

Disabled Facilities Grant (DFG) and Other Adaptations – External Review



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Main Report

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Foundations

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Ferret Information Systems

Acknowledgements

From the beginning we realised this was a rare opportunity to refresh and revitalise a programme that helps thousands of people every year but has become overly complicated through a changing health and care environment and nearly 30 years of custom and practice. With only three months to complete the field work we are very appreciative of all the contributions received.

Thank you to everyone who contributed to this review. Around 200 people came to the initial free consultation workshops to consider, debate and vote on a range of options that set the direction and tone of the narrative, supported by Foundations' commercial partners. Hundreds more watched the online videos and gave detailed feedback on the options. A number of organisations also submitted more detailed written responses that helped to further shape our recommendations. The passion and dedication with which people expressed their views was remarkable.

We also spoke to a range of experts from within the sector and beyond whose knowledge and varying perspectives either challenged our preconceptions or reinforced our thinking – but in either case strengthened our recommendations. Particular thanks also go to the members of the DFG Champions Facebook group who provided instant opinions, case studies and data when we needed it.

A number of home improvement agencies and local authorities had previously participated in 'Rethinking DFG' workshops with Foundations and the Social Change Agency that strongly influenced our thinking on assessment and the upper limit.

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Finally, we would like to thank all our colleagues who provided support and encouragement while we were busy writing up the findings. We would also like to thank Anna Bornioli of the Centre for Public Health and Wellbeing who did the final edit of the report.

We set out to #fixtheDFG and make it fit for purpose for the next 30 years and beyond. We think our recommendations will go a long way to achieving that aim.

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Glossary

We have tried to avoid using acronyms, but you will see some abbreviations in the text. They have had to be used in tables and diagrams to fit the space.

AA	Attendance Allowance
ALMO	Arms-Length Management Organisation
BAME	Black, Asian and minority ethnic
BCF	Better Care Fund
CA	Carers Allowance
CSCR	Care and Support (Charging and Assessment of Resources) Regulations 2014
CCG	Clinical Commissioning Group
DFG	Disabled Facilities Grant
DHSC	Department of Health and Social Care
DLA	Disability Living Allowance
DWP	Department of Work and Pensions
ESA	Employment and Support Allowance
EHS	English Housing Survey
FOI	Freedom of Information request
HB	Housing Benefit
HIA	Home Improvement Agency
HRA	Housing Revenue Account
HMPP	Home Modification Process Protocol
HWB	Health and Wellbeing Board
ICES	Integrated Community Equipment Service
IIDB	Industrial Injuries Disablement Benefit
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Child
MHCLG	Ministry of Housing, Communities and Local Government
NHF	National Housing Federation
ONS	Office of National Statistics
OT	Occupational Therapist
PIP	Personal Independence Payment
RCOT	Royal College of Occupational Therapists
RP	Registered Provider
RRO	Regulatory Reform (Housing Assistance) (England and Wales) Order 2002

Note: where web addresses are given in the text, these were live Nov 2018.

Chapter 1. Introduction

The aims of this review

- 1.1 Across England the population is ageing, there are high numbers of disabled working age adults and rising numbers of families with disabled children. The majority live in ordinary housing, but most homes are not well designed for disabled people. In 2014 just 7% of homes (around 1.7 million) had all four basic accessibility features of level access, flush threshold, downstairs toilet, and sufficiently wide doorways and circulation space¹.
- 1.2 The Disabled Facilities Grant (DFG) is a means tested capital grant which can contribute towards the cost of adapting a home, for example by installing a stairlift, creating a level access shower room, widening doorways, providing ramps and hoists or creating a ground floor extension. However, delivery of the grant is changing. It is increasingly being used to provide a wider range of solutions to the problems people face in their home.
- 1.3 This review is divided into two parts which will:
 - A. Provide an assessment of how the DFG is currently being used
 - B. Make evidence-based recommendations about how the DFG should change.
- 1.4 There are two main aims:
 - 1) **To support more people to live in suitable housing so they can stay independent for longer.** Many disabled and older people spend most of their time in their home and the accessibility, warmth and comfort of that home has a vital role to play in health and wellbeing. For disabled people of working age, the home also needs to be a place that makes it easy for them to earn a living. For families with disabled children the home should enable children to grow, develop and lead as normal a life as possible.
 - 2) **To make the case for more joined-up action across housing, health and social care.** Suitable housing plays a key role in preventing accidents, allowing swift return from hospital, restoring health and wellbeing, supporting carers and encouraging independent living. Responsibility for the DFG at local authority level is often split between different departments and directorates. The review will look at the need for the DFG to be joined more closely with other services to provide better support for disabled and older people.

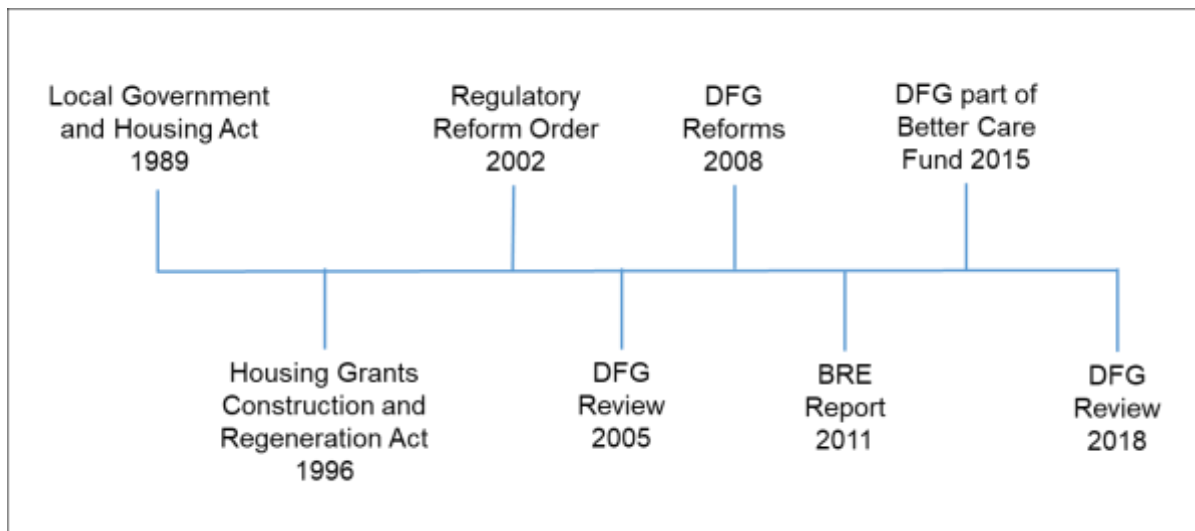
¹ Ministry of Housing Communities and Local Government (2016b) English housing survey 2014 to 2015: Housing for older people report, London: MHCLG.
<https://www.gov.uk/government/statistics/english-housing-survey-2014-to-2015-housing-for-older-people-report>.

Why the review is needed

Changes since the last review

- 1.5 The Disabled Facilities Grant (DFG) is now nearly 30 years old. It was introduced in 1989 as one small part of a raft of grants designed to improve the poorest housing stock. The legislation was reviewed in the early 1990s, and it is the 1996 Housing Grants Construction and Regeneration Act which governs operation of the DFG today (Figure 1.1). Further changes to introduce more flexibility in the use of the DFG were brought in with the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). Over the intervening period, all the housing renewal and improvement grants that were part of the original legislation have been discontinued and the only grant that remains is the DFG.
- 1.6 The DFG is a mandatory grant, which means that it is a legal requirement for local authorities to provide help to people who meet the eligibility criteria, whether or not the authority has sufficient budget². These criteria include ensuring that the works are necessary and appropriate to meet the needs of the disabled person, and that they are reasonable and practicable given the age and condition of the property.

Figure 1.1 DFG Timeline



- 1.7 The last major review of DFG was in 2005, which immediately led to the removal of the means test for children and young people aged 18 or under and other significant changes which came into effect in 2008. These took away the ring fence on funding; raised the maximum grant limit from £25,000 to £30,000; and allowed passporting of people on certain mean-tested benefits through the test

² A high court ruling in 1998 stated that local housing authorities are not entitled to have regard to their financial resources in determining whether or not to approve an application for a DFG for purposes within Section 23(1) of HGCRA 1996 (R v Birmingham City Council ex p Taj Mohammed (1998) Times Law Reports 429, QBD).

of resources to remove unnecessary bureaucracy. The 2008 reforms also allowed more flexibility in the use of the grant, for example: to fast-track grants; to make homes safe and warm for people being discharged from hospital; or to help people relocate to more suitable housing. However, not all the recommendations arising from the 2005 review were implemented. Many of the remaining issues are dealt with in this review.

- 1.8 In 2011, the Building Research Establishment (BRE) did an in-depth review of the means test and the allocation methodology. The formula they developed for the allocation of resources has been used to distribute most of the additional central government funding since this date. However, a more recent report on the DFG suggested that the distribution of resources might need further changes to provide a more equitable spread³.
- 1.9 Recent and substantial changes to house prices, benefits, retirement ages and the costs of work mean that the allocation formula, the means test and the upper limit all need reviewing.
- 1.10 Over the years there have also been a considerable number of court judgements, Ombudsman reports and letters of guidance which have had an impact on the use of the grant and the delivery process. This plethora of different sources of information needs bringing together to give local authorities a blueprint for effective operation of the grant.

Changing context

Integration

- 1.11 The context in which the DFG is delivered has also changed significantly in the last decade. Although the DFG is about altering the built environment, it is also about supporting disabled and older people to be independent, enabling carers to continue their role safely, preventing accidents and helping people to return from hospital. It therefore crosses the boundaries between housing, health, and social care
- 1.12 Reflecting this cross-sector role, in April 2015 the grant became part of a joint health and social care budget, the Better Care Fund (BCF). Responsibility for funding the DFG is now held by the Department of Health and Social Care (DHSC). The Ministry of Housing, Communities and Local Government (MHCLG) continues to lead on policy and the distribution of funding.
- 1.13 At national level there is beginning to be a clearer focus on the integration of housing with health and care services. In March 2018 an updated Memorandum of Understanding on Improving Health and Care Through the Home was signed

³ Mackintosh, S. and Leather, P. (2016) The Disabled Facilities Grant Before and after the introduction of the Better Care Fund, Glossop: Foundations.
<http://www.foundations.uk.com/media/4665/dfg-report-final-interactive-converted-draft-6-small.pdf>

by all the principal national organisations concerned with the delivery of housing, health and care services.

- 1.14 The way services are delivered at local level is also changing, driven by the 2014 Care Act, Sustainable Transformation Planning for health and social care, and local authority restructuring and devolution. Good practice is evolving as transformation and service integration takes place. The review looks at the different models that are developing and how this is beginning to join-up formerly separate services and provide more holistic solutions for disabled and older people.
- 1.15 New local structures at strategic level may be needed to ensure that this best practice gets properly embedded across the country to enable disabled and older people get access to fast and effective services no matter where they live.

Increased resources

- 1.16 Since the DFG became part of the BCF there has been a significant increase in central government resources. In 2014/15 central government contributed £220m, but by 2017/18 this had more than doubled to £473m in total. There is a need to show how this has impacted on local funding contributions and whether there has been a significant increase in the number of people helped to remain independent each year.

Ageing population and rising numbers of disabled people

- 1.17 The impact of the ageing population in the UK has begun to be much more apparent. The pressures on health and social care have been increasing, particularly in the winter of 2017/18 when there were delays in accident and emergency departments and a shortage of hospital beds. Research is beginning to demonstrate the role adaptations play in reducing accidents, enabling faster hospital discharge, providing support to carers, and enabling people to remain living in their own homes for longer, rather than needing residential care. The need for services that wrap around the patient or service user, rather than them having to seek out relevant services from a myriad of different sources is also becoming better understood, which will affect the findings of the review.

Changing expectations and impact of technology

- 1.18 The review also needs to consider the evidence about what people feel about their homes, the type of adaptations that they want to see provided and how this might affect how the DFG could develop in future. Expectations are changing and there are new materials and advances in information technology and artificial intelligence which are rapidly being incorporated into people's homes. The DFG needs to evolve if it is to remain relevant for the next decade and beyond.

Changes in tenure

- 1.19 When the DFG was originally conceived it was mainly for people who were low income home owners living in poorer housing. Since then, registered provider tenants (housing associations) have begun to use the DFG in much greater

numbers, but the DFG it is not used by tenants in the council stock who have a separate funding stream through the housing revenue account.

- 1.20 The mix of tenures is changing with increasing numbers of disabled people now in the private rented sector. Adaptations in the private rented sector are more difficult to deliver as people often have short-term tenancies. This report makes some suggestions about better ways of working with landlords. Tenure issues are not explored in depth and need further review.

Problems with service delivery

- 1.21 Over the years there have been continual complaints about DFG delivery. A CLG Committee report on Housing for Older People pointed out that the DFG followed 'a *clunky process*' and that waiting times varied significantly between authorities⁴. A report by the Equality and Human Rights Commission also said that grant delivery was too slow⁵.
- 1.22 The 2005 review pointed out the lack of strategic oversight, the paucity of evaluation information and the absence of effective performance targets. It also made the point that part of the strategic challenge was to shift the thinking from 'welfare' to 'investment' so that decisions were not made on the basis of lowest cost but instead looked at the long-term health and wellbeing of the disabled person and their family. These issues are key areas that this review addresses.

The focus of the report

- 1.23 This review examines the current situation and shows some of the ways in which the grant might not be working as well as it might. However, the emphasis is on ways in which DFG delivery could change in future and how it can move from being a stand-alone service to being part of a package of provisions to help people remain independent. It is a practical review with detailed information about new ways of working that could drive service change. It also uses evidence to provide options for Government about future allocation of resources and means testing.
- 1.24 Throughout the report, the focus is on the disabled or older person and how they can be put at the centre of service provision. The report considers what would make it easier for them, and their families, to find their way through what can be confusing service pathways. It also considers how those who are not eligible for the DFG, or chose not to use this funding route, might go about getting advice,

⁴ Communities and local Government Committee (Feb 2018) Housing for older people: Second report of session 2017-19, London: House of Commons.

<https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/370/370.pdf>.

⁵ Equalities and Human Rights Commission (2018) Housing and disabled people: Britain's hidden crisis. <https://www.equalityhumanrights.com/sites/default/files/housing-and-disabled-people-britains-hidden-crisis-main-report.pdf>.

information and support to create a home environment that helps them remain active and independent.

- 1.25 Prevention is a major issue. Many services are not delivered in an optimal way because they are dealing with people at crisis point. The DFG has a key role to play in prevention as providing adapted housing when people are first experiencing difficulties is much more effective long-term than reacting when they have a serious injury or have become very frail. The review will look at how this preventative role might be delivered more effectively.
- 1.26 The report only covers the DFG in England. The legislation and arrangements for providing adaptations are different in the other parts of the UK. However, where lessons can be drawn from other jurisdictions these will be mentioned in the report.

Chapter 2. Methodology

The review

2.1 There are two main parts to the review, each with several components:

Part A: How the DFG is used currently

- DFG funding
- Who receives the grant
- Types of adaptations and costs
- Costs and benefits to local authorities
- Processing arrangements and waiting times

Part B: How the DFG should change

- The bigger picture
- Local delivery
- Working better together
- Allocation of resources
- Funding
- The means test
- Regulation and the upper limit
- Developing a market
- Tenure and equality

Methodology

2.2 The review took place over a very short period: February-May 2018. The team conducting the review already had a depth of understanding about the DFG. They had worked on previous reviews or had been involved in national or local service improvement. They understood the variation in delivery across the country, particularly the differences in operation between unitary and county authorities. They knew the data sources available, had carried out evaluation of delivery methods, and examined the evidence about the outcomes of adaptations. Although the methodology was inevitably constrained by the restricted time frame, the team was able to access a considerable amount of national and local evidence and consult a wide range of organisations. Sources of evidence included:

- **Analysis of data from LOGASnet returns** made annually by local authorities to the Ministry of Housing, Communities and Local Government combined with **data from a series of Freedom of Information requests**. This gave a

national picture of annual budgets, the value of work, information on who receives the grants, time scales, costs of work and type of work carried out.

- **Three consultation events** were held, each with about 70 participants from local authorities, home improvement agencies and other organisations. **An online survey provided further feedback** with responses from 234 people. There was almost equal representation from people working in occupational therapy roles (44% online) and those in housing (43% online). Opinions were obtained relating to key aspects of the review, including: how the means test might be reformed; whether the upper limit should be changed; how best to link the DFG to health and social care; effective methods of delivering the grant; and how to help people outside of the DFG.
- **The review also drew on the findings of previous consultation events** held by Foundations, the Home Adaptations Consortium and the Royal College of Occupational Therapists (RCOT) such as: the DFG Summit December 2016; DFG Champions events over the period 2015-17; and comments on the DFG Champions Facebook page.
- **Means test** - The review considered the existing means test and compared it with means tests being used for state benefits (both legacy and those being introduced) and social care. The methods and results of assessing the levels of income needed for recipients, the methods by which earnings, income and capital are used to determine resources and the ways in which those are used to determine eligibility were all examined. These were modelled against a number of household types using a model derived from Ferret's Future Benefits Model (FFBM) which enabled outcomes to be compared. The effects of bringing the existing means test in line with the parameters used in other current means testing was considered, allowing a number of options to be proposed.
- **Allocations methodology** - the starting point for the review of the allocations methodology was to create a baseline of the number of people within the local authority or region who could potentially benefit from adaptations to their home and then add in 'adjustment' factors one by one to examine the cumulative effect of each stage on the allocation of funds (using 2016/17 funding levels); this helped determine where the greatest shifts in the distribution of allocations might occur. All adjustment factors, which were considered suitable proxy indicators of DFG demand, were given equal weight to help assess their impact. Due to the timescale of this project, the review focussed on two regions; London, which is very diverse, and Yorkshire and Humberside, which has a mix of rural and urban authorities. As with the previous BRE review in 2011, it was considered imperative that the data available for the proxy indicators of DFG need should meet specific criteria; simplicity, transparency, be readily accessible, be fair, and provide sustainability over the medium-term (at least 5 years) but be responsive to changes in the population and their circumstances.
- **Interviews with staff from selected local authorities demonstrating aspects of good practice in grant delivery.** These provided more detail

about budgets, operating costs, sources of income and management structures.

- **Collaboration with other researchers conducting parallel lines of inquiry** provided further information, including: a pilot study of DFG-funded bathroom adaptations being conducted in Nottingham⁶; minor adaptations research being carried out by the Royal College of Occupational Therapists and the Housing LIN⁷; and a study of good practice in the delivery of adaptations to older people by the Centre for Ageing Better and Care & Repair England⁸.
- **Meetings with representatives of the national organisations** providing support to local government and the housing association sector were held to discuss how DFG delivery and oversight might change and to determine how it might be better joined up with other health and social care services. One meeting was done in conjunction with the researchers involved in the study of minor adaptations.
- **Meetings with the private market sector**, combined with online searches and a short literature review, looked at how the DFG could evolve to embrace new products and materials and how more people could be helped outside of the DFG.
- **Telephone and email contact with academic and policy staff** in other parts of the UK enabled the team to gain insights into alternative methods of DFG delivery and effective integration of the DFG with health and social care services.
- **A short review of the academic, policy and practice literature** provided additional material to determine what disabled and older people want to see in terms of adaptations and DFG reform.

2.3 The first part of the report, Part A, looks at the evidence relating to the current situation and the need for change, with a summary of the main findings at the end of each chapter. In the second section, Part B, these findings are used to assess the options for to improve services, with a list of recommendations at the end of each chapter. The main findings and recommendations are brought together at the end of the report.

⁶ Whitehead, P., James, M., Belshaw, S., Dawson, T., Day, M. and Walker, M. (2016) Bathing adaptations in the homes of older adults (BATH-OUT): Protocol for a Feasibility Randomised Controlled Trial (RCT) BMJ Open. <http://dx.doi.org/10.1136/bmjopen-2016-013448>.

⁷ Royal College of Occupational Therapists (In Press) Adaptations without delay: a guide to thinking about and delivering adaptations differently. London: Royal College of Occupational Therapists.

⁸ Adams, S. and Hodges, M. (2018) Adapting for ageing: Good practice and innovation in home adaptations, London: Centre for Ageing Better. https://www.ageing-better.org.uk/sites/default/files/2018-10/Adapting-for-ageing-report_CfAB_0.pdf.

Part A

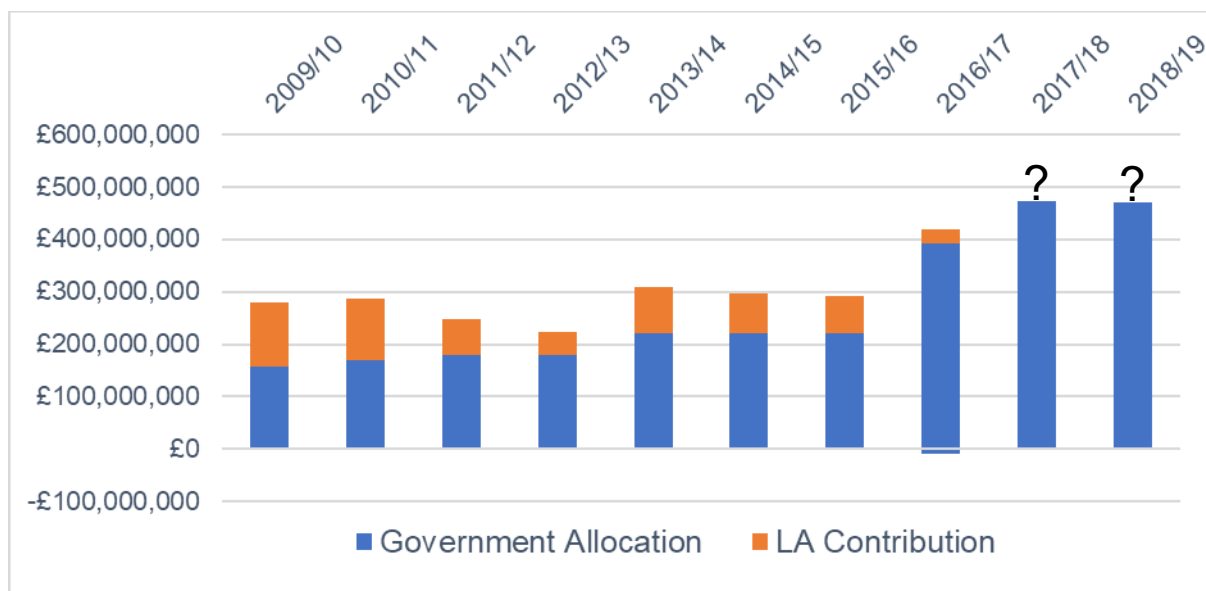
How the DFG is used currently

Chapter 3. DFG funding

Funding sources and trends

- 3.1 Information on DFG budgets and spending nationally comes from two main sources: the annual returns made by local authorities to central government (LOGASnet); and Freedom of Information requests (FOIs) by Foundations. LOGASnet returns have become less complete over the last few years (only returned by 66% of authorities in 2016/17), but they are still one of the best sources of information at national level⁹. The returns for 2016/17 included some additional questions on the use of discretionary grants and the time taken to process cases.
- 3.2 DFG funding has fluctuated over the last decade (Figure 3.1). Until 2008, local authorities had to provide a 40% contribution to DFG budgets to match the 60% coming from central government. The total amount was ring-fenced and had to be spent on mandatory work as laid down in the 1996 Act. In 2008 the ring fence was removed to give local authorities more flexibility to use the grant for discretionary purposes. It was thought this might reduce local authority capital contributions, but despite the greater freedom, matched contributions continued for several years (Figure 3.1).

Figure 3.1 Annual DFG budget for England



Source: Annual Government allocations from official figures, LA contribution based on average percentage contribution from LOGASNET (2009/10 – 2014/15) and Foundations FOI request (2015/16 – 2016/17).

2016/17 shows negative contribution due to top-slicing of allocation for other purposes.

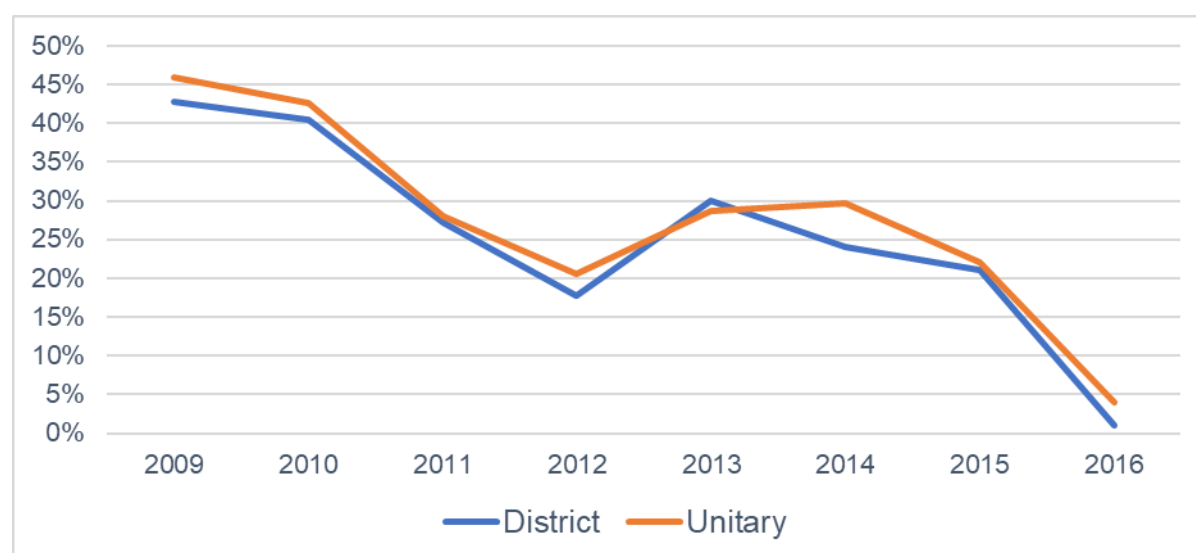
Data on LA contribution not yet available for 2017/18 onwards.

⁹ For further details about LOGASnet see Mackintosh, S. and Leather, P. (2016) *ibid*.

3.3 Austerity measures were introduced in the 2010 Autumn Statement. Central government funding for Repairs Grants ceased entirely at this point which removed £300m of annual funding from private sector housing. This was often used to supplement the adaptations budget, and when it disappeared local authority contributions were cut in many areas, although the impact was not fully felt until 2012/13. Local authority funding picked up in 2013/14 but declined to a very low level in 2016/17 at the point when central government funding increased significantly. The overall budget is now considerably higher than it was in 2009/10.

3.4 Figure 3.2 shows that local authority contributions have declined in both unitary and two-tier authorities. They have also fallen at a similar rate in areas with retained council stock, compared to those where the stock has been transferred.

Figure 3.2 Average local authority contributions 2009-2016.



Source: LOGASnet and Foundations FOI requests

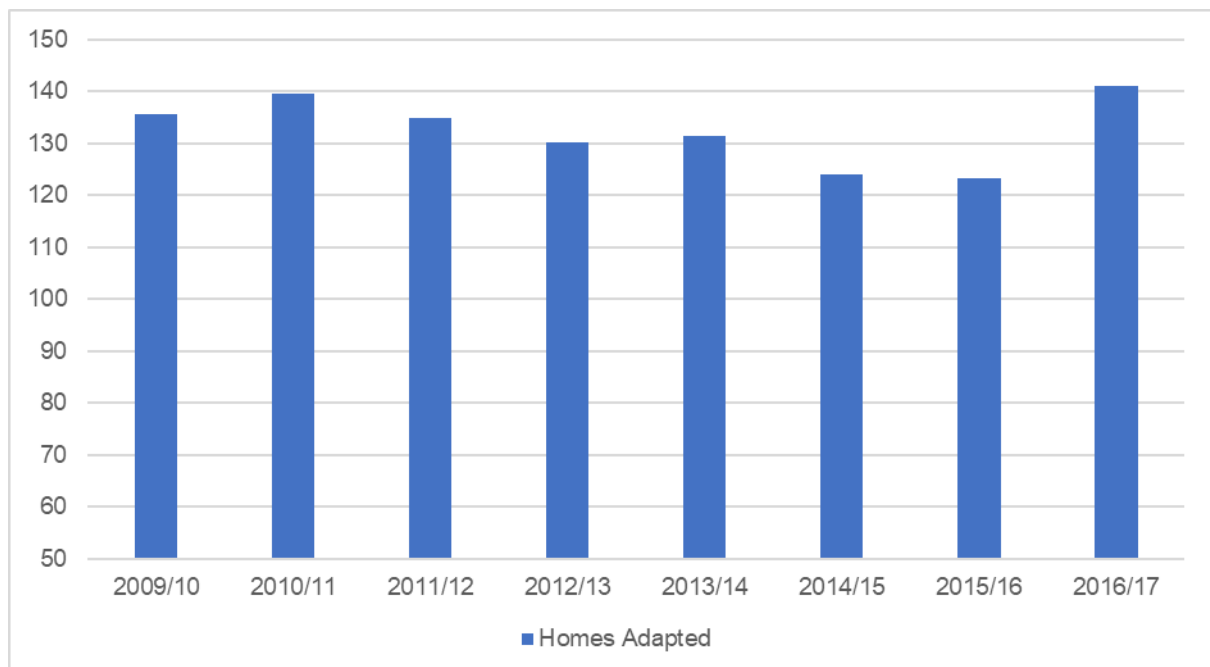
3.5 In the 2015 Spending Review, it was announced that central government contributions to the DFG would increase until the end of the decade to help meet the objectives of the 2014 Care Act and the Better Care Fund.

