

3.1.8 The service provides items of equipment for demonstration to customers, to enable them to trial and select those items that will increase their independence, facilitate their discharge and prevent readmission. We know that Tele Care equipment which is widely available can support customers to return home safely and quickly as possible and aim to ensure that as many people as possible have the opportunity to view, experience and benefit from this technology.

3.1.9 The newly developed role of Community Engagement Worker is a dedicated person who will support links to local communities, signposting to Third Sector services and facilitate a smooth discharge. Where appropriate the worker will continue working

with individuals for a period of time following discharge in relation to community engagement including peer support and befriending.

3.2 Skills for Independent Living Service - Update on the last year

3.2.1 The service model for home based reablement delivered by the Skills for Independent Living Service has been subject to adjustments based on learning since the initial roll out in 2012. The most significant changes were implemented in July 2017.

3.2.2 The key changes made to the service were:-

- The service moved to a fully seven day a week service rather than having a lower level of "out of hours" service during evenings and weekends.
- The service accepts referrals now from identified Social Care and NHS assessors and where necessary, for example to support hospital discharge, visit within 4 hours of the person being at home. A new post of Case Officer was created who carries out the first visit and talks to the person about how they are managing activities at home and the goals that they want to achieve, and then agrees with the person the initial level of support to be provided. This replaces assessments that were previously carried out by Social Work staff or identified trusted assessors in the NHS.
- In addition to the new role of Case Officer, the previous role of Supervisor was retained but the role changed to be more directly supporting the front line Support Workers on a day to day basis. This role was designed with Trade Union colleagues to be a good opportunity for Support Workers to take the first step into a line management role without moving too far away from customer contact.
- The change to a full service 7 days a week from 7am to 10pm required the new Case Officer role to be introduced as a 7 day a week extended hours role, and that change was also applied to the Business Support staff who carry out the important role of rostering customers visits and providing performance information. An additional post of Business Manager was also introduced so that the service had a responsible manager available from 7am to 10pm every day.

3.2.3 Full consultation with Trades Unions took place and they supported the benefits to front line staff of having increased support available covering all the hours they were working with customers in their own homes. They also welcomed the opportunity for career development the new service model offers.

3.2.4 NHS partners welcomed the new service model which allowed the development of a Trusted Assessor approach, one of the key High Impact Changes advised by NHS England, and enabled the including the newly created Leeds Integrated Discharge Team, based in LTHT to make direct referrals and for the service to accept and respond on the same day. This change has made a significant reduction to the number of people waiting for a service within LTHT as it can provide a 'same day' discharge service to LTHT, preventing any delay in the process. Since the end

of 2017, along with the changes that have been made to the way the social work teams operate, there has been a significant reduction in days delayed in LTHT and this service provides significant contribution towards that outcome.

3.3 Occupational Therapy Recovery Team- Update on the last year

3.3.1 The Occupational Therapy Recovery team was established in response to the need to support both the new reablement service and the first of the Recovery Hubs at East Leeds by registered staff with assessment and care management skills across the 7 days and extended hours. The role of the Occupational Therapists is to optimise the benefit of the recovery model. They assess and develop rehabilitation plans with individuals who need that from a registered health professional, but also to provide support and guidance to the Support Workers in the Recovery Hub and in the Skills for Independent Living Service.

3.3.2 The team was established with 5 Occupational Therapists and a part time manager and later increased in size to 9 Occupational Therapists so that they could also support the RecoveryHub@SouthLeeds and the RecoveryHub@NorthWestLeeds.

3.3.3 This was a significant development for the Council as its other well established Occupational Therapy teams in Adults and Health, Resources and Housing and Children's Services are all Monday to Friday 8.30am to 5pm services.

3.3.4 The Recovery Occupational Therapists see people when they are admitted to a Recovery Hub and work as part of the team to support people to identify the activities that they want and need to do as part of working towards going home. They will consider the use of equipment at the Hub and for home to increase the customers' independence and safety. The Occupational Therapist will also be involved in the discharge home from the Hub, including making the necessary contacts with other health and care professionals.

3.3.5 Being there over 7 days and in the evenings mean that the Recovery Occupational Therapists have good opportunities to also talk to family carers and other relatives and friends and to involve them in the customer's progress and discharge.

3.3.6 The occupational therapists support Skills for Independent Living Service by carrying out risk assessments and providing advice and guidance to staff on the best way to help people regain their skills. This is particularly important when there is a possibility that the Skills for Independent Living Service are not able to support a person safely at home so that all steps are taken to avoid the person needing to leave their home to receive the short term support they need.

