The Public Sector Equality Duty

The Equality Duty requires public bodies to have ***due regard*** to the need to:

- Eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

Protected Characteristics:

- Age
- Disability
- Gender Reassignment
- Pregnancy and Maternity
- Marriage and Civil Partnership (elimination of discrimination only)
- Race
- Religion or Belief
- Sex
- Sexual Orientation

Due Regard means consciously thinking about the three aims of the Duty as part of the process of decision-making. For example:

- How they act as employers
- How they develop, evaluate and review policy
- How they design, deliver and evaluate services
- How they commission and procure from others

Advancing equality of opportunity involves considering the need to:

- Remove or minimise disadvantages suffered by people because of their protected characteristics
- Meet the needs of people with protected characteristics
- Encourage people with protected characteristics to participate in public life or in other activities where their participation is low

Fostering good relations involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

Complying with the Equality Duty may involve treating some people better than others, as far as this is allowed in discrimination law. This could mean making use of an exception or positive action provisions in order to provide a service in a way that is appropriate for people who share a protected characteristic.

Officers should:
Keep an adequate record showing that the equality duties and relevant questions have been actively considered.
Be rigorous in both inquiring and reporting to members the outcome of the assessment and the legal duties.

Final approval of a proposal, can only happen after the completion of an equality impact assessment. It is unlawful to adopt a proposal contingent on an equality impact assessment

Central Bedfordshire Equality Impact Assessment

Title of the Assessment:		**Domiciliary Care Retender**	**Date of Assessment:**	31/10/16
Responsible Officer	**Name:**	Kamla Loi		
	Title:	Contracts Manager	**Extension Number:**	
	Email:	Kamla.loi@centralbedfordshire.gov.uk		

Stage 1 - Setting out the nature of the proposal and potential outcomes.

Stage 1 – Aims and Objectives

1.1 What are the objectives of the proposal under consideration?

The existing Domiciliary Care Framework is due to expire in May 2017 and has been rolled over until October 2017 to fit in with the Executive forward plan. Agreement has been reached to retender this contract using the current Framework – but using this as an opportunity to reengage with current and new providers to resolve some of the outstanding issues which have been reported over the last 3 years. This Tender has been combined with the Extra Care and Independent Living Scheme contract, CBC Children's and Clinical Commissioning Group for Continued Healthcare packages with tailored specifications for each Service.

The objectives of the Domiciliary Care retender process:

- Put in place a functional provider framework by October 2017
- Improve the delivery of care and the experience for our customers
- Create efficiency through joint procurement with other users of Care services such as Children's Services and the Clinical Commissioning Group
- Consider and mitigate against any negative effects to the provider market as a result of this activity.

1.2 Why is this being done?

The Domiciliary Care Framework contract is due to expire and the contract needs to be retendered to meet the care and support needs of clients in a domestic setting. The Extra Care and Independent Living Scheme contract is also being retendered. Adult Social Care is also taking the opportunity for joint procurement with the Clinical Commissioning Group and CBC Children's Services to achieve efficiency and enable Providers in the market more stability through the merged volume of business.

1.3 What will be the impact on staff or customers?

The changes being made to the specification are:

- **Quality/cost** - The evaluation criteria has been amended from a 60% quality and 40% cost criteria to a 55% quality and 45% cost criteria to further balance the need to provide an affordable, sustainable service with the need to commission a good quality service. The impact on customers could therefore be a poorer quality of service. Quality is assessed using questions around:
    - Involvement and information
    - Personalised care and support
    - Safeguarding and safety
    - Suitability of staffing
    - Quality of management.

- **Increase access to services in rural areas** - Providers are invited to bid for six lots for the new contract rather the current four lots with the intention of minimising the financial

and time difficulties that providers' cite when having to travel between clients. This should improve the equity of provision by minimising the barrier to providers taking on customers in rural areas. Increased plurality in the domiciliary care market will benefit services users by promoting more consistency in care and improved quality, as well as choice and control.

- **Extension of day time care hours** - Day time care hours have been extended to allow for a more flexible bed time service and to improve customers' access to social activities in the evening. The previous contract allowed for the bed time services to be available up to 10pm, but this has been extended to 11pm to provide customers more choice and control as to when they go to bed. For customers who require more flexibility in their bedtime there are other ways in which they can use their personal budget which allows for later or variable bedtimes such as a Personal Assistant.

- **Incentivise longer calls** - It is the Council's intention to eventually remove 15 minute calls from domiciliary care contracts and replace these visits to check welfare and medication by increasing the availability of services provided by the community. However there is not the capacity to replace 15 minute calls at this stage. Instead time thresholds for the payment of visits have been amended to incentivise carers to stay longer for calls.

  The current contract allows 15 minute calls to be paid if the carer visits from 0 to 17 minutes. This has now been extended for an additional 5 minutes to 22 minutes. 30, 45 and 60 minute visits have also had time limits extended by 5 minutes. This gives carers the opportunity to spend more time talking to, relating with, and understanding the lives of their customers, supporting them with activities and signposting to appropriate community services to improve their health and well-being.

  Developing a positive relationship with the carer was important to a number of domiciliary care clients responding to the Healthwatch Survey of CBC domiciliary care clients conducted in July and August 2016. When responding to the question 'what works well for you', comments included:

  "They have time for you, work very well together".
  "I think the carers should stay for the full amount of time they are being paid for, even if they have washed/shaved/changed me etc. They could have a five or ten minute chat."
  "Carers are kind, trustworthy and I have a very good rapport with them."

  The 2016 Healthwatch survey found that of the 84 responses, 84% said that they always or mostly had the same carer attending. 52% felt that their carer was always staying for the whole time allocated for each call and 34% said mostly.

- **Joint working with Adult Social Care, Children's Service and Health** - Adult Social Care is working with Children's Services to investigate how the domiciliary care contract could also meet Children's Services commissioning requirements. This joint working could improve the continuity of services for young people that are transitioning to adult social care services. Health colleagues are also engaged in the development of the tender to see whether clients requiring Adult Social Care and Continuing Health Care can receive these services from the same carer in the same visit. This will decrease the number of service providers visiting the customer's house, provide more consistency and reduce the costs and time associated with travel.

- **Removal of enhanced rate** - The current contract has an Enhanced Support Service rate for services where the skills level required of care and support staff are over and above those required to deliver Standard Support services. This includes:
    - customers who exhibit behaviour that may be challenging or physical issues that may require specialist training for staff, for example customers with an autistic spectrum condition
    - customers whose needs are less stable or less predictable who may need a varied and flexible support service, for example customers with mental health needs.