“The Care Act reforms introduced in April focus on wellbeing, prevention and delaying the need for social care. In support of these principles, the Spending Review includes over £500 million by 2019-20 for the Disabled Facilities Grant, which will fund around 85,000 home adaptations that year. This is expected to prevent 8,500 people from needing to go into a care home in 2019-20”¹⁰.

¹⁰ HM Treasury (Nov 2015) Spending Review and Autumn Statement 2015, Adult Social Care, Section 1.109, p. 33. <https://www.gov.uk/government/publications/spending-review-and-autumn-statement-2015-documents>.

3.6 It was clearly hoped that local authorities would continue to add resources and that the number of grants delivered would more than double from the 41,000 completed in 2014/15. With the decline in local authority contributions, overall DFG funding levels only rose 44% from 2015/16 to 2016/17, and a further 13% to 2017/18 (Figure 3.1). Grant completions have taken longer to respond. The average number of grants per authority declined after 2010/11. Completions only increased after 2015/16 when they rose from an average of 123 to 141 per authority in 2016/17; a rise of only 15%. This takes the levels of completions back to the amount achieved in 2010/11, before austerity measures were introduced (Figure 3.3). In 2010/11, about 45,500 grants were completed nationally, and we estimate it was only 46,000 in 2016/17.

Figure 3.3 Average number of DFGs completed per authority 2009/10-2016/17



Source: LOGASnet – includes both mandatory and discretionary grants for 2016/17

Reasons behind the trends

3.7 The reasons why numbers of DFG completions are not increasing as fast as expected are complex and may include the following:

- a) **Time lag** – in the first year that funding increases, the number of grant approvals may rise. However, due to the time it takes to schedule building work the number of grant completions may not show in the figures until the following year. The figures for 2017/18 are not yet available to show the true impact of the increase in central government funding.

- b) **Delays in obtaining DFG allocations** - DFG resources used to be passed directly from central government to the housing authorities based in unitary authorities and at borough or district level. Now the grant is part of the BCF, in shire authorities it goes to the county before being passed to the boroughs or districts.

In 2016/17, there was a small negative contribution when 22% of authorities saw their budgets top sliced for other purposes, mainly to meet social care obligations under another funding stream that was discontinued. Other authorities may have received their allocation quite late in the year. The guidance issued in a letter to all authorities and in the BCF planning requirements for 2017-19 states clearly that the statutory duty on local housing authorities to provide the DFG to those who qualify for it remains¹¹.

“DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations.”¹²

Although top slicing may have impacted grant completion levels in 2016/17 (the most recent LOGASnet data currently available), it appears to have affected few authorities in 2017/18.

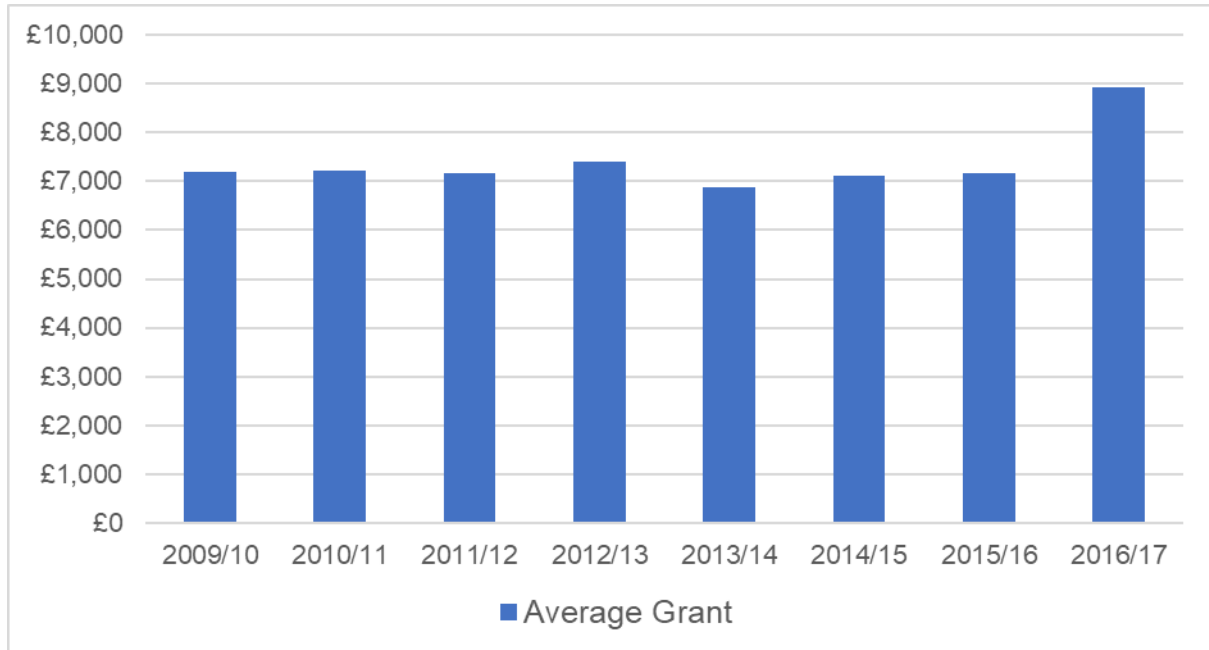
- c) **More discretionary grants** - discretionary grants include: fast-tracked grants for hospital discharge; grants for people with dementia; funding to improve heating; and a range of other measures to ensure that people can remain safely at home. Many are given without a means test to ensure that they can be delivered quickly. These grants are only just being introduced in most areas and may not be reflected in the figures until 2017/18. LOGASnet returns in 2016/17 included totals of discretionary grants for the first time (they are included in the data in Figure 3.1 above). However, three quarters of authorities did none, 17% did less than 10 and only 5% of local authorities did more than 50 in 2016/17 (Foundations FOI 2017). It is hoped that more of these flexible grants will be shown in the data for 2017/18.
- d) **Rising cost of work** – until central government contributions increased after 2015, local authorities were struggling with restricted DFG resources relative to demand. Therefore, there was a focus on value for money and on driving down costs. As a result, the average remained constant for many years, despite rising building costs (Figure 3.4).

¹¹ NHS England (2017) Integration and Better Care Fund planning requirements for 2017-19. <https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf>.

¹² NHS England (Aug 2017) The Better Care Fund Planning Requirements 2017-19: Frequently Asked Questions, p. 9. <https://www.england.nhs.uk/wp-content/uploads/2017/08/bcf-planning-requirements-faqs.pdf>.

In 2016/17 average costs rose from around £7,000 over the period 2009/10-2015/16 to nearly £9,000 in 2016/17, showing that the overall increase in resources has allowed prices to rise, perhaps to more realistic levels (Figure 3.4). Cost rises may also reflect the increased complexity of cases which is discussed later in the report. Minimal specifications may not provide the best solutions, and a relaxing of very tight cost controls may be beneficial, but it has the effect of reducing the overall number of grants delivered.

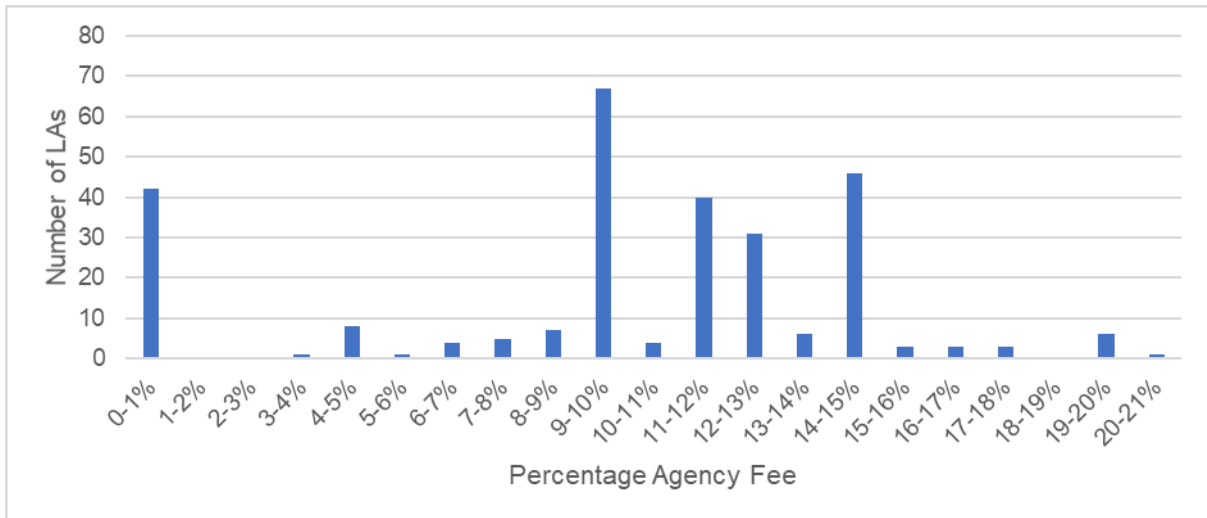
Figure 3.4 Trends in average grant value 2009/10 to 2016/17



Source: LOGASnet

- e) **Problems with revenue funding** – the increase in DFG capital allocations happened at a time when local authorities were continuing to cut staff to reduce costs. This may have impacted on their ability to deliver more adaptations in 2016/17. To maintain staffing levels, some authorities began to look at other ways of finding revenue funding. As a result, more started to charge fees of 10-15% on top of each DFG grant to cover running costs (these fees are not charged on to DFG recipients). A few other authorities top-sliced the budget to cover service costs. This may have further reduced grant completion numbers (Figure 3.5).

Figure 3.5 The range of agency fees charged as part of the DFG in 2016/17



Source: Foundations FOI 2017

The need to increase the number of grants

3.8 Given the pressures on health and social care and the rising numbers of people living with impairments or long-term conditions, it is essential to enable more people to remain independent in their homes. There is an urgent need to work towards the target of 85,000 grants per year, which was set when central government funding increased in 2015. How revenue funding could be increased and DFG funding used to help more people is discussed further in Section B.

Summary - funding issues

- There are several reasons why numbers of grants have not increased as much as expected by 2016/17. These include: reduction in local authority contributions; delays in funding being passed to authorities; lack of detail about use of discretionary grants; a rise in the complexity of work; and the relaxation of strict cost controls resulting in an increase in the average cost of work.
- Austerity has affected the ability of local authorities to add their own investment, both in terms of grant spending and revenue costs. Using the grant to provide fees to cover staff and overhead costs has further reduced outputs.
- It will not be until the LOGASnet figures for 2017/18 are available that the full benefits of increased central government spending will become apparent.

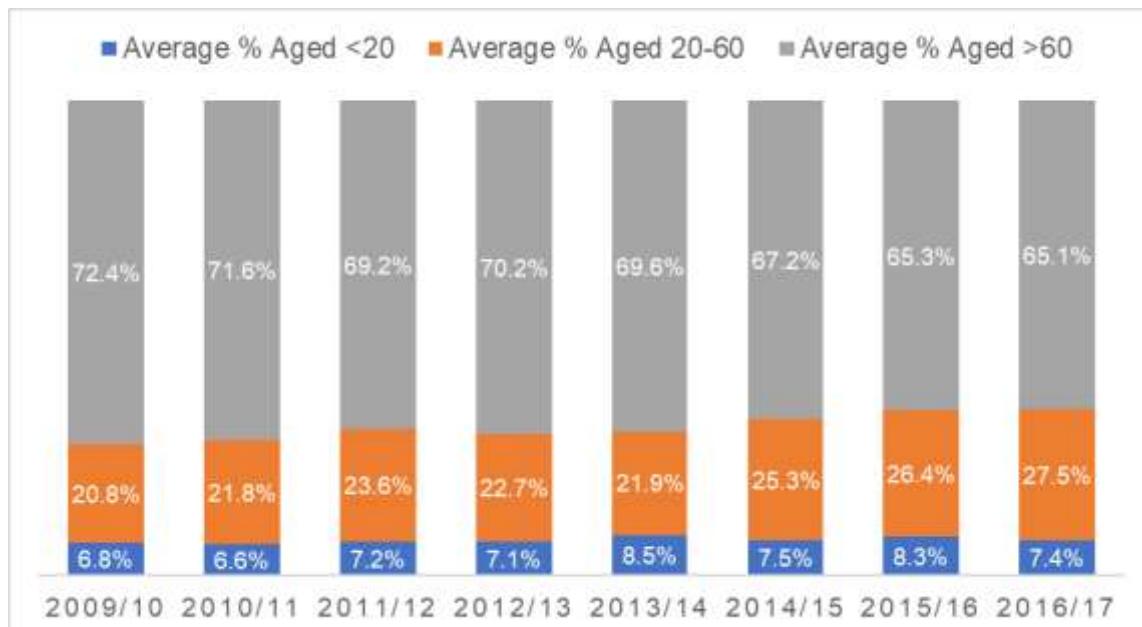
Chapter 4. Who receives the grant

- 4.1 The DFG is designed to help people of all ages and with a range of impairments. A person is deemed disabled if: their sight, hearing or speech is substantially impaired; they have a mental disorder or impairment of any kind or they are physically substantially disabled by illness, injury, or an impairment present since birth.
- 4.2 The grant provides adaptations to allow access to the home and garden, permit use of all the normal facilities and, where appropriate to enable a disabled person to provide care for others. It also allows for a care plan to be implemented to enable the disabled occupant to remain living in their existing home as independently as possible¹³.

Age of DFG recipients

- 4.3 In 2016/17 most grants (65%) went to people aged 60 and over. The proportion has gradually decreased since 2009/10, with slightly more grants going to people of working age and to children and young people under 20 (Figure 4.1). However, the number of grants going to people under 20 is still relatively small and fluctuates slightly from year to year.

Figure 4.1 Trends in age of people receiving the DFG

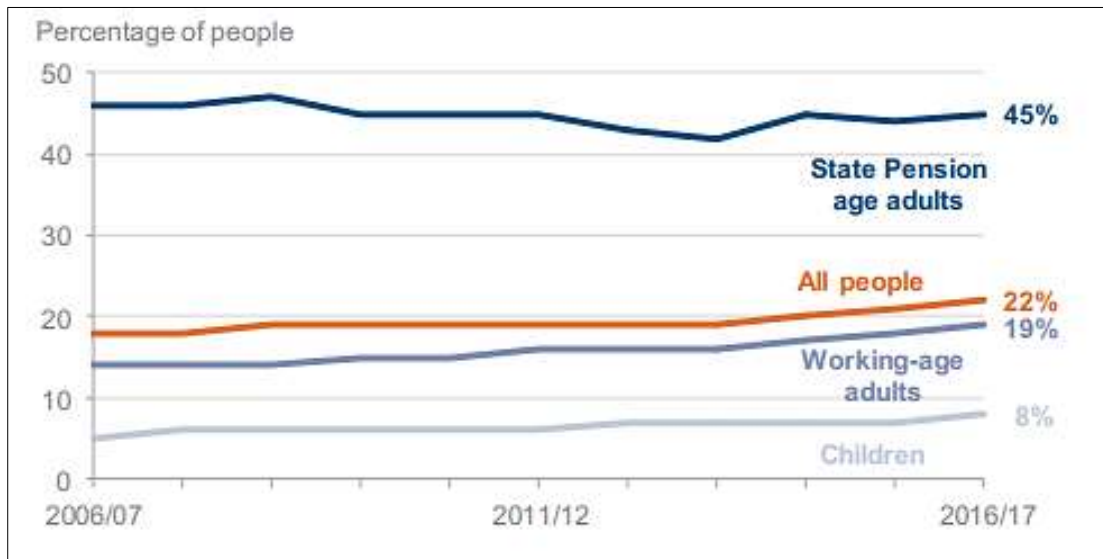


Source: LOGASnet

¹³ Wilson, W. and Fears, C. (Dec 2016) Disabled Facilities Grants for home adaptation, Briefing Paper No. 03011, London: House of Commons Library. <http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN03011>.

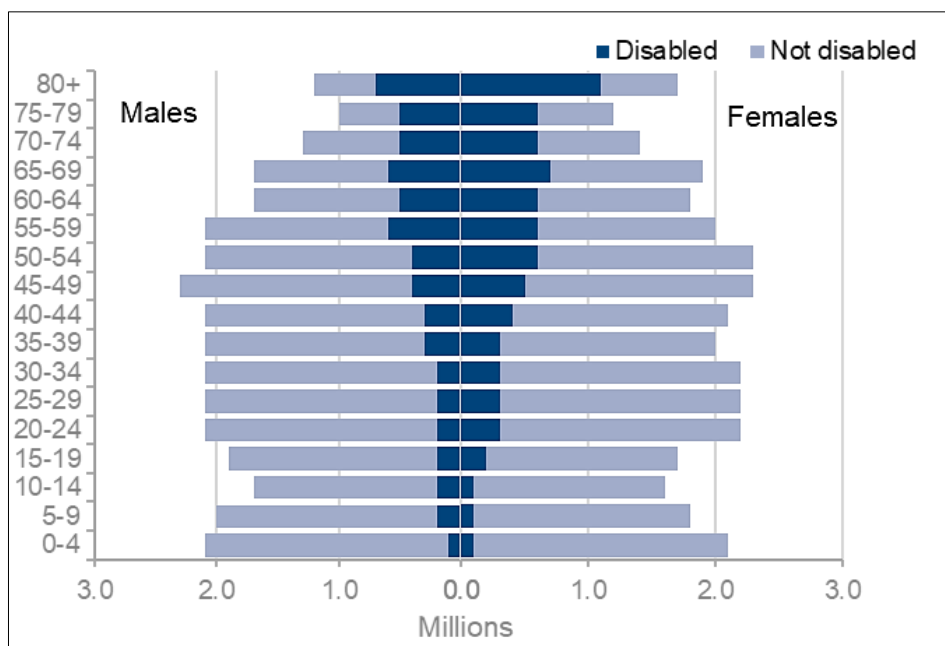
4.4 These proportions reflect broader trends in levels of disability in the UK, with a rise in the number of children and working age adults with impairments. Medical advances are enabling disabled children to live longer lives and helping more people survive illness and accidents (Figure 4.2). There is a predominance of disabled boys in childhood, while women are slightly more likely to be disabled than men as people age. There is high proportion of disabled women in the later stages of life due to their longer life expectancy (Figure 4.3).

Figure 4.2 Disability prevalence by age group 2006/07 to 2016/17



Source: Department of Work and Pensions (Mar 2018) Family Resources Survey 2016/17, Table 4.1. Note: figures are for the UK.

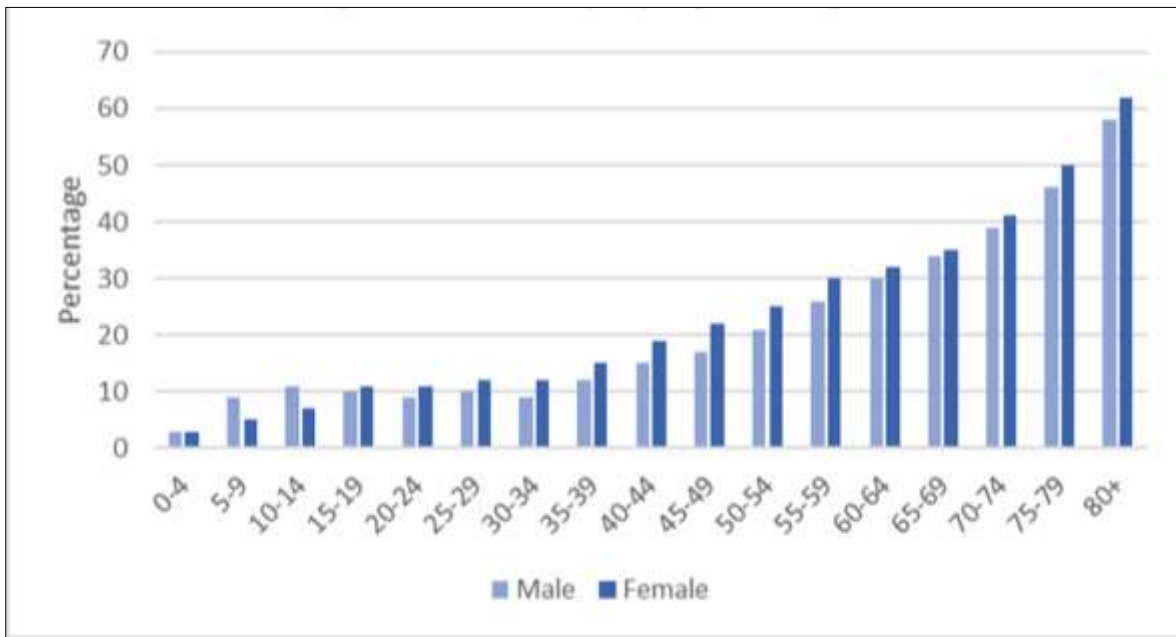
Figure 4.3 Prevalence of disability by age and gender UK



Source: Family Resources Survey 2016/17 Table 4.3 - average of 2014/15-2016/17

4.5 Higher numbers of older people are likely to get DFG funding in any year due to the substantial rise in the proportion of people with impairments as people reach their 70s and 80s (Figure 4.4). The preventative role of adaptations in helping people before they reach crisis point needs to be addressed. Services also need to reflect the fact that many of those needing help will be on their own. The English Housing Survey shows that in 2014/15 47% of those aged 75-84 and 61% of those aged 85 and over were living alone¹⁴. Many of those will be single women.

Figure 4.4 Disabled people by age UK



Source: Family Resources Survey 2016/17 Table 4.3

Tenure of DFG recipients

4.6 It is useful to look at who gets the grant by tenure, and the likely future trends, to see how this might affect grant allocations and the delivery process. Applicants for DFG funding can be owners, those renting privately and tenants of registered providers, but not council tenants. Landlords are allowed to apply directly on behalf of their tenants.

Home owners

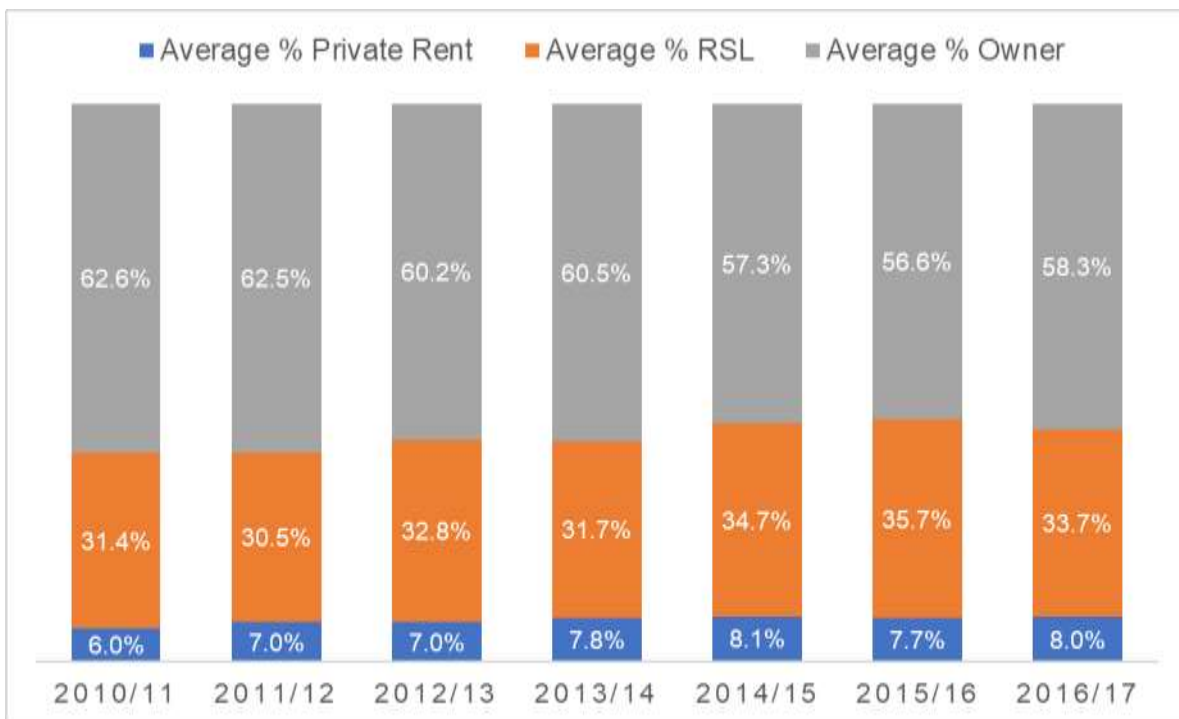
4.7 Home owners on low incomes have always been the biggest recipients of DFG funding as the grant mostly goes to older people, and 76% are home owners. In 2016/17, 58% of grants went to home owners but there has been a slight decrease in the proportion going to this tenure since 2010/11 (Figure 4.5). It is

¹⁴ Ministry of Housing, Communities and Local Government (2016b) English housing survey 2014 to 2015: Housing for older people report, *ibid*.

an optimistic sign that in the English Housing Survey over half (55%) of households over 75 that required adaptations in their home said that they already had them installed (although there was no independent check on the quality or appropriateness of these adaptations)¹⁵. There has been a lot of investment in the owner-occupied stock over the last 30 years, with showers and wet rooms seen as desirable features which may start to reduce the need for the replacement of baths.

4.8 However, the English House Condition Survey shows that people over 65 are still by far the biggest group requiring adaptations. Home ownership is also common in the cohort approaching retirement and as the population continues to age, grants for older home owners will continue to dominate DFG allocations.

Figure 4.5 Trends in tenure of DFG recipients



Source: LOGASnet

Registered providers

4.9 A third of grants go to tenants of registered providers. Many disabled people are in this sector as they tend to have lower incomes and cannot afford home ownership. However, registered providers only hold between 5 and 15% of the housing stock in any local authority area. From previous research, areas where

¹⁵ Ministry of Housing, Communities and Local Government (2016a) English housing survey 2014 to 2015: Adaptations and accessibility of homes report, London: MHCLG. <https://www.gov.uk/government/statistics/english-housing-survey-2014-to-2015-adaptations-and-accessibility-of-homes-report>.

stock has been transferred have a higher proportion of grants going to registered providers than those with retained council stock¹⁶.

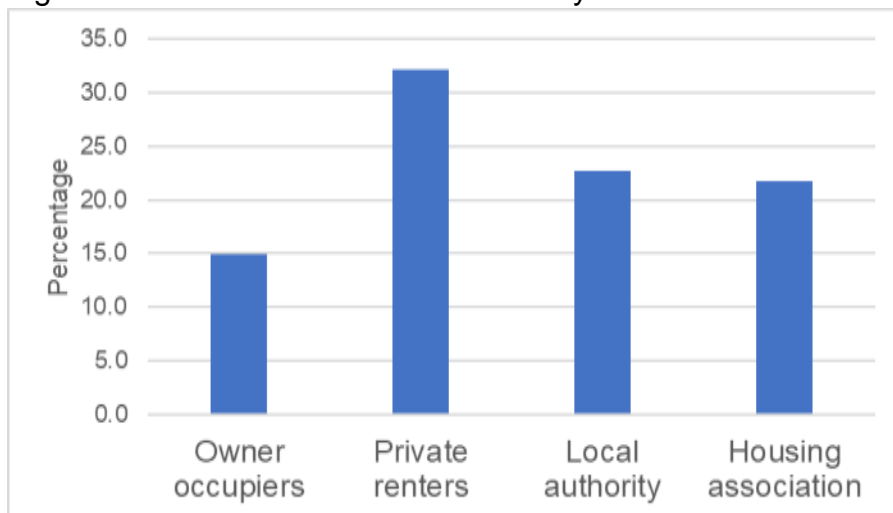
4.10 Registered providers' use of the DFG seems disproportionate as their housing is newer on average, with a higher proportion of accessible homes. It is probably because registered provider tenants have a clear route. They are signposted directly to the DFG with some landlords applying on their behalf. In contrast, home owners and private tenants have very few ways of finding out about the grant, as it is seldom advertised and not easy to find on local authority websites.

