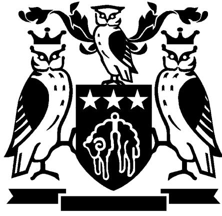

Leeds CITY COUNCIL

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Report of the Director of Adult Social Services

Scrutiny Board (Adult Social Care)

Date: 13 April 2011

Subject: Domiciliary Care and Reablement Update

Electoral Wards Affected: All	**Specific Implications For:**
☐ Ward Members consulted (referred to in report)	Equality and Diversity ☐ Community Cohesion ☐ Narrowing the Gap ☐

Executive Summary

This report provides Members with information regarding the provision of in-house domiciliary care and the development of reablement services.

In terms of in-house provision, the report describes the significant work that has been undertaken, in partnership with staff and Trade Unions, to downsize the long-term homecare service through a programme of voluntary early retirement and voluntary severance, to restructure the remainder of the Community Support Service, and to improve productivity and sickness absence.

It also provides a progress update on the development of reablement. Phase I of the Leeds Reablement Service will be rolled out city-wide by April 2011, followed by phase II by July 2011.This report provides information on service development to date, describes the outcomes and customer satisfaction that has been achieved so far, as well as how the service will continue to develop over the next months.

This work, together with the outcomes of the current Scrutiny Inquiry, will inform the Executive Board report in July 2011, which will consider the future strategic direction of the in-house Community Support Service

1.0 Purpose Of This Report

1.1 This report was requested by Members further to the Scrutiny Board Inquiry into 'The Future Provision of Domiciliary Care and Reablement Services'. It provides a progress update on development and improvement work relating to these services.

1.2 In particular, Members asked to receive an update on the reablement Early Implementers, and progress relating to VER/VS, changes in productivity levels and sickness absence since the last report to the working group in November 2010. This will provide a further opportunity for Scrutiny input before the matter is reported to Executive Board in July 2011.

2.0 Main Issues: Provision of In-House Domiciliary Care Services

2.1 Scrutiny received a report in November 2010 regarding the current and future in-house provision of domiciliary care services. That report described some of the inefficiencies in the way the in-house service was operating, and actions to address these. Significant work has been ongoing since that time, in partnership with staff and Trade Unions, to reduce the size of the overall service through a programme of voluntary early retirement (VER) and voluntary severance (VS), restructure the remainder of the Community Support Service, improve productivity and sickness absence.

Early Leavers' Initiative – VER and VS

2.2 Since the last report, good progress has been made regarding the downsizing of the service through VER and VS, with the business case for phase I being signed off in December 2010. Under this, 196 employees will leave the service by 31st March 2011. A further 11 staff working in Extracare housing have also expressed an interest in leaving and will be released once their posts can be filled by staff currently working elsewhere within CSS as part of the restructure.

2.3 As a result, savings of £6,254,337 will be made over a five year period. This figure takes account the cost of purchasing additional provision from independent sector organisations, but excludes the costs of compensatory payments to staff as these are funded corporately.

2.4 Where possible, the number of service users transferred to a new, independent sector provider has been minimised by consolidating work programmes within the in-house service. However, it has been necessary to transfer a proportion of service users. The following table provides a breakdown of the number of service users affected:

Month	**No. of service users transferred**
Dec	0
Jan	74
Feb	92
March	102
Total number of SU transferred	**268**

2.5 To minimise disruption to both service users and staff, consideration has been given to the following points when determining which service users would need to be transferred to a new provider:

- capacity within the service – based on the rota patterns staff are currently working to.
- continuity of care
- minimising the number of carers visiting each service user to cover the package
- minimising the risk of missed visits

So, for example, split packages (where part of the package is provided by the in-house service and part by another provider) are avoided, as these impact on the continuity of care , increase the number of carers visiting and increase risks of service disruption.