  The new contract states one standard rate and expects all care providers to ensure their staff have the skills to deliver services for all customers' needs. Providers will need to provide their staff with additional training to ensure they are able to deal with challenging situations. This will increase customers' choice and control but there is the risk that care providers can decline a customer with complex needs or challenging behaviour. The loss of a financial incentive could therefore reduce the availability of services willing to accept this type of customer.

  The contract sets out a range of minimum standards and skills required for care workers. This includes the Skills for Care Code of Practice, The Nursing Midwifery Council (NMC) codes of conduct and the East of England Service Outcomes and Standards of Care.

- **Hospital Discharge Supplement (HDS)** - The aim of this new arrangement is to support swifter hospital discharges for customers whilst at the same time responding to requests from providers to reduce the current requirement for packages to remain open for two weeks, without payment. To qualify for the HDS care providers are required to keep the customer's provision open for 7 days and to resume the homecare provision if the person is discharged within this 7 day period. If a customer remains in hospital for longer than 7 days the domiciliary care provider can reallocate carers and is not required to keep the care provision open. The package of care will first be offered to the care provider that previously provided homecare to the customer to allow for continuity of care. If the original provider declines the package, the package will be offered to other providers on the framework through the normal allocation process. The provider accepting the package and putting this in place within two full days (48 hours) of the package referral notice will be eligible for the HDS. This new process and the Hospital Discharge Supplement arrangement will be kept under review and the Council reserves the right to discontinue the provision at any point.

  The 2016 Healthwatch survey found that of the 84 responses, 84% said that they always or mostly had the same carer attending. Continuity of care was cited as important to many survey respondents:

  "If possible seeing the same friendly faces each day – not different ones all the week", "Consistency with regular carers who understand my needs"
  "Continuity of carers - Carers arrive anytime within 2.5 hours i.e., 8.15 – 10.45. One particular week recently five different carers in 5 days, surely the idea is to build rapport with same couple of carers? "
  "Mostly OK. Difficult with different staff and family needs to be around to guide the agency workers – would not be effective if living alone."

  Continuity of care is a key performance indicator of the contract and is subject to monthly review whereby poor performance will be challenged with the provider. The

contract also included continuity of care as a key question that will lead to rejection of the bid if the response is not to the level expected. Splitting the Council area in to smaller lots should also ensure that providers are more likely to provide continuity of care.

- **Dissatisfaction with the complaints process -** A survey of home care clients in July/August 2016 found that a high number of clients were unhappy with the complaints process. 84 clients (which it should be noted is less than 8% of all home care clients) responded to the survey. Respondents were asked if they had ever made a complaint about the care they received and 34% answered yes. Of those who made a complaint 71% were not satisfied with how the complaint was handled. Reasons for dissatisfaction included:

  "There need to be some improvement in managing complaints",
  "It was never handled properly […]. Complained to agency but has had no reply",
  "Because nothing changed, and they still do not arrive at the correct times" and
  "If late for example reason for lateness not always given, and no follow up the following day".

  The complaints process is one of the compliance monitoring methods used to ensure that services are provided to a sufficient quality. Complaints help the Council and its service providers make improvements. A poorly administered complaints process could therefore have an impact on the quality of the service and as a result dealing with complaints is a question included in the tender documentation to measure the quality of the provider.

- **Fair Price of Care**

The specification does not advise service providers that they should pay staff National Living Wage (25+) or the National Minimum Wage (21-24 years old) nor for this to include travel time or when sleeping at work when authorised by the employer to do so. EHRC Home Care Inquiry raised the issue of travel time not being included in National Minimum Wage in 2011 but this is still affecting some care workers in England in 2016. The Council influences National Living Wage (NLW) compliance by advising care providers on the requirements and paying providers in accordance with the NLW requirements. The Council is carrying out a Fair Price of Care exercise to ensure that the Council funds providers of care sufficiently so that the uplift reflects costs of the whole business including the costs associated with travel time.

The Domiciliary Care Contract is supported by the development of the Care and Support Plan with the customer by CBC adult social care staff. This ensures that the customer's care needs and individual preferences in how those care needs are met are agreed and set out for care providers to follow. Each care package therefore takes account of the customer's sex, age, ethnicity, sexuality and disability. For example the Council's Brokerage team ask the customer if they have a preference for the sex of their carer.

1.4 How does this proposal contribute or relate to other Council initiatives?

Domiciliary care is a key method of delivering care in Central Bedfordshire. Extra care contributes to both the Adult Social Care and Housing agendas.

The retender of the contracts will support the following Council priorities set out in the Five Year Plan:

- great resident services
- protecting the vulnerable and improving wellbeing
- a more efficient and responsive council

1.5 In which ways does the proposal support Central Bedfordshire's legal duty to:

- Eliminate unlawful discrimination harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it

The retender of the domiciliary care contract will advance equality of opportunity for vulnerable people, primarily older people and people with disabilities.

The Council has made changes to the specification of the contract (as set out in 1.3) to ensure equality of opportunity for those:

- living in rural areas,
- wishing to engage in a social life in the evening,
- with challenging behaviours,
- vulnerable customers requiring hospital treatment,
- transitioning from Children's Services to ASC services and
- customers with both adult social care and health needs.

The evaluation method (Pre-Qualification Questionnaire) also supports the Council's equality duties by scoring care providers on their compliance with equality legislation. The specification sets out the service provider's equal opportunities requirements which include:

- compliance with the equality duties,
- adoption of an equal opportunities policy approved by the Council,
- compliance with Accessible Information Standard,
- monitoring and reporting of staff compliance with the equality duties and
- monitoring and reporting of the diversity of the workforce.

The Council supports service providers to provide continuity of care where the customer is temporarily absent from home, for example due to a stay in hospital. This is referred to as the Hospital Discharge Supplement (HDS) and helps promote dignity in care for customers vulnerable due to their age or disability.

The contract monitoring method includes regularly seeking customers' views on the quality of their care and using this to discuss with service providers how services can be improved. The Equality and Human Right Commission (EHRC) Home Care Inquiry in 2011 stated that the key value of a person-centred approach to contract monitoring is that it is much more likely to help protect older people's human rights than a more process-based approach.

The Council monitors the quality of service and whether the service is meeting individual needs in a variety of ways:

- Feedback from customers and/or their carers
- Contract monitoring processes which include compliance visits and quality checks to Providers, quality and safeguarding alerts through internal teams and external agencies.
- Customer surveys

- By the investigation of complaints
- Through external inspection reports from the Care Quality Commission.
- Care and support plan reviews (annually or when there is a change in circumstances or request for a review).