Private rented sector tenants

4.11 Private renting is becoming increasingly common and the share of grants going to this sector is inevitably going to continue to rise, particularly for younger age groups. However, one in four privately rented dwellings do not meet the Decent Homes standard and they are more likely than other tenures to have Category 1 hazards such as excess cold or risk of falls¹⁷. One in three disabled private rented sector tenants feels that their home does not meet their needs, which is higher than any other tenure (Figure 4.6)¹⁸.

4.12 There are now almost as many disabled households in the private rented sector as renting from registered providers (Figure 4.7). Although they are worse housed, they get a fraction of DFGs (8%) compared to registered providers (34%).

Figure 4.6 Unsuitable accommodation by tenure 2014-15



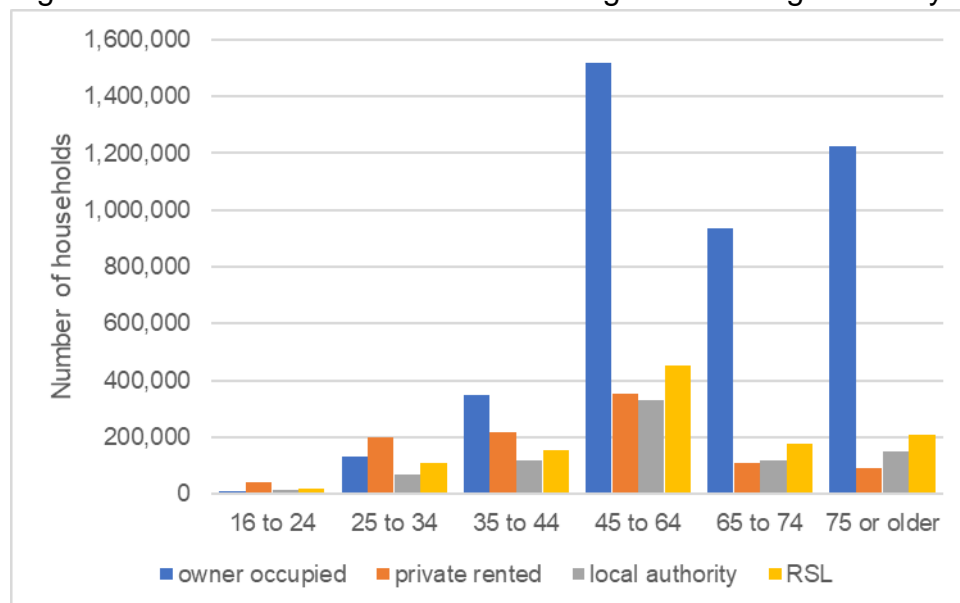
Source: MHCLG (2016) English Housing Survey, Table 1.3

¹⁶ Mackintosh S. and Leather P. (2016) *ibid*.

¹⁷ Department of Communities and Local Government (Mar 2018) English Housing survey: Headline Report 2015/16, London: DCLG. <https://www.gov.uk/government/statistics/english-housing-survey-2015-to-2016-headline-report>.

¹⁸ Department of Communities and Local Government (2016a) English Housing survey: 2014 to 15, Adaptations and accessibility of homes report, *ibid*.

Figure 4.7 Number of households with long-term limiting illness by age and tenure



Source: English Housing Survey 2014-15, full household sample

4.13 Most households with long-term limiting illness are of working age. Increasingly they are in private rented homes as it becomes harder to get into social housing or on to the home ownership ladder. The focus of government policy is on getting as many disabled people as possible into work, but this is difficult if the home is not accessible, lacks level access to the street outside, or does not facilitate home working.

4.14 There are now more children in the private rented sector than in social housing¹⁹. Households with dependent children rose from 30% of all privately renting households in 2005-06 to 36% in 2015-16 and half a million (510,000) children live in privately rented homes that are unsafe. Research has shown that disabled children tend to be the worst housed of any age group²⁰. They also tend to spend a lot of time at home and are often very isolated, meaning the accessibility and quality of the home assumes even greater importance²¹.

4.15 Despite the rise of families in the tenure, the private rental sector remains an insecure place to live²². A third (34%) of private renters have lived in their current home for less than a year, and two thirds for less than three years (67%).

4.16 Until recently, the number of older people in the private rented sector was low. In 2014-15, households over 65 made up just 8.5 per cent (360,000) of all those

¹⁹ Parker, I. and Isaksen, M. (2017) A state of disrepair: Why renters deserve a better deal. <https://www.citizensadvice.org.uk/Global/CitizensAdvice/Housing%20Publications/PRS-AStateofDisrepair.pdf>.

²⁰ Beresford, B. and Rhodes, D. (2008) Housing and disabled children, York: Joseph Rowntree Foundation.

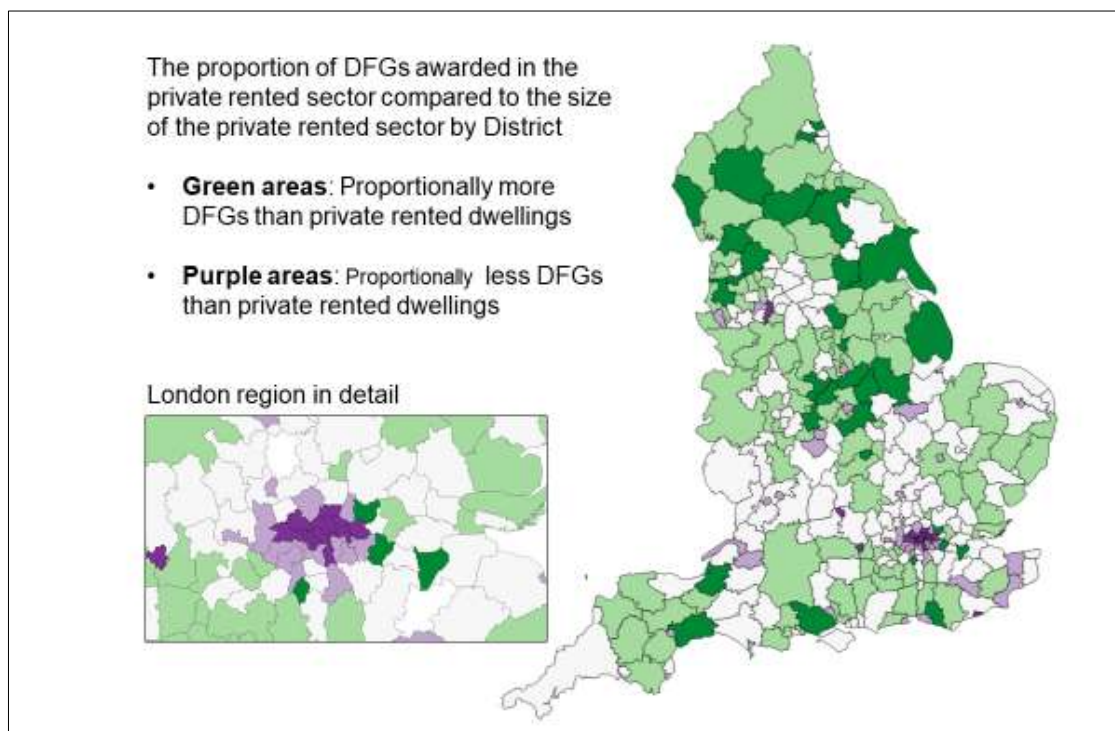
²¹ Contact a Family (2011) Forgotten Families: The impact of isolation on families with disabled children across the UK, London: Contact a Family.

²² Parker and Isaksen (2017) *ibid*.

renting privately²³. However, there is a diversity of supply and tenancy arrangements, with some older tenants living in very poor conditions²⁴. Numbers of older people in this sector will begin to increase in the 2020s as higher proportions are in the cohorts approaching retirement age (Figure 4.7 above). A survey in 2016 for Citizens Advice revealed that 40% of people aged 55-64 and 34% of those over 65 renting privately have a tenancy that lasts six months or less²⁵. As numbers in this tenure increase, for a significant proportion, it may become difficult to age in place successfully.

4.17 There are problems delivering the DFG in this tenure. Grants are difficult to approve if the home is in poor condition, but in many areas of the country alternative accommodation is not easy to find at a price people can afford. Short-term tenancies also have a major effect on DFG approvals as residents are supposed to show they plan to remain for at least five years. In addition, landlords may not always give permission for the necessary changes to the property. Parts of the country with high proportions of private renting, such as central London, appear to be getting fewer grants than might be expected, probably because of these reasons (Figure 4.8).

Figure 4.8 Distribution of DFGs in the private rented sector



Source: LOGASnet

²³ Ministry of Housing, Communities and Local Government (2016c) English Housing Survey 2014 to 2015: Private Rented Sector report, London: MHCLG. <https://www.gov.uk/government/statistics/english-housing-survey-2014-to-2015-private-rented-sector-report>.

²⁴ Rugg, J. and Croucher, K. (2010) Older People's Experiences of Renting Privately, London: Age Concern and Help the Aged.

²⁵ Parker and Isaksen (2017) *ibid*.

Council stock

- 4.18 The main DFG budget cannot be used to fund adaptations to local authority properties²⁶. Council landlords are expected to use their own resources from the local authority Housing Revenue Account (HRA). Additional funding was included for disabled adaptations in self-financing determinations from 2012²⁷. Compared to registered providers, council tenants tend to be older, and the stock was built at an earlier date.
- 4.19 How funding levels and delivery processes differ using the HRA relative to the DFG is outside the remit of this review. However, if more stock is transferred and becomes eligible for the DFG, account will need to be taken of this in the national allocation of resources. A FOI in 2017 to 176 authorities with more than 100 units of retained stock was returned by 76% of authorities (80% of those with significant amounts of stock). This showed that the majority were using the HRA (91%). Those that were not using the HRA were all Arms-Length Management Organisations (ALMOs). It is hoped that they have their own budgets for adaptations, but some may be using the DFG.
- 4.20 Whichever funding source is used to access assistance with home adaptations (DFG or HRA), it should be tenure neutral with all applicants given equal access to funding. In some areas, local adaptation teams handle council stock modifications alongside DFG work, making it easier to apply to apply the same standards.

Rural housing

- 4.21 The rural population is ageing faster than in urban areas. In the next 20 years it is estimated that half of rural households will be aged over 65. There are already more 75- year olds in rural than in urban areas²⁸. There are higher levels of home ownership with around 80% of older people owner occupiers. However, homes in rural areas are less likely to be adapted²⁹. People are less likely to move as they want to stay in their communities where rehousing options may be more limited. Delivering adaptation services to more scattered and isolated populations is costlier and will need to be adequately resourced.

²⁶ Department for Communities and Local Government (2008) Disabled Facilities Grant – The Package of Changes to Modernise the Programme, London: DCLG.

²⁷ Wilson, W. and Fears, C. (Dec 2016) *ibid* p. 27.

²⁸ Porteus, J. (Apr 2018) Rural Housing for an Ageing Population: Preserving Independence, The Rural HAPPI Inquiry, HAPPI 4.
<https://www.housinglin.org.uk/Topics/type/Rural-Housing-for-an-Ageing-Population-Preserving-Independence-HAPPI-4/>.

²⁹ Connors, C., Kenrick, M. and Bloch, A. (2013) Rural Ageing Research: Summary Report of Findings, London: DEFRA.

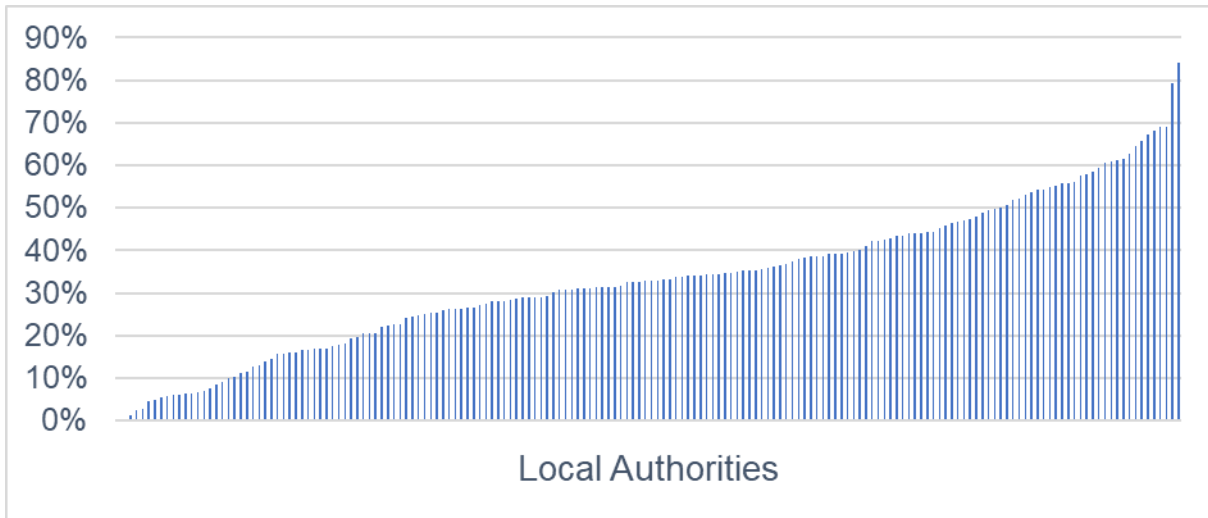
Who is excluded from the DFG?

4.22 It is important to look at who drops out of the grant process and why this happens. If specific groups are being excluded, it may reflect issues to do with assessment process, difficulties in dealing with landlords as discussed above, or the way the means test operates. Any issues identified will need to be addressed in the review. Unfortunately, it is hard to get exact figures as there are several stages when people may drop out:

- a) **Before reaching the local authority or home improvement agency** – There may be people looking for help who never locate it. In most areas the DFG is not advertised and it is hard to find information on most local authority websites. Telephone systems are confusing with numerous push button options.
- b) **At the social care help desk** – It is impossible to know who might have been eligible for a DFG who drops out at this stage. Local authorities with significant pressures on social care budgets may exclude people, sometimes inadvertently, as eligibility for social care differs from that for the DFG.
- c) **At the assessment stage** (usually in social care) – some people may be given equipment or minor adaptations, others may have a preliminary means test and realise they would not be eligible for a DFG. Others may decide they do not wish to proceed further with local authority help. There is no source of data for who might have been eligible for a DFG who drops out at this stage.
- d) **At the referral stage** – when the assessment has been completed and the case referred, but it does not proceed to grant application. This is the first point in the process when those who might be eligible for a DFG are recorded reasonably consistently. The reasons for exclusion at this stage were explored using a Freedom of Information request (FOI) with the following question: *For Disabled Facilities Grant referrals received from social care between 1 April 2016 and 31 March 2017, how many did not proceed to full application?* The FOI also asked for a breakdown by age, tenure and a pre-coded list of reasons.

4.23 The results of the FOI show that, on average, two thirds of grants proceed and a third are closed at the referral stage, but there is a lot of variation (Figure 4.9). In a few places, only a very small proportion proceed, while in others almost all go to full application. This may be because some places do a preliminary means test earlier in the process to screen out people who would be ineligible. Why other authorities have such high closure rates is less clear.

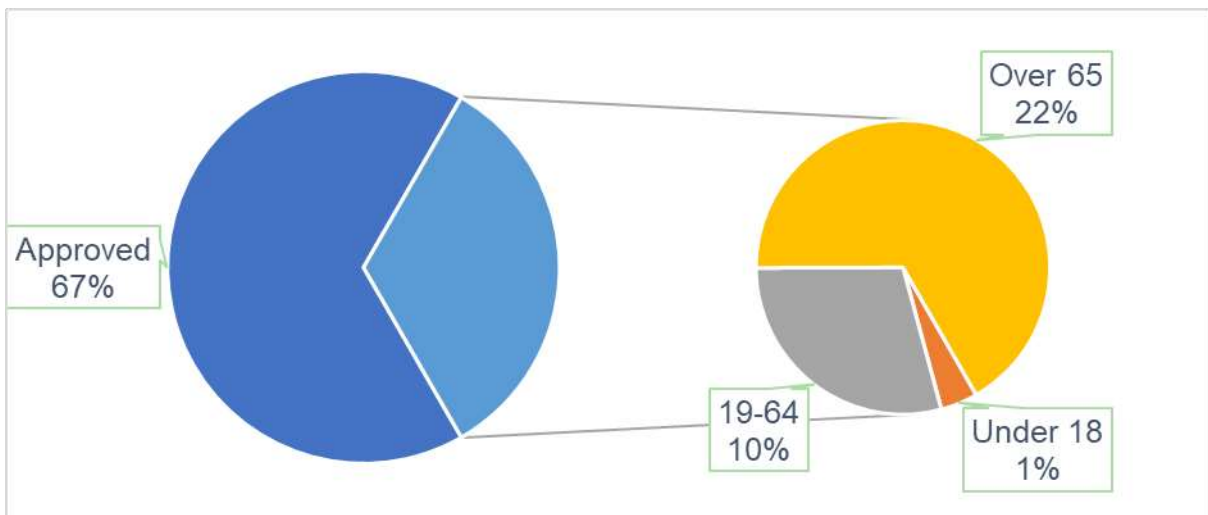
Figure 4.9 Referrals that do not proceed to full application by local authority



Source: Foundations FOI 2018

4.24 Looking at overall averages, of the third that do not proceed, the drop out by age is similar to the proportion proceeding with their application (Figure 4.10). Slightly fewer children’s cases drop out, perhaps because they are not means tested. However, there are some substantial differences at regional level (Table 4.1). In the West Midlands more children’s cases fail to proceed compared to other areas, whereas in London more people of working age drop out.

Figure 4.10 Closed referrals by age 2016/17



Source: Foundations FOI 2017

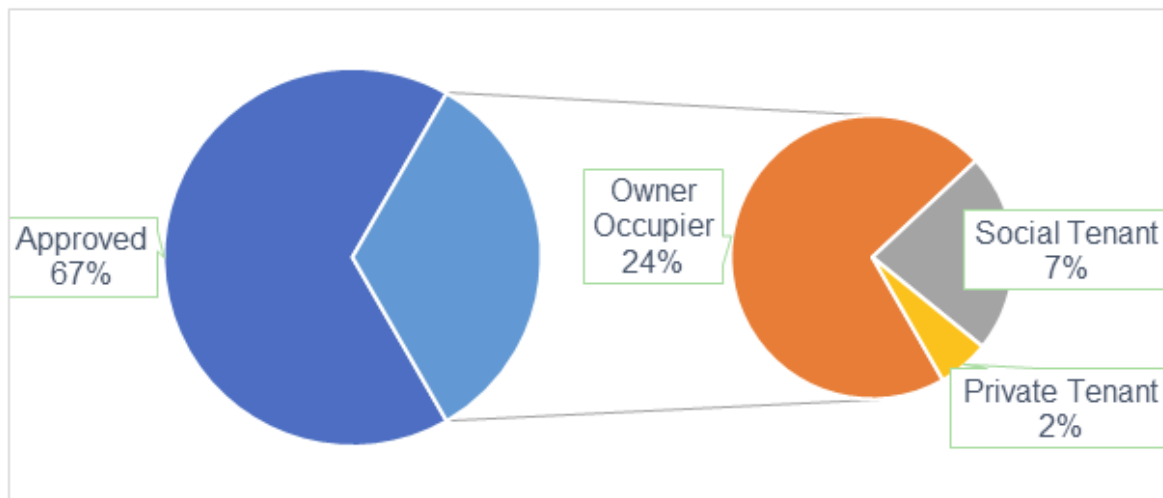
Table 4.1 Regional differences in percentage of referrals closed by age 2016/17

Region	Under 19	19-64	Over 65
East Midlands	3%	30%	67%
East of England	3%	24%	73%
London	2%	40%	58%
North East	3%	30%	66%
North West	3%	28%	69%
South East	5%	27%	68%
South West	4%	31%	65%
West Midlands	11%	31%	58%
Yorkshire and The Humber	3%	26%	70%
ENGLAND	4%	29%	67%

Source: Foundations FOI 2017

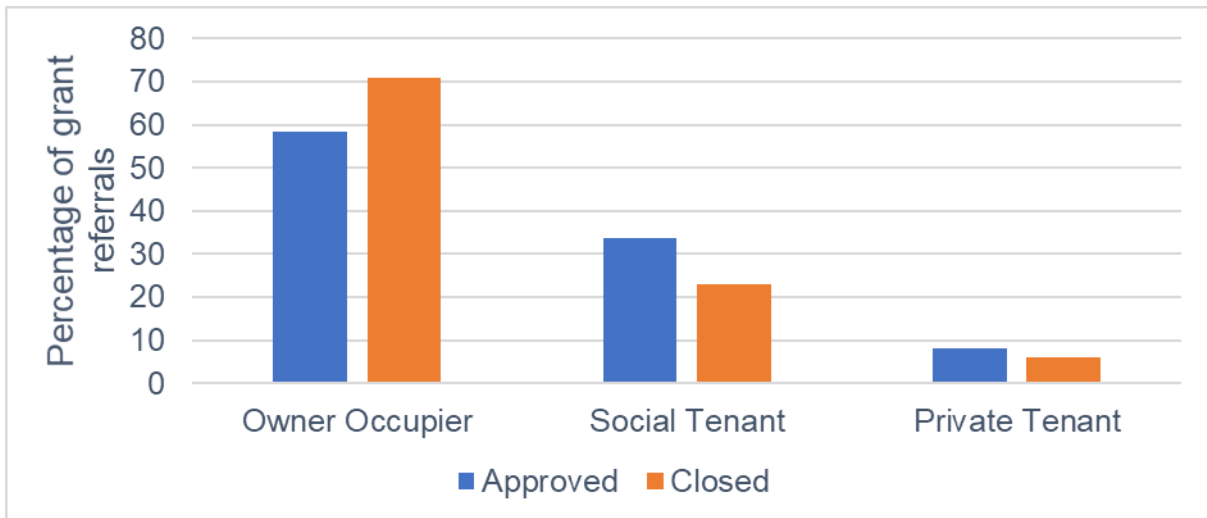
4.25 Overall, fewer owners seem to go ahead than tenants, particularly compared to those from the social rented sector, presumably because more owners are deemed able to contribute (Figure 4.11 and 4.12). But again, there are regional differences. In the South West and North East more tenants drop out, while more owners go ahead. Conversely, in the East of England and East Midlands more owners are excluded (Table 4.2).

Figure 4.11 Closed referrals by tenure 2016/17



Source: Foundations FOI 2017

Figure 4.12 Approved and closed referrals by tenure 2016/17



Source: Foundations FOI 2018

Table 4.2 Regional differences in percentage referrals closed by tenure 2016/17

Region	Owner Occupier	Social Tenant	Private Tenant
East Midlands	79%	15%	6%
East of England	77%	19%	4%
London	66%	30%	4%
North East	61%	33%	5%
North West	72%	22%	7%
South East	71%	23%	6%
South West	63%	28%	9%
West Midlands	76%	20%	4%
Yorkshire and The Humber	73%	21%	5%
ENGLAND	71%	23%	6%

Source: Foundations FOI 2017

Reasons for exclusion

- 4.26 Reasons for exclusion are hard to identify, as so many fall into the categories 'other' or 'insufficient information'. Many local authorities do not know, or do not record, the reason why applicants do not proceed. This is of concern, as so many seem to drop out in some areas. However, key points stand out about excluded cases. There appear to be very few dropping out because the work costs over £30,000 or because the work wasn't reasonable or practicable given the state of the home. Only a limited number decide to move rather than adapt the home. Unfortunately, a small number die before they get the grant.
- 4.27 The biggest identifiable category, about a quarter of those who drop out, do so because they have to make a contribution to the costs. It explains why more owners drop out than tenants, as mortgage costs are not taken into account in the means test. There is some regional variation, with drop-out due to contributions appearing to be highest in the North East and Yorkshire/The Humber and lowest in the South West (Table 4.3).

Table 4.3 Regional differences in percentage closed by reason 2016/17

Region	Contribution	Over £30k	Not reasbl/ pract	No Info	Moved	Died	Other
East Midlands	26%	0%	2%	18%	6%	9%	40%
East of England	24%	0%	2%	15%	6%	8%	45%
London	21%	0%	2%	15%	9%	13%	40%
North East	30%	0%	2%	7%	12%	11%	39%
North West	21%	2%	2%	20%	7%	11%	36%
South East	28%	1%	3%	13%	8%	8%	39%
South West	19%	0%	4%	4%	6%	7%	59%
West Midlands	28%	1%	1%	10%	6%	10%	44%
Yorkshire and The Humber	30%	0%	1%	10%	7%	9%	44%
ENGLAND	24%	1%	2%	14%	7%	9%	42%

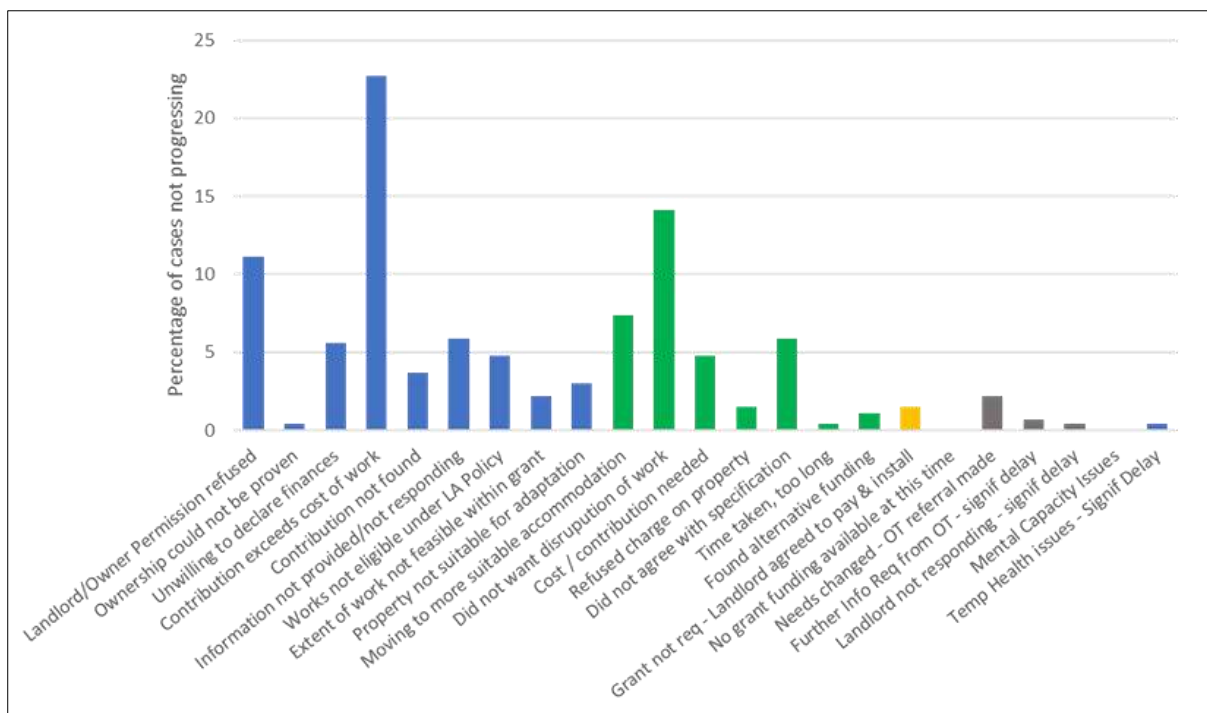
Source: Foundations FOI 2017

- 4.28 More detail about the reasons people drop out comes from other sources. Pooled outcome data from one county authority adds weight to the findings from the national FOI. The most important reason for people failing to proceed is because their assessed contribution was more than the cost of work (almost a quarter of

those dropping out) (Figure 4.4). The operation of the means test, and how this might exclude certain types of people, is explored further in Section B.