2.6 Once the necessary transfers were identified, a significant amount of work has been invested to ensure the smooth transition to new providers. All service users have been kept informed of the changes, through letters sent in September and October 2010. In addition, for those service users personally affected:

- CSS staff made contact with the service user and family to advise that their package would be transferred to a new provider
- A care manager was allocated to support the service user through the transfer
- The care manager checked all information to ensure the service user would receive an appropriate package of care and forward the information to the Care Communication Centre to broker the package with the new provider.

Providers have been identified for all service users due to transfer in January and February. For those due to transfer at the end of March, we are still working to broker the last remaining 15 packages.

2.7 As expected, as a result of the correspondence in September and October and individual discussions, some service users contacted us seeking further information and 68 representations have been received, with the majority (60) expressing concern about their package being transferred to the independent sector. A procedure has been adopted to ensure a timely response is given to the concerns raised, and to date 65 representations have been resolved (95%), with 3 ongoing (5%). Following the initial response letter, only five cases have progressed to the formal complaints procedure, with three cases outstanding whilst investigations are carried out.

2.8 Since the sign off of the Phase I business case, staff have been given a further opportunity to express interest in VER/VS. A further 61 staff have done so and a business case relating to these leavers has now been submitted to corporate Finance for approval. Assuming these are approved , staff are likely to be released between April and June 2011. This will deliver a further potential five year saving of £960,86. A further 27 staff have expressed interest in vacancies in other areas of ASC that have been created following staff in those areas asking for VER/VS. Assuming these ‘switches’ all go ahead, a further potential five year saving of £483,942 will be achieved.

Restructure of the Community Support Service

2.9 As noted in the November report, following VER/VS the Community Support Service as a whole is being restructured, in such as way as to maximise efficiency and ensure it can meet the needs of service users in the most effective way. The services covered by this restructure are:

- Long-term generic homecare
- Homecare reablement (SkILs team)
- Mental health reablement
- Mental health long-term
- Extracare housing.

2.10 Work to plan and develop new structures has been ongoing since November, in partnership with key stakeholders. Formal fortnightly meetings are held with Trade Unions: these have been positive, and have ensured plans are developed using a collaborative approach, with engagement from all parties so that that the key issues of the affected workforce have been identified and addressed.

2.11 In addition, all staff have received several letters regarding the changes to the service. A series of consultation 'roadshows' have been held at various locations across the city. In excess of 650 employees attended these sessions, which were then followed up with staff surgeries. An infopack for staff, with further details was also distributed to staff and they are kept further updated through regular newsletters, e-bulletins, intranet articles and managers' briefings.

2.12 Formal structure proposals have now been developed, detailing the new structures, taking into account the number of leavers through VER/VS. Work has also been carried out to determine the size of the new reablement service based on detailed analysis of activity levels and expected demand. Due to changing demographics, the Mental health reablement service has also had additional resources allocated to it as part of the process. As such, the long-term generic homecare service has been reduced from 545 FTEs, contracted to work 20,165 hours to a total of 197 FTEs, contracted to work 7,318 hours.

Inefficiencies in the in-house service and measures to address

2.13 Following VER, VS and the restructure, it is essential that the in-house homecare service works in the most efficient way possible. Work has therefore been ongoing to improve productivity. At the time of the last report, average productivity within the CSS was 52% in terms of delivered care hours, against a target of 65% for the long-term service. It is important to note that this definition of productivity relates solely to delivered care hours (i.e. direct contact with service users)[1].

2.14 Significant improvements had already been made at the time of the last report through close working with staff and Trade Unions, from a low in February 2010 of 45% productivity. Managers have worked hard to make further progress, and a steady increase was realised during 2010: by December, the average productivity was 55-56%. These have been great improvements but have been suspended during this period of service upheaval, while staff leave the service and the transfer of service users is completed.