1.6 Is it possible that this proposal could damage relations amongst groups of people with different protected characteristics or contribute to inequality by treating some members of the community less favourably such as people of different ages, men or women, people from black and minority ethnic communities, disabled people, carers, people with different religions or beliefs, new and expectant mothers, lesbian, gay, bisexual and transgender communities?

The change from 60% quality/ 40% cost to 55% quality/ 45% cost could lead to a marginal reduction in the quality of domiciliary care provision for Central Bedfordshire Council customers. This decision could have an impact especially on disabled people and older people because they are the key group of customers receiving the service. The questions used to score the quality of the service cover issues such as:

- the providers' ability to support the customer's choice and control over their care and support,
- dealing with customers exhibiting challenging behaviour,
- safeguarding and
- the management of the service.

Therefore a reduction in the weighting given for quality may impact the effectiveness of the service in these areas.

Stage 2 - Consideration of national and local research, data and consultation findings in order to understand the potential impacts of the proposal.

Stage 2 - Consideration of Relevant Data and Consultation

In completing this section it will be helpful to consider:

- **Publicity** – Do people know that the service exists?
- **Access** – Who is using the service? / Who should be using the service? Why aren't they?
- **Appropriateness** – Does the service meet people's needs and improve outcomes?
- **Service support needs** – Is further training and development required for employees?
- **Partnership working** – Are partners aware of and implementing equality requirements?
- **Contracts & monitoring** – Is equality built into the contract and are outcomes monitored?

2.1. Examples of relevant evidence sources are listed below. Please tick which evidence sources are being used in this assessment and provide a summary for each protected characteristic in sections 2.2 and 2.3.

Internal desktop research			
	Place survey / Customer satisfaction data	x	Demographic Profiles – Census & ONS
	Local Needs Analysis	x	Service Monitoring / Performance Information
	Other local research		
Third party guidance and examples			

x	National / Regional Research		Analysis of service outcomes for different groups
x	Best Practice / Guidance		Benchmarking with other organisations
	Inspection Reports		

Public consultation/ feedback related activities

	Consultation with Service Users		Consultation with Community / Voluntary Sector
	Consultation with Staff	x	Customer Feedback / Complaints
	Data about the physical environment e.g. housing market, employment, education and training provision, transport, spatial planning and public spaces		

Consulting Members, stakeholders and specialists

	Elected Members		Expert views of stakeholders representing diverse groups
X	Specialist staff / service expertise		

Please bear in mind that whilst sections of the community will have common interests and concerns, views and issues vary within groups. E.g. women have differing needs and concerns depending on age, ethnic origin, disability etc

Lack of local knowledge or data is not a justification for assuming there is not a negative impact on some groups of people. Further research may be required.

2.2. Summary of Existing Data and Consultation Findings: - Service Delivery Considering the impact on Customers/Residents

- Age: *e.g. Under 16 yrs / 16-19 yrs / 20-29 yrs / 30-44 yrs / 45-59 yrs / 60-64 yrs / 65-74 yrs / 75+*

Local data

Potential population growth of older people - Information from POPPI

	2010 current figure	2015 figures and % increase	2020 figures and % increase	2025 figures and % increase	2030 figures and % increase
All people aged 65+	39,300	47,000 20%	53,200 35%	60,100 53%	68,900 75%
People aged 85+	10,000	11,800 18%	14,500 45%	17,700 77%	22,700 127%

Key factors that may influence potential changes in demand for health and social care in people aged 65 and over – Information available from POPPI and is available for the following health issues

- Limiting long term conditions
- Depression
- Severe depression
- Dementia
- Heart attack

- Stroke
- Bronchitis/emphysema
- Falls
- Falls – hospital admissions
- Continence
- Visual impairment
- Hearing impairment
- Mobility
- Obesity
- Diabetes

The significant increase expected in the older population is likely to lead to more people needing care and support. On average older people are more likely to report lifestyle limiting illness (circa 17,000 in 2010), live alone (circa 14,000), live in poverty and rely on public services and informal carers for support.

Dementia is most common in older people, with prevalence rising sharply amongst people over 85 years. It is also one of the main causes of disability in later life. The number of people over 65 years of age with dementia is forecast to increase by circa 46% between 2010 and 2020 rising from 2,500 to 3,700.

Age profile of Central Bedfordshire Council home care clients

The majority of home care clients are aged 85 and over (35%). 74.5% of clients are aged 65 and over.

Age of client with a home care package on 31/08/16

Age group	Count of clients	Count of clients
18-24	49	4.1%
25-34	28	2.3%
35-44	30	2.5%
45-54	81	6.7%
55-64	118	9.8%
65-74	153	12.7%
75-84	323	26.9%
85+	419	34.9%
Grand Total	1201	100.0%

The most expensive packages (average weekly cost of package) are for those aged under 65, chiefly 25-34 year olds.

Average weekly cost for provision per age group of live packages on 31/08/16

Age group	Average weekly cost for provision
18-24	£195
25-34	£366
35-44	£232
45-54	£283
55-64	£213
65-74	£200
75-84	£187
85+	£191

Grand Total	£205

National research

There are 10.3 million people aged 65 and over in the UK. This is an 80 per cent increase over six decades, from in 1951. Over the last 60 years there has been a substantial change in the age composition of older people. In 1951, those aged 65-74 represented 67 per cent, and those aged 85 and over made up just 4 per cent, of the 65 and over population. Today, the two age groups represent 51 per cent and 14 per cent respectively. (ONS, 2012).

The age structure of the UK population will gradually become older. The number of people of ages 65 and over is projected to increase by 23 per cent from 10.3 million in 2010 to 12.7 million in 2018. Growth in this age group is projected to continue for the foreseeable future, with the 65+ population expected to reach 16.9 million by 2035. In terms of the projections' underlying assumptions, life expectancy at birth in the UK is projected to rise from 78.5 years in 2010 to 83.3 years in 2035 for men; and from 82.6 years in 2010 to 87.0 years in 2033 for women. (ONS 2012).

Health and well-being is critical for this age group, to prevent or delay deterioration into ill-health and social isolation. Social isolation can lead to deterioration in health.

Rural communities are ageing faster than other parts of the UK with approximately half of the rural population aged over 45, compared with 36 per cent in major urban areas. Across rural England, the number of people aged over 65 with social care needs is projected to increase by 70 per cent over the next 16 years. The number of cases of depression, stroke, falls and dementia is also projected to grow between 50 and 60 per cent, compared with up to 42 per cent in urban areas (Age UK 2013).