3.4 Assistive Technology- Update on the last year

3.4.1 Leeds Community Equipment and Tele Care Services (LCETs) are jointly commissioned by the Council and the Clinical Commissioning Group and are co-located at Assisted Living Leeds and under a single management structure.

3.4.2 While assistive technology, of which community equipment and telecare are two commonly used examples, is often used alongside other health and care support, it has a key role in helping people to be avoid or delay the need for support from others in daily activity. This also offers increased opportunities for people to be able to retain their choice and control over their daily life.

3.4.3 The Council are the lead commissioner and the lead provider of the service with Leeds Community Healthcare being a partner in the delivery of Leeds Community Equipment Service. The budget for the service is within a Better Care Fund arrangement.

3.4.4 The service reports quarterly to joint LCC and CCG commissioners and a quarterly Advisory Group is chaired by and elected member and has representation form all stakeholders, including the Telecare and Equipment Service User Group (TETSUG) which is supported through Leeds Involving People.

3.4.5 Developments in the last year, as reported to the joint commissioners and the Advisory Group are;

- The roll out of online referrals to assessors across the Council and NHS. This reduces the paper work and duplication for assessors and also provides them with access to a history of their customer's equipment and telecare.
- Continued implementation of a weekly Quality Assurance Panel to ensure best value choices are made by assessors and that higher cost items of equipment are provided within budget and targeted at people in high risk situations
- A bid to iBCF for funding for additional staff and vehicle to target collections, not only from customers but also care homes and Council recycling centres
- Work commenced to achieve non-mandatory accreditation by a national organisation for both community equipment and telecare
- Joint work with Asset Management and City Development to identify an alternative site for Assisted Living Leeds, to allow for the current site to be used for the South Bank Development.

3.5 <u>The Impact of the Recovery Service</u>

3.5.1 The Recovery Service has attracted income of £25m over 5 years from the NHS for the delivery of the Recovery Hubs and this allowed the continuation of permanent employment in two of the care homes for 55.87fte members of staff within the Council.

3.5.2 The Council also benefits from the increased independence people achieve through this approach which delays or reduces the need for long term social care support. For example, 61% of people who are identified as needing homecare support at home, and receive that as short term support from Skills for Independent Living Service, do not need homecare at the end of that intervention.

3.5.3 The staff who are working in the newly developed reablement service and in the Recovery Hubs have benefitted from the training and development that has

increased their own skills and confidence. Seeing how customers get back to the lives they want to lead provides job satisfaction and a sense of achievement. New roles in the Skills for Independent Living Service offered better opportunities for Support Workers to have a career pathway to senior roles and those opportunities have been taken up with excellent results.

3.5.4 Most importantly the Recovery Model is giving older people a chance to maximise their own potential to get back to doing the activities they want and need to do and to have choice and control over their daily life. The stories below are just two examples of the difference the Recovery Service has made for an individual.

3.6 Case Studies

3.6.1 Cynthia came to the RecoveryHub@SouthLeeds instead of being admitted to hospital.

3.6.2 Cynthia, 95 years old, fell in mid-July 2018 and went to hospital for an x-ray but no abnormalities were found. However, by 31 July 2018 she was unable to get out of her chair as her mobility had got worse over a period of weeks following the fall. She was receiving assistance from a neighbour to go to the toilet and was unable to move by herself. She was referred to the Hub from A and E to prevent a hospital admission and was accepted for rehabilitation. She was very clear that she wanted to return home as soon as it was safe to do so.

3.6.3 Cynthia had been living alone and doing all her own cooking and until the fall had been very independent with all her daily activities. She has links within the community and involved in social groups, faith groups, coffee mornings and lunch clubs. She has a car which she still drives.

3.6.4 Cynthia made good recovery at the Hub with Occupational Therapy input to agree with her staged goals to start to undertake her own personal care and then to prepare her own meals. Her home environment was reviewed and hand rails for her staircase were fitted. She declined the offer of support from the reablement service for a short period on her return home, feeling confident she could now manage everything. Cynthia left the Hub for home on 14 September 2018 and picked up her life again.