2.15 Sickness absence is an important factor in improving productivity, and good progress has again been made. In September 2010, a reduction in the predicted days absence per FTE had been delivered, from 23.86 to 16.55 days, with a reduction in the number of long term sickness cases from 64 to 46. Over the winter months, we have experienced an anticipated seasonal increase, and again staff leavers and service user transfers have interrupted our focus on this. However, overall levels have improved significantly since this time last year, and we will resume our efforts once this period of change is over.

2.16 The restructure provides an opportunity to make significant progress through the implementation of new rota patterns, more flexible working practices and electronic rostering. We have been working closely with the Trade Unions to agree new rota

[1] As such, it does not take account of travel, supervision, training, meetings, annual leave etc, all of which are essential to deliver the service. If these other elements were taken into account, staff were utilised for 77% of their contracted hours. The remaining time related to sickness absence and periods when staff were not ulitised.

patterns and these have now been agreed with both Trade Union convenors and stewards. This represents a big step forward, and a joint statement from the Chief Officer and the Trade Unions has been issued to all staff within the CSS advising them of the changes that will be implemented as part of the restructure. We are confident that this will result in significant improvements in productivity.

3.0 Main Issues: Development of Reablement Services

3.1 This section provides a summary regarding the reablement service model being developed, as well as information on service activity to date, outcomes we are achieving with service users, levels of customer satisfaction, how we are performing in comparison with other local authorities, and how we will continue to develop the service across the city.

Developing the Leeds Reablement Service

3.2 As reported in the October Scrutiny report, the Leeds Reablement Service includes a number complementary services through which people can receive reablement, including:

- The new Skills for Independent Living (SkILs) Team, providing homecare reablement
- Assistive Technology (AT) Services - providing equipment, alarms and adaptations that help people live more independently, including the provision of telecare.
- The Outreach Service – providing support for service users in community settings so planned day activities fit with individual preferences and circumstances within local networks.
- Day Service Reablement – providing a programme of reablement in a Day Centre, often as part of a package of services.

3.3 Some of these services are well established, like many of our Assistive Technology Services; others are new, like the CSS SkILs team. The Leeds Reablement Service brings old and new together, providing a coherent and coordinated reablement service for all adults in Leeds who are eligible for help from Adult Social Care and suitable to take part in a reablement programme. Appendix A provides a breakdown of the customer’s journey through reablement.

3.4 As noted in earlier reports, in Leeds we have deliberately developed a broader based reablement service than most other local authorities to maximize the benefits reablement can offer:

- Delivering truly person-centered care packages designed and delivered at the point of entry with customer outcomes at their heart,
- Maximizing the number of diversions away from on-going services during the assessment period and following reablement provision, and
- Delivering greater financial efficiencies for the authority.

3.5 Phase one of service development is nearing completion. By April 2011, a city wide service will be offered to all new customers to Leeds ASC, and all customers discharged from a Leeds Teaching Hospital. Work is now starting on phase two, when other key pathways into the Leeds Reablement Service will be opened up. By July 2011, the service will receive existing Leeds ASC customers from the community, plus those from out of Leeds hospitals and other health routes, and those customers received by Leeds ASC from the Transitions Team. With these referral routes open, the service will run to full capacity city-wide.

Activity to Date

3.6 A number of early implementer pilots have been running in the city, the first commencing in May 2010 in the WNW. In that time, 394 reablement assessments have been completed, with a significant proportion of customers on all open pathways[2] diverted to reablement from long term care at this point. In particular:

- 17% of assessments have resulted in a referral to AT services
- 23% of assessments have resulted in a referral to the SkILs team.
- 30% required no further action or were signposted
- 2% fast tracked (end of life care)
- 7% referred to Intermediate Care Team (health service)
- 18% referred for a community care assessment for an on-going service
- 4% deceased during assessment period.

3.7 To ensure Leeds delivers a fast and responsive service, assessments for reablement have been undertaken within existing KPIs for prompt hospital discharge, and in the community within the 28 day indicator for community care assessments. The average length of reablement programme is just under 4.5 weeks, and the average SkILs hours provided per week is 3.5 hours. In terms of service cost benefit, the average cost of a SkILs intervention currently stands at £417, and the indicative whole year saving (for reablement against the alternative scenario of a long term care package) per service user comes to £2111.00.

