11 October 2011

To: All Members receiving information about Cabinet Member Signings

Dear Member,

Cabinet Member Signing - Monday, 17th October, 2011

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

4. THE NEW REABLEMENT SERVICE AND THE CLOSURE OF THE IN-HOUSE HOMECARE SERVICE (PAGES 1 - 74)

(Report of the Director for Adult and Housing Services - To be introduced by the Cabinet Member for Adult Services and Health) The report will seek approval for the proposed introduction of the new reablement service following the closure of the in-house homecare service.

Yours sincerely

Ayshe Simsek
Principal Committee Co-ordinator
0208 489 2929

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Agenda Item 4

Haringey Council

Agenda item:

[No.]

Cabinet Member Signing **17th October 2011**

Report Title: **The new Reablement Service and the proposed closure of the in-house Home Care Service**	
Report of: **Mun Thong Phung, Director of Adult and Housing Services** Signed:	
Contact Officer: Lisa Redfern, Deputy Director, Adult and Community Services	
Wards(s) affected: All	Report for: Key

1. Purpose of the report

1.1. The issue under consideration is whether the Cabinet Member for Health and Adult Services should confirm the Cabinet decision in principle, initially taken on 21st December 2010, to close the home care service and commence a new reablement service, taking into account the consultation outcomes, as well as the relevant equalities impact assessments.

1.2. If agreed, the jobs of some staff in the current home care service will be placed at risk; however, some will be recruited to work in the new reablement service and some will be opting for voluntary redundancy in advance of any changes becoming operational in February 2012.

2. Introduction by Cabinet Member

2.1. This proposal follows the imposed budgetary cuts on Local Authorities by the Coalition Government. Whilst Haringey's own small in-house home care service offers a good quality service, it is expensive to run and we must be satisfied that we deliver good quality services in the most efficient and cost effective way. The new reablement service will not only improve quality and maximise a person's independence and quality of life outcomes but through better ways of working,

service re-design, more flexible contracts, an integrated service with the NHS, greater efficiencies can be achieved. This model is tried and tested and has been used successfully elsewhere, i.e., a smaller in-house service but completely re-modelled with its focus on joint, short-term reablement.

2.2. We face a challenging budgetary framework in which to operate and a number of proposed Adult Social Care reductions to consider, including this proposed closure of the in-house home care service. I am being asked, as the responsible Cabinet Member, to consider closing this service, saving a total of £1.563 million in 2012/13. I am confident that we have equally high quality personal care providers in the independent sector as evidenced by the Care Quality Commission's assessments.

3. State link(s) with Council Plan Priorities and actions and /or other Strategies:

3.1. Adult and Community Services Council Plan Priorities are:

- Encouraging lifetime well-being at home, work, play and learning;
- Promoting Independent living while supporting adults and children in need; and
- Delivering excellent customer focused cost effective services.

Full Council Plan Priorities can be found on the left hand side of the page at http://harinet.haringey.gov.uk/index.htm.

3.2. This is in line with the transformation of Adult Social Care: "Putting People First" (December 2007) and "Think Local, Act Personal" (last updated April 2011) as Reablement is seen as the preliminary step as part of assessing a person for a personalised budget.

4. Recommendations

4.1. The following recommendations are being made for consideration by the Cabinet Member, in the context of the Haringey Efficiency and Savings Programme [HESP]: In considering the following recommendations, the Cabinet Member should take into account the outcome of the consultation process and the attached Equalities Impact Assessment (Appendix 3), including the outcome of the consultation with trade unions and staff (Appendix 5)

a) The gross cost of the current Home Care service is £2.805 million. The Cabinet Member is recommended to agree to close the current in-house home care service by end March 2012, at the latest, thus confirming the Cabinet decision in principle taken in December 2010; and
b) The Cabinet Member is recommended to agree the establishment of a new, focused, in-house reablement service, at a cost of £1.242 million, to be operational by end March 2012 at the latest.

4.2. Agreement of both these recommendations will result in net HESP savings of £1.563 million from April 2012 onwards.

5. Reason for recommendation(s)

5.1. The proposal to close the in-house home care service was first considered by Cabinet as part of the HESP proposals and discussed by Members on 21st December 2010. A separate proposal to establish a new smaller reablement service, funded by savings from the current home care service, was proposed at the same meeting.

5.2. The issue under consideration is whether the Cabinet Member should confirm the Cabinet decision in principle, initially taken on 21st December 2010, to close the home care service and, separately, commence a new reablement service, taking into account the consultation outcomes, as well as the relevant equalities impact assessments.

5.3. If agreed, the jobs of some staff in the current home care service will be placed at risk, though some will be recruited to work in the new reablement service via the redeployment process and some will be opting for voluntary redundancy in advance of any changes becoming operational in February 2012.

5.4. The importance of the new reablement service is that it will become a key part of the overall transformed adult social care service. This is planned to be in place and to be fit for purpose in the lead up to the April 2013 roll out of Personal Budgets for all people receiving social care by April 2013. This expected outcome is set out in the national policy document “Think Local Act Personal”. Where appropriate, people will be offered reablement /rehabilitation before they are assessed for their personal budgets which, in many cases, will reduce their long-term dependency and thus the size of ongoing care packages. The new reablement service is therefore part of a bigger jigsaw of service developments aiming for that ultimate objective.

5.5. It is also clear from a range of sources, most recently the Audit Commission “Improving Value for Money in Adult Social Care” (June 2011) that a well-run reablement service is capable of generating direct Value for Money [VFM] efficiencies and that other local authorities (21%) have already begun or completed the process of outsourcing the home care services and are converting the remainder to providing a reablement approach. 54% of all Councils have made efficiencies by using reablement and other intermediate care schemes. 81 Councils have cited reablement in their 2009/10 efficiency statements as generating savings of varying amounts (See Appendix 1 - What is a Successful Reablement Service?).

5.6. The size of the proposed new in-house Reablement Service will be approximately 30% of the current home care service. (30 Full Time Equivalents (FTEs), including

4 FTE office based staff, in comparison to 94.4 FTE prior to the voluntary redundancy process) due to the fact that it will be focused on providing services for a maximum of six weeks following which people still requiring a personal care service will be passed on to external contracted providers in the independent sector for any ongoing care needs. Achieving a high standard of service and throughput is critical. We need to sustain our "excellent" performance indicator on delayed discharges from hospital.

5.7. The approach will be to frequently review and reduce levels of support to the minimum necessary as the capacities and abilities of the person increases (the ideal will be that the person will no longer need the service after six weeks, if not before, and therefore not need any form of ongoing personal care/support service, thus reducing ongoing pressures on the commissioning budgets for older people).

5.8 The service will also be proactively working in partnership with Age UK to use the services of volunteers during and after the reablement period to add an extra dimension to the process of rehabilitation and eventual independence of service users. All those passing through the reablement process will also receive a fire risk assessment, a Telecare assessment, a basic foot care assessment to reduce the risk of falls, an assessment for the Handy Person service and a discussion with them/their family as to whether additional input to reduce social isolation is required. This would be provided during the six week reablement period via The Haven day centre

5.9. The budget for the proposed reablement service is £1.242 million, following the first phase of the HESP programme. It is now proposed to design and establish a new reablement service and close the current in-house home care service, rather than reorganise it, in order to increase efficiency and flexibility of delivery and thus release a further tranche of savings (£500k).

5.10. This process will be carried out in the wider context of readily accessible guidance, based on best practice as set out by the Department of Health, via the Care Services Efficiency Delivery (CSED) work stream.

5.11. It is intended that staff in the new reablement service are to be recruited from those currently working in the home care service, as part of the Council redeployment processes. Any displaced home care staff that have either chosen not to apply for roles in reablement or have been unsuccessful in obtaining a role in the new reablement service, will be issued with notice of redundancy.

5.12. It is considered that, subject to the agreement of the Cabinet Member and at Corporate Committee, both options will be achievable within the Human Resources and Financial procedures of the Council, within the planned timescales. There are a considerable number of CQC registered home care providers (circa 80) in the independent sector both in Haringey and on Haringey borders. There are only four people still in receipt of an ongoing long-term home care service.

5.13. Detail in relation to the manner in which the new service is to run is included as Appendix 2 – "Reablement; the new service model".

6. Other options considered

6.1. Members will be aware that a saving of £1.062m has previously been agreed, resulting from closure of the existing Home Care service and creating the new reablement service. The model for the new service was, at that time, based on a 50:50 contact/non-contact time ratio, in line with the current home care service. As plans are developed further, and with the abolition of time slots, it is anticipated that a ratio of 70:30 contact/non-contact time can be achieved and thus an additional £501k saving will result.

7. Summary

7.1. This report lays out the rationale for closing the in-house home care service by the end of March 2013 and establishing, as a separate work-stream, a new, more focussed, reablement service. Recruitment to the new service will be via the Council redeployment processes, given that the current in-house home care service is recommended to close. However, it is anticipated that staff in the current home care service whose jobs are at risk will fill the majority of the new posts in the reablement service. The detail of the implications for staff will be considered by the Council's Corporate Committee. Agreement to these proposals will not only deliver savings of £1.563 million as part of the HESP programme, but will also improve the prospects of ultimate independence for a group of mainly older people being discharged from hospital.

8. Chief Financial Officer Comments

8.1. The remaining overall Council budget gap for 2012-2014 has been previously reported to Members. Each Directorate has, therefore, been asked to put forward budget reduction proposals.

8.2. Proposals for Adult and Housing Services were considered on 27th June 2011 and this report provides additional detail on the Reablement Efficiency proposal.

8.3 The original proposal to close the in house Home Care service and create a new Reablement service gave rise to savings of £1.062m, i.e. gross cost of the home care service £2.805m less £1.743m for the new reablement team. Further development of reablement services has shown that, with the abolition of time slots, increased efficiency can be achieved thus increasing the saving by a further £501k. The total saving to be achieved from remodelling this service will be £1.563m.

9. Head of Legal Services Comments

9.1. The decisions of the Cabinet member concerning the recommendations set out in the report need to be taken in line with legislative requirements and must be informed by and take into account the outcome of the consultation with service users, providers and other stakeholders, which is set out at section 12 of this report.

9.2. In reaching a decision the Cabinet member must also have specific regard to the authority's public sector equality duty and thus should take into account the attached full equality impact assessment included at Appendix 3 to the report. The Cabinet member should note in particular section 3 of the attached equality impact assessment.

9.3. The extent of the public sector equality duty on the Council, enforced by the Equality Act 2010, is set out in Appendix 7 to this report. The attached equality impact assessment highlights the effect of proposals on a number of specific user groups within the community, defined as those with protected characteristics under the Equality Act 2010 (by reason of their age, disability or religion). The Cabinet member must give particular consideration to those effects and to the proposals made to reduce or mitigate them.

9.4. A decision to close or reconfigure the care service will have specific consequences for the staff who are employed by the Council within these services. The Council's Corporate Committee retains responsibility under the terms of the Council's Constitution for decisions regarding changes to the staffing establishments. However in view of the implications of the recommendations contained in this report, the Cabinet member should, before making any decision concerning the closure or reconfiguration of these services, give due consideration to the staffing implications highlighted at section 11 of this report and the completed consultation with staff and trades unions (at Appendix 5) while taking into account the outcome of the consultation with service users and other stakeholders.

10. Head of Procurement Comments

10.1. N/A

11. Equalities & Community Cohesion Comments

11.1. A detailed Equalities Impact Assessment has been carried out in relation to the proposals about home care and the reablement service. The full EqIA is attached as Appendix 3. However, key points from that document are as follows (all references to Tables are to those contained in the full Equalities Impact Assessment.

11.2. **Home Care/Reablement proposals – key findings**

- **Age** – the proportion of older people discharged as Hospital referrals as a proportion of the adult population in Haringey shows that there are higher proportions of older people in the upper age ranges from age 65 and up who will potentially use the reablement service. Table 2.1.4 shows that the majority of Hospital Discharge referrals are older people aged 65+ (87%) as against 9.4% of people of that age range in the Haringey population generally. 87.5% of current home care users of the internal service are aged 65+ (Table 2.1.3) which is roughly equivalent. This reflects the increased frailty and disabilities of people as they get older, therefore needing higher levels of support and assistance on coming out of hospital. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their chronological age meaning no disproportionate impact is anticipated against 'Age' in the future.
- **Sex** – no disproportionate impact identified. Tables 2.1.1 and 2.2.2 show a higher proportion of females to males discharged as Hospital referrals (58% female) against the borough gender profile (51% female); however, as with 'Age', this is broadly to be expected considering the changing profile of males to females across the age ranges 65 years and above (Tables 2.1.3 and 2.1.4). There are currently equal numbers of males using the current service as women; however, males are marginally under-represented (41% against a Borough profile of 49%) in terms of overall hospital discharge referrals. This could have something to do with the age profile of those referrals and general levels of life expectancy among the sexes. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their gender, therefore no disproportionate impact is anticipated against 'Sex' in the future.
- There is a disproportionate impact identified with '**Race'**. It has been identified that there will be no disproportionate impact for Black or Black British, but Mixed, Asian or Asian British adults are, according to the data, under-represented in the current service – refer tables 2.1.5 and 2.1.6. 20% are from a Black or Black British background and 3% from Chinese/Other ethnic groups, identical to their profile in the general population. Less than 1% are from a mixed race background against a Borough profile of 4.6% and 5.3% Asian or Asian British against a profile of 6.7% although the numbers of Asian or Asian British using the current service is 10.7%. This may be due to the age profile of those populations, which are younger in general and thus less likely to need hospital care. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their ethnicity, therefore no disproportionate impact is anticipated against 'Race' in the future.
- As regards **'Disability'**, all older people referred to the Council as Hospital Discharges have met Council eligibility criteria (critical and substantial) as per Department of Health (DH) guidance, and are considered to have a disability as defined by the Equalities Act 2010. Fair Access to Care Services has been replaced with Guidance on Eligibility Criteria for Adult Social Care (2010) from the Department of Health, with the guidance retaining the four eligibility bands set out in Fair Access to Care Services – that is, Critical, Substantial, Moderate and Low. Haringey Adult and Community Services will continue to provide services to individuals who are assessed as having needs that are Critical or Substantial both inside and outside the new reablement service.

- **'Religion'** - Muslims would appear to be under-represented by roughly half (6% as opposed to a Borough profile of 11%) both in terms of the current list of users and overall numbers of hospital discharge referrals. Christians are seemingly under-represented (37% against a Borough Profile of 50%) among current service users. However, the numbers recorded as 'other religion' and 'not stated' are sufficiently high to account for all or some of this imbalance. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their spiritual beliefs, therefore no disproportionate impact is anticipated against 'Religion' in the future
- No disproportionate impact was identified in respect of **'Marriage or Civil Partnership'** or **'Sexual Orientation'.** There is no data for the protected characteristic of **'Pregnancy and Maternity'.**

11.3 – **Staffing implications**

The proposals to close the in-house home care service and establish a separate new reablement service are based on the need to make financial savings and to provide services that are more in line with "Putting People First" and "Think Local, Act Personal". The proposals have been adapted in response to matters arising from public and staff consultation. If the proposals are agreed, the Director of Adult and Housing Services will review required levels of staffing and take any necessary steps in the light of this to apply the Council's restructuring procedures for staff.