4.29 These local data also revealed that almost 15% dropped out because they did not want the disruption of work. Over 10% did not proceed because the landlord or owner refused permission, reflecting some of the concerns about the private rented sector outlined above. Data from the English Survey also shows that adaptations for private rented sector tenants needing adaptations are refused in 10% of cases³⁰.

Figure 4.4 Cases that did not proceed by reason in one county authority 2017/18



Source: outcome data provided to the review by a county authority in April 2018

4.30 Authorities do not normally follow up on closed cases to find out what happens to them afterwards. There is no way of knowing how many closed cases proceed with work themselves or how many take no action and remain living in homes that are un-adapted and potentially inaccessible or unsafe. How more people might be helped using statutory funding and how to provide help for people outside the DFG is discussed further in Section B.

4.31 Evidence about numbers who proceed or drop out according to ethnic origin is limited. Any information collected locally is not aggregated at national level.

³⁰ Ministry of Housing, Communities and Local Government (2016a) English housing survey 2014 to 2015 Adaptations and accessibility of homes report, *ibid*.

There is evidence of higher levels of limiting long-term illness in BAME groups than in the White British population³¹. One academic paper analysed English Housing Survey data to show that non-white households had fewer adaptations than were needed and they were twice as likely as white households to have no adaptations at all³². They may be less aware of what services are available. Cultural differences may mean that home adaptations need to be implemented in a much more personalised way to take account of ways of sleeping, washing, bathing and preparing food or maintaining space in the home for religious observance or for extended family to meet. There may be a lot of good practice in different local authorities, but further research is required to evaluate and disseminate this information.

Summary - who gets the DFG and who is excluded

- Overall there are more disabled people of working age than in any other age group, but the percentage of people with impairments rises significantly in later life. The proportion of people in younger age groups receiving the DFG has been rising, reflecting the increase in disabled people under retirement age.
- Older people remain the group most likely to obtain a DFG and this is likely to rise in the 2020s due to a bulge in the population of people with impairments getting to retirement age.
- The distribution of grants by tenure is dominated by owner occupiers as most older people are home owners.
- Registered providers continue to make significant use of the DFG. Registered provider tenants have an advantage as they are clearly signposted to the DFG while the grant remains hidden to most owners and private tenants.
- The council stock remains outside the DFG, which does not help with strategic planning of accessible homes for disabled and older people.
- Private tenants are in a weak position, but private tenants will need more grants as numbers in this tenure are increasing. They currently get far fewer grants than registered provider tenants. Disabled children in this sector are a particular concern.
- Rural areas may need more resources due to their rapidly ageing populations and the added cost of providing services to more scattered populations.

³¹ Bécaresyet, L. (2013) Dynamics of Diversity: Evidence from the 2011 Census, Manchester: Centre on Dynamics of Ethnicity

³² Ewart, I. and Harty, C. (2015) Provision of Disability Adaptations to the Home: Analysis of Household Survey Data, *Housing Studies*, 30:6, 901-923, DOI: 10.1080/02673037.2014.991379.

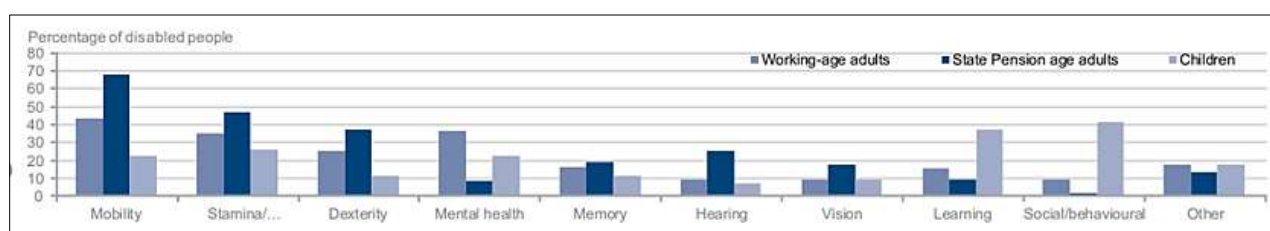
- There is little information on use of the DFG by people from BAME groups and whether they have different needs. This needs more research.
- The high number of people who drop out of the DFG process in some authorities is a cause of concern.
- The biggest reason why people drop out is due to the need to contribute to costs. This will be addressed later in this report in the review of the means test to ensure that the test is as fair as possible.
- What happens to people who drop out of the DFG process needs to be recorded more consistently, and people should be signposted to appropriate advice, information and support services.

Chapter 5. Types of adaptations and costs

Types of impairment

- 5.1 Prior to looking at the categories of work funded by the DFG, it is useful to look at the types of impairment in different age groups and at how this is changing.
- 5.2 The types of impairment people are likely to experience vary by age. Mobility, stamina and dexterity difficulties are the most common impairments in older and working age adults. Learning difficulties and social/behavioural impairments are more prevalent in children (Figure 5.1). Sensory impairment and memory problems tend to increase with age. Mental health conditions are increasing in people of working age, although long-term mental health issues, such as depression, are known to be under-recorded in older age groups³³.

Figure 5.1 Main types of disability by age



Source: Department of Work and Pensions (Mar 2018) Family Resources Survey 2016/17

- 5.3 Research shows that multiple conditions are also becoming more common, particularly among women and people with low income, but that they are also increasing in younger age groups. Those with multiple health problems are more likely to be disabled. This research also shows that chronic physical conditions are often found alongside mental health problems, particularly depression³⁴. Memory problems, particularly dementia, are also increasing. Most people affected by these conditions remain living in their own homes and may need specific types of adaptations.
- 5.4 Discussions with local authority staff and written submissions to the review support the fact that the medical conditions DFG staff are dealing with are becoming more complex. Due to austerity measures, social care services may only be referring people with urgent, critical or substantial needs. The increased

³³ Age UK (Oct 2016) Hidden in plain sight: The unmet mental health needs of older people, London: Age UK.

https://www.ageuk.org.uk/brandpartnerglobal/wiganboroughvpp/hidden_in_plain_sight_older_peoples_mental_health.pdf.

³⁴ The Academy of Medical Sciences (Apr 2018) Multimorbidity: a priority for global health research, London: The Academy of Medical Sciences. <https://acmedsci.ac.uk/file-download/99630838>.

complexity of cases may be a further reason why the average cost of work is increasing. Staff may need additional training to deal with complex cases and people with mental health issues. Cases may also take longer to process.

- 5.5 There is a strong relationship between low income, poor health, fewer impairment free-life-years, and lower life expectancy (Marmot, 2015)³⁵. There is also evidence that frailty (loss of muscle strength, falls and confusion) occurs almost 10 years earlier in people that are in the lowest third in terms of wealth (Micra, 2017)³⁶. In areas with high proportions of people on low incomes, people in their 60s may be experiencing health conditions that normally only appear in people when they reach their 70s or even later. This may need to be better reflected in the national allocation of resources. Frailty is an issue that health services are very concerned about. An optimal pathway has been developed to try to ensure that people with frailty are supported to remain living independently; adaptations could play a much bigger role in this process³⁷.
- 5.6 At local level, health and social care managers do not routinely work with DFG teams to develop preventative strategies to adapt and improve homes before people reach crisis point. Many home improvement agencies and DFG teams have tried to link up with hospital discharge teams, GP surgeries, community matrons, and care navigators to identify people needing help. There has been some success, which will be discussed in Part B, but the referral pathways could be improved.

Impairment of DFG recipients

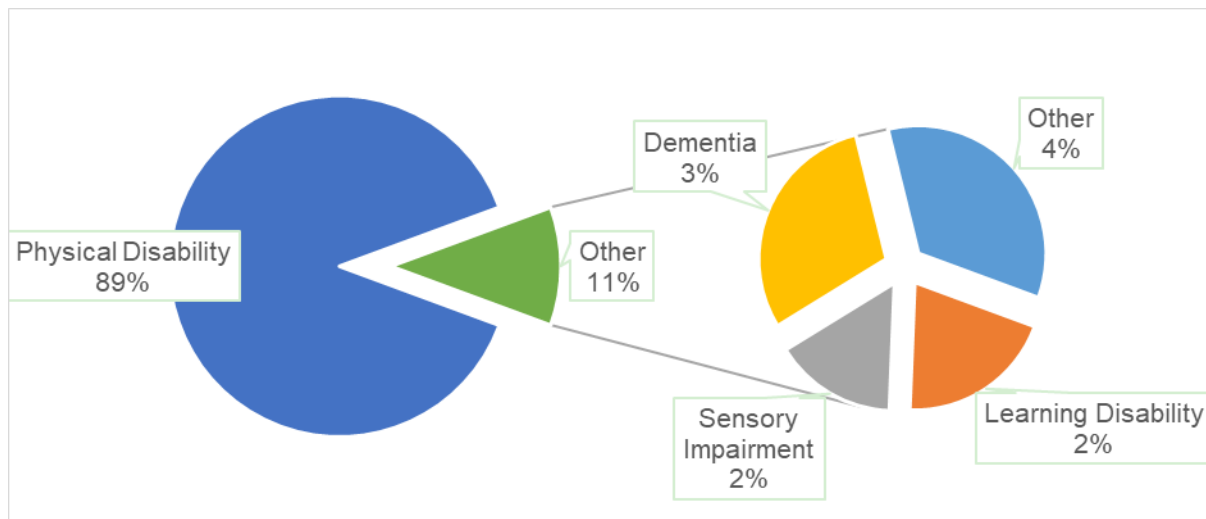
- 5.7 The only information about types of impairment of DFG recipients at national level comes from a FOI in 2017 (Figure 5.2). This gives a snapshot at one point in time and does not provide much detail. It shows that most grant recipients had physical disabilities as their primary impairment, and only 11% were recorded as having another principal impairment. Of that 'other' group, dementia, sensory impairment, and learning disability were the main issues identified. The number of grant recipients who had multiple conditions and mental health issues was not recorded.

³⁵ Marmot, M. (2015) *The Health Gap*, London: Bloomsbury.

³⁶ MICRA (2017) *The Golden Generation: Wellbeing and Inequalities in Later Life*, Manchester: University of Manchester Institute for Collaborative Research on Ageing.
<http://hummedia.manchester.ac.uk/institutes/micra/reports/golden-generation-report-2017.pdf>

³⁷ NHS England (2016) *The variation between standard and optimal pathways - Janet's story: Frailty, RightCare scenario*. <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/08/janet-story-narr.pdf>.

Figure 5.2 Primary impairment of DFG recipients



Source: FOI 2017

Type of work allowed

5.8 The types of adaptations that the mandatory DFG can cover includes:

- a) Making it easier to get into and out of the dwelling by, for example, widening doors and installing ramps;
- b) Ensuring the safety of the disabled person and other occupants by, for example, providing a specially adapted room in which it would be safe to leave a disabled person unattended, or improved lighting to ensure better visibility;
- c) Making access to the living room easier;
- d) Providing or improving access to the bedroom and kitchen toilet, washbasin and bath (and/or shower) facilities; for example, by installing a stairlift or providing a downstairs bathroom;
- e) Improving or providing a heating system in the home suitable to the needs of the disabled person;
- f) Adapting heating or lighting controls to make them easier to use;
- g) Improving access and movement around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares;
- h) Facilitating access to and from a garden for a disabled occupant or making access to a garden safe for a disabled occupant.

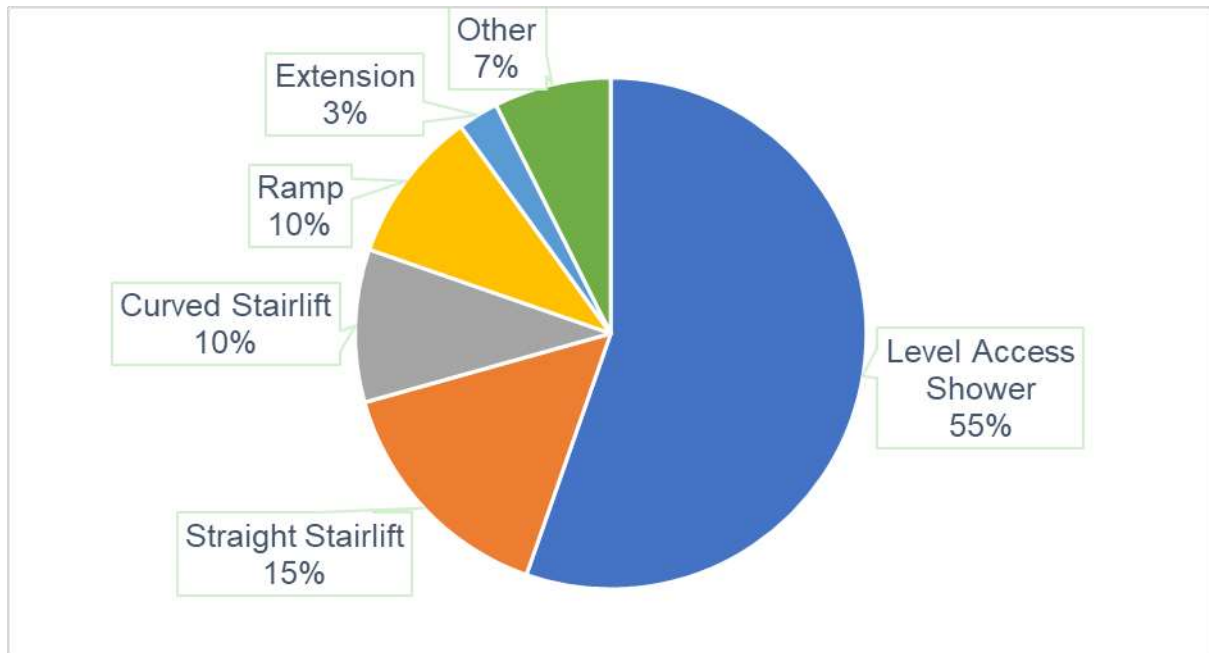
5.9 The items on the list focus on physical impairment and mobility, which reflects the view of disability in 1989, when the grant was first introduced. In the original legislation, there was little about dementia, mental health, learning difficulties or the needs of children with autism spectrum disorder or social/behavioural conditions. Regulation, orders and guidance have introduced more flexibility, particularly the 2002 RRO and the updates in 2008, but this may need to be made clearer. As the 2005 review pointed out:

“The needs of disabled children and their siblings or other family members, or of people with seriously challenging behaviour, are not covered with unequivocal clarity in the provisions of the mandatory DFG”³⁸.

Type of work carried out

5.10 Figure 5.3 shows that the most common DFG adaptation is a level-access shower (55%). Stairlifts (either straight or curved) make up a quarter of applications approved and ramps 10%. Bedroom and bathroom extensions, the most expensive adaptations for people with more severe impairments, only comprise 3% of approvals. Often a DFG includes smaller adaptations in addition to a shower or stairlift, such as grabrails, heating or lighting improvements, but these are not shown in the figures. Discretionary DFG grants are starting to be used to pay for a range of other work, such as home from hospital services, repairs, decluttering and deep cleaning, but there are no national level data at present.

Figure 5.3 Type of DFG applications approved 2016/17



Source: Foundations FOI Jan 2018

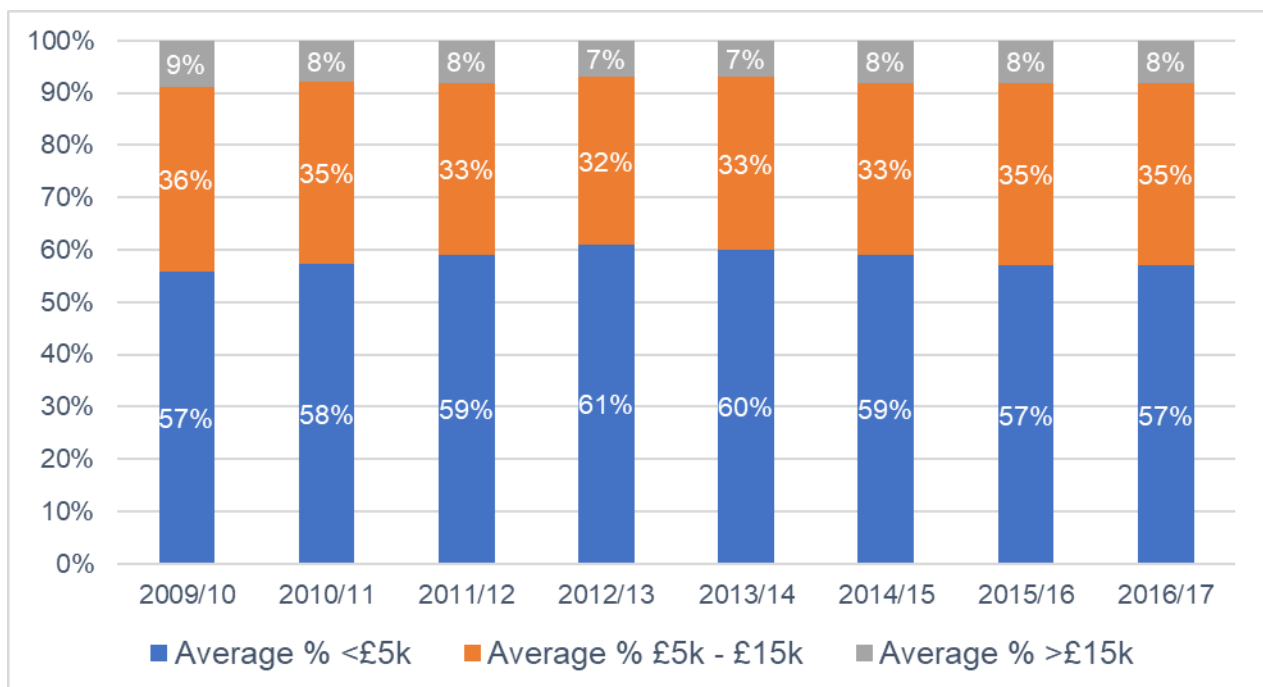
³⁸ Heywood et al (2005) Reviewing the Disabled Facilities Grant Programme, Bristol: School for Policy Studies, p. 6.

The cost of DFG work

5.11 Average costs reflect the type of DFG work that is most common: showers and stairlifts. The majority of works (57% in 2015/16) cost less than £5,000, while a further 35% were under £15,000. On average, only 8% of DFGs were over £15,000 (Figure 5.4). The proportions by cost group have remained relatively constant over the past eight years, although as was shown in Figure 3.4 (Chapter 3) the average cost of a grant has risen slightly from just over £7,000 in 2009/10 to nearly £9,000 in 2016/17. This might be due to a combination of two factors: first, the increased complexity of cases, and second, specifications beginning to take account of the rise in building costs, following the increase in overall levels of funding.

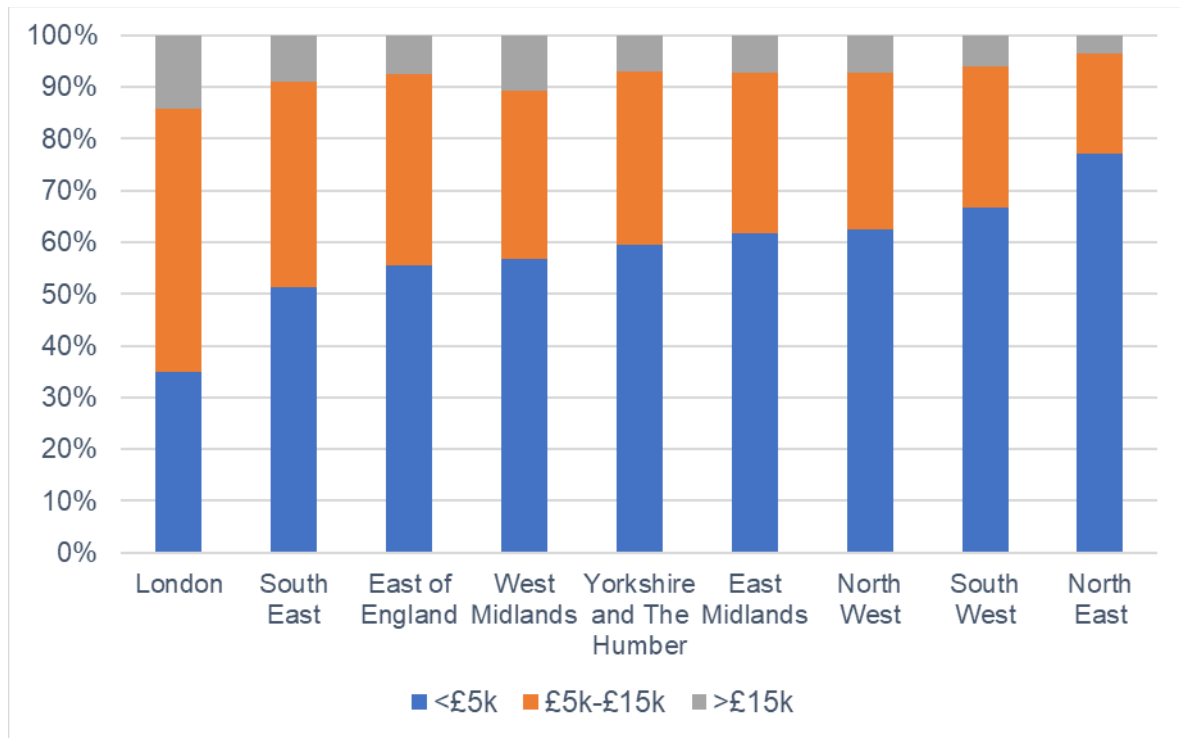
5.12 However, there is considerable regional variation. Costs in London are significantly higher, with only a third of work under £5,000, whereas in most other areas between a half and two thirds is under £5,000. The North East has the lowest costs, with three quarters of cases under £5,000 (Figure 5.5).

Figure 5.4 Trends in average value of works



Source: LOGASnet

Figure 5.5 Average size of grant per region 2009-2017



Source: LOGASnet

5.13 Average adaptations costs by region for each of the main types of work is shown in Table 5.1. Level access showers cost just under £5,000 on average, ranging from £3,600 in the North East to £5,900 in London. The average stairlift cost is around £2,400 for a straight stairlift and £4,500 for a curved stairlift. Ramps vary more in price, partly reflecting topography as places with hills often need more complicated ramping systems.

Table 5.1 Average adaptation cost by type of adaptation and by region 2016/17

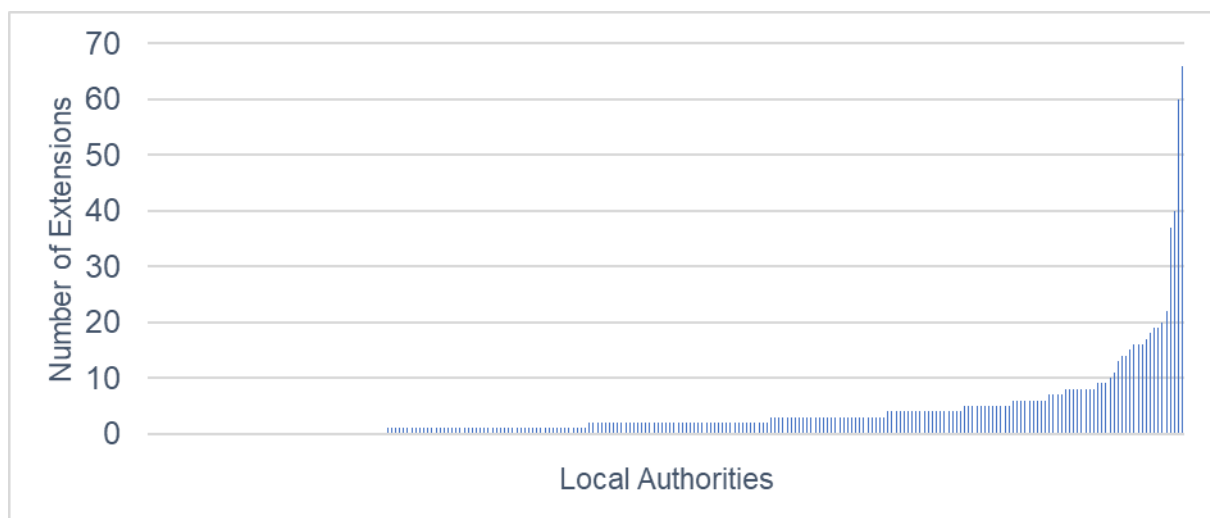
Region	Level Access Shower	Straight Stairlift	Curved Stairlift	Ramp	Extension
East Midlands	£4,601	£2,211	£4,211	£3,231	£28,269
East of England	£5,122	£2,617	£4,770	£4,421	£30,218
London	£5,911	£3,882	£5,109	£5,327	£55,243
North East	£3,617	£1,580	£3,801	£2,769	£27,667
North West	£3,967	£2,202	£4,380	£2,833	£29,362
South East	£4,979	£2,134	£4,697	£3,692	£32,870
South West	£4,290	£2,029	£4,126	£5,317	£34,642
West Midlands	£5,032	£2,635	£4,923	£4,270	£29,841
Yorks/Humberside	£4,440	£2,012	£4,267	£3,721	£30,107
ENGLAND	£4,755	£2,358	£4,495	£3,928	£31,939

Source: Foundations FOI 2018

More expensive grants and those over the upper limit of £30,000

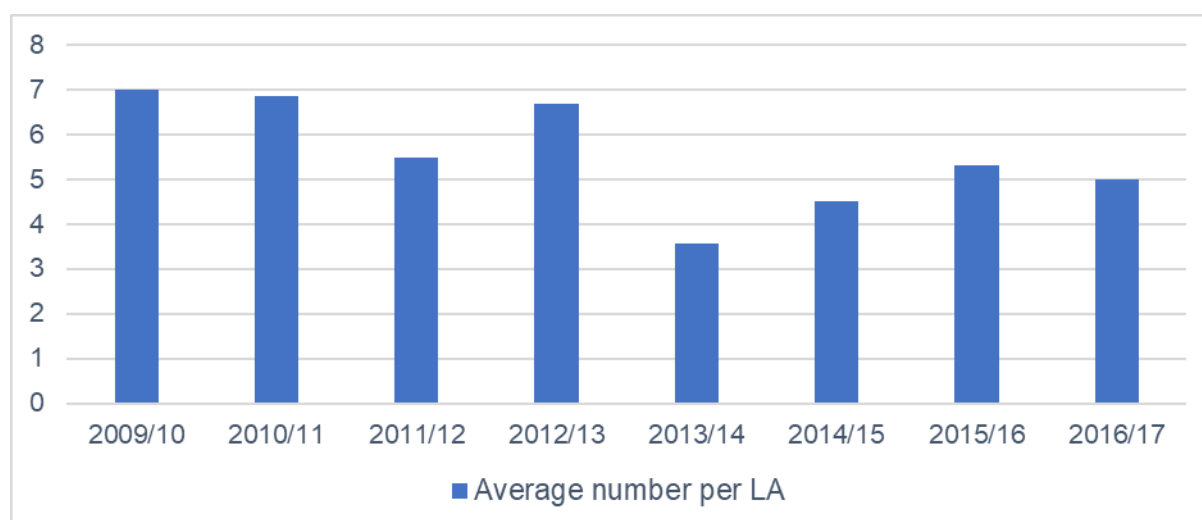
- 5.14 In all regions there are relatively few cases of works over £15,000; the figure varies between 3% in the North East and 14% in London, with the average in 2016/17 being 8% (see Figure 5.5 above). Expensive grants are usually for more complex cases, where people have severe impairments or limited mobility, particularly wheelchair users. Children with learning disabilities, autism spectrum disorder or social/behavioural problems may need additional space separate from siblings. The work may include major reorganisation of the existing living space and/or the building of a bedroom/bathroom extension.
- 5.15 The upper limit of the DFG is £30,000. It has not increased since 2008 and has not kept pace with inflation. However, in London the average cost of an extension is £55,000. Outside of London, build costs seem to be affected by what can be achieved within DFG limits, as most seem to cost around £30,000 – although costs in the South East and South West seem to be a little higher. The drive to stay within the grant limits may affect the quality of what is achieved.
- 5.16 Not all authorities do extensions. Figure 5.6 shows that some do none, most only do two a year, although at the other extreme a few do 20 or more. Small authorities may have very few complex cases over a period of several years, whereas some of the larger authorities may have high caseloads every year. The average number of adaptations over £30,000 has been decreasing in parallel with reductions in funding and does not seem to reflect changing levels of need (Figure 5.7).