Outcomes being Achieved

3.8 A lot of work has gone in to collecting data to report on outcomes being delivered via the Leeds Reablement Service. This data is presented in three ways:

(1) Outcomes immediately following reablement in terms of required ongoing care needs

Since the first reablement pilot began in May 2010, of the people who have received and completed reablement from the SkILs service:

- 86 service users required no further service (56%)
- 57 were referred for long term care (37%)
- The remaining 10 (7%) were currently being assessed for an ongoing care package at time of writing

(2) Service user's perception of outcomes achieved

Using the new perception-based national *Adult Social Care Outcomes Tool* (ASCOT), service users report that following a reablement programme:

- 67% feel they have as much or adequate control over their daily lives (up from 60% prior to reablement),
- 70% feel clean and presentable in they way they like (up from 50% prior to reablement)
- 100% feel they get all or adequate food and drink they like when they want (up from 50% prior to reablement)
- 63% feel as safe as they want (up from 50% prior to reablement)

[2] i.e. New customers from the community and all LTHT discharges

(3) Individual service user outcomes[3]

Appendix B provides two recent case studies on the outcomes achieved by individual service users following reablement. Extracting key information from the case studies:

- Jonathan's story records how Jonathan progressed from significant mobility issues to six weeks later being able to get out and about in his car and begin a local college art course
- Harry's story records how he progressed from significant self-esteem and confidence issues (with health complications), to being able to cook for himself and begin to improve his mobility, with a longer term goal to get out and about to his local shops.

Customer and Staff Satisfaction

3.9 A systematic customer satisfaction survey is still to be completed. However, the service has received a number of compliments from service users regarding the quality of care. Full case studies are provided in Appendix B, showing how, for example Jonathan says:

"the support I've received from the SkILs team has been invaluable. They are like my extended family. I'll be sad to see them go, but without their help I'd have ended up in a group home and now I can live in my own home. The entire SkILs team have been fantastic".

3.10 The Reablement Project team have also received encouraging feedback from operational staff working in the new service. According to the SkILs team Area Manager:

"When CSA's move into the SkILs team their positive attitude shines out. They feel valued and empowered and are more involved in supporting the customer in achieving their goals. They can see they are making a big contribution to the customers outcomes and helping them maximise their independence."

3.11 This has also been noticed in other areas of ASC. an area social worker working in assessment and care management has noted that:

"I have had a positive experience with the reablement service… it does what it says on the tin. Customers are accurately assessed for the tasks they require and the length of time this will take. Care managers are updated about customer progress with the input from the SkILs team, allowing packages to be reduced to meet customer's changing needs. Customers are part of the planning process at every stage, so are aware the SkILs team are only assisting on a temporary basis and also happy with the service they receive."

Comparisons with other Local Authorities

3.12 Leeds Reablement Service has been developed in line with Department of Health best practice guidelines[4]. A major national report recently reported the key features of successful reablement services. Appendix C provides a full breakdown of how Leeds has developed its service in line with key features of these best practice authorities. To draw a few key comparisons from that report with what has been achieved in Leeds:

National Best Practice	The Leeds model
Joined up reablement assessment,	The Leeds reablement model has been

[3] Extracted from individual reablement plan reviews, recorded on a case-by-case basis with service users and presented here as case studies.