The service has been the subject of an Equalities Impact Assessment to consider the impact on staff of the proposal to close the home care service and commence a separate reablement service, in relation to then protected equalities groups of ethnicity, gender, age disability and maternity. It does not consider issues relating to sexual orientation, gender re assignment, pregnancy and religion/belief, as the relevant data is not available for these groups.

Currently, 71 staff at varying grades work in the home care service; an estimated 36 minimum will potentially be recruited into the new reablement service subject to the Council redeployment processes, leaving approximately 35 staff at risk, if the decision is taken to close the home care service.

Staffing implications will be reviewed and reassessed and reported to Corporate Committee as required. A separate and detailed EqIA in relation to the matters of staffing will be submitted to the Corporate Committee at the same time.

However, of the current staff group, only 2 are male (3%) and 69 are female (97%) as against 30% female staff in this grade group across the Council.

61 (86%) are from a Black/Minority Ethnic group, whereas only 10 (14%) are from a White/White other group. Only 54% of staff across the Council are from a BME group

People in the 45-54 age range are disproportionately affected by these proposals, comprising 47% of the total staff group as against 35% in this age group across the

Council.

2 of the current staff group have a declared disability as against 7% across the Council.

12. Consultation

12.1. Formal consultation with service users, staff and the trade unions began on 1st August 2011 and continued for 31 days. The outcomes of this consultation process have been included in the equalities impact assessment, which is attached to this report as Appendix 3.

12.2. A total of 10 completed questionnaires were returned by post. No on-line questionnaires were completed although the consultation web page New Community Reablement Service Consultation was viewed 74 times.

50% (5) of respondents either strongly agreed or agreed with the creation of a new Community Reablement Service. 30% (3) strongly disagreed or disagreed and a further 20% (2) neither agreed nor disagreed.

40% (4) of respondents either strongly agreed or agreed with the commissioning intentions (actions) identified. 20% (2) strongly disagreed or disagreed and a further 40% (4) neither agreed nor disagreed or did not say.

Of those who commented further:

Some said a new Community Reablement Service seemed a good thing, that it sounded great on paper and said how they were looking forward to seeing the service up and running. Others were content with the changes proposed, provided the current quality and standards were maintained or wanted them to go further – for example, providing help with shopping.

Some said they needed a service such as this and that others would benefit from its introduction. Others said a lot of thoughtful research had clearly gone into this proposal or how the increased independence would bring them 'peace of mind'.

There were worries, however, over how existing users of services and [home] carers would be absorbed into the new service. Worries were also expressed about the short-term nature of the provision by those who said they needed long-term care and how six weeks would do nothing for them. There were queries as to the steps the Council was taking to ensure independent providers met required standards.

Those who disagreed with the proposal said that closing the current home care service would inconvenience those who already used the service, were worried that it would affect their well-being, or considered that the financial impact of this proposal would have a dramatic effect on users of the service. Others were dismissive of everything the Council did.

Others have questioned the consultation itself and said that they saw little point in putting time, effort, goodwill and expertise into responding when, having, as they saw it, "pointed out the pitfalls", the proposal would go ahead anyway.

Detailed comments were received from UNISON and Age UK which are attached as Appendices 4 and 5, which include the associated responses as Appendices 4a and 5a. Comments from Haringey Disability First Consortium are attached as Appendix 6 with the associated response as Appendix 6a

13. Service Financial Comments

13.1. The budget for the in-house Home Care service is £2.805m. The proposal in the report is to create a reduced focused Reablement Service to support the Personalisation agenda. The original proposal to close the in house Home Care service gave rise to savings of £1.062m (gross cost of the home care service budget of £2.805m less £1.743m for the new Reablement team). Further development of Reablement services with the abolition of time slots has increased the savings by a further £501k. The total saving to be achieved from remodelling this service will, therefore, be £1.563m.

13.2. Efficiencies
The total efficiencies achievable from these proposals are £1.563m. The achievable efficiencies have increased from £1.062m to £1.563m by developing plans further, and with the abolition of time slots. It is anticipated that a ratio of 70:30 contact/non-contact time can be achieved, thus achieving the additional £501k saving.

14. Use of appendices

14.1. Appendix 1 - What is a Successful Reablement Service?
14.2. Appendix 2 - Reablement; the new service model; and
14.3. Appendix 3 - Equalities Impact Assessment.
14.4 Appendix 4 - Letter from Age UK and response to their comments (4a)
14.5 Appendix 5 - Trade Union Comments and Staff Consultation Report (5a)

14.6 Appendix 6 - Letter from Haringey Disability First Consortium and response to their comments (6a)
14.7 Appendix 7 – The public sector single equality duty

15. Local Government (Access to Information) Act 1985

15.1. January 2011, "Think Local, Act Personal", Cabinet Office; and
15.2. No reason for confidentiality or exemption.

Appendix 1

What is a Successful Reablement Service?

A recent study of five well established reablement services highlighted the following as key features of successful reablement services:

- Working with people who have been discharged from hospital/A&E with the potential for independence;

- The ability to assess service users potential for independence, to encourage and motivate them, and to provide appropriate but reducing levels of support as the coping capacity of the service user increases and they gain confidence;

- Effective assessment and task planning set out in Reablement Plans;

- Prompt supply of equipment to service users and rapid access to occupational therapists for more complex assessments;

- Staff training/re-training and on-going supervision that underpins and reinforces that staff are there to encourage and motivate service users to maximise their own skills so that they can do specified tasks within a timeframe rather than doing tasks for them;

- Teams that are involved, well motivated, organised, deployed and rostered to work with service users in flexible ways that enable swift responses to the changing needs of service users and their increasing capacity over time following the initial inputs;

- Flexibility over the timing, duration and content of home visits;

- Close working arrangements at the front-line with Whittington Health community health based services such as Physiotherapists and Community Nurses; and

- Users needing long-term care are referred to external agencies after the initial 6 week period, with the possible exception of individual complex cases where there are safeguarding concerns.

Appendix 2

Reablement; the new service model

There will be two reablement areas, East and West with boundaries equivalent to those in the current home care service.

Front-line staff will communicate between themselves and the central office, using service-supplied mobile phones. In the future, these may also be used to 'touch in' and 'touch out' of the homes of service users to monitor time spent with individual service users and generate performance data for the service generally, for example, contact time/client. This model will enable people who receive the service to adjust the input they receive, according to their wishes on that particular day and will give much increased flexibility to the service provided on a daily basis, for example, getting up times, meal times, times for rehabilitation/reablement activities and the time devoted to such activities.

The service will not be charging for the reablement phase. A financial assessment will be carried out at the end of that time on the reduced package, if necessary. Ceasing charges will therefore enable the current time "slots" to be abolished and for a much more flexible and fluid system of visits to people to be put in place, front loaded to maximise input immediately after discharge and reducing the further the service user gets from that date. Priority tasks such as personal care can be done at peak times, and the workers can then return to carry out reablement training with service users when they are less busy.

The Team Manager/Team Leaders will work a 36-hour week, mainly Monday to Friday, but with the requirement to work in the evenings/at weekends on occasion, as the service requires. The reablement service will operate between 7am and 10pm, seven days a week, including Bank Holidays.

Community Reablement Workers and Senior Community Reablement Workers will work a standard 30-hour week. These hours will be worked on a 5 day/week rota basis, including weekends and bank holidays, Monday to Sunday. An early shift will either be 7-2 or 8-3 including an hour break; a late shift will be either 2-9 or 3-10 including an hour break. Staff may be asked to work a split-shift or long day on occasion but this will be seen as the exception rather than the rule. These hours of work are similar to those already in operation in the Councils' residential care homes.

Where at all possible, it is proposed that Community Reablement Team workers will be car drivers, or have alternative modes of transport to enable them to move between service users with maximum efficiency. Routine use of public transport will be discouraged for that reason. All members of the team will be seen as casual car users and will be issued with an essential car user pass, paid for by the service.

All staff will be issued with new contracts setting out the above terms and conditions for the Reablement Service, including also relevant Council terms and conditions for all the posts in question.

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HARINGEY COUNCIL

EQUALITY IMPACT ASSESSMENT (EqIA) FORM

Service: **Adult and Community Services**

Directorate: **Adult and Housing Services**

Title of Proposal: **Joint Community Reablement Service** Proposed closure of current internal homecare service and creation of a new community reablement service.

Lead Officer: **Len Weir**

Names of other Officers involved:

Step 1 - Identify the aims of the policy, service or function

1.1 **The Proposal**

1.1.1 Haringey Council is looking to close its in-house home care service and develop a new reablement service. The purpose of reablement is to maximise independence in people post-hospital discharge by intensive multi-disciplinary support over a time limited six-week period. This rolling EqIA covers **Phase 1** of the process, up to making the recommended decision to close the in-house home care service by March 2012 and establish a new reablement service, to commence operation by end March 2012 at the latest. **Phase 2** of this rolling EqIA will cover the business processes and associated operational policies in relation to the proposed new reablement service, including the inclusion/exclusion criteria whereby service users will be selected for reablement, or not.

1.2. **Overall Aims and Objectives**

1.2.1 The importance of the new reablement service is that it will become a key part of the overall transformed adult social care service. This is planned to be in place and to be fit for purpose in the lead up to the roll out of Personal Budgets for all people receiving social care by April 2013. Introduction of this service is in line with the transformation of Adult Social Care: "Putting People First" (December 2007) and "Think Local, Act Personal" (last updated April 2011) as Reablement is seen as the preliminary step as part of assessing a person for a personalised budget.

It is also in line with Adult and Housing Services and Council Plan Priorities to:

- Encourage lifetime well-being at home, work, play and learning;
- Promote Independent living while supporting adults and children in need; and
- Deliver excellent customer focused cost effective services.

1.3 Benefits and Outcomes

1.3.1 The new reablement service will benefit service users in a number of ways. The service received will be more flexible than the current home care model, where the service is currently delivered in time designated and time limited 'slots'. During the free six week reablement period, the amount of time delivered will be varied to reflect the level of dependency – as the person regains independence, the level of support can be reduced to reflect that. In addition, there are potential financial benefits for service users in that, where a financial assessment is required for a long term service, the amount the service user has to pay will be reduced to a minimum. The new service should also deliver considerable savings to the Council in a time of financial austerity by delivering a reduction of some 30-40% in the size of on-going care packages, on average (CSED figures).

1.3.2 Under the scheme, we propose:

- To work with people who have been discharged from hospital/A&E for a six week period to help them regain and then maximise and maintain their independence and offer a greater level of choice and control over their lives;
- To encourage and motivate those discharged by providing appropriate support that increase their ability to cope and helps them regain their confidence;
- To effectively assess people and create individual Reablement Plans; accessing occupational therapists and other allied professionals such as physio-therapists for more complex assessments
- To quickly supply equipment to service users when they need it;
- To deliver home visits that are flexible in terms of timing, duration and content;
- To refer users needing long-term care to external agencies after the initial 6 week period, with the possible exception of individual complex cases where there are safeguarding concerns in line with current Fair Access to Care Services assessment procedures;
- To have teams that are involved, well motivated, organised, deployed and rostered to work with service users in flexible ways that enable swift responses to the changing needs of service users and their increasing capacity over time; and
- To have close working arrangements at the front-line with community health based services such as Physiotherapists and Community Nurses.

1.3.3 This provision will be carried out in the wider context of readily accessible guidance, based on best practice as set out by the Department of Health, via the Care Services Efficiency Delivery (CSED) work stream.

1.4 Budget Savings

1.5.1 As a result of unprecedented cuts to local authority budgets, we face a challenging budgetary framework in which to operate and a number of proposed Adult Social Care reductions have been put forward for consideration, including this proposed closure of the in-house home care service. The proposal to close the in-house home care service was first considered by Cabinet on 21st December 2010. A separate proposal to establish a new smaller reablement service, funded by savings from the current home care service, was proposed at the same meeting.

1.5.2 It is much more expensive to directly provide Haringey's in-house home care service (over fifty percent more) than our main independent sector providers. This is because it operates a "traditional home care model" and Council conditions of service apply. Current Government and Audit Commission guidance suggests that Local Authorities should only directly provide services i.e. where there is a clear value for money case for doing so.

1.5.3 To ensure that we continue to offer the highest quality of service we can to some of Haringey's most vulnerable people, we need to consider and agree our priorities; our statutory "must dos". We need to constantly review what we provide and/or commission and the most value for money (quality and cost) ways in which to do so. We must be satisfied that we deliver good quality services but in the most efficient and cost effective way.

1.5.4 The gross cost of the current Home Care service is £2.805 million. Closure of the Home care service would generate savings of £1.563 million in 2012/13. The establishment of a new, focused, in-house reablement service, to be operational by end March 2012 at the latest would cost £1.242 million.

1.6.5 It is clear from a range of sources, most recently the Audit Commission "Improving Value for Money in Adult Social Care" (June 2011) that a well-run reablement service is capable of generating direct VFM efficiencies and that other local authorities (21%) have already begun or completed the process of outsourcing the home care services and are converting the remainder to providing a reablement approach. 54% of all Councils have made efficiencies by using reablement and other intermediate care schemes. 81 Councils have cited reablement in their 2009/10 efficiency statements as generating savings of varying amounts (See **Appendix 1** - What is a Successful Reablement Service?).

1.5 Details of the Proposed Changes

1.5.1 In broad terms, this change would see us:

- Closing the current in-house home care service by March 2012 at the latest;
- Establishing a new, smaller and more flexible reablement service, supporting service users for a maximum of six weeks; and
- Using independent sector partners to provide all long-term home care in future.

1.5.2 **<u>How the current service operates today</u>:**

1.5.2.1 The majority of current service users are already short-term (using the service for a maximum of six weeks) and have routinely been discharged to long-term service providers in the independent sector for some time now. Only 10 service users had previously received an on-going long term service in-house as of July

2011. All long-term service users were reviewed and passed over to an appropriate independent sector provider with the same level of care, and in consultation with them and their families.

1.5.3 **How the new service would operate:**

1.5.3.1 Detail in relation to the manner in which the new service is to run is included as **Appendix 2** – "Reablement; the new service model".

1.5.3.2 There will be two reablement teams; each team will have just under 9 staff on duty per day, some on the morning shift and some on the evening shift. Staff will be flexibly and responsively deployed across the Borough to where the demand is, based on working with an estimated 400 people per year, selected from the overall pool of some 1500 hospital discharges/year Working arrangements will be sufficiently fluid for staff to move to meet any surge in demand or even spread of clients. A full staffing EqIA is being completed to illustrate the impact of this process, which will also be considered by Corporate Committee.

1.5.3.3 In general, setting up a Reablement service enables the Council to improve service and reduce non contact 'down' time. The model is based on best practice from elsewhere and development work carried out last year with CSED. We need to employ staff to cover patterns of work that enable us to provide reablement tasks at times that are relevant for service users as well as spreading work across the day in a more even manner. By bringing in the new working arrangements we are not only able to achieve this aim but at the same time avoid the significant amounts of non-contact 'down' time which is currently experienced in Homecare due to the mismatch of required service user contact times with the contract hours and working arrangement for home carer workers

1.5.3.4 Prompt assessment and delivery of equipment is key to an efficient reablement service. We will train the Senior Reablement Workers as 'trusted assessors' with regard to provision of basic equipment such as bath seats, chair raisers etc to facilitate their work. Hospital discharge referrals are already a priority for the provision of items such as grab-rails, which can be fitted within 5-7 days.

