



Foundations

The Disabled Facilities Grant

Before and after the introduction of the Better Care Fund

June 2016 / Sheila Mackintosh and Philip Leather



Preface

2014 was a big year for the Disabled Facilities Grant. It marked 25 years since the original legislation was enacted and more importantly it was the year when it was first announced that the money would become part of the Better Care Fund. Incorporating DFG funding within the Better Care Fund is a big deal. For the first time it means Housing has to be involved in local discussions about the health and social care commissioning.

For Foundations this report is an essential part of our role in leading on improvements in the delivery of DFG. For those looking to commission better services it reviews past delivery and analyses emerging new models that will heavily influence what they plan and do next.

The field of home adaptations is under researched in comparison to other areas of housing and care where large, well-funded organisations regularly commission new studies. This research was crowd funded from a wide range of organisations who recognise the importance and value of collaboration.

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And finally, thanks and congratulations to Sheila Mackintosh and Philip Leather for producing such an excellent report; recognising the major impact that DFG has had on the lives of hundreds of thousands of people living with a disability and providing a steer on how we can do things better in the future.

Paul Smith
Director, Foundations

Disclaimer: The views expressed in this report are those of the authors and do not necessarily reflect those of the funders and sponsors of this research.

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Executive summary

The Disabled Facilities Grant (DFG) provides funding to older and disabled people in owner occupied, privately rented and registered provider properties to help them make changes to their home environment, such as the installation of showers, stairlifts and ramps. More than 1 in 10 adults say that they are either unable, or find it difficult, to move, walk or stand independently and a further 1.25 million people in England live with significant sight loss. As the population ages the numbers of people with disabilities is rising. However, only 5% of the housing stock is fully accessible and few accessible homes are being built. Not all people with disabilities will be eligible for the means-tested DFG, but the grant is essential to help those unable to carry out work themselves to change their home environment so that they can lead more independent lives or be cared for at home.

The grant has been in existence for 25 years but in 2014 it became part of the Better Care Fund, a pooled health and social care budget. The aim of the fund is to provide more joined-up and customer focussed services to reduce hospital and care admissions and enable people to return from hospital more quickly. In recognition of the rising need for adaptations central government funding for the DFG has been increased considerably. In 2016/17 it rose by 79% from £220 million to £394 million and it is projected to increase to over £500 million by 2019/20.

This report is a comprehensive history of the grant in England. It has mainly been produced to help commissioners understand the way the grant is delivered to help guide service improvements, but it will be useful for anyone with an interest in this subject. The first part of the report looks back at the evolution of legislation that led to a number of different organisations being given responsibility for different parts of the adaptation process. This has had a considerable impact on service delivery as some parts are delivered by health and social care, some by housing authorities and others by home improvement agencies. Handovers between organisations cause confusion for service users and have sometimes led to long delays. There are also anomalies in funding, for example, adaptations in the social housing stock are funded in a variety of ways, not all by the DFG. It is useful to stand back and look at why the different strands of policy developed and how the various elements might be better joined together.

The history of service development provides the context for the second section of the report. This uses previously unpublished LOGASnet data relating to the DFG which is collected for financial monitoring purposes by the Department of Communities and Local Government. This information is limited in scope but gives a picture of overall funding levels, distribution by age and tenure, the size of grants and how resources have been distributed geographically over the past decade.

Use of the DFG

Analysis shows that on average the DFG helps about 40,000 people a year with adaptations to their homes. Older people over 60 receive the most grants (71%) with 22% going to people aged 20-60 and 7% to children and young people.

Most grants go to owner occupiers, but they seem under-represented compared to registered provider tenants who receive a third of all DFGs. Not enough is known about how much registered providers contribute to DFG funding, but there is concern that they are getting an unequal share of resources and are not fully engaged in planning which homes should be adapted, what new accessible housing is needed and how disabled people can be helped to move to homes more suited to their needs.

Only 7% of grants go to tenants in the private rented sector, although this is expected to rise as this sector expands and matures. As some privately rented homes are difficult to adapt there is concern about how to manage adaptations in this sector in future, unless more opportunities become available for people to move into social housing.

Surveys and focus groups show that most people do not know about the DFG. People outside of the social rented sector who are more isolated appear to be the least likely to find out about the grant. This suggests that better ways need to be found of targeting resources on people who need help, perhaps by referrals from GPs or other health professionals. However, the links between housing and primary health care are still poorly developed.

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The average grant is around £7,000 but 58% are under £5,000 which suggests that there is considerable scope to cut bureaucracy to ensure these grants are delivered faster and more effectively. At the other extreme only 5% are over the maximum of £30,000. These large projects can get held up because people often struggle to find the additional funding themselves. It may be better to move, but this is also difficult as there is so little accessible housing available. Local authorities can use their discretionary powers to provide additional funding, but there may be a case to raise the upper limit to ensure that people who have more severe disabilities do not experience long delays.

Spending relative to need

The distribution of spending was examined in relation to a number of variables to see which areas had the higher spending levels in relation to specific indicators. Overall, spending appears to be higher in the metropolitan authorities than other areas. Most shire authorities had lower levels of expenditure than might be expected given their ageing populations.

Disability tends to be higher in poorer areas and in England there is a general north-south divide, with the highest levels in the North East, the North West and the East Midlands. The LOGASnet data showed that spending on grants in relation to levels of disability was almost the reverse of the pattern of need with areas of higher levels of disability in the north having lower levels of spending than London and the South East. However, the pattern of expenditure in relation to the number of people on disability benefits showed a more even distribution. It is difficult to put a great deal of weight on these findings as the figures are only indicative. The numbers of people receiving grants per authority are relatively small and the measurement of people potentially eligible for the grant is quite complex. However, it suggests that there may be a need to re-examine the allocation formula.

Funding the DFG

Funding for the grant is provided by both central government and local authorities. Funding rose steadily over the past decade, but when austerity measures were introduced in 2010 local authority contributions fell quite sharply which affected the number of grants given in subsequent years. Local authority contributions have begun to increase since the introduction of the Better Care Fund, but the picture is variable with some authorities contributing significantly more than others. Some areas appear to have more than enough resources, while others have backlogs and delays.

The report calls for local authorities to continue to fund DFGs and to make sure they are seeking out those who need help to remain independent at home. A better allocation formula might help those authorities struggling to meet demand. There also needs to be more representation of DFG teams on Health and Wellbeing Boards or Better Care Fund Committees to ensure that there are adequate resources to meet local needs. However, this will also require authorities to provide better data about levels of need, the effectiveness of service delivery and the outcomes for disabled people and health and social care organisations.

Filling gaps in the data

Unfortunately, the national data collection system does not record timescales for completion of DFG work, nor does it record the type of work carried out. It is clear that most work is to provide level floor showers, stairlifts, WCs and ramps but we do not know the relative proportions or how this varies by area, but these categories probably account for 80% of all work completed. Timescales vary between authorities and from year to year. Some are clearly able to deliver straightforward showers and stairlifts within a very short timeframe, while others take months.

The complexity of the pathway is partly responsible. Authorities that have multi-skilled teams and have adopted lean systems appear to be delivering faster services with fewer staff. These systems need to be adopted elsewhere. Funding levels also clearly affect delivery times as backlogs occur when funding is restricted. This is less of an issue where teams have strong management, are outward looking, engaged with the Health and Wellbeing Board, and where they have the support of elected officials. Amalgamating some of the teams in smaller authorities or across

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counties might enable them to be more effective and have more influence over funding decisions.

More robust information is needed on the outcomes of adaptations. Better data would enable the case for additional resources to be made much more effectively. Up to now the focus both locally and nationally has been on presenting data on expenditure rather than the impact on customers and on health and social care spending. There is a need to improve the way data on the DFG is collected and presented. This report makes suggestions about how this could be done through the LOGASnet return.

It is proposed that the return should be made to local Health and Wellbeing Boards and then passed to the Department of Communities and Local Government and/or the Department of Health for collation. The results should be published so that individual authorities can start to benchmark their performance. However, it is acknowledged that it is difficult to improve data collection until services are properly integrated and IT systems updated. The previous fragmentation of service delivery means that many different computer systems are in use. Use of NHS numbers on all data systems would assist with end-to-end measurement of DFG cases.

Reforming DFG delivery

It was previously difficult to reform the DFG delivery process as it fell into a policy vacuum; not really belonging to housing, health or social care. The accessibility of the home is finally being recognised as important for successful hospital discharge, to enable care to take place at home, and to allow people to live independent lives. Now that the DFG is part of the Better Care Fund and has had a substantial increase in central government funding it is in a much more central position in the policy framework. It is possible to join up the previous disjointed pathways and link the DFG to other related health and care services in a way that will make much more sense to customers. Rather than standing alone as a single solution it can be part of a more holistic range of interventions to help older and disabled people remain independent at home.

The final part of the report looks at how home adaptation services are changing. Examples are presented of new approaches to service delivery in a range of different local authority areas. These include:

- New combinations of services – particularly linking DFG delivery to equipment services, minor adaptations, handyperson services, home from hospital services and telecare
- Rapid ways of delivering the DFG without a test of resources to meet the aims of the Better Care Fund
- Bringing together services across districts in county authorities to join up the end to end pathway, provide greater consistency in delivery and economies of scale
- The potential to develop one-stop-shops in some areas to bring all services for older and disabled people together based around independent living centres.

There is no single model, but in all the good practice organisations the focus is on joining up services around the customer so that people with disabilities do not have to find their own way through complex service pathways. Given that the majority of older and disabled people will not be eligible for a DFG there is also a need to provide non-statutory advice and support to ensure people can remain living independently for as long as possible. The lessons from the experience of transformation so far are pulled together in Table 11 Section 6 which shows key elements of effective service delivery. This reformed service could be provided by a local authority, an independent home improvement agency or a combination of the two. There is also potential to set up an 'arms'-length' management organisation. More robust evaluation is needed to assess which models of service delivery provide better solutions for customers, greater value for money and the best outcomes to reduce pressures on health and social care.

Foundations (the national co-ordinating body for home improvement agencies and handyperson services) has a key role to play in the dissemination of good practice and in encouraging further service change. They are developing local Memorandums of Understanding to bring together health, social care and housing organisations. The aim is for each area to develop an action plan to enable people to remain living at home by ensuring that housing is safe, free from hazards, warm, and accessible. Foundations also provides training, regional and national meetings and conferences for all people working in this sector. They are supporting a network of DFG champions to offer support and mentoring to neighbouring authorities.

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The final part of the report presents a number of recommendations about issues that need to be addressed to allow further transformation to take place. The report argues that consultation with older and disabled people needs to be an intrinsic part of transformation planning to make sure that the services provided are what they really want and need.

Recommendations

1. Combine services for improving the home environment so that disabled and older people do not have to search out solutions. Fully integrate DFG teams with a single manager controlling the end to end customer pathway.
2. Better Care Fund plans to show more detail about the DFG including: financial and staffing resources; the DFG delivery process, targeting and outcome measurement.
3. Review the DFG allocation formula
4. Provide guidance on use of the Regulatory Reform Order 2002
5. Update the DFG test of resources
6. Revise the upper limit of funding
7. Memorandums of Understanding and action plans for each area
8. A higher profile and more publicity for services to help people improve their home environment - ideally, have a one-stop-shop for all these services.
9. Involve GPs and health professionals in referrals to provide better targeting
10. Design - work with the supply chain to develop new cost effective and more aspirational designs.
11. Rationalise the way social housing adaptations are funded and delivered
12. Provide better information and advice to help people to move in all tenures. Advertise the FirstStop service. Work with planners, developers and social housing providers to develop more effective accessible housing policies
13. Minor adaptations and handyperson services - better co-ordination
14. Self-funders – services to provide advice and information in each area
15. New LOGASnet forms - returns to be made by Health and Wellbeing Boards. Publication of annual returns to enable benchmarking
16. More research - independent evaluation of new, integrated DFG service delivery models

Introduction

- 1.1** The Disabled Facilities Grant (DFG) was introduced as part of the 1989 Local Government and Housing Act and the first grants were given in 1990, so it has been in use for over a quarter of a century. The most fundamental change came in 2014 when it was announced that the DFG would become part of the pooled health and social care budget, the Better Care Fund, and responsibility for its administration would pass from the Department of Communities and Local Government to the Department of Health.
- 1.2** In the Comprehensive Spending Review of November 2015 it was announced that the central government allocation for the grant was to more than double from £220m in 2014/15 to over £500m by 2019/20 and there has already been a substantial increase in resources for 2016/17 to £394m. The future of the grant appears more secure than it has been for many years. This seems a good time to look back at what it has achieved, where the difficulties lie with its delivery and how these might change in future as a result of the process of integration of health, social care and housing.
- 1.3** Since it was introduced the DFG has helped to transform the lives of thousands of disabled people. About 17% of people are born with disabilities, but most develop them during their lifetimes, particularly in their later years¹. Over a third of people 55-64 have a long term illness or disability that reduces their ability to undertake daily activities, but this rises to more than a half for those aged 75 and above.² These numbers are likely to increase as the population continues to age. However, the vast majority of disabled people of all ages are not in specialised accommodation but in the general housing stock. If people cannot manage stairs, have to sleep in the living room, wash at the kitchen sink or use a commode they can lose their self-respect and become trapped and isolated in their homes. Unadapted housing can also lead to an increased risk of falls and injury.
- 1.4** The DFG, by providing new amenities and services, or altering the layout and accessibility of the home, allows people to live more independent, safer and more dignified lives. It can also make a considerable difference to the lives of carers, most of whom are partners, parents and other family members. Adapting an inappropriate property makes caring safer and more straightforward and can have a positive impact on the whole family. The overall effect of increasing personal wellbeing, preventing accidents and reducing strain on carers means that the cost savings to health and social care are potentially extremely high.
- 1.5** The report brings together information about the development of the DFG since its introduction and data on grant spending patterns across England. It begins by looking back at the history of the grant as this has had a significant effect on the way that it is currently delivered. This is because the DFG began as part of a suite of grants used for housing renewal and it remains the responsibility of housing authorities. Home improvement agencies evolved as another component of housing renewal policy to provide additional support for older home owners and private tenants with repair, improvement and adaptation work. However, parallel strands of legislation gave social care services the ultimate responsibility for disabled people. Service delivery has not been as effective as it might have been as it crosses administrative and organisational boundaries. The report looks at the development of the legislation, the different organisations involved in delivering the grant, and how the divisions in the way the service is provided have affected customers.

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- 1.6** This provides the background for an analysis of previously unpublished data on the DFG contained in the 'LOGASnet' returns submitted annually by each authority in England to the Department of Communities and Local Government. The information on the DFG is a small part of a larger data collection exercise relating to local authority expenditure. The dataset, like many developed for administrative rather than research purposes, has limitations, however, it is the only information we have at national level so it is important to put it into the public domain. The data reveals the level of resources committed to the DFG from both central government and local authorities. The report examines how these resources have been distributed geographically, the share of funding going to different age groups and tenures, and the value of work carried out. The report also makes use of other national datasets to put the LOGASnet data in context by looking at the distribution of grants relative to demographics, tenure, levels of ill health and disability and other indicators of need. It covers England only, as different grant funding and delivery systems have developed in Wales, Scotland and Northern Ireland.
- 1.7** The grant delivery process is now beginning to change fundamentally. The introduction of the Better Care Fund in April 2014 and the Care Act in April 2015 is leading to the creation of new integrated services centred on the home. This could potentially make grant delivery more effective, efficient and customer-focussed. Different models of service delivery are developing. However, there is a need to balance the preventative role of the DFG in keeping people living safely and independently with the need for the grant to be used in more flexible and responsive ways to help reduce pressures on health and social care.
- 1.8** Even with the increase in funding, the DFG will only be able to help about 85,000 per year by the end of the decade. There is a need for better information, advice and support for the majority of people who will need to use their own resources to alter and adapt their homes, particularly the increasing numbers of people now in their later years.
- 1.9** As services develop in new ways data collection will need to change to help with resource allocation and planning. The report looks at how local and national statistics could be improved to give more accurate and detailed information for government departments and local commissioners. This will also enable individual local authorities and home improvement agencies to begin to benchmark their performance more effectively.
- 1.10** Both authors of this report have been involved in research into the DFG since its inception. With other colleagues, one of the authors has recently been involved in the reorganisation of home adaptation services in a number of local authorities and has carried out numerous interviews and focus groups with disabled people and users of DFG services.³ Extensive interviews have also been conducted with staff involved in all parts of the customer journey including hospital discharge teams, occupational therapists, caseworkers, technical staff, home improvement agency staff and contractors. In 2015 further interviews were conducted with local authority and home improvement agency staff to see how services were changing as a result of the Better Care Fund and the Care Act 2014 to produce a series of cameos of good practice in the delivery of adaptations.⁴ Additional interviews were carried out in 2016 to look back over the past decade and the changes that staff have experienced. Previous research into adaptation agreements between local authorities and registered providers is also drawn on in this report.⁵

Introduction

1.11 It is hoped that this report will be useful to a wide variety of organisations. This includes: government departments, Health and Wellbeing Boards, service commissioners, Clinical Commissioning Groups, local authority departments, home improvement agencies, registered providers, disability organisations, user groups, suppliers, the construction industry, academics and all other organisations interested in the delivery of adaptation services and in the integration of health, social care and housing services.

When they said he could have a stairlift and a wetroom I cried. Now he can get upstairs to bed and can have a shower. It has made it possible to keep him at home.

I'm so grateful we've had this work done. I can now keep the house warm, I've got hot water and a shower. It has helped me as well as my husband.

We could have had carers, but we prefer to manage ourselves and we can now.

It gives you back your dignity

1.12 The report covers five main areas:

- The LOGASnet data are put into context by describing the parallel strands of legislation and guidance that led to a jigsaw puzzle of services developing to deliver equipment and adaptations prior to the introduction of the Better Care Fund and the Care Act 2014.
- The next section presents findings from LOGASnet and other sources showing trends in resource levels over time, contributions made by central government and local authorities, grants given by tenure and age group, trends in the value of work and how this relates to levels of need.
- The report goes on to present a typology of service delivery, looks at how services are changing following the introduction of the Better Care Fund and what can be learnt from reforms that have taken place so far.
- It examines how new outcome measures could be developed to provide better national information about home adaptations in future.
- Finally, a series of recommendations are made about how delivery of the DFG could be improved.

I can do things on my own and not worry about getting help

The development of the Disabled Facilities Grant (DFG)



Why the grant is needed

2.1 The Disabled Facilities Grant (DFG) enables disabled children, young people and adults to live more independently in their homes and stay in the community. It also has a key role to play in reducing admission to hospitals, providing safer and more effective discharge, preventing an increase in demand for social care and delaying or reducing admittance to residential care. The cost savings to health and social care are potentially very high, particularly where it reduces falls. Almost 1 in 3 people aged 65 and over, and 1 in 2 aged 80 and over fall each year. About 5% experience a fracture or require a stay in hospital with a cost to health services of over £2 billion a year⁶. A study in New Zealand estimated that 60% of falls take place in the home and that a package of relatively low cost adaptations can reduce falls by around 26%⁷. Falls are one of the major reasons for people to move from their own home to residential care. A number of studies from the UK have indicated that adaptations may delay admission by about four years.⁸

2.2 There are about 10 million disabled people in England (19%) and more than 1 in 10 adults say that they are either unable, or find it difficult, to move, walk or stand independently. There are also around 1.25 million people in England living with sight loss which has a significant impact on their daily lives. Rates of disability tend to be higher in poorer areas as low income and disability are inextricably linked. There is a general north-south divide with the highest levels in the North East, the North West and the East Midlands with correspondingly lower levels in London, the South East and the East of England. The prevalence of disability also rises with age:

- 7% of children (0.7 million)
- 16% of adults of working age (5.0 million)
- 43% of adults over 65 (4.2 million)⁹

You don't think of yourself as vulnerable until you get older or a disability hits you

2.3 The majority of housing is poorly designed for disabled people or those getting frailer with age. Steep stairs, narrow corridors and doorways, small bathrooms, upstairs toilets and steps outside make ordinary life difficult for many people with mobility problems, sight loss or other conditions. Some people have to deal with disabilities from a young age (17%), but most people do not become aware of the problems with their home until there is a change in their circumstances such as an illness, an accident or growing frailty in later life.

You know, you get to a certain age and the hardest transition is going from useful to useless. I had to watch my previously very healthy and fit wife go up and down the stairs on her bottom for a year, it's so very stressful and upsetting.

2.4 In 2012 the Building Research Establishment looked at two levels of accessibility in the English housing stock.¹⁰

- Visitability standard - for a property to be 'visitable' by someone who is disabled it needs four key features of: level access, flush threshold, toilet at entrance level and sufficiently wide doors and circulation space. It was estimated that only about 740,000 homes (3.4%) met this standard. An additional 2.6 million homes (12%) could reach the standard with minor works and a further 9.6 million could comply if more major work was carried out.
- For a person with restricted mobility to live permanently in a home - additional features are required including: suitable parking on the plot, downstairs living space, shower on the ground floor, bedroom or bed-space on the ground floor, adequate space for turning a wheelchair in key rooms, and the entrance illuminated and covered. Only 111,000 dwellings (0.5% of the stock) were fully accessible.

Why the grant is needed

- 2.5** Accessibility features are more likely to be found in newer properties and in the registered provider sector. However, the biggest group of disabled people are those in older age groups who are predominately in owner occupied dwellings (76%). Although involving smaller numbers, evidence shows that disabled children are the least well housed of any disability group.¹¹
- 2.6** The importance of the DFG in helping people to adapt their homes has been recognised by an increase in resources and the grant will make up 10% of the Better Care Fund in 2016/17. Many people involved in health and social care may not be familiar with the grant so it is useful to understand what it covers and how it works.

I'm partially paralysed and had trouble getting in and out of the bath and getting up and down stairs. I fell a couple of times on the stairs and now my son has to help me up and down

One of my arms is very weak. I became very scared of falling and stopped using the bath as I couldn't get in or out

My husband had three minor strokes which affected his balance and he couldn't get in or out of the bath. After a further brain haemorrhage he now can't get upstairs

What is the DFG?

- 2.7** The DFG is a grant designed to help disabled people and families with disabled children alter their home to allow access, permit use of all the normal facilities and, where appropriate to enable a disabled person to provide care for others. A person is deemed disabled if:
- Their sight, hearing or speech is substantially impaired
 - They have a mental disorder or impairment of any kind
 - They are physically substantially disabled by illness, injury, impairment present since birth, or otherwise.
- 2.8** The vision underpinning the DFG reflects the social model of disability "which views disability as arising from the barriers presented by society and the built environment rather than being inherent in the person themselves. The focus is therefore on identifying and implementing an individualised solution to enable a person living within a disabling home environment to use their home more effectively".¹²

I used a perching stool to sit on to wash which was very undignified as my partner had to help me

I had eight years of standing on a towel to wash, too frightened to use the bath

What is the DFG?

2.9 Funding for the grant comes in part from central government. Local authorities initially contributed a further 40% to match the 60% from the government, but this requirement was removed in 2008, along with the ring fence around the grant, so that it could be used in ways more suited to local needs. Most local authorities still contribute but amounts now vary. The DFG can be used for:

- **External access** - to get into and out of the home e.g. widening doors, ramps, rails
- **Safety** – e.g. improved lighting, a room made safe so a disabled person can be left for a period unattended
- **Internal access** – to make it easier to get into the living room
- **Washing/bathing/cooking/sleeping** - to provide/improve access to the bedroom/kitchen/toilet/washbasin/bath/shower e.g. by altering the layout, installing a stair lift, providing a downstairs WC or putting in an accessible shower
- **Heating** – improving/providing a heating system suitable to the disabled person's needs
- **Ease of use** – e.g. adapting heating or lighting controls to make them easier to use
- **Facilitate caring** - to enable the disabled person to care for someone else who lives in the property, such as a spouse/partner, child or other person
- **Garden access** – this was added in 2006 with the aim of providing access to and from a garden or to make a garden safe (in practice this may only cover a limited amount of larger gardens)

2.10 It is a mandatory grant, but unless the adaptation is for a child or young person, applicants are subject to a test of resources. If a household is in receipt of a means tested benefit they are automatically 'passported' through and awarded a 100% grant. If not, a standard set of allowances for living costs are used to calculate if the household could afford to take out a loan and whether that would pay for the cost of the required adaptations. If the calculated loan amount is the same or greater than the cost of the adaptations, they do not get any grant. The Building Research Establishment looked at the test in 2011 and suggested various changes to target the grant better on those with the lowest levels of wealth, but these have not been implemented. The test needs a further review to bring it up to date.

2.11 Amendments introduced through the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 allowed more flexibility in its use enabling housing authorities to give discretionary assistance as a grant, loan or equity release, provided they can still meet their mandatory requirements and they publish a policy¹³. This also provided the potential to remove the test of resources in some cases which is discussed later in the report.

2.12 In 2006 the maximum grant was raised to £30,000 and a charge was allowed to be made against the property to recoup all or some of the costs of work costing between £5,000-15,000 if the home is sold in less than 10 years. More recent guidance notes in relation to the Better Care Fund indicate that there is scope to use the DFG where other work is needed, for example to deal with small repairs and heating problems provided it supports prevention, promotes independence and deals with delayed transfers of care.¹⁴

How the DFG developed

2.13 Before going on to look at the data about the use of the DFG over recent years it is important to look back at how and why it developed as this helps to explain why the delivery of the DFG service may appear rather confusing to people not familiar with it. There are a mix of organisations involved because of the way the various strands of legislation developed. This section outlines how this came about and why change is required. The advent of the Better Care Fund and the integration agenda will finally allow services to be transformed. Some authorities have already gone through this change process and are operating fast, effective, customer-focussed systems (Section 6 goes on to look at this in more detail). By putting the historic LOGASnet data in context it will hopefully allow commissioners to understand the different parts of the home adaptations process that need to be pulled together to provide improved services that are more holistic, better coordinated and that work more effectively for older and disabled people.

Origins in housing renewal

2.14 It is easy to forget that 50 years ago house conditions in many parts of the UK were very poor. A comprehensive programme of housing renewal developed from the late 60s onwards to improve the dwelling stock and to supply missing amenities such as bathrooms, kitchens and inside toilets. To stimulate investment, renovation grants were made available to private landlords (who at that stage owned a lot of the stock in the worst condition) and to individual home owners, to encourage them to bring properties up to a decent standard and to install or improve bathroom and kitchen facilities.

2.15 Local government staff administering grant aid became aware of circumstances where an occupant was disabled, where additional work was required to make new facilities accessible, or where it seemed appropriate to provide specialised amenities. Some conditions of grant aid (such as the level of contribution required from owners) limited the help which could be provided through this channel, and the scale and scope of eligible works were tailored towards renovation rather than to adaptations.

2.16 Over time, pressure developed, mainly from front line officers delivering grant aid, for the creation of a specific grant targeted on the provision of adaptations for disabled people alongside grants for repairs and improvements. New legislation in 1989 introduced a mandatory grant for people with disabilities, the DFG, which was subject to a test of resources and also tied to bringing the home up to the legally defined Fitness Standard. There was also a smaller discretionary grant, Minor Works Assistance, which could be used for a specified range of small repairs and minor adaptations costing up to £1,080. Following a review, the legislation was updated and it is this Housing Grants Construction and Regeneration Act 1996 that still stands today (subject to later amendments and guidance). However, of all the grants introduced as part of that Act, the DFG is the only one that remains. Over the last 25 years all other repair, improvement and minor works assistance has been withdrawn, although a few local authorities still continue to fund some discretionary repairs grants from their own budgets.

How the DFG developed

2.17 The only link in the DFG legislation to health and social care was the requirement for the housing authority to consult the welfare authority to see if the DFG works were 'necessary and appropriate' for the individual.

The role of social care and health services

2.18 Parallel to the development of the DFG, social care authorities had been given the responsibility under the Chronically Sick and Disabled Persons Act 1970 to identify the numbers of disabled persons in their area, to inform them of the help available and to arrange adaptations. As a result, they developed their own budgets and adaptation teams.

2.19 Over time informal arrangements developed under which social care departments took responsibility for moveable equipment and small adaptations, while the housing authority dealt with more major physical changes to the property and fixed equipment. As housing renewal programmes grew in the 1980s, social care authorities gradually withdrew their funding for major adaptation works, apart from providing some top-up funding for people unable to raise money for their share of the costs of DFG work, or where costs exceeded the upper limit of the grant. However, they have maintained a role in providing minor adaptations costing £1,000 and under (including installation costs and materials).

2.20 Equipment and minor adaptations are frequently used before, or alongside, the installation of more major home adaptations. Until 2003 there were separate NHS and local council services providing community equipment and minor adaptations for home nursing, daily living and communication. This included such things as commodes, shower chairs, raised toilet seats, grab rails, lever taps, improved lighting, and telecare equipment such as fall alarms. Duplication, lack of choice, gaps in service provision and delays in hospital discharge had been criticised by disabled people and the organisations representing them for many years. As a result, the Community Care Act 2003 introduced Integrated Community Equipment Service (ICES) budgets to provide more co-ordinated and responsive services to people of all ages.¹⁵

2.21 This pooled health and social care budget pre-dated the Better Care Fund by over a decade. Many of the goals were the same: to help the development of disabled people (especially children), prevent deterioration or escalation of disability, help people maximise their ability to live independently, prevent unnecessary hospital admissions or prolonged hospital stays and avoid inappropriate admissions to long term residential or nursing home care. It also introduced a unified, person-based IT system linking assessment, stock tracking, purchasing, equipment re-use and management information. Equipment and minor adaptations are now often outsourced to a number of national organisations, although some local authorities and health services maintain their own warehouse, delivery and installation services. However, in most areas, until recently, this system was not very effectively joined up with the delivery of the DFG.

2.22 Community occupational therapists started to play a much more important role in the delivery of social care services for older or disabled adults and children with disabilities from the 1970s onwards. By 2007 they were estimated to make up only 2% of the workforce and yet they dealt with approximately 35% of the referrals for adult social care services (not including children's services).¹⁶ Occupational therapy teams are responsible for assessments for equipment, minor works and for the DFG. Social care teams have their own IT system for casework and care planning but there is seldom a link between this system and that used for the DFG. This makes it difficult to track and measure the end-to-end progress of cases.

2.23 Until recently there were few links between most DFG teams and hospital social work, occupational therapy or discharge teams, although these are now beginning to develop. There is also a need to develop closer working relationships between DFG services and primary care, including: GPs, community matrons, health visitors and district nurses. This would help to ensure more targeted referrals, but it is only just beginning to happen in most areas.

How the DFG developed

Customer pathway split between services

2.24 The split in responsibility for disabled people between housing, social care and health was not a major issue initially, but over time it led to a rather complicated customer pathway particularly as housing renewal programmes were wound down through the 1990s and the big teams that ran them were disbanded. DFG referrals were routed into social care call centres and a typical pathway developed, which remains the norm in most areas. Occupational therapy teams in social care (adults and children's) take initial enquiries, do the triage to send people down different pathways, deliver any necessary equipment, minor works, moving and handling support, do the care assessment and carry out the assessment for major adaptations. Cases are then referred on to the housing authority or a home improvement agency for casework support, the test of resources, and technical services such as surveys, designs, schedules, planning consent, contractors and costs.

2.25 Children's services are sometimes separate from the adult teams with their own locality offices and call centres. The same occupational therapist will often stay with a disabled child until they reach adulthood and they work closely with schools and hospitals. Often the occupational therapist is only professional a disabled child and their families encounter from social services. For home adaptations services this is another piece of the jigsaw that needs to be brought together to enable more effective delivery of the DFG. Children's DFG cases are small in number, but tend to be more complex and expensive and require a close working relationship between occupational therapists, technical staff and builders over a longer period of time.

2.26 To further complicate matters, in most two tier authorities the occupational therapists are usually based at county level with the DFG casework and technical support at district level. Even in unitary authorities the team that delivers the DFG is often managed separately from the occupational therapists and located in a different department and sometimes a different directorate. In small authorities this is not a problem as teams are usually in the same building, or even the same office, but in larger unitary and two tier authorities communication between the different teams can be more difficult and it is sometimes hard to maintain consistent approaches. The handovers between staff can appear seamless if services are fast, but can be confusing both for customers and for other professionals, when resource constraints lead to multiple waiting lists and long delays. The lack of integrated IT systems makes it hard to track the progress of cases. The DFG team often does not know the time the customer first enquired about help, or the time they have had to wait before being referred for an adaptation. The timeframe may be extended because reablement has taken place first, or equipment has been tried, but in some instances the case may have been on a waiting list for some time before the referral is made for a DFG. More recently teams have begun to amalgamate and develop leaner and more effective systems which is discussed later in Section 6.

How the DFG developed

Home Improvement Agencies

2.27 A further element of service delivery that later became inextricably linked with the evolution of adaptations policy started to emerge in the late 1970s onwards. Housing renewal programmes were focussed on property conditions. If a home owner applied for a grant they had to fill in the paperwork, get quotes from builders and often organise the work themselves. Not all applicants could cope with this process and as a result some would not go ahead with work. Home Improvement Agencies developed to improve the housing conditions of older people, particularly low income home owners, to enable them to live independently for as long as they wished. They provided the additional support required by older and more vulnerable people to carry out repairs and improvements. They gave information, advice, help with funding and provided a full technical service including producing specifications, securing quotes from reputable builders and supervising job completions. Most agencies later evolved to offer additional services such as handyperson schemes to do smaller jobs. The original agencies were charities or not-for-profit organisations, independent of local authorities, and many were set up by housing associations (now called Registered Providers), most notably Anchor Housing. Most were originally called Care & Repair or Staying Put but now operate under a range of names.