3.6.5 **Gertrude was referred to the RecoveryHub@EastLeeds from St James' Hospital and was supported at home by Skills for Independent Living on leaving the Hub.**

3.6.6 Gertrude is an 83 year old lady who was living alone in a ground floor flat. She had regular contact with her daughter and was able to carry out her daily activities independently. She had a fall at home on 2 July 2018 and required surgery for a

fractured hip. She wanted to go home after her surgery but she didn't feel she would be safe and so on 12 July she went to the RecoveryHub@EastLeeds.

3.6.7. Gertrude was seen by the Recovery Occupational Therapist and the staff at the Hub worked with Gertrude on getting back to carrying out her daily routines. On 2 August she was ready to leave the Hub but still lacked confidence about being at home alone. She was worried about managing her meals at home and the Hub staff were concerned about her nutrition and hydration as she had very little appetite anyway and wasn't eating well even when food was prepared for her.

3.6.8 On that same day Gertrude went home, was visited by Skills for Independent Living Service and her support visits started that evening. The Recovery Occupational Therapist had already arranged for some equipment to be in place and the Skills for Independent Living Service also arranged for a Tele Care pendant alarm. The Support Workers visited Gertrude three times a day. They monitored her food and drink intake and encouraged her to cook the kind of meals she enjoyed and to make more use of her microwave as a safe and quick way of cooking.

3.6.9 On 15 August the number of visits each day were reduced and by 24 August Gertrude and her daughter agreed that she was now able to manage at home without support.

3.6.10 Gertrude sent the following compliment;
"I have been very happy with the carers that have been helping me I could not have had any better anyway. Especially she showed me how to make a bacon sandwich in the microwave which is much better than on my cooker. Also other meals that can do in the microwave. I would like to add, everyone that has been, for one thing and another, have all been very good and helpful. That includes H, she has been very good to me".

3.7 Next Steps for the Leeds Recovery Service

3.7.1 Developments within the Recovery Service

- To achieve an overall "outstanding" Care Quality Commission rating for the three Hubs and for the reablement service.
- Further develop strengths based working within the recovery approach.
- Development of the use of Adults and Health's Client Information System (CIS) for reporting reablement activity and move of case records and daily recording in the Hubs into the Client Information System (CIS) to provide joined up information and reporting.
- Further develop joint working between staff in reablement and the Hubs.
- To contribute to work to reduce the digital divide in the city by increased use of technology for people to manage their own health and care.
- Application by Recovery Hubs to join a national programme called Teaching Care Homes in partnership with Leeds Community Healthcare Trust and Leeds Teaching Hospital Trust along with one of the universities in Leeds. The aim of

the Teaching Care Homes programme is to develop a geographically spread network of homes that are centres for learning, practice development and research, actively engaging with staff, students, residents and the community, and are a resource for other care homes. This aim was developed in recognition of the issues of recruitment and retention of both registered nurses and carers, attempting to raise the profile of long term social care as an exciting, rewarding and forward thinking career choice.

3.7.2 Work with Partners to improve customer journey and experience

- Work with LTHT to ensure people discharged from hospital are supported by the appropriate part of the Recovery Service. This is part of the Decision Making Workstream which is led by Julian Hartley, Chief Executive, LTHT and was one of the key recommendations from the recent Newton Europe report.
- Reduced rate of readmission from the Hubs to hospital.
- Work with Leeds Community Healthcare therapy and community nursing staff to maximise the benefits of the partnership.
- Smarter and more efficient discharges with a reduction in the length of stay in the Hubs, maximising opportunities for earlier discharge from the Hubs into reablement driven by Occupational Therapists and maximising use of community equipment and telecare
- A greater number of people admitted to reablement and to the Hubs to avoid inappropriate acute hospital admissions.
- Review and improve pathways between Occupational Therapists supporting the Recovery Service and Leeds Community Healthcare clinical staff in Neighbourhood Teams to reduce duplication and ensure customers receive the most appropriate support.
- Review and improve joint working between Skills for Independent Living Service and clinical staff in Neighbourhood Teams.
- Reduced waits in Skills for Independent Living Service transitions for people who require an ongoing home care service.

4 Corporate considerations

4.1 Consultation and engagement

4.1.1 Consultation took place on the homes within the Better Lives Phase 3 programme (which included The Green now known as the RecoveryHub@EastLeeds) from 1st October to 23rd December 2015. The consultation followed a similar process and best practice used during consultation in Phases 1 and 2 of the *Better Lives for Older People* programme.

4.1.2 The South Leeds Independence Centre and Suffolk Court (now known as the RecoveryHub@SouthLeeds and the RecoveryHub@NWLeeds) already provided

intermediate care beds and therefore no consultation was required. Customers who were residing at these services on the 1st November 2017 continued to receive support until they had fully recovered and could return home.