1.5.3.7 The impact of this change for the people using the service and also the staff is further discussed at Step 3.

1.5.4 **The main differences from the current in-house Home Care Service**

1.5.4.1 This service will be strictly short-term, for six weeks maximum. It will be much smaller and more flexible and responsive than the current home care service, and will focus purely on reabling/rehabilitating people post hospital discharge with a view to speeding hospital discharge and maximising their independence of long-term services, with the associated costs of providing them, as well as improving their quality of life

1.5.4.2 Where appropriate, people will be offered reablement /rehabilitation before they are assessed for their personal budgets which, in many cases, will reduce their long-term dependency and thus the size of ongoing care packages.

1.5.4.3 We will not be charging for the six week reablement phase. A financial assessment will be carried out at the end of that time on the reduced package, if

necessary, in line with normal charging arrangements. This financial assessment will be carried out in accordance with the principles of Fair Access to Care Services and is common to all recipients of social care services.

1.6 Planning Assumptions

1.6.1 The structure and numbers of front line staff involved in the proposed new reablement service will consist of approximately 34 front-line workers (26 FTE@30 hours contract/person) split evenly across the two sites, with a central team of three managers and an administrative worker. This is roughly 50% of the current front-line staffing following the recent voluntary redundancy process.

1.6.2 Planning assumptions are based on, among other things, the following:

- circa 400 hospital discharges per year who would benefit from this service;
- reablement will be for a six-week period (exceptionally 8 weeks) and once the six-week period is ended, the individuals in question will be passed on to external contracted providers in the independent sector;
- the Team will no longer be providing a service to long-term clients as currently.

1.6.3 Assumptions have also been based on introducing best practice ways of working such as variable contact time, more flexible working arrangements, greater use of technology and other improved ways of working. Assumptions made are that staff will operate on the basis of 70% contact time/30% non- contact time. Non contact time in this context includes travel time, annual leave, sickness absence and training.

1.6.4 Home care workers are well trained and come with a proven track record and we will be positively looking to appoint as many of these staff as possible, in the context of the Councils redeployment processes, provided they can cover the required hours should the proposal be approved thereby addressing key issues such as trust, skills and competencies, local knowledge etc.

1.6.5 Independent sector providers. We have a range of high quality personal care providers in the independent sector (circa 80) as evidenced by the Care Quality Commission's assessments. The alternative providers are also regulated by the Care Quality Commission and Haringey Council's Service Provision policy is to only use high quality services, that is services rated as 'Excellent' or 'Good' in the previous inspection regime. This approach will not change. Our performance in this area has been acknowledged by the Care Quality Commission as excellent over the past three performance years.

Further information will be added to this section in Phase 2 of this EqIA, after a Cabinet decision

Step 2 - Consideration of available data, research and information

2a) Using data from equalities monitoring, recent surveys, research, consultation etc. are there group(s) in the community who:

- ***are significantly under/over represented in the use of the service, when compared to their population size?***
- ***have raised concerns about access to services or quality of services?***
- ***appear to be receiving differential outcomes in comparison to other groups?***

Service User Equalities Information

Equalities monitoring information has been collected from data of some 1500+ individuals (Hospital Discharge referrals) from 1 Nov 2009 to 30 June 2011 and also, where available, from relevant ACS managers with responsibility for commissioning and contracting external services. For comparison, the Haringey population data is available in the 2008 Borough profile.

http://harinet.haringey.gov.uk/19821_boroughprofileguide_.pdf

2.1 **Key findings:**

- **Age** – the proportion of older people discharged as Hospital referrals as a proportion of the adult population in Haringey shows that there are higher proportions of older people in the upper age ranges from age 65 and up who will potentially use the reablement service. Table 2.1.4 shows that the majority of Hospital Discharge referrals are older people aged 65+ (87%) as against 9.4% of people of that age range in the Haringey population generally. 87.5% of current home care users of the internal service are aged 65+ (Table 2.1.3) which is roughly equivalent. This reflects the increased frailty and disabilities of people as they get older, therefore needing higher levels of support and assistance on coming out of hospital. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their chronological age meaning no disproportionate impact is anticipated against 'Age' in the future.
- **Sex** – no disproportionate impact identified. Tables 2.1.1 and 2.2.2 show a higher proportion of females to males discharged as Hospital referrals (58% female) against the borough gender profile (51% female); however, as with 'Age', this is broadly to be expected considering the changing profile of males to females across the age ranges 65 years and above (Tables 2.1.3 and 2.1.4). There are currently equal numbers of males using the current service as women; however, males are marginally under-represented (41% against a Borough profile of 49%) in terms of overall hospital discharge referrals. This could have something to do with the age profile of those referrals and general levels of life expectancy among the sexes. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their gender, therefore no disproportionate impact is anticipated against 'Sex' in the future
- There is a disproportionate impact identified with '**Race'**. It has been identified that there will be no disproportionate impact for Black or Black British, but Mixed, Asian or Asian British adults are, according to the data, under-represented in the current service – refer tables 2.1.5 and 2.1.6. 20% are from a Black or Black British background and 3% from Chinese/Other ethnic groups, identical to their profile in the general population. Less than 1% are from a mixed race background against a Borough profile of 4.6% and 5.3% Asian or Asian British against a profile of 6.7% although the numbers of Asian or Asian British using the current service is 10.7%. This may be due to the age profile of those populations, which are younger in general and thus less likely to need hospital

care. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their ethnicity, therefore no disproportionate impact is anticipated against 'Race' in the future

- As regards **'Disability'**, all older people referred to the Council as Hospital Discharges have met Council eligibility criteria (critical and substantial) as per DoH guidance, and are considered to have a disability as defined by the Equalities Act 2010. Fair Access to Care Services has been replaced with Guidance on Eligibility Criteria for Adult Social Care (2010) from the Department of Health, with the guidance retaining the four eligibility bands set out in Fair Access to Care Services – that is, Critical, Substantial, Moderate and Low. Haringey Adult and Community Services will continue to provide services to individuals who are assessed as having needs that are Critical or Substantial both inside and outside the new reablement service.
- **'Religion'** - Muslims would appear to be under-represented by roughly half (6% as opposed to a Borough profile of 11%) both in terms of the current list of users and overall numbers of hospital discharge referrals. Christians are seemingly under-represented (37% against a Borough Profile of 50%) among current service users. However, the numbers recorded as 'other religion' and 'not stated' are sufficiently high to account for all or some of this imbalance. Service users will be selected for the new reablement service on the basis of their reablement potential, rather than their spiritual beliefs, therefore no disproportionate impact is anticipated against 'Religion' in the future
- No disproportionate impact was identified in respect of **'Marriage or Civil Partnership'** or **'Sexual Orientation'.** There is no data for the protected characteristic of **'Pregnancy and Maternity'.**

Tables

Based on the number of Hospital Discharge referrals since 1st November 2009. These tables focus on individuals rather than the number of episodes created. A graph showing the number of Hospital Discharge referrals per hospital is however included for information purposes.

Table 2.1.1 Sex of people currently using the current in house home care service (July 2011)

Sex	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
Female	28	50%	51%	56.3%
Male	28	50%	49%	43.7%
Grand Total	56	100%	100%	100%

Table 2.1.2 Sex of people discharged as Hospital Referrals (1 Nov 2009-30 Jun 2011)

Sex	Total	Percentage	Haringey Borough Profile (all	Haringey Borough Profile

			adults)	(people over 60)
Female	916	58%	49%	56.3%
Male	644	41%	51%	43.7%
Unknown	11	1%		
Grand Total	1571	100%	100%	100%

Table 2.1.3 Age of people using the current in house home care service (July 2011)

Age	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
40-44	1	1.79%	8.7%	n/a
45-49	0	0	6.4%	n/a
50-59	2	3.57%	8.9%	n/a
60-64	4	7.14%	3.2%	27.4%
65-69	2	3.57%	2.9%	20.9%
70-74	12	21.43%	2.5%	19.1%
75-79	12	21.43%	1.8%	15.1%
80-84	6	10.71%	1.2%	9.0%
85-89	7	12.50%	0.6%	5.4%
90-95	9	16.07%	) 0.4%	) 3.1%
95+	1	1.79%	)	)
Grand Total	56	100%	100%	100%

Table 2.1.4 Age of people discharged as Hospital Discharge Referrals (1 Nov 2009-30 Jun 2011)

Age	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
18 - 24	1	<1%	31.5%	n/a
25 - 34	9	<1%	22.1%	n/a
35 - 44	24	1.5%	18.5%	n/a
45 - 54	61	4%	11.1%	n/a
55 - 64	116	7%	7.4%	27.4%
65 - 74	299	19%	5.4%	40%
75 - 84	544	35%	3.0%	24.1%
85+	516	33%	1.0%	8.5%
Unknown	1	<1%		
Grand Total	1571	100%	100%	100%

Table 2.1.5 Race of people using the current in house home care service (July 2011)

Race	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
White Total	39	69.6%	65.6%	75%
White British	31	55.36%	45.3%	
White Greek / Cypriot	3	5.36%		
White Irish	4	7.14%	4.3%	
White Other (please specify)	1	1.79%	16.1%	

Black or Black British Total	11	19.6%	20%	13.9%
Caribbean (Black or Black British)	7	12.50%	9.5%	
African (Black or Black British)	4	7.14%	9.2%	
Asian or Asian British Total	6	10.7%	6.7%	6.7%
East Asian African (Asian or Asian British)	1	1.79%		
Indian (Asian or Asian British)	2	3.57%	2.9%	
Kurdish	2	3.57%		
Pakistani (Asian or Asian British)	1	1.79%	1.0%	
Chinese or Other Ethnic Groups Total			3.1%	2.6%
	0			
Not Stated Total				0%
	0			
Grand Total	56	100.00%	100%	100%

Table 2.1.6 Race of people discharged as Hospital Discharge Referrals (1 Nov 2009-30 Jun 2011)

Race	Sub Ethnicity	Total	%	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
White	British	732		45.3%	
	Irish	104		4.3%	
	Any other White Background	222		16.1%	
White Total		1058	67.3%	65.6%	75%
Mixed	Black and White	3			
	White and Asian	1		1.1%	
	White and Black African	1		0.7%	
	White and Black Caribbean	4		1.5%	
	Any Other Mixed Background	2		1.3%	
Mixed Total		11	<1%	4.6%	1.8%
Asian or Asian British	Indian	37		2.9%	
	Pakistani	2		1.0%	
	Bangladeshi	11		1.4%	
	Any Other Asian Background	34		1.6^	
Asian or Asian British Total		84	5.3%	6.7%	6.7%
Black or Black British	Caribbean	210		9.5%	
	African	78		9.2%	
	Any Other Black Background	21		1.4%	
Black or Black British Total		309	19.6%	20%	13.9%
Other Ethnic Groups	Chinese	8			
	Any other group	39			
Chinese or Other Ethnic Groups Total		47	3%	3.1%	2.6%
Not Stated	Information Not Yet Obtained	61			
	Refused	1			
Not Stated Total		62	3.9%		0%
Grand Total		1571	100%	100%	100%

Table 2.1.7 Disability of people using the current in house home care service (July 2011)

Primary Disability	Total	Percentage
Blindness or partial loss of sight	4	7.14%
Deafness or partial loss of hearing	4	7.14%
Dementia	2	3.57%
Mental Health	5	8.93%
Other disabilities (please specify)	2	3.57%
Physical Disability	21	37.50%
Physical Frailty	18	32.14%
Grand Total	56	100.00%

Table 2.1.8 Disability of people discharged as Hospital Discharge Referrals (1 Nov 2009-30 Jun 2011)

Primary Disability	Total	Percentage
Physical disability frailty and sensory impairment	1389	88%
Mental health	93	6%
Vulnerable people	75	5%
Learning disability	12	<1%
Substance misuse	2	<1%
Grand Total	1571	100.00%

Table 2.1.9 Religion of people using the current in house home care service (July 2011)

Religion/ Belief	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
Christian	21	37.50%	50.1%	70.8%
Jewish	1	1.79%	2.6%	3.9%
Muslim	3	5.36%	11.3%	5.0%
No religion	2	3.57%	20%	6.6%
Not Stated	16	28.57%	11.0%	10.6%
Other (please specify)	13	23.21%	0.6%	0.4%
Grand Total	56	100.00%	100%	100%

Table 2.1.10 Religion of people discharged as Hospital Discharge Referrals (1 Nov 2009-30 Jun 2011)

Religion/ Belief	Total	Percentage	Haringey Borough Profile (all adults)	Haringey Borough Profile (people over 60)
Not Stated	572	36%	11.0%	
Christian	551	35%	) 50.1%	
Catholic	151	10%	)	
Greek Orthodox	66	4%	)	
Muslim	80	6%	11.3%	
Buddhist	5	<1%	1.1%	
Hindu	32	2%	2.1%	
Jewish	29	2%	2.6%	
Sikh	1	<1%	0.3%	

Other Religion	29	2%	) 0.6%	
Rastafarian	1	<1%	)	
No Religion	54	3%	20%	
Grand Total	1571	100%	100%	

Table 2.1.11 Sexual Orientation of people using the current in house home care service (July 2011)

* office of National Statistics, Integrated Household Survey, September 2010

Sexual Orientation	Total	Percentage	National Data*
Heterosexual	25	45%	94.5%
Bisexual			0.5%
Gay			1.0%
Lesbian			0.5%
Other			0.5%
Not known/disclosed	31	55%	3.0%
Grand Total	56	100%	

2b) What factors (barriers) might account for this under/over representation?

2.2.1 Age

Over 85% of hospital discharge referrals in the past 18 months are over 65 years of age of which a third are aged between 75-84 and a further third are over aged 85. The nature of reablement is such that it predominantly impacts on the vulnerable people for which it is intended – ie older people. This reflects the increased frailty and disabilities of people as they get older, therefore needing higher levels of support and assistance to return to living independently when they are discharged from hospital.

2.2.2 Sex

Nationally, women tend to live longer than men – in Haringey the life expectancy of men is currently 76.3 years of age, whilst for women it is 83.1 years of age[1]. Therefore it is expected that there are higher numbers of older women using this service given the general age profile of hospital discharge referrals/users of current services.

2.2.3 Race

There is no disproportionate impact for people from a Black and Black British or Chinese and Other ethnic background. Mixed and Asia/Asian British ethnic backgrounds are under-represented in terms of hospital discharge referrals in the period from Nov 2009 to Jun 2011 but among current users, Asian/Asian British are over-represented – 10.7% against a Borough profile of 6.7%. Using the same comparators, White and White British are marginally over-represented in terms of hospital discharge referrals or accessing the current service: 67/69% against a Borough profile of 65% but under-represented against the profile of those aged over 60 across the Borough. There may however be no actual barriers (see paragraph 2.1).

2.2.4 Disability

The nature of reablement is such that it predominantly impacts on the vulnerable people for which it is intended – i.e. older people. Over two-thirds of hospital discharge referrals have a physical disability or frailty either permanently or temporarily. This reflects the increased frailty and disabilities of people as they get older in areas such as increased

1 Haringey Borough Profile 2010

risks of falls, therefore needing higher levels of support and assistance to return to being confident in living independently when they are discharged from hospital.