2.28 They began to expand rapidly from 1987 following an injection of central government funding as part of the Assisted Agencies Initiative.¹⁷ This was also a time when large institutions were being closed and the concept of Care in the Community meant a new emphasis on helping people remain in their own homes in later life. As about half of home improvement agency clients had a health condition or disability, adaptations became a significant part of their caseload.¹⁸ Home improvement agencies became established across the country and they continue to offer a range of services, both to people who are getting statutory funding through the DFG, and to those who want, or need, to use their own resources.

Services provided by Home Improvement Agencies

- Advice and information
- Housing options advice and support
- Home adaptations – some provide the full DFG service, others help vulnerable customers or complex cases, others do no DFG work but support self-funders
- Minor adaptations – a few HIAs have taken on the full social care minor works function while others only help people who self-fund
- Home from hospital services
- Handyperson and trusted assessor services
- Home repairs
- Removal of trips and falls hazards
- Decluttering/deep cleaning
- Energy efficiency and home warmth measures
- Home security
- Help to obtain additional funding for repairs and adaptations
- Welfare/benefits advice and debt counselling
- Peer to peer support through the 'Silverlinks' service

How the DFG developed

2.29 Some home improvement agencies have pioneered innovative approaches. This started with handyman services, housing options advice and help to move. They have also developed fast and effective home from hospital services using caseworkers in hospitals to find patients needing housing help and handyman services to make homes safe and warm ready for people to return home. This latter approach fits with the latest National Institute for Health & Care Excellence (NICE) guidance on hospital discharge.¹⁹

2.30 The value of home improvement agencies is their holistic approach, drawing together a number of housing-related interventions alongside the DFG. This is exactly the type of integrated service delivery that the Care Act 2014 and the Better Care Fund aims to encourage. They can also work across local authority boundaries reducing the variation in service delivery. Many smaller districts have limited staff resources to deliver the DFG and pooling resources with neighbouring authorities can provide a more effective service. It is a particularly useful approach in two-tier authorities.

2.31 There are now a variety of home improvement agencies; some remain independent but many are now in-house local authority services and they are present in about 80% of local authority areas. The challenge since the recession has been to maintain the whole range of non-statutory services outside of the DFG. There is an increasing need to address, not just adaptations, but the poor house conditions of older people and agencies play a key role in helping people deal with repairs and issues of home warmth. The Care Act 2014 requires people who are not eligible for statutory services to be signposted to a place where they can receive further help which should help to focus attention on the need to support these services in future. The critical role that the independent advice given by home improvement agencies plays in enabling people to make informed choices about their homes in later life has been spelt out in a number of reports.²⁰

Independent Living Centres

2.32 A separate strand of service provision was developing alongside those already mentioned. The Disabled Living Foundation was founded in 1969 at the time the Chronically Sick and Disabled Person's Act first came into being and they set up the first disabled living centre to demonstrate equipment in 1971. The Independent Living Movement gained momentum as the old long-stay institutions were being run down in the 1990s. It was about disabled people themselves getting control over their lives, developing their own choices and obtaining the financial packages to enable them to live in the community. Accessible housing and personal assistance were key elements of this strategy. Centres for Independent Living were set up in many parts of the country to provide support and advice²¹. The Disabled Living Foundation subsequently developed: Trusted Assessor Training to enable people who were not occupational therapists to assess for, and install equipment; an internet advice tool called AskSARA; and the Living Made Easy website to provide free and impartial information on equipment.

2.33 In January 2005, the government gave a commitment that by 2010, each upper tier or unitary authority should have a user-led organisation, modelled on existing Centres for Independent Living²². There is now a network of these centres around the country. The focus was originally on equipment with demonstration areas for aids for independent living and assistive technology in most centres. However, they now often include adapted bathroom and kitchen layouts and stairlifts.²³ Until recently few were connected to home adaptation services or home improvement agencies; another symptom of the rather disjointed way that services have developed for disabled people. This is now becoming more coordinated and there are demonstration centres linked to adaptation services such as those run by West of England Care & Repair and Knowsley council.

How the DFG developed

Tenure issues

2.34 To add yet further to the complexity, there are differences in the way home adaptations are provided across tenures.

2.35 Home owners - The original aim of the DFG system was to help private landlords and home owners in inner city areas tackle poor conditions. As levels of home ownership rose in the latter part of the twentieth century DFG funding was mainly directed at low income home owners, and this is still by far the biggest group requiring help with adaptations as 76% of people over 55 are owners²⁴.

2.36 Private rented sector - tenants in this sector have always been able to apply for a DFG, but until recently numbers were relatively low. The expansion of this sector as house prices have escalated beyond the reach of many on low and average incomes, alongside declining availability of social housing, means that increasing numbers of disabled people, particularly disabled children, are likely to be in this tenure in future. Use of the DFG in this sector could become problematic. In 2012 it was estimated that 40% of privately rented homes are not feasible to adapt.²⁵ Short term tenancy agreements, poor housing conditions and overcrowding exacerbate these problems.²⁶

2.37 Adaptations in the council stock – these are funded from the Housing Revenue Account (HRA) rather than the DFG. Self-financing was introduced for local authorities in 2011 to put landlords in the position where they could manage their stock from their own income. This provided additional funding for local authorities to pay for disabled adaptations. It was based on research done by the Building Research Establishment which estimated that councils would need £60 per dwelling per year across the whole stock to adequately meet arising needs. This estimate was incorporated in the self-financing settlement and extra funding of around £116m was included for adaptations²⁷. There are often separate adaptation teams for the council stock, many with their own occupational therapists, but in other areas they are co-located with the DFG team. Council adaptations are often more straightforward as the stock is more uniform and average costs appear to be slightly lower. The Housing Revenue Account funding stream has not been analysed in this report.



How the DFG developed

2.38 Registered Providers – this sector only made up 3% of the housing stock when the DFG was first introduced in 1990 and they already had their own direct subsidy for adaptations from the Housing Corporation. This had been introduced in 1981 in response to the ‘UN Year of the Disabled Person’ and by 1996 had reached £21m a year (£36m at 2015 prices). In the late 1990s the sector grew rapidly as stock was transferred from council ownership. Adaptations that would previously have been paid for from the Housing Revenue Account were now paid using Housing Corporation subsidy. However, after 1996, due to a major reduction in the Housing Corporation’s own budget, direct funding was cut back. In 1998 funding was withdrawn for associations with reserves over £500,000 and it was finally discontinued for all associations in 2008. The remaining money left in the fund only amounted to £1.5m, a fraction of what had been available a decade earlier for a much smaller number of properties, and this was all that was transferred to the DFG.²⁸ It has resulted in a patchwork of different funding arrangements. Some transfer associations have their own budgets and their own teams, however others now take a substantial proportion of DFG resources. Other registered providers only fund minor adaptations, or major adaptations that are part of substantial improvement work, referring all other tenants to the local authority for a DFG. Some providers contribute to funding, some pay variable amounts in different areas and others do not pay anything at all. To obtain contributions local authorities have had to develop their own local agreements with each provider. More information is needed on how much registered providers contribute to DFG funding in order to gauge the true impact on DFG resources. Unfortunately, recent rent reductions and caps on rents may make some social housing providers less likely to invest in adaptations or to contribute to DFG funding. In Wales a separate grant has been maintained for registered providers which has resulted in a much more streamlined delivery system, faster end-to-end times for tenants and greater consistency with the way adaptations are organised in the council stock.²⁹

2.39 The fragmentation of social housing funding and delivery - where there are adequate DFG budgets and co-located teams there can be a uniform service across all tenures and all landlords get the advantage of using skilled staff. However, in most places the social housing picture is complicated and there are a variety of different funding and delivery arrangements. This leads to a number of issues:

- Increased competition for limited DFG resources leads to long waiting times for people from all tenures.
- Where different landlords offer very different services it results in inequality for tenants.
- When landlords do not contribute to funding DFG resources are often wasted as adaptations may be removed at the point properties are re-let.
- It has implications for the management of the housing stock and the re-letting process. Landlords who fund and deliver their own adaptations are more likely to treat the expenditure as an investment. This helps them engage with their disabled tenants, adapt the right properties, use more innovative designs, put better information on property registers, have less rigid time targets for reletting adapted properties and they provide more help for tenants to move home. The reverse may be true if there is no engagement with the adaptation process.
- All applicants for home adaptations should be treated equally and HRA funded adaptations should follow the same guidelines as the DFG. However, social housing tenants often get treated very differently from other DFG applicants as more people are encouraged to move. For some this provides a much better solution, but others may not be given the same choice to stay put that is given to home owners.
- If social housing landlords were more involved in the adaptation process and understood the needs of disabled tenants it might ensure that more new accessible housing is built.

How the DFG developed

Help with moving rather than adapting

- 2.40** In recognition of the fact that some people would prefer to move, and that some dwellings are unsuitable for adaptations, the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 allowed the DFG to be used to adapt the new home rather than the existing property and in some cases to pay for removal expenses. Many adaptation teams and home improvement agencies now include specialist housing options and rehousing staff (although services may have been affected by recent staff cuts). However, it is important that housing options are discussed early in the process, not after people have been left on a waiting list for a long time when it may be too late to start looking for a new home. It is also important to ensure that the household's views about moving are fully taken into account. As a recent ombudsman report has underlined, the local authority still has to allow the DFG if the person does not want to move or if no alternative accommodation can be found. Where adaptation teams offer housing options support it can be very effective in delivering better housing solutions. It can also result in considerable cost savings; in the first year that Bristol City Council employed a rehousing specialist it saved around £250,000 in home adaptation costs.³⁰ Similar savings have recently been achieved in Cornwall.
- 2.41** A study some years ago estimated that, of families with disabled children, half would rather move than have their current home adapted, provided suitable accommodation can be found near schools and support networks.³¹ Older people are more likely to want to stay put, although a proportion might move if suitable accommodation was available. However, most older people are home owners and choice is lacking in this sector. Moves are currently more likely to happen in social housing where there are higher levels of specialised housing.
- 2.42** For people searching for a home in the private sector, few property websites or estate agents display adequate information to enable accessibility features to be identified.³² Disabled people in properties with the lowest value, which are more likely to be unsuitable and the most expensive to adapt, have the least choice.³³ The constant rise in property prices and the premium placed on the price of the limited number of bungalows in most areas further restricts the choices available. The national FirstStop website and helpline offers advice and information about moving to older people, their families and carers. In the period 2013-15 eight out of ten clients helped had long term health issues or were disabled, and of all users 37% wanted to move and 38% needed adaptations.³⁴ The Elderly Accommodation Counsel site also has a directory of homes to rent and for sale suitable for older people. Home improvement agencies and some Age UK offices also offer housing options advice.
- 2.43** In most areas the planning of new build accessible housing has not been properly joined up with health, social care and adaptations needs. London is an exception following a report in 2005 that identified that disabled people were twice as likely to be living in unsuitable housing as non-disabled people. From 2007 The London Plan required that *"In all housing developments, including conversions and change of use, the Mayor will, and boroughs should, seek to ensure that 10 per cent of the units are designed to be wheelchair accessible, or easily adaptable, for residents who are wheelchair users. This percentage should be applied to both market and affordable housing, should be evenly distributed throughout the development, and cater for a varying number of occupants"*.³⁵ As a result, by 2012 87% of new homes in London were built to the Lifetime Homes Standard and 9% were built to be fully wheelchair accessible³⁶.

How the DFG developed

- 2.44** However, it is difficult to know how far accessibility standards have been maintained. Since the recession developers have used financial viability as a reason for non-compliance with some planning conditions. More recently rising land prices and construction costs combined with recent reductions in rents for social housing have further altered development plans.³⁷ A mystery shopping exercise revealed that even when accessible properties are built, many older and disabled people find it hard to get information. Marketing personnel on London development sites did not have information about which properties were built to lifetime homes or wheelchair standards and often did not understand what the terms meant³⁸.
- 2.45** Allocation policies in the social sector are also not as effective as they might be, even in London where there has been more emphasis on building accessible housing and where some authorities have developed accessible housing registers. In 2011 Habinteg found that only 35% of wheelchair accessible homes in London were actually let to wheelchair users. A number of reasons were identified which were: properties wrongly described as being fully accessible, lack of co-ordination to match potential applicants to properties, pressure from social landlords to let dwellings quickly if a disabled applicant is not found, lack of support through the process, properties not being in the right location or the right design, but in some cases tenants were holding out for their ideal property even if this meant waiting a long time.³⁹
- 2.46** Across the rest of the country the situation is less clear. In 2014 it was estimated that only 42% of local authorities had a policy requiring all or some of new housing development to be built to Lifetime Home Standards, although a further 34% had a policy encouraging compliance. However, there was considerable variance in requirements from 20-30% of new housing up to 100% as in the London Plan⁴⁰. A report by Leonard Cheshire in 2015 found that, despite the fact that one in six disabled adults and half of all disabled children live in housing that isn't suitable for their needs, only 16% of councils could provide data on the number of homes in their area which are wheelchair accessible, only 10% knew how many homes in their area were built to Lifetime Home Standards and only 17% had a separate accessible housing register.⁴¹
- 2.47** Building more accessible homes is not getting any easier. New technical access standards introduced in October 2015 only make the Category 1 standard mandatory. Local authorities wanting to build Category 2 (broadly comparable to Lifetime Homes) and Category 3 (equivalent to wheelchair standard) homes have to use a 'viability test' that is heavily weighted in favour of developer return. This is despite the National Planning Policy Framework requirement for local authorities to '*plan for a mix of housing based on current and future demographic trends, market trends and the needs of different groups in the community, which includes older people and people with disabilities. Local Plans, where they are being revised or developed, can only require new optional access standards 'if they address a clearly evidenced need, and where their impact on viability has been considered'*'.⁴² In rural areas, developments of less than 10 properties are now excluded from Section 106 agreements which makes it even harder to ensure that there is sufficient accessible housing. Yet the latest report of the Housing our Ageing Population Panel for Innovation (HAPPI) estimates that if more age appropriate housing was built 7 million older households might be willing to move. If only half did so it would unlock 18% of the housing market and free up larger homes for younger purchasers. They call on the government to move away from an exclusive focus on first time buyers towards building better designed homes for downsizers.⁴³
- 2.48** The current lack of housing opportunities means that people who would prefer to move end up having homes adapted even when moving might have resulted in a far better outcome. This makes the role of the DFG even more important.

I would consider moving out of my own home into level accommodation like a bungalow but I would not get enough money selling my house to purchase a bungalow in the same area where I want to be. So I am dependent on the DFG to enable me and my wife to get up and down the stairs and get washed



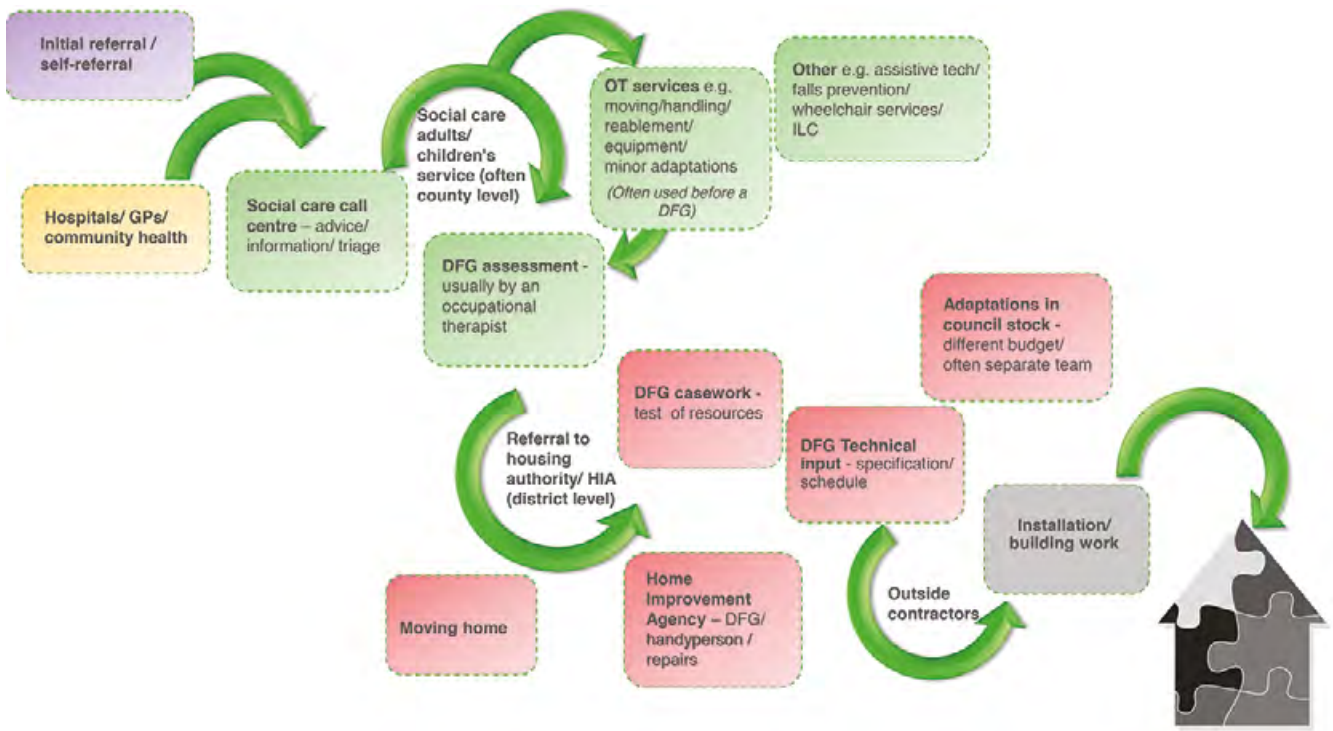
Joining up home adaptation services



The need for integration

3.1 As the previous section has shown housing and social care developed parallel services for disabled people with separate teams, often in different locations, some in-house and some independent. Figure 1 shows the typical customer pathway. This split pathway is still the standard route in many areas although teams tend to work much more closely together than before and some have developed lean systems and minimal paperwork to try to progress cases more quickly.

Figure 1. The typical customer pathway



3.2 Focus groups with older and disabled people invariably reveal that only a small proportion know the grant exists. A report by The Muscular Dystrophy Campaign showed that only 50% of 200 young disabled people surveyed had heard of the grant.⁴⁴ Surveys done as part of service reorganisations of people who have received the grant revealed that more than half find out about it through word of mouth. It means that people who are more isolated may not find out that help is available. The reason for the lack of publicity is because of limited resources, concerns that services might be overwhelmed if they were advertised and a lack of coherence in the approach to service delivery. Hopefully with the additional resources available from 2016/17 and the greater focus on keeping people out of hospital and residential care there should be a greater emphasis on researching local needs and seeking out the people who most need help.

I'm lucky as my children found out about it for me, but for those on their own and isolated, they might not be so lucky

Once you are in the know or on the books it's easy, but perhaps they need to advertise it better for people who don't know

**Where do you go for help?
I was in despair – I didn't know what to do**

The need for integration

3.3 Despite the fragmented nature of service delivery customers place enormous value on the benefits provided by home adaptations as the changes make their lives easier, and in many cases can be transformative. This has been shown by focus group discussions and surveys carried out as part of service reorganisation projects by one of the authors and is confirmed by numerous other studies.^{45 46} Customers seldom have anything but praise for the staff they have come into contact with.

It can't be improved – it's very good. The people that come don't just give you a number; they contact other people for you

I can't see how they could have done it better – I'm very satisfied

Would recommend them to anybody – they are so helpful

3.4 However, the complexity of the pathway means that there is the potential for duplicate assessments and multiple waiting lists. Two examples show the difficulties resulting from split service pathways:

- In one small unitary authority a review revealed that there were two customer service points, at least four places where people could be assessed and a number of teams providing separate services for occupational therapy, private sector adaptations and council stock adaptations. Each used slightly different criteria, had different policies, and used different contractors. Teams were small and no part of the service could provide adequate cover if people were on holiday or off sick. This authority is now bringing the different components together to provide a single, much more efficient, integrated and customer-focussed equipment and adaptation service.
- In county authorities these issues are magnified. A review in one two-tier authority in southern England identified 30 customer access points, 10-12 separate information services, 23 customer databases, at least seven different product stock lists and more than three different eligibility criteria being used across children's and adult's equipment and adaptation services. Reorganisation is underway to bring these elements together, eliminate duplication and provide a more effective county-wide service.

The need for integration

3.5 The main problems for customers that result from these split services are with delays and lack of communication as several Ombudsman reports highlight.⁴⁷ Waiting times vary between authorities. Within authorities it changes from year to year according to demand, the availability of funding, staffing levels and any backlog from the previous year. In the slowest authorities it can take up to eighteen months from first enquiry to completion of work, although most have tried to streamline services and reduce the wait to a maximum of a few months. Reorganisation, better triage, lean systems, fast tracking and streamlining of service delivery can dramatically reduce processing times.⁴⁸ For customers, lack of information, long waits and handovers between different teams leave them unsure about what stage they have reached. It also reduces their chances of seeking other solutions for themselves.

It's very difficult for an individual to understand why there is such a long delay

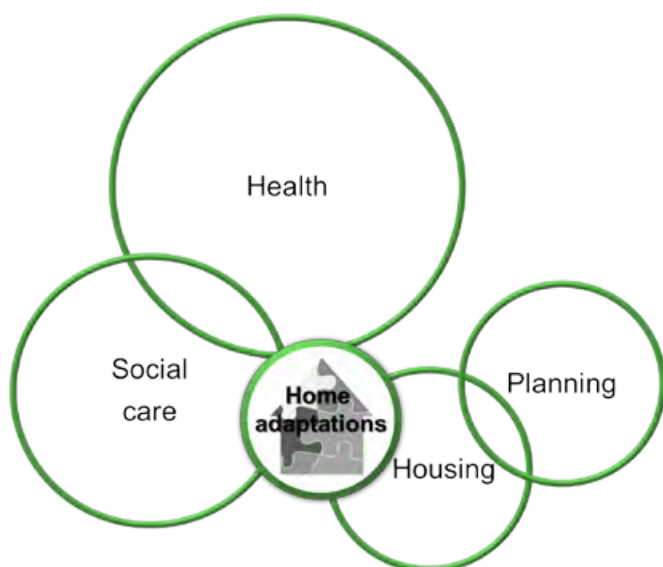
You get given stuff to read but that's no help – you need to be able to talk to someone



Policy vacuum

3.6 Service delivery has remained fragmented, underfunded and largely hidden from public view for a long time partly because it was left in a policy vacuum as large scale housing renewal programmes were wound down from the mid-1990s onwards. All other grants were repealed and the DFG was effectively left orphaned. Figure 2 illustrates the position of home adaptations, sitting between all the major services, yet not really belonging to any of them.

Figure 2 The home adaptations policy position



3.7 The split in responsibility between health, social care and housing has led to a number of problems:

- The DFG is often poorly understood and unappreciated
- Local government contributions to DFG funding have been affected as this is usually the responsibility of housing authorities. When most cost savings accrue to social care and health there is little incentive to increase budgets. It makes it hard to meet changing needs and can contribute to delays for customers
- In many local authorities no strategic team has overall responsibility for the end-to-end customer journey. It is very difficult to instigate change when no one 'owns' the service
- Teams in each part of the service are often quite small and find it hard to have a voice in strategic decision-making
- The lack of influence means that service reorganisation can further fragment the different teams
- The lack of influence also makes it hard to tackle other significant issues such as: the inconsistent funding contributions of registered providers; difficulties with social housing property registers, the allocation of adapted housing; and the lack of accessible homes in new housing developments
- Until recently there was little contact with health teams to get better targeted referrals or develop effective hospital discharge services.

The beginning of change

- 3.8** For a brief period from the mid-2000s there were considerable improvements in both funding and service delivery as a result of Audit Commission inspections. For several years they carried out a programme of short notice inspections of aids and adaptations services, initially for local authorities, and later for registered providers. These looked at access to services, customer care, diversity and value for money. These inspections started to have a considerable impact, resulting in significant service improvements and additional funding going into to adaptation budgets.⁴⁹ However, the Audit Commission inspection role ended in 2010 as part of shift in power away from central government to councils and communities as part of the localism agenda.
- 3.9** A more fundamental change of approach began to develop following the publication of some significant reports. In 2007 the report 'Better Outcomes: Lower Costs' provided evidence that adaptations and equipment produced significant savings in the costs of residential placements, social care and hospital admissions for all age groups and that they had a substantial beneficial effect on people's wellbeing and mental health⁵⁰ In 2008 a strategy for housing in an ageing society 'Lifetime Homes, Lifetime Neighbourhoods', set out a clear vision to 'future-proof' our society and to have 'a more coherent, joined up plan'.⁵¹ It made the case for investment in home adaptations, announced an increase in resources and stated the need to reconnect housing with health and care. At the same time a 'Vision for Social Care' put forward an ambition for a person-centred service *'to reform health and social care, alongside an integrated public health service focused on prevention'*⁵². In 2010 a Foundations report on *options for the future delivery of home improvement agency services looked at the way agencies 'can play a strategic part in transforming adaptations services from the current focus on a single grant process to one that is integrated into a range of options for independent living'*. A further report 'Are we Ready for Ageing' in 2013 called for a transformation in health and care services stating that *'the home must become the hub of care and support' and that, 'if preserving independence is to be a central goal, appropriate and safe housing will become increasingly important'*.⁵³
- 3.10** The Health and Social Care Act 2012 began the reorganisation of health services and led to the formation of Clinical Commissioning Groups, the return of public health to local authority control and the establishment of Health and Wellbeing Boards (HWB). Upper tier and unitary authorities were given new responsibilities to improve the health of their populations and to focus on prevention.
- 3.11** In relation to the DFG, the most fundamental change was announced in the summer of 2013. This was the transfer of the delivery of DFG funding from the Department of Communities and Local Government to the Department of Health and the payment of the DFG through the Better Care Fund. This came into operation in April 2014.

The Better Care Fund

3.12 The Better Care Fund is a 'single pooled budget for health & social care services to work more closely together in local areas based on a plan agreed between the NHS & local authorities'.⁵⁴ Its aim is to move "away from a 'sickness service', and towards one that enables people to live independent and healthy lives in the community for as long as possible by joining up services around the person and their individual needs"⁵⁵. It has a number of specific objectives which include:

- Reducing pressures on health services, particularly emergency admissions (the national goal is to reduce this by at least 3.5%)
- Protecting local adult social care services
- A move towards seven day working to support discharge and prevent admissions
- A joint approach to assessments and care planning with an accountable professional where there are integrated packages of care
- Use of the NHS number to facilitate data sharing
- Reductions in admissions to residential and care homes
- More effective use of reablement,
- Reductions in delayed transfers of care
- Improvements in the patient/service user experience.

3.13 The Better Care Fund pooled a number of existing funding streams and is administered locally by Health and Wellbeing Boards. However, the lower tier housing authority still has the statutory duty to provide adaptations to the homes of disabled people who qualify for a mandatory DFG. In the related 'Policy Framework' upper-tier authorities are compelled to pass on the DFG funding from the pooled budget to enable housing authorities to continue to meet this mandatory duty. Conditions to this effect have been added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003).⁵⁶ Although in the first year the DFG only made up a small amount of the total budget, it placed the DFG into a completely new framework to allow a different approach to its delivery that is potentially much more joined up with health and social care. For the first time there is a clear focus on the health and care outcomes of the service user (including statutory outcomes and targets), rather than on just delivering service outputs.

3.14 Better Care Fund allocations for 2016/17 showed that the DFG will play a more prominent role. The Social Care Capital Grant (SCCG) has been discontinued and the capital allocation, along with a small amount of additional funding, transferred to the DFG. In 2016-17 the DFG reached £394m, making up 10% of the total fund; a 79% increase over the previous year. Announced in the 2015 Autumn Spending Review was a commitment to raise the DFG budget still further to more than £500m by 2019/20 as part of an improved Better Care Fund⁵⁷. The aim is to fund around 85,000 home adaptations by 2019/20 which is expected to prevent 8,500 people from needing to go into care.

Table 1. DFG Better Care Fund allocations

Year	BCF funding	DFG funding	DFG as % of BCF	% increase in DFG from 2015-16
2015-16	£3.8 billion	£220 million	5.8%	-
2016-17	£3.9 billion	£394 million	10.1%	79%
2019-20*	£5.3billion	£500 million	9.4%	127%

The Care Act 2014

- 3.15** The Care Act 2014 repealed most of the previous social care legislation and guidance and marks a fundamental reform of service delivery. Alongside the Act there is extensive statutory guidance to help with interpretation. The Act requires local authorities to deliver services built around an individual's needs in order to promote wellbeing and, where possible, support independent living. The definition of wellbeing has several components which relate to adaptations: personal dignity; physical and mental health, emotional wellbeing, control over day-to-day life and the suitability of a person's living accommodation.
- 3.16** The Act recommends that wherever possible there should be a single assessment, with carers entitled to their own assessment. The housing part of the assessment should include: *'suitability, access, safety, repair, heating and lighting.'* There should also be one point of contact to help join up pathways and prevent people falling through gaps in service provision.
- 3.17** There is a focus on prevention with the guidance stating that *'Local authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/ reablement services, e.g. community equipment services and adaptations'* (para 2.9). Prevention includes: providing good quality information, including housing advice; and also encompasses support for safer neighbourhoods, promotion of healthy and active lifestyles and ways of reducing isolation.
- 3.18** To achieve these aims partnership working will be essential and the importance of social care services working with both health and housing is mentioned numerous times. *'Integrated services built around an individual's needs are often best delivered through the home. The suitability of living accommodation is a core component of an individual's wellbeing and when developing integrated services, local authorities should consider the central role of housing within integration'* (para 4.90)⁵⁸.
- 3.19** In the past, strict application of the Fair Access to Care Services (FACS) eligibility criteria sometimes screened out people who might have benefited from adaptations, despite the separate right to an assessment for a DFG as defined by the Housing Grants, Construction and Regeneration Act 1996. This has changed under the Care Act 2014. Assessment should now occur if it appears that an adult may have needs for care and support irrespective of the level of need or their finances. Combined with a more holistic approach to assessment this should expand the number of people who could benefit from a DFG and give more access to advice and information for people needing or wishing to self-fund. The guidance also says that assessors have to be 'skilled, knowledgeable, competent and appropriately trained' which may give local authorities more flexibility in deciding on the combination of non-qualified and professionally qualified staff they wish to use depending on the complexity of the case, but they will need provide a rationale for their approach.
- 3.20** Previous legislation sometimes made it difficult to determine which organisation was responsible for equipment, minor works and major adaptations. The new Care Act tries to clarify this by stating that if a housing authority has legal obligations under the Housing Grants, Construction and Regeneration Act 1996 then the (social services) authority does not have to meet those needs (para 15.51) and that the DFG continues to be the responsibility of the housing authority. However, it stresses that this should not prevent joint working. Health and social care continue to have responsibility for community equipment (aids and minor adaptations) for the purpose of assisting with nursing at home or aiding daily living. They also retain responsibility for providing minor adaptations where the cost of making the adaptation (purchase and fitting) is £1,000 or less. Equipment and minor adaptations should be provided free of charge in order to meet eligible needs or as a preventative service.⁵⁹ These are clearly seen as vital services to help people remain living in their own homes.

The Care Act 2014

3.21 Although not about housing, the requirements of the Children and Families Act 2014 should result in provision of more holistic assessments that are more person-centred. The Chronically Sick and Disabled Persons Act 1970 still applies to children but the new Children and Families Act extends responsibility for young people from 18 to 25 which should allow better planning for the transition from childhood to adulthood.

3.22 Integration of services still has some way to go but the government's plans for health and social care to be joined by 2020 means that change is proceeding rapidly. Across health and social care there is much greater understanding of the importance of improving the home environment and in joining up services which means that vacuum in policy surrounding the DFG is now being filled. The inclusion of the DFG in the Better Care Fund, the rise in resources available and the changes being introduced by the new Care Act means that home adaptations can begin to play a much more central role in keeping people out of hospital and care and as independent as possible in their own homes.

3.23 The next section looks in detail at the way the grant has been funded since its inception, the age groups and tenures that have been the recipients of grant aid and the value and type of work funded. It only includes one year of the Better Care Fund but it provides a baseline to judge the impact of the major changes to service delivery that are taking place at the present time. The final section of the report will then go on to look at the way DFG service delivery is changing and the need for better data on both service outputs and the outcomes for grant recipients.



Data Sources



LOGASnet data

4.1 The data on the DFG used in the following section is mostly taken from LOGASnet. This is the Department of Community and Local Government's web-based data capture and payments system. It is used to obtain data both for statistical purposes and to assist with the processing of grant claims and payments such as Housing Revenue Account Subsidy and Supporting People grant. Forms are created and maintained by the Department and completed online by each authority. Information about the DFG is submitted annually and relates to expenditure on grants completed during the preceding financial year.

4.2 Data on the DFG from LOGASnet are available going back to 2004. From 2004-2007 information is relatively limited and varied significantly from year to year. From 2008 onwards the scope of the information collected was expanded, and subsequent changes have been more limited, although still significant. As a result, the data is most useful from a research perspective for the period since the financial year 2008-09. The information currently collected includes:

- central government allocations
- local authority matched-funding contributions
- overall expenditure
- the number of grants allocated per year
- average grant size and the size of grants (number of grants in pre-defined cost bands)
- the age of recipients (banded to distinguish people under 21 and those aged 65+)
- tenure of recipients
- allocations to ex-service personnel (since 2014-15 only)
- use of charges on property and recycling of grants

4.3 The headline data have not been published since 2010/11 and the complete contents of the dataset have previously not been analysed in any detail. Appendix B contains an example of a data collection form.