Many older people are not as active as they could be. People who are physically active reduce their risk of developing major chronic diseases by up to 50%. (DWP)

In 2006, 63% of people aged 65 to 74 reported having a longstanding illness and 38% said longstanding illness limited their ability to carry out daily activities. (ONS) 70% of people aged 75 and over reported having a longstanding illness and 50% said longstanding illness limited their ability to carry out daily activities (Office for National Statistics (ONS)).

In 2006/07 an estimated 2.5 million older people had some need for care and support. (Kings Fund / Commission for Social Care Inspection) Older people can experience limiting health and social care options. (Department of Health (DOH)) Assumptions are sometimes made that it's natural for older people to have lower expectations, reduced choice and control and less account taken of their views. (DOH).

Seven million people are estimated to be under-saving for retirement which means they may find themselves living in poverty in retirement. (DWP)

<u>Summary of Equality and Human Rights Commission's Home Care Inquiry 2011 Findings:</u>

Service Delivery Issues:
Around half of the older people, friends and family members who gave evidence to the inquiry expressed real satisfaction with their home care. At the same time the evidence revealed many

instances of care that raised real concerns such as:

- Older people not being given adequate support to eat and drink (in particular those with dementia) and an unfounded belief that health and safety restrictions prevent care workers preparing hot meals.
- Neglect due to tasks in the care package not being carried out, often caused by lack of time.
- Financial abuse, for example money being systematically stolen over a period of time.
- Chronic disregard for older people's privacy and dignity when carrying out intimate tasks.
- Talking over older people (sometimes on mobile phones) or patronising them.
- Little attention to older people's choices about how and when their home care is delivered.
- Risks to personal security, for example when care workers are frequently changed sometimes without warning.
- Some physical abuse, such as rough handling or using unnecessary physical force.
- Pervasive social isolation and loneliness experienced by many older people who lack support to get out and take part in community life

It is the view of the EHRC that many of these incidents amount to human rights breaches. The cumulative impact on older people can be profoundly depressing and stressful: tears, frustration, expressions of a desire to die and feelings of being stripped of self-worth and dignity – much of which was avoidable. Many affronts to dignity stemmed from easily rectifiable issues, such as not covering somebody with a towel while washing them. The underlying causes of these practices are largely due to systemic problems rather than the fault of individual care workers and are caused by a failure to apply a human rights approach to home care provision.

Many of these problems could be resolved if local authorities made more of the opportunities they have to promote and protect older people's human rights in:

- the way home care is commissioned
- the way home care contracts are procured and monitored.

It appears that commissioning is not being consistently used to protect human rights effectively. Indeed some commissioning practices make the experiences that older people described more likely to happen. Although practices varied a great deal, very few seemed to be consistently underpinned by local authorities' awareness of their duties under the Human Rights Act, including their positive obligations to promote and protect human rights. Local authorities appear to have a patchy understanding of these obligations, as reflected in their commissioning documents.

We found that:

- Some commissioning was driven by quality, and referred to human rights standards throughout the process, while other practices focused foremost on price. Cost pressures lead to shortened care visits and increase the risks to older people's human rights and to the quality and safety of their care.

- Whilst financial restraint is an inescapable reality, our evidence shows that some local authorities are still successfully finding innovative ways of doing things differently, rather than doing less of the same.

- In some cases, the terms for delivering home care were so tightly defined and inflexible that older people received a 'one size fits all' service that did not take into account their diverse preferences based on their religion, gender, sexual orientation, disability or cultural heritage. A 'time and task' approach which did not reflect people's wishes or fluctuating needs made some older people feel like "a task to be undertaken". Most said they had little or no choice over what support they got or the timing of care visits.

- Monitoring of contracts often focused on checking outputs and processes. Good practice, using a more person centred approach, looked at quality of outcomes including human rights standards.

- There is a clear need for supportive senior leadership on the central importance of quality, including respect for human rights principles such as dignity and personal autonomy, in the services commissioned.

- Where there is good practice by local authorities who understand their legal obligations under the Human Rights Act, their commissioning approach benefitted from listening to older people

Employment Issues:

- The lack of investment in care workers – the low pay and status of care workers – is in sharp contrast with their level of responsibility and the skills they require to provide quality home care. Poor pay and conditions also affect staff retention, causing a high turnover of care workers visiting older people

- Care workers are low paid, and may get little training and inadequate supervision and support. The workforce is predominantly female and part time and there are no qualification requirements.

- Although the National Minimum Wage (NMW) Regulations do not require workers to be paid for travelling time, their pay when averaged over all qualifying working hours must be at least the NMW level. Qualifying working hours for these purposes includes time spent travelling between visits. It is estimated that travelling time between visits adds approximately 20 per cent to a care worker's paid time.

- Only a very small number of the local authority service specifications we analysed included any reference to the terms and conditions of home care workers, and only one mentioned that pay rates should be above the NMW to take travelling time into account.

- A number of local authorities responding to our survey identified the poor pay and conditions of home care workers as a key barrier to promoting human rights. The effect on staff retention, training levels and the quality of staff attracted to the industry all have a knock-on effect on older people

- Interviewees from local authorities and independent sector home care providers raised concerns about the impact of commissioning at very low rates on workers' pay and conditions. Given the very low rates in some local authority contracts, some could not see how these would cover the essential costs of service delivery. Although providers are free to take contracts and incur a cost, this may not be a sustainable approach to commissioning home care.

- These concerns have been echoed by the Low Pay Commission, which has repeatedly recommended that the commissioning policies of local authorities should reflect the actual costs of care, including the National Minimum Wage

- The inquiry evidence also indicates potential risks to human rights when care workers lack core skills to do the job, including literacy and English. A number of older people felt the verbal and written English language skills of some care workers – often, though not always, from migrant communities – meant they couldn't do some aspects of their job as well. They couldn't fully understand conversations with older people, keep accurate written records or pick up on areas of concern, and there was the possibility of serious misunderstandings.

Contract monitoring
Again, we found a range of practice – from process-based (checking outputs and processes) to a more proactive, person-centred approach.

Interviewees from local authorities and voluntary sector organisations seeking to adopt good practice felt that including human rights principles and quality of outcomes in contract monitoring and management (rather than just checking outputs and processes) was the way to make sure providers prioritised and delivered on these areas.

Good practice that we were told about included:

- Quality monitoring using face-to-face interviews with service users, commissioned from a local voluntary sector organisation that specialises in working with older people – this uncovered issues that would not have been raised in paper-based questionnaires.