2.2.5 Religion
The bulk of users of this service are Christian. Muslims appear under-represented but this might be accounted for in the high numbers recorded in the categories 'not stated' and 'other religion'. No other disproportionate impact identified.

2.2.6 Gender Reassignment
No disproportionate impact identified. None of those users of the current service identified themselves as going through 'gender reassignment'.

2.2.7 Sexual Orientation
No disproportionate impact identified. None of those users of services going through the current service identified themselves as gay, lesbian or bi-sexual.

2.2.8 Maternity and Pregnancy
No data.

Step 3 - Assessment of Impact

3a) How will your proposal affect existing barriers? (Please tick below as appropriate)

	Increase barriers	Reduce barriers	No change
Service Users			**X**
Staff	**X**		

3.1 **Summary of impact of proposals**

This assessment considers the impact on users/potential users of services of the proposal to close the current in-house home care service and introduce a new Community Reablement Service in relation to the protected equalities groups of ethnicity, gender, age, disability and religion or belief. It does not consider issues relating to sexual orientation and gender reassignment or maternity/pregnancy, as the data is not available/relevant for these groups

3.1.1 Impact on Age:
Older people over the age of 74 would appear to be disproportionately impacted by this proposal, representing, as they do, some two-thirds of those people who are discharged from hospital. However, this is a positive impact due to the fact that the new service will be increasingly flexible and centred around their needs rather than the needs of the service, and will ultimately increase their levels of independence and save them money.

3.1.2 Impact on Sex:
More women than men would appear to be potential users of this service (58% versus 41%) based on the data. This figure is higher than the overall Borough profile

for adult women (49%). However, the figures for both sexes are far closer when comparing user rates with the number of men and women in their sixties and over in the Borough. This is a positive impact due to the fact that the new service will be increasingly flexible and centred around their needs rather than the needs of the service, and will ultimately increase their levels of independence and save them money.

3.1.3 Impact on Disability:
All users of the in house home care service are considered to have some form of disability either temporary permanent in order to be eligible for the service. Therefore the proposals will have an impact on people with a disability.

3.1.4 Impact on Race:
In broad terms the groups affected by these changes are consistent with the overall borough profile for ethnicity. Therefore no significant adverse impact has been identified for any particular ethnic group. The sole criteria on which people will be selected for this service is on the basis of their ability to be re-abled.

3.1.5 Impact on Religion:
In broad terms the groups affected by these changes are consistent with the overall borough profiles for religion/belief. Muslims appear under-represented and Christians appear under-represented among current service users. However, these figures may be misleading given the high percentages under the 'other religion' and 'not stated' categories. . The sole criteria on which people will be selected for this service on the basis of their ability to be re-abled.

3.1.6 Impact on other protected characteristics:
There is no adverse impact identified in respect of the other protected characteristics – that is: sexual orientation, gender reassignment. The protected characteristic of pregnancy and maternity and marriage and civil partnership is not known or not relevant.

3.1.7 Impact on staff:
The workforce implications of the proposed changes are covered in separate organisational restructure EqIAs.

3b) What specific actions are you proposing in order to respond to the existing barriers and imbalances you have identified in Step 2?

3.2 **Mitigating Factors**

3.2.1 The needs of the protected groups identified as potentially most adversely affected by these proposed changes (i.e. older people). will be addressed through a person centred approach to planning with individuals. This approach will focus on an holistic assessment of needs which will inform clear and documented reablement goals. The approach will specifically address provision of the service in the wider context of their cultural, spiritual and social/emotional needs An approach will be taken with older carers that will include a focus on "future planning" and planning in case of emergency that may arise due to ill health /hospitalisation. All reablement plans will take account of the outcomes determined by the service user.

3.2.2 Our performance indicator for delayed discharges from hospital is “excellent”; we do not see this situation changing; if anything, it will continue to further improve as a result of the new reablement service.

3.2.3 If this proposal is agreed, all remaining long-term service users will be reviewed and passed over to an independent sector provider, on the same size care package, in consultation with them and their families. There are currently 4 long-term service users (Sept 2011) remaining in the home care service and there is sufficient capacity available in the independent sector to take over their care.

3.2.3 The alternative providers are regulated by the Care Quality Commission and only good and only services previously rated as “good” or “excellent” will be will be used. There are a considerable number of CQC registered home care providers (circa 80) in the independent sector and there is sufficient capacity and quality in the independent sector to take over their care.

3.2.4 Front-line staff will communicate between themselves and the central office, using service-supplied mobile phones. This model will enable people who receive the service to adjust the input they receive, according to their wishes on that particular day and will give much increased flexibility to the service user on a daily basis, for example, getting up times, meal times, times for rehabilitation/reablement activities and the time devoted to such activities.

3.2.5 As previously stated, we will not be charging for this service.

3.2.6 It is clear from a range of sources, most recently the Audit Commission “Improving Value for Money in Adult Social Care” (June 2011) that a well-run reablement service is capable of generating direct efficiencies and that other local authorities (21%) have already begun or completed the process of outsourcing the home care services and are converting the remainder to providing a reablement approach. 54% of all Councils have made efficiencies by using reablement and other intermediate care schemes. 81 Councils have cited reablement in their 2009/10 efficiency statements (See Appendix 1 - What is a successful Reablement Service?).

3.2.7 This process will be carried out in the wider context of readily accessible guidance, based on best practice as set out by the Department of Health, via the Care Services Efficiency Delivery (CSED) work stream.

Creating and supporting an effective reablement team

3.2.8 These reablement workers will receive specialist training where they are assessed not to have the competencies and skills already in order to enable them to work **with** people to increase their independence, rather than do things **for** them in a way that makes them dependant. This will improve an individual clients’ quality of life and future prospects for independence.

3c) If there are barriers that cannot be removed, what groups will be most affected and what Positive Actions are you proposing in order to reduce the adverse impact on those groups?

3.3.1 **Users of services** - We do not envisage that there are barriers arising from existing delivery model that would made worse by a move to the delivery model in 3(b) above. However, there will be continuous monitoring through contact with social workers, consultation with service users via organisations such as the Haringey LINk and the Older Peoples Forum, Learning Disabilities Carers Sub-groups and other stakeholder groups on how the new model is working. We will use the feedback from these in the years to come to identify areas that will need market development, and where necessary, corrective measures will be put in place. We will also proactively work with the wider voluntary sector, in particular in relation to the use of available trained volunteer support to target those service users who could benefit from "light touch" monitoring that can be offered during and after the six-week reablement period, thereby empowering those older people to return sooner to living their lives independently

3.3.2 **Staff** – there is a separate EQIA dealing with staffing issues.

Step 4 - Consult on the proposal

4a) Who have you consulted on your proposal and what were the main issues and concerns from the consultation?

4.1.1 Haringey Council is committed to involving the users of services and others in decisions that affect them – especially decisions about the care and support services they receive.

4.1.2 We have consulted directly with some 200 people referred to Adult Services for this service since leaving hospital in January 2011. We have also contacted NHS, voluntary and independent sector colleagues, including Age UK, sought the views of the Older Peoples and Carers, Learning Disabilities Partnership Boards and the wider public via social media and other local networks.

When we consulted

4.1.3 The consultation ran for one month from 1st to 31st August 2011 to enable sufficient time to talk to people about the proposals and give them time to respond.

How we consulted

4.1.4 There were several main channels for the consultation, as set out below:

Consultation web page, email address and telephone helpline

4.1.5 A web page (Community Reablement Service Consultation) was created to ensure people were able to read about the proposals and kept informed of the consultation. The web page has received 74 viewings.

4.1.6 We didn't, however, rely on this electronic means of communication, especially for those without access to the internet.

Consultation Questions

4.1.7 We also produced hard copy versions of the survey questionnaires so that users of services and others could respond to specific questions and/or add comments of their own about the proposed changes.

4.1.8 It was also a way of capturing equalities data that would help us to determine alongside the other information we had collated, the Equalities Impact of our proposals and allowed people who wanted to, to have their say anonymously.
The other reason for the questionnaire was that we not only wanted to know what people thought of the proposal but for people to help commissioners of services and others shape future services in the Borough if the proposed changes went ahead.

Overall structure of the questionnaire

4.1.9 The questionnaire invited respondents to indicate:

1. Their support or opposition to the proposal and our commissioning intentions
2. Say why they supported or opposed the proposal
3. Provide details about themselves

4.1.10 This amounted to 2 key questions and 2 free-text boxes to enable people to have their say.

4.1.11 In total, some 200+ questionnaires were produced according to the perceived needs of the service user group. These were produced in both printed and electronic forms with copies made available for completion via the web page, sent out to users of services, Older People and Carers Partnership Boards, NHS, voluntary and independent sector colleagues and others. Freepost envelopes were made available so that people could return completed questionnaires 'free of charge'.

Letters and e-mails

4.1.12 The Council recognised the anxiety caused by the proposals and the need to keep people informed as a way of minimising this. Inaugural letters and emails were sent to users, health, voluntary and independent sector colleagues (primarily via HAVCO and Haringey Link) and others (see 4.1.14 below).

Partnership working

Community and voluntary sector

4.1.14 A local network of the independent and voluntary sector, the local online community and NHS colleagues were also used to promote the consultation with the likes of Haringey Association of Voluntary and Community Organisations (HAVCO) reaching a membership of over 1400 and Harringay Online, the Haringey Health and Social Care Local Involvement Network (LINK), Carers and the local NHS reaching a wide range of others, including NHS Discharge co-ordinators, GPs, members of the online community and individuals and community group representatives in Haringey working to improve the way Health and Social Care Services are delivered.

4.1.17 We made sure that details of the web page as well as other details, including how people could contact a single point of contact within the council (FeedbackandSupport@haringey.gov.uk and telephone query line: 020 8489 1400) should they wish to, for more information or in order to have their say were also made widely available and ensured that this information was included in all correspondence.

Consultation with Staff

4.1.18 We have done our best to work with staff during the course of the consultation to enable them to contribute to the consultation process, to come to terms with the

impact of the potential closure of the home care service and creation of a new reablement service and to identify ways in which we can mitigate against compulsory redundancy by identifying those employees who have decided that they want to leave voluntarily as well as identifying suitable redeployment opportunities for those that don't – should the proposals be agreed. These redeployment opportunities will include the possibility of joining the new reablement service.

4.1.19 Formal and informal staff consultation took place from 20th Dec 2010 until 31st Aug 2011. This was conducted via individual letters to staff, Formal Staff Consultation meetings with trade union representatives and several staff briefings with those members of staff affected were held, including 5 face to face briefings and question/answer sessions which were carried out during August 2011. The purpose of these meetings was to explain the process and provide information on the new reablement service and how it will work, as well as receive comments back to inform the ongoing development of the service business systems. Some of these comments have been incorporated in the plans for the new service, and will continue to be so incorporated, as they arise, subject to the needs of the service.

Consultation – Summary of what people said

4.1.20 **Impact for users, relatives and carers**

Some said a new Community Reablement Service seemed a good thing, sounded great on paper and said how they were looking forward to seeing the service up and running. Others were content with the changes proposed, provided the current quality and standards were maintained or wanted them to go further – for example, providing help with shopping. Some welcomed the idea of a more structured, 6-week, plan of care after hospitalization and better training of staff.

Some said they needed a service such as this and that others would benefit from its introduction. Others said a lot of thoughtful research had clearly gone into this proposal or how the increased independence would bring them 'piece of mind'.

There were worries however over how existing users of services and home carers would be absorbed into the new service. Worries were also expressed about the short-term nature of the provision by those who said they needed long-term care and how 6 weeks would do nothing for them. There were queries as to the steps the Council was taking to ensure independent providers met the new scheme's standards. Others were worried that they would no longer be seen by the same people everyday as they had built up friendships and trust with staff concerned.

Those who disagreed with the proposal said that closing the current home care service would inconvenience those who already used the service, were worried that it would affect their well-being, or considered that the financial impact of this proposal would have a dramatic effect on users of the service. Others were dismissive of everything the Council did.

4.1.21 **Trade Union view of impact on service and staff**

Unison's view is that the proposed changes would result in a narrowing of the current service provision and amount to a reorganisation of the current Home Care service. Concerns were raised as to what would happen to those people who came out of

hospital and for whom, the more "traditional" Home Care skills would still be relevant. Consideration also ought to be given to allowing service users longer than six weeks of input if it is reasonable to believe that they will benefit from this given the fact, for example, that there can sometimes be delays in delivering equipment to service users, which can delay their recovery.

One of the other features of the service unions highlighted is that people needing support after an initial six-week period of reablement would be passed onto private sector agencies. Whereas this, they argued, already happened with the current service, Unison's principal objection was to making greater use of private agencies in the provision of Home Care, and its belief that Home Care should be provided by in-house services.

Unison was concerned that barriers were being put in the way of current staff applying for posts in the Reablement service. Those barriers include the requirement to drive a car, a lack of flexibility in the staff rotas, and the proposal for, and nature of, the selection process.

They were also concerned that 'rhetoric during the consultation' as they saw it "had been designed to put off some staff", noticeably women with childcare or other caring responsibilities and those holding down second jobs, from applying or that that there were suggestions that some staff were not "the right people for the job". The lack of flexibility was therefore seen as impossible for many staff of what was a predominantly female workforce.

During the consultation, Home Carers had made clear that they already carry out Reablement work within their current roles and reablement was an integral part of the current Home Care service in Haringey. In Unison's view, the current workforce would be more than capable of carrying out the requirements of the new roles and/or should be retrained to do so.

Other staffing issues raised sought clarification around ring fences and confirmation of the actual number of posts have been addressed in the staffing EQIA and/or management's response to the formal staff consultation.

Age Concern was also concerned about maintaining the right staff numbers and skills, particularly during peak times and wanted more information on the size and structure of the proposed team. It also felt the proposal forgot to mention the support trained volunteers could offer during and after the six week reablement period.

4.1.22 **Comments on the proposal**

A total of 12 completed questionnaires were returned by post. No on-line questionnaires were completed although the consultation web page New Community Reablement Service Consultation was viewed some 74 times.

42 % (5) of respondents either strongly agreed or agreed with the creation of a new Community Reablement Service. 33% (4) strongly disagreed or disagreed and a further 25% (3) neither agreed nor disagreed.

42% (5) of respondents either strongly agreed or agreed with the commissioning intentions (actions) identified. 25% (3) strongly disagreed or disagreed and a further 33% (4) neither agreed nor disagreed or did not say.

The proposal was of particular interest to AgeUK Haringey because the majority of users of the proposed reablement service are older people.

AgeUK Haringey broadly supported the proposal, particularly the intention to abolish time slots and provide increased flexibility in timing, duration and content of visits and to work with clients as opposed to do things for them.

AgeUK saw the success of the service depending on the accountability and competencies of the Team and welcomed the inclusion of the need for positive attitudinal behaviours in staff competencies. However, AgeUK said that it would like:

- a clearer statement of intention to establish a closer working relationship between the reablement team, care agencies and the wider voluntary sector.
- A commitment to a reablement plan that takes account of outcomes determined by the client.
- A robust monitoring regime, an effective and easily accessed complaints service and the availability of independent advocacy.
- From the outset, appropriate technology to monitor time spent with individual users of services.