[4] Primarily via the CSED homecare Reablement Toolkit

planning and progress reviews	developed in line with Leeds ASC's new Single Assessment Process, with weekly service progress reviews undertaken in the customers' home as standard
Rapid access to Assistive Technology Services	A key feature of the Leeds model, taken forward by JIP as an example of regional best practice, is that AT is fully integrated into the reablement pathway.
Rapid access to Occupational Therapists	A key feature of the Leeds model, taken forward by JIP as an example of regional best practice, is that OT is fully integrated into the reablement pathway.
Comprehensive staff (re) training programme	A major programme of operational staff (re)training is underway with over 250 staff having attended induction training in the last four months
Development of a specialist Mental Health reablement service	A key feature of the Leeds model, with further service development planned in 2011
Development of reablement services for support outside the home	The Leeds Outreach Service is a key feature of the Leeds model, offered as standard during reablement assessments

<u>Further Development of the Service</u>

3.13 As the Reablement Service has expanded the customer base has grown. As things stand, by April 2011 the SkILs team will offer a service in all three wedges of the city for both new community customers and LTHT discharges. A great deal of effort has gone in to carefully moving CSAs from the long term homecare service into SkILs in a managed way which does not impact on levels of service quality for customers in either service. As mentioned earlier in this report, when phase one of service development completes phase two will begin so that by July 2011 a full capacity Leeds Reablement Service will be in operation city-wide.

3.14 At that point in time, the service will operate to a capacity that in the remainder of the financial year 2011/12 will accept 2000 customers per annum, moving to 3000 customers per annum in its first year of full service capacity (2012/13) – in line with the recommended service size proposed by the Department of Health. We will also continue our work with health, taking forward our commitment to joint working with Intermediate Tier services.

4.0 Conclusions

4.1 This report provides Members with information about the future provision of in-house domiciliary care. The report highlights the significant work undertaken, in partnership with staff and Trade Unions, to reduce the size of the overall service through a programme of voluntary early retirement (VER) and voluntary severance (VS), restructure the remainder of the Community Support Service, and improve productivity and sickness absence. It also details the progress made in developing reablement services in Leeds, and the positive outcomes resulting from this work, both for ASC and for service users.

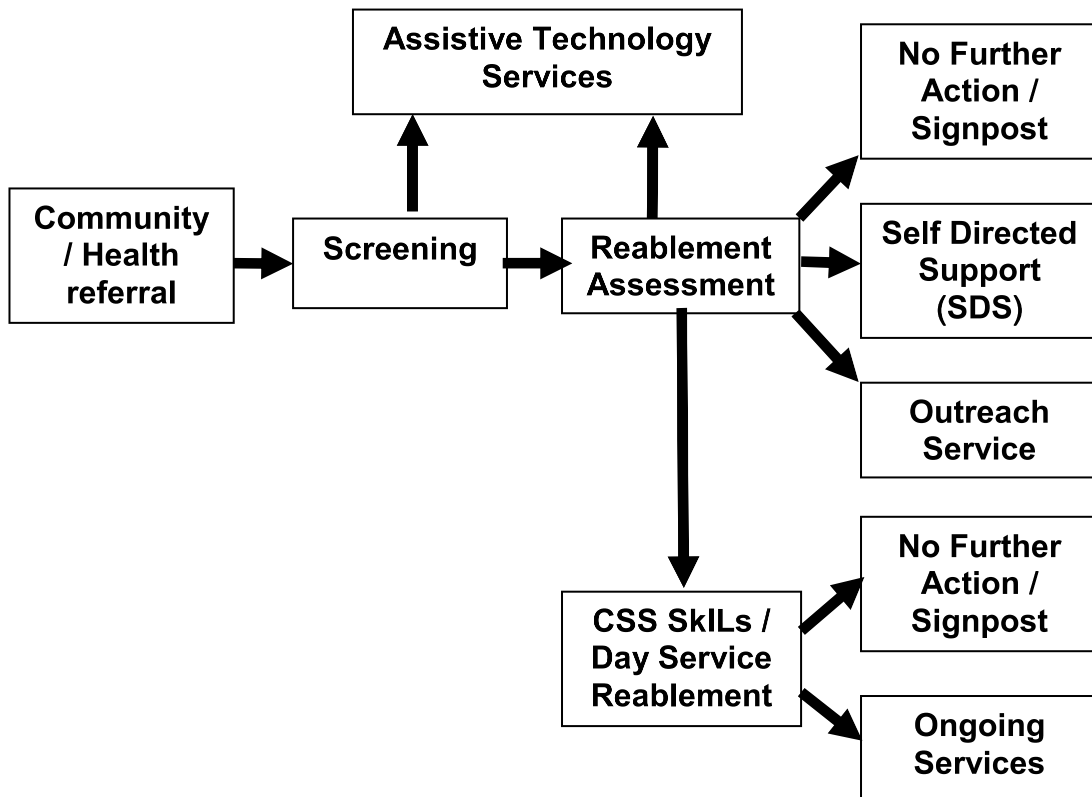
4.2 Leeds' ASC will continue to work with Trade Unions, staff and colleagues in Commercial Services over the coming months, in order to complete delivery of Phase I and II of VER/VS, the restructure of the CSS, and Phase II of reablement service