Figure 5.6 Variation in provision of extensions by authority



Source: Foundations FOI 2018

Figure 5.7 Trend in average number of £30,000 grants



Source: LOGASnet returns

5.17 Some authorities have specific policies not to do extensions, particularly those with relatively small budgets – where just one or two expensive cases might use a very high proportion of the funding available for all users. Instead, they require additional reception rooms to be used as bedrooms, through-lifts or stairlifts to be installed to give access to upstairs bedroom and bathrooms, or for internal layouts to be reorganised. However, Ombudsman findings have shown that these solutions are not always in the best interest of the grant recipient³⁹. Loss of reception rooms can be detrimental if they reduce the ability to socialise, prevent children having quiet space for homework, or take away space used for religious or cultural activities.

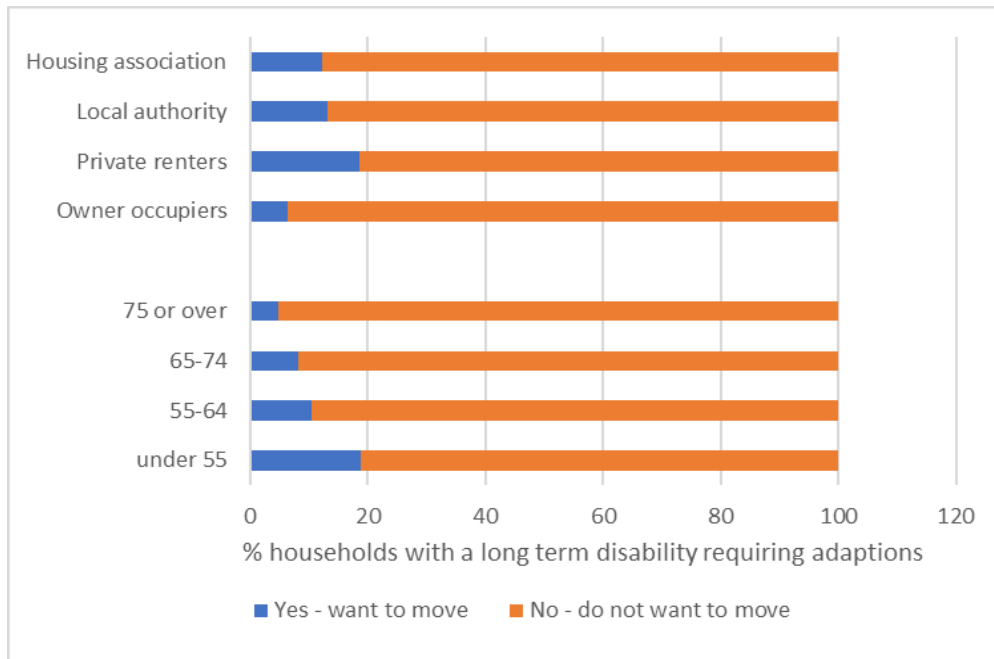
5.18 At a time when local authority finances are under serious pressure, managers have no option but to stay within budget. Although payment for adaptations could make enormous savings elsewhere in health or social care, in the absence of integrated decision-making managers have little or no power to make effective, joined-up decisions for the disabled customer, their family and carers.

Rehousing as an alternative to expensive grants

5.19 Rehousing is an alternative to adapting where a property is unfeasible or very expensive to adapt, or where rehousing would provide a better solution and providing the household is willing to move. People in private renting are most keen to move, while home owners are the least keen (Figure 5.8). Almost 20% of households under 55 were willing to move; however, desire declines with age, with people over 75 being the least prepared to relocate.

³⁹ Local Government Ombudsman (2016) Making a house a home: Local authorities and disabled adaptations. <https://www.lgo.org.uk/information-centre/news/2016/mar/delays-to-disabled-facilities-grant-process-have-major-impact-on-people-s-lives-says-ombudsman>.

Figure 5.8 Households that required an adaptation wanting different accommodation, by age and tenure, 2014-15



Source: MHCLG (2016) English House Condition Survey 2014/15

5.20 With pressures on local authority resources, many housing options services have been discontinued. In 2015/16 only 20% of authorities provided support for people to move rather than adapting, and only 268 individuals across the whole country were helped to move (Foundations FOI, 2016). Given the savings to DFG budgets, these services could pay for themselves in a relatively short period of time, but better strategic management at local level is needed to enable this to happen.

The Means Test

5.21 The means test is discussed in detail in Chapter 14. Only 14% of approved DFGs required a contribution in 2016/17. The assessed contribution averaged £1,500, which is worth £9.3m nationally. However, some people will have dropped out before this stage, as was discussed in the previous chapter. A quarter of cases that did not proceed dropped out because of the need for a contribution. Contributions have also been kept down by keeping the most expensive adaptations within the £30,000 upper limit.

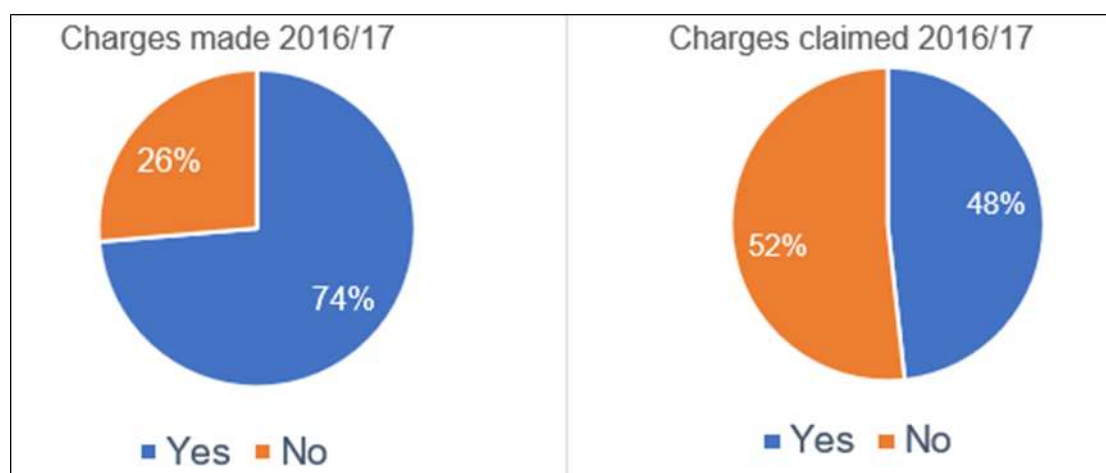
5.22 A number of authorities have removed the means test for certain types of work to speed up the delivery process. For example, Manchester and Dorset have removed the test for grants under £5,000. With the help of additional CCG funding, for an 18-month period Wigan removed the test for households

assessed by occupational therapists to be ‘at risk’ of going into hospital or residential care⁴⁰. These options are considered in Section B.

Land Charges

5.23 Local Authorities can place a local land charge if the cost of work is over £5,000, with a maximum of £10,000 able to be claimed back. In 2016/17, three quarters (74%) of authorities reported placing charges, with an average of 28 charges per authority (Figure 5.9). In most cases there is a considerable delay before charges can be reclaimed, as this is done when the house is sold. In 2016/17 only 48% reported claiming charges (Figure 5.10). Among those that did, an average of £31,600 per authority was returned. Some authorities get charges returned to the DFG account, but others find the charge is simply absorbed into the local authority general fund, meaning there is no direct benefit to future DFG applicants.

Figure 5.9 DFG land charges 2016/17



Source: LOGASnet

Summary - types of adaptations and costs

- Most grants (89%) are provided for people with physical disability issues and only 11% relate to dementia, sensory issues, learning disability or other impairments.
- Cases are becoming more complex as higher numbers of people have multiple conditions, including a mix of physical and mental health impairments. It indicates that some may take longer to process, and staff may require more training.

⁴⁰ Mackintosh, S. and Collingbourne, L. (2015) Home Adaptations for Disabled People Good Practice Case Study: Wigan. <https://homeadaptationsconsortium.files.wordpress.com/2013/10/cameo-wigan1.pdf>.

- The DFG was originally devised to solve physical impairment problems. There needs to be better guidance about the use of the DFG for mental health issues. Better guidance is also needed for children's cases, which are increasingly likely to be about learning disability, autism spectrum disorders or behavioural issues.
- Specific grants for sensory impairment, mental health issues and dementia may be required, with small grants available for better lighting, deep cleaning and decluttering to help improve living conditions. There is scope for these to be delivered using the flexibility inherent in the RRO.
- The average cost of a grant rose from just over £7,000 in 2009/10 to nearly £9,000 in 2016/17, reflecting increases in building costs that had been kept down through strict approaches to value for money. Increased costs may also reflect a change in the complexity of work.
- The most common adaptations are showers (55%) and stairlifts (25%). The average cost is just under £5,000 on average for showers, £2,400 for a straight stairlift and £4,500 for a curved stairlift.
- Overall 57% of DFGs cost less than £5,000, 35% were under £15,000 and only 8% were over £15,000, but there is considerable regional variation. In London, only a third of work is under £5,000, whereas in most other areas between a half and two thirds is under £5,000. There are only about 8% of cases over £15,000 on average, varying between 3% in the North East and 14% in London.
- Some places do no extensions, most only do about two each year, with only a few places doing more than 20 per year. Extension costs are highest in London – averaging £55,000 – but in most other places average costs are kept around the £30,000 upper limit. Some places with small DFG budgets avoid doing extensions to keep costs down.
- Reorganisation of internal space may be cheaper but may not provide adequate solutions. Changes to the grant limit are required to deliver better outcomes.
- Relocation support could provide better solutions for some of the worst housed, as nearly 20% of those under 55 might be willing to move, but housing options services need to be adequately resourced.
- Three quarters of authorities use land charges to recoup some of the costs, but the money is not always recycled back into the DFG.

Chapter 6. Costs and benefits to local authorities

The benefits of adaptations and potential cost savings

- 6.1 The benefits of adaptations are numerous but are very difficult to quantify. Local authorities have generally been good at recording outputs, such as grants completed and amount spent, but much less effective at recording longer term benefits to the individual or the impact on health and care spending.
- 6.2 Previous studies have shown the difficulties disabled and older people face when their home becomes inaccessible and how much they value adaptations. Heywood (2001), in one of the most comprehensive studies of both minor adaptations and the impact of the DFG in England, said that *“The evidence about what was achieved by bath or shower adaptations was overwhelming. The interviews showed how adaptations restored confidence, dignity and self-respect, promoted independence and reduced stress”* (p.11) and that, *“Good adaptations transform lives, improve health and keep people out of institutional care”* (p.1)⁴¹.
- 6.3 A review conducted in 2017 by the University of the West of England for the Centre for Ageing Better found strong evidence about the benefits of minor adaptations such as grab rails and removal of trip and fall hazards on the rate of falls, improvement in activities of daily living and the impact on mental health⁴². However, the evidence relating to the more common major adaptations provided by the DFG, such as the replacement of baths with wet rooms or the provision of stairlifts is much less robust. Most surveys are retrospective, asking people what they feel after work has been carried out. There are few studies using objective measurement of levels of independence, or the use of health and care services, before and after an adaptation is completed.
- 6.4 Better evidence is beginning to be obtained. A pilot randomised control trial (the BATH-OUT study) measured the impact and outcomes of replacing baths with showers on disabled older adults and carers’ quality of life and on their use of health and social care services⁴³. The study compared the outcomes for older adults receiving the usual local authority DFG service (the control group) compared with a similar size group getting quicker provision (the intervention group). Participants were followed up at three monthly intervals. Sixty

⁴¹ Heywood, F. (2001) Money well spent: the effectiveness and value of housing adaptations, Bristol: The Policy Press.

⁴² Powell, J., Mackintosh, S., Bird, E., Ige, J., Garrett, H. and Roys, M. (Nov 2017) The role of home adaptations in improving later life, London: Centre for Ageing Better. <https://16881-presscdn-0-15-pagely.netdna-ssl.com/wp-content/uploads/2017/11/The-role-of-home-adaptations-in-improving-later-life.pdf>.

⁴³ Whitehead, P., James, M., Belshaw, S., Dawson, T., Day, M. and Walker, M. (2016) Bathing adaptations in the homes of older adults (BATH-OUT): Protocol for a Feasibility Randomised Controlled Trial (RCT) BMJ Open. 6, e013448. <http://dx.doi.org/10.1136/bmjopen-2016-013448>.

participants were recruited and randomised and the results are presented using descriptive statistics⁴⁴. Physical and mental wellbeing and people's own perception of their health improved after the shower was installed in both groups. Ease of bathing also improved and fear of falling decreased. There was also a reduction in the use of both informal and formal care. This study has demonstrated "proof of principle" but was conducted in one local authority area only. A larger study is needed to further evaluate the clinical and cost effectiveness, including the effect of waiting times.

- 6.5 Determining the actual cost savings to health and social care is more difficult. This is an international problem, not just one affecting the UK. Chiatti and Iwarsson (2016) noted that there is a '*paucity of systematic evaluations*' and '*few studies containing economic appraisals*'⁴⁵. The reasons they give for this are: the heterogeneity of the client group; the variety of home environments; adaptations not being easily standardised as they are customised to the needs of the client; and the number and variability of outcomes. Most studies have tended to focus on functional ability and/or falls.
- 6.6 Public Health England (PHE) has produced a toolkit to help local areas prevent falls, and this estimates the impact of adaptations. Falls are a major issue for health and social care, as a third of people 65 and over fall each year, rising to half of those aged 80 and over, with about 5% of falls leading to fractures and stays in hospital. Fragility fractures in older people cost the NHS and social care about £4.4 billion a year, with about 25% of those costs attributable to social care. Falls are not just costly to public services, but also have major negative impact on the independence and quality of life of the person affected⁴⁶. Adaptations could potentially have a big impact as 75% of the deaths relating to falls happen in the home, and falls represent 10-25% of ambulance calls to older adults⁴⁷. Older people represent the greatest pressure on hospitals, as they use most bed days than other people once admitted in an emergency (65% of bed days)⁴⁸. Falls also often precipitate a move into residential care.
- 6.7 Using evidence from randomised control trials and systematic reviews, PHE compared the impact of different interventions on falls, including exercise classes and home adaptations. They estimated that adaptations produce significantly higher returns on investment with £1 of investment in home assessment and

⁴⁴ Whitehead, P., Golding-Day, M., Belshaw, S., Dawson, T., James, M. and Walker, M. Bathing adaptations in the homes of older adults (BATH-OUT): Results of a Feasibility Randomised Controlled Trial (RCT) Manuscript submitted to BMC Public Health March 2018.

⁴⁵ Chiatti, C. and Iwarsson, S. (2016) Evaluation of housing adaptation interventions: integrating the economic perspective into occupational therapy practice, *Scandinavian Journal of Occupational Therapy*, 21:5. 323-333, <https://doi.org/10.3109/11038128.2014.900109>.

⁴⁶ Public Health England (Feb 2018) A return on investment tool for the assessment of falls prevention programmes for older people living in the community. <https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning>.

⁴⁷ Communities and local Government Committee (Feb 2018) *ibid*, p. 15.

⁴⁸ National Audit Office (Mar 2018) Reducing emergency admissions. <https://www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions.pdf>.

modification saving £3.17 on health and care costs. If quality of life gains for the individual are considered, savings rise to £7.34 per £1 spent. However, the cost savings only apply to interventions for people who have been admitted to hospital for a fall, they are mainly for minor adaptations and assume that qualified staff, usually an occupational therapist, provide the assessment. The financial returns are opportunity costs rather than actual savings, such as: reductions in pressure on accidents and emergency departments and fewer hospital admissions.

- 6.8 BRE has calculated the costs associated with the most common Category 1 hazards in the homes of older people. These include excess cold (690,000 households); and falls on stairs and the level (467,000 households) and would save the NHS £624 million in first-year treatment costs. The cost of remedying excess cold is the most expensive, at almost £3 billion. The cost of remedying falls is estimated to be around £982 per house for falls on stairs and £792 for falls on the level. Providing handrails and better lighting is relatively cheap but work to communal areas of flats may be much more expensive. Overall, work to remedy Category 1 hazards would pay for itself in around 6.5 years for remedying cold and 4.5 years for falls⁴⁹.
- 6.9 PSSRU also looked at the cost of falls and estimated that the provision of equipment and adaptations might result in a reduction in demand for health and social care equivalent to £261 per recipient per annum, with quality of life improvements valued at £1,379 per annum (using their more conservative assumptions). Scaling this up to a client base of 45,000 individuals and an overall expenditure of £270 million (equivalent to the total annual expenditure on Disabled Facilities Grants in 2011 when the calculations were carried out) was deemed likely to generate reductions in the demand for health and social care services worth £156 million over the estimated lifetime of the equipment, and to achieve quality of life gains of £411 million⁵⁰.
- 6.10 A study of a broader range of adaptations in housing association properties in Scotland showed that investment led to increased independence, confidence, health, and autonomy for tenants. It also contributed to a shift in the balance of care away from residential homes and hospitals by preventing accidents and reducing care needs. It showed a total return on investment of £5.50 to £6.00 for every £1 invested if benefits to tenants as well as those to health and social care were included⁵¹. Using records about length of tenancy, they were able to compare their sample with tenants who had not had adaptations. Findings

⁴⁹ Garrett, H. and Burris, S. (2016) Homes and ageing in England.

https://www.bre.co.uk/filelibrary/Briefing%20papers/86749-BRE_briefing-paper-PHE-England-A4-v3.pdf.

⁵⁰ Snell, T. Fernandez, J. Forder, J. (2012) *Building a business case for investing in adaptive technologies in England*, Personal Social Services Research Unit, Discussion Paper 2831, London: School of Economics and Political Science.

⁵¹ Kempton, O. and Warby, A. (2011) Measuring the Social Return on Investment of Stage 3 Adaptations and Very Sheltered Housing in Scotland. <https://www.hanover.scot/wp-content/uploads/2015/11/SROI-VSH-and-Adaptations-full-report-final-Sept-2011.pdf>.

showed that adaptations allowed tenants to remain in their sheltered housing unit for an extra 2.7 years before needing residential care.

- 6.11 A survey of social care departments by Foundations attempted to link data on DFG recipients with care data⁵². Only a few authorities were able to provide returns due to the difficulties of linking datasets. The findings revealed that only 16% of people receiving a DFG had a domiciliary care package, and that there was only a slight fall in the number of hours required a year after the DFG had been completed. Most DFG recipients are likely to have either no care or informal care from family and friends. However, as over a quarter of informal carers are over 65, adaptations are likely to benefit them as well as the grant recipient⁵³.
- 6.12 The Foundations survey used data from local authorities on the average age of people taking up residential or nursing home places, age of death, and whether they had previously received a DFG (Table 6.1). Results need to be treated with caution as numbers were small; however, they indicate that people who lived in homes adapted using a DFG had gone into care four years later than those who had not had a DFG, and that they had only needed two, rather than six years, in care. With residential care costs at around £28,000 a year, compared to average DFG costs of around £7,000, this highlights the potential savings of providing adaptations, but it needs further research.

Table 6.1 DFG and residential care

Average age	No previous DFG	Had DFG
Age moved into residential care / nursing home	76	80
Age at death	82	82

Costs savings of adaptations for children and young people

- 6.13 Cost savings for younger people are likely to be higher. The costs of care are greater and the benefits spread over a longer period. A study in Leeds of a small sample of young people with Autistic Spectrum Disorders and challenging behaviours showed the impact of providing adaptations on the ability of families to continue their caring role⁵⁴. In all cases, the young people's behaviour carried

⁵² Foundations (2016a) Linking Disabled Facilities Grants to Social Care Data.

<http://foundationsweb.s3.amazonaws.com/4210/foundations-dfg-foi-report-nov-2015.pdf>

⁵³ Department for Work and Pensions (2017b) Family Resources Survey, Carers data tables, Table 5.2

⁵⁴ Clements, L. and McCormack, S. (2017) Disabled Children and the Cost Effectiveness of Home Adaptations & Disabled Facilities Grants: A Small-Scale Pilot Study, Leeds: Cerebra, University of Leeds. <http://www.cerebra.org.uk/research/university-of-leeds-cerebra-legal-entitlements-and-problem-solving-project/student-research-projects/>.

a risk of serious harm to themselves and/or serious damage to property or harm to other people if unsupervised.

- 6.14 Six families were interviewed by student researchers. Results showed that four had had adaptations completed (or nearly completed) with the full costs being met by a DFG ranging from £20,000 to £90,000 (average just under £60,000). Three of the six families were certain that without the adaptations, their disabled son or daughter would have become a 'looked after child' (LAC). The adaptations did not fully solve the problems, and all the young people still needed substantial care packages, but the changes gave much needed space in the home and enabled the parents and the rest of the family to cope. In the other three cases, one family thought they might have managed without the work, and in another case the work had been on site so long that the family could see no benefit. At the time of the interviews, the final family had experienced long delays and was still waiting for work to start. They were concerned that they would not be able to continue caring if something did not happen fast. The work was still not on site when a few months later their child went into local authority care.
- 6.15 The study estimated that about 14 years of costs as a 'looked after child' had been avoided by the adaptations. The costs of care at a weekly rate of £2,000 were estimated to be about £1.5 million compared to the average cost of the adaptations of £60,000. However, this does not include the ongoing costs of care at home and excludes any assessment of the impact on the wellbeing of the disabled young people and their families.
- 6.16 The families had all experienced considerable delays in getting the work approved and carried out. Even though the savings were considerable, the research highlights the problems that arise for housing authorities trying to fund high-cost adaptations from limited DFG budgets, when the savings relate to social care and the NHS. Justifying such a high proportion of DFG expenditure on a single case, particularly one that is not about physical disability, seems to be a major reason why these cases take so long to be resolved.

“Some of the student researchers considered it extraordinary that a grant of £60,000 might be refused even though the consequence was a five-fold (or more) cost impact to the public purse”.

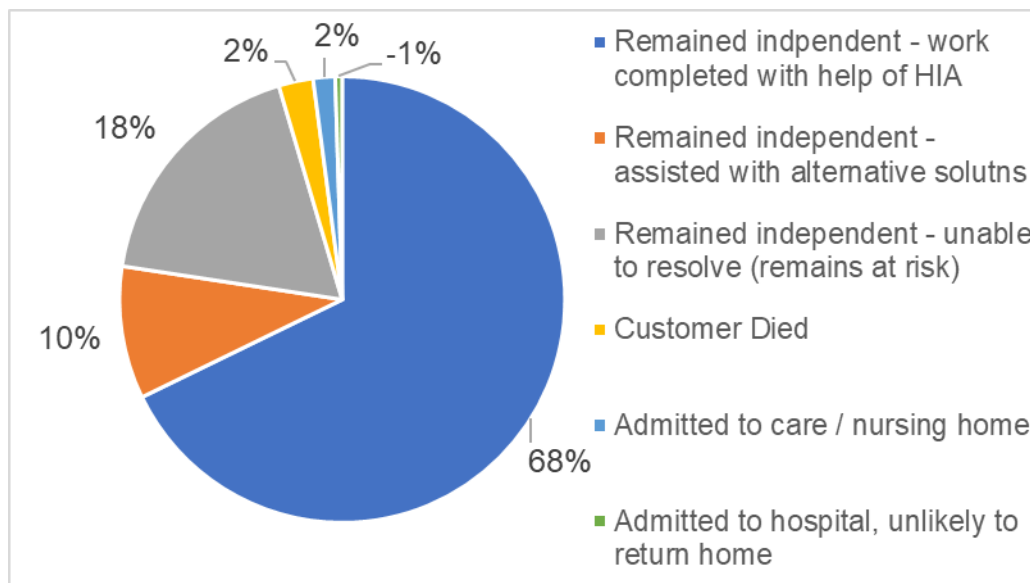
DFG outcome data

- 6.17 None of the research so far shows a definitive cost saving to the NHS or social care, but they all show a very significant amount of cost avoidance. They also show that adaptations deliver a health and wellbeing return that is worth far more than the costs of the DFG in first year savings alone. Far more research is needed to better quantify the outcomes of adaptations in terms of cost savings to health and care.

6.18 Some authorities are beginning to record what happens following adaptations. However, it is hard for authorities with limited staff and large caseloads to spare the time to revisit completed cases and record outcomes. The poor quality of IT systems and lack of data sharing between health, social care and housing is a further issue preventing good outcomes analysis. Despite the 2014 Care Act and the BCF requiring use of NHS numbers on all case files, this is still not common practice for DFG cases. The changes to data protection in May 2018 may further hamper data sharing unless effective protocols are established.

6.19 One county authority with pooled data from all boroughs and districts was able to show that most people (68%) had remained independent at home after work was completed, while 10% had alternative solutions (possibly rehousing) (Figure 6.1). Only a small proportion had gone into residential or nursing care, been admitted to hospital or had died. However, 18% remained at risk as the cases had not been possible to resolve, but there are no details as to why.

Figure 6.1 Outcomes of completed cases – one county authority 2017/18



Source: outcome data provided to the review by a county authority in April 2018

The revenue costs of delivering the DFG

6.20 The revenue costs of delivering the DFG are not collected as part of LOGASnet returns. The data are difficult to obtain as service delivery in most areas crosses departmental boundaries. Occupational therapy staff are usually based in social care and have other roles in addition to doing assessments and recommendations for the DFG. The DFG team in housing authorities may be part of a private sector housing or environmental health team, sometimes also with additional duties.

6.21 Funding for most in-house local authority DFG services comes from the general fund. Where occupational therapists are based in social care or children’s services, their salary and overhead costs are from social care budgets, while the revenue costs of most caseworkers, grants officers, technical officers and administrative support are provided by housing departments budgets.

6.22 Although some authorities are trying to cover costs through fees, the evidence indicates that it can only provide a proportion of the total amount. An example is given in Table 6.2 of one local authority service in the North of England with a DFG budget of over £1 million. They were expected to raise more than a third of the revenue and overhead costs of £254,000 through fees charged as part of the DFG but had only managed to raise a quarter of the costs. They had not received any money from the BCF or social care to cover the service costs, despite providing a home from hospital service and using an RRO policy to deal with cold and damp homes to improve health. All revenue funding is from the district council.

Table 6.2 Funding targets for a district council (excl occupational therapy costs) 2017/18

	Expenditure costs £		Income Target £	Actual income £
Salary	169,000	Fees Target %	92,500 36%	64,000 25%
Estimate of accommodation /services/supplies	85,000	District Council contribution	161,500	190,000
Total cost	254,000		254,000	254,000

Source: written submission to the review

6.23 This is a common problem for Housing Authorities, that the benefits of adaptations relate to both health and social care, but neither provide substantial amounts of revenue funding, apart from covering the costs of occupational therapists. In 2013 an Astral Advisory report based on surveys and interviews with district councils concluded that services were under-resourced and recommended that housing-related preventative work to delay or avoid hospital admissions should be funded by CCGs⁵⁵.

Independent HIAs

6.24 Most DFG services are within local authorities and there are now very few independent HIAs. Those that remain do not always deliver the DFG, and where they do, they often provide a range of other services. However, it is useful to look

⁵⁵ Astral Advisory (2013) Disabled Facilities Grants in England: a research report, London: The District Councils’ Network (DCN) and the Society of District Council Treasurers (SDTC).

at their funding sources and compare them to those of internal local authority agencies.

6.25 HIAs have a much wider mix of funding sources and it is very different from internal DFG teams. Overall, three quarters come from health and social care, with 29% from the BCF, 30% from adult social care and 15% from Clinical Commissioning Groups (CCGs). Only a small amount comes from housing authorities (7%). HIAs have a long history of charging fees but this only amounts to 10% of the total, showing how difficult it is to rely on this for revenue funding. Charitable funding is a source not available to local authorities, but only makes up a very small amount of HIA resources (5%).

Staff costs by type of work

6.26 Staff costs are an important consideration when estimating the costs of providing home adaptations. A study commissioned by PSSRU and undertaken by Astral/Foundations identified the time inputs of staff involved in assessing clients and in administering the process of supplying adaptations. Information was received from 17 organisations (85% response rate). This included ten local authorities, six Home Improvement Agencies (HIAs) and the British Association of Occupational Therapists⁵⁶. Table 6.3 shows the results. Level access showers, the most common type of adaptation, take 26 hours of staff time to process and deliver, excluding construction time. There may be efficiencies to be gained by better use of staff time and better training of builders and tradespeople to cut some stages of the process.