AgeUK Haringey also said that it was actively considering ways in which its own organisation could add value to reablement and offered to help and felt that independent sector partners could be used to provide all long term home care in Haringey. It also thought the Older People's Partnership Board could have usefully discussed the proposal before any final decision was taken.

AgeUK also sought several other clarifications of detail about the proposal.

Haringey Disability First Consortium (HFDC) found the proposal, in general, hard to comment on. In its view, there was very little detail about the team, the competencies of the team, and how the services to refer onto would be funded. Haringey Disability First Consortium also reiterated its concern that there was a real need for independent advocacy and brokerage in the borough to enable this, and other changes, to work effectively for the most vulnerable.

Haringey Disability First Consortium welcomed the desire to promote independence, flexibility and being 'customer focused' alongside creating and maintaining closer links with external agencies. It was concerned however about the lack of clarity and specificity on certain issues:

- How, within this consultation, the Council was defining "individual complex cases" and "safeguarding concerns" and who at the point of delivery would be assessing the same?
- How the Council was defining 'independent sector partners', and how does this differ from external agencies and "contracted providers in the independent sector"?
- How the council would ensure that there were appropriate external agencies to refer to after the 6 weeks?
- The 'financial assessment'

- ‘An individuals’ quota of timeslots
- How the council would ensure that there was not a gap in service prevision between coming off the 6 weeks, getting assessed (potentially appealing) and brokering services?
- Who decides “if [it is] necessary”?
- Whilst ‘front loaded’ support may work for some, many people discharged from hospital only want to sleep for the first week (this is part of getting better too!). Is there a way of being flexible on this as some patients will benefit from front loading, others from back loading?
- What is meant by ‘Crossing professional boundaries’ There would be serious safeguarding concerns about using PA/care staff to do the work of OT/ physio?
- Given Haringey Disability First Consortium’s concerns about gaps in the current training, who would be providing the “specialist training” and what competencies would be required.
- Whether ‘supervision’ was seen as contact or non-contact and that 30% included AL/sick leave/travel.
- As training is absolutely vital to this proposal working, what safeguards the council has put in place to ensure that training and supervision do not get lost within the 30% non contact time
- Who and how will there be monitoring of 70/30 split and the competency of the workers
- Who will be doing the frequent reviews? Will this eat into the hours of reablement, or the 30% non contact time?
- How will those individuals who are assessed, either at point of discharge or within the 6 weeks, as being likely to need ongoing support be handled

4.1.23 **Comments on the consultation**

Others have questioned the consultation itself and said that they saw little point in putting time, effort, goodwill and expertise into responding when, having, as they saw it, “pointed out the pitfalls”, the proposal would go ahead anyway. Unison queried why existing Home Care staff were not, in its view, involved in the development of the proposals for this service arguing that frontline staff’s input could have improved the proposals.

Whilst Haringey Disability First Consortium welcomes the Council’s commitment to involving users of services and others in decisions that affected them, it was very concerned that the processes used by the council did not support this commitment in that:

- Haringey Disability First Consortium was not considered a ‘target’
- the timescale was only a month

- the document was not produced in plain English
- the document was only distributed electronically

there seem to be gaps in training around reasonable adjustments, disability equality and statutory obligations in the team administering this and other consultations at a time of significant change.

This was, it argued, despite the priority in the council's Disability Equality Scheme to "ensure disability equalities principles are mainstreamed

The Haringey Forum for Older People felt that the consultation period had been insufficient for them to comment, and requested a meeting to put forward their views on the proposals.

4b) How, in your proposal have you responded to the issues and concerns from consultation?

4.2.1 ***Users of Services -*** We have sought to reassure people of the mitigations in place. There is no change to Haringey Council's eligibility criteria to access adult social care services, so if a vulnerable adult is assessed as needing services s/he will continue to receive services after the end of the reablement phase. We will ensure that there are appropriate transitional arrangements in place for those few long-term users of services in receipt of services during any transitional period from the current home care service to the new reablement service. We will follow communication of the outcome of the decision; produce guidance for future users of the reablement service as to what they can expect of the service with answers to Frequently Asked Questions, seeking to address any concerns in the process. Research by CSED indicates that six-weeks is the optimum period for reablement to be effective – all necessary long-term care after that period will be supplied by an external supplier – nobody who requires long-term care will not receive it, as is currently the case.

All external suppliers are independently inspected by the Care Quality Commission and only those seen as "good" or "excellent" will be used. The Council is also currently piloting its own Accreditation Scheme for a range of social care services, including home care suppliers. A specific management response to the detailed comments received from Age UK is appended to the Cabinet report, which includes a commitment to individualised support planning during and after the reablement period, a multi-disciplinary approach to reablement, use of volunteers to enhance the reablement process and after (as appropriate), specialist training to assist stroke recovery and the fact that all charges for services are made in the context of a statutory national framework which regulates charges for social care services.

The process of developing the policies and procedures for the new reablement service will include ongoing dialogue with all interested parties, including those in the voluntary sector. However, there would be an impact on service budgets of extending the reablement service beyond six weeks, due to lack of affordability.

4.2.2 **Staff -** We have allowed sufficient time after any decision to ensure that, if the decision is taken to close the in house Homecare service, we will be able to work with staff to arrange alternative outcomes that best meet their individual needs and provide them with the support they need. Issues raised have been addressed in a separate staffing EQIA and in management's formal response to the trade union

comments, which is appended to the Cabinet report. Some of the suggestions made by staff and the trade union during the consultation discussions, in particular to rota patterns, car driving and the nature of the selection process, have directly influenced the planning of the new service and how staff will be selected. Many of the current staff will be recruited to the new reablement service via the Council redeployment processes. A specific management response to the comments from UNISON is appended to the Cabinet report, which deals with issues of staff selection for the new service, rota patterns and a number of other issues. A specific management response to the detailed comments from HDFC is appended to the Cabinet report which deals with issues of service flexibility and responsiveness to the needs of service users, training and supervision arrangements for staff, issues of the ratio of contact time/non-contact time and transition arrangements to a long-term care service, should that be necessary.

4c) How have you informed the public and the people you consulted about the results of the consultation and what actions you are proposing in order to address the concerns raised?

Details of the consultation are contained in the report to Cabinet, which has been placed on the Council website along with this EqIA. This has been widely made available beforehand.

Step 5 - Addressing Training

Do you envisage the need to train staff or raise awareness of the issues arising from any aspects of your proposal and as a result of the impact assessment, and if so, what plans have you made?

5.1 Staff in the new service are there to encourage and motivate service users to maximise their own skills so that they can do specified tasks within a timeframe rather than doing tasks for them. Home care workers are already experienced and well trained and we will be positively looking to appoint as many of these staff as possible, and build on their current skills and knowledge.

However, the reablement service will be operating using a different conceptual framework than that current in the in-house home care service. As a consequence staff training/re-training will be provided during the two weeks leading up to 'go live' for those staff selected for the reablement service in order to ensure the required adjustment in approach. It will be re-enforced by on-going supervision and appraisal. Job descriptions identify the skills and competencies required to deliver services differently. During the selection process, we will ask staff to evidence relevant skills and competencies where it is justified or indicate their willingness and ability to train for it where it not a justifiable requirement for staff to have this in the first place.

The training needs of staff will be independently audited through the Care Quality Commission inspection process which sets out a number of core training requirements, including equalities.

This will be identified as a key action in section 8 and will be expanded in Phase 2 of this EqIA once the new business processes, policies and procedures have been put in place

Step 6 - Monitoring Arrangements

What arrangements do you have or will put in place to monitor, report, publish and disseminate information on how your proposal is working and whether or not it is producing the intended equalities outcomes?

6.1 We will be using the Council's equalities monitoring form and reporting procedures to track the actual effects of the new delivery model when implemented and where adverse impacts are identified steps will be taken to address them. The form has been recently updated to include the new equalities protected characteristics identified by the Equality Act 2010.

6.2 Monitoring arrangements will include:

- Direct monitoring of the impact of the changes on the performance of the teams including hospital discharge data, user and staff satisfaction levels, duration of service and level of care package at the end of service.
- Quality assurance of providers through Adult and Community Services new Accreditation Framework, which is currently being rolled out across all provider services
- Analysis of complaints and user feedback (feedback forms will be issued to all users of the service at the start of this new service)
- Results of an audit we've conducted of people who have 'piloted' the service since January 2011 which will be used as a baseline for further audits and comparisons.

6.3 Engagement with providers and partners will include:

- Ongoing work by Market Development.
- Routine forums with health colleagues
- 'Cold calling' process for quality monitoring

- ***Who will be responsible for monitoring?***

6.4 The relevant Heads of Service will be responsible for monitoring the equalities impacts of the proposals. Commissioning will need to continue to ensure that providers are meeting the needs of their users, including those protected groups highlighted through this Equalities Impact Assessment are protected from any potential discriminatory practice, including ensuring an appropriately balanced staff group in terms of equalities strands.

- ***What indicators and targets will be used to monitor and evaluate the effectiveness of the policy/service/function and its equalities impact?***

6.5 The 'personalisation' of social care process has built in systems for review, risk assessment and quality assurance for those clients who require an assessed service as a result of the proposals. Data relating to those clients will be collected and analysed by equalities strands.

- ***Are there monitoring procedures already in place which will generate this information?***

6.6 Standard equalities monitoring documentation already exists and will be used. This includes contract monitoring and performance management arrangements of external organisations. Adult Services has a specific team responsible for generating and analysing performance and quality monitoring data

- ***Where will this information be reported and how often?***

6.7 This information will be reported quarterly to Adult and Community Services Divisional Management Meetings and Adult and Housing Services Directorate Management Teams.

Step 7 - Summarise impacts identified

	Age	Ethnicity	Disability	Sex	Religion	
Users of Services	This has a disproportionate impact for elders aged 75-44 and the very old (85 and over) with these two groups alone accounting for over two-thirds of hospital discharge referrals.	No disproportionate Impact identified*	This has a disproportionate impact for those with a physical disability or frailty. This is to be expected given the high numbers of Older People who would be using the service.	No disproportionate Impact identified* Men are marginally under-represented (41% of hospital discharge referrals against Borough profile of 49%).	Muslims would appear to be under-represented among both current users and referrals discharged from Hospital over the course of the last two years (6% versus Borough profile of 11%). Christians appear to be under-represented among users of the current service (37% versus 50%). These figures may however be misleading.	No disproportionate Impact identified with regard to sexual orientation and the other protected categories
Staff	Disproportionate Impact identified particularly age ranges at the 45-54 and 55-64 age	Disproportionate Impact identified for BME staff in this group.	No disproportionate Impact identified*	Disproportionate Impact identified – 98% of the Homecarers are female.		

	groups.					

* **'No disproportionate Impact identified'** signifies that the percentage of people using the particular service is not significantly different to the overall Borough profile of all users of the service. All settings have been compared individually against Borough overall figures in the summary spreadsheet

Step 8 - Summarise the actions to be implemented

Please list below any recommendations for action that you plan to take as a result of this impact assessment.

Issue	Action required	Lead person	Timescale	Resource implications
Project Implementation	A project board sponsored by the Deputy Director Adult and Community Services is in place to manage the arrangements around the proposals for the new service. Literature to be produced for future users of the reablement service as to what they can expect of the service with answers to Frequently Asked Questions, seeking to address any concerns in advance of entering the service.	Head of Assessment and Personalisation Head of Service (Older People)	Ongoing	Existing resources
Service Design	• We are planning to conduct ongoing QA audits of those who will use the service and will be monitoring hospital discharge and outcomes data, including size of care package on	Head of Assessment and Personalisation Head of Service (Older People)	From decision to March 2012 and onwards	Existing resources

Issue	Action required	Lead person	Timescale	Resource implications
	exiting the reablement service. We have already been auditing those who have gone through the 'pilot' since January 2011 – some 200+users of services in all. The results of this audit will feed into the detailed design of the new service that would be offered if the proposal is approved.			
Risks of need for other forms of support and care services in future	• Identifying non-traditional options and improving take-up of personal budgets • Commissioning more services in the independent sector capable of dealing with clients on personal budgets • Developing a diverse market in community based care/support services	Head of Assessment and Personalisation Head of Adult Commissioning	Ongoing July 2011-March 2012 Ongoing	Existing resources
Risk of insufficient capacity in home care market to meet surplus demand	• Commissioning and Market development work with existing and potential new providers in ensuring the right level of capacity (of the right quality) • Ensure capacity for specific disabilities requirements – dementia care, and learning disabilities	Head of Adult Commissioning	July 2011-March 2013 and ongoing	Existing resources
Improve equality monitoring in relation to transformed services	• Ensure that all service users in transformed services are fully equality monitored against the Equality Act 2010 categories	Heads of Services	Ongoing	Existing resources
Staffing issues	• Via senior management project review meetings, formal and informal staff	Heads of Services	Ongoing	Existing resources

Issue	Action required	Lead person	Timescale	Resource implications
	consultation meetings, interviews for roles within the new service and the budget monitoring review process. • Ensure a change process that is as smooth as possible for staff, that achieves as many deployments as possible and that processes VR requests as effectively as possible should the proposals to close the in house home care service be approved. • Following that, remaining staff then being referred to the redeployment co-ordinator. • Emphasise the benefits to staff of the 'supporting changes' package that has been put in place in terms of dealing with change and other forms of staff support. • Use Council flexible working arrangements where possible to facilitate the work/life needs of staff			
Training	• To check officers involved in the new Reablement Service, commissioning services directly, or through the market development function and, where appropriate, some NHS, voluntary and independent sector organisations, have received up to date equalities training. • Ensure reablement workers receive specialist training on reablement concepts and new processes, including working with stroke, to	Head of Assessment and Personalisation Head of Adult Commissioning Head of Service (Older People)	Ongoing July 2011-March 2012	Existing resources

Issue	Action required	Lead person	Timescale	Resource implications
	enable them to work **with** people to increase their independence, rather than do things **for** them in a way that makes them dependant. Competencies/skills required have been identified within the new Job Descriptions. During the selection process, we will ask staff to evidence skills and competencies where it is justified or indicate their willingness and ability to train for it where it not a justifiable requirement for staff to have this in the first place. There will be a two-week induction for staff appointed to the new service.			

Step 9 - Publication and sign off

There is a legal duty to publish the results of impact assessments. The reason is not simply to comply with the law but also to make the whole process and its outcome transparent and have a wider community ownership. You should summarise the results of the assessment and intended actions and publish them. You should consider in what formats you will publish in order to ensure that you reach all sections of the community.

When and where do you intend to publish the results of your assessment, and in what formats?

9.1 On the Council's website after all the EqIAs has been approved and signed off.

Assessed by (Author of the proposal):

Name: Lisa Redfern

Designation: Deputy Director

LISA REDFERN

Signature:

Date: 4th October 2011

Quality checked by (Equality Team):

Name: Helena Pugh
Designation: Policy, Equalities and Partnerships Manager
Signature: *Helena Pugh*
Date: 7th October 2011

Sign off by Directorate Management Team:

Name:

Designation:

Signature:

Date:

Appendices

Appendix 1 - **What is a successful Reablement Service?**
Appendix 2 – **Reablement: the new service model**

Appendix 1

What is a Successful Reablement Service?