development. This work, together with the outcomes of the current Scrutiny Inquiry, will inform the Executive Board report in September 2011, which will consider the future strategic direction of the in-house Community Support Service.

4.0 Recommendations

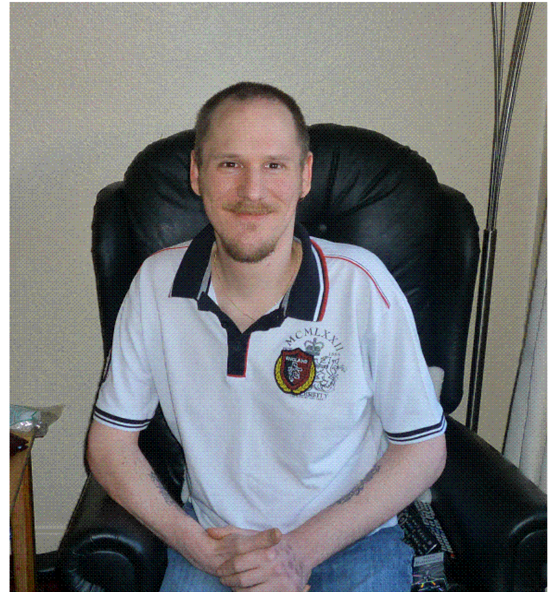
4.1 Members are asked to note the content of this report.

Appendix A
The customer's journey through reablement



The following case studies provide a snapshot of the way that reablement services in Leeds are helping people live more independently in their own homes and local communities.

Jonathan Burton's story: "Now I can live in my own home!"



Profile:
Jonathan, 30, lives alone in Horsforth, with a supportive family living close by, and used to work full-time in Green Flag customer services.

Jonathan was diagnosed with Becker Muscular Dystrophy when he was 16 years old which has gradually made mobility difficult.

In the last few years his condition worsened, reducing his mobility significantly and making everyday activities such as sitting up in bed, preparing food and grooming difficult.

Hospital Admission
The decline in his condition led to him to feel isolated and he found coping extremely difficult; suffering episodes of depression; and in late 2010 he was admitted to hospital for three months.

Jonathan feels that his admission into hospital was not conducive to improving his MD and explained that he was not mobilising enough because he spent most of the day in his wheelchair. In hospital he was reliant on staff and this was frustrating for him as he wanted to do things for himself.

In December he was discharged from hospital. Jonathan was concerned about going home, mainly because he felt he would not be able to manage without some support. It was at this time that hospital social workers assessed that Jonathan would benefit from receiving a reablement package of support from the SkILs team, and some community equipment.

SkILs intervention, with AT
When Jonathan was first discharged he received four visits per day. This was the right level of support at first, Jonathan feels, as it gave him confidence.

Sharren, his SkILs support worker, explained that Jonathan was very excited about the things he wanted to achieve once home and started with a lengthy page of 40 outcomes! When asked what his top three outcomes were he said he wanted to be able to wash himself without support, get out and about, and cook for himself.