Table 6.3 Mean time inputs for staff involved in providing major adaptations

	Initial enquiry	Average minutes					Total time
		OT	LA grants officer	HIA technical officer	HIA caseworker	HIA administrator	
Level access shower	9.8	210	462	420	287	168	1,557 (26 hours)
Stairlift (straight)	9.8	72	186	120	474	120	982 (16.4 hours)
Stairlift (more complex)	9.8	156	756	306	96	120	1,444 (24.1 hours)
Convert room for downstairs WC/washroom	9.8	498	792	672	276	312	2,560 (42.7 hours)
Build downstairs extension for WC washroom	9.8	816	1,188	1,578	144	174	3,910 (65.2 hours)
Build downstairs extension for bedroom and en-suite facilities	9.8	1,068	1,356	1,272	372	234	4,312 (71.9 hours)

Source: PSSRU, Unit Costs of Health and Social Care 2017.

⁵⁶ PSSRU (2017) Unit Costs of Health and Social Care 2017 [online]. <https://www.pssru.ac.uk/pub/uc/uc2017/services.pdf?label=uc2017-services>

6.27 Research by the Royal College of Occupational Therapists in 2013/14 involved a survey of local authorities and home improvement agencies to obtain information on the time inputs for staff for 18 commonly fitted adaptations⁵⁷. The results show:

- **Major adaptations** - total mean cost £16,647 (range £2,474 to £36,681). Staff costs were up to 24% of the total mean cost.
- **Minor adaptations** - total mean cost £451. Average staff costs were 76% of total mean cost.

6.28 Given the shortage of occupational therapists and the high proportion of DFG delivery costs absorbed by outlay on staff, it is important to gain efficiencies so that limited DFG resources can help more people. Part B looks at how better routing of cases at the outset can make more effective use of more highly trained staff, with more straightforward cases handled by trusted assessors. A tool is provided to help work out what cases require occupational therapy input. RCOT is also publishing a report on minor adaptations to show how they can be delivered more effectively and efficiently⁵⁸.

6.29 The reason why data on costs and benefits is so limited reflects a lack of governance and oversight. LOGASnet has been an administrative tool, rather than one designed to manage the service. At local level, the split in the way services are managed between social care and housing means that there is little data relating to the whole end-to-end DFG process. When the DFG became part of the Better Care Fund, there was scope to develop better measurement of inputs and outcomes, but no national metric was set about independence in the home. As housing authorities are under-represented on Health and Wellbeing Boards, no-one has clear responsibility to determine how well the DFG is operating.

6.30 Staff at the operational end do not have a strategic view and do not have the time or resources to follow up cases to determine the longer-term impact. Without adequate data, operational staff find it very difficult to argue the case for additional revenue funding, as they are unable to demonstrate the true costs of the service and the benefits it delivers. Services have therefore remained under-resourced even when central government funding has been increasing.

⁵⁷ Curtis, L. and Beecham, J. (2018) A survey of Local Authorities and Home Improvement Agencies: identifying the hidden costs of providing a home adaptations service. <https://kar.kent.ac.uk/66433/>.

⁵⁸ Royal College of Occupational Therapists (In Press) Adaptations without delay: a guide to thinking about and delivering adaptations differently. London: Royal College of Occupational Therapists.

Summary - costs and benefits to local authorities

- Analysis of the economic value of adaptations is difficult because of heterogeneous disabled populations, differences in housing and care circumstances, and the customised nature of many adaptations.
- Benefits are also hard to measure because information on outcomes is not routinely collected, data sharing is difficult and IT systems are poor.
- Academic analysis is based on a limited number of systematic reviews, most relating to the impact of minor adaptations on falls. However, these show significant cost savings.
- Cost saving for young people can be very high relative to the cost of adaptations when it reduces numbers of 'looked after children'.
- There is little robust research relating to the outcomes of the type of major adaptations provided by the DFG such as showers and stairlifts. However, the BATH-OUT pilot shows a positive impact on health and wellbeing and a reduction in the fear of falling. A larger study is needed to further evaluate the clinical and cost effectiveness and the effect of waiting times.
- Two small studies indicate that adaptations can delay entry to residential care by nearly three to four years.
- The costs of delivering the service are currently difficult to determine as services straddle departmental and administrative boundaries. However, they appear to be high, with occupational therapy costs alone being 24% of the costs of an average DFG. Improved routing of cases would make more effective use of the most highly skilled and expensive staff.
- Without adequate data on costs and benefits it has been difficult to argue the case for additional revenue funding. Services have therefore remained under-resourced even when central government funding has been increasing.
- Council-run DFG services get little support with revenue or capital costs from health or social care despite the considerable potential impact of the DFG on health and care outcomes. Independent HIAs have been better at obtaining funding from a wider mix of sources.
- Fees cannot address the shortfall in revenue costs and their use reduces the amount of capital resources available for adaptations to people's homes.
- The paucity of data reflects a lack of governance and oversight. Despite the DFG being part of the BCF, there are no national metrics about housing outcomes or independence in the home. The need for better strategic oversight is addressed in Part B.

Chapter 7. Processing arrangements and waiting times

- 7.1 The legislation itself contains very little about how the grant process should work, apart from saying that:
- The grant cannot be approved if works have already started
 - There is a need to consult the social services authority
 - A decision notice is to be issued within 6 months of the date of application.
- 7.2 The process arrangements and delays are where there are significant concerns about the current operation of the DFG. In 2016 the Local Government Ombudsman said that *“All too often in the cases we see, applying for and receiving a Disabled Facilities Grant (DFG) is beset by delay”*⁵⁹.
- 7.3 The Communities and Local Government Committee also commented that *“Our predecessor Committee considered the operation of the DFG in its inquiry on adult social care, concluding that it was “slow and cumbersome”, so we were interested to return to the issue. Once again, we heard that it was a “clunky process” and that waiting times for implementation varied significantly between local authorities, ranging from days and weeks in some places to two or three years in others”*⁶⁰.
- 7.4 An FOI in 2015 by Leonard Cheshire got a 68% response rate from all 360 councils and revealed that almost 2,500 disabled people were waiting over a year to get a DFG to make their homes accessible: *“These delays are leaving disabled people stuck sleeping in their lounge, washing at their kitchen sink or at risk of falling down the stairs and needing hospital treatment”*⁶¹.

Processing arrangements

- 7.5 When the DFG was first developed, the help provided by the local authority was relatively limited. Applicants were given the application forms and asked to return the completed paperwork with the requisite documentation and quotes for the building work. Social care was consulted but the housing authority remained in charge of the case. Figure 7.1 below shows that as the ‘minimal process’.

⁵⁹ Local Government Ombudsman (2016) Making a house a home: Local authorities and disabled adaptations, p. 1. <https://www.lgo.org.uk/information-centre/news/2016/mar/delays-to-disabled-facilities-grant-process-have-major-impact-on-people-s-lives-says-ombudsman>.

⁶⁰ Communities and local Government Committee (Feb 2018) *ibid*.

⁶¹ Leonard Cheshire Disability (2015) The Long Wait for a Home. <https://www.leonardcheshire.org/sites/default/files/Leonard-Cheshire-Disability-The-Long-Wait-for-a-Home.pdf>.

- 7.6 Over time, the main call centre for local authorities became based in social care. This became the route into local authority services and calls about the DFG ceased going direct to housing. This led to a new type of minimal process (termed 'DIY' in Figure 7.1).
- 7.7 Community occupational therapists began to play an increasingly important role in the process. In 2003, the joint health and social care Integrated Community Equipment Service (ICES) budget came into use and minor adaptations and equipment became an alternative option to try before people were referred for a DFG. For children's cases there was often a separate call centre and a different team of occupational therapists. The customer pathway evolved into the service that is most common today: the 'traditional process'. Social care (adults and children's) controls who is accepted as eligible for assessment and decides what route to send people down. As social care has different eligibility criteria to the DFG, some people are excluded from help or may not go down fast-track pathways direct to the DFG leading to delays.
- 7.8 This traditional process also means that there can be different waiting lists. There may be a wait for an initial assessment for aids, equipment or minor works; another wait for a full occupational therapy assessment; and a further wait for a DFG means test and grant approval. These handovers are confusing for customers who may not know what department or member of staff is handling their case. The 2014 Care Act said that service users should have a single point of contact throughout the customer pathway, but this seems very difficult to apply when service provision crosses departmental and administrative boundaries.
- 7.9 It is only recently that this traditional process has begun to change, as new integrated teams have developed, comprising occupational therapists, casework and technical staff. Teams can more easily work together, considerably simplifying and speeding up the customer journey. This integrated model is discussed in detail in Part B.
- 7.10 How processing arrangements work on the ground was explored at the consultation events and in the online survey. Participants were asked to identify which of the four different models they thought was closest to the way the DFG service worked in their area. The majority said that their service was 'traditional'. However, when asked what service they would prefer, the majority opted for an 'integrated' service (Figure 7.1).

Figure 7.1 Types of DFG process

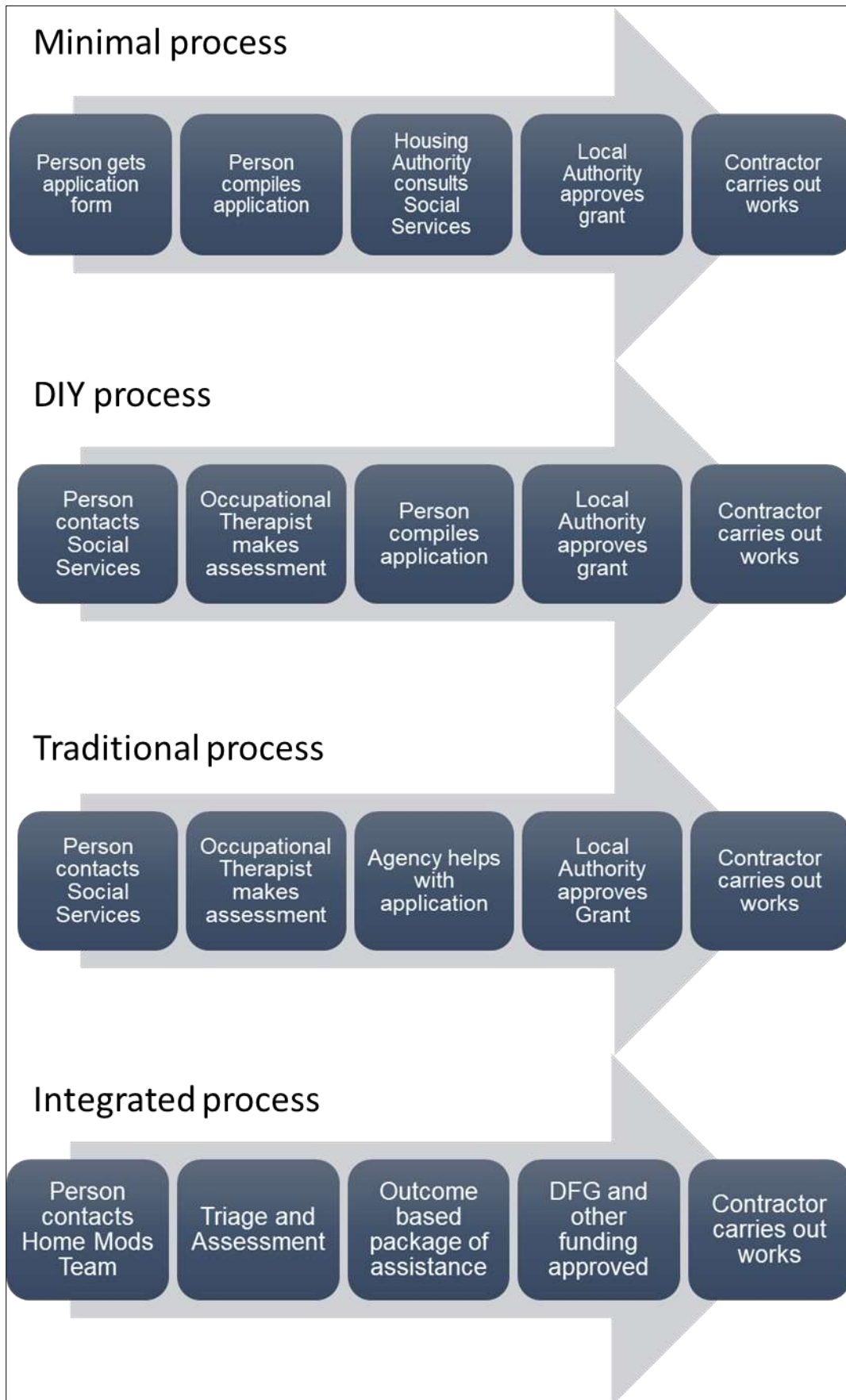
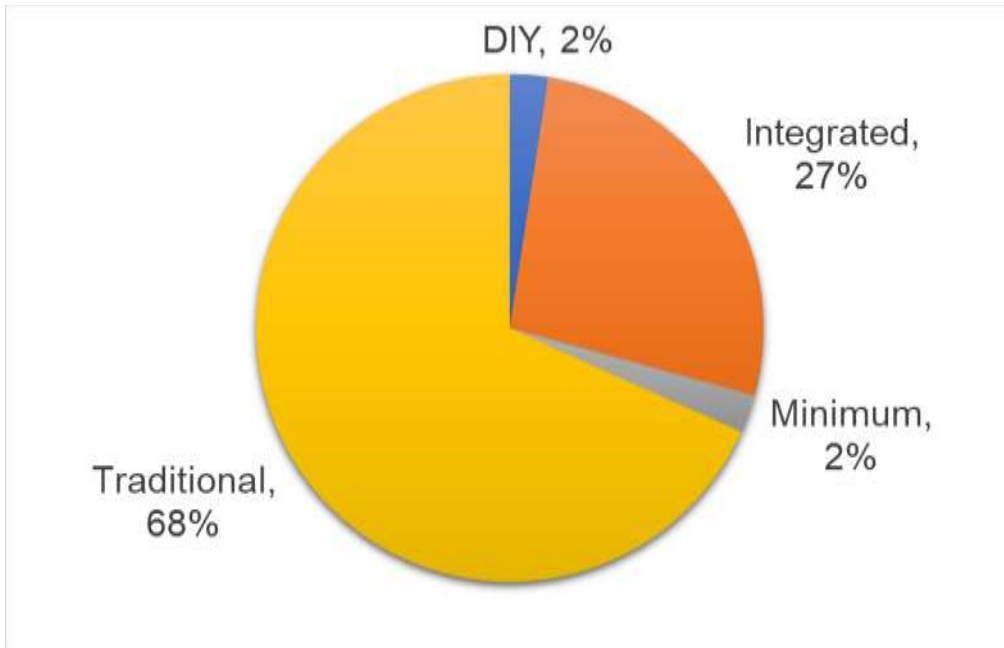
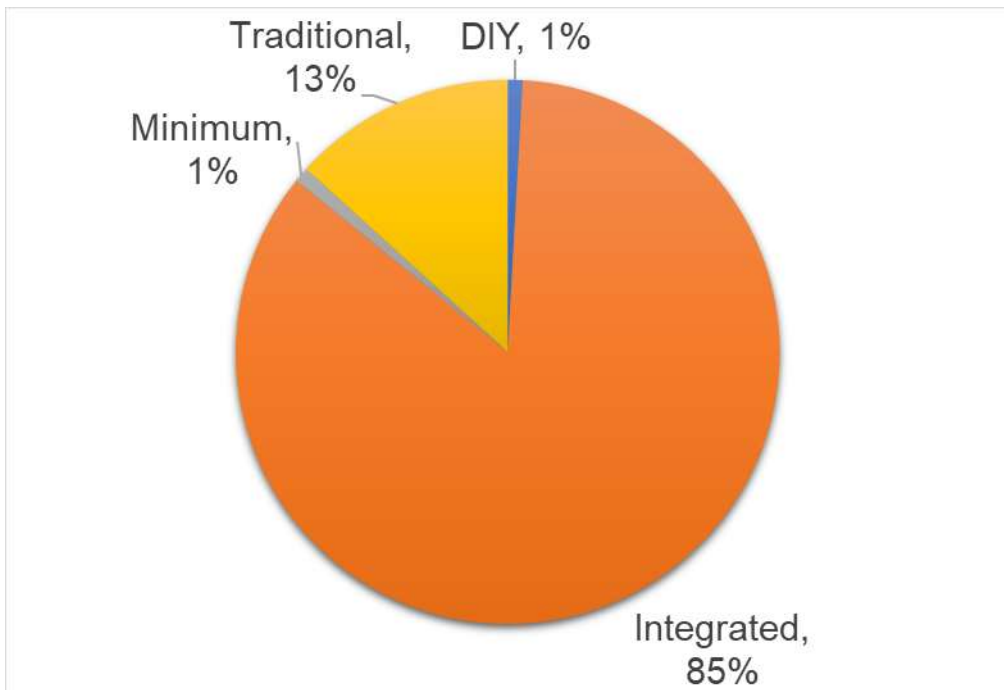


Figure 7.2 Current DFG process



Source: voting at consultation events

Figure 7.3 Future DFG process



Source: voting at consultation events

Online survey: 76% integrated, 19% traditional, 3% minimum, 2% DIY

Time taken to process grants

7.11 It is difficult to determine end-to-end processing times with any accuracy because of the way services cross administrative boundaries. DFG teams with minimal, DIY or traditional arrangements (where occupational therapists are in other departments, or in county offices) often do not know the date of first enquiry or how long a person has waited for an occupational therapy assessment. Housing teams may not have access to social care IT systems to look this up. The only comprehensive data collected by housing teams therefore relates to the end of the customer pathway, when a DFG application has been submitted, often many months after the first enquiry.

7.12 LOGASnet recorded some limited information on time periods for the first time in 2016/17. Table 7.1 shows that the average time from application to completion of work is almost 7 months, but there is a huge range. As the CLG Committee report indicated, some places appear to process work very quickly but in other places it is extremely slow⁶². These time periods do not include the time spent waiting for an occupational therapy assessment.

Table 7.1 time taken to process grants 2016/17

Average time between application and approval (working days)	Average time between approval and certified date (working days)
Nearly 10 weeks (range: 1 day to over a year)	Over 17 weeks (range: 3 weeks to 1 year)

Source: LOGASnet (Note - waiting time for occupational therapy assessment not included)

The effect of RRO policies on timescales

7.13 Since 2008, local authorities have been able to develop their own policy to improve the delivery of adaptations. However, at the end of 2016 47% still had no policy (Foundations FOI, Nov 2016). Some have been unwilling to take the risk of spending mandatory money on discretionary schemes, while others have so much demand for mandatory work, or are too short staffed, to be able to explore more innovative ways of spending the money.

7.14 What is clear from more recent research is that those authorities with RRO policies are, on average, delivering results faster, although some authorities are very quick at delivering standard DFGs. Quicker services may be because they have removed the means test or have some method of fast-tracking different types of cases. Building work still takes the same amount of time (or longer if an

⁶² Communities and Local Government Committee (Feb 2018) *ibid*.

increase in throughput of cases cannot be matched by availability of contractors) but the period from application to approval is more than halved (Table 7.2).

Table 7.2 Time taken to process cases for authorities using an RRO policy

	Average Application to Approval (working days)	Average Approval to Completion (working days)
Used RRO for more than 50 adaptations*	20.4	86.2
Did not use RRO at all	45.8	84.5
DFG Guidance (Non-Urgent)	See note**	80.0

Source: Foundations FOI 2017

*10 LAs reported that they completed 50 or more adaptations under RRO policies

**The 2013 Guidance has a target of 50 days from OT recommendation to approval

The effect of shortages of contractors on timescales

7.15 Regions with a shortage of contractors have longer delays between grant approval and completion of work, particularly London, where it takes nearly six months on average to get from approval of the grant to completion of work compared to just over four months elsewhere (Table 7.3).

Table 7.3 Time taken from approval to completion by region

Region	Approval to Completion (working days)
East Midlands	97
East of England	85
London	114
North East	84
North West	81
South East	85
South West	86
West Midlands	74
Yorkshire and The Humber	91
ENGLAND	89

Source: LOGASnet 2016/17

Effect on disabled and older people, their families and carers

- 7.16 This analysis of how the DFG currently operate demonstrates how complex the DFG system is for disabled and older people. If they are home owners or private tenants, the first challenge is to find out about the grant, as in most areas it is not advertised, and information is not freely available. Previous research has shown that almost half of grant recipients found out about the DFG by word of mouth, which does not seem a fair way to allocate public resources⁶³. It means that those who are less well-connected, more isolated, have mental health problems or learning disabilities will be excluded, or only come to the attention of statutory authorities at the point of crisis when adapting the home may be too late.
- 7.17 A study by Northumbria University and the Centre for Ageing Better found that *“People actually don’t know that these services are out there. And also how to access them”*. They added that *“Navigating the route to getting the right adaptations in place for the right person can be a challenge. If professionals working in the field are unable to find their way through a system, then how can we expect non-professionals to manage it?”*. They recommend that local authorities simplify the process of getting help and advice⁶⁴.
- 7.18 Even when people get into the system, it is difficult to navigate. It crosses administrative boundaries and few authorities have ways of ensuring that one member of staff handles the case from end to end. There may be waiting lists at each stage of the process. Few authorities or home improvement agencies have online assessment systems which might speed up the process and allow people to understand more about what the adaptation process entails.
- 7.19 The Lightbulb Project is an integrated adaptation service that is discussed further in Part B. A customer insight project was carried out in 2015. This revealed that health, housing and social care are not seen as separate services, and 95% of respondents wanted a joined-up approach and less people to deal with.
- 7.20 In addition, filling in the application forms is not simple. Since 2008, LAs have been able to develop their own more ‘user-friendly’ and less bureaucratic forms. However, this has been very slow to change. In 2016, a Foundations FOI identified that 45% of authorities were still using the old ‘prescribed form’. This makes it difficult for those less able to deal with complex paperwork.

⁶³ Mackintosh, S. and Leather, P. (2016) *ibid*.

⁶⁴ Centre for Ageing Better (July 2018) Homes that help: A personal and professional perspective on home adaptations. <https://www.ageing-better.org.uk/sites/default/files/2018-07/Homes-that-help-research.pdf>.

The suitability of the six-month time limit

- 7.21 Cerebra and students from The University of Leeds explored the application process⁶⁵. The 1996 Housing construction and Regeneration Act, Section 34 requires housing authorities to approve or refuse a grant application as soon as is reasonably practicable and not later than six months after the date of application. Under Section 36 the actual payment of the grant may be delayed until a date not more than 12 months following the date of the application.
- 7.22 The Cerebra evidence suggests that some local authorities frustrate this process by: not making the forms available until social care departments have provided supporting evidence; delaying the pre-application process by a shortage of assessors; or advising potential applicants that the budget for the year has been spent and deferring applications until the following year. The 2013 good practice guide states clearly that the six and 12-month deadlines are the maximum, rather than the norm, and that a delay of 12 months is exceptional and contrary to the intention of the DFG programme⁶⁶.
- 7.23 A report by Leonard Cheshire in 2015 found that a third of authorities had failed to approve DFGs within the statutory period of 6 months and that about 4,000 people waited longer than they should have for a decision⁶⁷. About 2,500 waited more than a year for a decision, and almost half of councils had examples of people waiting for more than two years.
- 7.24 The good practice guide points out that the legislation allows an individual to complete and lodge an application themselves or with the help of a third party. Authorities cannot put obstacles in the way of this process and must consider any application that has been made.
- 7.25 Cerebra sent out a FOI in November 2017 to 54 local authorities comprising a mix of district councils, metropolitan authorities, unitaries and London Boroughs. By March 2018, they had received 43 responses. Just over half (53%) said they made DFG forms freely available, but several said this was only after an occupational therapy assessment, a referral, or a HIA visit. Only 7% had forms available online. The difficulties in obtaining a form was indicated by the fact that only 42% of the authorities sent a copy of the form to the researchers as directly requested in the FOI. It was noted that several of the forms received appeared '*inappropriately complex and demanding*'.

⁶⁵ Clements, L. and McCormack, S. (July 2018) The accessibility of Disabled Facilities Grant application forms in England. Leeds: University of Leeds, Access Committee for Leeds.

⁶⁶ Home Adaptations Consortium (2013) Home adaptations for disabled people: a detailed guide to related legislation, guidance and good practice, Nottingham: Home Adaptations Consortium. <http://careandrepair-england.org.uk/wp-content/uploads/2014/12/DFG-Good-Practice-Guide-30th-Sept-13.pdf>.

⁶⁷ Leonard Cheshire (2015) *ibid.*

7.26 The Cerebra research recommends that the Government provide explicit guidance, or issue regulations under section 2(4) of the 1996 Act, to ensure local authorities provide a statutory application form.

The impact of delays

7.27 Delays and complexity make the DFG process very frustrating for disabled and older people coping with the inaccessibility of their homes and the indignity of not being able to wash or use a toilet unaided. Where people are in pain or have depression, their medical problems may be made worse. Problems are particularly acute for people with life limiting conditions. Research by DEMOS for the Motor Neurone Disease Association (MND) suggested that in many authorities there was little understanding of the needs of people with MND, and no fast-track process for people with rapidly deteriorating conditions⁶⁸.

7.28 The results of the BATH-OUT randomised control trial suggest that physical wellbeing slightly worsened while older adults were waiting for adaptations but improved once the shower was installed⁶⁹. There was also a difference in mental wellbeing between those who had had an adaptation and those who were still waiting. Fear of falling got slightly worse during the waiting period but decreased once people had the shower fitted⁷⁰.

7.29 On average, there was only a three-month delay between the intervention group and control group in the BATH-OUT study. The delays that most people experience before they get an adaptation installed in many local authorities is considerably longer. The BATH-OUT findings indicate a potential decline in physical and mental function during that waiting period, although this requires further evaluation. Focussing on prevention and speeding up the process are therefore key recommendations of this review.

Summary of issues - processing arrangements and waiting times

- Most DFGs are delivered using a 'traditional' process. This is complex, slow and difficult to understand from a user's perspective.
- There is seldom a single point of contact for the service user despite this being an obligation in the 2014 Care Act.
- Services cross administrative boundaries which make it difficult to determine end to end times.

⁶⁸ Vibert, S. (2017) MND Costs: Exploring the Financial Impact of Motor Neurone Disease, London: DEMOS. <https://www.mndassociation.org/wp-content/uploads/DEMOS-FULL-report.pdf>.

⁶⁹ Whitehead, P. et al. (2018 in press) *ibid*.

⁷⁰ NB – confidence intervals were wide and non-significant as this was a pilot study and the sample size was small.

- Customers do not understand these administrative divisions and want services that are simpler, quicker, more joined-up and with fewer people to deal with.
- The time from approval of grant to completion of work varies considerably between authorities. Those authorities using an RRO policy appear to be processing cases more quickly.
- Some authorities seem to be manipulating the application process to manage waiting lists and demand and very few have simple application forms that are easily available.
- Delays appear to have a detrimental effect on health, mental wellbeing, and fear of falling, even over a three-month period, although this needs further research.
- A quarter of authorities responding to the consultation have developed more integrated processes and most authorities see this as the way forward.

Part B

How the DFG should change

“With a bit of courage and innovation, we have a chance to improve a system that, when it works, dramatically changes disabled and older people’s lives for the better.”

Papworth Trust 2012.

Chapter 8. Introduction to Part B

- 8.1 In 1994, not long after the DFG was introduced, Heywood said that *“the difficulty in writing about adaptations is that the systems for arranging them are so complex; many people are involved, working for different organisations, with different budgets and practice varies greatly from area to area”*⁷¹. Unfortunately, this is still true.
- 8.2 This is a practical review that aims to simplifying the process for the customer. The intention is to make recommendations that will work in all areas, despite the fact there is a huge range of authorities from small districts to large unitaries, each starting from a different baseline.
- 8.3 It must be emphasised at the outset that the review confirms the need for the DFG to remain a mandatory grant. It is essential that disabled and older people everywhere can get the help they need to remain living in their own homes.
- 8.4 During the course of this review we met a lot of very committed people delivering home adaptations but having to work around outdated regulations. There is a need to bring the regulations and guidance up to date, and to ensure that the flexibility given by the 2002 Regulatory Reform Order (RRO) is used to provide people with a more holistic service. It is no longer just about the delivery of showers, stairlifts and ramps, but joining up a range of services to give disabled and older people a more independent life.
- 8.5 In Scotland, a working group was established in 2011 to review adaptations practice and propose recommendations. In the 2016 report ‘Adapting for Change’⁷², they set out core principles for developing the adaptations service of the future. Altered slightly and expanded, these principles also apply to England:
- The person and their carer(s) should be placed at the centre of service provision and be in control.
 - Support for adaptations should have a prevention focus.
 - Adaptations should promote enablement.
 - Access to assessment and provision should take account of need and be fair, consistent, reliable and reasonable and take a holistic view of a person’s life.
 - Assessment and access to financial and other non-financial support for adaptations should be equitable, fair, anti-poverty and complement systems for personalised support.
 - It is essential that housing services are coordinated with health and social care to achieve joined-up, person-centred approaches.
 - There should be strategic oversight and a focus on outcomes that feed back into continual service improvement.