- Training older people from the local community as 'citizen assessors' to talk to older people receiving home care in their own homes about their experiences, as a key source of intelligence to inform their work.

- A proactive, hands-on approach to contract monitoring that places older people's views and experiences at the heart of assessing quality of care.

The key value of a person-centred approach to contract monitoring is that it is much more likely to help protect older people's human rights than a more process-based approach. It also means that any problems that may place human rights at risk are likely to be picked up early.

Personalised service does not have to mean a personal budget

When we asked older people what would improve their current home care service, most of those who volunteered an opinion indicated that they would like it to be more responsive to their needs and wishes:

- covering a range of different tasks
- flexibility to respond to changing situations rather than a rigid list of tasks to be carried out at specific times, regardless of anything else going on in their life, and
- care workers who listened to them.

Choosing a provider:
Many older people we spoke to were unsure how their provider had been chosen, or assumed there was no choice. In some cases, individuals who had expressed a preference felt that they

were not listened to.

Some older people had had their provider changed against their preference, causing upset and disruption. For example, one older man had recently been told by the local authority that his care provider had been replaced. Although he was much less happy with the services of the new agency, he felt he had little choice but to accept it, even though he was paying towards the cost of care from his own funds.

There was some good practice. In a few of the interviews it emerged that the local authority had replaced an agency because the interviewee was unhappy with the service they were getting. However, there was little evidence that the older people concerned had been consulted or involved in the change process. They simply accepted the next agency chosen by the local authority.

Some older people and their families, particularly those paying for their own care, told us about feeling overwhelmed when faced – often at a difficult time – with choosing a home care provider. In some cases they were only given a long list of care providers, and had no other source of information. In written evidence, some explained the difficulty of differentiating between organisations without any indication of quality

Summary - Ageism and age discrimination in social care in the United Kingdom A review from the literature commissioned by the Department of Health carried out by the Centre for Policy on Ageing - 2009

There is evidence that services for over 65's are worse in the following ways:

- Assumptions are made about the needs and capabilities of older people
- concepts of independence and social care are often interpreted differently and more restrictively for older people than for other adult client groups Independent living as the basis of access to individual family and social life has only recently been extended to older people.
- Services for older people have been slow in adopting the philosophy of independent living and user led practices. Social care staff and users may have become accustomed to social care provision that prioritises meeting personal care needs and avoiding crisis. There is a need to encourage resources to focus on goals outcomes and inclusion.
- Services for older people and younger adults have been managed separately with very different standards and expectations. Older people have had to make do with a poorer services and a system that neglects their social need and wellbeing
- Older people are expected to accept a different and inferior quality of life. E.g. it is accepted that older people can move into a home with 30 or 40 other people but 40 people with a learning disability living in a hostel has long been regarded as outrageous
- We expect to pay significantly higher amounts for residential care for younger people. It's historical based on lower expectations
- shift the focus of community care to that of enhancing quality of life rather than the narrower one of reducing risk
- the voices of older people with high support needs are so quiet as to be practically silent or indistinguishable from the other people who speak on their behalf
- the focus and quality of assessments are different for older people. The pressure on resources and professional assessment of risk can inhibit the development of person centred assessments for older people
- focus of social care for older people tends to be on maintenance with task based activities such as washing, dressing, eating rather than enabling people to participate in

social and community life. Social care needs to include the social aspects as well as the care aspect
- low level support can be particularly important in maintaining independence dignity and control
- historically spending per head on older people using social care services has been lower than for other adult client groups
- institutionalised inequalities in the resources allocated between different groups of people who use social care services. Differential funding of care packages for older people and younger adults with disabilities is explicit
- use of cost ceilings for care packages for older people
- key concerns re residential care loss of control, of identity, of personal possessions, not being valued, cultural / religious needs not met, lack of privacy / activity, insufficient staff, inadequate training, failure to provide care at appropriate pace
- whilst there is an argument for providing specialist services to meet the needs of older people the division between 18-64 and 65+ actually results in differentiated services that can be discriminatory in a negative way page

- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*

National data

Using the widest definition there are more than 11 million disabled people in the UK, which is more than one in five of the adult population and one in 20 children. 80% of people experience a year of being disabled at some point in their lives. Disability also covers people who may not recognise themselves as having a disability, such as those with long-term conditions (e.g. diabetes or cancer) or older people.

An investigation into the health inequalities experienced by people with mental health problems or learning disabilities found that many people reported problems with gaining access to services, with staff attitudes, and with getting the necessary treatment and support. (Equality Review).

Social care services are vital in order to progress equality for disabled people. If these services are not part of the solution in actively removing the barriers to living independently that disabled people face, they can become part of the problem in creating barriers to equality.

Local data

Residents with a health problem or disability that limits their day to day activities.
Central Bedfordshire residents were less likely to state that they had a health problem or disability that limited their day to day activities

	Central Bedfordshire		**England**
Day to day activities limited a lot	15,500	6.1%	8.3%
Day to day activities limited a little	21,100	8.3%	9.3%
Day to day activities not limited at all	217,800	85.6%	82.4%
Total	**254,400**	**100%**	**100%**

(ONS, 2011)

Disability profile of home care clients

Care need category of clients receiving home care as of 31/08/16

Client Category	Count	%
Learning Disability Support	147	12.2%
Memory & Cognition Support	85	7.1%
Mental Health Support	57	4.7%
Physical - Access & Mobility Support	116	9.7%
Physical - Personal Care Support	747	62.2%
Sensory - Dual Impairment Support	2	0.2%
Sensory - Hearing Impairment Support	3	0.2%
Sensory - Visual Impairment Support	15	1.2%
Social - Social Isolation/Other Support	22	1.8%
Social - Substance Misuse Support	2	0.2%
Support to Carer	5	0.4%
Grand Total	1201	100.0%

Physical disability (72%) was the most common type of disability for client receiving a home care service, followed by learning disability (12%) and those with memory and cognition support needs (7%).

- Carers: *A person of any age who provides unpaid support to family or friends who could not manage without this help due to illness, disability, mental ill-health or a substance misuse problem*

3 in 5 people will become a carer at some point in their lives. Over 2 million people become carers every year.

By 2026 more than 10% of the population will be over 75 and significant numbers of the workforce age 45+ will have caring responsibilities.

Over 1 million people experience ill health, poverty and discrimination at work and in society because they are carers.

18% of carers have left a job or been unable to take one due to caring responsibilities. Between 46% and 62% of carers are not getting adequate services to help them work and 40% of carers new to caring are not getting the right information and support to help them managed their lives (Carers UK).