4.2 Equality and diversity / cohesion and integration

4.2.1 There are no specific equality, inclusion and diversity issues as the service is offered city wide to any customer who meets the criteria for accessing the service.

4.3 Council policies and Best Council plan

4.3.1 The Leeds Recovery Service will contribute to the delivery of key outcomes in the Best Council Plan 2018/19 to 2020/21, specifically to improve the quality of life for people and particularly those who are vulnerable or in poverty.

4.3.2 The Leeds Recovery Service also makes significant contributions to the Leeds Health and Wellbeing Strategy, supporting the objectives:

- An Age Friendly City where people age well
- Maximising the benefits from information and technology
- The best care, in the right place, at the right time

It also supports the Leeds Health and Care Plan and its priority to maximise people's recovery and support system flow.

4.4 Resources and value for money

4.4.1 The Leeds Recovery Service enables people who would otherwise have gone into residential care to be supported in the community at a lower cost, or to fully regain their independence and require no ongoing support. There has been a year on year reduction in the number of people admitted to residential care within Leeds in the last three years.

4.4.2 The development of the new service model for the Leeds Recovery Service has taken into consideration the Council's statutory duties and Adult Social Care's specific duties, including new duties contained in the Care Act 2014.

4.4.3 The Council invested capital of £350k in each of the Recovery Hubs which has created a warm and welcoming environment. This was funded from within the contract income received for each hub. The enhanced staffing model is funded from the income from the CCG as part of the Community Beds Service 5 year contract. The total contract value is £25m.

4.4.4 The additional investment in the Skills for Independent Living Service, agreed in September 2017, was £655k, which was funded by a reinvestment of funding associated with the Executive Board decision to close the Council's in house long term home care service.

4.4.5 The total cost of the Recovery Occupational Therapy team is £458k and the additional investment comes from £200k from the Council tax precept, plus income from the CCG related to the commissioning of the Recovery Hubs which was £87k for the East Hub and £206k for the South and North West Hubs.

4.4.6 The LCETs budget is a Better Care Fund arrangement. For 18/19 the base budget is £5.315m. In order to meet known demand this is supplemented by £350k from the iBCF/Spring Budget for 2018/19 and 2019/20 only with any further demand pressures being supported jointly by LCC and the Leeds CCG.

5 Legal implications, access to information, and call-in

5.1 There are no legal implications.

6 Risk Management

6.1 Services within the Recovery Service, including Skills for Independent Living Service and the three Recovery Hubs are registered with the Care Quality Commission. There is a comprehensive risk management approach within the service which ensure that the registration standards are maintained, and any risks associated with service delivery are mitigated.

6.2 This approach also ensures that those services that are jointly commissioned meet that required standards and adhere to contract requirements. There is a governance structure in place with Leeds Community Healthcare Trust, with a Board and sub-groups, which manage the quality, delivery and finances of the Alliance structure.

7 Conclusions

7.1 The services outlined in this report work strategically to meet the aspirations of the Health and Wellbeing Strategy, the Leeds Plan and the Better Lives Strategy. By working in partnership with key NHS partners, they support the delivery of a reduction in demand in the hospital and a contribution towards reducing delays and improving system flow. Acting swiftly when people are in crisis and supporting recovery are key aspirations of the Leeds Health and Care Plan.

7.2 By taking a strengths-based approach we are building on the strengths people have in their lives as part of their road to recovery and independence. Where we find people are experiencing isolation and loneliness, we are taking positive steps to help people build a supportive network of friends that strengthens their resilience and mental well-being.

7.2 The partnership with LCH and achieving the contract with the CCG enabled the council to retain jobs, embed and develop the Recovery Service as a coherent and innovative service, improve outcomes for customers and continue to meet demographic demands in a challenging environment.

8 Recommendations

8.1 Executive Board are asked to note the strategic significance of the Recovery Service to the Leeds system.

8.2 Executive Board are asked to note progress within the Leeds Recovery Service and the positive outcomes for customers and family carers that have been achieved through the service changes that have been made.

8.3 Executive Board to note that the Director of Adults and Health is responsible for the implementation of the services outlined in this report.

9 Background documents[1]

None

Appendices

Appendix 1 - Activity and Performance
Appendix 2 – Equality Diversity Cohesion and Integration Assessment

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.