Caveats about the data

4.4 The dataset is far from perfect as it was developed for administrative rather than research purposes. It may be completed by people in finance departments, rather than those in home adaptations teams, who may not always fully understand the adaptation process. There are some missing returns and anomalies in the way the return has been completed, perhaps arising from a lack of clarity in definitions in the LOGASnet questionnaire. It also reflects the different policies of local authorities. For example, most authorities take the minor works threshold to be work under £1,000, but a few set it at £500 and others at £1,500 which either increases or decreases the number of DFG grants. Some social care services pay for items like hoists and moveable ramps while in other authorities these are done under the DFG, again altering the figures. Checking some authorities with unusually high figures for grant completions revealed that some had included the adaptations completed in the council stock (funded from the Housing Revenue Account) in the DFG figures. At the other extreme, some figures seemed unusually low. A number of authorities have used discretionary grants rather than mandatory DFG grants to speed up the process by removing the test of resources and these grants were not always recorded on LOGASnet.

4.5 Given the cutbacks in local authority staff resources, and the level of reorganisation currently going on in many adaptation departments it was difficult to ask local authorities to fill in gaps or to check back on historical data. Instead information that is clearly inaccurate has either been adjusted or screened out and estimates made to fill gaps in trend information.

LOGASnet data

Data omissions

4.6 The LOGASnet dataset is also limited in that it does not give information on certain variables of key interest to service commissioners which include:

- **End-to-end customer journey times** – LOGASnet does not record how long a disabled person has to wait from first enquiry to be assessed by an occupational therapist and to get the work planned and completed. The reasons for this omission relate to the way grant delivery is split between different directorates and departments and the fragmented nature of IT systems which makes it hard to extract information on dates.
- **Type of work carried out** – this vital piece of information is also missing. Again it is mainly a data recording and IT problem. Multiple jobs for a single customer are put together making it hard to separate out the different elements for analysis.
- **Moving** - there is no information about how many people are helped to move rather than have their homes adapted or how many people are waiting to move.
- **Service structure** - the data also tell us nothing about staffing levels, the nature of the service (e.g. in-house local authority service or independent agency), or about others services that run alongside the DFG (e.g. council stock adaptations, full range of home improvement agency services).

4.7 Allowing for errors and omissions LOGASnet is still the best national dataset relating to the DFG that we have at the present time. It gives a good indication of the geographical spread of resources, the distribution by age group and tenure, average grant value and trends over time. It provides a useful baseline of information relating to the period leading up to the introduction of the Better Care Fund.

The Findings



The Findings

5.1 This section provides an analysis of the LOGASnet data. It looks firstly at the number of grants provided and their distribution by tenure, age and size of grant, before moving on to look at expenditure and sources of funding both nationally and by type of authority. Finally, an assessment is made of DFG spending in comparison to various measures of potential need. In all the tables, figures and maps in this section, the source of data is the LOGASnet database except where stated otherwise. The table in Appendix B includes some more detailed figures.

Provision of DFGs

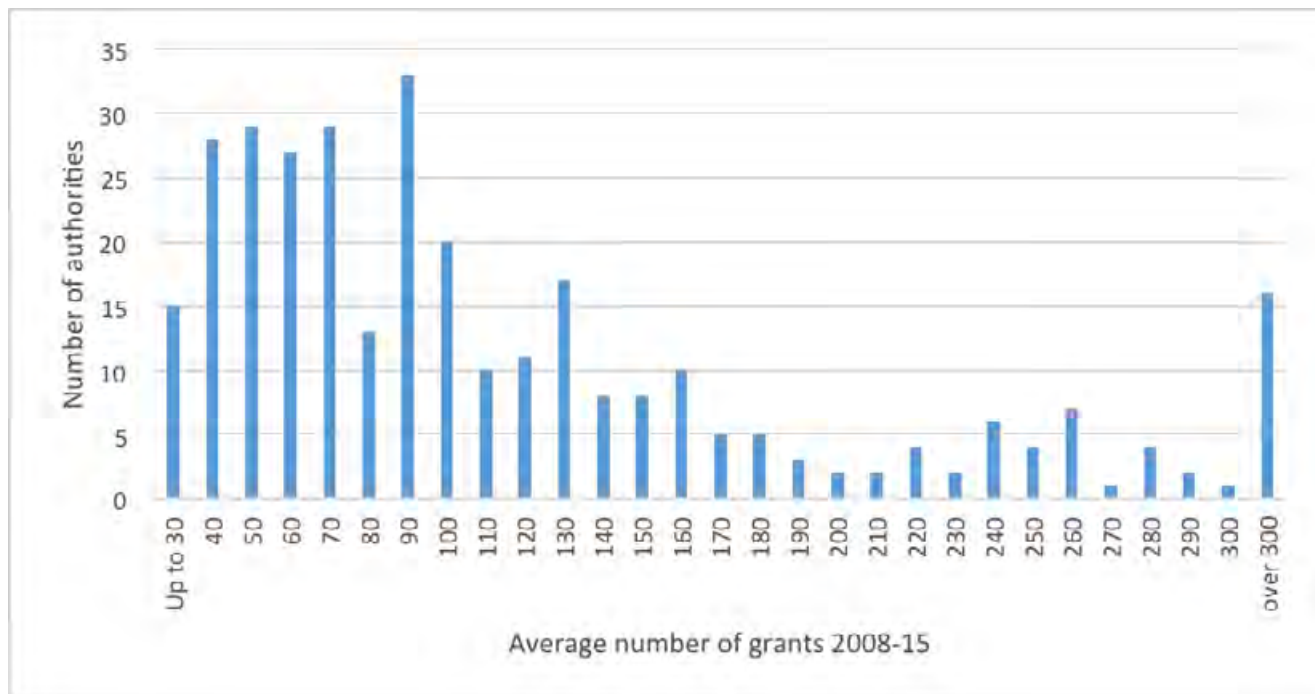
5.2 Overall there has been a national decline in total DFG provision since 2010-11 with 54% of authorities reducing the number of grants approved between 2010-11 and 2014-15 (Table 2). However, against the trend 26% increased the number of grants. (The remaining 20% did not provide data for one or both of these dates). The average number of grants shown in Figure 3 demonstrates that most authorities provide less than 100 grants per year on average. With the increase in resources from 2016/17 the number of grants should increase to around double current levels. However, some authorities provide very small numbers of DFGs suggesting that there might be scope to amalgamate services in certain areas.

Table 2. Total number and amount of DFGs provided

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Average 2008-15
Number of DFGs	42083	44626	45549	43865	42125	42770	40645	43095
Average amount £	7429	7178	7215	7167	7396	6870	7729	7255
Average 2014-15 prices £	8061	7802	8031	7866	7875	7074	7729	-

Provision of DFGs

Figure 3. Average number of grants by local authority



Tenure of grant recipients¹

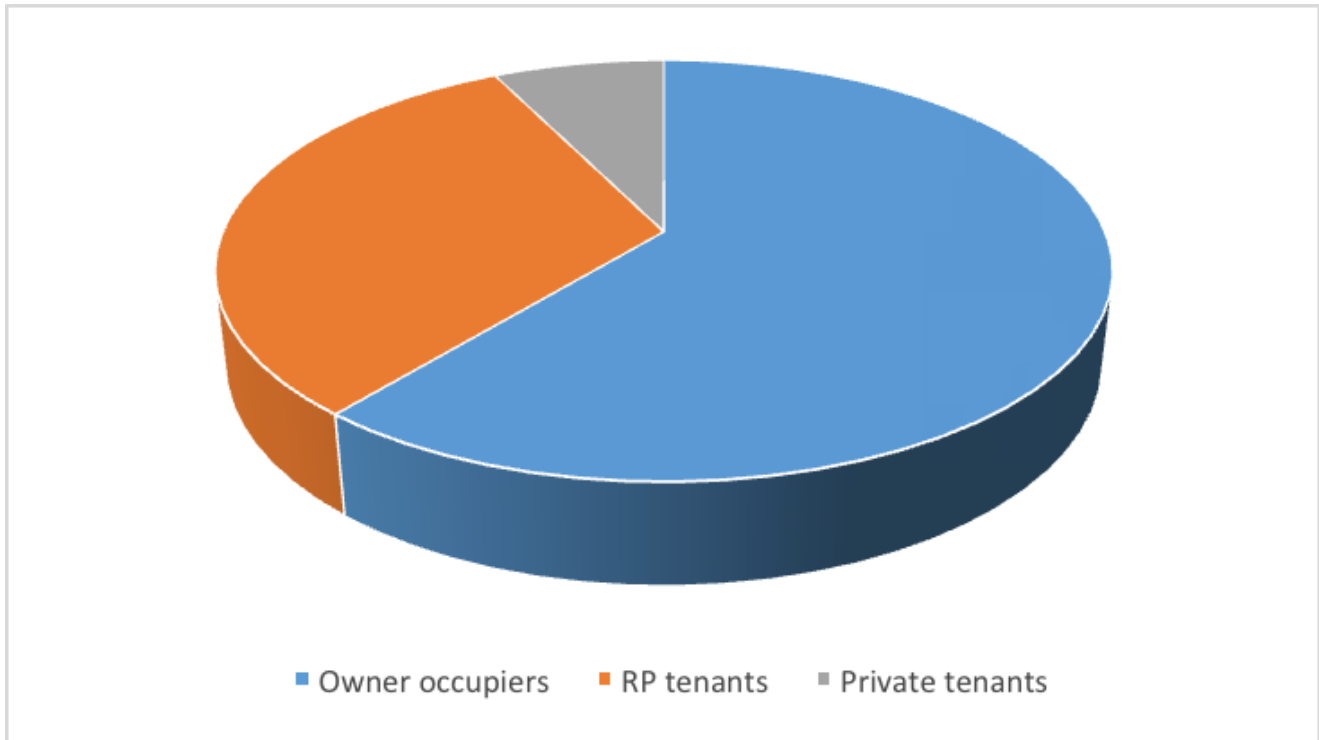
5.3 As Figure 4 shows, owner occupiers received the largest share of grants – 61% on average over the 2008-15 period, although on a declining trend year on year. This is a smaller proportion than would be expected on a pro rata basis, as owner occupiers made up 70% of eligible households in England in 2011 (that is as a proportion of all households excluding council tenants). Tenants of registered providers received on average 32% of DFGs, although forming only 9% of all households. Private rented sector tenants received 7% of DFGs on average, although they formed 19% of eligible households (or 20% if people living rent free are included in this category).

5.4 On the surface this suggests that registered provider tenants were much more likely to obtain a DFG than other groups, owner occupiers somewhat less likely to do so, and private rented sector tenants much less likely to do so. However, there is no reason to expect a pattern of provision closely related to the underlying pattern of tenure, as variations in need or resources are also likely to be significant. To give two obvious examples, the private rented sector has a very high proportion of younger households, who are much less likely to have disabilities requiring adaptations, so a lower level of DFG provision to households in this tenure would be expected; and households in the owner occupied sector tend to have higher incomes and savings than tenants (even in older age groups) and access to equity in their homes, and so may be more able to fund adaptations from their own resources.

¹ As a result of data entry errors, or the method used to estimate missing data, the totals for the breakdown of grants by tenure, amount and age of recipient do not exactly match the total number of grants. Percentages are based on the actual total for each category.

Tenure of grant recipients

Figure 4. Tenure of DFG recipients 2008-15



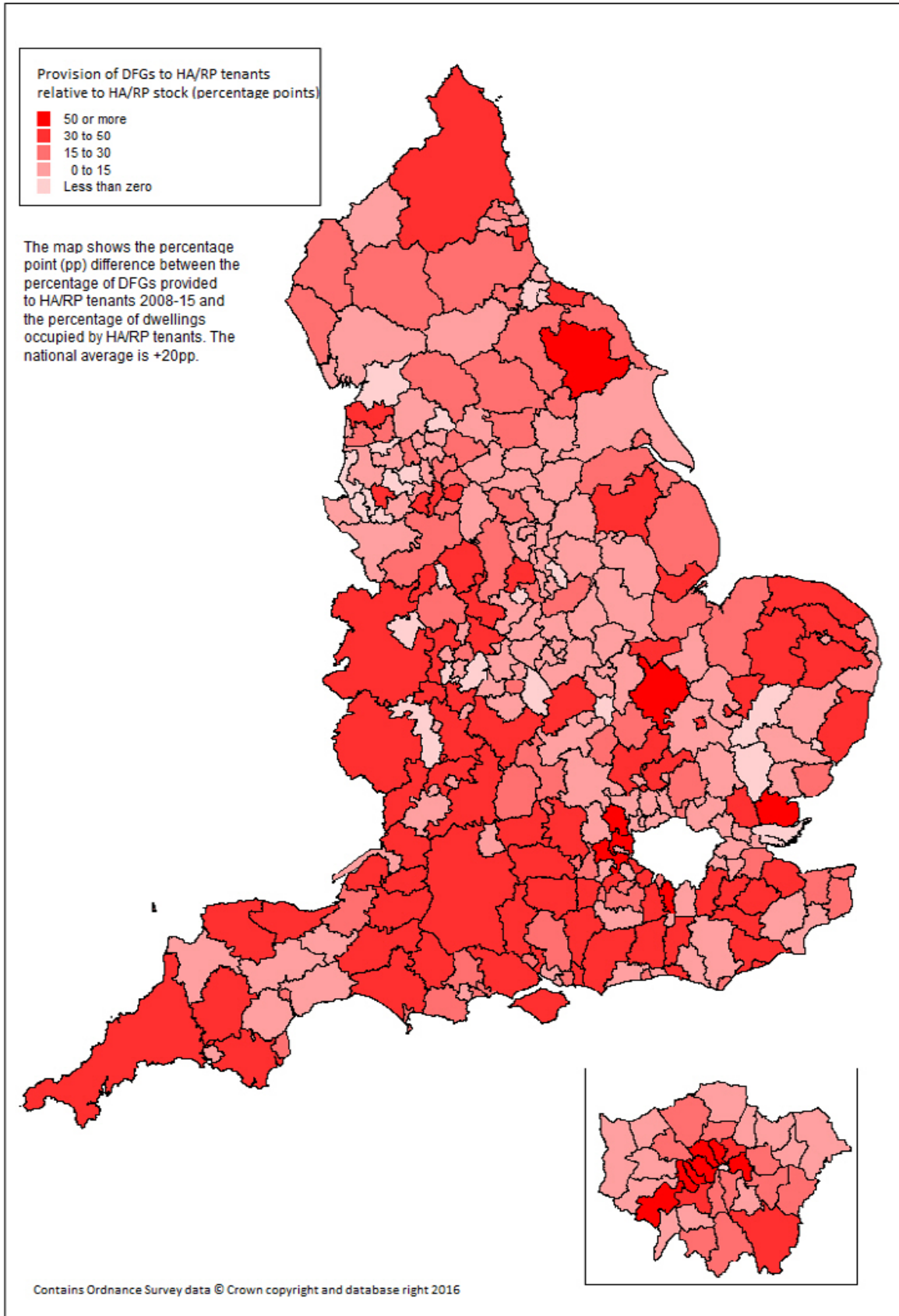
5.5 Having said this, registered provider tenants are around three and half times more likely to access a DFG than their level of representation would suggest. Map 1 shows which authorities have the highest level of provision to these tenants relative to the proportion of registered provider-owned stock in their areas. It shows the difference in percentage points² between grants to registered provider tenants and registered provider owned dwellings by local authority. There is a clear north-south split with a higher difference between the proportion of grants provided to registered provider tenants and the proportion of registered provider stock in the southern half of the country (and within London, in central and west London), although there are clearly some exceptions to this pattern. In the areas of darkest shading, the level of provision to registered provider tenants exceeds the proportion which would be expected from the stock profile alone by the largest extent.

5.6 There could be many factors underlying and explaining this pattern. The social housing stock overall houses proportionately more people with disabilities (48.5% compared to 26.8% in owner occupation and 21.9% in PRS) and registered providers house more disabled children (5% compared to 4.1 in the PRS and 2.1% in owner occupation)⁶⁰. However, the registered provider stock is newer on average and has more accessibility features and it has been estimated that a third of older tenants over retirement age are in specialist housing.⁶¹ Properties should therefore need less adaptation than the owner occupied and privately rented stock.

² A percentage point (pp) difference is simply the result of subtracting one percentage from another.

Tenure of grant recipients

Map 1. Provision of DFGs to registered provider tenants relative to proportion of registered provider stock



Tenure of grant recipients

Table 3 Grants to registered provider tenants compared to size of registered provider stock

Type of area	Average % of grants to RP tenants 2008-15	Average % of stock in area owned by RPs
No LSVT – stock ownership retained by local authority/ALMO	18%	5%
Partial LSVT – some stock transferred	39%	12%
Full LSVT – all stock transferred	39%	13%

Source: CLG records of LSVTs, Homes and Communities Agency Statistical Data Returns (various years)

5.7 As Table 3 shows, the areas with a high level of grant provision to registered provider tenants are often those where the former council stock has been transferred to a registered provider through the process of large scale voluntary transfer (LSVT) which may have been in poorer condition at the time of transfer. In areas where no transfer of stock has taken place, registered providers owned on average 5% of the housing stock, but registered provider tenants received on average 18% of DFGs, or 13% more than a pro rata share would suggest. In areas where a full or partial stock transfer has taken place, 39% of grants were provided on average to registered provider tenants, whereas registered providers owned only 12-13% of the stock, a difference of 26-27%. So there is a strong association between past transfer activity and the proportion of DFGS provided to registered provider tenants. As is explained in Section 3 in some cases registered providers, particularly transfer organisations, may contribute funding to the DFG, but in other cases they do not.

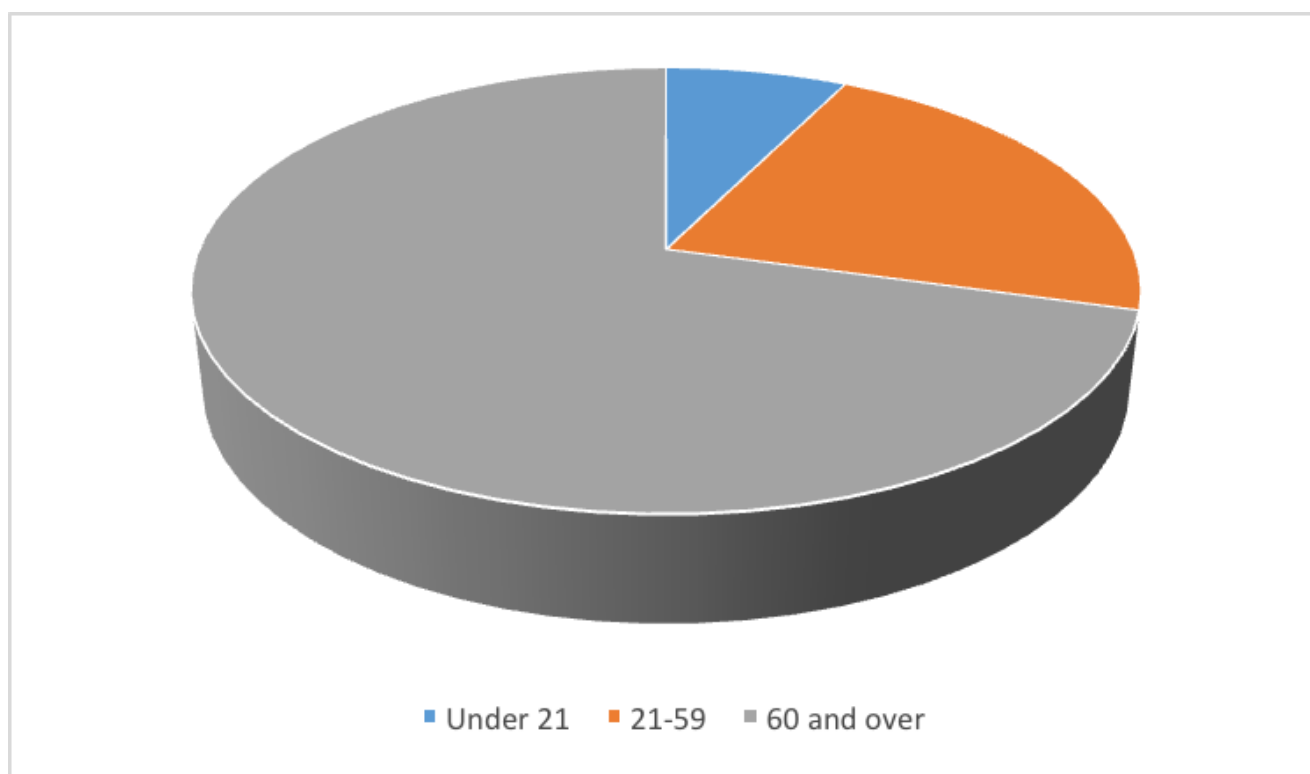
5.8 There are clearly some issues about the tenure distribution that would warrant closer investigation if better data were available. We need to know more about how much registered providers put into the DFG in each authority as LOGASnet does not capture any of these financial contributions. In some areas this may compensate for their high use of DFGs, but it is apparent from other studies that not all registered providers make these contributions.⁶² There is also a need to look further at how this apparent tenure imbalance affects owner occupier's use of the DFG. The grant is not well known as was discussed in Section 4. Many owner occupiers do not realise that help is available from the council; unlike registered provider tenants who will be directed to the service by their landlord. When owners do apply, the test of resources may exclude many who are unable to go ahead with work if their incomes and savings are only just above the threshold. For home owners, disability, low income and low equity tend to go hand in hand and many will not be able to find the resources to self-fund.⁶³

Age of grant recipient

5.9 Data on the age of grant recipients should be treated with caution, as the LOGASnet database reports only the numbers of grants to people under 21 and people aged 60 and over. The number of grants to those aged 21-59, and the percentage shares by age group have been inferred from the total number of grants reported. This may have had the effect of exaggerating the share of grants to the 21-59 age group.

5.10 As Figure 5 shows, 71% of all DFGs provided over the period 2008-15 were to people aged 60 or more, with 22% provided to people aged 21-59 and 7% to people under 21. This breakdown by age of recipient was remarkably constant from year to year since 2009-10. Older people are thus the main recipients of the grant. Anecdotal evidence suggests that children and young people (here necessarily defined as people aged under 21) with disabilities often receive larger grants, but the LOGASnet dataset does not provide this information directly.

Figure 5. Age breakdown of DFG recipients 2008-15

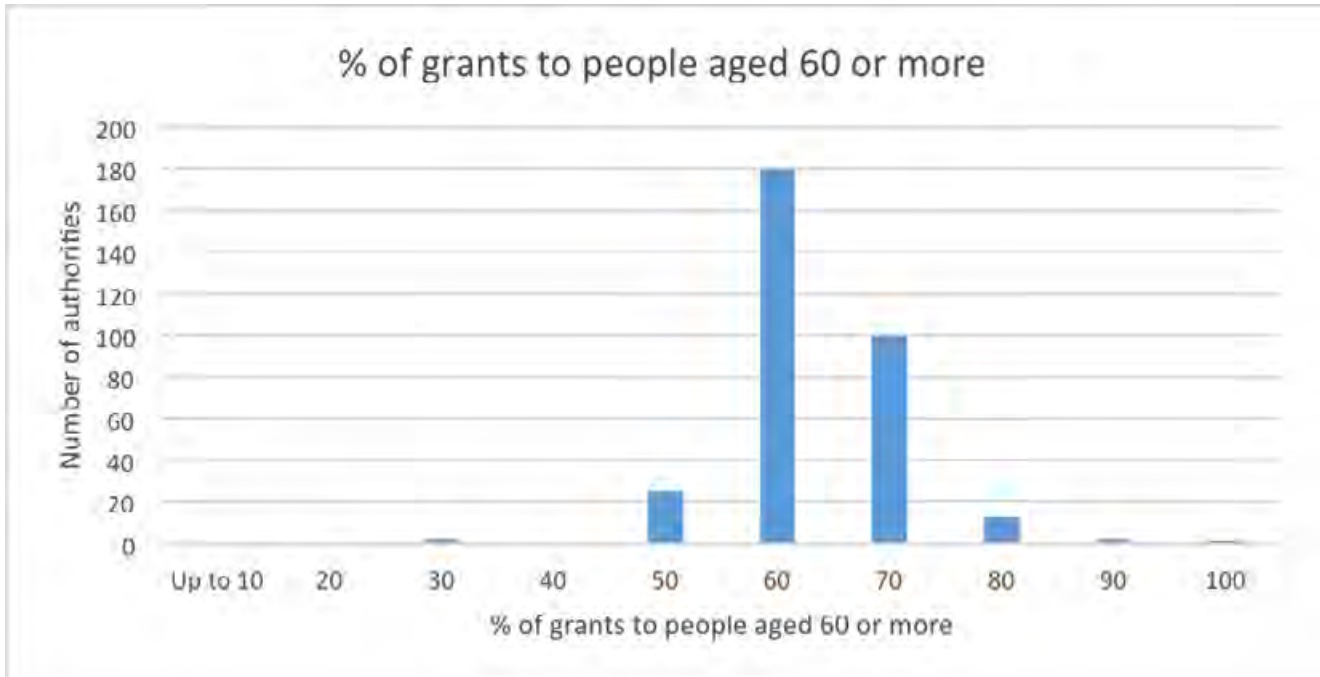


5.11 Older people are more likely to have disabilities than other age groups which is reflected in the way resources are allocated. On average across all authorities the proportion of grants to people aged 60 or more was 13 percentage points greater than their share of the population, suggesting a higher rate of provision than average to older people. Figure 6 shows that few local authorities deviate from the pattern of providing most grants to people aged 60 or more. The median and the average levels of provision to older people at local authority level were both 63%³, and a half of all authorities provided between 59% and 67% of grants to older people. The outliers with lower levels tend to be smaller authorities where a few expensive grants to other age groups might distort the picture.

³ The overall percentage of DFG provision to older people cited in the previous paragraph is based on the overall number of grants to this group. The average (and median) cited in this paragraph are based on the percentages for each individual local authority.

Age of grant recipient

Figure 6. Grants to people aged 60 or more, 2008-15



Size of grant⁴

5.12 As Table 2 above shows, the average amount of grant provided by all authorities over the 2008-2011 period was £7,255. The average has fluctuated in the range £6,870-£7,729 and so has remained, remarkably, more or less unchanged (minus 5% to plus 7%) over the whole period. This suggests a stable picture of either the nature of the demand for grant aid or of the management of grant supply by providers, or a combination of both. Allowing for price inflation, the trend shows this level of consistency, excepting a sudden drop in 2013-14 when the average fell, but there was a recovery in 2014-15.

5.13 There is, however, more variation in average grant level at local authority level. As Table 4 shows, London Boroughs have a much higher average than other types of authority, which are all relatively similar.

5.14 The average of the average grant provided by local authorities was £7,256 and the median of the averages was £6,797. A quarter of authorities had an average below £5,625 and a quarter above £8,024. Figure 7 shows the distribution, with relatively few authorities averaging below £4,000 or more than £9,000.

⁴ The database for 2014-15 did not report any grants at the maximum level, but this seems unlikely to be correct. In terms of grant amounts, the LOGASnet database reports grants in the ranges 'Up to £5,000', '£5,001 to £15,000', '£15,001-£30,000' and 'At maximum entitlement'. As the maximum grant is £30K, grants in the last of these categories should be included in the £15,001-£30,000 rather than being additional to it and this is assumed to be the case.

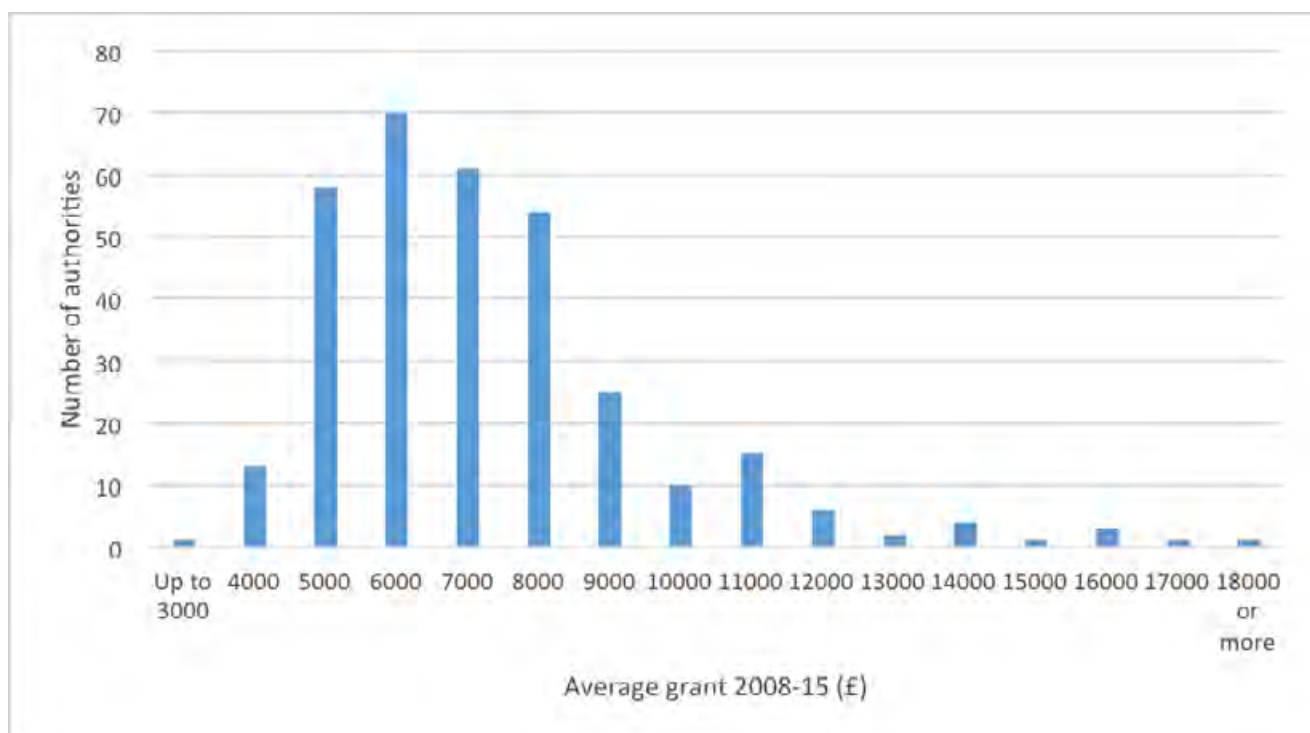
Size of grant

Table 4. Average grant levels and value of grants by type of authority 2008-2011

Type of authority	Average of average (£)	Average percentage of grants			
		Under £5,000	£5,000-£15,000	£15,000-£30,000	At max level (£30,000)
Metropolitan District	7,470	58%	34%	8%	4%
Non-met unitary authority	6,980	57%	35%	8%	5%
Shire District within county	6,801	59%	33%	8%	4%
London Borough	10,234	34%	52%	14%	7%
All authorities	7,256	56%	35%	9%	5%

Note: the percentage of grants at the maximum level is included in the percentage for the range £15,000-£30,000.

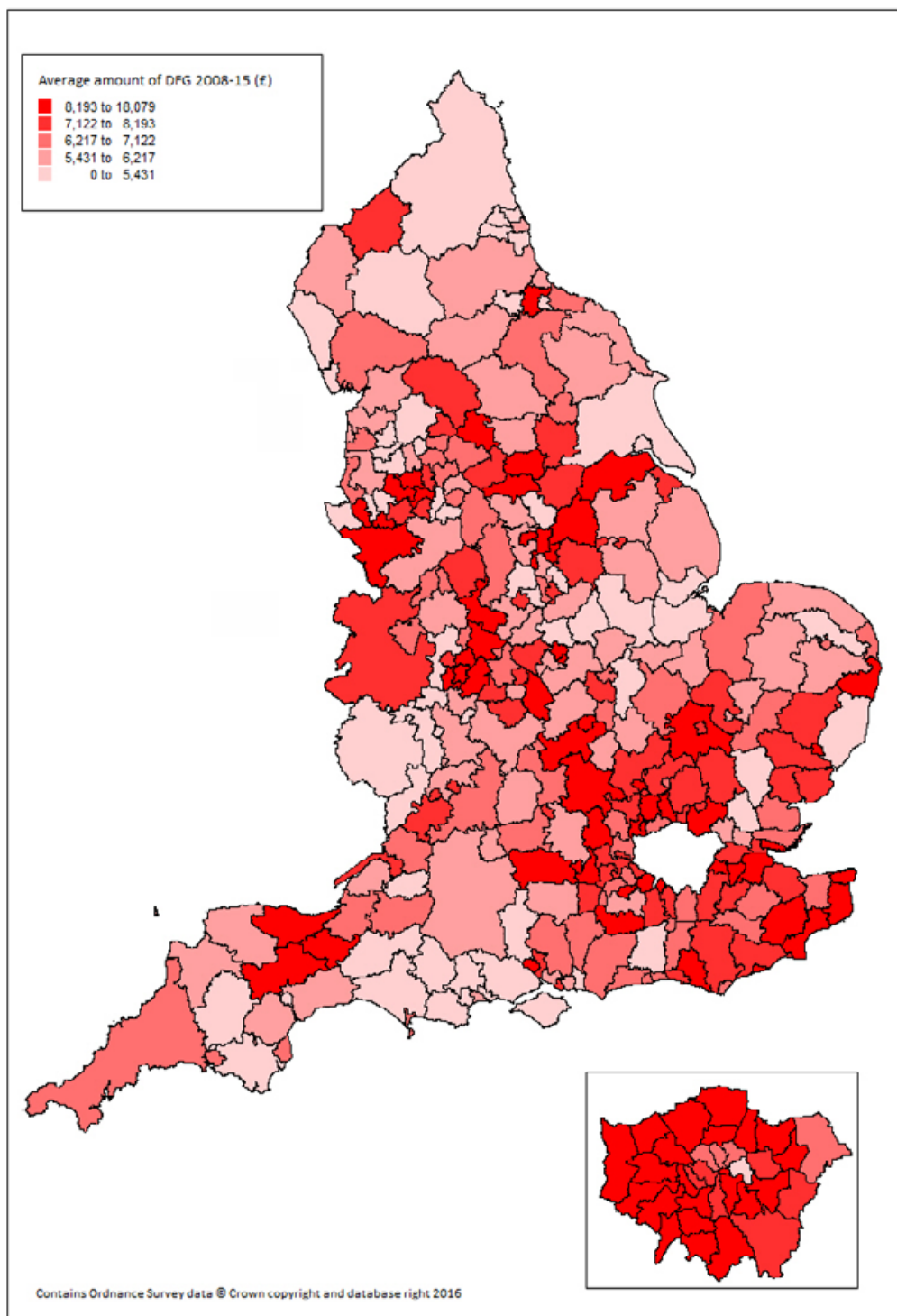
Figure 7. Average size of grant 2008-2015 by local authority



Size of grant

5.15 Map 2 shows the pattern of average grant levels. As well as the London Boroughs, as we have seen, a ring of authorities around London in the South East and East Anglia have high average grant levels and this is also probably related to higher building costs. Many of the other areas with higher average values outside this area are urban, for example in the West Midlands, Merseyside/Greater Manchester and South/West Yorkshire, but some urban areas such as Tyneside do not have high average values.