A recent study of five well established reablement services highlighted the following as key features of successful reablement services:

- Working with people who have been discharged from hospital/A&E with the potential for independence;
- The ability to assess service users potential for independence, to encourage and motivate them, and to provide appropriate but reducing levels of support as the coping capacity of the service user increases and they gain confidence;
- Effective assessment and task planning set out in Reablement Plans;
- Prompt supply of equipment to service users and rapid access to occupational therapists for more complex assessments;
- Staff training/re-training and on-going supervision that underpins and reinforces that staff are there to encourage and motivate service users to maximise their own skills so that they can do specified tasks within a timeframe rather than doing tasks for them;
- Teams that are involved, well motivated, organised, deployed and rostered to work with service users in flexible ways that enable swift responses to the changing needs of service users and their increasing capacity over time following the initial inputs;
- Flexibility over the timing, duration and content of home visits;
- Close working arrangements at the front-line with Whittington Health community health based services such as Physiotherapists and Community Nurses; and
- Users needing long-term care are referred to external agencies after the initial 6 week period, with the possible exception of individual complex cases where there are safeguarding concerns.

Appendix 2

Reablement; the new service model

There will be two reablement areas, East and West with boundaries equivalent to those in the current home care service.

Front-line staff will communicate between themselves and the central office, using service-supplied mobile phones. In the future, these may also be used to 'touch in' and 'touch out' of the homes of service users to monitor time spent with individual service users and generate performance data for the service generally, for example, contact time/client. This model will enable people who receive the service to adjust the input they receive, according to their wishes on that particular day and will give much increased flexibility to the service provided on a daily basis, for example, getting up times, meal times, times for rehabilitation/reablement activities and the time devoted to such activities.

The service will not be charging for the reablement phase. A financial assessment will be carried out at the end of that time on the reduced package, if necessary. Ceasing charges will therefore enable the current time "slots" to be abolished and for a much more flexible and fluid system of visits to people to be put in place, front loaded to maximise input immediately after discharge and reducing the further the service user gets from that date. Priority tasks such as personal care can be done at peak times, and the workers can then return to carry out reablement training with service users when they are less busy.

The Team Manager/Team Leaders will work a 36-hour week, mainly Monday to Friday, but with the requirement to work in the evenings/at weekends on occasion, as the service requires. The reablement service will operate between 7am and 10pm, seven days a week, including Bank Holidays.

Community Reablement Workers and Senior Community Reablement Workers will work a standard 30-hour week. These hours will be worked on a 5 day/week rota basis, including weekends and bank holidays, Monday to Sunday. An early shift will either be 7-2 or 8-3 including an hour break; a late shift will be either 2-9 or 3-10 including an hour break. Staff may be asked to work a split-shift or long day on occasion but this will be seen as the exception rather than the rule. These hours of work are similar to those already in operation in the Councils' residential care homes.

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Registered Charity No. 1005145

Lisa Redfern
Deputy Director
Adult and Community Services
40 Cumberland Road
Wood Green
London
N22 8HQ

2nd September 2011

BY POST & E-MAIL

Dear Lisa,

Re: Community Reablement Service Consultation

This proposal is of particular interest to AgeUK Haringey because the majority of users of the reablement service are older people

We broadly support the proposal, particularly the intention to abolish time slots and provide flexibility in timing, duration and content of visits, and to work with clients rather than do things for them

We agree that the success of the reablement team will, critically, depend on accountability and the competencies of the team. We are pleased to note that staff behaviour (by which we assume positive and supportive attitudes towards clients) is included in the required competencies.

However we would like to:

- see a clearer statement of intention to establish a close working partnership between the reablement team and care agencies and the wider voluntary sector

and

- see a commitment to a reablement plan that takes account of outcomes determined by the client

Clarification of the "possible exception [to referral to external agencies after 6 weeks] of individual complex cases where there are safeguarding issues" would be helpful. For, example, would individuals whose needs cannot be met by external agencies be included? Would such an instance constitute a "safeguarding issue"?

In response to your consultation on Adult Social Care Savings earlier this year we emphasised how essential it would be that the Council robustly monitor performance and ensures that there is an effective and easily accessed complaints service, with

independent advocacy available. These points, strongly made at the Older People's Partnership Board, apply equally to the introduction of a new community reablement service.

It is unfortunate that the new Community Reablement Service and associated consultation paper will be presented to Cabinet without having been considered at the Older Peoples Partnership Board where, no doubt, it will have searching analysis.

As you know, we have also previously urged you to ensure that external agencies are monitored and themselves use appropriate monitoring (e.g. of time spent with individual clients). This monitoring both ensures accurate billing and crucially offers the client of home care increased control/flexibility. In the reablement support phase, albeit without charges, this monitoring is equally important as it is relevant to in-house provision.

In your "What will the service look like?" section we are pleased to note mention of both increased flexibility (of tasks) and 'the ability of clients to adjust the input they receive'. We feel strongly that a new service must commence with the appropriate technology to support the team to monitor time spent with individual services users from day one and not at some undetermined point in the future.

We would suggest that evaluation of the usefulness of the deployed 'touch in touch out' technology would form part of a time specific evaluation as new arrangements are introduced and we would like to:

- see a statement of how the performance of the reablement team will be monitored.

and

- see plans drawn up with service user to enable their involvement in critiquing the changes as they are being introduced.

You signal in your "Proposed changes to the staffing structure" section a staffing reduction of 25%. We are concerned about maintaining adequate staffing levels, in terms both of numbers and the correct skills mix, especially during peak holiday periods. It would be helpful to have

- more information on the size and structure of the proposed reablement team. (The figure of around 400 hospital discharges per year suggests that there will be some 50 clients at any given time.)

When in December 2011 we wrote to Barbara Nicholls offering to explore with her how we might work to unlock wider community support for older people - including low cost ways for older people to make their personal budgets go further – we were keen to explore how older people can gain from accessing all available support. We are still keen to explore this. Our thinking has progressed since we raised this with her and we are actively considering ways in which our own service offer adds value to reablement and is cost effectively priced to support individuals necessary re-socialising / confidence building.

We feel that reablement in Haringey can utilise independent sector partners to provide all long term home care. But, to maximise the local support available, resources do need to be deployed in a range of community delivered 'reablement wraparound' supports.

Lisa Redfern
2nd September 2011 / page 2

These would include, for example, practical tasks interventions to address known hazards in the home. The interim findings of York University's February 2011 Handyperson Evaluation (which includes money benefits calculated on the assumption that re-admissions are prevented) highlights that it is the preventative nature of the service that avoids costs elsewhere.[1]

The proposals without mention of the community context omit mention of the available interventions of trained volunteer support targeting 'light touch' monitoring that can be offered *during and after* the six week reablement support and thereby empower more older people to return sooner to living their lives independently.

I hope you find the suggestions made in this letter helpful. We would be very pleased to discuss them further with you and your colleagues as would we to have early sight of any paper that is to be presented as a result of your proposals in the light of consultation responses received.

Yours sincerely

Robert Edmonds
Director

cc: Mun Thong Phung
Barbara Nicholls
Anne Daley

[1] Handyperson Evaluation – Interim Key Findings, Dept for Communities and Local Government / University of York Feb 2011

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Dignity and Respect through Personal Service

Dear Robert

Re: - Community Reablement Service Consultation

Thank you for your letter of 2nd September 2011, addressed to Lisa Redfern (Deputy Director), which has been passed to me for a response as the relevant Head of Service. Your letter was sent in response to a process of consultation with key stakeholders about a proposal to close the in-house home care service and establish a new, smaller, reablement service to work intensively with some 400, mainly older people, following their discharge from hospital. This input would be for a period of six weeks, following which, were they still to require a care and support service, that service would be supplied in the longer term by one of a number of home care providers in the independent sector.

A report dealing with those proposals, initially agreed in principle by Members on 20th December 2011, is due to be finally signed off by Cllr Dogus, Cabinet Member for Adult and Community Services on 17th October 2011. The report will be published on the Council website in accordance with the usual arrangements. Your letter made a number of helpful comments and suggestions which have been incorporated into the body of that report and the Equalities Impact Assessment. This letter sets out a more lengthy response for your information and a copy will be appended to the final report for her information.

Firstly, may I confirm that the report now contains a clear statement of intent to establish a close working relationship between the reablement team, care agencies and the voluntary sector, as you suggested. In particular, the potential positive impact to be gained by the proactive use of volunteers during and after the reablement period, where appropriate, will add an additional dimension to the process of rehabilitation and eventual independence of long-term services being aimed for.

All reablement planning will be overseen by trained occupational therapists in the multi-disciplinary reablement team. As a consequence, all such plans will be goal-

orientated and will be working towards outcomes previously agreed with the individual service user, as basic good practice.

The reablement service will not be charged for during the first six weeks, but it is currently planned that, following that period of time, any ongoing need for support will be passed on to a provider in the independent sector to be met. Should there be safeguarding issues to be considered during the reablement period, these will continue to be dealt with as a parallel process and would not be seen as a reason for delay in transferring the case to an external provider. Only if a brief period of additional input were to result in a service user definitely becoming independent of long-term services would consideration be given to extending the six-week period of reablement for a couple of weeks, but no longer. Individual cases where external agencies felt they could not meet the needs of a service user would need to be analysed and the reasons resolved – however, this would not in itself be seen as justification for continuing reablement input.

We will, of course, be monitoring time spent with individual clients at an operational level, by use of the team leaders and senior reablement workers. Time spent will change on a daily basis, depending on the needs of the individual service users. However, as the service is not being charged for, what are more important are the outcomes for individual service users, so we will be concentrating our efforts to assess the effectiveness of the reablement service on those outcomes for service users – e.g. how many leave the service without any need for further input. We will be checking quality of service delivery by a combination of spot checks and cold calling, as well as an end of service satisfaction questionnaire which will, in part, ask the service user how the service might have been improved for them.

The size of the reablement team has been calculated to deal with approximately 400 hospital discharges per year. These will be selected against set criteria, but broadly according to their reablement potential, in order to get the maximum benefit for the intensive input they will receive. Allowing for annual leave, training and other absence, we estimate that each service user will receive just over two contact care hours input/day, on average, though this will be front-loaded to the first weeks in the service, to maximise their confidence and their drive to independence.

Finally, as part of the multi-disciplinary approach to this reablement period, there will also be individual assessments for fire safety, Telecare, the need for foot care in the wider context of falls prevention and a discussion with the service user/their family as to whether additional input to reduce social isolation is required. It is clear that an additional assessment as to whether the use of your Handy Person scheme could reduce identified hazards in the home would be a useful addition to that wider input, so that will be factored in.

Yours sincerely,

Len Weir
Head of Service

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UNISON COMMENTS ON THE INTRODUCTION OF A HOME CARE REABLEMENT SERVICE

Introduction

Existing Home Care staff have questioned why they were not involved in and consulted on the development of the proposals for this service. They are at the front line, carrying out the work with service users, and they already provide a Reablement service. Therefore, they may well have had useful knowledge that could have improved the proposals.

Management have been keen to state that this is not a "restructure" of the Home Care service; rather, that it is the closure of that service and the introduction of a new one. This has then been used in an attempt to suggest that some current Home Care staff may not be "suitable" for the "new service" and to justify creating barriers to them applying for posts within it. We do not believe that this is backed up by the available evidence. During the consultation, Home Carers made clear that they already carry out Reablement work within their current roles – that is, working intensively for short periods with people who have come out of hospital in order to maximise their independence, with a view to trying to ensure that they no longer need long term care support when the period of input has ended. The Home Care page on Haringey Council's website states that *"The Prevention and Enabling Team provides short-term intensive rehabilitation and support so that older people can regain skills to remain independent."* The council's service user guide for Home Care states that all staff receive specialist training in rehabilitation and enabling. Although the word "reablement" is not used, this is clearly what is being referred to here.

The Domicilary Care National Minimum Standards state that support is provided to help people to *"maximise their own potential and independence."* The standards dealing with Autonomy and Independence state: *"Care and support workers carry out tasks* with *the service user, not* for *them, minimising the intervention and supporting service users to take risks."* There is reference to the *"need to maintain and promote independence wherever possible, through rehabilitation and community support."* A further extract states: *"The purpose of the provision of personal care to people who are living in their own home is to sustain and whenever possible improve their independence. As well as ensuring their involvement in all decisions relating to their care this also means involving them and supporting them to assist in the care activities themselves rather than increasing dependence by taking over and doing everything for them."* The standards contain other references to promoting independence, and also refer to *"a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable service users to be able to return home following (or to avoid) hospitalization, or to prevent admission to long term residential care."* This is basically a summary of what Reablement is. It should be noted that this document was written in 2003

One of the features of the “new service” is that long term cases, those where support is needed after the six-week Reablement period, will be passed to private sector agencies. Our understanding is that this already happens in the current service, further undermining the claim that this is a “new service”.

A study by researchers at the University of York, *“Home Care Re-ablement Services: Investigating the longer-term impacts”*, states that Reablement is *“a particular approach within Home Care.”* Reablement is clearly an integral part of Home Care, and it already takes place within the current Home Care service in Haringey. More generally, the concepts of Reablement – intensive rehabilitation to prevent the need for further input, maximising independence, trying to support people to do things for themselves, flexibility to respond to changing needs - are firmly embedded within the existing concept of Home Care, and have been for some time, as shown by the extracts from the National Minimum Standards. The change that management are proposing is a narrowing of the current service, from providing Reablement plus other forms of Home Care to providing Reablement only, and a reduction in staffing levels. This is not the closure of Home Care and the opening of a completely new service; it is a reorganisation of the current Home Care service.

This leads to the question of why management have been so keen to try and claim that this is a “new service”. This is perhaps linked to management putting what amounts to barriers in the way of current staff applying for posts in the Reablement service. Those barriers include the requirement to be a car driver, a lack of flexibility for staff in terms of working hours, and the proposal for a written test as part of the selection process. Management are fully aware that these issues will put some people off applying or simply make it impossible for them to apply. In addition, management rhetoric during the consultation has clearly been designed to put staff off applying; for example, there have been repeated pronouncements that “some staff may not want to work in this way” and at one meeting staff were told that “we can’t base the service around your child care responsibilities.” Management have also spoken about “needing the right people for the job”, which suggests that some of the current staff may not be “right.” This is an unfair attack on a highly skilled, committed and experienced group of staff.

The fact is that the current workforce would be more than capable of carrying out the requirements of the new roles. We will not accept any of them not being successful in applying due to failing to meet unnecessary requirements, or because management do not consider them to be “right” for the service, an extremely vague concept that is open to abuse. We sincerely hope that management are not attempting to use this situation to get rid of staff they do not want. If any staff have capability issues or training needs, then these should have been addressed before now. Reorganisations of services (which this is, despite what management say) are not opportunities to address these issues by pushing staff out.

In the study referred to above, all five Reablement services that were looked at retrained their existing Home Care workers to take on new roles.

Ringfences

Details of who is in what ringfence have not been provided, despite the fact that this information is essential to any consultation. This should be provided as soon as possible. We also need confirmation of how many posts there will actually be, rather than just the number of full time equivalents.