Rural carers are very slightly more likely than urban carers to mention a lack of suitable services in their area, to say they do not know what is available locally, or to be held back in using services because they are too expensive (Carers UK).

Carers' contribute an extra £1 billion a year in helping to set up and run services in the community helping disabled and older people and in advising organizations and public authorities. They did this on top of the care they already provided as carers. The basic saving

to the NHS, social services and other statutory bodies resulting from the work of carers starts at something in excess of £34 billion a year.

Ethnic minority carers were especially likely to say they felt restricted in using services because they lacked information, or because services were too expensive, lacked flexibility, or were not suitable for their individual needs.

As of 31/08/16 5 (0.4%) clients were receiving support categorised as support to carer out of 1,201 clients in total.

- Gender Reassignment: *People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex*

- Trans people are a wide and very varied group of people: care should not be presumed but should be agreed with the individual
- People should be accommodated according to their presentation: the way they dress, and their current names and pronouns
- Views of family members may not accord with the trans person's wishes: the trans person's view takes priority
- Privacy, confidentiality, dignity and respect are of the utmost importance
- Records should protect the confidentiality of trans people's gender history while flagging for appropriate screening, diagnosis and treatment.

Older people: Dignity, compassion and respect are more important than ever for older people, particularly as their care needs increase or with the onset of dementia. Health staff should make every effort to assist older trans people to continue living as they wish, whether this is at home or in a residential care setting. Trans people may be encouraged to write instructions about how they wish to be treated. These instructions should prevail even where relatives take a different view (Unison guide for health staff).

- Pregnancy and Maternity: *e.g. pregnant women / women who have given birth & women who are breastfeeding (26 week time limit then protected by sex discrimination provisions)*

N/A

- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*

Local data:

Ethnicity of home care clients as of 31/08/16

Ethnic origin	Count	%
African	4	0.33%
Asian Any Other Background	5	0.42%
Black Any Other Background	5	0.42%
Caribbean	11	0.92%
Chinese	1	0.08%
Indian	5	0.42%

Unknown or refused	14	1.17%
Other Ethnic Group	8	0.67%
White Any Other Background	32	2.66%
White British	1101	91.67%
White Irish	15	1.25%
Grand Total	1201	100.00%

The most common ethnicity of home care clients is white British, followed by White Any Other Background which is not vastly dissimilar to Central Bedfordshire's White British population of 89.7% (2011 Census).

The most expensive packages, therefore those with more complex care and support needs are Chinese (although this just relates to once client) and White Irish (£251 average weekly cost of provision).

Ethnic Origin	Average Weekly Cost for Provision	Number of clients
Black Any Other Background	£165	5
African	£166	4
Asian Any Other Background	£167	5
Unknown or refused	£181	14
White Any Other Background	£189	32
Indian	£193	5
White British	£205	1,101
Caribbean	£219	11
Other Ethnic Group	£241	8
White Irish	£251	15
Chinese	£469	1

A survey was conducted by Healthwatch in July/August 2016 to find out home care clients' views on the service they receive. When asked 'Do you have any other needs which are not currently being met by your home care providers?' one respondent stated "Someone to speak my language to communicate fully".

National research:

Research published in 2014 indicates that White British people had a better understanding of the social care system than South Asian people, and that the language needs of South Asian people were not usually met in mainstream social care services (CQC 2014).

People from Black and minority ethnic (BME) groups have reported lower levels of satisfaction with social care services than the White British population (NHS NIHR S Asian attitudes towards social care).

Language may be a barrier to understanding for staff and for people using services. This will be particularly important if the numbers of people with dementia increase across ethnic groups, as people can lose the ability to communicate in languages that they have acquired later in life as their dementia progresses.

- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*

Research evidence has demonstrated that some religious groups have lower levels of awareness and take-up of services e.g. the Muslim community.

A lack of awareness about a person's religious or other beliefs can lead to discrimination. This is because religion can play a very important part in the daily lives of people. Discrimination can occur if specific requirements are not taken into account for example Diet / fasting Religious observance / prayer and festivals and specific customs and practices.

The then Commission for Social Care Inspections (now CQC) published *Putting people first: Equality and Diversity Matters 2 Providing appropriate services for black and minority ethnic people* in 2008. Research found that there were a number of misconceptions about black and minority ethnic communities that may contribute to a lack of action on the part of service providers:

- Assumptions that the needs of black and minority ethnic people can be wholly met by responding to cultural needs as they arise and that more general work on race equality is not required.
- Assumptions that there are no black and minority ethnic people in the area, so race equality is not an issue for the service.
- Assumptions may still persist that black and minority ethnic communities 'look after their own'
- Assumptions that the service is not equipped to work with people from a particular minority ethnic community.
- Assumptions that black and minority ethnic people do not want to use the service as they do not enquire about it.

- Sex: *e.g. Women / Girls / Men / Boys*

National data

Women currently live longer than men, but elderly women tend to have worse health than elderly males of the same age: fewer elderly men survive, but those who do tend to be fitter than their female counterparts. This means that elderly women have proportionally greater need for social care services than men. (Information source: Why women live longer than men, David Goldspink, Liverpool's John Moores University). The average life expectancy at birth of females born in 2007-2009 in England was 82.3 years compared with 78.3 years for males.

Age Concern estimates that at least 1.7 million single older men could be living in isolation in the UK. Nearly 400,000 of these are single older men aged 75 and over. Furthermore, it is estimated that 289,000 single older men are living in poverty.

There is some evidence that men may not be as good at accessing services as women, which we perhaps need to consider. Differences in service take up between men and women, therefore, appear to be related to differences in need and are not evidence of unequal treatment.

The Equality Act 2010 states that sex discrimination does not apply where the service (which is proportionate and achieving a legitimate aim) is likely to involve physical contact between the service user and another person and that other person might reasonably object, (Equality Act 2010, sc3, para 27). The Health and Social Care Act 2008 regulation 10(1) guidance also supports this: When providing intimate or personal care, provider must make every reasonable effort to make sure that they respect people's preferences about who delivers their care and

treatment, such as requesting staff of a specified gender.

Local data

The average life expectancy at birth of females born in 2007-2009 in Central Bedfordshire was 82.5 years compared with 79.2 years for males.