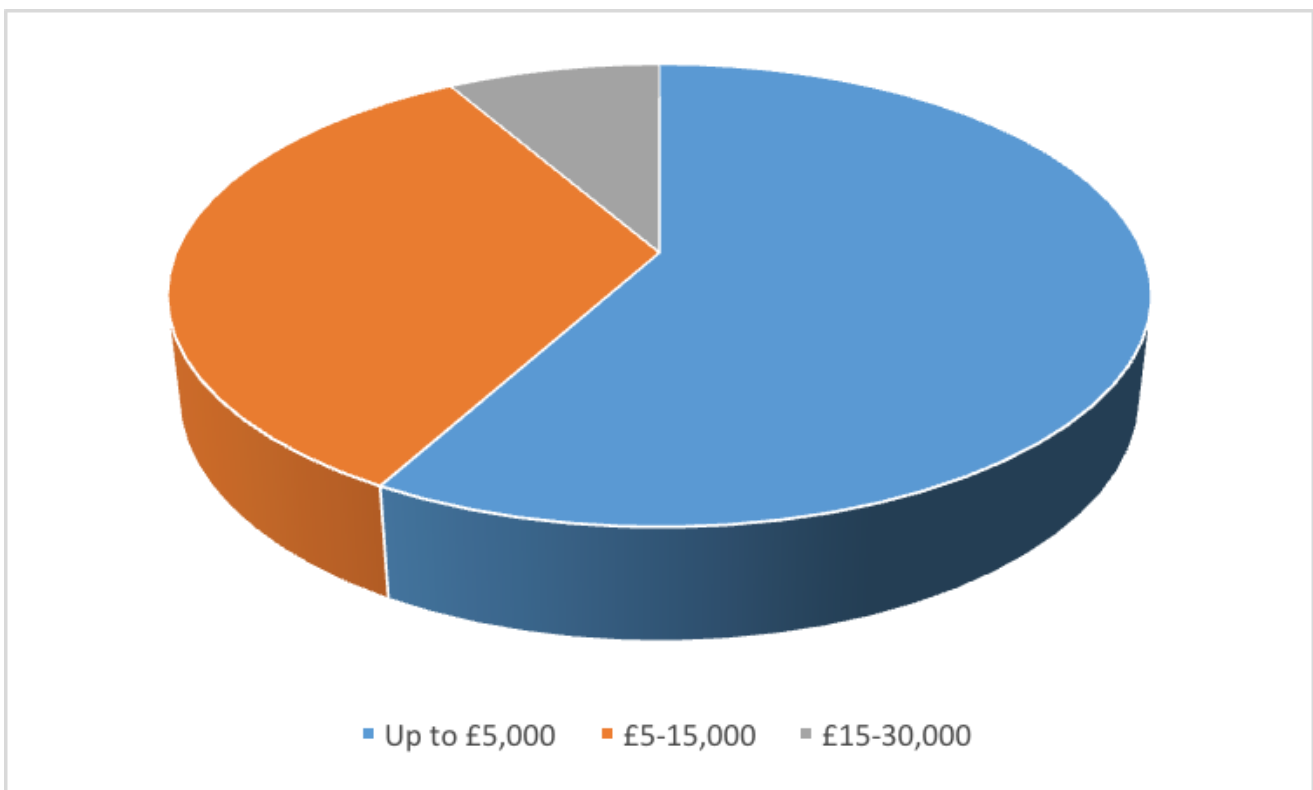
Map 2. Average amount of DFG 2008-15



Size of grant

- 5.16** The dataset does not provide any basis for disentangling the effect of higher building costs (due to geographical variations or differences in procurement methods), from policy-related differences in the scale or type of work carried out, and there is no external data source on local building cost variations which could be applied to these average costs to try to isolate their impact. There are many reasons why average grant sizes may differ. Some authorities may be better at negotiating rates with suppliers/builders than others, but others may have found it hard to reduce costs as they are locked into framework agreements. Some authorities carry out fewer cases involving large scale adaptations than others. There are variations in policies towards expensive work, with some authorities funding fewer extensions and preferring to change the internal layout. There has also been a trend towards employing specialist staff in adaptations teams to help people move home rather than stay put in properties that require extensive alteration.
- 5.17** Average grant levels, of course, conceal the distribution of grants by size, but the LOGASnet database provides a breakdown of grants by broad amount. Across all authorities, 58% of grants were up to £5,000, 34% in the range £5,001-£15,000, and 8% in the range £15,001 to £30,000. Of the latter 5% were reported as being for the maximum amount of £30,000.

Figure 8. Breakdown of DFGs by amount 2008-15



Size of grant

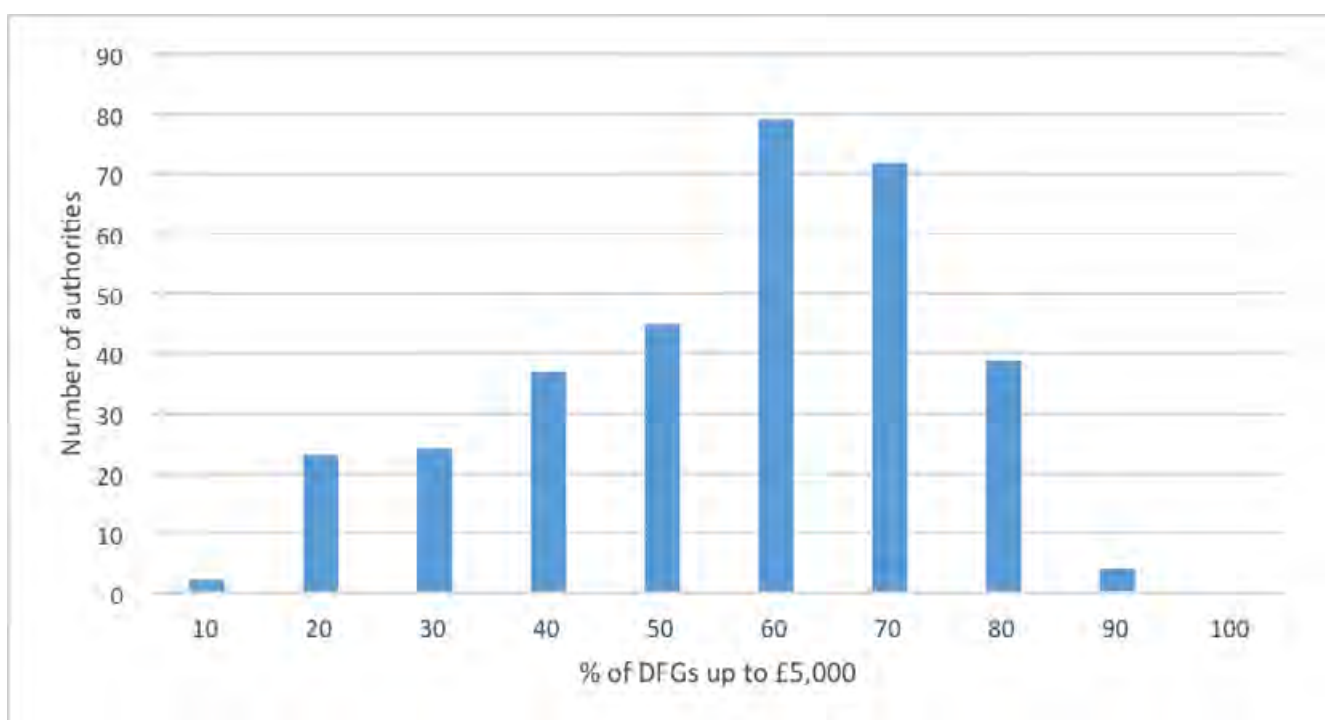
5.18 Hence it is highly misleading to think of the DFG as a large grant, since only one in twenty grants are at the maximum level. In practice most authorities report even fewer maximum grants than this, with the average inflated by around 20 authorities with 10-30% of grants at the maximum level. Even the average grant level of just over £7,000 is atypical, with probably around two thirds of grants below this level. As Figure 9 shows, in almost 50% of authorities, between 60% and 79% of grants were for £5,000 or less, and a further 15% provided more than this proportion. This suggests that complex assessment, means-testing and specification processes could be greatly simplified to be more commensurate with the actual cost of the work. This is happening in a number of areas but is still not accepted everywhere.

5.19 It is hard to reliably conclude that the provision of grants at the maximum level is declining, because of the large volume of missing entries in this field in the dataset, which rose from 15 authorities in 2009-10 to 41 in 2013-14. This data is missing altogether from the 2014-15 returns. This certainly accounts for some of the decline in the reported number of maximum grants from 2,034 to 713 in

2013-14, but not all. In addition, the number of authorities reporting that they did not provide any grants at the maximum level rose from 69 in 2008-09 to 76 in 2013-14. So it is probable that there has been a decline in grants at £30,000, particularly after 2012-13.

5.20 The grant ceiling that currently stands at £30,000 is often not adequate for children's cases as sometimes the only solution is to provide a purpose built extension which can cost anywhere up to £70,000. Top-up funding from social care services has become increasingly hard to obtain and, although interest free loans are available in some cases, finding additional funding can often lead to long delays. Clarification is required about the responsibilities of the social care authority as this seems to be inconsistent across the country. A DFG summit held by Foundations in 2015 called for the upper limit of the DFG to be raised as the long term cost savings to health and social care of keeping a family together and avoiding residential care are very high.⁶⁴ This has also been called for by disability organisations for people of all ages who need more extensive adaptations.⁶⁵

Figure 9. Distribution of local authorities by the percentage of grants of up to £5,000 2008-15



Grant expenditure and sources of funding

5.21 Table 5 below shows aggregated data on funding for, and expenditure on, DFGs in England over the period since 1998 from local authorities and central government. Spending in cash terms increased steadily throughout the 1990s, and more rapidly in the 2000s, peaking in 2010-11 at over £300 million. It subsequently fell to only £286 million in 2013-14 before increasing again in 2014-15. In real terms (Figure 10), the trajectory of growth has been slower but still positive except between 2004-6 when it remained static and 2010-13 when there was a significant reduction.

* The totals do not include additional contributions made by registered providers or local health authorities which are not collected by LOGASnet.

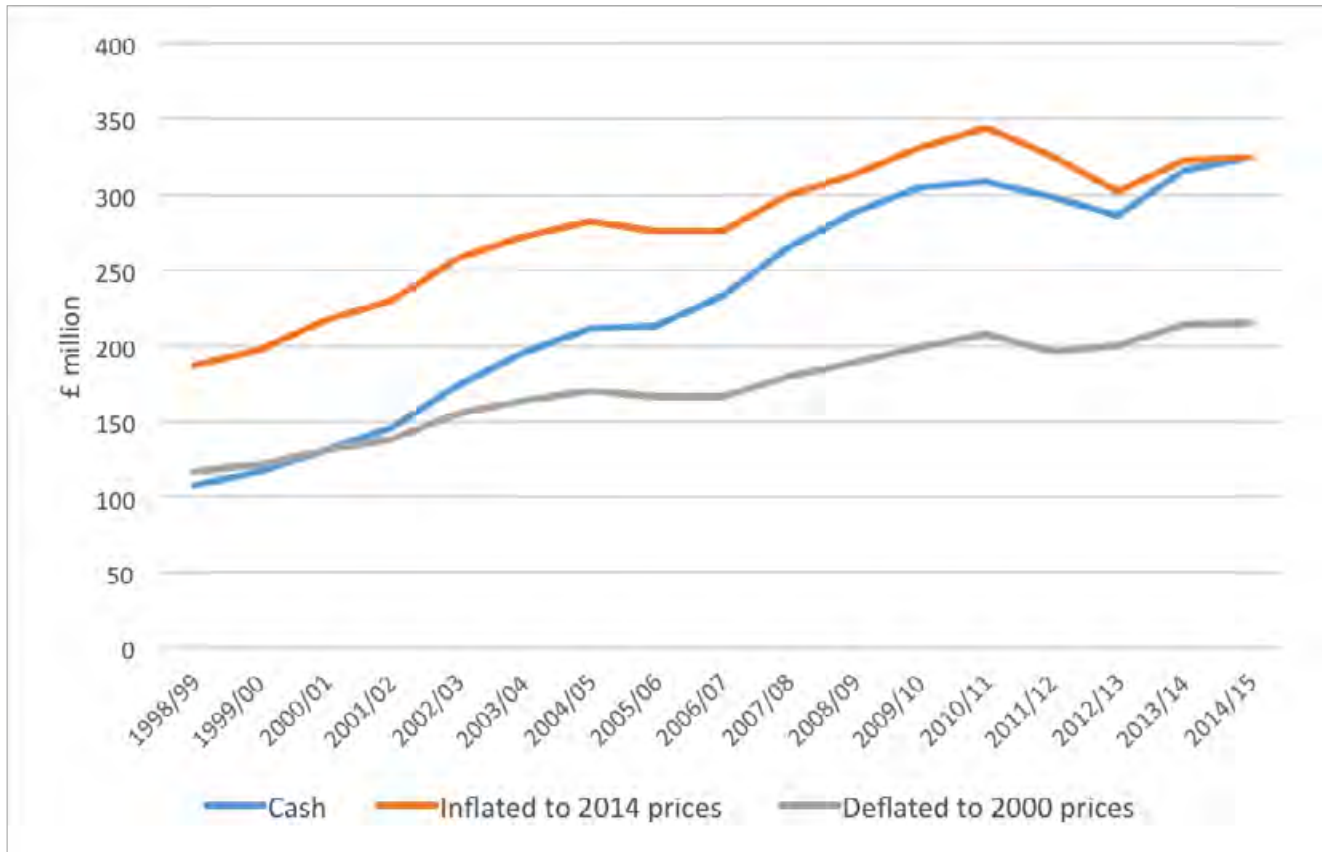
Sources: 1990-2007: DCLG – reported in Heywood, F. and Mackintosh, S. (2008) *Housing Associations and Home Adaptations: Making it work smoothly*, London: Habinteg; Wilson, W. (2013) *Disabled Facilities Grants (England)*, Standard Note: SN/SP/3001, House of Commons Library, Social Policy Section; 2008-15: LOGASnet analysis.

Table 5. DFG and adaptation funding/expenditure in England 1990 – 2014/15 (£m)*

Year	Government contribution (pre-2008 60%) (incl DH funding after 2011) £m	Local authority contribution (pre-2008 40%)	Local authority contribution %	Total spend on DFG £m	Total spend at 2014 prices £m	Total spend at 2000 prices £m
1998/99	59	48	45%	107	187	118
1999/00	65	52	44%	117	197	122
2000/01	72	59	45%	131	217	131
2001/02	86	60	41%	146	230	139
2002/03	88	86	49%	174	259	156
2003/04	99	96	49%	195	272	164
2004/05	100	111	53%	211	283	170
2005/06	103	110	52%	213	276	166
2006/07	121	112	48%	233	277	167
2007/08	138	127	48%	265	299	180
2008/09	150	138	48%	288	314	189
2009/10	156	149	49%	305	332	200
2010/11	166	143	46%	309	345	208
2011/12	200	98	33%	298	326	196
2012/13	220	66	23%	286	302	201
2013/14	220	96	30%	316	323	215
2014/15	220	105	32%	325	325	325

Grant expenditure and sources of funding

Figure 10. DFG spending 1998-2015 in cash terms, at 2000 prices and 2014 prices*



Source: Table 5

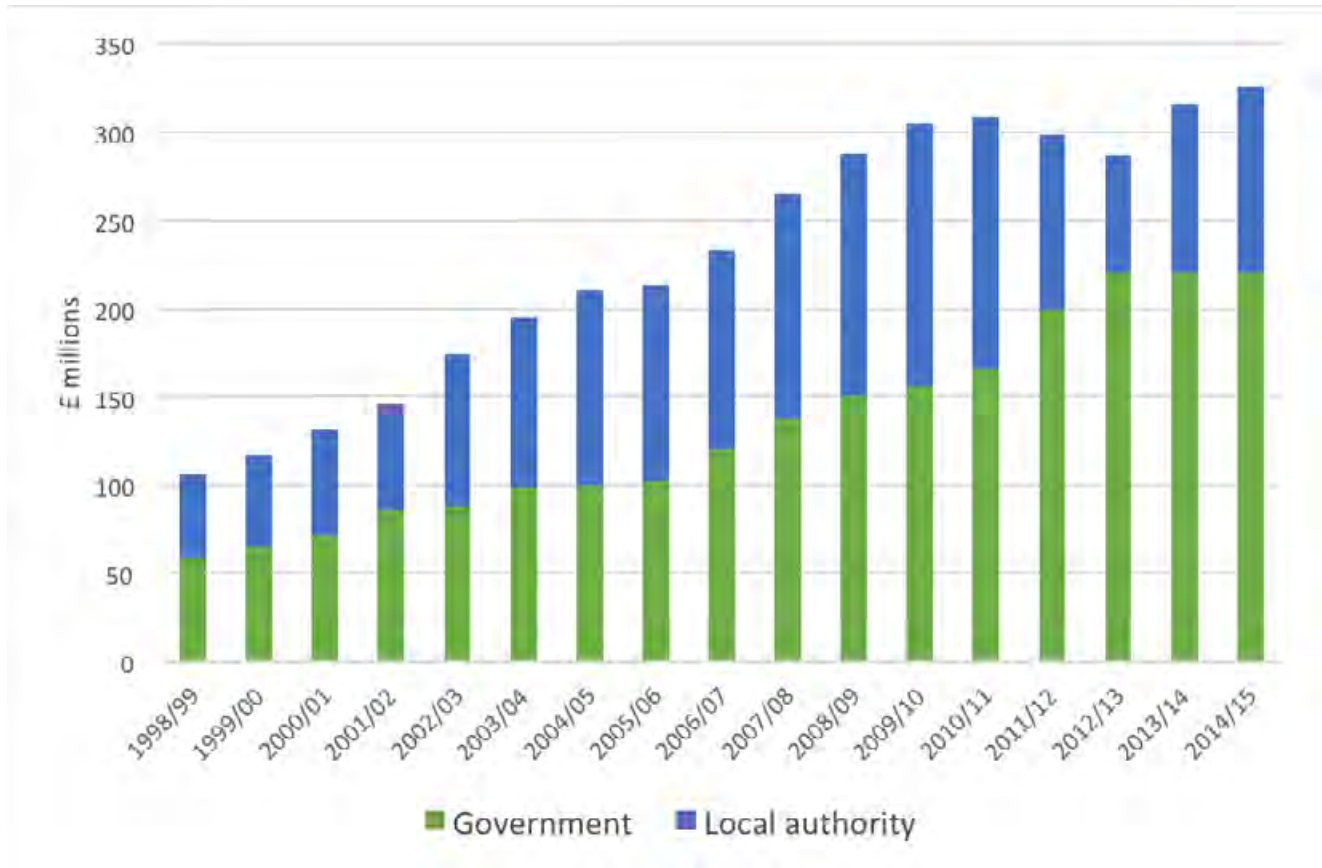
5.22 The split of funding provision between government and local authorities was close to 60%:40% until 2008. Local authorities used to bid for an allocation from Department of Communities and Local Government which was expected to cover 60% of local expenditure on DFGs. They were required to provide the remaining 40% from their own resources, and the budget was ring-fenced. After April 2008, local authorities received an allocation from the government without any specific requirement to match fund, and the ring-fence was removed. The aim was to allow the grant to be used in more flexible ways to fit with local delivery arrangements and the needs of individual applicants. After this change in arrangements, the proportion of spending accounted for by local authority resources increased to around 50%, until 2010-11.

5.23 After 2011 additional resources were added by the Department of Health. From then on a core of resources has continued to be distributed in a similar way to the pattern established before 2011, but a proportion, plus all additional new resources, was distributed according to need using a formula devised by the Building Research Establishment (BRE)⁶⁶.

5.24 The size of the government contribution to spending has remained almost constant since 2011-12. This means that variations in total expenditure in recent years have in practice been accounted for by variations in the amounts which local authorities have provided from their own resources. Figure 11 shows the trend in DFG expenditure from 1998-99 and the breakdown between central government and local authority contributions.

Grant expenditure and sources of funding

Figure 11. Breakdown of DFG funding by source



Source: Table 5

5.25 The fall in local authority contributions after 2010/11 came after the Comprehensive Spending Review in November 2010. Announced in that review was the removal of the last housing renewal grant, the Repairs Grant. Some of this funding had been used to provide repairs alongside adaptations in properties that were in poor condition and it also supplemented overall DFG funding. During this period most local authorities also faced reductions in their overall funding allocations from national government and restrictions on the local income that they could generate from Council Tax. In the face of this financial situation capital allocations to the DFG and associated revenue funding for staff reduced in many areas. As this analysis shows, aggregate contributions fell to just over one third of the total with a low of only 23% in 2012-13.

5.26 The Audit Commission short notice inspections of aids and adaptations services also came to an end in 2010. These had been having a considerable impact and resulted in significant service improvements and additional funding going into to adaptation budgets. The loss of this inspection regime may have also contributed to the fall in local authority contributions after 2010.

5.27 One major urban authority questioned as part of this research revealed that everything had been working well until 2010. However, following the spending review the local authority contribution to the DFG was reduced which meant they only had 85% of the resources they had before. Perhaps more significant was a 50% cut in staff resources which severely impacted service delivery. Other authorities have reported similarly drastic cuts in staffing levels which will have had an effect on the throughput of cases.

Grant expenditure and sources of funding

5.28 The Better Care Fund was only introduced in 2014 so its impact cannot be assessed with any confidence from the available data. Prior to its introduction some commentators thought that housing authorities would see the fund as confirmation that DFG spending was a health/social care responsibility and cut their funding accordingly. Against those expectations in 2014-15 the aggregate amount of local authority contributions and the share of overall funding contributed by local authorities increased by a small amount.

5.29 It is not clear at this stage what will happen in 2016/17 and beyond. Financially hard-pressed authorities could respond to the increase in funding from central government via the Better Care Fund by reducing their own contributions. Initial feedback shows that this is occurring in some areas. Continuing austerity measures means that budgets will remain constrained. However, it is hoped that the provision of grant resources will remain a partnership between local and central government and between housing, health and social care. It is also hoped that authorities will at least maintain, if not increase, staffing levels in response to the significant uplift in the DFG capital budget, which may double the number of grants from 2016/17 onwards, as there are concerns in some areas about capacity. However, simply doubling central government allocations is not enough to ensure that more grants are delivered. It may be that other funders, such as Clinical Commissioning Groups, will have to step in to provide additional resources if there are significant shortfalls in revenue and capital at local level. It will be important for local Health and Wellbeing Boards to be aware of and monitor overall budgets, staffing resources and the delivery processes. Section 6 considers issues around transforming services to ensure that they can meet the demands for increased output.

Expenditure at local authority level

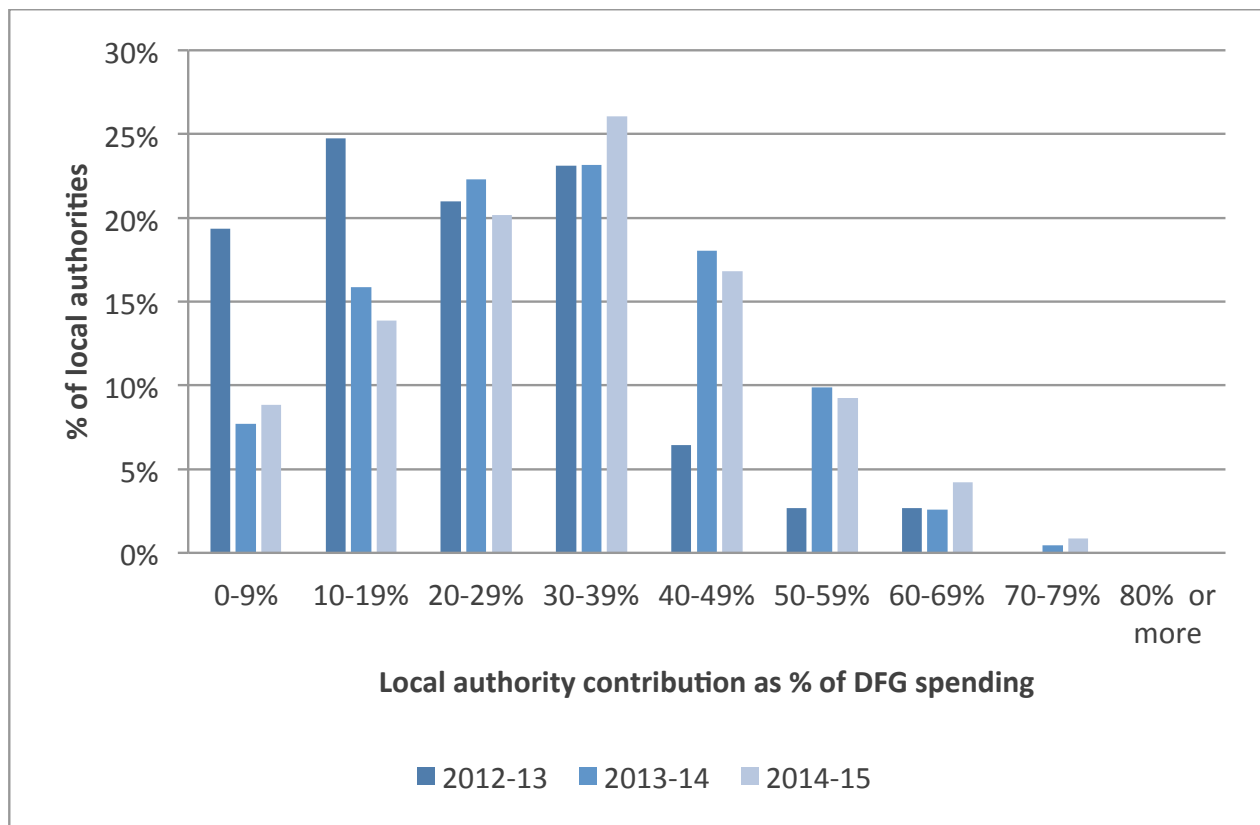
- 5.30** Expenditure on DFGs by individual local authorities varies significantly, as would be expected given the variations in population between authorities. Expenditure from year to year by the same authority can also vary, although there is a significant degree of correlation in many cases. For smaller authorities dealing with limited numbers of grants, expenditure totals in particular years can be influenced by the timing of payment of a small number of large grants.
- 5.31** The average expenditure by all authorities over the 2008-15 period was about £850,000 per annum, but 69% of authorities had average spending below this level and the median was £580,000 per annum. There was a high degree of correlation with previous years' spending over the whole period. For authorities which provided complete data, the standard deviation of spending at local authority level⁵ was on average about 17% of mean spending, so very roughly, spending has typically varied in the range plus or minus one fifth from one year to another, which indicates a substantial level of stability.
- 5.32** Over the period 2008-15, the average local authority contribution to DFG expenditure (as distinct from the contribution from central government funding) was about 37% of total spending. The annual average contribution fell from about 47% in the first two years of this period to just over 30% in the last two years. There was no correlation between the proportion of spending contributed by local authorities from their own funds and the overall level of spending; 5% of authorities had an average contribution of 60% or more and a further 10% contributed, on average, 50% or more. At the other end of the spectrum, only 3% contributed less than 20%. A quarter of authorities averaged from 27-33%. The reported level of local authority contribution from year to year was often volatile and the correlation between percentage contributions from year to year was much lower than for overall spending. This means that local authorities have, to some extent, used their own resources to make up for shortfalls in central government funding in any one year – for example where commitments turned out to be substantially greater than the central government allocation – rather than seeing this contribution as a permanent and immutable feature of their budgets.

⁵ A measure of the amount of deviation of expenditure each year from the mean level of expenditure.

Expenditure at local authority level

5.33 Figure 12 shows how contributions have varied over the last three years. Although almost a fifth of authorities contributed less than 10% in 2012-13 contributions have improved more recently with much fewer numbers in this bottom group in 2014-15. Most are clustered in the range 20-40%. At the other extreme more than 10% more than match central government allocations.

Figure 12 Changes in local authority contributions 2012-15



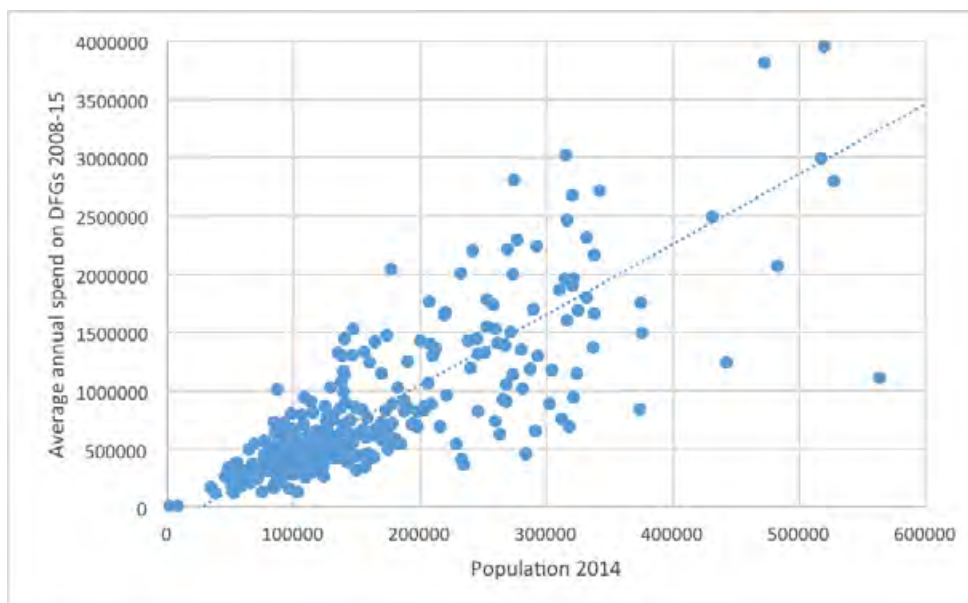
Expenditure by size of authority

5.34 However, expenditure totals are relatively meaningless if not standardised by reference to measures of size and, potentially, of need. However, this type of comparison is difficult because of the characteristics of the DFG. Firstly, the number of grant beneficiaries, even over a period of several years, is very small, so measures such as expenditure per capita or per dwelling face the problem that almost all of the population will not be a beneficiary. The second, more serious, problem is that the needs which the grant is intended to address are complex and variable, and the benefit conveyed by the grant itself also varies, although the size of grant provides a proxy. The client group for DFGs includes the whole population (with the exception of tenants of council landlords) but the incidence of need is much higher amongst older people, so areas with a large population of older people are likely to have greater need. A proportion of DFGs address the needs of younger people, including children, whose numbers are more likely to be evenly distributed, but there is no pre-determined split in grant provision between these various

potential client groups, or over the size of grant provided, or if there is, this is matter of local policy. The various means-testing arrangements applied to DFGs also impact on the potential level of need, but not in a straightforward way, as the means-testing arrangements are complex. These problems not only beset attempts to explain the pattern of past DFG spending but also the development of needs-based allocation formulae for DFG, as other studies have shown⁶⁷. Anecdotal evidence is that some authorities have more than enough resources to meet need while others have a backlog of cases and long waiting lists, but how this is affected by the allocation formula, level of local authority contributions, local needs or inefficiencies in processing the grant is hard to assess.

5.35 Setting these problems aside Figure 13 shows a strong relationship between DFG expenditure and population, but with substantial levels of variance for any given population level.