There is some confusion over whether the ringfences for the Community Reablement Worker and the senior are open or closed. The documentation states that they are open, but management have said at consultation meetings that they are closed. We are concerned that there is a fundamental misunderstanding of what open and closed ringfences are. The only justification for having an open ringfence would be the proposed change in working patterns. Indeed, when faced with Home Carers' protestations that they already carry out Reablement work, this has been the only justification that management have been able to come up with for describing this as a "new service." Other than a proposed change in working patterns, the skills that will be needed for Reablement are essentially Home Care skills. It is true that the roles will involve staff carrying out some tasks that they are not currently expected to do, but training should be provided for these. It will also be the case that the new roles will require more of an intense focus on certain skills than others, particularly with regard to encouraging people to do as much as possible for themselves. However, the skills still sit comfortably within the term "Home Care."

Also, it is an unfortunate fact that some people who come out of hospital are not going to be able to regain the skills they had, and sadly some may not improve to any significant extent. For these people, staff will mainly just be providing personal care rather than Reablement, therefore some of what could be described as the more "traditional" Home Care skills – doing things for people who can't do them themselves – will still be relevant. The University of York study found that workers in Reablement services were still doing a significant amount of "traditional" Home Care.

Existing Home Carers are a highly skilled and committed group of staff who would be entirely suited to working in the Reablement service, particularly as they do such work already to some extent. If any additional skills are needed in the new role, then we believe that current staff could develop those skills with training.

Regardless of whether the ringfences are actually open or closed, we expect all the posts to be filled by existing Home Care staff, as the jobs are not substantially different to what they do now. We will not accept any Home Carer not being given a job because they do not drive, they need some flexibility in their working hours, or they have some literacy issues.

Selection process

The documentation states that selection will be by interview and a written test, and that there will also be an application form. As I have stated, staff are already carrying out Reablement tasks to some extent, and this is not an entirely new service. Therefore, staff should not have to complete a written application form. This is simply management putting up an extra barrier to prevent staff from applying. Staff should merely have to express an interest in the posts. If there are sufficient jobs for the number of people applying, then there should not be a selection process and staff should be slotted into the posts, as they are not substantially different from their current roles. In this situation, what may be appropriate would be for management to have a discussion with individual staff members about hours/working patterns, training needs, the requirements of the senior role, etc. This should not be a formal interview. The only reason that a selection process should be used is if there are more people applying than there are posts.

In terms of interviews, the proposal is that they will be *"based on the new job requirements and commitment for participating in furthering the aims of the new service."* This is unacceptable. The jobs involve working in a Reablement service, so the interviews should be about that. *"Commitment for participating in furthering the aims of the new service"* is

vague and ill-defined and therefore difficult for staff to demonstrate or for management to measure objectively. This is open to abuse, and there is a risk that this will be used to exclude people who management have already decided that they do not want in the service, or that staff will be prevented from being successful because they are deemed to not have the right “attitude”, a particularly nebulous concept. Interviews should only be used to pick the best candidates from those who have expressed an interest, on the understanding that all the candidates have the ability to do the job and there are simply too many people applying for the available posts.

In terms of the written test, our members have made clear that they do not accept this as a valid form of selection, and they overwhelmingly rejected it the last time it was proposed. A written test is not acceptable for a practical job such as this. We are concerned that there is a prejudiced assumption here that Home Carers will have literacy problems. There was a recent restructure of Care Management, where the roles require a much higher level of literacy, but there was no written test; why should Home Carers be treated differently? The fact is that Home Carers have to read and write in their job now; we accept that the new jobs may involve a larger element of reading and record keeping, but not to a substantially higher level than currently, and staff will still mainly be carrying out practical tasks. Also, management have claimed that most (if not all) staff have NVQ level 2; completing this would require a reasonable level of literacy, which further undermines the case for having to test Home Carers’ literacy before they take on new roles.

Management have openly claimed during the consultation that literacy is an issue for some staff. If management are aware that some staff have difficulties with literacy to the extent that it affects their ability to do their job, then these issues should have been addressed by now. Managers should have sensitively raised this, and offered a literacy assessment and then training through a Skills For Life programme. This training is free and readily available, and joint union/management Skills For Life work has taken place successfully with other employers in both the public and private sector. UNISON has tried for several years to get the council to take this seriously, with only partial success. In Adults, interest from management seems to have been minimal. Therefore, if it is being claimed that some staff do not have the required literacy levels to work in Reablement, we would say that this means that management have failed in their duty to ensure that staff have the necessary skills to do their job, they may have put both staff and service users at risk, and they have done so despite the fact that through Skills For Life there is a well-established way of addressing these issues.

Given that this is a management failure, no member of staff should end up without a post in the new service due to possible literacy issues. What we are suggesting is that management consider offering literacy training to staff now, in advance of the Reablement service being set up. This can be a contentious and upsetting issue for people, so it needs to be handled extremely sensitively and it needs to be emphasised that this is not about capability or being punitive. The union would be more than happy to provide support in explaining the benefits of Skills For Life training to staff.

Therefore, we are formally stating our objection to a written test being part of the selection process.

Flexibility

Staff have expressed deep concern at the proposed working hours and patterns. Some staff currently have certain work patterns due to caring responsibilities or other commitments. Some work part-time and have second jobs, which they need in order to make a reasonable living. The proposal is for all staff to be working shifts on 30 hours a

week contracts in a service that is provided between 7.00am and 10.00pm. This will be impossible for many staff. In addition to causing major difficulties to those who care for dependents, working 30 hours a week will mean that some staff will not earn enough to survive, yet it will be difficult for them to have a second job. Management said to staff during the consultation that “we can’t run the service around your child care needs.” Other inappropriate comments made by management include “nobody is forcing you to apply” and that staff should “sort out their child care arrangements” in advance of the service starting. The comments are unacceptable, especially to an almost entirely female group of workers, they show a lack of understanding of flexible working and they have caused a great deal of anger amongst staff. They feel that they are being asked to show flexibility whereas management are showing none. Many longstanding, skilled and committed staff may find themselves unable to work in the service due to this rigidity from management, and it would be a significant loss if such staff were prevented from taking on the new roles.

We do not expect the service to be run around the needs of staff. All we are asking is that management offer some flexibility as well as demanding it, and that they realise that in the modern world, good employers are offering working patterns that allow staff to have a positive work/life balance, recognising that this boosts morale and productivity. Legislation in recent years has also promoted greater flexibility at work. There is a level of agreement between unions and employers’ organisations on the benefits of flexible working, and even the coalition government seems to be intending to extend workers’ rights in relation to flexible working. In 2011, it is simply unacceptable to say to a group of almost entirely female workers “this is how we require you to work, take it or leave it” without looking at other options. Management have stated that their proposed working patterns are similar to those used in residential care, which is correct. However, even in those services I am aware that some staff have a variety of flexible working arrangements without affecting service delivery.

We will not accept staff being denied posts in the service because they require a flexible working pattern or they need to work less than 30 hours a week, without some effort being made to see if these requirements can be met. Therefore, we are asking for management to enter into a negotiation with staff to find out what their current working arrangements are, and whether these or an acceptable variation on them can be accommodated in the service.

Transport

The management report states: *“In order to minimise travel time between service users, where at all possible, it is proposed that Community Reablement Team workers will be car drivers, or have alternative modes of transport to enable them to move between service users with maximum efficiency. Routine use of public transport will be discouraged for that reason.”* This does refer to “alternative modes of transport”, but in reality what this amounts to is a requirement for staff to have a car and be able to drive. This is an unreasonable and unnecessary requirement. Management have also said that they will only pay casual car allowance, when staff would clearly meet the criteria for the essential allowance. Haringey is a relatively small, urban borough with comprehensive public transport links. The proposal is to split the borough into East and West areas, as happens currently, with these being subdivided in smaller geographical areas. Although I assume there may be occasions when staff may need to cross boundaries, they will not routinely face having to travel from Tottenham to Highgate, for example. Therefore, the distances that staff will have to travel, which will normally be within one section of the East or the West, should be manageable by public transport. Traffic jams do affect buses and cause delay, but they affect cars in exactly the same way, and car drivers also face the added

problem of finding somewhere to park, which can take time. Having a parking permit does not always alleviate the problem of actually being able to find a space.

The council is committed to the green agenda, which includes reducing car use due to the damage that this causes to the environment, and promoting use of public transport instead. Given this, it is extremely difficult to see why management would come up with a proposal that contradicts this unnecessarily.

We are concerned that this is a further issue that will have the effect of putting some staff off from applying for posts in the service. This requirement is unnecessary and unfair and should be removed.

Seniors/management responsibilities

The service will have what management have described as a “chargehand” system, where a senior worker at the front line will have responsibility for checking that all tasks are covered, checking work standards and alerting Team Leaders to any issues. We would like to know what evidence there is for this being a good way of running a Reablement service. Although it is difficult to say at this point, we are concerned that there may be a lack of management support for both the Reablement Workers and the seniors.

Monitoring will be needed to ensure that the tasks that these staff will be expected to do are appropriate to their grade, and that we avoid a situation where tasks that should be carried out by managers are simply delegated to seniors. If this happens, and/or if seniors face excessive workloads, both staff and service users could be put at risk.

It is proposed that seniors will carry out work with service users in addition to having the extra responsibilities. The balance between the two needs to be reasonable and realistic. Please confirm what percentage of the seniors’ time will be spent on front line work and on supervisory responsibilities.

We are concerned about the number of seniors (12 FTE) compared to the number of Reablement Workers (14 FTE), and we believe that this needs to be reviewed. This would mean that almost half of the front line workforce would have some supervisory/management responsibilities. If the balance between these responsibilities and front line duties is wrong, and seniors have less time for the latter, then this may lead to excessive workloads for Reablement Workers and/or capacity issues in the service. Also, current Home Carers will not have any supervision/management experience, and therefore may be put off applying for these roles, leading to unnecessary redundancies and the loss of excellent and committed staff. On this point, some further explanation of what the role will actually involve may help to avoid this happening.

There is reference to the Community Reablement Officers "directing their own work" and also to front line staff meeting "to co-ordinate day to day service provision and client priorities." I think there needs to be clarity on what the responsibilities of front line staff will be. These staff will need to have proper support, direction and supervision from a fully accountable manager, and sufficient managers will need to be provided for this.

Other issues

1) We will need more details on any proposals to require staff to, in effect, clock in and out of service users' homes to generate performance data etc. This may constitute excessive and unreasonable monitoring of staff.

2) It is not reasonable to require staff to have a clear CRB check, and this is not council policy. In particular, such a requirement may lead to discrimination or other unfairness. What matters is whether a caution or conviction etc. is relevant to the post. If it is not relevant, then it should not prevent appointment.

3) There is mention of staff working split shifts and long days. We will need to have further discussion if this is a serious proposal. Shift work generally can have major health and safety implications for an individual, and these can be significantly exacerbated by working split shifts or long days.

4) The facilities for breaks will need to be suitable.

5) We need to see an Equalities Impact Assessment for the issue of requiring workers to be car drivers, which is what the management proposal on transport amounts to.

6) Consideration needs to be given to allowing service users longer than six weeks of input if it is reasonable to believe that they will benefit from this. In the University of York study referred to above, all five services that were looked at allowed for this.

7) Staff have pointed out that there can sometimes be delays in delivering equipment to service users, which can delay their recovery. An example was given of someone who was struggling at home and was fine once a grab rail was fitted, but had to wait three weeks for it. It seems that quick delivery of equipment will be key to this service.

8) Management have claimed in consultation meetings that this is a closure of what is an extremely important and valued service. Consequently, the decision on this should be taken by Cabinet, not an individual Cabinet member.

9) If this proposal goes through, the result will be that most service users will receive Home Care from private agencies rather than the council. Although some individual workers used by them may be skilled and committed, private agencies generally have a reputation for poor wages and working conditions, not vetting or training staff, cutting visit times, high staff turnover and generally delivering poor quality services. UNISON objects to the move towards making greater use of private agencies in the provision of Home Care, and believes that it should be provided by in-house services, which are usually of higher quality.

Job description/candidate specification comments

Community Reablement Worker

NVQ2 in care or equivalent essential, NVQ3 an advantage – Council guidelines on candidate specifications state that there should only be a requirement for a qualification if this is a statutory or otherwise genuine requirement. Previously, there was a requirement for employers to train all care staff to a minimum of NVQ level 2, but this has now been removed from the new national minimum care standards. UNISON supports the reinstatement of this requirement, but at this point it no longer exists. The council should offer a commitment to train all staff to NVQ level 2, and perhaps it would be better to say that staff should either already have the qualification or be willing to obtain it, rather than saying that having it is essential in order to even be considered for the job. In terms of NVQ level 3, staff have been asking to do this and have been refused. This is certainly not an essential requirement for the job, so it should be removed from the candidate specification. No staff member should be prevented from applying for a post because they

do not have NVQ level 2. Any staff who do not have this qualification should be offered the opportunity to obtain it as soon as possible.

Senior Community Reablement Worker
The job description is almost exactly the same as for the Community Reablement Worker. Although a job description does not have to list every last detail of what is involved in a post, perhaps some further explanation of what extra tasks are involved in this role are required, particularly so that staff can make an informed choice about whether to apply for it.

Team Manager
To have overall responsibility for leading a team of Reablement Workers to ensure that a high quality individualized reablement service is provided, with the overall goal of ensuring service users have regained full independence within 6 weeks – It is clearly not going to possible to "ensure" that all service users regain full independence within 6 weeks, so perhaps this should be expressed as "aiming to ensure." (This also applies to the Team Leader post).

A good standard of general education – Vague requirements such as this are unhelpful. What constitutes a "good standard of education" and how is this measured? This may discriminate against some people who have not had full access to formal education or the opportunity to benefit from it. A requirement such as this should be expressed in terms of the skills needed; form example, if management want someone to be literate and numerate, they should simply say that. (This also applies to the Team Leader and Administrator posts).

Administrator
To develop and implement administrative systems for the enhancement of the service, including the collection and analysis of data for quality management purposes – Please clarify to what extent the postholder will be expected to develop such systems.

To carry out any other duties that may be delegated by managers and which are consistent with the basic objectives or duties of the post – Any such duties should also be consistent with the grade of the post.

Ability to devise and maintain accurate electronic/manual record keeping systems – Please clarify to what extent the postholder will be required to devise such systems.

Recognized typing, word processing and spreadsheet qualifications would be useful – Please see earlier comments regarding council guidelines on when it is appropriate to ask for qualifications. Are qualifications for these duties really necessary? Perhaps it would be better to state the skills needed, e.g. Ability to use Excel spreadsheets.

Chris Taylor
UNISON

30th August 2011

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THE STAFF CONSULTATION PROCESS ASSOCIATED WITH THE PROPOSED DELETION OF ALL POSTS IN HOMECARE AND THE ESTABLISHMENT OF POSTS IN A NEW REABLEMENT SERVICE.

On 20 December 2011 the Director of Adults Culture and Community Services (as was) wrote to all staff stating that due to the significant savings that had to be made, proposals were going to Cabinet on 21 December 2011 regarding a number of options to reorganise services, including options to close or cease a range of services.

On 21 December 2011 Cabinet gave the approval to commence formal consultation with stakeholder groups.

This paper focuses on the process that was applied in connection with the staff consultation process for the deletion of all posts based in the Homecare Service and the establishment of a new Reablement Service.