⁷¹ Heywood, F. (1994) Adaptations: finding ways to say yes, Bristol: SAUS Publications, p.5.

⁷² Scottish Government (2017) Evaluation of Adapting for Change, Edinburgh: Scottish Government. <http://www.gov.scot/Resource/0052/00524668.pdf>.

The structure of Part B

- 8.6 The first section of Part B looks at the context in which the DFG is now operating. Proposals are made for a new form of strategic oversight to drive forward changes in the way the DFG and adaptation services are delivered in both unitary and county authorities. It links the governance of adaptations more firmly into the Better Care Fund (BCF), or any new funding system that replaces the BCF, and gives a clearer role for Health and Wellbeing Boards (HWBs).
- 8.7 The customer journey is very much faster in places that have joined up elements of service delivery. Evidence from good practice examples is used to demonstrate how the process could be improved in both unitary and county authorities. There are also recommendations about new ways for staff to work together to provide person-centred and consistent solutions and for the DFG to be better linked to health and social care to provide a more preventative and holistic service for disabled and older people.
- 8.8 The distribution of DFG resources nationally does not always relate to need, with budgets under greater pressure in some areas than others. Options are presented about how the national allocation formula can be updated to provide a more equitable distribution. It looks at how risk can be shared better between authorities, particularly for more expensive adaptation cases. There is a role for other funding sources where adaptation work relieves pressure on health and social care. There is also a need for better integration with social care budgets, such as the Integrated Community Equipment Service (ICES).
- 8.9 The regulatory framework is also part of this review. The current £30,000 upper limit needs adjusting to account for inflation and to better reflect the cost of work. The means test also needs to be updated. Options are given to show the effect of taking into account changes to benefits or matching the DFG means test to that for social care. Other aspects of regulation and guidance are discussed such as developing an RRO policy or including warranties in the DFG.
- 8.10 Linked to changes in the way services are delivered is the need for transformation in the design of adaptation solutions and the use of more innovative products for the next generation of disabled and older customers. There are opportunities for DFG spending power to be used to shape the market and drive innovation. This leads into a discussion of how people who are not eligible, or chose not to use the DFG, can be helped with advice, information and support and how it might be delivered.
- 8.11 The last section gives recommendations for improving adaptations delivery in different tenures and looks at the impact of the introduction of Section 36 of the Equality Act 2010 for people living in accommodation with communal areas.

Chapter 9. The bigger picture

“Fundamental reform is the only way that the preventative benefits of home adaptations can be achieved nationally and the long-term cost savings for health and social care realised. Anything less than major reform, we believe, would just be a ‘sticking plaster’ on a failing system.”
Papworth Trust 2012⁷³

- 9.1 As Section A has shown, although there are pockets of good practice, the process of grant delivery is not working effectively in most areas. A high proportion of disabled and older people do not know about the grant; it is split between administrative organisations, it is too slow, and too many people drop out of the process (about 35% of applicants on average), often without recourse to other forms of assistance. What people want is an easy to access, simple understand, responsive service where they can get advice, information, funding and practical help within a reasonable timeframe.

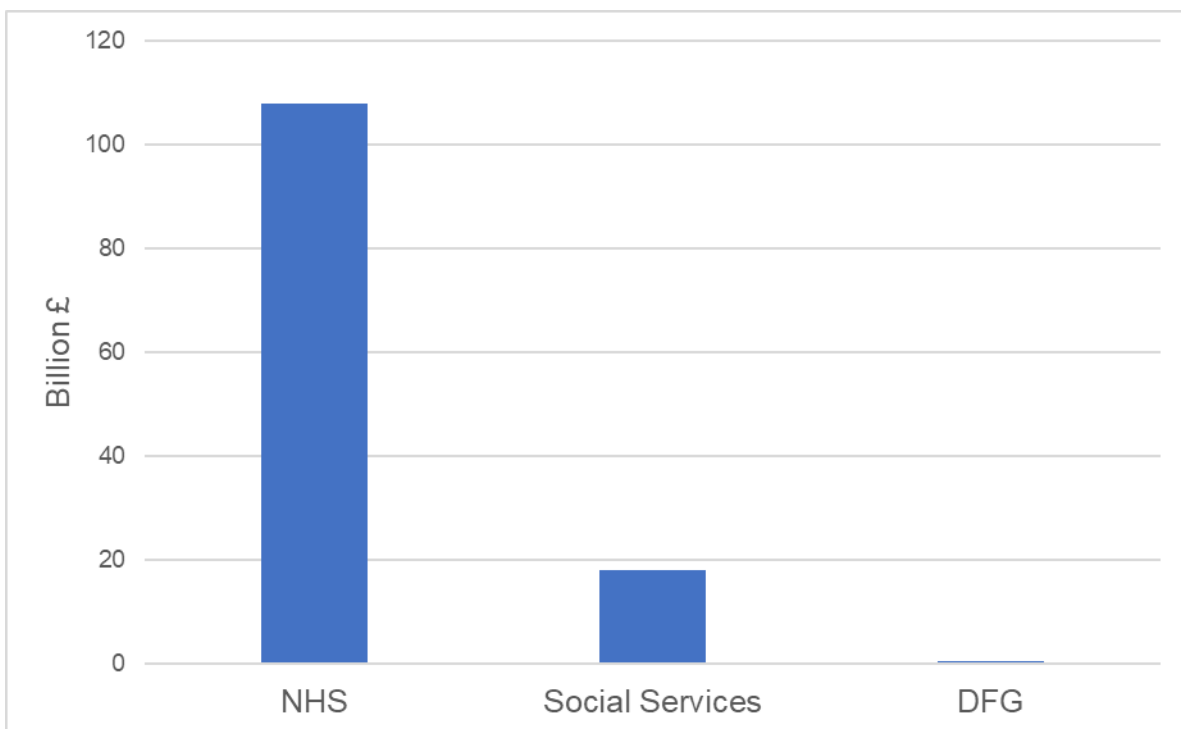
The Disabled Facilities Grant - a hidden service

- 9.2 A key reason for the difficulties in the operation of the DFG is the split in responsibilities. Housing authorities have the mandatory duty for the DFG, but social care has the ultimate duty for disabled and older people as well as disabled children. The DFG legislation requires the housing authority to consult the social care authority, resulting in occupational therapists in social care handling the first part of the customer journey with a handover to the housing authority to complete the work. There is no service with overall responsibility. This means that in many areas the DFG is effectively hidden, as there is no single senior strategic manager speaking up for it, and it has become so complex that people outside of the service do not understand it.
- 9.3 Joining up services was recommended in the 1996 circular on private sector renewal and in the 2005 review. It is time it actually happened. Disabled and older people deserve a better service, and it requires stronger strategic oversight to drive reform.
- 9.4 It has been difficult for central government to reorganise DFG services over the last decade. Policies such as localism and devolution have put the focus on place-based decision-making and reduced the ability of central government to provide strong guidance.

⁷³ Papworth Trust (2012) Home solutions to our care crisis, Cambridge: Papworth Trust.
https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/homesolutionstoourcarecrisis.pdf.

- 9.5 In the media, the discourse about housing and local policy-making tends to be dominated by new-build and development issues. Few people understand what a small proportion new-build adds to the stock each year, or that disabled and older people are mostly in the existing stock (over 90%) not in specialised accommodation. These misconceptions further disadvantage the DFG in the policy arena.
- 9.6 Integration planning for health and social care might have been expected to give greater prominence to safe and accessible homes, but Figure 9.1 shows that the DFG is dwarfed by the funding available to health and social care. As it is a comparatively small budget, it has been all too easy to ignore its importance, especially when social care and health services have been under so much pressure. It has not been enough to provide more funding for the DFG. To create fundamental change in the way that it is delivered requires much stronger strategic oversight to give more importance to the role of housing in the delivery of health and care services.

Figure 9.1 The comparative size of health, social care and housing budgets 2018/19

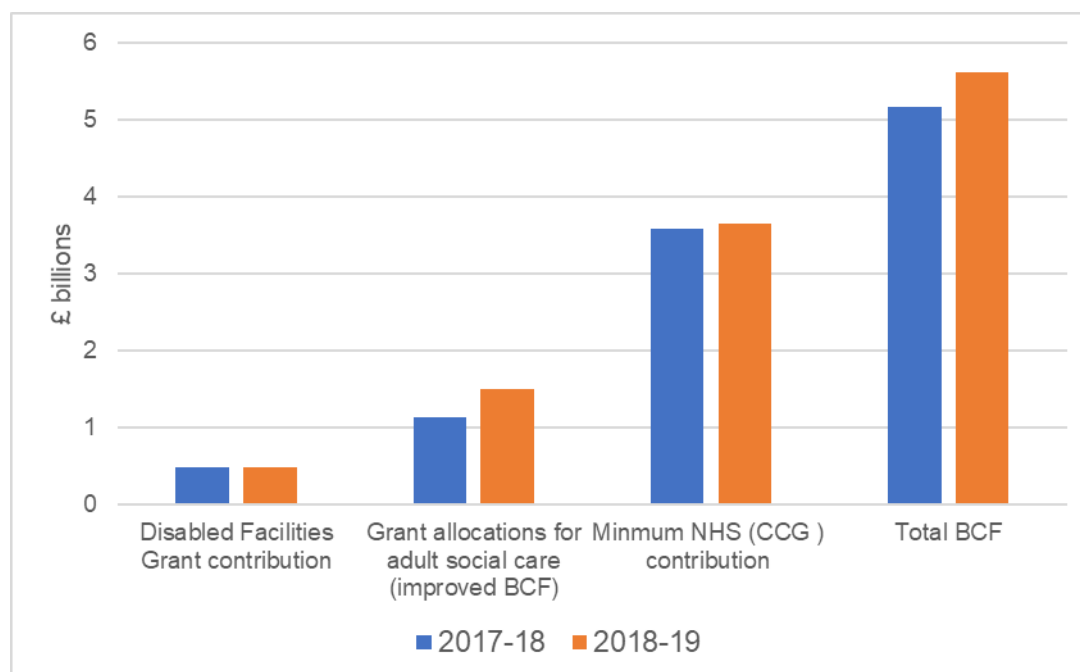


DFG and the Better Care Fund (BCF)

- 9.7 The DFG has been part of the Better Care Fund (BCF) since it first began in April 2015. This seemed like a better home for the grant and a way of bridging the boundaries between housing, health and social care. But, perhaps inevitably, the

focus of the BCF has been on short-term health and social care interventions to speed hospital discharge, or to reduce accident and emergency attendance and admissions to care homes. Although the DFG can be delivered fast, it is mainly about prevention and medium to long-term solutions. Added to that, it is only a small part of the fund and the BCF did not require statutory reporting of housing outcomes, which gave it little prominence in health and care planning (Figure 9.2).

Figure 9.2 DFG as a proportion of the Better Care Fund 2017-19



Source: Department of Health (2017) 2017-19 Integration and Better Care Fund: Policy Framework⁷⁴

9.8 A report by the National Audit Office in 2017 said that although the BCF was the principal integration initiative, it had still not achieved its potential to produce substantial cost savings or reduce acute hospital activity. Where the BCF had delivered the greatest success was in incentivising local areas to work together, although local authorities' engagement in planning and decision making was variable⁷⁵.

9.9 Each county and unitary authority has a Health and Wellbeing Board (HWB) which brings together key health and social care commissioners with the local Healthwatch. They have responsibility for signing off BCF Plans. The BCF planning documents say that "*Housing authorities should be involved in the*

⁷⁴ Department of Health (Mar 2017) 2017-19 Integration and Better Care Fund: Policy Framework https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf.

⁷⁵ National Audit Office (2017) Health and social care integration. <https://www.nao.org.uk/report/health-and-social-care-integration/>.

*development of the BCF plan elements related to housing and DFG*⁷⁶. However, there appears to be little representation of housing on HWB boards, or on the BCF committees that feed into these boards, which has made it very difficult for the role of the DFG to be fully understood and appreciated.

- 9.10 A further complication in the original structure of the BCF is that it did not include the already well-established, joint health and social care budget: the Integrated Community Equipment Service (ICES) which funds equipment and minor adaptations. This seems a significant oversight. It is very difficult to develop joint working without the DFG and ICES being considered by the same oversight body. Reablement services were included in the BCF, but they do not typically use the DFG; instead, they use ICES funding to supply the short-term needs of people coming out of hospital.
- 9.11 In contrast, community occupational therapists rely on both ICES and DFG funding, as most disabled people needing their home adapting require a range of services including: equipment, such as specialist beds, perching stools, or walking aids (ICES budget); minor adaptations such as grab rails or stair rails (ICES or part of DFG budget); alongside more major works, such as showers and stairlifts (DFG budget). A few areas chose to include ICES in the BCF to provide more integrated services (such as Worcestershire, Warwickshire, Camden, and Norfolk) but it was not a statutory requirement.
- 9.12 The Audit Office report agreed that that ‘place-based planning’ was the way forward but that local areas were not on track to achieve the target of integrated health and social care by 2020. The BCF will remain in place until 2019-20 and it will be reassessed at the next Spending Review. Local partnership working in some form seems set to continue. The aim of this review is to ensure that, whatever funding and organisational structure is in place, there is a clear focus on helping people to live well for longer in their own homes.

Strategic oversight

- 9.13 A new strategic oversight structure is needed to provide clear responsibility for planning adaptation services, setting priorities and making services accountable for performance delivery and outcomes. The best way of delivering this is through a formal partnership between the local housing authority, health authority and social care, as has happened in Scotland and has been proposed in Wales.

“When the partnership approach works well, and in particular where all the necessary services are round the table and are engaged and committed participants, the approach not only supports positive change in the field of adaptations but can radiate out and have a positive effect across a range of housing, social care and health functions. Building new working relationships and an increased understanding of others’ roles

⁷⁶ NHS England (Aug 2017) *ibid.*

was at the heart of this very positive outcome". Scottish Government (2017) Evaluation of Adapting for Change, p.18⁷⁷.

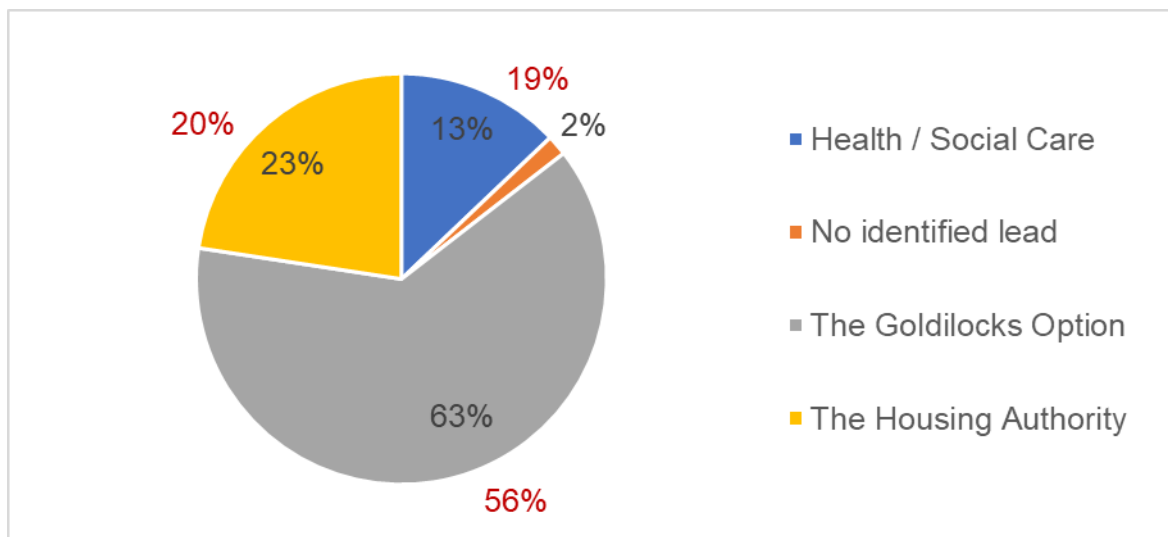
"Effective partnerships allow delivery organisations to make the best use of their resources to maximise impact and value for money. To be truly effective, organisations should therefore seek to align activity and work in partnership." Wales Audit Office (2018) Housing Adaptations⁷⁸.

The options for strategic oversight

9.14 The consultation process for this review focussed on four options for strategic oversight: having no identified lead as now; the housing authority being the lead; health and social care being the lead; or a partnership of housing, health and social care. This latter option was termed the 'goldilocks' option because it appears to be the only one that brings all the key players together. In the goldilocks story there were three bowls of porridge, one that is too hot, one too cold and another that is 'just right'. In this situation, if housing or social care take the lead, it could perpetuate service divisions. However, bringing in health creates a more balanced 'just right' solution.

9.15 Almost two thirds (63%) of those at the workshops thought the 'goldilocks' option should be the way forward, although slightly fewer (56%) of those providing returns online favoured this option. The other alternatives were either housing or social care as the lead, with slightly more favouring the housing authority, particularly at the workshops (23% for housing compared to 13% for social care) (Figure 9.3).

Figure 9.3 Options for strategic oversight



Source: voting at consultation events / online survey

⁷⁷ Scottish Government (2017), *ibid.*

⁷⁸ Wales Audit Office (2018) Housing Adaptations, Cardiff: Wales Audit Office.

<http://www.audit.wales/publication/housing-adaptations>.

9.16 Table 9.1 outlines the advantages and disadvantages of each option. There were a lot of written comments in response to the online survey about the issue of strategic oversight, with the majority (118 responses) commenting about the 'goldilocks option'. Most respondents said that housing and social care need to work together to facilitate integrated solutions alongside health. There was a strong feeling that housing must be the key partner at strategic and operation level, and that the housing authority needs to be a statutory member of HWBs. However, many respondents added the caveat that it was not always easy to get joint working and that it requires strong leadership.

Responses to the online survey about partnership working

"In our authority, a specialist service was created 20 years ago where housing and social services were brought together to work together on adaptations. This has proved hugely successful. We all now sit under Social Care and will be integrating further with the NHS from 1st April 2018."

"I accept (as a Housing Authority) that Social Care have a huge part to play in the system. Bringing the two tiers together in this way (and at an operational level too) has great benefits."

"Collaboration and an integrated service are the only way to streamline the process."

"No one department has statutory responsibility for, or knowledge of, all parts of the process of providing housing and adaptations that are fit for purpose. Collaboration and effective strategic partnership is only effective way forward."

"No single organisation has all the necessary skills to oversee this - a partnership approach if managed effectively works very well - although it has its challenges and relies on individuals to make it work".

"It seems like a fairy tale that such an approach could be possible because of everyone protecting "their own" budgets but actually if the decision makers/budget holder's hands were forced to work together by a change to the strategic oversight then in the longer term I think this would be the best outcome for all parties."

"There needs to be a holistic, whole house approach to assessing a person's needs and so we cannot get away from the need to involve both the housing and social care sectors in strategic oversight."

"Goldilocks solution is best as it encourages consideration of the most appropriate solution to meet needs. In some cases rehab/re-ablement/equipment/rehousing would be a more appropriate way to meet presenting need."

"I've worked in a two-tier authority and currently for a unitary managing the DFG programme. Neither system appears to work properly, there are still silos. The Goldilocks Solution appears in principle to be a way forward, subject to Management "buy in" and accountability."

"This option has the potential to be confusing though and will need very clear roles and leadership if it is to be successful and improve upon current processes and timescales for delivery. The devil of this will be in the detail and that could benefit from very much more unpicking and consultation."

Table 9.1 Four options for strategic oversight

Lead authority	No identified lead	Housing authority	Health and social care	Partnership - 'goldilocks' option
	Continue as at present with no oversight of the whole DFG process.			
Advantages		Has the statutory duty for the DFG and already oversees home adaptation programmes.	Care Act responsibilities for disabled and older people - and under the Children Acts for disabled children	Formal strategic partnership between housing, health and social care
		Retains link to other housing services - housing options, private housing, homelessness and planning.	Link to equipment and minor adaptations provided by ICES funding and to other aspects of care in the home	Oversight and co-ordination of adaptations, equipment, housing options, planning etc.
			Directly benefits from investment in adaptations and could more clearly develop a business case for expensive adaptations.	Recognises the knowledge and expertise that each contributes
			Already covers county areas - would not require another layer of strategic management	Maintains the housing authority as the lead with statutory duty for the DFG but involves all key players
Disadvantages	Complex process, varies between authorities, high drop-out rate and often slow.	More difficult to develop links to equipment, minor adaptations, telecare and care services for disabled and older people.	Would not have such clear links to housing and planning policies	It involves the creation of a new layer of strategic oversight
		Although the housing authority provides the investment it does not receive any direct financial benefit	Health and social care under considerable financial strain – have more pressing concerns than the DFG. Concern that DFG budget would be 'swallowed up'.	Would require housing to have a more major say in the BCF and HWBs.

- 9.17 Consultation with the national organisations representing local authorities gave a largely positive response to joint working. A County Council's Network representative said that they would like to see a single policy across county and unitary authorities based on the needs of locality with the policy reviewed annually to ensure flexibility and adjustments of budget allocations and priorities. The Association of Directors of Adult Social Services (ADASS) referred to the Secretary of State for Health's seven principles for reforming adult social care which includes 'whole person integrated care' and said that, "*delivering a seamless service that wraps around the individual requires greater coordination and strategic leadership across social care, health and housing across every local authority area.*"
- 9.18 The Local Government Association added that "*councils must have the flexibility to ensure that funding can be directed towards meeting the health and care needs of their residents, without overly prescriptive national requirements which might adversely affect local impact and innovation.*" Councils will want to ensure that BCF plans support housing as a central component in improvements in people's health and wellbeing with a shift to a more preventative approach, and HWBs need to be fully involved in shaping, approving and monitoring plans.
- 9.19 The only organisation not in favour of a 'Goldilocks' partnership option was the District Council's Network (DCN). They were supportive of models which increase the efficiency of the DFG locally and were person centred. However, they felt that the housing authority was best placed to take the lead on preventative action because of their statutory duty, the range of housing services they deliver and their role in community leadership. If districts were to be part of a county-wide body, there was "*potential for funding to be subsumed into the acute end of social care.*" They felt that oversight sitting with HWBs would not be appropriate, as they covered much larger areas and would not be able to respond to the needs of each locality. They were also concerned about adding another layer of bureaucracy and about the potential burden on staff of having attend meetings and deal with the administration.

Making partnerships work

- 9.20 The transformation work relating to home adaptations in Scotland shows that any partnership approach is not easy, and that it is hard for partners to let go of the way things have always been done.

"The need to improve adaptations services is a longstanding one, but also an area in which truly transformative change has been very difficult to deliver. The need for sustained partnership working between a range of key services was generally seen as being the single greatest challenge". However, "even when progress has been slow, there have been some signs of attitudes changing even in the

latter stages of the AfC initiative” Scottish Government (2017) Evaluation of Adapting for Change⁷⁹.

9.21 Some areas already have a form of partnership board such as Leicestershire, Lincolnshire and Worcestershire. A national requirement for these types of partnership arrangements, perhaps called a ‘**Housing and Health Partnership Board**’ would encourage their development and strengthen the functioning of these boards.

Existing partnership boards

Leicestershire Lightbulb Programme – is managed by the Lightbulb Programme Board and a Steering Group made up of stakeholders from district, borough and county councils⁸⁰. In the pilot phase, employees were managed by Blaby District Council, but the full service includes an integrated locality team in each district. Funding is pooled, and a central hub provides management support, performance monitoring and service development. The Programme Board and Steering Group were critical to developing the model and funding approach across all the partners.

Lincolnshire Housing Health and Care Delivery Group is a county-wide formal partnership between housing, health and care and reports to the HWB. This provides strategic oversight of DFG policy. It has already had successes in improving the delivery of DFG's and would be the most appropriate way of moving forward. (Response to online survey).

Worcestershire Strategic Housing Partnership – is a county-wide board responsible for co-ordination, commissioning and securing funding for new projects and supporting business as usual. Its priorities are to: a) improve homes and, “transform places”; b) drive the growth of the right type of homes; and c) create a partnership approach to enable people to live as independently as possible through prevention and early intervention. It is supported by five delivery groups, one of which is about independent living. The partnership is underpinned by a local Housing Memorandum of Understanding⁸¹.

⁷⁹ Scottish Government (2017) *ibid*.

⁸⁰ Moran, A. (Jul 2017) The Lightbulb Project: Switched on to integration in Leicestershire, London: Housing LIN.

https://www.housinglin.org.uk/assets/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_135_Lightbulb_Project.pdf.

⁸¹ Worcestershire Housing Partnership Plan 2017

<http://moderngovwebpublic.redditchbc.gov.uk/documents/s27809/170322%20Final%20Worcestershire%20Housing%20Partnership%20Plan%2011d.pdf>.

9.22 One option for the establishment of Housing and Health Partnership Boards would be to **use a similar structure to Local Safeguarding Children's Boards (LSCBs)**. This would need to take account of the findings of the review of LSCBs and look at the flexibility in their composition⁸².

National level oversight

9.23 To make partnership working a reality, central government will need to ensure that a new strategic structure is established as a requirement of DFG funding. The Ministry of Housing, Communities and Local Government and the Department of Health and Social Care will also need to work together to issue guidance about the role of the DFG in the BCF or any successor body after 2020.

9.24 Governance arrangements should be aligned to the process of setting BCF budgets and plans, with Clinical Commissioning Groups, District Councils and County Councils as signatories, ultimately signed off by the HWB.

9.25 Requiring the BCF and HWBs (or any successor bodies) to report on a **metric that relates to DFG outcomes** such as **'the number helped to remain independent at home'** would focus attention on the importance of adaptations and ensure that more weight was given to the DFG in both strategic planning and in reporting of outcomes and impact.

Cultural change

9.26 It is not just about new strategic structures and government regulation. It is as much about cultural change. There are key people in housing authorities and in occupational therapy roles who have spent their lives delivering the DFG. They are some of the most dedicated staff working in the public sector. But it is hard to let go of well-established ways of working. There has already been a lot of reorganisation in local authorities due to austerity, and no additional revenue funding was provided when DFG capital resources were increased.

9.27 Staff will need support to understand what will happen and to be involved in developing new ways of working. However, it is unrealistic to expect them to maintain day to day DFG delivery while at the same time moving to new, more integrated ways of working. Transformation funding and strong leadership support will also be required. Transformation funding is discussed further in Chapter 13.

⁸² HM Government (Mar 2015) Working Together to safeguard children: A guide to inter-agency working to promote the welfare of children, Chapter 3: Local Safeguarding Children Boards. http://www.workingtogetheronline.co.uk/chapters/chapter_three.html.

Recognising the broader role of the DFG

9.28 A partnership board could also allow more holistic, person-centred decision-making. Up until now, the DFG has been largely about fitting showers, stairlifts and ramps. Minor adaptations under £1,000 are delivered separately through the ICES budget, and additional needs, such as telecare, done by other organisations. Decision-making relating to more complex and expensive cases has been hampered by a cost of ceiling of £30,000 that has been too low to deliver effective solutions.

9.29 A stronger focus on helping someone be as independent as possible, wrapping services around the individual and reducing strain on carers, can result in new combinations of work and has the potential to draw in other sources of funding alongside the DFG. Drawing together DFG and ICES budgets into the same funding pot (either the BCF or its successor) will be essential.