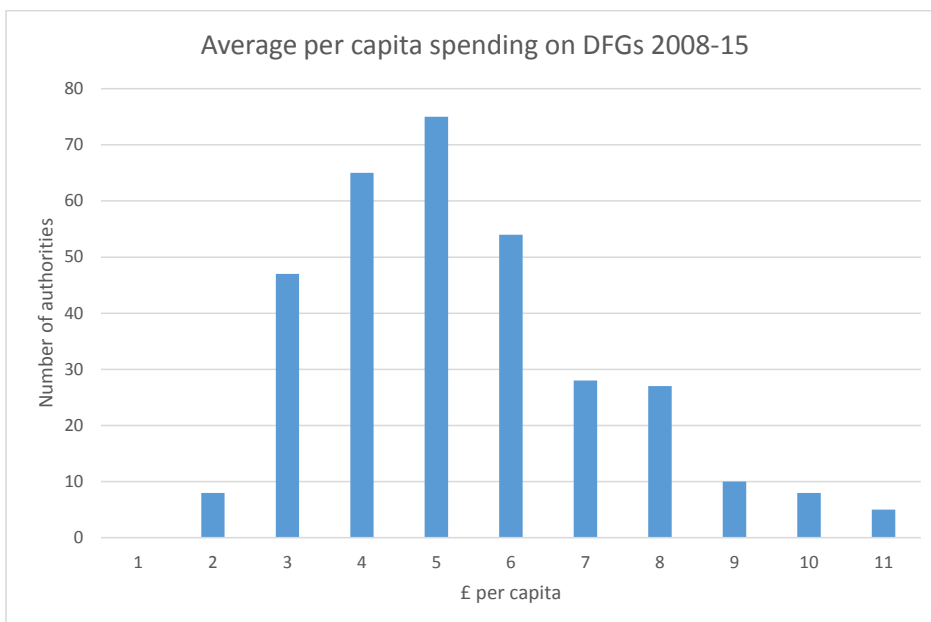
Figure 13. Spending on DFGs by population



Expenditure by size of authority

- 5.36** Authorities spent an average of £5.38 per resident per annum over the 2008-15 period, and the median spend was £5.08. Figure 14 shows that the interquartile range (containing the middle 50% of authorities in spending terms) was from £3.99 to £6.29 with the remaining 50% spending more or less than this amount. The annual average figure, as with overall spending, rose until 2011 and then fell, although with some fluctuation from year to year.
- 5.37** Map 3 below shows the pattern of average spending per capita by local authority. The map shows no clear pattern, such as higher/lower per capita spending by region, type of authority, or urban/rural classification. There was only a weak positive correlation between per capita spending and overall spending, suggesting that some larger authorities might tend to spend more per capita, that is even after discounting their larger size, but the trend is not very strong.
- 5.38** The most obvious feature of the map is the number of clusters of higher (or lower) per capita spending, for example in West London, or in parts (but by no means all) of Lancashire or Devon and Cornwall. There are no obvious explanations for such clusters. There are clearly no regional level patterns of spending, nor any reasons why there should be. Looking at type of authority, there is a highly consistent pattern of per capita spending which has been sustained throughout the period since 2008, irrespective of changes in overall spending levels (Table 6). The metropolitan districts (urban authorities within former metropolitan counties) have consistently had the highest per capital spending level throughout the whole period since 2008, with a significant gap between these and all other types of authority. The second highest per capita spending has been achieved by the non-metropolitan unitary authorities⁶. The two remaining types of authority are located within two tier systems of government, although the lowest level of per capita spending was by the London Boroughs, who have responsibility for both housing and social care services.

Figure 14. Average spending on DFGs per capita 2008-15



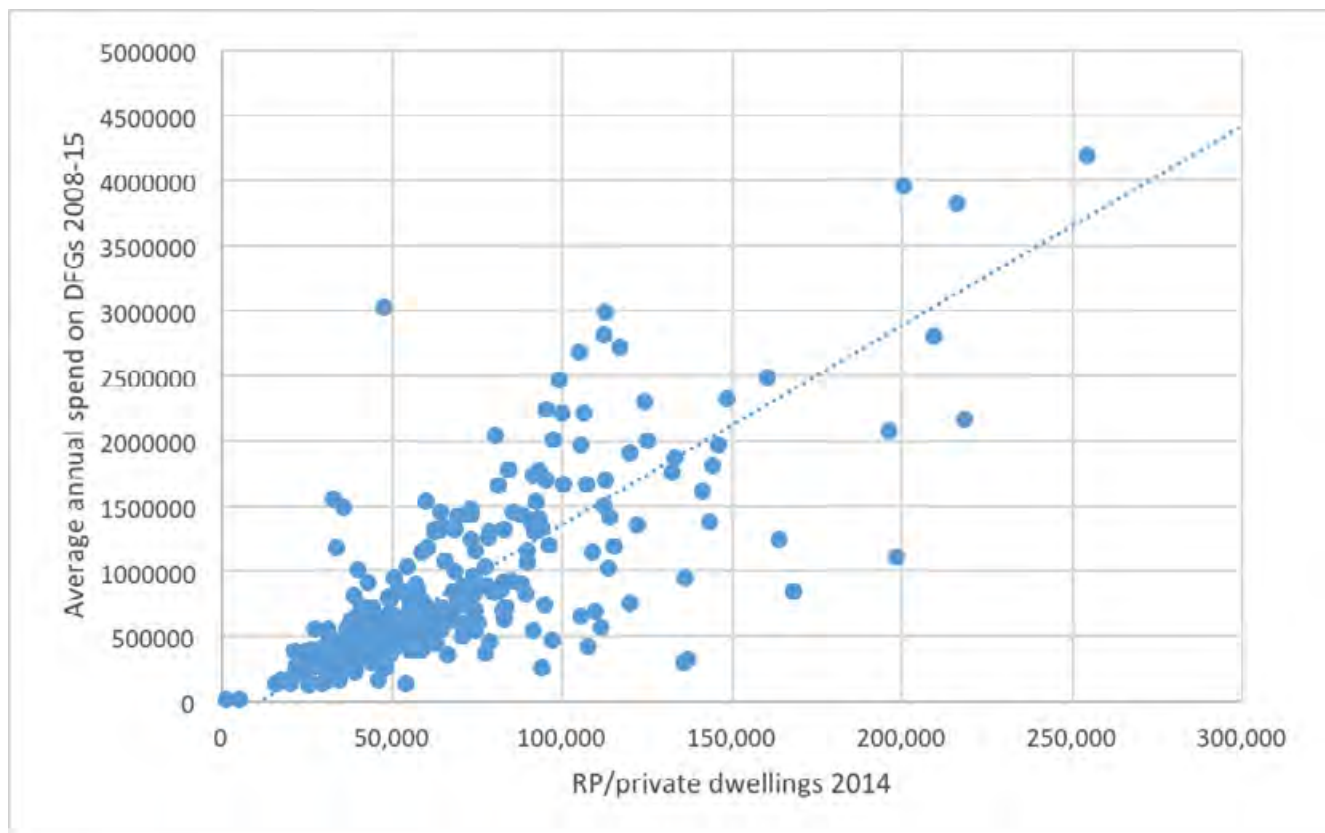
⁶ Note that some of these authorities did not come into being until 2010-11. Their spending in earlier years is the aggregate of the districts which were subsequently amalgamated.

Expenditure by size of authority

Table 6. Per capita DFG spending by type of authority

Type of authority	£ per capita spend on DFGs							
	08-09	09-10	10-11	11-12	12-13	13-14	14-15	Average 08-15
Metropolitan District	7.17	7.77	7.67	6.78	6.65	6.48	6.63	7.02
Non-met unitary authority	5.69	6.54	6.05	5.99	5.73	5.15	5.19	5.76
Shire District within county	5.17	5.24	5.31	5.31	4.99	4.80	4.93	5.11
London Borough	4.31	4.44	4.82	4.52	4.07	3.79	4.55	4.36

Figure 15. Spending on DFGs by dwelling stock (excluding local authority owned dwellings)

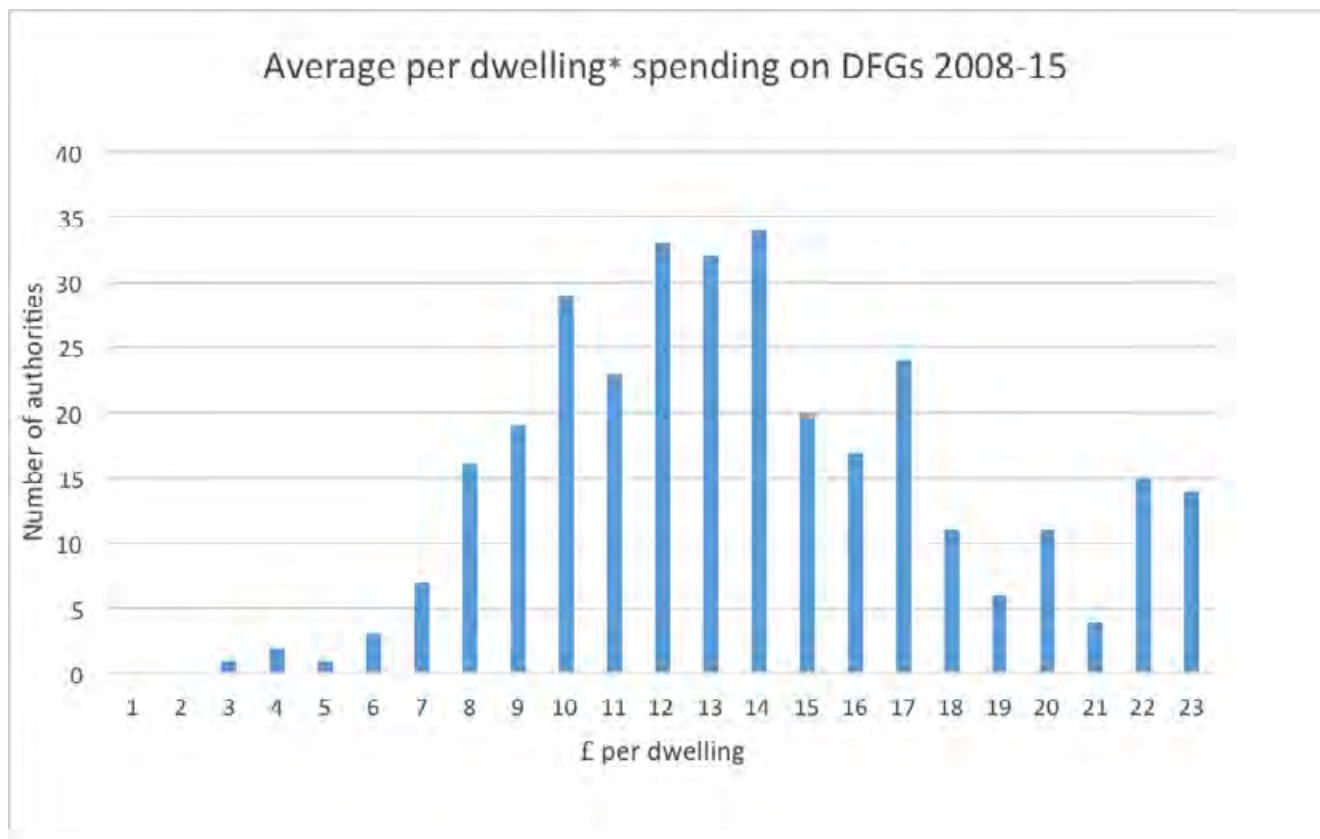


Expenditure by size of authority

5.39 Figure 15 and 16 and Table 7 show average spending per dwelling, with the exclusion of dwellings which were owned by local authorities⁷. The degree of correlation between spending and the dwelling stock is similar to, although slightly less than that between spending and population.

5.40 As the base is smaller than for population, average spending per dwelling is higher (£13.39), but the profile of spending also differs, with a wider interquartile range (£9.60-£15.66), and a more significant group of relatively high spending authorities. Metropolitan districts had a much higher level of spending on average than other types of authority, and in contrast with per capita spending, the lowest average level of spend was in shire districts within counties. This pattern of spending, as with per capita spend, was very consistent across the 2008-15 period. Map 4 shows the pattern of average spend per dwelling 2008-15 across England. This is similar to that for per capita spending (Map 3).

Figure 16. Average spending on DFGS per dwelling 2008-15



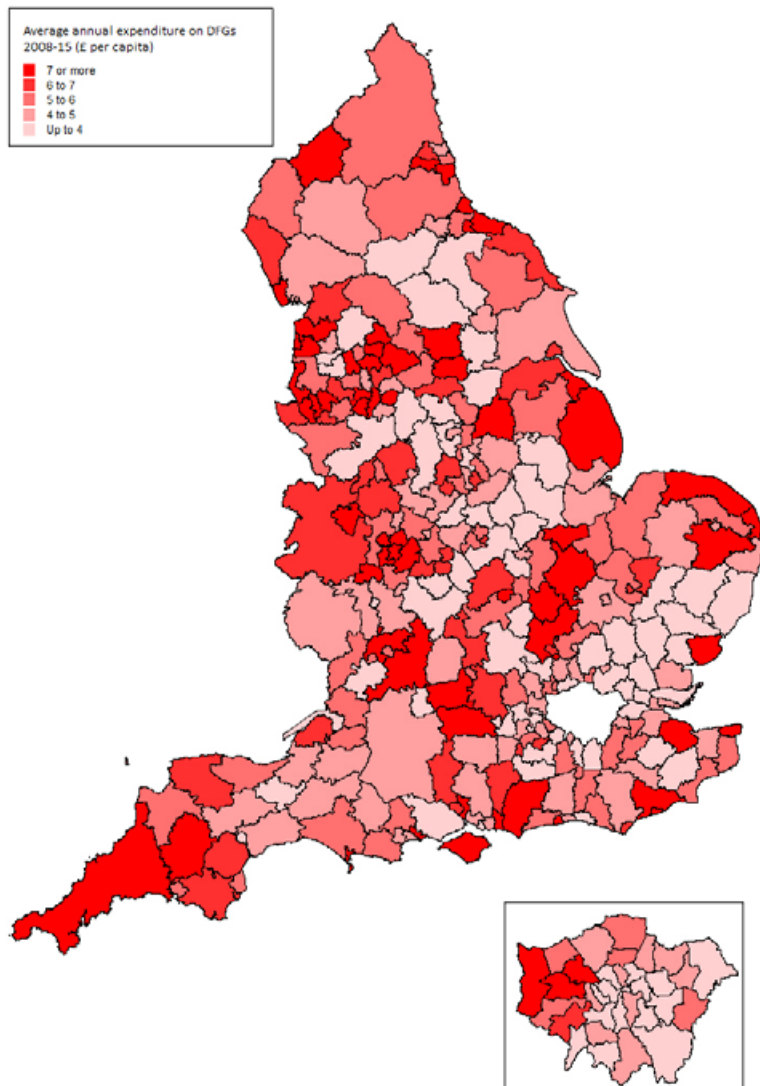
* Excluding dwellings with tenants of local authorities

⁷ DFGs are not targeted on dwellings, but households are the effectively unit of delivery and so provide a valid point of comparison. However, local authority tenants are not eligible for DFGs. The only source of data on household tenure is the Census of Population, and there are known inaccuracies in the Census estimates of local authority and registered provider tenants. To address this, estimates of dwelling numbers were used, drawing on CLG Live Table 100. This separately distinguishes local authority dwellings which can then be deducted from the total dwelling stock, assuming that these estimates are accurate. In many cases, transfer of stock has resulted in zero or very low numbers of excluded dwellings. A further benefit of this source is that it provides annual estimates for application to annual DFG data, whereas the Census of Population provides estimates only every 10 years.

Expenditure by size of authority

Table 7. Per dwelling DFG spending by type of authority

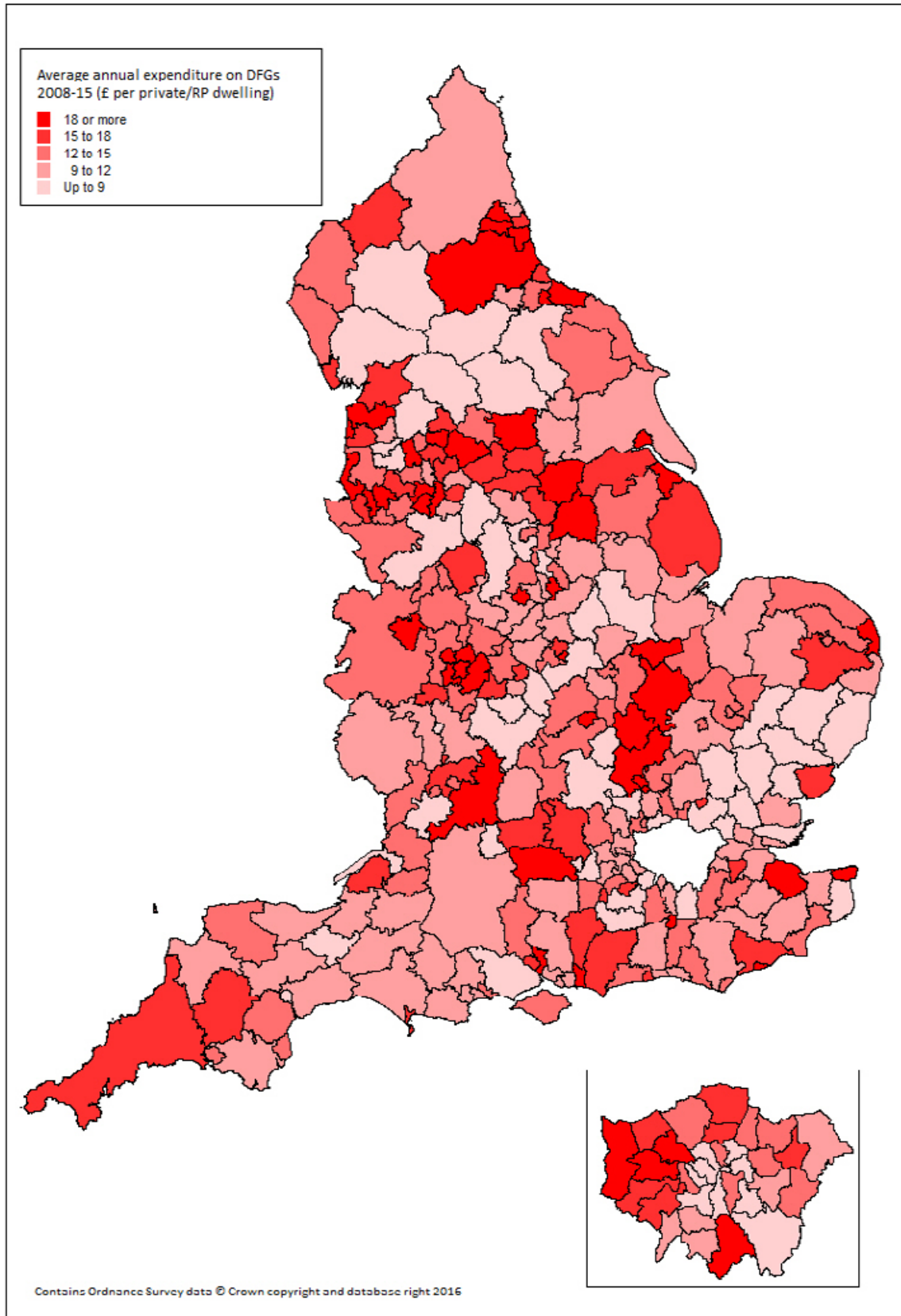
Type of authority	£ per dwelling spend on DFGs							
	08-09	09-10	10-11	11-12	12-13	13-14	14-15	Average 08-15
Metropolitan District	19.69	21.58	20.80	18.37	18.61	17.91	18.42	19.08
Non-met unitary authority	14.49	16.43	15.38	15.22	14.60	13.34	13.27	14.77
Shire District within county	12.13	12.29	12.47	12.43	11.71	11.28	11.70	12.05
London Borough	12.83	13.52	14.86	13.54	12.55	11.25	14.06	13.05



Map 3. Average spending on DFGs per capita 2008-15

Expenditure by size of authority

Map 4. Average spending on DFGs per dwelling* 2008-15



*Excluding dwellings with tenants of local authorities

Spending in comparison to need

5.41 As discussed above (5.34), it is very difficult to identify and to measure the need groups on whom DFGs are targeted and to assess how spending patterns compare to need. This section looks at a number of potential need indicators. At the end of the section these indicators are considered in relation to the previous work done to provide a new formula for the grant by the Building Research Establishment in 2011.⁶⁸

Age

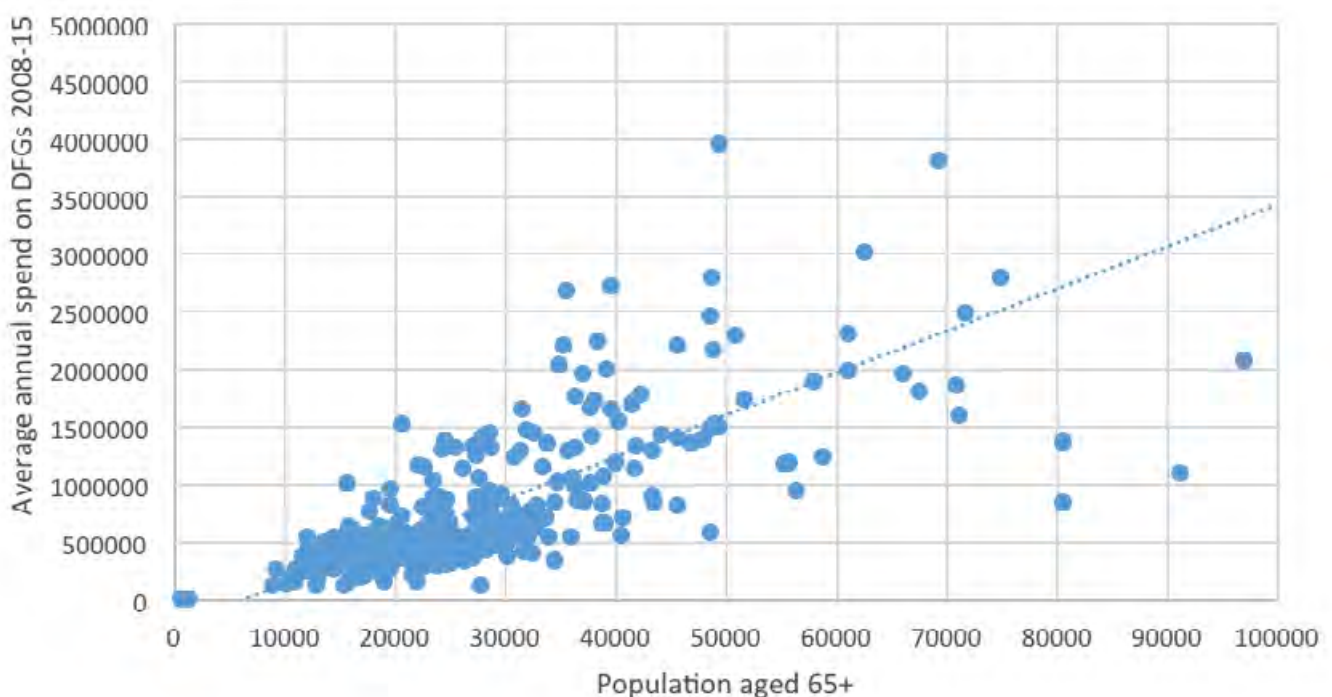
5.42 As we have seen, on average and across all authorities, around 71% of DFGs are provided to clients aged 60 or more, although the actual proportion varies substantially between authorities and from year to year. Detailed up to date estimates of the older population are available for those aged 65+, who we will assume receive around 60% of all DFGs. Thus, variations in the proportion of older people aged 65+ in the population could at best be expected to explain only 60% of spending, on average. As well as being affected by differences in the size of the 65 and over age group, these

variations might also arise as a result of differences in the incomes/savings of people in this group, as a result of policies targeting particular age groups (or perhaps adaptations which are relevant to the needs of particular age groups), or from other factors such as the mix of applicants coming forward where there is no filtering process affecting the award of grants.

5.43 Figure 17 below shows the relationship between overall DFG spending averaged over the 2008-15 period and the number of people aged 65 in each local authority. The relationship is of about the same strength as that for the number of dwellings.

5.44 Figure 18 below shows the distribution of average spending per resident aged 65+ over the period 2008-15. The mean spend per resident aged 65+ was £29,387, and the median spend was £26,711. A quarter of authorities spent less than £20,861 and a quarter more than £34,381. As Table 8 shows, metropolitan districts again tend to have the highest levels of spending per resident aged 65+, followed by London Boroughs, with unitary authorities spending less when measured

Figure 17. Spending on DFGs by population aged 65+



Spending in comparison to need

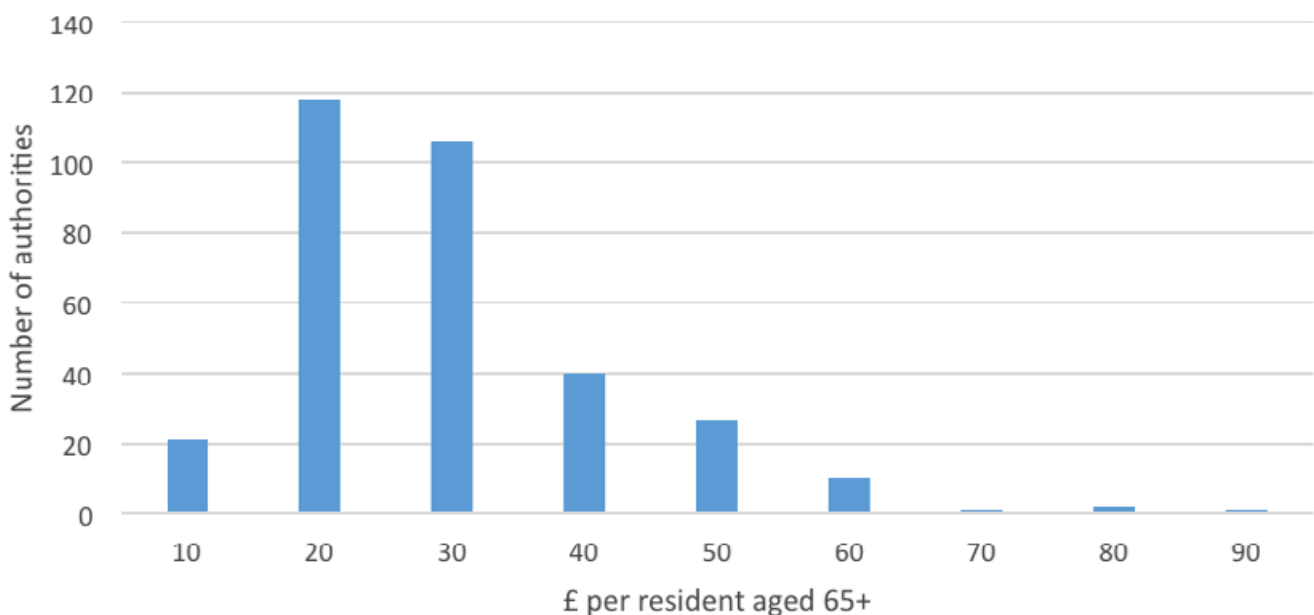
by this indicator, and shire authorities again having the lowest average spending. The relative positions have remained consistent throughout the 2008-15 period. The relatively high spending by metropolitan districts and the London Boroughs can in part be explained by the smaller proportions of older people in the populations of these authorities. Many shire districts have ageing populations, but their spending does not fully reflect this. The average annual level of spending per registered provider/private dwelling (£13.39) compares to an estimate of the 'need to spend' for housing in the local authority sector of £60 per annum made by The Building Research Establishment.⁶⁹ In some respects the need to spend in the local authority housing sector might be higher than in the registered provider/private sector (as a result of the presence of significant numbers of older people), but against this local authorities often have the option of rehousing their

older tenants into adapted/purpose built housing. Registered provider tenants might also typically be expected to have higher average needs than private tenants or owner occupiers, but they form only a relatively small proportion of the total of registered provider/private households.

Disability

5.45 More direct measures of the need for DFG spending are difficult to develop because the grant addresses a wide variety of disabilities and client groups, and because of the lack of data on the incidence of disability at local level. Figure 19 shows the distribution of average spending on DFGs from 2008-15 plotted against the number of people living in the owner occupied or private rented sectors reporting in the Census 2011 that their activities were limited a lot by health/disability. People living in the registered provider sector cannot be included because the data source does not distinguish them from council tenants.

Figure 18. Average spending on all DFGs per resident aged 65+ 2008-15



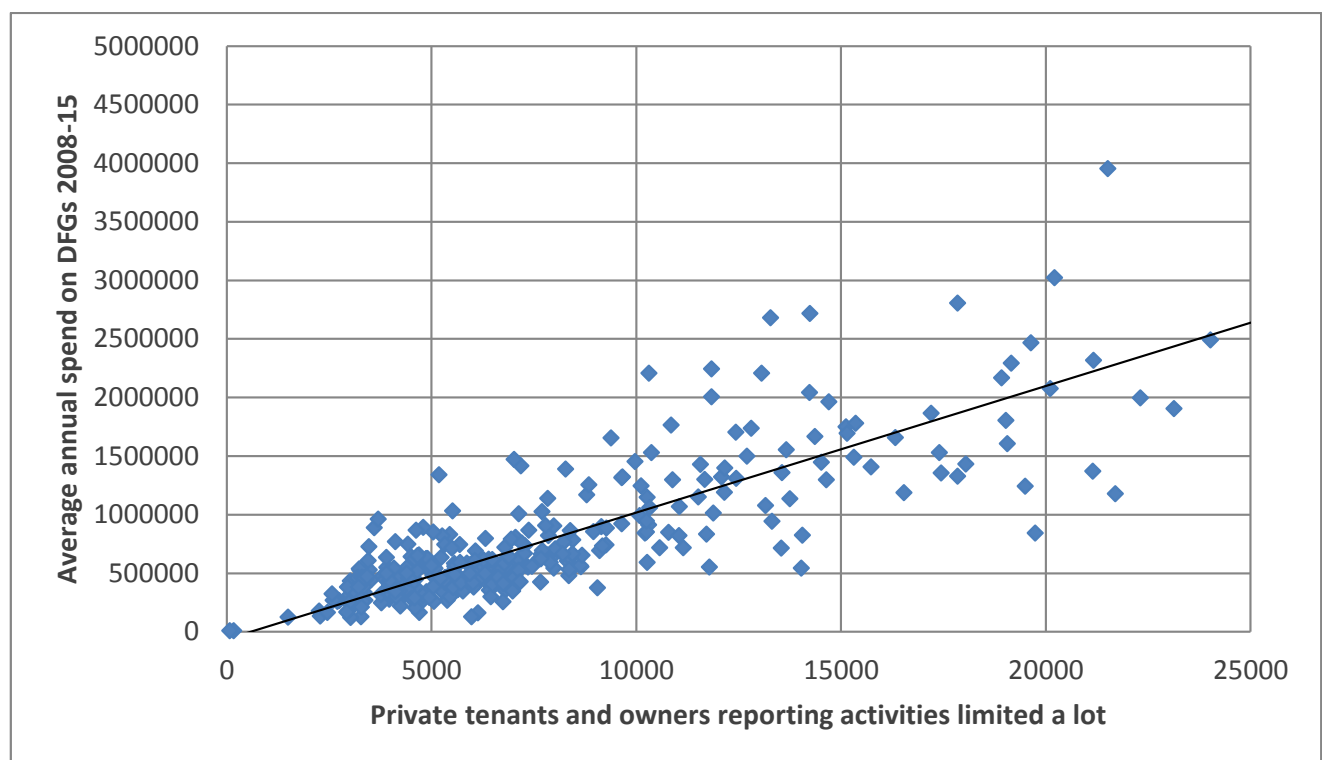
Spending in comparison to need

Table 8. DFG spending per resident aged 65+ by type of authority

Type of authority	£ per resident aged 65+ spend on DFGs							
	08-09	09-10	10-11	11-12	12-13	13-14	14-15	Average 08-15
Metropolitan District	41.84	45.22	45.07	39.66	39.36	38.60	39.77	40.90
Non-met unitary authority	31.79	36.83	34.85	34.17	32.22	29.72	30.28	33.23
Shire District within county	24.77	25.20	25.67	25.77	24.30	23.57	24.54	24.95
London Borough	35.58	37.50	40.90	38.92	34.93	32.32	39.69	37.19

5.46 Spending against this indicator is more variable than on any previously-examined indicators, ranging from only £41 to £260 per person reporting activities limited a lot. The mean spend per person was £107.02 and the median was £96.16. A quarter of authorities spend less than £78 per person in need and a quarter more than £126. Figure 20 shows the distribution of spending at various levels, and Table 9 shows average spending by type of authority. Average spending per person reporting that their activities were limited a lot is consistently highest in London, followed by the metropolitan districts, then unitary authorities, with shire districts spending the least per person on average.

