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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.

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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

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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%	

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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%	

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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.

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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.

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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

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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

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- 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

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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?***

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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.

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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.		

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	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

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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

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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

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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.			

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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**

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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.

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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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