Gender profile of home care clients as of 31/08/16

Gender	Count	%
Female	735	61.2%
Male	466	38.8%
Grand Total	1,201	100.0%

The majority of home care clients are female (61%), this is most likely in part related to the fact that women live longer than men (life expectancy of men 2012-2014 was 81.5, women 83.8 year). 42% of female clients are aged 85+, whereas there is more of a spread of male clients across the age groups with the highest proportion of male clients is in the 75-84 age group (25.11%). 80% of female clients are aged 65+ compared to 66% of male clients. Men's care packages were slightly more expensive at an average of £211 per week compared to £202 for women.

Female

Age group	Count of clients	% of clients
18-24	12	1.63%
25-34	18	2.45%
35-44	15	2.04%
45-54	44	5.99%
55-64	59	8.03%
65-74	74	10.07%
75-84	206	28.03%
85+	307	41.77%
Grand Total	735	100.00%

Male

Age group	Count of clients	% clients
18-24	37	7.94%
25-34	10	2.15%
35-44	15	3.22%
45-54	37	7.94%
55-64	59	12.66%
65-74	79	16.95%
75-84	117	25.11%
85+	112	24.03%
Grand Total	466	100.00%

- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*

While there is a lack of recent evidence, in a large-scale survey in 2010, 60% of lesbian, gay

and bisexual people were not confident that social care services could meet their needs (CQC 2014).

National data

From police stations to family courts and from housing to health services, gay people remain uncertain of fair treatment, an uncertainty which is often derived from personal experience. Contact with any LGB people needs to be carried out with sensitivity, they must feel assured that their privacy will not be breached and that their confidentiality will be guaranteed.

Older LGB people grew up at a time when homosexual acts were 'against the law' until 1967. This can impact upon older LGB people's sense of well-being and upon their feelings about their sexual orientation making them reluctant to discuss their private lives with strangers.

Of the UK population over State Pension Age, it is estimated that between 500,000 to 800,000 people are lesbian, gay or bisexual. (Age Concern)

Older LGB people are 2 ½ times more likely to live alone and 4 ½ times less likely to have no children to call upon in times of need be without informal care and support networks, making their need for appropriate social care services even more acute. (Stonewall)

Within social care there is generally a low level of awareness of lesbian, gay and bisexual disabled people. Although there is no firm data on the number of Gay, Lesbian and Bisexual people, the Government estimates that it is between 5% and 7% of the UK population. Stonewall, www.stonewall.org.uk, confirms the accuracy of this estimate. Although there is very little research on the health of gay and lesbian and transgender people, there is research that suggests the LGB communities experience high rates of mental health problems than in general population.

Stonewall published *Building Safe Choices* in June 2016 which examined the current provision of housing and related care and support for the older LGBT population. It found that 'at the moment there is no answer for older LGBT people as to where they can access the best LGBT care and support. It is a great source of worry as no-one can predict what levels of help they may need in future, given people are living longer, but often with long term health conditions to deal with. Their fears and concerns are about access to good quality care that takes account of the life you have lived and who you are. There are numerous examples of older people who have been out all their adult lives, going back into the closet and hiding their sexuality once they are either living in a care home or receiving care in their own home'.

'What tends to happen is that people end up choosing a care home, or domiciliary care provider because of a specific crisis. This might be following a fall or illness or hospital admission. Their primary concern in choosing a provider might not at that moment in time be around their LGBT needs. What's then necessary is for some sort of quality assurance that can give prospective customers the confidence that the care providers they are choosing are aware and well trained to meet their LGBT needs'. (Building Safe Choices in 2016).

- Other: *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion, Marriage and Civil Partnership*

Rural areas

Age UK's *Later Life in Rural England* (2013) reported that 'in general older people living in rural areas enjoy better health than those living in urban areas, but they can face difficulties in accessing health and social care services due to distance, lack of public transport and services not working together. Rural areas are also ageing faster than urban areas, so demand for health and social care services is rapidly increasing'.

The number of people aged 65 and over with social care needs is projected to increase by 70 per cent across rural England over the next 20 years. (Age UK, 2016).

Depression, stroke, falls and dementia are projected to grow by between 50 per cent and 60 per cent in rural areas, compared to increases of between 34 per cent and 42 per cent in urban areas (Age UK, 2016).

By 2029, there will be around 930,000 people with social care needs living in rural areas. It is estimated that to meet these needs through publicly funded social care will require an additional £2.7bn per year (Age UK, 2016).

2.3. Summary of Existing Data and Consultation Findings – Employment Considering the impact on Employees
- Age: *e.g. 16-19 / 20-29 / 30-39 / 40-49 / 50-59 / 60+*
- Disability: *e.g. Physical impairment / Sensory impairment / Mental health condition / Learning disability or difficulty / Long-standing illness or health condition / Severe disfigurement*
- Carers: *e.g. parent / guardian / foster carer / person caring for an adult who is a spouse, partner, civil partner, relative or person who lives at the same address*
- Gender Reassignment: *People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex*
- Pregnancy and Maternity: *e.g. Pregnancy / Compulsory maternity leave / Ordinary maternity leave / Additional maternity leave*
- Race: *e.g. Asian or Asian British / Black or Black British / Chinese / Gypsies and Travellers / Mixed Heritage / White British / White Irish / White Other*
- Religion or Belief: *e.g. Buddhist / Christian / Hindu / Jewish / Muslim / Sikh / No religion / Other*

- Sex: *Women / Men*

- Sexual Orientation: *e.g. Lesbians / Gay men / Bisexuals / Heterosexuals*

- Other: *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion, Marriage and Civil Partnership*

2.4. To what extent are vulnerable groups more affected by this proposal compared to the population or workforce as a whole?

1) The key customer groups receiving domiciliary care are older people and disabled people, therefore any changes to the quality of domiciliary care will have an impact on these vulnerable groups. The change from 60% quality/ 40% cost to 55% quality/ 45% cost could potentially lead to a marginal reduction in quality of domiciliary care provision for Central Bedfordshire Council customers.

2) The Council is changing the way it will meet the needs of customers with higher support needs such as those exhibiting challenging behaviour. Rather than a few specialist providers delivering this service at an enhanced rate (as is the current practice), all providers will be expected to have staff skilled to deal with challenging behaviour. This improves choice and control and the availability of service providers, however dealing with customers exhibiting challenging behaviour is a key quality factor and so future provision may not be as effective for those with dementia or a disability that affects their behaviour.

2.5. To what extent do current procedures and working practices address the above issues and help to promote equality of opportunity?

1) When considering the cost/quality ratio, colleagues weighed up the need to retain the quality of care and ensure that the service is sustainable. The 5% change could have a marginal impact on the quality of the service but improve sustainability of the service. Safeguards and contract monitoring processes are in place to ensure standards are still met by service providers to deliver a service that meets customers' care and support needs.