Figure 19. Spending on DFGs per private tenant/owners reporting activities limited a lot by health/disability

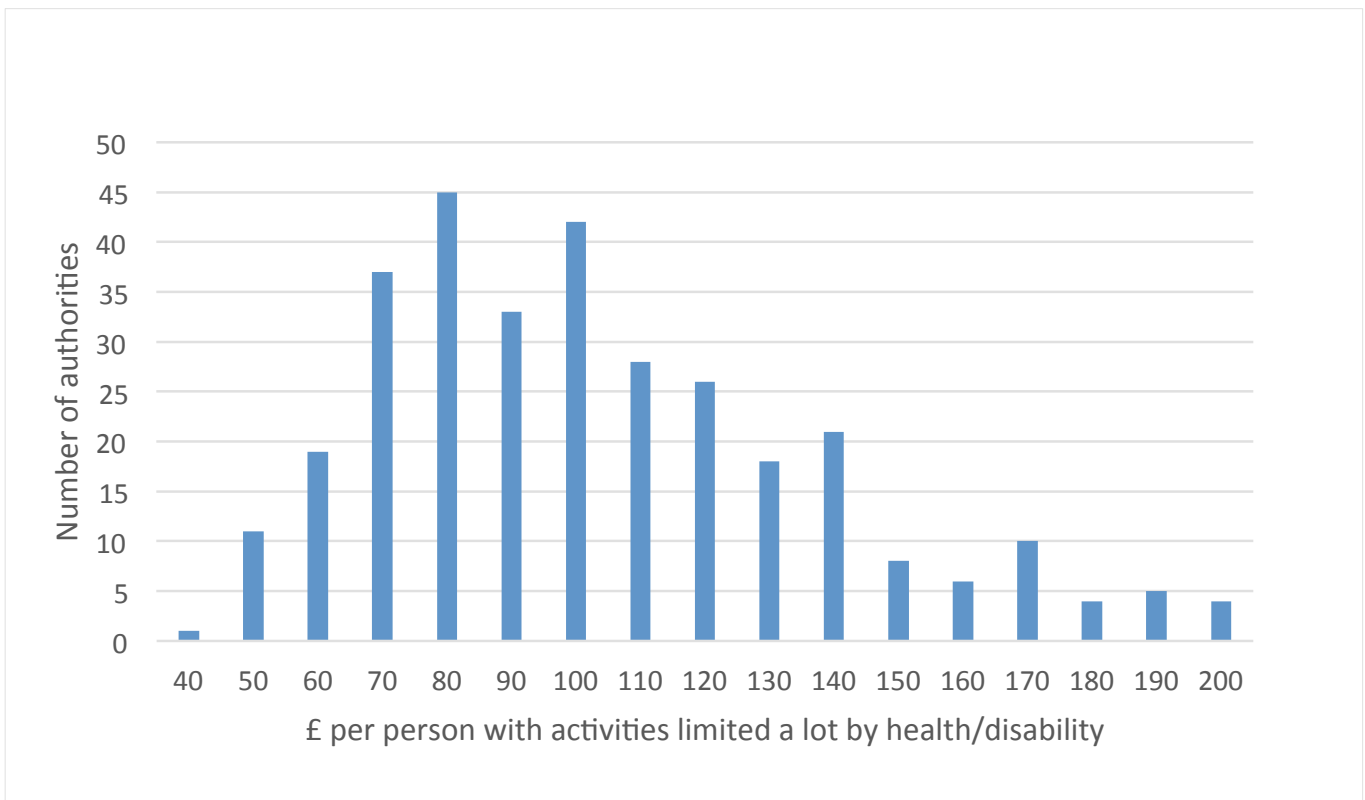


Spending in comparison to need

However, as Map 5 shows, not all shire districts have low spending levels. In addition to London, the highest levels of spending per person on this indicator are generally in parts of the south of England (excluding East Anglia and the South West) and the West Midlands. Conversely, spending per household is generally lower across much of the north of England. As Map 6 shows, this pattern of spending is the converse of the pattern of need as measured by the percentage of persons living in owner occupied or privately rented housing reporting that their activities were limited a lot by disability or health. The highest proportions of households reporting their activities were limited a lot are found in Lancashire, Yorkshire, Cumbria, the North East and in coastal areas of the South West and East Anglia. The pattern of need in many areas reflects the high proportion of older

people in retirement destinations, and in the north the legacy of past concentrations of manufacturing industry and mining. Levels of spending on DFGs in these areas do not compensate for the higher proportion of households in need so per capita spending is lower. We cannot conclusively say that spending is too low (or too high in the areas with lower levels of need) because the indicator of need used does not directly measure the need for DFG provision, but the results raise important questions.

Figure 20. Spending on DFGs per private tenant/owners reporting activities limited a lot by health/disability

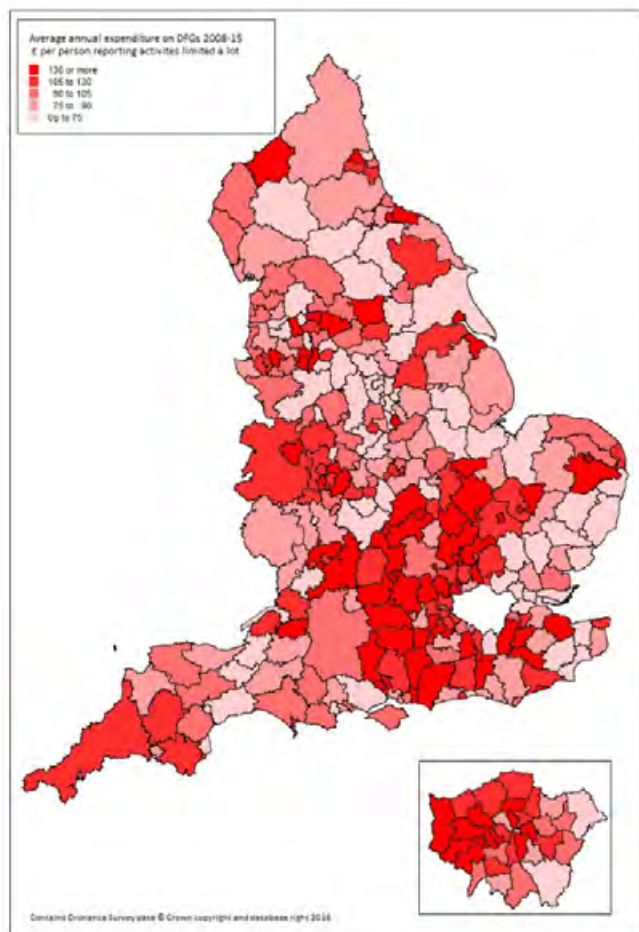


Spending in comparison to need

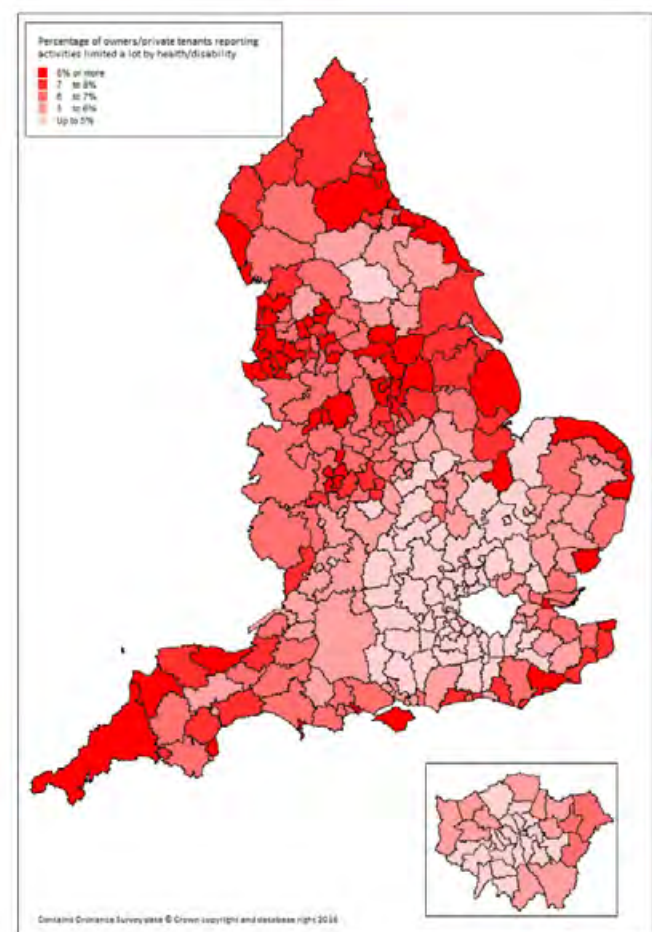
Table 9 DFG spending per private tenant/owners reporting activities limited a lot by health/disability by type of authority

	08-09	09-10	10-11	11-12	12-13	13-14	14-15	Av. 08-15
Metropolitan District	115.29	123.81	123.81	109.78	107.49	106.75	109.63	112.76
Non-met unitary authority	105.51	118.24	113.45	113.84	110.07	100.48	104.41	109.99
Shire District within county	100.34	101.88	104.27	104.55	96.19	95.06	99.35	100.78
London Borough	125.46	131.84	146.06	139.36	125.56	113.03	137.54	133.70

Map 5. DFG spending 2008-15 per person in owner occupation/private renting reporting activities limited a lot by disability/health



Map 6 Percentage of persons in owner occupation/private renting reporting activities limited a lot by disability/health 2011



Spending in comparison to need

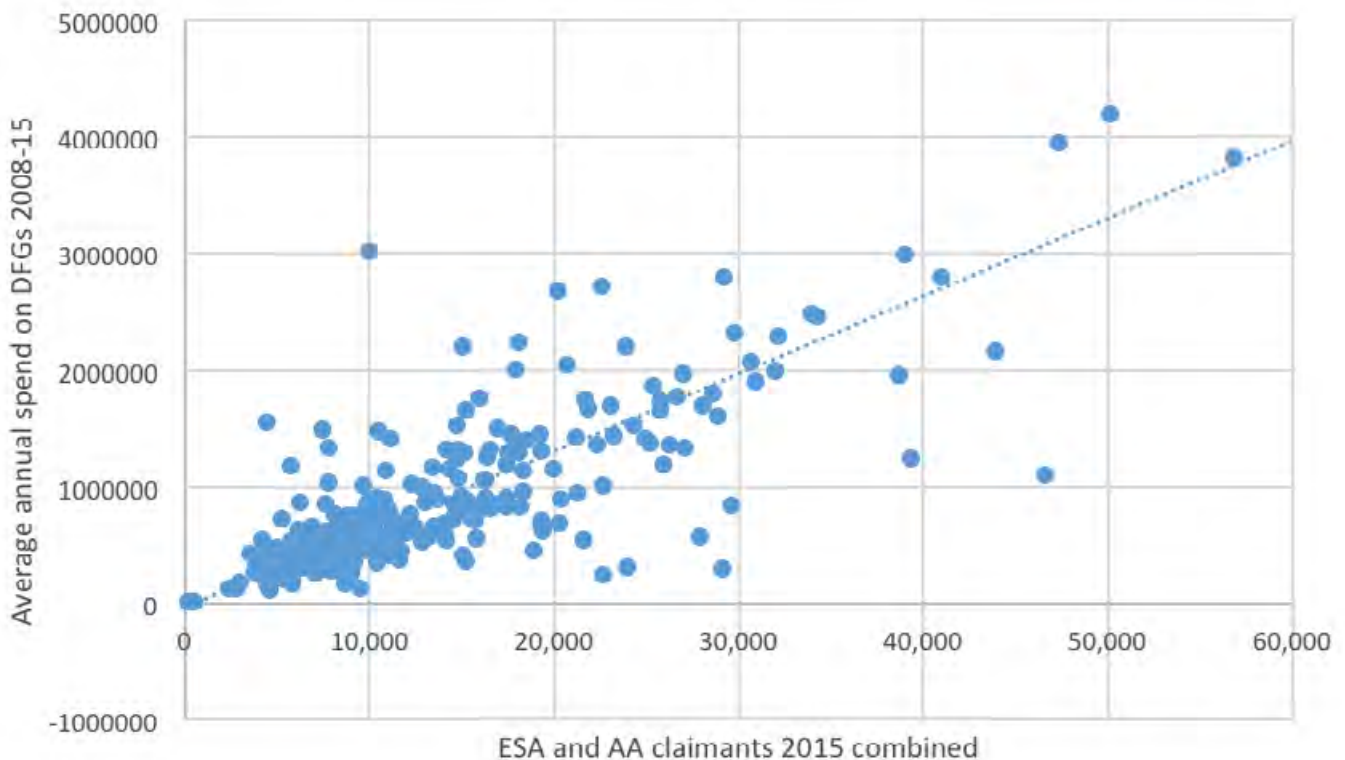
Financial resources

5.47 Two other potential indicators of the need for DFG spend were also examined. The first illustrates the impact of taking financial resources into account. Average DFG spending in 2015 was standardised against the number of claimants for Employment and Support Allowance (ESA), currently the main means-tested benefit for people unable to work due to illness or disability⁸. Map 7 shows the pattern of spending per claimant. The picture is broadly similar to that for spending standardised against households reporting their activities were limited by disability/health, issues even though this indicator is focused only on the working age population. The main areas of higher spend per claimant are concentrated in the midlands and south of England, although there are some gaps and a few high spending areas in the north.

5.48 The second indicator standardised spending against the number of Attendance Allowance claimants, who are all aged 65 and over. This benefit is not means tested. Map 8 shows the pattern of spending. The level of concentration of high spending areas is still focussed mainly on the south of England, but there is also a band of higher spending across Lancashire and Yorkshire.

5.49 Figure 21 plots average spending 2008-15 against the combined number of ESA and AA claimants in each local authority which thus includes measures of both the working age and the older population who might represent need. The relationship between spending and the number of claimants is weaker than that between spending and the number of households in registered provider/private dwellings reporting someone in bad or very bad health.

Figure 21. Spending on DFGs by EDSA and AA claimants combined

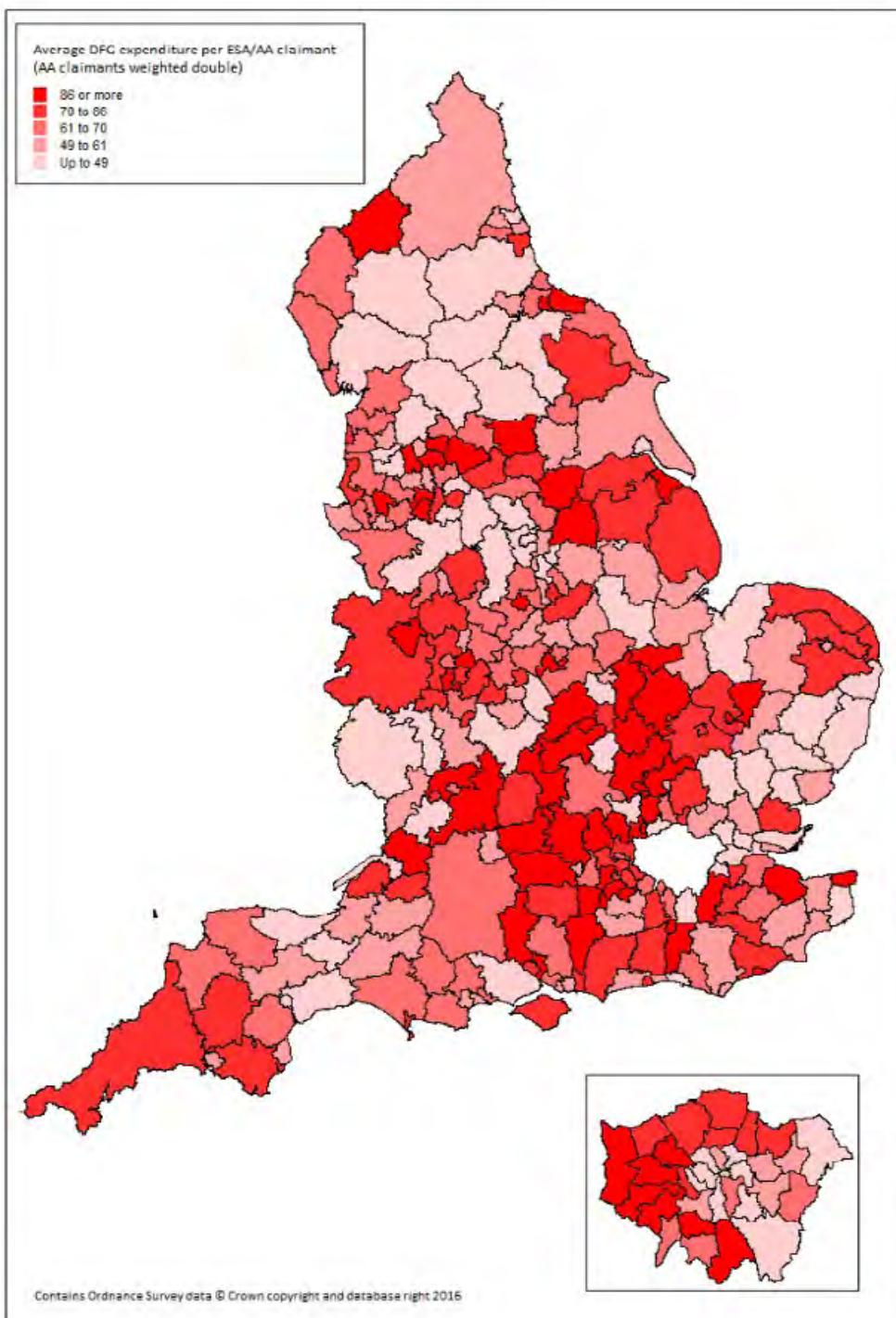


⁸ Data on ESA and AA claimants was obtained from the Work and Pensions Longitudinal Study via NOMIS for May 2015.

Spending in comparison to need

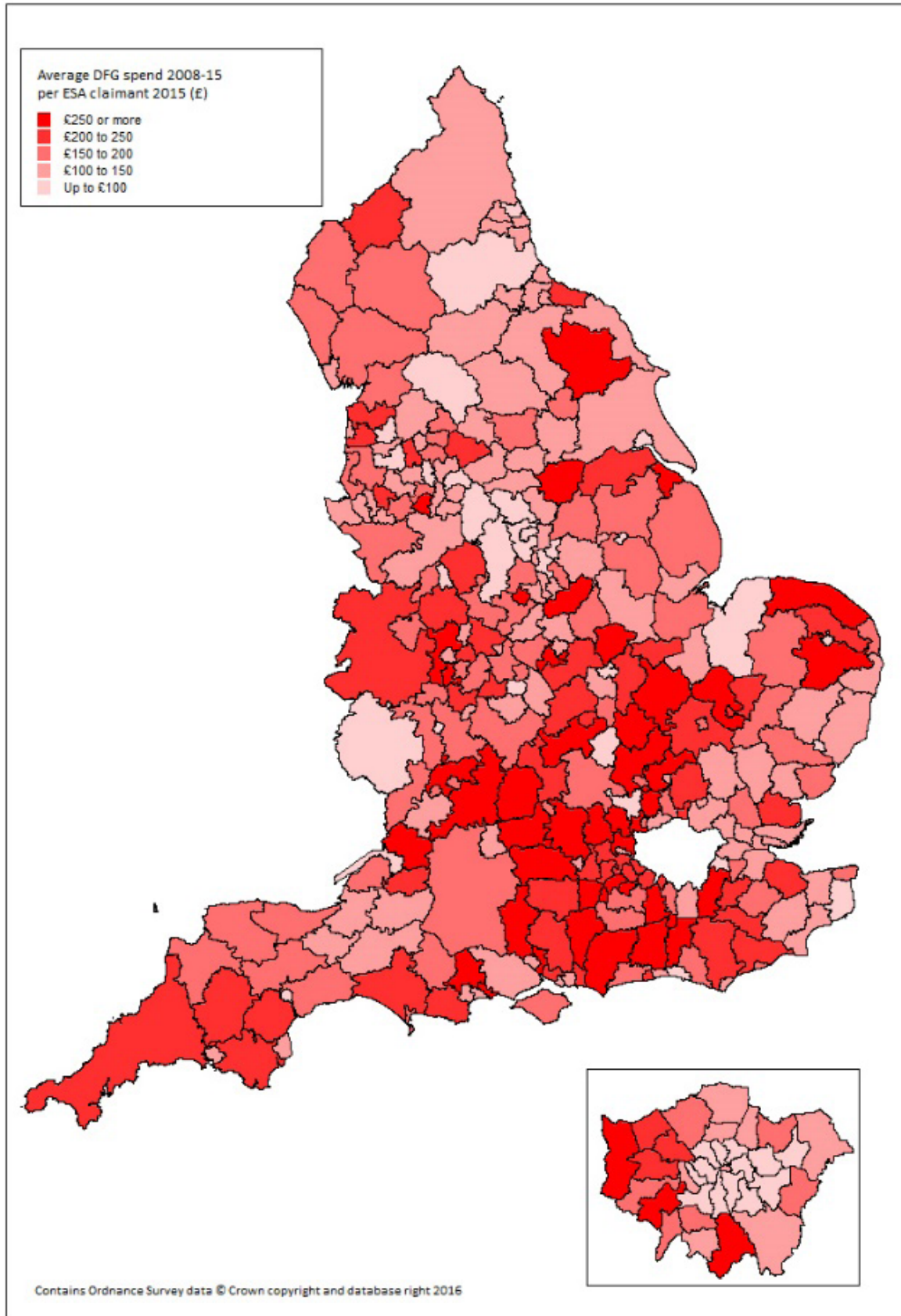
5.50 Maps 9 and 10 show the pattern of need against spending. Map 9 gives equal weight to each type of claimant. Map 10 reflects the high proportion of DFG spending targeted on older people and gives a double weighting to AA claimants. Essentially the pattern of spending per claimant is the same. Doubling the weight given to AA claimants does not improve the strength of the relationship with spending. The similarity of the two indicators gives some confidence that the picture which they provide is robust, although of course both indicators suggest relative rather than absolute spending needs.

Map 7. Average spending on DFG 2008-15 per ESA claimant 2015



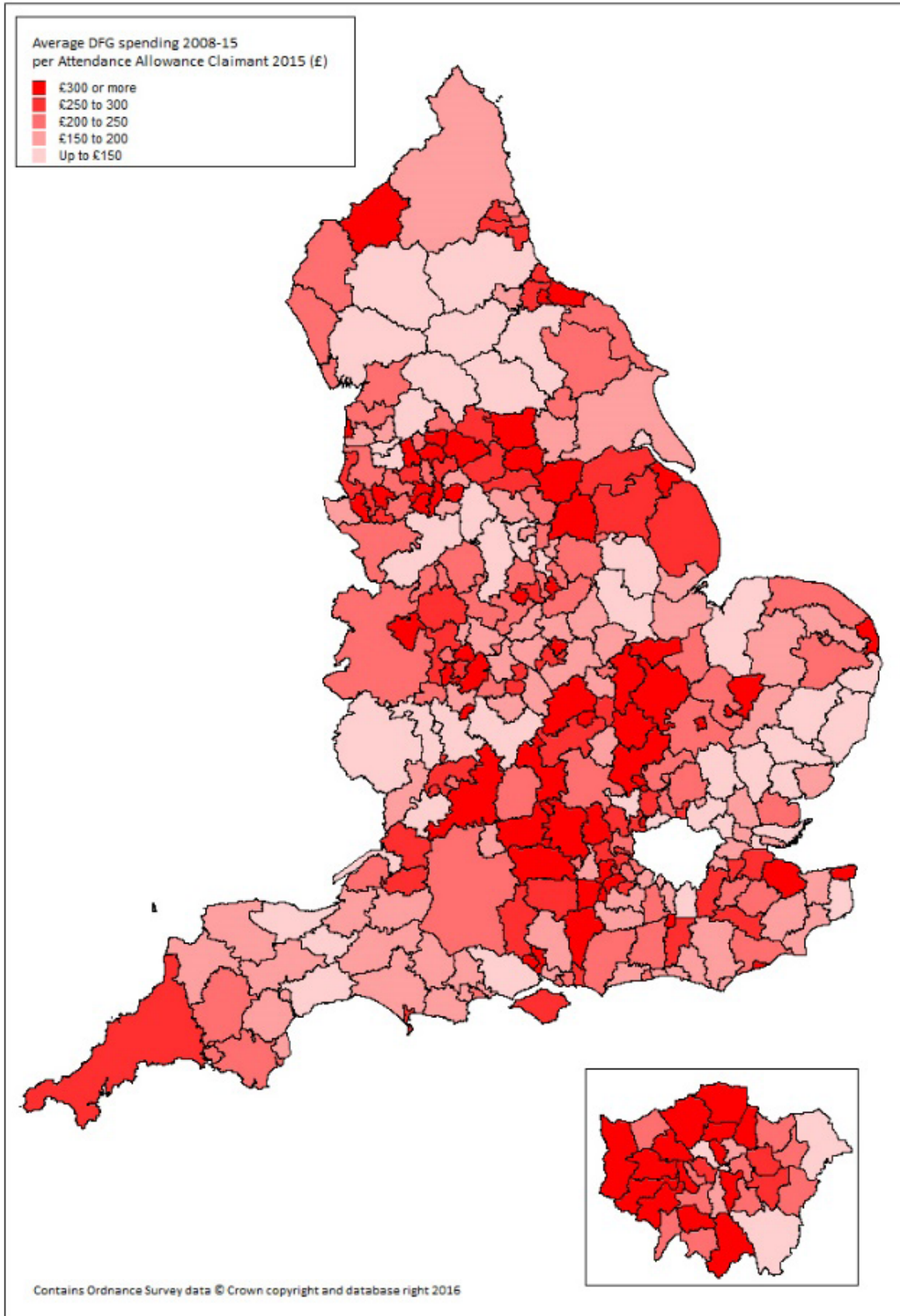
Spending in comparison to need

Map 8. Average spending on DFG 2008-15 per Attendance Allowance claimant 2015



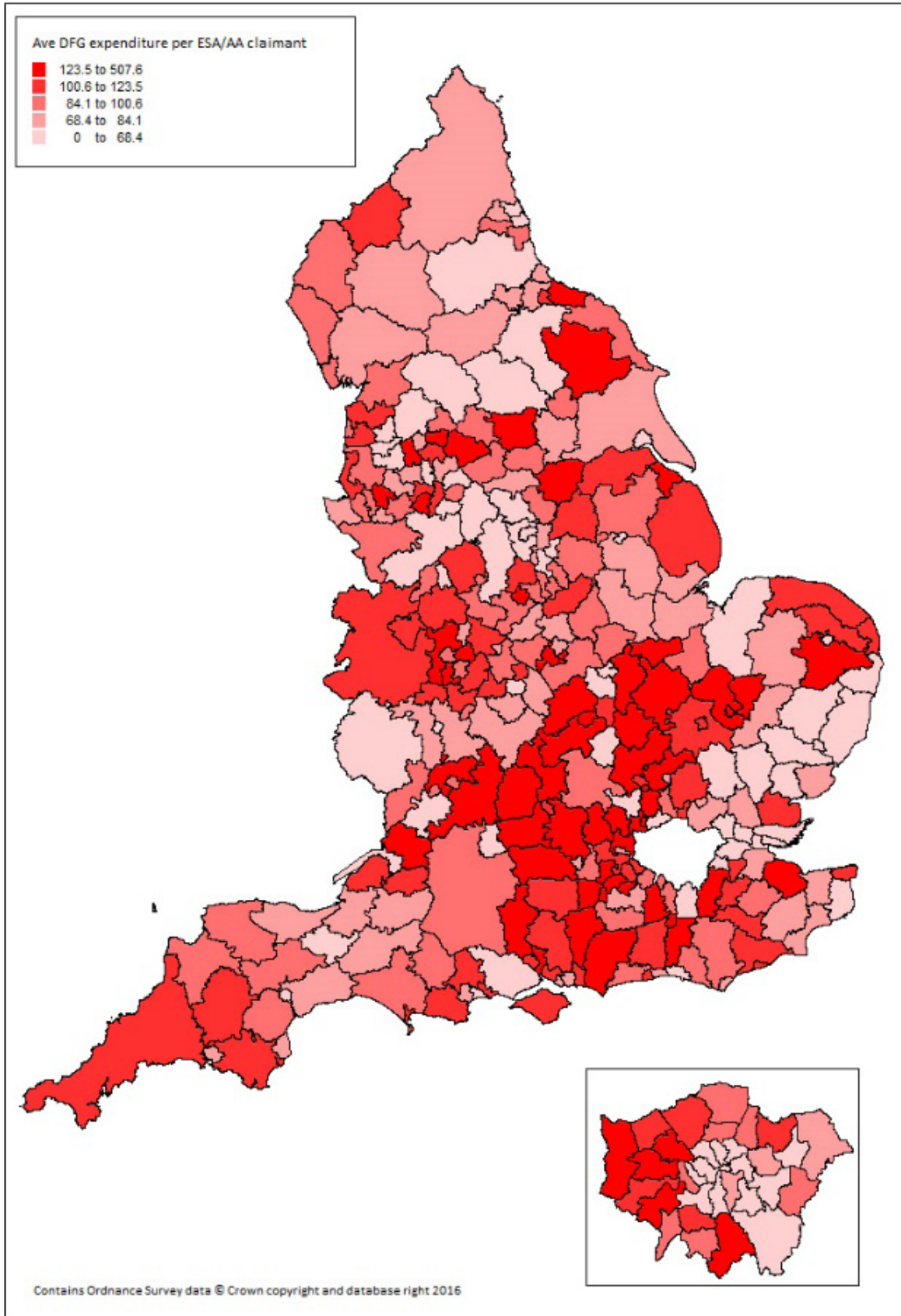
Spending in comparison to need

Map 9. Average spending on DFG 2008-15 per ESA/AA claimant combined 2015



Spending in comparison to need

Map 10. Average spending on DFG 2008-15 per ESA/AA claimant combined 2015 (AA claimants weighted double)



How much spending is needed?

- 5.51** The LOGASnet database tells us how much has been spent on grants and (to a limited extent) who has received help and at what cost, but it does not tell us whether the amounts spent are adequate to meet needs, or whether they have been spent effectively. The measures of 'need' which we have compared to spending (ranging from simple ones such as population/dwelling stock to more complex ones) are only relative measures (suggesting which authorities might be spending more or less than average) rather than absolute indicators (telling us whether the actual level of spending is adequate).
- 5.52** As we have already indicated, it is extremely difficult to assess how much would be required to ensure that all adaption needs were met in a timely fashion over an extended period. To pick only a few reasons why: DFG addresses a variety of needs ranging from the simple to the very complex; there are often alternative solutions or strategies to meet client needs, such as seeking short or longer term solutions, involving different levels of spending or even no spending (in the case of rehousing as an alternative to grant); clients have differing abilities to fund some adaptations from their own resources.
- 5.53** Despite these problems, a serious attempt was made by the Building Research Establishment to cast some light on this issue⁷⁰. Using English Housing Survey data for 2005, BRE estimated that 947,000 households required some adaptations or additional adaptations to their home, and of these 720,000 households owned their homes or were private or registered social landlord tenants and so were eligible for DFG. In total, 367,000 of these were assessed as being eligible for a grant of at least £1,000. The average amount of grant for those eligible was about £6,000 and so the amount needed to cover these grants was £1.9bn at 2005 prices. This estimate thus excludes spending by households who were judged to be able to afford work from their own resources (through application of the then applicable Test of Resources for DFG).
- 5.54** This is by far the most robust estimate of the required expenditure available and it deserves to be taken very seriously. Even without any upward adjustment to current day prices it represents about seven times the current level of expenditure. The Building Research Establishment's estimate is not, however, an estimate of the required annual level of spending on adaptations over an extended period – it represents the 2005 'backlog' of requirements rather than the annual 'flow'. The 2014 backlog will be made up of a different set of households than that for 2005. But, if anything, the continued ageing of the population since 2005 will have further increased it, despite some subsequent DFG provision. Addressing some or all of the backlog would reduce the required level of spending per annum (the flow) significantly, but given the scale of the shortfall it is safe to say that DFG spending could be boosted by a very considerable amount – tripled for example – for several years before backlog needs would be eliminated and new needs addressed promptly at the point when they first arose. There would also of course be many practical issues relating to delivery, such as local government staffing levels and the capacity of the building industry, to be addressed if such a policy were to be considered. In addition, active measures would be required to promote awareness of the availability of DFGs to potential clients, as in many areas awareness of this form of assistance amongst potential recipients is limited.

Summary of LOGASnet findings

5.55 The analysis of LOGASnet data has found that:

- The number of grants provided peaked at about 45,500 in 2010-11, but has subsequently fallen back by about 11%. More than half of authorities reduced the number of grants approved between 2010-11 and 2014-15, but against the trend 26% increased the number of grants provided over this period. On average each authority provided 121 grants with a median of 90 grants.
- As might be expected older people over 60 are the main recipients of the DFG receiving 71% of grants, with 22% going to people aged 20-60 and 7% to children and young people under 21.
- Distribution of grants by tenure shows that registered provider tenants are around three and half times more likely to access a DFG than their level of representation would suggest (particularly in authorities where stock has been transferred) even though the stock is newer and more accessible and a high proportion of older people are in specialist housing. Registered providers are known to contribute variable amounts to DFG costs but LOGASnet does not tell us how much, something that might be remedied by a revised data collection system.
- Owner occupiers received the largest proportion of grants, 61% on average over the 2008-15 period. This was less than might be expected as they make up 70% of all households overall (and 76% of older households), perhaps because some can afford their share of costs. However, they may be under-represented because they are unaware of the grant or they are deterred by the cost of resources. Private rented sector tenants, because they tend to be younger, received only 7% of DFGs on average, although they formed 19% of eligible households. These proportions may change in future as the private rented sector continues to expand.
- The average size of grant has remained relatively stable over the period 2008-15 and is quite small at just over £7,000, with the vast majority in the range £4,000 and £9,000 and 58% under £5,000. The relatively small size of many grants suggests that simplified systems could be developed to deliver the grant, particularly where this would save money for health and social care.
- As might be expected some of the highest costs are in London, the South East, the home counties and East Anglia and in some of the bigger urban areas. Overall only 9% of grants are over £15,000 (although this is higher in London) and of these only 5% are at the maximum of £30,000. Many authorities have very few grants at this level and 76 said they gave none in 2013/14; the average is inflated by a very small number of authorities with higher levels. The small number of the largest grants may add weight to the argument to increase the level above the current £30,000 maximum to help those wait a long time in inaccessible housing because they are unable to find additional resources or cannot find more suitable accommodation. However, there is also a need to clarify the position of social care in providing top-up funding.
- Spending in cash terms increased steadily throughout the 1990s, and more rapidly in the 2000s, remaining static between 2004-6 before peaking in 2010-11 at over £300 million. It subsequently fell to only £286 million in 2013-14 before increasing again in 2014-15. As the size of the government contribution to DFG spending has remained relatively constant the recent fall in spending was entirely due to cuts in local authority funding. It is encouraging that local authority spending increased again in 2014-15 when the grant became part of the Better Care Fund, but there is concern that this might not be maintained now that central government contributions have increased so significantly to £394m in 2016-17. If the aims of the Better Care Fund are to be delivered local authorities will need to continue to add their own resources both to capital and revenue costs if the service is to meet needs and be transformed in the way that is required. Health and Wellbeing Boards may need to play a more important role in monitoring resource levels to ensure these can meet local needs.