A couple of weeks after starting Reablement, everyday tasks started to get easier for Jonathan. With equipment from LCES and the encouragement and support from the SkILs team he developed coping strategies to help him get out of his chair and with the new equipment including a profiling bed, shower chair and trolley he was able to sit up and stand up more easily, shower himself and prepare meals.

Reducing Jonathan's care package
As things became easier for Jonathan, the SkILs team gradually reduced the number of visits. This was done slowly by firstly removing the dinner visit, then the tea-time visit and then just visiting him in the morning and in the evening.

The SkILs workers often rang him to check on him throughout the day to make sure he was coping.

In the last couple of weeks Jonathan has improved immensely and has even been able to drive his car again. He looks elated and animated when he talks about this and feels he has taken a giant step forward in getting his independence back.

Jonathan's reablement experience
Jonathan says the SkILs team provided the right level of support and encouragement and he feels sure that without their existence he would have lost all his independence.

He likes the way the SkILs team suggest ideas of how to make things easier so he can do them independently, and says he would not have considered home care but would have opted to go into a group care home:

> *"the support I've received from the SkILs team has been invaluable. They are like my extended family. I'll be sad to see them go, but without their help I'd have ended up in a group home and now I can live in my own home. The entire SkILs team have been fantastic".*

Sharren explains he has gone from having no independence to being almost completely independent.

Jonathan is also a talented artist. His enthusiasm and renewed confidence has meant he has returned to his passion for arts and crafts and is currently looking into starting a foundation degree in Art this year.

Jonathan is excited about the future and looks forward to getting his powered chair so that he can start his Art degree and get out and about.

Harry's story: "Support from the SkILs team has been reassuring… My next goal is to walk to my local Co-op"

Profile:
Harry, 84, lives in a 2nd floor flat in Anchor sheltered housing in Beeston. Born in Leeds he has lived in the city with his wife Clara for 60 years. Harry retired from a working life in engineering 20 years ago.

Harry's son and daughter-in-law live in Morley and have been very supportive over the past ten months; though Harry is a very proud man and only reaches out to his family when absolutely necessary.

Harry has a history of chronic obstructive pulmonary disease, ischemic heart disease and anxiety. He has been caring for his wife at home whose health had been deteriorating. Over time, Harry's own health started to suffer. A severe bout of anxiety resulted in him being admitted to The Mount in September 2010.

Hospital admission and discharge
After two months in The Mount, Harry suffered heart problems and was transferred to St James' hospital in November 2010. In late November he was well enough to be discharged.

Although he had previously wanted to move into a care home Harry recognised his health had improved and wanted to return home; though he was concerned about his continued levels of anxiety, and his breathing problems. It was at this point that hospital social workers assessed Harry and decided he would benefit from receiving reablement.

SkILs intervention, with assistive technology
Following discharge, Harry initially received four visits from a SkILs worker each day. The visits focussed on emotional support to increase Harry's confidence and independence to achieve outcomes such as going to bed unaided and increasing his mobility. Harry also received support from the team to eat more healthily, keep his house clean and tidy, sleep more comfortably at night and to organise his medication.

To help him improve his diet, Harry's SkILs worker suggested having Country Fayre meals delivered; purchased a microwave to cook meals quickly and easily; and helped Harry to cook the meals by himself. To keep his house clean and tidy, the SkILs team also helped organise for a private cleaning company to clean the flat and do the laundry each week.

In terms of assistive technology, because Harry finds breathing more difficult when lying down, the SkILs team ordered a support pillow and made sure he was comfortable with it. Harry also has over ten different types of tablets which he needs to take every day. Whilst he is capable of organising his own medication, the SkILs worker noted that this was taking up a lot of his time. To help with this, the SkILs team organised a dossett box through the community pharmacist.

Reducing Harry’s care package
As Harry’s confidence grew the SkILs team gradually reduced the number of visits.

With meals delivered and a microwave to cook with, the SkILs team gradually withdrew from meal preparation.