These proposals were consulted upon in 2 phases

The first phase covered the proposal to delete the posts based in the internal Homecare Service.

First Phase - Closure of internal Homecare

In essence the impact for staff would be that this proposal would result in all posts in Homecare being deleted and staff being made redundant unless they requested voluntary redundancy or alternative employment was found for them within the Council.

Staff were alerted at this stage that proposals were being drawn up for a new Reablement Service and that once the detailed proposals were worked up we would look to ring fence the new posts to Homecare staff.

The formal staff consultation process on this phase commenced on 31 January 2011 and was due to last until 30 April 2011 however this was extended until May 2011 in order to allow sufficient time for full responses to be received.

Several briefing sessions were held with Homecare staff. UNISON trade union representative also was present at these sessions.

At the sessions various issues were raised regarding ways in which staff could contribute to the consultation process about the proposals to close the internal Homecare service as well as the timetable and process that would be applied if it was agreed that the internal Homecare service would close. The majority of the issues that were raised by staff focussed on matters to do with the value of the service to service users and the implications if the service closed. Staff also raised questions about the timetable and likelihood of deployment and/or redundancy if approval was given. Council procedures regarding reorganisations were fully explained.

Staff were handed a leaflet at each of the first briefings. This leaflet confirmed the ways in which staff could contribute to the consultation process with contact details for trade union representatives and managers and the dates of Formal Trade Union Consultation meetings so that they could feed into these via their trade union representatives. It also set out ways in which staff could make enquiries about voluntary redundancy and redeployment as well as ways staff could access support that had been put in place for staff at them at this difficult time.

In addition to the above 6 Formal Consultation meetings were held between Senior Managers of the Department and Trade Union Representatives on 25 January 2011, 17 February 2011, 15 March 2011, 6 April 2011, 7 April 2011 and 26 May 2011.

The formal Trade Union Response to various proposals, including the one to close the internal Homecare Service, was submitted on 6 May 2011 and is attached.

Throughout the process the main focus for staff and trade union was the nature of the impact of the business changes on the various user groups.

Neither staff, nor trade union representatives, raised any issues to do with the characteristics of the workforce that is affected by these potential closures.

Following on from this many staff in Homecare did decide to request voluntary redundancy and these requests have been approved.

Second Phase - Creation of the New Reablement Service

Due to the nature of the new service, which have been fully set out in the service proposals, the most significant change for staff working in the new Reablement service would be that we would require fewer (i.e. 30 Reablement workers instead of 63 existing Homecarers) and the operation of the new Reablement Service would rely on staff working to new contracts with new working patterns that would enable a service to be provided 7 days a week and at times outside the requirements for current Homecare staff. The new working patterns would be significantly different to those operated by current Homecare staff.

The detail of the proposals for the staff structure and the new shift patterns and working arrangements required for the Reablement Service were issued to Homecare staff and their trade union representatives on 1 August 2011 and formal consultation ended on 31 August 2011.

Homecare staff were invited to attend one of 5 briefing sessions that were set up in order to go through the detail of the proposals for the new service and new working patterns with them as well as remind them of ways in which they could contribute to the consultation process direct or via their trade union representatives.

The Trade Union response was received on 30 August 2011 and it contained a significant number of points which contributed positively to the process. These points were taken on board and responded to and are attached as Appendix……..

For the reasons outlined above it will be important that staff do understand the new working shift patterns so that they can make informed choices as to whether they are in a position to apply for the new roles. It will also be important that the Council is able to make evidence based decisions as to which of the 63 staff to appoint to the 30 roles based on justifiable job requirements. It is for this reason that that it will be necessary to assess applicants ability to read and understand Reablement Plans based on short relevant and proportionate written tests. We will continue to liaise with Trade Union representative on this aspect of the process to assist with effective change management even though the formal consultation has ended.

We have done our best to work with staff during the course of the consultation to enable them to contribute to the consultation process, to come to terms with the impact of the proposals on them and to identify ways in which we can mitigate against compulsory redundancy by helping staff make informed choices as to whether they were in a position and able to apply and be considered for the new roles working in Reablement on new and different working patterns or whether they wanted to opt for voluntary redundancy.

This approach has resulted in very many Homecare staff electing to take voluntary redundancy which has greatly reduced the impact on staff.

We have also emphasised the benefits to staff of the ‘supporting changes’ package that has been put in place in terms of dealing with change and other forms of staff support.

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Haringey Disability First Consortium's response to Lisa Redfern letter dated 29th July 2011, titled NEW Community Reablement Service

"Haringey Council is committed to involving the users of services and others in decisions that affect them – especially decisions about the care and support services they receive"

Whilst Haringey Disability First Consortium welcomes this statement we are very concerned that the processes used by the council did not support this commitment in that:

- **Haringey Disability First Consortium was not considered a 'target'**
- **the timescale was only a month**
- **the document was not produced in plain English**
- **the document was only distributed electronically**
- **there seem to be gaps in training around reasonable adjustments, disability equality and statutory obligations in the team administering this and other consultations at a time of significant change.**

This is despite the priority in the council's Disability Equality Scheme to "ensure disability equalities principles are mainstreamed".

Haringey Disability First Consortium welcomes the desire to promote independence, flexibility and being 'customer focused' alongside creating and maintaining closer links with external agencies. We are concerned however about the lack of clarity and specificity on certain issues

- *How, within this consultation, are you* ***defining "individual complex cases" and "safeguarding concerns" and who at the point of delivery would be assessing the same****?*
- *How are you defining* ***'independent sector partners', and how does this differ from external agencies and "contracted providers in the independent sector"****?*
- *How will the council ensure that there are appropriate external agencies to refer to after the 6 weeks?* ***Will there be wrap around or additional funding for 'after reablement'? What will be the tendering process? How will your ensure continuity of provision?***
- *The 'financial assessment' described –* ***is this means tested entitlements or a move onto direct payments? Who does this assessment? Will the assessment be about Health and Social Care requirements, rather than about finances?***
- *'At the end of that time' – does this mean that* ***part of the 6 week reablement period will be used to do 'self assessment questionnaires' (SAQ) and broker ongoing services?*** *If so, will this use up individuals' quota of timeslots – thereby* ***impacting on their reablement?***
- *If this is not done within the* ***6 weeks, but after, how will the council ensure that there is not a gap in service prevision between coming off the 6 weeks, getting assesse****d (potentially appealing) and brokering services? This could potentially undo 6 weeks good work?*

- *Who decides* ***"if [it is] necessary"? Again is this financial, clinical, self assessed?***
- *Whilst 'front loaded' support may work for some, many people discharged from hospital only want to sleep for the first week (this is part of getting better too!). Is there a way of being flexible on this as some patients will benefit from front loading, others from back loading? In fact,* ***perhaps a 'bell shaped curve' approach might suit most?***
- 'Crossing professional boundaries'? *Do you mean they will work as an interdisciplinary team with agreed client goals - rather than crossing professional boundaries? There would be* ***serious safeguarding concerns about using PA/care staff to do the work of OT/ physio?***
- *Given Haringey Disability First Consortium's concerns about gaps in the current training we ask* ***who will be providing the "specialist training"*** and ***what competencies will be required to work on this team?***
- "Non contact time in this context includes travel time, annual leave, sickness absence and training". ***Is 'supervision' seen as contact or non-contact? How can 30% include AL/sick leave/travel? Will these staff be agency?***
- *As training is absolutely vital to this proposal working, what* ***safeguards has the council put in place to ensure that training and supervision*** *do not get lost within the 30% non contact time?*
- ***Who and how will there be monitoring of 70/30 split and the competency of the workers?*** *The service user?*
- "The approach will be to frequently review". ***Who will be doing the frequent reviews? Will this eat into the hours of reablement, or the 30% non contact time?***
- *How will those individuals who are assessed, either at point of discharge or within the 6 weeks, as being likely to need ongoing support be handled?* ***Leading people to think they'll be 'better' after 6 weeks, and then allowing them to 'fail', would be very bad for recovery.***

In general this document is hard to comment on.

There is very little detail about the team, the competencies of the team, and how the services to refer onto will be funded.

Haringey Disability First Consortium would like to reiterate our concern that there is a real need for independent advocacy and brokerage in the borough to enable this, and other changes, to work effectively for the most vulnerable.

We thank Barbara Nichols for meeting with us

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Dignity and Respect through Personal Service

Dear Mhairi,

Proposals in relation to home care and community reablement services – HDFC response to consultation

Thank you for your helpful comments submitted in response to the consultation in relation to proposals regarding the Council in-house home care service and also those to establish a new reablement service. Please accept my apologies for any miscommunication that led to HDFC not receiving a copy of the original consultation documentation. However, it is important tom emphasise that your comments have been taken into account and included in the report to Cabinet.

The purpose of the reablement service is to work intensively with mainly older people, following hospital discharge, for a period of six weeks, in order to maximise their confidence and abilities in activities of daily living. Ideally, clients will not require any further support at the end of that period. The reablement team in question, which will be working at the front-line in peoples' homes, will be part of a wider multi-disciplinary team of social workers and occupational therapists. Each will have their own clear role within that team.

Service users will be selected for a reablement service, using set inclusion criteria, based on their potential to participate positively in the reablement process and to achieve independence at the end of the six-week period of support. People will be offered reablement which, in many cases, will reduce their long-term dependency and thus the size of ongoing care packages, before they are assessed for their personal budgets.

Front-line staff will communicate between themselves and the central office, using service-supplied mobile phones. This model will enable people who receive the service to adjust the input they receive, according to their wishes on that particular day and will give much increased flexibility to the service provided on a daily basis, for example,

getting up times, meal times, times for rehabilitation/reablement activities and the time devoted to such activities.

The service will not be charging for the reablement phase. A financial assessment will be carried out at the end of that time on the reduced package, if necessary. Ceasing charges will therefore enable the current time limited "slots" to be abolished and for a much more flexible and fluid system of visits to people to be put in place, front loaded to maximise input immediately after discharge and reducing the further the service user gets from that date. Priority tasks such as personal care can be done at peak times, and the workers can then return to carry out reablement training with service users when they are less busy. Reablement goals will be set with the service user and their family, as part of our individualised care approach.

The approach will be to frequently review and reduce levels of support to the minimum necessary as the capacities and abilities of the person increase (the ideal will be that the person will no longer need the service after six weeks, if not before, and therefore not need any form of ongoing personal care/support service, thus reducing ongoing pressures on the commissioning budgets for older people). Where more long-term support is required, this will be planned in such a way as to ensure a smooth transition. Nobody will leave the reablement service without a receiving care arrangement being in place, should that be required.

Should a personal budget arrangement be chosen by a person seeking to arrange long term care, this will be put in place to fund their long term arrangements. There are currently some 80 registered home care providers in Haringey and in neighbouring boroughs – these suppliers are all inspected and regulated by the Care Quality Commission. Haringey Council has a policy of only using suppliers who have been previously graded as good or excellent by the Care Quality Commission. There will be no need for a further tendering process as a result of these proposals.

The service will also be proactively working in partnership with Age UK to use the services of volunteers during and after the reablement period to add an extra dimension to the process of rehabilitation and eventual independence of service users. All those passing through the reablement process will also receive a fire risk assessment, a Telecare assessment, a basic foot care assessment to reduce the risk of falls, an assessment for the Handy Person service and a discussion with them/their family as to whether additional input to reduce social isolation is required. This would be provided during the six week reablement period via The Haven day centre.

Any issues of safeguarding will be dealt with as a parallel process, in accordance with Council procedures. Safeguarding concerns would not be seen as a reason for a person not to move on from the reablement service on schedule.

For clarification, non contact time includes travelling time between clients, holidays, any sickness absence, training and supervision/appraisal. It is a requirement of the Care Quality Commission, as well as the Council, that staff receive regular supervision and support – this will be the case in the reablement service. Due to the flexibility of the service model, we do not anticipate needing to use agency staff on a routine basis, preferring to meet additional demand and cover needs from within the reablement team.

Training needs will be identified and met in part through the team members, and in part via more formal arrangements with the Council Training Section. Guidance derived from

Skills for Care will be used to inform that process, but it is important to point out that the majority of people in the pool of current home care workers from which the reablement workers will be recruited are already very experienced and most will have either NVQ2 or NVQ3 in Care.. In addition, it is planned to have a two week period before the new service goes live to ensure everyone in the new service is up to speed with new policies, procedures and concepts of service provision before "go live" day .

There will be a detailed information pack for all prospective users of the reablement service, which will set out how the service works, including timescales, charging arrangements and the philosophy of the service. This will be in easy to access language, including availability in translation where necessary. Your specialist knowledge and advice in helping us to devise this pack would be of considerable assistance.

I hope the information above has served to respond to the questions in your submission. However, if you would like to discuss this matter further, I am happy to meet with you at a time of your convenience.

Yours sincerely

Len Weir
Head of Service

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Appendix 7

THE NEW DUTY – THE SINGLE EQUALITY DUTY

EQUALITY ACT 2010

Introduces the **Single Equality Duty** which covers all eight strands, namely **race, disability, sex, gender identity, pregnancy and maternity, religion/belief, age** and **sexual orientation** and which came into force on 06 April 2011.

Section 149 of the Equality Act 2010 Public Sector Equality Duty states

(1) A public authority must, in the exercise of its functions, have due regard to the need to –

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

(2) – A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

(3) – Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to –

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

(4) – The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

(5) – Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to –

(a) tackle prejudice, and
(b) promote understanding.

(6) – Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

(7) – The relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

(8) – A reference to conduct that is prohibited by or under this Act includes a reference to –

(a) a breach of an equality clause or rule;
(b) a breach of a non-discrimination rule.

THE COUNCIL'S EQUALITIES SCHEME 2010-2013 AND DELIVERY PLAN

The Council's current Equality Scheme includes the three existing equality duties, namely race, disability and gender as well as the additional equality strands, namely religion or belief, age and sexual orientation, introduced by the Equality Act 2006, The Employment Equality (Age) Regulations 2006 and The Equality Act (Sexual Orientation) Regulations 2007.

TYPES OF DISCRIMINATION

Types of discrimination by way of an overview only include

- direct discrimination that is when someone (falling within one or more of the equality strands) is treated less favourably than others in the same circumstances
- indirect discrimination is when a provision, criterion or practice is applied to all but which puts a person (falling within one or more of the equality strands) at a disadvantage
- victimisation is when a person (falling within one or more of the equality strands) is treated less favourably than others having complained about discrimination in some way whether by way of proceedings or providing information or the making of allegations
- harassment is where there is unwanted conduct which has the purpose or effect of violating the person's (falling within one or more of the equality strands) dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment.

FOR INFORMATION

STATUTORY CODES OF PRACTICE

These are statutory codes relevant to each of the duties and whilst a breach of the code does not of itself make a person liable in any proceedings it will be taken into account by a court in certain types of proceedings. This means that they are admissible in evidence and if any provision of one of the codes appears to a court or a tribunal to be relevant to any question arising in the proceedings it has to be taken into account.

The existing codes continue to have effect until revoked by the Secretary of State at the request of the Equality and Human Rights Commission. The Commission has the power to issue new codes.

The draft code of practice on the Public Sector Equality Duty is scheduled to be laid before Parliament in Summer 2011.

GUIDANCE

The Commission has also produced non statutory guidance which includes the guidance on how to complete the assessments