Summary of LOGASnet findings

- As the Building Research Establishment found in trying to develop a new formula for grant allocation in 2011 there are no easy direct measures of need for the DFG because the grant addresses such a range of disabilities and because the lack of good data on disability at local level⁷¹. Several variables were looked at in this research including the population over 65 and disability benefit claimants. The research also looked at spending in relation to people in private sector and registered provider housing reporting their activities limited a lot by disability or health factors. This showed that the pattern of DFG spending across the country is almost the reverse of the pattern of need with the highest spending concentrated in London and the south east but lower across much of the north of England. Data limitations mean that we cannot conclusively say that DFG allocations are misaligned but the results raise important questions. It is also difficult to assess what resources might be needed to ensure that all existing adaption needs are met.
- In 2011 BRE provided a robust estimate of the number of people who might require adaptations and who might be eligible under the test of the resources in use at that point, using house condition figures from 2005. At today's prices it would take about seven times current levels of expenditure to deal with the total backlog of cases. This is likely to be an underestimate as number of people in older age groups have increased since 2005. Having said that, the current substantial increase in funding represents a major stride towards meeting demand.



The gaps in the data

- 5.56** The data do not provide any information on other important questions such as speed of delivery or the type of work. Evidence from a limited amount of anonymised benchmarking data is that speeds are still quite slow in many areas, but like the LOGASnet data, returns have been less complete in recent years so it is hard to give any weight to this evidence. Discussions with staff in a number of case study authorities revealed huge variations with some able to deliver very quickly while others take many months. The split nature of the service means that there are multiple waiting lists and occupational therapists and adaptations teams do not always know how long a case waits at each stage. In some services there are also a lot of bureaucracy and process delays. Some authorities have developed lean systems and fast track services to deliver simple, lower-cost solutions such as stairlifts and level-access showers, particularly for people deemed at risk of needing health and care services, which is discussed in the next section.
- 5.57** As services improve to meet Care Act and Better Care Fund requirements, and a single person is appointed to be responsible for the customer journey, it should make it easier to measure end-to-end times. Use of NHS numbers on all casefiles should also enable better joining up of information. Speed is not always the most important criteria to measure the success of a service, but if services are unnecessarily slow it increases the risk of accidents and injury (and hence of calls on the NHS), as well as leaving people living in difficult situations which can have a detrimental effect on their own, and their carers', health and wellbeing. Any new data collection system needs to address the timescale issue even though there may be difficulties in getting accurate information from some authorities. A focus on grants under 10,000, which form the majority of cases, would give better average figures than trying include more complex and expensive work that takes much longer to process.
- 5.58** The type of work the DFG is spent on is also missing from LOGASnet. Evidence from case studies is that the main use of the grant is to provide level access showers, which may account for between 50-60% of spend depending on the area, followed in importance by stairlifts. However, expenditure will vary geographically, for example, areas with steep slopes or specific building types may have more need of ramps or step lifts. It is also affected by policy decisions, for example some authorities try not to do extensions but help people move instead. Type of work will be an important variable to look at in future and the results could help drive better bulk purchasing agreements.
- 5.59** Finally, there is no information on people wanting or needing to move home, because this is their preference, because it would provide a better solution, or because it simply is not possible to adapt the current home. More information on the number who manage to move, tenure of moves and those who remain waiting for accommodation could help to influence housing providers and planners about the need for more accessible homes.
- 5.60** The focus of LOGASnet has been on accounting for expenditure. There is a need in future to look, not just at outputs, but also at the outcomes achieved by this expenditure, particularly improvements in health and wellbeing and potential savings for health and social care. However, outcome variables are much more difficult to define and to quantify. A list of measures that might be considered for a new national data collection system is suggested in Section 7.

How service delivery is changing



How service delivery is changing

- 6.1** The Comprehensive Spending Review in November 2015 announced 'an ambitious plan for health and social care services to be integrated across the country by 2020, with plans in place by 2017 and implemented by 2020'. Housing needs to be part of this integration process, and the home, where older and disabled people spend most of their time, placed at the centre of service provision. The DFG has an important part to play. It has survived for a quarter century but in many areas it is still stuck in an old system of delivery not suited to current policy aims which require a fast, nimble service to speed hospital discharge and reduce pressures on health and care services. The customer journey for DFGs is overly complex and needs to be joined up more effectively, both end-to-end and with other related services.
- 6.2** As more customer-centred and personalised approaches develop it is hoped that the DFG can be used in a more holistic way to enable people to remain living in their own homes in the community. The DFG is rarely a single solution and needs to be used more flexibly as part of a mix of options. Rather than an older person, a disabled person or a family with a disabled child having to seek out all the different services that relate to their home environment and negotiate access, the services need to be pulled together around the person, regardless of whether those were traditionally run by health, social care or housing. With the increase in resources more people can be helped. To ensure it is targeted better on those in need it could be prescribed by GPs or other health professionals. More information needs to get out to these professional to ensure that they understand the grant and who to refer.
- 6.3** The Regulatory Reform Order (2002) and other changes to the Housing Grants Construction and Regeneration Act 1996 allow flexibility in the use of the grant, but until now few authorities have been using these powers. The scope of the order is very wide and allows councils to provide grants, loans and advice for the purpose of repairing, improving, extending, converting or adapting housing accommodation provided there is a written policy. There may need to be more central government guidance to demonstrate to finance and audit departments what is actually allowed. There is scope to:
- Remove the test of resources to speed up DFG delivery
 - Use a discretionary grant to top up if a grant costs over £30k
 - Provide loans
 - Use the DFG where other work is needed, for example to deal with repairs and heating problems provided it supports prevention, promotes independence and deals with delayed transfers of care.⁷²
- 6.4** There used to be repair grants and minor work assistance to deal with disrepair, but since these were removed there has been increasing reliance on finding charitable funding which takes much longer to obtain. House condition problems are increasing as the population ages and they can have a significant effect on health. Care and Repair England has called for a targeted programme of 'repairs and adaptations on prescription'. This could be linked to fast track hospital/health related interventions carried out by home improvement agencies and handypersons.⁷³ Using the DFG to facilitate this could make a big difference, particularly to help people return from hospital faster.

How service delivery is changing

6.5 There is also a need to consider how the competing needs of more acute cases (such as hospital discharge cases, those with a breakdown of care, palliative care needs, or someone who might otherwise go into residential care) are reconciled with the need to provide more preventative solutions for those with less urgent needs. If older and disabled people are to avoid getting to that crisis point there must still be scope to provide the DFG to this latter group who have historically been the biggest group receiving DFG support. There is also a need to ensure that the increasing focus on older people does not prevent families with disabled children and younger households from getting access to resources. Reconciling these the competing demands on funding may be a difficult balance to achieve in some areas, even with the increase in resources.

6.6 The Care Act 2014 also requires there to be much better signposting for people not eligible for statutory services. This could include advice, help with finding alternative funding sources, handy person service, lists of vetted contractors and a fee-paying service for plans, specifications and supervision of building work. This could be part of a single, fully integrated service or it could be provided by a separate, independent home improvement agency. It is important that this element is not ignored. Even with a doubling of DFG resources not everyone who needs help will be able to obtain funding. There are large numbers of people with incomes and savings only just above the test of resources threshold who will require assistance. Even those with adequate resources need advice and help finding appropriate technical solutions. The focus should be on allowing everyone to remain at home regardless of income level or degree of disability.

Figure 22. The potential for integrating services



6.7 Figure 22 shows the range of services that could potentially be integrated in better ways. This excludes care and other personal support services which would also need to be part of a holistic solution. Instead Figure 22 focuses on related activities that could relatively easily be integrated with home adaptation services. The DFG is part of a continuum of services which may begin with a home from hospital service, reablement and the provision of equipment and minor adaptations such as rails and small ramps before more permanent changes to the home are made through major adaptations. It also fits with a range of other statutory and non-statutory interventions as many customers also need help with repairs, home warmth, home security, telecare, telehealth and other services. Parallel adaptation services that operate in the council stock or in transfer associations may also need to be integrated to create a tenure-wide service.

Innovation and change

6.8 Reorganisation of the DFG and broader home adaptation services has been underway for some time but, inevitably when it is part of a wider transformation programme, progress in some areas is faster than others and it is not consistent across the country. Table 10 shows a typology of DFG service delivery and how change is beginning to occur. Through integration there is a move away from the original split service DFG delivery model towards a consolidated or integrated service method of delivery involving a wider range of components. Inevitably the typology is simplistic and there may be many different and valid approaches, but it gives a picture of how services might change and what elements might be included. There is no one model that will apply everywhere. Large, rural, two tier authorities will have different needs, and very different patterns of service delivery, to an urban unitary authority or a small metropolitan district. Each area will need to establish their own approach to working across traditional boundaries to join up previously fragmented services.

Table 10. A typology of home adaptation service delivery

Split service	Consolidated
<ul style="list-style-type: none"> • Occupational therapists in social care – in two-tier authorities at county level • Adaptation team in housing authority (in two tier authorities at district level) • Separate team for council stock (funded by HRA) • HIA providing some aspects of the service – minor works, handyperson, DFG cases needing more support - approval has to be obtained for DFG spending decisions 	<ul style="list-style-type: none"> • Team of occupational therapists/DFG/HRA/HIA staff co-located or in close proximity • If HIA delivers all DFGs – delegated responsibility for approval of spending decisions • If HIA not doing DFG but delivering handyperson service and service to self-funders – working closely with OTs and DFG team • Lean systems, fast track services
Integrated	One stop shop
<ul style="list-style-type: none"> • Multi-skilled, cross-tenure team including: occupational therapists, trusted assessors, caseworkers, technical staff, handypersons • Single manager • Holistic assessments • Effective triage and fast track services for home from hospital, ‘at risk’ and straightforward cases • Mix of services which may vary from area to area: e.g. major/minor adaptations, equipment, repairs, handyperson, home warmth, assisted technology, sensory services, reablement etc. • Advice and support for self-funders 	<ul style="list-style-type: none"> • Single manager • Multi-skilled, cross-tenure team • Covers all age groups • Holistic assessments • Effective triage and fast track services for home from hospital, ‘at risk’ and straightforward cases • Complete range of services e.g. e.g. major/minor adaptations, equipment, repairs, handyperson, home warmth, assisted technology, sensory services, reablement etc. • Equipment service including repair/recycling facility • Wheelchair service • Falls services • Blue badge scheme • Advice and support for self-funders and ‘future-proofing’ • Advocacy service • User involvement • May be located in a design centre, ILC or other service hub – may be a visible shop-front type premises

OT = Occupational therapist

HRA = Housing Revenue Account – used to fund council stock adaptations

HIA = Home improvement agency

Innovation and change

- 6.9** The process of integration is generally easier in the unitary authorities. Some of the metropolitan authorities were the first to combine the DFG service with the occupational therapists and the home improvement agency. For example, St Helens co-located the occupational therapists, the equipment service, the DFG service and the home improvement agency under a single manager many years ago. They also occasionally base occupational therapists from the hospital in the DFG team to enable them to understand housing issues and use consistent assessments. Others such as Walsall have occupational therapists located in a shop front premises near the town centre and lean systems so that DFG cases can be fast-tracked very quickly. Many of these areas have high levels of disability which may have focussed attention on adaptation services and the LOGASnet data indicates that some of these authorities have historically had higher levels of DFG resources relative to their population.
- 6.10** Other small unitaries authorities such as Southend are only at the beginning of the change process, but are planning to bring together a cross-tenure service with the occupational therapists, equipment service and adaptations delivery in one location. In the larger unitary authorities integration can take longer to achieve as departmental structures are more complex with occupational therapy, DFG and home improvement agency staff based in a number of different offices. Some examples of new types of service provision are as follows and further details can be found in a number of cameos of good practice.⁷⁴

Innovation and change

Integrated arms-length organisation

Sunderland has set up a single, arms-length organisation for care and support to provide more flexibility in the delivery of services. The DFG is one part of an integrated, holistic service which includes the home improvement agency, equipment and telecare under one manager. They have lean systems, cost-effective procurement policies and a focus on using local tradespeople to promote employment. Cross training of staff means that most people visiting the home can see if there are hazards that need to be remedied or if the person has additional needs. They have also trained more people to deal with falls to reduce demands on emergency services and hospitals. Becoming an arm-lengths organisation has given greater freedom innovate and to communicate with staff and customers in new ways. It has also enabled better partnership working. A panel has been established consisting of Sunderland's largest housing provider Gentoo, the Sunderland home improvement agency and the occupational therapy service. They to work together to consider requests for complex adaptations to enable people to be rehoused into more suitable accommodation. One particularly complex case involved a customer who had been discharged from hospital but was living in intermediate care accommodation because he could not access his home where his wife and three children lived. The home improvement agency was able to influence the design of a build property so that it would meet the customer's needs. The DFG contribution is less than £5,000 whereas adapting the exiting home would have been in excess of £30,000. They are in the process of replicating this approach with other housing providers.

Fast, effective service linked to health

Ealing has an in-house multi-skilled team which works across all tenures, including the council stock. Their management has an outward facing viewpoint and liaises with other related services, the Health Service, Older People's Partnership Board, the CCG and Joint Management Team who administer the Better Care Fund, to make others aware of the role of the home improvement agency and to bring in additional funding. They have developed a fast and effective handyperson service for hospital discharge and similar service to work alongside reablement teams on a 7-day a week basis. Handyperson services are provided by outside contractors so the service can be scaled up if required. The Regulatory Reform Order (2002) allows them to be flexible with how they use DFG funding. They have removed the means test for most cases and paperwork and bureaucracy are kept to a minimum so they can deliver services quickly. The next planned step will deliver adaptations and housing repairs for customers leaving hospital to prevent re-admissions. The authority has a five year rolling programme for funding which means that contributions from the local authority are known well in advance and customers do not suffer from the stop/start cycle of work that happens in many other authorities. It demonstrates that even in a London borough with high construction costs lean and efficient services can be developed.

Innovation and change

Non-means-tested service for 'at risk' cases

Wigan has pioneered a new approach to the DFG that specifically relates to the aims of the Better Care Fund. It is in the Greater Manchester area, which is the first to have devolved health service budgets. The occupational therapy and private sector housing adaptation teams work closely together and are doing joint training on new ways of working, which involves new holistic person-centred assessments. In 2015-16, the home adaptations service received £2m in funding from the Council and CCG Joint Commissioning Group, which doubled the adaptations budget. It enabled them to pilot a new rapid non-means-tested adaptations service for hospital discharge and people defined by health and social care teams as being 'at risk' of admission to hospital or care. They propose to continue this service in 2016, funded from the increase in DFG resources, with no means-test for adaptations costing less than £5,000, such as showers, stairlifts and ramps. Other DFGs will be processed as usual. This two-pronged approach may be a useful model for others to follow. The non-means-tested DFG provides a rapid response for more acute cases that fits with the aim of reducing pressures on health and care systems. The alternative route of a standard means-tested DFG enables higher cost adaptations, often involving extensions that increase the value of the property, to continue to be delivered.

6.11 The county authorities have the most difficult integration task as most cover large areas with relatively scattered populations. Many have high proportions of older people, particularly counties such as Cornwall, Devon, Dorset, and Cumbria which have been popular retirement locations for many years. Integration of services in these areas is happening in different ways to suite local circumstances. There is considerable scope to amalgamate small teams delivering low numbers of grants in different districts to provide economies of scale and more consistent services.

Bringing services together

Cornwall is a large rural area with almost two in every five households containing at least one person with a long term health problem or disability. A few years ago DFG services were fragmented between the County Council and six districts and were extremely slow. Cornwall is one of the first wave of 'super-unitaries' which has brought together the district and county services into one unitary authority. This new structure has allowed them to develop a multi-skilled and integrated service with pooled budgets called Cornwall Home Solutions. It has amalgamated the DFG and occupational therapy teams with the previously external home improvement agency and handyman services and they now operate out of three area offices. The service offers a range of housing solutions for older and disabled people including minor adaptations and equipment, major adaptations, handyman services, access to grants and loans, energy efficiency advice, winter wellness campaigns, support to relocate including financial assistance, and housing options advice to enable people to plan for future needs. It has reduced costs, speeded service delivery, resulted in more innovation and is having a strategic influence informing policies such as the Local Plan and the Housing Strategy.

Innovation and change

Holistic approach

Leicestershire is an example of a county working to integrate services through the 'Lightbulb Project'. They estimated that a third of all hospital admissions for people aged 75 and over were avoidable but the housing support offer was complex, bureaucratic, too narrowly focussed and each district had services organised in different ways. They obtained transformation funding and did a lot of consultation with service users and local people to co-produce solutions. Lightbulb pilot projects have brought together the adaptations service, assistive technology, home warmth, home safety checks and the handy person service into one joined up pathway supported by a holistic needs assessment tool (the Housing MOT). It is easier to access, better targeted, and reduces the hand-offs between organisations. They have a multi-skilled team including housing support co-ordinators, occupational therapists and technical officers. One pilot is working with a GP practice to proactively target individuals who may benefit from housing support before they hit crisis point. Opportunities for self-help and smarter procurement are also being explored. The aim is to roll out this new model across all districts. They have developed a dashboard to measure outcomes as the key to the success of the project is to demonstrate improvements in customer wellbeing, timely hospital discharge, prevention of hospital admissions/readmission, reduced admissions to residential care and better value for money.

6.12 Other county authorities have used different approaches, often using a single home improvement agency to deliver a more consistent service across a number of districts. Somerset, Staffordshire and Suffolk are all examples of this approach. Suffolk is particularly focused on health outcomes and has an integrated team that offers hospital discharge, falls prevention and dementia support services. Somerset has top-sliced the adaptations budget to provide non-means tested minor adaptations up to £1,000 for works to help with palliative care, to speed hospital discharge and to prevent readmission.

6.13 Perhaps the best example so far of a completely integrated service is Knowsley in the north west of England. Service commissioners agreed to pool budgets several years before the introduction of the Better Care Fund and the service is now well established.

One-stop-shop

Knowsley is metropolitan authority located between Liverpool and Manchester. In 2010 authority had the opportunity set up an Independent Living Centre for the first time. There was a considerable amount of consultation with older and disabled people and families with disabled children about the best approach to transforming the way services were delivered. From this consultation an agreement was reached to bring together a comprehensive range of services for all age groups as a one-stop-shop. The result is a completely integrated service in one location for disabled people of all ages. There are two adjoining warehouse units with consulting rooms, demonstration spaces for equipment and adaptations, meeting rooms and an equipment store with a repair and recycling facility. It is on a bus route and there is plenty of parking outside. The space used by customers is painted in bright and cheerful colours so it feels welcoming. The centre brings together minor and major adaptations, equipment service, the home improvement agency, handy person service, assisted technology, sensory services, children's health, reablement, falls service, postural stability service, and the wheelchair service. It also is the location for the blue badge scheme, an advocacy service and meetings of various voluntary and community groups. Users continue to be involved via a management board and as volunteers. There is also a Knowsley User Led Organisation (KULO) which meets at the centre.

Innovation and change

6.14 The Knowsley approach is not going to work everywhere as it very much depends on geography. It is probably more suitable to urban rather than rural locations where populations are more dispersed, although there is still the potential to develop hubs in county authorities which has been done in Dorset. Where this type of provision is appropriate it has enormous potential to transform the experience of using local services for people with disabilities. It also has scope to bring people together so that they can get peer support. It could also help to make ageing and disability issues more visible and give older and disabled people more 'voice' in policy decisions. It brings back the original ethos of disabled living centres about giving disabled people control over their own lives.

6.15 At the present time it is quite difficult to develop these types of purpose-built facilities as there are restrictions on new investment in most local authorities. However, as health and social care services begin to be combined there may be scope to use existing facilities in different ways. There may be potential to develop these types of centres in community hospitals or as part of new health and care hubs. There is also scope to base them in more visible town centre locations to encourage more people to think about preparing for old age and disability and the need to 'future-proof' their homes.



Involving older and disabled people

6.16 The need to involve disabled people in service transformation is vital. A recent review of the 2010 Equality Act by the House of Lords states that certain major issues came up repeatedly in their investigations, three of which are directly relevant to the operation of the DFG which are⁷⁵:

- **The needs of disabled people still tend to be an afterthought in planning services and buildings.** *'We should from the outset plan for the inevitability of disability in everyone as they get older, as well as for those who suffer accidents and for all those other disabled people'.*
- **The need to be proactive, rather than reactive or process driven.** *'We should be planning so that disabled people can as far as possible avoid facing the problems in the first place'.*
- **Communication** – *'so many of the problems of disabled people are exacerbated by a failure to make them aware of their rights in a manner that is clear and is adapted to their needs. But communication is a two-way process. If all those responding to the needs of disabled people engaged with them, listened to them, and took account of their views, all would benefit'.*

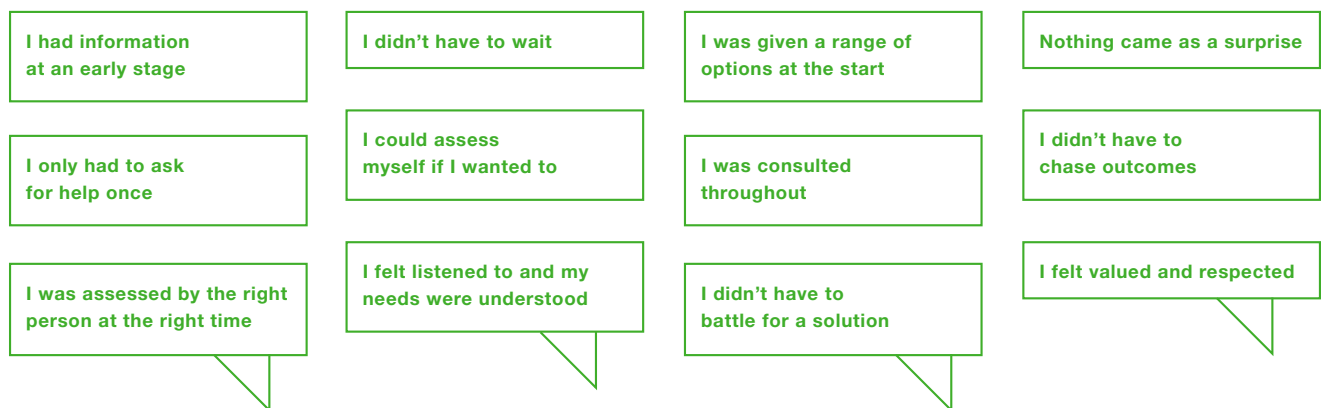
6.17 Consultation - it is clear that some of the best service improvements have come about when disabled and older people have been fully consulted and involved from the start of the integration process, such as in Leicestershire and Knowsley. Advice from the Local Government Association, NHS England, and other government departments about integration and Better Care Fund Planning emphasises the importance of consultation and use of co-production techniques in the design of services.⁷⁶ The problem is that time and resources are limited and engagement is often an afterthought rather than part of the process. As integration moves forward it is vital that older and disabled people are fully involved. Consultation is not easy as some of the most ill, frail or isolated are hard to reach. They may not come to meetings, or if they do, they may need assistance. Those who agree to be on committees may only be able to attend when they are well enough. Families with disabled children may also need help to take part in discussions. Effort needs to go into this process to ensure that new services truly meet their needs. It is not always possible to translate what they say into tangible action plans, but it will inevitably produce insights that would not be obtained any other way. However, it is not just about holding meetings. Service users need to be brought in to test new developments such as new service pathways, new websites or choice based lettings systems. Until they are trialled with older or disabled people it is very difficult to know that they are truly effective.

Involving older and disabled people

6.18 Better targeting and outreach - from interviews with DFG customers as part of transformation projects there are a number of issues about services that older and disabled people and their families would like to see improved which are revealed by the quotes illustrated in Figure 23. Firstly, they need to know that adaptations services actually exist and are easy to find. People who are dealing with disability for the first time have no idea where to turn. They are already coping with major life changes so everything has to be made as simple as possible. Older and disabled people are less likely than other groups to be digitally literate and online so although this communication route is becoming the norm, other avenues need to be available to enable people to

find out about the service. As a lot of people seem to find out about the DFG via word of mouth ways also need to be found to reach those who are more isolated. This is where a visible one-stop-shop solution would come into its own. Walsall has located its occupational therapy service in a shop front premises next to a large supermarket in the town centre for this very reason. There is also clearly an urgent need to engage more effectively with primary care services to find people suffering from ill health, who are at risk of falling or are unable to manage because of the condition and accessibility of their home. This should include GPs, community matrons, health visitors, district nurses, care providers and other people providing community services.

Figure 23. Customer service needs and improvements



Involving older and disabled people

6.19 Triage – the social care call centre is where the customer journey normally begins. Some services are excellent and can direct callers to a dedicated occupational therapy team who can begin the assessment process immediately. Urgent cases where care may break down, or where there are palliative care needs, can be seen very fast. Other cases where all that is required is minor adaptations or equipment can have that ordered and delivered quickly. However, it is all too common for other cases to be placed on a waiting list to be seen by an occupational therapist in date order. This is where delays often occur if demand exceeds the staff resources available. Some authorities have tackled this by further refining the triage. Effective triage can make a real difference to the speed and effectiveness of the rest of the customer journey. For example:

- Urgent/at risk cases or those that would help hospital discharge sent to a specialised rapid response team possibly for a DFG without a test of resources
- Straightforward cases and self-funders sent to the local centre for independent living which refers them direct to vetted and authorised contractors
- People who want to move directed to a rehousing team
- Simple cases separated from the more complex so that scarce occupational resources can be used for the latter and less qualified assistants or trusted assessors for the former.

6.20 Listen to service users - good communication is vital, both at the beginning and throughout the process. People want to be listened to, their opinions valued and to be given a personalised service. They (and their carers) are the ones who know themselves and their home the best and the assessment process needs to be a dialogue. Bristol City Council adaptation service began holding assessment sessions for straightforward bathing and stairlift cases in the local home improvement agencies' design centre. It resulted in very different conversations taking place when people could actually see the range of options available. Wigan is developing a new holistic assessment process, moving away from providing standard solutions to a more bespoke approach by listening much more carefully to what people themselves want.

6.21 Design is a key issue - people want a reasonable amount of choice, not too much to be overwhelming, but enough that they can find a solution that works for their situation. Design and technological advances are improving the range of adaptation solutions available and people's aspirations about the fixtures and fittings they would like in their homes are changing. People have invested a lot of time and energy into making their homes personal to them. They want products that look attractive and that do not label them as 'disabled'. However, DFG specifications have not always kept pace with these aspirations. Cut backs in staffing levels and training budgets in recent years have meant that it is more challenging for occupational therapists and technical staff to keep abreast of design developments and the relative costs of new solutions. It would help if organisations delivering home adaptations could work more closely with the supply chain to develop new, aspirational, value for money solutions and for the results to be shared nationally. There is also a need for better dissemination of good practice in design to help with condition specific issues such as sight loss and dementia.

I don't want visitors to use my bathroom. My bathroom looks like it's for a disabled person and I don't want to look disabled

Involving older and disabled people

- 6.22 Invest in better systems** - there also need to be better ways of involving users in discussing and selecting design solutions, for example by making more use of 3D displays on tablets or for people to be able to look at room settings in independent living centres. Virtual reality displays may not be that far off. Customers may also want to put some extra money into a scheme to get a slightly better specification, or to do some additional work. Finance systems need to be set up to allow this to happen.
- 6.23 Keep customers informed** - customers want adaptations delivered in reasonable timeframes and to be informed and given reasons if there is any delay. Complaints are nearly always about delays and the lack of communication. It is clear that effective triage, lean systems, fast-tracking and, where appropriate, removal of the test of resources can dramatically speed up customer journeys. The lessons from good practice authorities need to be adopted more universally. One person needs to be responsible for the end-to-end customer journey, particularly where services cross administrative boundaries.
- 6.24 'Future-proofing'** - to reduce future public expenditure there is a need to encourage more self-funded preventative work well before people get to a crisis point. There has been little research into how people plan adaptations, how they search for solutions, what work they actually carry out, or how the retail trade is adapting to this market. A small study reported by Age UK indicated that 1 in 5 people aged 60-69 are making adaptations to their homes to make them more suitable as they age. Of people aged 70 and over, about a third of those who had carried out adaptations had done so because their home was no longer suitable for their needs and a similar proportion to make caring for a relative easier. The most popular adaptation was the installation of a level access shower or wet room. However, a quarter of older people were not planning ahead and would only consider making changes if they had an accident that affected their physical ability. Further research is needed to see what products and services are required to help people 'future proof' their homes and what additional support might need to be provided, particularly for those who may not be eligible for a DFG but are still on relatively low incomes. There might be scope to pass on the cost-savings gained by procurement consortia to people who need to self-fund adaptations. This can be provided as part of the home improvement agencies comprehensive offer.
- 6.25 Services need to be inclusive for younger age groups** - the demands placed on health and social care by the ageing population are driving service transformation. However, disability affects all age groups and the DFG is also available for children, young people and adults of working age. It also needs to be remembered that the next generation of older people will not be like the present generation. Services need to encompass all age groups and include assessment, communication and design solutions suitable for younger people and people who do not want to be categorised as old or disabled.

The transformation process

- 6.26 Avoid further fragmentation** - adaptations services straddle service boundaries and what appears to be effective reorganisation for one service can often further fragment the adaptations team. To ensure this does not happen it is important to look at the whole customer pathway including, health, social care, housing, independent agencies and the voluntary sector.
- 6.27 Consult with staff** - staff often feel they have little control over the process and that no-one is listening to their views, but they often already know how the service needs to be altered if only someone would ask them. They also know what has been tried before that did not work. In one recent reorganisation exercise the head of the equipment service said he had never been consulted about any service transformation before. He had seen integrated services broken up in the past, but had clear ideas about what would work to join up services better in future and a willingness to put energy and time into a new service transformation.
- 6.28 Resource allocation** - the increase in DFG resources and the transformation of services is taking place during a phase of continued shrinkage of local authority budgets when there is unlikely to be any increase in revenue funding for staff. An Institute for Fiscal Studies report showed that housing has been particularly affected by the cuts to local authority finance losing at least 30% of funding on average, compared to 17% in social care. There is also a geographical dimension with the London boroughs, the North East and the North West seeing the largest average cuts to spending per person over the last five years. Future spending reductions are likely to be concentrated on the most deprived authorities that have already seen the largest reductions; exactly the areas that are likely to have the highest proportion of people with health and disability problems. These are also the areas least likely to be able to make up shortfalls from keeping 100% of the business rates or raising council tax⁷⁷. Although inconclusive, there are some indications from the LOGASnet data that these are the same areas that may not be getting enough DFG resources relative to need. The allocation formula may need to be revised to ensure areas of highest need receive enough resources. Health and Wellbeing Boards need to take a more active role to ensure resources meet local needs.
- 6.29 Leadership** – the split service model means that there is seldom a single person at strategic level responsible for the end-to-end customer journey. This is essential if service transformation is to be effective.