At the end of week six Harry was able to walk from his chair to the hallway and back. Having achieved all his reablement outcomes the SkILs team withdrew completely.

To ensure Harry continues to live independently at home, neighbourhood warden Ricky visits Harry twice a week, taking time to talk to Harry and continue to encourage him with his walking. With Ricky’s support, Harry can now walk to the lift down the corridor outside his front door.

Harry’s reablement experience
Harry says that support from the SkILs team has been reassuring, helping him to cope at home, especially when going to bed at night. He says his new pillow makes him feels less anxious about going to bed, and that the cleaning service and his dossett box are both a great help.

Harry looks forward to his twice weekly visits from Ricky. He says it’s nice to see a friendly face.

Harry is now working to build up his confidence to venture outside on his own and walk to his local Co-op to shop for himself.

Appendix C: CSED Homecare Reablement Prospective Study: final report findings & how Leeds compares

	National Findings / Best Practice	Leeds position
Assessment arrangements	• There is a need for and importance of the initial homecare reablement assessment and ongoing progress reviews • It is important that the initial review is completed in the client's house	• Assessment and progress reviews aligned to ASC's new Single Assessment Process • Progress reviews completed in clients house as standard
Discharge and onward referral arrangements	There is a need to ensure smooth entry and discharge from the service by: • unblocking decisions about support for any ongoing care needs • Securing capacity in the provider market (see Implementation Toolkit)	• End-to-end ASC process mapping / regineering underway creating leaner gatekeeping / care management processes • Leeds Homecare Framework Agreement implemented and in use, with 36 providers identified
Key features of reablement services	There is a need to: • Access to community equipment / aids to daily living, and telecare since these support the reablement process (see Implementation Toolkit) • Address workers training for existing staff transferring from 'conventional' homecare services both in terms of skills and a change in mindset (see Implementation Toolkit)	• Integral, innovative feature of the Leeds model – AT accessed early on customer pathway • Taken forward by JIP as regional best practice • Reablement training programme in use inc. culture change, core skills, processes & systems, and learning into practice training modules
Skill mix in the team	There is a need to • establish speedy access to OTs and other specialist services for some users • Have adequate and rapid access to OTs and other specialists rather than having those professionals necessarily embedded in the reablement team	• Integral, innovative feature of the Leeds model - OTs available on community and hospital discharge pathways into service • Taken forward by JIP as regional best practice
Staff commitment, attitude, knowledge and skills	It is important that reablement is seen as an 'attitude' or an 'approach' to care for the reablement service to operate effectively	• Reablement culture change and learning into practice training deliberately targets this service development requirement
Service user characteristics	• The most difficult cases tend to be service users who have a history of long periods of home care because they are more likely to expect things to be done for them • People with dementia and mental health problems require different patterns of engagement • Reablement for older people who had had a fall or fracture focuses more on personal care and confidence building • Reablement for younger people tends to be more about social interaction	• Not enough local data to compare • Integral, innovative feature of the Leeds model – Leeds has a dedicated MH Reablement Service to meet this different service demand • Not enough local data to compare / validate • Not enough local data to compare / validate. The Leeds reablement offer includes Outreach to meet this service demand
Service user and carer views	• The involvement of service users in setting their own goals is highly motivational • In a small number of cases service users and carers feel that the reablement goals they had identified had been thwarted by restrictions on the service • Service users are often disappointed about the changes to their eating habits through limited support to improve food	• Reablement assessments and plans are co-produced as standard with the service user and their carers • Not enough local data to compare / validate • Not enough local data to compare / validate

	National Findings / Best Practice	Leeds position
	preparation skills • The focus of services on activities of daily living (ADLs) within the home and not on instrumental activities (IADLs) outside the home results in a ‘shortfall’ in meeting user’s goals on mobility.	• Integral, innovative feature of the Leeds model – he Leeds reablement offer includes Outreach to meet this service demand