2) There is sufficient flexibility in the commissioning of domiciliary care to enable the Council to procure the services of a specialist care provider when caring for those with challenging behaviour outside the mainstream provision and there will be occasions where the Council will pay a higher rate for specialisms.

2.6. Are there any gaps in data or consultation findings

Diversity monitoring was not included in the Healthwatch Survey and so the feedback could not

be analysed to understand whether certain groups were experiencing specific issues.

2.7. What action will be taken to obtain this information?

Diversity monitoring will be requested for inclusion in future surveys.

Stage 3 - Providing an overview of impacts and potential discrimination.

Stage 3 – Assessing Positive & Negative Impacts					
Analysis of Impacts	**Impact?**		**Discrimination?**		**Summary of impacts and reasons**
	(+ve)	(- ve)	YES	NO	
3.1 Age	x	x		x	+ve • Increase access to services in rural areas where a higher proportion of older people live. • Later bed time services • Incentivise longer calls • Joint working with Adult Social Care, Children's Service and Health • Increased availability of service providers for customers who exhibit behaviour that may be challenging. • Retention of care worker during period in hospital. • Higher rate specialist care providers available for challenging behaviour. -ve • 55% quality/ 45% cost criteria – marginal impact on quality of care.
3.2 Disability	x	x		x	As above.
3.3 Carers	x	x		x	As above.
3.4 Gender Reassignment				x	
3.5 Pregnancy & Maternity				x	

3.6 Race				x	
3.7 Religion / Belief				x	
3.8 Sex				x	
3.9 Sexual Orientation				x	
3.10 Other *e.g. Human Rights, Poverty / Social Class / Deprivation, Looked After Children, Offenders, Cohesion Marriage and Civil Partnership*	x			x	+ve • Increase access to services in rural areas where a higher proportion of older people live.

Stage 4 - Identifying mitigating actions that can be taken to address adverse impacts.

Stage 4 – Conclusions, Recommendations and Action Planning

4.1 What are the main conclusions and recommendations from the assessment?

There are a number of positive changes being made to the specification for the domiciliary care contract:

- Increase access to services in rural areas where a higher proportion of older people live.
- Later bed time services
- Incentivise longer calls
- Joint working with Adult Social Care, Children's Service and Health
- Increased availability of service providers for customers who exhibit behaviour that may be challenging.
- Retention of care worker during period in hospital.

However to maintain the sustainability of the domiciliary care services in times of limited budgets and an ageing population increasing demand for services, the Council has reviewed the scoring criteria from 60/40 quality/cost to 55/45, thereby potentially leading to a reduction in the quality of the service received.

Of the 84 clients that responded to the Healthwatch Survey, 71% were not satisfied with how the complaint was handled. The complaints process is one of the contract monitoring methods to ensure that services are provided to a sufficient quality. A poorly administered complaints process could therefore have an impact on the quality of the service.

4.2 What changes will be made to address or mitigate any adverse impacts that have been identified?

The quality of service provided to customers with higher support needs such as those with challenging behaviour will specifically be monitored to ensure that service providers are meeting their needs effectively. Availability of domiciliary care services for this customer group will also be monitored to ensure the removal of the enhanced rate does not deter care providers delivering the service required. The Council is able to procure the services of a specialist care provider when caring for those with challenging behaviour outside the mainstream provision and there will be occasions where the Council will pay a higher rate for specialisms.

Promote complaints escalation process so that complaints not dealt with effectively by the service provider are brought to the attention of the contract monitoring officers.

4.3 Are there any budgetary implications?

No.

4.4 Actions to be taken to mitigate against any adverse impacts:			
Action	**Lead Officer**	**Date**	**Priority**
Introduce specific monitoring of outcomes, complaints and feedback from customers with higher support needs e.g. challenging behaviour (that are currently identified as eligible for the enhanced rate service).	Kamla Loi	May 2017	M
Introduce monitoring of the number of customers refused a service by a care provider due to their high support needs and the delay this may have caused to receiving a care service.	Kamla Loi	May 2017	M
Promote complaints escalation process so that complaints not dealt with effectively by the service provider are brought to the attention of the contract monitoring officers.	Kamla Loi	May 2017	M

Stage 5 - Checking that all the relevant issues and mitigating actions have been identified

Stage 5 – Quality Assurance & Scrutiny:
Checking that all the relevant issues have been identified

5.1 What methods have been used to gain feedback on the main issues raised in the assessment?

Step 1:
Discussion with Domiciliary Care Retender project team.

Has the Corporate Policy Advisor (Equality & Diversity) reviewed this assessment and provided feedback? *Yes*

Summary of CPA's comments:

The CPA agreed with the positives and possible negatives identified in the EIA. There was however a query around the requirement that all providers will need to be able to work with challenging behaviour and there will no longer be an enhanced rate. Although this has the benefit of providers having an increased availability of staff for suitable for more service users, the change could potentially lead to a requirement for better qualified staff, thereby narrowing the pool of staff to recruit from. The CPA recommended that this aspect could have more of an explanation in the EIA.

The CPA highlighted that there is a possibility that there will be some service users who are so challenging that mainstream domiciliary care will find it very hard to provide ongoing support. The EIA should explain what the Council will do in these situations.

Response: The Council is able to procure the services of a specialist care provider when caring for those with challenging behaviour outside the mainstream provision and there will be occasions where the Council will pay a higher rate for specialisms.

Step 2:
5.2 Feedback from Central Bedfordshire Equality Forum N/A

Stage 6 - Ensuring that the actual impact of proposals are monitored over time.

Stage 6 – Monitoring Future Impact
6.1 How will implementation of the actions be monitored? Annual review of monitoring data to understand the impact of removing the enhanced rate has had on customers with complex support needs or challenging behaviour.
6.2 What sort of data will be collected and how often will it be analysed? Number of customers refused a service by a provider due to their complex needs. Number of customers requiring specialist services as service providers are unable to support the customer at the standard rate.
6.3 How often will the proposal be reviewed? Every 3 years.
6.4 Who will be responsible for this? Nick Murley, Assistant Director – Resources.
6.5 How have the actions from this assessment been incorporated into the proposal? The actions above will be addressed by Contracts team as part of their contract monitoring function.

Stage 7 - Finalising the assessment.

Stage 7 – Accountability / Signing Off
7.1 Has the lead Assistant Director/Head of Service been notified of the outcome of the assessment **Name:** _____ **Date:** _____
7.2 Has the Corporate Policy Adviser Equality & Diversity provided confirmation that the Assessment is complete? **Date:** _____