The transformation process

- 6.30 Single manager for equipment and adaptations** - given the restrictions on revenue funding for staff, new integrated services have to focus on where existing staff can be most effective. A key improvement is to try to get away from the split service delivery model where possible co-locate the occupational therapists with the home adaptations casework and technical team under a single manager. This may be an in-house integrated service within the local authority or an external independent or arms-length agency service. It seems obvious to bring these teams together, as equipment, minor adaptations and the DFG are part of a continuum of service delivery for the customer, but this integration is still not common practice. It improves communication and decision-making and speeds up the delivery process. Having a single manager responsible for the entire customer journey is essential to ensure an end-to-end streamlined service. It will also give the service much more 'voice' in discussions about funding and staff resources.
- 6.31 Use skilled staff more effectively and develop new multi-skilled roles** - it might also possible to reorganise the assessment process by using qualified occupational therapists more effectively as these are often in short supply. If trusted assessors or occupational therapy aides are allowed to provide assessments in straightforward cases it means that occupational therapists can be focussed on more complex work. The Care Act 2014 gives much more flexibility in the use of staff resources and this may allow new multi-skilled roles to emerge. This would enable more holistic assessments and cut down on the number of people who need to visit the home. This is the process that has already been developed in places like Sunderland.
- 6.32 Coordinated and consistent minor adaptations service** - There is scope to consolidate and co-ordinate minor adaptations, handyman and trusted assessor services to remove duplication and overlap. There are sometimes several services such as: a handyman service, the community equipment minor works service, hospital based providers, services run by Age UK or other charities and help provided by the fire brigade. Private building contractors also fit minor adaptations, often as part of more major works funded by the DFG. Some registered providers also have their own teams doing minor adaptation work. There are also a variety of hospital discharge teams. Each area needs coordinated services with consistent training.
- 6.33 Update Minor Adaptations Without Delay** - the College of Occupational Therapy published a handbook in 2006 called Minor Adaptations Without Delay. This was originally designed to enable housing associations do minor works without the help of an occupational therapist. This report is now quite old and needs updating and promoting. It would provide a consistent approach and take pressure off occupational therapists if more people could do simple adaptations without their input. Foundations could potentially include a wider range of people in Trusted Assessor training.
- 6.34 Employ disabled people** - ideally services should be looking to employ disabled people themselves in as many roles as possible. They often find it difficult to get employment yet they could add so much to adaptation teams. Middlesbrough Staying Put employs disabled people in its handyman service. This is a model that could be copied more widely as these staff inevitably have a great deal of understanding of the needs of home adaptation customers.⁷⁸

The transformation process

- 6.35 More transformation funding** - many of the authorities that are further ahead with integration have received transformation funding. There is clearly a need for those areas that are not as advanced to receive help with the change process and for mentoring and support to be provided from similar authorities that have already been through the process. This is particularly important given the cut backs in local authority funding for housing authorities. The Local Government Association has argued that the Better Care Fund needs to be accompanied by a much bigger 'Transformation Prevention Fund' to permit changes to be put in place, yet still allow services to maintain normal caseloads⁷⁹.
- 6.36 Longer funding cycles** – stop-start funding makes it very difficult to run effective adaptation services or home improvement agencies. If funding has to be negotiated every year it takes up a huge amount of staff time and it adds to delays for customers. If the DFG is to play a more effective role in the Better Care Fund local authorities need to commit to fund services over a three or five-year period.
- 6.37 Engagement with Health and Wellbeing Boards** – housing staff have been unrepresented on these boards. As new services are developed it is important to have a single manager responsible for the end-to-end DFG process, for them to have a place on Better Care Fund committees and be fully involved in the Better Care Fund planning process.
- 6.38 Input into Joint Strategic Needs Assessments (JSNAs) and Better Care Fund plans** – the need for adaptations is often missing from JSNAs and should be added. Better Care Fund plans often only have a few lines about the DFG. Now that it makes up 10% of the fund there should be a much more in-depth statement in each plan about how the DFG is actually resourced (how much the local authority, clinical commissioning groups, registered providers and other contribute), staffing levels, the process of service delivery and specific outcome measures.
- 6.39 More research and evaluation** - in addition, more research is needed to guide the transformation process. So far there has been no national evaluation of which type of service transformation offers the most effective adaptations service for disabled and older customers, or generates the best health and social care outcomes. There also needs to be more information on the relative costs of different service models, for example the costs of setting up a one-stop-shop as a base for the service. Without this information a patchwork of very different models of service delivery for the DFG could develop across the country; some more effective than others.

Lessons from service changes so far

6.40 Table 11 brings together the learning from service reviews, good practice case studies and numerous interviews, discussions and conversations with commissioners, staff and customers conducted over the past few years to show the main elements of an effective integrated DFG and home adaptations service.

OT = Occupational therapist

OTA = Occupational therapy aide

TA = Trusted assessor

VFM = Value for money

HWB = Health and Wellbeing Board

Table 11. Key elements of effective service delivery

1

Senior level commitment to drive change

2

Involve older/disabled people in service design

3

Single manager responsible for customer pathway

4

Co-location of staff - OT, casework, technical

5

Better targeting e.g. via GPs/community health

6

Fast, home from hospital service

7

Effective triage

8

Single holistic assessment

9

Single person responsible for customer pathway

10

OTs/TAs take straightforward cases

11

No test of resources for specified cases

12

Minimal paperwork, fast-track solutions

13

Use NHS number to link records

14

Aspirational VFM designs, design for sight loss/dementia

15

Regularly review standard specifications

16

Effective procurement

17

Recycling facility

18

Advice for self-funders

19

Customer choice - demonstration centre/3D images

20

Protocol with registered providers

21

Effective housing options advice and support

22

Independent appeals process

23

User board/advisory group

24

Employ disabled people where possible

25

Continual service improvement - cross-training, job swaps, involve users

26

Representation on HWB board or sub-groups

27

Monitoring and outcomes measurement - feedback to HWB

The development of local action plans

6.41 This is only the beginning of a process of change. Foundations is the national co-ordinating body for home improvement agencies and handyperson services. Foundations will play a key role in the transformation of services. In 2016 Foundations was re-commissioned by the Department of Communities and Local Government with a wider brief to work with organisations in health, housing and social care to improve customer services. This is clearly needed to bring a greater consistency of approach across the country. Foundations are supporting a network of DFG champions to offer support and mentoring to neighbouring authorities.

6.42 A 'Memorandum of Understanding' (MoU) was signed in 2014 by a number of government departments along with health, social care and housing organisations to ensure that housing issues continue to be part of the health and social care agenda⁸⁰. The aim is to provide integrated and effective policies to ensure that housing is:

- Warm and affordable to heat
- Free from hazards, safe from harm and promotes a sense of security
- Enables movement around the home and is accessible, including to visitors
- There is support from others if needed.

6.43 Foundations has taken on the secretariat for the MoU and is responsible for helping to develop action plans at local level by providing workshops, training and regional meetings. The aim is to start building a toolkit that will enable people in different organisations to work together more effectively. There is still a long way to go in joining up services and in providing fast and efficient delivery across the whole country but action plans will be a very effective start. This is not just about the DFG but in bringing together a broader range of services to ensure that older and disabled people do not have to seek out solutions relating to their home environment for themselves.

Improving data collection



Improving data collection

7.1 As part of the transformation process there is a need to improve the collection of data on the DFG both locally and nationally. This is required to show Health and Wellbeing Boards, Clinical Commissioning Groups, other commissioners, Department of Communities and Local Government and the Department of Health the value of home adaptations and the contribution they can make to reducing health and care costs and keeping people independent in their own homes. Local adaptation teams are already starting to address this issue and Foundations is taking a lead to ensure this is coordinated nationally.

The data collection process

7.2 Standard measures need to be used that are clearly defined and relate directly to the aims and objectives of the Better Care Fund which are: to improve delayed transfers of care, reduce further demands on health and social care, and improve the service user experience. However, data collection systems also need to recognise that services are doing a great deal of additional adaptation work that is preventative in nature that may fall outside the DFG but still needs to be captured, particularly some of the work being done to help self-funders.

7.3 Up to now LOGASnet has been a dataset associated mainly with the financial aspects of DFG, with only a small amount of data collected on applicant characteristics, no data on the types of work covered, and nothing on pipeline times and other aspects of administration. So these would be the main areas where additional material could be sought. LOGASnet is also a compilation of aggregated data so no cross tabulations are generally possible, for example age of recipient by size of grant. To extract information that could be manipulated in this way would require all DFG teams to have a casework IT system that covered the whole customer journey from first enquiry to completion of work, which may not be possible.

7.4 Some home improvement agencies already have casework systems, but this is still not common in local authority DFG services. Most have unconnected systems with occupational therapists using casework files and technical staff a property-based system, often with invoicing and financial transactions on a further system. To get details at case level someone in each authority would have to go through all the files for each year, extracting the relevant data into a spreadsheet before putting it into LOGASnet, which is not realistic given the limited staff resources available. Teams are already having to cope with higher caseloads as DFG budgets increase and they have not received similar increases in revenue resources to provide additional staff. Some are still facing further staff cuts. This is reflected in LOGASnet returns which have definitely become less well filled in in recent years, even in their present limited state, though this might change if there were perceived to be clear benefits to compliance.

7.5 As teams join together in different configurations following the Care Act there may be quite a long transition phase before IT systems improve and automated systems developed to provide a dashboard of information for management, monitoring and reporting purposes. At the very least there is a need for all services to use NHS numbers to comply with the requirements of the Better Care Fund and to facilitate the joining up of records on different IT systems. The more progressive home adaptation and agency services are already transforming their IT and data collection systems as they realise the need to provide Health and Wellbeing Boards with clearer information about service outputs and customer outcomes.

Future data collection

- 7.6** Table 12 lists possible variables that could be collected through a new version of the LOGASnet system. Authorities will still have to account for their spending which means the core of the old system will have to remain. However, it would be useful if a number of other aspects of service delivery could also be measured. The table lists those that are essential and, in italics, those that are desirable but possibly more difficult to collect given the fragmentation of services and the limitations of IT systems at the present time. Definitions will need to be made much more exact to avoid the problems that have plagued data collection in the past.
- 7.7** It would be preferable for local Health and Wellbeing Boards to be responsible for collecting the data and then sending it on to the Department of Communities and Local Government or the Department of Health. That way each local authority is accountable to their local board for DFG spending. This would help ensure that there is data return from every authority and it would improve the overall quality of the data. It would also help with service transformation if each service was made more accountable. It is important that national data is published each year so that overall patterns of resource allocation and spending can be monitored and individual services can benchmark their performance.
- 7.8** It is very important that data collection relating to the DFG tries to capture some information about the outcomes of interventions for disabled people and the impact on health and social care services. However, measurement of outcomes is difficult to achieve in practice. Each service usually asks users to complete a satisfaction form but this only records customer's views of the process and works carried out at the time of completion. Ideally follow up visits should take place some months after adaptation work has been completed to see the longer term effect. Staff are keen to do this but when staffing levels are low it is difficult to go back to see how well people are managing, what difference adaptations have made to their health and wellbeing or to do follow-up checks to see if needs have changed. However, this may improve as more integrated services develop with follow-up and reassessment becoming standard practice. Some suggestions are made in Table 12 about how simple outcomes could be measured but even this limited amount of information may be difficult to achieve in practice. Foundations is developing systems for individual agency teams to use to try to measure outcomes more effectively.

Future data collection

Table 12. Possible variables to include in a new DFG information collection system

Background information

- Name of local authority
- Name of service
- Date return completed
- Does service cover more than one authority? (list others)

Figures for the previous financial year: Year: 20 __ / __

- **Total DFG budget** (mandatory and discretionary)
 - o central government contribution
 - o amount of contribution from: a) local authority, b) CCG, c) registered providers, d) recycled funds from property charges, e) other
- **Total cost of completed DFG expenditure** (mandatory and discretionary)
- **Total number of DFG grants completed** (mandatory and discretionary)
- **DFGs without test of resources** – total number of grants completed
- **Number of grants for different age groups** – 0-20, 20-59, 60-74, 75 and over
- **Number of grants by cost band** – less than £1,000, £1,001-5,000, £5,001-10,000, £10,001-15,000, £15,001-£30,000, over £30,000 (upper limit could change)
- **Tenure of cases where work completed** – owner occupier, privately rented, registered provider, other
- **Top-ups to £30k+ grants** – number, amount and source of funding

Timescales

- For all DFG work under £10k (mandatory and discretionary) - average no of working days from:
 - o initial enquiry to referral of the proposed scheme,
 - o receipt of referral to approval of scheme
 - o approval of scheme to completion of work
- For all DFG work over £10k – as above

Discretionary grants

- Number and amount
- What they were used for - hospital discharge, handyperson, rapid adaptations

Note: The above list should exclude Housing Revenue Account expenditure although services providing adaptations in the council stock will want to record this information separately for comparison

DFG health and care outcomes (no of cases)

- Work allowed return from hospital
- Reduction in cost of care package following work (£ saving)
- Work prevented admission to long term care
- Work carried out expected to prevent falls
- Grant recipient reported improvement in wellbeing following work
- Carer reported improvement in wellbeing following work
- Number of people helped in previous financial year who are still living at home

Additional information that would be useful

Other details

- *Sources of original referral for completed cases: self-referral, hospital discharge, other health referral, reablement referral, social care referral, other*
- *Does the local authority have a facility to top up grants? (loans/other funding)*
- *Total number of new charges issued against properties and amount*
- *Number of people helped with moving who have relocated, number still waiting*

Type of work completed

- *Number of: minor adaptations under £1,000, ramps, level access showers, other bathing/washing adaptations, additional toilet provided, stairlift, through lift, fixed track hoist, change to internal layout, external changes, extension, other (will sum to more than the total number of cases as some people have more than one item)*
- *Number of cases with other interventions (telecare, warm homes, repairs, new fixtures, furniture moves, hoarding, advice/signposting, other)*

Self-funders

- Number of people helped with major adaptations who were self-funders outside of the DFG system - advice and information, plans and specifications, full technical service
- Total fee income from self-funders

DFG cases that don't proceed

- Number and reasons

DFG monies used for other purposes

- Amount and reason

Summary and conclusions



Summary and conclusions

- 8.1** Over the last decade the DFG has been a vital resource to help over 40,000 people a year live in more accessible homes. As the population ages the grant will become even more important because only 5% of the housing stock is completely accessible and very few new accessible homes are being built.

From policy vacuum to central position

- 8.2** The way the grant developed means that it crosses administrative and service boundaries with no single organisation responsible for the end-to-end customer pathway. The customer journey has been complicated with potentially multiple assessments, numerous handovers and sometimes long delays. Until recently it was not well targeted on hospital discharge or on people who might have to go into care. Resource constraints meant that it was seldom advertised and people tended to find out about it by word of mouth. The inclusion of the grant in the Better Care Fund and the increased share of resources going into the DFG means it now has a much more central position in policy planning. Integration of services around the individual and their home means that rather than being a single solution, the grant can be used as part of a holistic range of services to keep people living safely and independently in the community.

Future funding

- 8.3** DFG resources have risen steadily over the past decade, but when austerity measures were introduced in 2010 local authority contributions declined quite steeply, partly as a result of the loss of funding for the repairs grant that often supplemented the DFG. After the introduction of the Better Care Fund in 2013 contributions have begun to increase again in most areas. However, there is considerable variation, with some authorities contributing far more than others. Central government resources have risen substantially in 2016/17 and are projected to double by 2019/20. Local authorities will need to continue to contribute both capital and revenue costs to the DFG to ensure effective service transformation and to meet increasing needs from the ageing population. At local level there may be other contributions to funding from registered providers and local health authorities. Up to now these have not been recorded in LOGASnet data returns, an omission that can hopefully be remedied if the forms are redesigned.

- 8.4** Funding of adaptations in the social housing sector is confused and inconsistent. Too much reliance is placed on local authorities negotiating agreements with registered providers. Better guidance is needed to ensure consistency and equality of opportunity for tenants and to ensure that users from other tenures get a fair share of resources.

- 8.5** Now the DFG is part of the Better Care Fund and part of a clearer resource planning structure it might be easier to make the case for additional funds in future from local Health and Wellbeing Boards. However, it will be important for the managers responsible for the DFG to be on the committees that feed into these boards. There is also a need for much better evidence to be provided on the contribution DFG spending makes to improvements in the wellbeing of disabled people and their carers, and the potential savings for health and care. Partnership working will be essential and having a single service manager with an outward facing role to liaise with other departments and organisations will be essential if the DFG is going to be part of a fully integrated, well-resourced service.

The allocation of DFG resources

- 8.6** It is difficult to relate the distribution of DFG resources to levels of need as the grant addresses a wide range of housing issues for people of all ages and the number of grants given each year is quite small. The way national data sources are designed makes it hard to identify levels of need. The test of resources also affects the number of potential applicants. There is also a variation in the way central government allocations are topped up by additional resources from local sources. This report did not set out to make any recommendations about the funding formula for the distribution of DFG resources, but it does look at spending levels against some key variables that might need to be included in any new calculation. First of all, it looked at both spending per capita and per dwelling both of which showed similar patterns. Metropolitan districts spend more on average than the non-

Summary and conclusions

mets, shires and London boroughs; shires authorities on average appear to have quite low levels of spending. However, there was no clear regional pattern, although there was a cluster of higher spending in the west London boroughs and some of the unitary authorities also showed higher levels. A similar pattern emerged in relation to spending per resident aged 65+ with the shires having some of the lowest level of spending, despite many having ageing populations.

8.7 Patterns DFG expenditure were also correlated with numbers of owner occupiers and private rented sector tenants reporting that their activities were limited a lot by disability or health factors. This showed that the pattern of DFG spending across the country is almost the reverse of the potential pattern of need, with the highest spending concentrated in London and the south east, with lower levels recorded across much of the north of England. However, these patterns were not so obvious in relation to disability benefits. Data limitations mean that we cannot conclusively say that DFG allocations are misaligned, but the results raise important questions that warrant further examination to see if a more equitable funding formula can be devised. We were not able to say what amount of funding is required to address need. The best estimate of this still remains the Building Research Establishment analysis carried out in 2011 which needs updating.⁸¹ Some authorities are looking at this in more detail through local house condition surveys which might help to target resources better at local level.

8.8 There is also a need to review and update the test of resources. The Building Research Establishment made suggestions for changes in 2011 but these have never been implemented.

New service models

8.9 The typical split service model for DFG delivery described in this report, with occupational therapists based in separate teams from technical and casework staff, and the DFG being a single solution offered in isolation from other services has often led to inefficient and slow service delivery. To reduce pressures on health and care services the DFG needs to be delivered in a faster and more effective way. A key issue is to co-locate occupational therapists with technical

and casework teams. New models of consolidated and integrated service delivery are being developed, but there is no single model; it will depend on local needs. Services could be in-house, independent or a combination of the two. There is potential to combine DFG provision with a number of other services including: equipment, minor adaptations, handy person services, repairs and affordable warmth, home from hospital support, telecare, sensory services, falls prevention and the wheelchair service.

8.10 Even with the substantial rise in resources DFGs will reach less than 200 people a year in the average local authority area. Many older and disabled people needing adaptations will not be able to get funding, but many will have low incomes, few savings and little equity. There are also an increasing number of older people in poor condition homes needing repairs and help with home warmth. The Care Act 2014 requires people not eligible for statutory help to be signposted to alternative services to ensure they can remain living independently in their own homes or return from hospital safely. There is also a role to reach out to the wider community to encourage more people to 'future-proof' their homes to reduce the numbers who will ultimately need expensive health and social care support. These additional services could be provided by an integrated in-house service, an arm-length organisation or an independent home improvement agency. This needs to be included in any service transformation planning and be adequately resourced.

8.11 In all the good practice authorities studied as part of this research there were common elements of effective delivery. Having a multi-skilled team under a single manager leads to better decision making and creates a better working environment to devise and deliver adaptation solutions. Effective triage to route cases to the right places to avoid delays is also very important, and there needs to be one person responsible for the whole customer pathway to ensure good communication. Where possible there should be a single holistic assessment with the DFG being part of a range of measures to improve the home environment. More flexible use of staffing resources is needed to enable this to happen and training in new techniques is essential.

Summary and conclusions

8.12 It is possible to bring all services for older and disabled people together into a one-stop-shop as is demonstrated by Knowsley in the north west of England. If this model was copied elsewhere it would provide a much more customer focussed way of delivering services in keeping with the original aims of the independent living movement.

8.13 To make sure that new integrated services genuinely meet the needs of users it is vital to involve older and disabled people in service planning. This should not be an afterthought or a token gesture, but an integral part of service transformation. New ways of working also need to include more dialogue with customers and more bespoke solutions.

Better targeting

8.14 Owner occupiers are the main recipient of the DFG, but they may be under-represented because they are unaware of the grant, do not know where to turn for help, are put off by the test of resources or drop out because they are unable to contribute to costs. Registered provider tenants seem to receive a higher share of grant resources than might be expected, probably because they are directed to the service by their landlord. Better ways need to be found to reach people most in need, perhaps via GPs and other health providers. If the DFG is part of integrated services that are more clearly signposted it will help with this process.

Flexible use of the DFG

8.15 Most grants are relatively small in size with the average being just over £7,000, but 58% are under £5,000 particularly outside of London, the south east and some of the major urban areas. This has been relatively consistent over the past decade. This suggests that the grant process could be simplified considerably to remove paperwork, reduce touch times and enable more fast-tracking direct to contractors.

8.16 It is also possible to remove the test of resources for specific cases, and to use small grants to speed hospital discharge. There is scope to have several different DFG pathways: for example, a non-means tested grant for rapid hospital discharge or for people at risk of going into care such as in Somerset and Wigan,

combined with a more traditional DFG for less urgent cases focussed on prevention. This would need to be tailored to local needs.

8.17 Many home adaptation services still have very bureaucratic systems and service managers are finding it difficult to get authorisation to use the grant in a more flexible way. Further guidance may be needed so that adaptation managers have a document to show finance department and auditors that this is allowed. They may also need support to develop written policies. Authorities will also need financial systems that will allow individuals to top up their grant allocation to get bespoke solutions.

Raising the grant threshold

8.18 Over the last decade there were only about 5% of grants at and over the maximum threshold of £30,000 on average (although there is quite a lot of missing data for this variable). The LOGASnet data does not allow any cross-tabulations so it is not possible to say whether the majority of the bigger grants are going to children and young people or to a mix of age groups. The cost savings to health and social care of keeping disabled children at home with their families and preventing family breakdown is potentially very high. Households needing these more major and complex adaptations struggle to find alternative accommodation and find it difficult to obtain the additional funding to top-up funding. As a result, there has been a call from many of the organisations working in this field to raise the maximum threshold. There is also a need to clarify the role of social care in providing top-up funding. This would speed up the process of providing home adaptations for these more seriously disabled and 'at risk' cases.

Design

8.19 New materials are being developed that give more scope for different types of adaptation design and peoples' aspirations about what they want to see in their homes are changing. The DFG has not kept pace with these trends. Organisations delivering the DFG need to work more closely with suppliers and manufacturers to develop aspirational but value for money and robust solutions more in keeping with today's lifestyles.

Summary and conclusions

Support for moving

8.20 Adaptations are not always the right solution and some people would rather move if the right property could be found, particularly younger households. Moves are easier in the social housing stock, but home choice letting systems are not always tailored to the needs of disabled people and a focus on limiting void times leaves little opportunity for disabled people to view properties and make decisions. In some areas people have to go through another assessment to be assigned a place on the waiting list. These systems need to be better integrated with DFG services and the needs of health and social care.

8.21 At present few DFG funded adaptations take place in the private rented sector, but this may change as this sector grows in size. It may be difficult to adapt some of this stock and there are some concerns emerging, particularly about the increasing numbers of disabled children who are likely to be inadequately housed in this sector. Social housing providers may need to be persuaded accept some of these cases on to waiting lists to enable people to remain living in the community and avoid costly interventions by health and social care.

8.22 As the DFG becomes integrated into bigger teams focussed on improving the home environment there is scope to engage far more with planning departments, social housing providers and developers to try to increase the amount of new accessible housing. This is particularly important if land is being released by health authorities where there may be more control over what type of housing is developed.

8.23 The FirstStop advice service needs to be much better publicised so that people know they can get help with housing options.

Minor works

8.24 In each area there are often various providers of handyperson and trusted assessor services which may need to be better co-ordinated. Some are part of the equipment service, some provided by home improvement agencies, others by the voluntary sector or even the fire brigade. There are also teams working in the council and registered provider stock. There is a need for more consistent training and for them to have

more holistic roles in identifying and remedying hazards in the home to reduce falls and accidents. To facilitate this there is a need to update the Minor Adaptations Without Delay handbook and to make sure it is widely disseminated.⁸² Foundations also runs regular trusted assessor training in partnership with the Disabled Living Foundation that could potentially include a wider range of people.

Developing local memorandums of understanding

8.25 In order to guide the transformation of services at local level there is a need for local plans to be developed to bring all the commissioners and service providers together. Foundations is driving this process and toolkits, workshops and training will be provided to help people work together effectively.

Improving measurement

8.26 A better data collection system is necessary to measure the use of the DFG but this not easy to implement given the still fragmented nature of the service, the lack of joined up IT systems and the decline in quality of returns in recent years, probably because of staff reductions. A number of additional variables are suggested to fill gaps in the dataset, such as information on timescales, additional sources of funding, and use of non-means-tested grants, but there will need to be very precise definitions to avoid errors in completion.

8.27 It is important that data is returned to local health and wellbeing boards to ensure services are accountable, and that boards are aware of the work the home adaptations team is doing. Some services may be able to provide their boards with additional information if they have casework systems that enable cross-tabulations which can provide more sophisticated data. In all areas information on outcomes and savings to health and social care need to be include in returns, although this is the most difficult area to measure. Standard returns need to be forwarded to central government for collation, analysis and publication of national level results.

Summary and conclusions

- 8.28** There also needs to be independent research evaluation of the new service models to see which are most efficient, cost effective and provide the best result for customers. It would also be useful to look at fast tracking solutions with no means test to see how much they are speeding up processes and whether it affects the quality of work and customer satisfaction. Good practice needs to be disseminated.

Recommendations

8.29 The recommendations from this report are summarised in the following table.

Table 13 Recommendations

1

Combine services for improving the home environment so that disabled and older people do not have to search out solutions. Fully integrate DFG teams with a single manager controlling the end to end customer pathway. Potential to combine DFG provision with a number of other services including: equipment, minor adaptations, handyman services, repairs and affordable warmth, home from hospital support, telecare, sensory services, falls prevention, the wheelchair service, housing options advice and help for self-funders.

2

Better Care Fund plans - to show more detail about the DFG including: financial and staffing resources; the DFG delivery process, targeting and outcome measurement. More detail on the need for home adaptations in JSNAs.

3

DFG allocation formula - Review the current DFG funding allocation formula to see if it can be better targeted on areas with higher levels of need

4

Provide guidance on use of the Regulatory Reform Order 2002 including: dispensing with the test of resources; using the DFG for hospital discharge; topping up grants; providing loans; and using the grant for other work such as heating, lighting and repairs.

5

Test of resources - this needs to be updated

6

Funding over £30,000 - clarify the role of social care in providing top-up funding and consider raising the grant threshold above the current £30,000 threshold

7

Memorandums of Understanding – action plans to be drawn up in each area to enable effective joint working between health, social care and housing to help people live independently by ensuring homes are accessible, warm, safe and free from disrepair.

8

A higher profile and more publicity - given to services that help people improve their home environment to ensure that people know where to go for help and support. Ideally, have a one-stop-shop for all services for older and disabled people.

9

GPs and health professionals - to be given much more training and information about the impact of poor house conditions and accessibility on health. Provide clear referral routes and guidelines about the type of referrals required so that DFGs and adaptation services can be better targeted.

10

Design – a project to work with the supply chain to see if new cost effective designs could be developed to meet changing aspirations and make better use of new materials. Information and training will be needed to disseminate new ideas to home adaptation teams and to the wider public.

11

Social housing - rationalise the way social housing adaptations are funded and ensure registered providers contribute to DFG funding or offer their own effective adaptation services.

12

Moving home – provide better information, advice and support to help people move in all tenures:

- Improvements to social housing home choice systems to make better use of already adapted properties, stop removal of DFG funded adaptations, advertise accessible homes more clearly, prevent duplicate assessments of need, and give disabled people longer to view properties and move home.
- Work with planners, social housing providers and developers to ensure more new build accessible homes. Health authorities releasing land for development need to be fully engaged with the need to provide accessible housing
- Publicise the FirstStop advice service more effectively
- Work with estate agents to provide better information on accessible homes in the private sector.

13

Minor adaptation and handyperson services - better co-ordination where there are duplicate services at local level and more effective training to provide consistency

14

Self-funders – services to provide advice, information and support in each area to ensure that people can remain living independently regardless of income

15

New LOGASnet forms - returns to be made by Health and Wellbeing Boards. Publication of annual returns to enable benchmarking

16

More research - independent evaluation of new DFG service delivery models

See Table 11 Section 6 - for key elements of effective service delivery at local level

Appendix A

LOGASnet – sample questionnaire

- Main DFG allocation 2011-2012 including any additional grants and ex-service personnel
- Number of ex-service personnel who are in receipt of either War Pensions Scheme for disablement of 80 per cent or higher and a Constant Attendance Allowance and capital lump sums through the Armed Forces Compensation Scheme and Guaranteed Income Payment (tariff level 1-6),
- Between 1 April 2011 to 31 March 2012 - total cost of adaptations
- Total number of mandatory grants completed in previous year 2011-2012
- Number of mandatory DFGs where the applicant is aged up to 20 years' old
- Number of mandatory DFG where the applicant is 60 or over
- Forecast total number of mandatory grants to be completed in 2012-2013
- Forecast total number of mandatory grants to be completed in 2013-2014
- Number of recipients who received maximum DFG entitlement in 2011-2012
- Number of applicants in receipt of a DFG up to 20 years' old
- Number of applicants in receipt of a DFG aged 60 or over
- £5,000 or less / £5,001 to £15,000 / £15,001 to £30,000 / Total
- Owner Occupier, RSL/Housing Association, Other/Private Rented, Total
- Local authority contribution towards overall DFG expenditure in 2011-2012.
- DCLG allocation in 2011-2012
- Total overall DFG expenditure
- Forecast local authority contribution to overall DFG expenditure in 2012-2013.
- DCLG allocation in 2012-2013.
- Total overall DFG expenditure for 2012-2013
- Estimated local authority forecast contribution to overall DFG expenditure 2013-2014.
- Estimated recycled funds generated through charges on property issued in 2011-2012 (cost)
- Total number of charges issued against property in 2011-2012.

Appendix B

DFGs provided - breakdown by tenure, size of grant and age of recipient*

		Number or % of grants							
		2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Average 2008-15
All grants	Total number	42083	44626	45549	43865	42125	42770	40645	43095
Tenure	Owner occupiers	27031	28866	28719	27612	25691	25923	23038	26697
	RP tenants	12337	13771	14984	13818	14291	13767	13910	13840
	Private tenants	2735	3031	2978	3414	3284	3546	3540	3218
	Owner occupiers	64%	63%	62%	62%	59%	60%	57%	61%
	RP tenants	29%	30%	32%	31%	33%	32%	34%	32%
	Private tenants	6%	7%	6%	8%	8%	8%	9%	7%
Age of recipient	Under 21	2894	3116	3100	3239	3088	3709	3097	3178
	21-59	6918	9474	9975	10318	9541	9431	10466	9446
	60 and over	30317	32232	32923	30423	29704	29948	27238	30398
	Under 21	7%	7%	7%	7%	7%	9%	8%	7%
	21-59	17%	21%	22%	23%	23%	22%	26%	22%
	60 and over	76%	72%	72%	69%	70%	70%	67%	71%
Amount	Average amount (£)	7429	7178	7215	7167	7396	6870	7729	7255
	Average amount (£) 2014-15 prices	8061	7802	8031	7866	7875	7074	7729	
	Up to £5,000	21830	25052	26437	25696	25835	25767	24154	24967
	£5-15,000	14339	15760	15811	14576	13323	14068	13355	14462
	£15-30,000	3961	4010	3751	3708	3175	3253	3292	3593
	At max grant (£30,000)	2707	2708	2653	2137	2628	1006	NA	2306
	Up to £5,000	54%	56%	57%	58%	61%	60%	59%	58%
	£5-15,000	36%	35%	34%	33%	31%	33%	33%	34%
	£15-30,000	10%	9%	8%	8%	8%	8%	8%	8%
	At max grant (£30,000)	7%	6%	6%	5%	6%	2%	NA	5%

*The figures in the table are approximate, as an estimate has been made to account for missing data, by assuming that missing authorities provided the average number of grants for the relevant year. A small number of adjustments have also been made where an authority appeared to have erroneously provided the aggregate amount spent on DFGs rather than the number of grants.

Key organisations involved in home adaptations and DFG delivery

Foundations - is the national co-ordinating body for home improvement agencies and handyperson services and provides information, support, training and quality assurance across the sector. In 2016 Foundations was re-commissioned by the Department of Communities and Local Government with a wider brief to work with organisations in health, housing and social care to improve customer service for home adaptations. Foundations are supporting a network of DFG champions to offer support and mentoring to neighbouring authorities. They have a website with an extensive amount of information about home adaptations policy and the DFG. <http://www.foundations.uk.com/>

Care & Repair England - is an independent charitable organisation which campaigns to improve housing and services to enable older people to live independently in their own homes for as long as they choose. They raise awareness of the extent to which older people are living poor and unsuitable housing and of the importance of the DFG. They published the latest Good Practice Guide for the delivery of the DFG and provide regular policy updates about issues that affect older and disabled people. <http://careandrepair-england.org.uk/>

The College of Occupational Therapists -

The British Association of Occupational Therapists is the professional body representing occupational therapy staff across the UK. The College of Occupational Therapists is a registered charity and wholly owned subsidiary of the Association, which acts on behalf of all members. The College sets the professional and educational standards for the profession and provides training, continuing professional development, supports research and produces publications and journals. There is a specialist housing section which advocates for improved standards of housing for older and disabled people. <https://www.cot.co.uk/>

FirstStop - was set up by the Elderly Accommodation Counsel to help people make more effective housing choices in later life. It is a national, independent and free service offering advice and information to older people, their families and carers. The Elderly Accommodation Counsel site also has a directory of homes to rent and for sale suitable for older people. <http://www.firststopcareadvice.org.uk/>

The Home Adaptations Consortium - as a result of all the numerous strands of service provision it was difficult to develop effective policies or present the case for increased resources. The Home Adaptations Consortium was set up in 2008 to provide a forum for the many organisations and charities working in the adaptations field to share and promote good practice and bring key players together to better coordinate services to meet the needs of needs of disabled people, older people and those living in inaccessible, poor condition and badly heated housing. <https://homeadaptationsconsortium.wordpress.com/>

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Note: all web links in this report were accessed in May 2016, but no guarantee can be made that these links will remain live.

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