- **Wider prevention** – this includes determining local needs, working with other organisations to ‘Make every contact count’ to identify people struggling with their homes before they get to crisis point and looking at the whole situation in the home to provide holistic services.
- **Short-term interventions** - rapid response services to enable someone to come out of hospital or to prevent someone in crisis having to go into residential care by fixing trip and fall hazards, installing minor adaptations, repairing the heating system and providing an immediate deep clean and declutter.
- **Medium-term solutions** – typical DFG provision such as stairlifts and showers, but with a range of integrated services to maintain independence which might include: minor adaptations such as grabrails, key safes; a personal alarm system; other improvements such as repairs or a new heating system; and links to an exercise class or befriending service to improve health and wellbeing.
- **Solutions for people with long-term needs** – may require different solutions and joint working could provide a business case to consider likely health and care savings and draw in funding from other sources including the ICES, wheelchair and telecare budgets.

The need for person-centred services

9.30 As Heywood said in 1994 “*‘good practice’ means ‘good’ from the point of view of those who need adaptations; the users*”⁸³. It is not just about what is expedient from the vantage point of policy makers and service commissioners; it needs to be seen from the customer’s perspective.

⁸³ Heywood, F. (1994) Adaptations: finding ways to say yes, Bristol: SAUS Publications, p.7.

- 9.31 There is some use of focus groups and a few authorities involve users in meetings. However, during the discussions in this review, it was noticeable that very few authorities have carried out service transformations using co-production techniques with the client groups they aim to serve or have user scrutiny groups to drive further service improvements. In addition, few have a policy to directly employ people with impairments who can bring a different perspective to the service. Middlesbrough is an exception; their handyperson team is made up of disabled people⁸⁴.
- 9.32 The place that we are aware of that went through the most comprehensive consultation with disabled and older people prior to transforming services is Knowsley⁸⁵. This resulted in the establishment of a one-stop shop for all services related to disabled and older people including: assessment facilities for adults and children; equipment supply, recycling and repair (including wheelchairs); demonstration space, and the DFG, minor adaptations, HIA and handypersons services for all tenures all under one roof. They also set up a user board which continues to operate. Many of the places that have developed integrated services discussed in the next chapter, such as Leicestershire, have included consultation as part of service planning.
- 9.33 It is recommended that as part of the process to decide which options in this review might be best to take forward, that disabled and older people, their families, carers and organisations that represent them, are fully consulted. Guidance needs to be issued about co-production and consultation techniques to develop integrated local services.

Providing more choice by engaging with housing providers

- 9.34 At present the DFG is mostly about providing adaptations to a disabled person's existing home. However, moving might provide a much better solution, particularly where extensive adaptations are required or where a home is in poor condition. A new partnership board should bring in other housing providers and planners. This would improve local development and customisation of new accessible homes. It would also improve rehousing options by developing adaptation strategies with landlords, aid the establishment of accessible housing registers, and provide more effective matching of disabled people to existing adapted properties. It could also bring more funds into the DFG if registered providers contributed more to DFG funding. This is discussed further in Chapter 17 on tenure.

⁸⁴ Mackintosh, S. and Collingbourne, L. (2016) Home Adaptations for Disabled People Good Practice Case Study: Middlesbrough. <https://homeadaptationsconsortium.files.wordpress.com/2013/10/comeo-of-good-practice-middlesbrough-staying-put.pdf>.

⁸⁵ Mackintosh, S. and Collingbourne, L. (2016) Home Adaptations for Disabled People Good Practice Case Study: Knowsley. <https://homeadaptationsconsortium.files.wordpress.com/2013/10/comeo-of-good-practice-knowsley-centre-for-independent-living.pdf>.

What should the grant be called?

- 9.35 During many conversations we had in carrying out this Review, it became clear that the term DFG is synonymous with the function of funding the installation of ramps, stairlifts and level access showers. This was often unhelpful when trying to develop discussions about more person-centred support and more flexible use of the grant. In addition, potential recipients of the grant do not always want to be labelled 'disabled', they don't necessarily understand the word 'facilities' and even the word 'grant' may have paternalistic connotations.
- 9.36 In the 2005 review it was suggested the name be changed to the 'Accessible Homes Grant' which got considerable support. However, the name Disabled Facilities Grant is defined in legislation which means that changing it is not easy, and it was not taken forward at that time⁸⁶.
- 9.37 A number of authorities have used the opportunity of developing their RRO policy to change both the name of the grant and their service. But there is little consistency. Accessible Homes, Lightbulb, Home Solutions, At Home, Healthy Housing, Safe at Home, Care and Repair and Staying Put are just a few of the options in use across the country.
- 9.38 If we want services to be preventative, we need to ensure that disabled and older people and their families and carers are aware that advice, information and sources of funding are available to help them modify their home. There needs to be more consistency in what services are called. A new national advice service is also needed which should use the same name and branding so that all services dealing with adaptations and accessible homes are instantly recognisable. Home Independence Fund/Grant/Service or Home Adaptation Fund/Grant/Service are just two possible suggestions.
- 9.39 Services should not just be aimed at older people but recognise that there are more people with disabilities of working age than there are in later life, and that families with disabled children are also in need of help. Giving services a more youthful image will also appeal to the generation of people aged 50-70 who do not think of themselves as being 'old'.
- 9.40 The lack of a national brand makes it very difficult for relatives based in other local authority areas to know where to turn to help family members who are struggling with their homes. It is also very important for other professionals in health and social care to know where to signpost patients and service users. Many of these professionals do not know about or understand the DFG, which means that prevention opportunities are being missed.

⁸⁶ Department for Communities and Local Government (2008) Disabled Facilities Grant: Package of changes to modernise the programme, London: DCLG.
<http://www.communities.gov.uk/documents/housing/pdf/dfgpackagechange>.

9.41 Choosing a new name is much more than renaming and rebranding; it underpins an entirely new approach to adaptations and integrated service delivery to help people live independently at home. It needs to be focussed on prevention and have a youthful image which is immediately recognisable and well-known.

Recommendations - strategic oversight

- **A Housing and Health Partnership Board to be established in each area as a requirement of DFG funding with representatives from housing, health and social care.**
- **Each BCF and HWB to report separately on DFG funding and on a new metric on ‘the number of people helped to remain independent at home’.**
- **Housing and Health Partnership Boards to have a similar structure to Local Safeguarding Children’s Boards.**
- **The DFG and ICES budgets to be in the same funding pot (the BCF or its successor) to join up DFG services with equipment provision and minor adaptations.**
- **A single adaptations policy to be developed for each area, based on the needs of the locality, reviewed annually and signed off by the HWB.**
- **A new name for the grant, the services that provide it and the national advice organisation, and for that name to be used consistently across the country.**

Chapter 10. Local delivery

- 10.1 The aims of this chapter are to look at how local DFG delivery can change, and to give practical examples of places that demonstrate ‘what good looks like’. Services are continually evolving and, although no area can be said to have got everything right, some now have very effective services.
- 10.2 Most services have not had access to transformation funding, they have had to adapt services at the same time as continuing with business as usual. Sometimes restructuring has been fragile when the integration of health and social care services, with their vastly bigger staffing numbers, has unwittingly undone changes made to improve the much smaller adaptation service. Austerity and loss of staffing resources have compounded these problems.
- 10.3 Despite the constraints, many areas show that you can make substantial changes to improve the customer journey. By using the flexibilities given by the Regulatory Reform Order 2002, it is possible to provide a much broader range of services. These comply with the 2014 Care Act, Better Care Fund targets and the overall requirements of the integration agenda, while most importantly, giving consumers the streamlined, fast and flexible service that they require.

The need for integrated teams

- 10.4 As Section A showed, most authorities operate ‘traditional’, non-integrated DFG services. In the ‘traditional’ process, referrals come into social care call centres, assessment is carried out by social care occupational therapists, before cases are passed to the DFG team in the housing authority for the means test, grant application, preparation of specifications and plans, and practical help with building and installation work. In the shire authorities, social care services usually sit at county level and housing at district level. But even in unitary authorities, the social care call centre and occupational therapy service are often in different departments from the DFG housing team. In some areas, part or all of the process is handled by an independent home improvement agency.
- 10.5 At the consultation events, 85% wanted an integrated service. Slightly more of the online respondents wanted to keep the traditional service (most of these were based in housing authorities), but even online, three quarters (76%) voted for an integrated process (see Chapter 7, Figure 7.3).

How an integrated team works

10.6 To illustrate what integration means in practice, the simplest way is to show some examples.

HEART - The Home Environment Assessment & Response Team

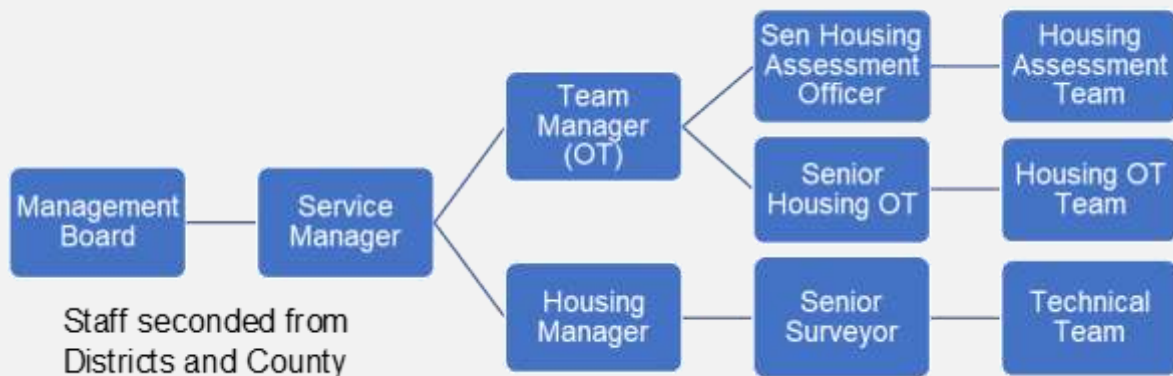
The Home Environment Assessment & Response Team (HEART) in Warwickshire is a partnership between the county and district councils.

Five years ago, the county and districts had competing priorities for the DFG with no overall control of the process. The result was multiple teams all with their own managers, with numerous access points and waiting lists. They mapped the customer journey and found that it was a 220-step process where 35% of people dropped out along the way.

The new service was originally set-up as a pilot in one of the districts, but it is now operating county-wide. Staff have been seconded from district and county authorities into two teams, one operating in the south and one in the north of the county, each with a similar structure (Figure 10.1).

There is an overall service manager, a team manager who is an occupational therapist supporting a housing assessment and occupational therapy team, and a housing manager supporting a technical team. The housing assessment officers are trained to combine the skills of a caseworker, occupational therapy assistant and grant officer which means only one person is needed to follow straightforward cases through from enquiry to completion.

Figure 10.1 Integrated team structure



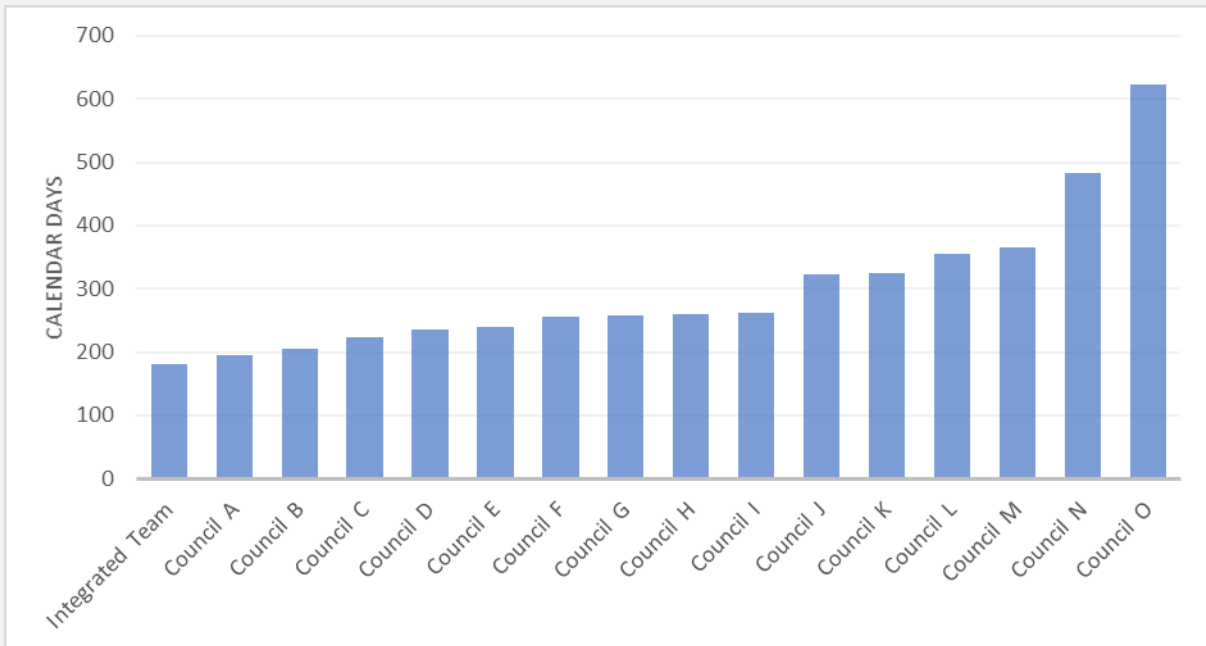
Five years since the first pilot they have a 22-step process, a fully integrated team and a drop-out rate of just 3% (Table 10.1). There is a shared understanding of what they are trying to achieve and a strategic direction. A single access point means enquiries and referrals come directly into the service and can be routed to the person with the right skills. More complex cases are directed to senior members of the team, but the

majority are handled by the housing assessment team. Time from first enquiry to completion has reduced significantly and the average completion time is now six months. In benchmarking against similar authorities, they were the fastest (Figure 10.2).

Table 10.1 Results of integration

Prior to integration	After integration
Multiple teams, managers, offices, access points, waiting lists	Single access point and one contact throughout the customer journey Use of multi-skilled workers makes single contact easier to deliver
Competing priorities, no overall ownership	The team has a shared vision, goals and strategic direction.
220 step customer journey	22 step customer journey
35% drop out rate	Dropout rate fell to 3%
	Quicker end to end completion times than equivalent authorities

Figure 10.2 Benchmarking end to end times - enquiry to completion



The aim is not just to provide standard DFGs, but to give advice and assistance to deliver disabled adaptations and home improvements that keep people safe, secure

and warm in their own homes. HEART provide smaller equipment and adaptations, like bath boards and stair rails, help with general repairs, and advice and support to move where this is a better alternative. They recognise that the DFG is a part of a patchwork of funding and services that people need, and that a ramp or a stairlift in isolation is unlikely to deliver the best outcomes.

In terms of revenue costs, the new approach appears to be cost neutral, but as 30% fewer people drop out they are delivering more cases for the same money. The result is that Warwickshire, as a county authority, is now far more integrated than many unitary authorities.

Transformation lessons:

- **Disagreement is inevitable** - there will be disagreement in any partnerships - senior leadership teams recognised that working together was the only way to meet the needs of residents.
- **It takes time** - to pilot new processes, train staff and embed the changes.

Dorset Accessible Homes Service

Dorset is a rural county with an ageing population. They realised that services needed to change to meet the demographic challenges and went through a two-year process of consultation and restructuring. Their integrated service went live in April 2015 covering six districts and two boroughs. The urban area of Bournemouth and Poole has retained its own separate service.

The Dorset service is delivered by co-located teams from two offices in Dorchester and Blandford Forum. It combines the ICES and DFG budgets to provide: advice and information, alternative accommodation options, assistive technology and telecare, minor repairs and adaptations, major adaptations, a handy van service and a safer home initiative. There is also a fast track service to facilitate hospital discharge.

The benefit is a seamless, joined-up approach to service delivery between partner agencies. It is preventative as people can self-refer into the service. They get a choice of options at an early stage, the support to exercise that choice, quick delivery, a single point of contact, and good feedback about progress.

The service has two 'Mi-life centres' where people can see and try bathing and shower products, a stairlift, an adapted kitchen, furniture, home equipment, mobility equipment, telecare and assistive technology products. This is complimented by frequent pop-up events across the county to raise the visibility and awareness of the service and what solutions are available - delivered by a mobile demonstration vehicle with clinical staff.

A bespoke IT system provides secure data transfer and allows staff to see the whole customer journey. It also allows effective outcomes and performance measurement.

Transformation lessons:

- **Communication** - with so many organisations involved it is important to check that messages are reaching everyone and that those messages are understood.
- **Cultural change** - new ways of working, pooled budgets and use of trusted assessors may all be resisted.
- **Understand partner's needs and motivations** - and be aware of other changes going on elsewhere as part of the integration of health and social care.

The Leicestershire Lightbulb project

The Lightbulb model aims to save time for customers and provide efficiencies for all the organisations involved. The original process for assessing and installing a stairlift had 24 stages with 8 handoffs which is now 9 stages with only 2 handoffs. Assessing and installing a level access shower had 27 steps and 9 handoffs which has been reduced to 13 stages and 5 handoffs.

They obtained a £1m Transformation Challenge Award from MHCLG which allowed development of pilot projects which have now been rolled out across the county. It is delivered through a 'hub and spoke' model:

- Each district council has an integrated locality team offering: minor adaptations and equipment, DFGs, other housing support such as warmth, energy efficiency and home security, assistive technology and falls prevention, housing options advice, and other housing related advice, information and signposting.
- A central hub provides management support, performance monitoring and development support.
- Similar to HEART they created a new role of Housing Support Co-ordinator combining technical and casework skills to provide one point of contact for customers.
- A 'Housing MOT' provides customer focussed assessment and solutions.
- They also work with other organisations such as community fire and rescue who carry out home safety checks.
- A Hospital Housing Enabler Team based in acute and mental health hospital settings helps resolve housing issues that are a potential barrier to discharge and provide low level support with the transition home.

A 'Lightbulb funding pot' combines existing resources across adult social care and district councils, including the DFG. Staffing levels are based on analysis of need across the county and assumptions about any increase in demand relating to the new service offer. Delivery costs, including the Hospital Housing team, are approximately £1m per year compared to a potential £2m per year saving to Leicestershire and the wider health economy.

Transformation lessons:

- **Clear communication** – this is vital

- **Be prepared to work across boundaries** - structural, administrative and geographical.
- **It needs active leadership from partners** who should meet regularly to oversee the project, provide strategic direction, sort issues and remove barriers.
- **Get agreement on information sharing and how to deploy IT**
- **Robust performance monitoring and reporting** is essential to demonstrate the impact of the project, generate 'buy-in' and help obtain secure funding.
- **Everyone needs to be flexible**
- **It takes time and tenacity** - once people begin to see results and benefits the new service can really start to develop.

10.7 The examples above are all from county authorities and show what can be achieved when DFG services that were originally split at district and county level are brought together. The transformation process should be easier in unitary authorities, but there are still barriers when services are divided between social care and housing.

10.8 It is useful to look at how this has been achieved in Salford because it illustrates what can happen as health and social care become more aligned. Here the adaptation service was already integrated as it was based in social care, but it has now moved to health. This has allowed different services supporting disabled people to be brought together in a way that makes much more sense for the customer. This is a model that may work in other areas going through a similar process of merging of health and social care.

Salford Accessible Accommodation Team - transformation and integration

Salford Care Organisation - part of the Northern Care Alliance NHS Group

Background: In July 2016 Salford City Council Adult Social Care (ASC) services transferred into Salford Royal NHS Foundation Trust to integrate health and social care. This included the Accessible Accommodation Team (AAT) responsible for managing and delivering adaptations for disabled people.

The AAT has been managed within ASC for several years and has a single Head of Service responsible for Social Work, Adaptions, Community Services and Therapy. The Principal Manager for AAT also manages the Occupational Therapy Service, Equipment Services, Wheelchair Services and Care on Call Service.

There are other services co-located in the building alongside ATT. These are the Sensory Team, Intermediate Home Support Service, Paediatric Services, Community Rehabilitation Team, the charity Disabled Living and a private retailer

Ableworld. This ensures closer working arrangements so that people with disabilities have improved service provision and clearer pathways.

The ATT service works in partnership with a number of agencies including the local handyman service which installs grab rails and banister rails along with minor home repairs and building maintenance works. Affordable warmth and heating replacements are referred to the Local Energy Advice Program. The ATT can also help residents access loan assistance through a commissioned provider regulated by the Financial Conduct Authority.

Customer pathway and outcomes: The adaptations pathway has been streamlined. Adult Social Care has developed a Centre of Contact 'open referral model' supported by Customer Care Officers, Social Workers, and Occupational Therapists. Health professionals such as District Nurses and Intermediate Care Clinicians will eventually be included in this team. They provide information and advice on the complete range of services. Adaptations are considered at the earliest opportunity. The AAT service provides more specific advice and information on adaptation work, specifications and suitable contractors.

The AAT team is looking at their systems and processes to ensure the service continues to be person centred. The prevention agenda is very important, and they are working to improve outcomes for people that promote independence. They know they need to capture more about health and wellbeing outcomes post intervention and work is going on to develop a new outcomes model.

To ensure that people with disabilities have a voice, their views, aspirations, strengths, problems and issues are discussed during the assessment process to establish an accurate picture of their circumstances. This also involves talking to carers, significant others and professionals. People also have access to an advocacy service if needed.

Powers provided under the Regulatory Reform Order are reviewed periodically to ensure assistance is flexible enough to deliver better outcomes for individuals and supports the priorities of the Health and Social Care prevention agenda. A recent example has been to increase access to adaptations to prevent falls.

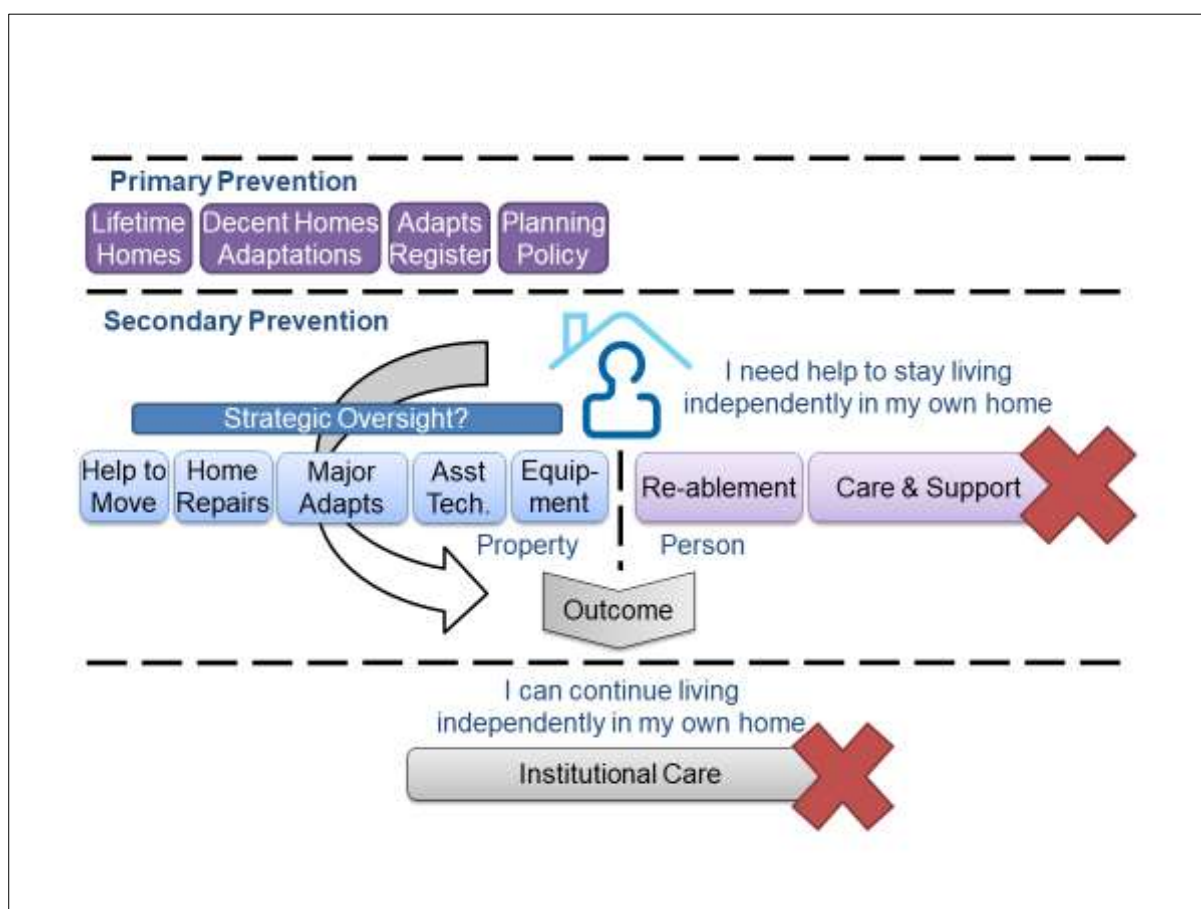
Strategic management: Budgetary responsibilities are overseen by the Head of Service who has a remit for a wide range of funding streams. This allows for other funding beyond DFG to be considered when required, including community care provision such as equipment, home support services and personal budgets.

There is a governance framework in place that ensures accountability and transparency. This covers consistent management, cohesive policies, guidance, processes, decision-making responsibilities and proper oversight by relevant managers. The AAT service is governed by the Integrated Care Division Provider Board, which is overseen by the integrated advisory board and committees from Salford City Council, Salford Royal NHS Foundation Trust, Salford Clinical Commissioning Group and relevant stakeholders.

Key elements of integrated services

- 10.9 The key finding from these examples is that service integration, even across large rural county authorities, is possible. There are different models, but they have many elements in common including:
- **A strategic partnership board and a strategic plan.**
 - **Linked services** using the ICES and DFG budgets, but with the potential to include additional funding.
 - **A single access point.**
 - **Integrated teams under a single manager** which includes staff with occupational therapy and technical skills.
 - **A new cross-trained staff role** combining trusted assessor, grant officer and casework skills to provide better customer support.
 - **An RRO policy** to provide fast, flexible DFG solutions tailored to the needs of the locality (this is discussed further in Chapter 15 Regulation)
 - **Preventative services** providing advice, information and housing MOTs.
 - **A range of wrap-around services** for the customer including: alternative accommodation options, assistive technology and telecare, minor repairs and adaptations, major adaptations, a handyperson service, energy efficiency, a safer home initiative and a fast track services for hospital discharge.
 - **Effective end-to-end IT systems** using bespoke systems and/or NHS numbers and data sharing protocols.
 - **Effective reporting on outputs, outcomes and impact** and use of this information to continually improve the service.
- 10.10 The results show that fewer people drop out, there are less steps in the customer pathway, handovers are minimised, and services are much quicker. Customers don't get lost in the system but have a single point of access and a contact person to call if they have a query.
- 10.11 It should be noted that the legislation still provides the right for people to make an application in their own right. While this is a small minority, this right would still remain.
- 10.12 Figure 10.3 shows the types of services that have been linked and given strategic oversight to deliver more effective health and care outcomes.

Figure 10.3 The outcomes of effective service redesign



National transformation fund

10.13 At the moment, integrated services are still the exception rather than the rule. To drive change across the whole of England will require additional resources for transformation. The limited number of staff currently providing DFG services cannot be expected to deliver transformation while at the same time trying to process more grants. There has got to be a way to allow business as usual to continue while changes are made.

10.14 Integrating services is not an easy process. The transformation work in Scotland showed that *“The test sites have tended to find the change process to be both more challenging and requiring a longer overall time period than originally anticipated”*⁸⁷.

10.15 The pioneers such as Leicestershire’s Lightbulb had £1m in transformation funding and they know they could not have changed the service without this injection of resources. There is now a lot of learning to draw from, so the

⁸⁷ Scottish Government (2017), *ibid.*

process may not be as hard for those just beginning to restructure. Costs should also be less in smaller counties or small unitaries.

10.16 The LGA runs a Housing Advisor programme designed to support councils seeking to innovate in meeting the housing needs of their communities. The programme will fund adviser support for up to £14,000 to each council. This has been calculated on the basis of 20 days at a set day rate of £700⁸⁸. To provide a similar level of support to all 326 housing authorities would cost £4.564m, around 1% of the current national DFG funding allocation. Not every council would necessarily need external support, but it does provide an indication of the level of investment required to support the transformation of DFG delivery.

10.17 There is scope for secondments to allow the learning from areas with successfully embedded integrated services to be passed on. There also needs to be better guidance to allow effective service design to be copied in other areas. The following chapter looks in more detail at different elements of integrated service delivery.

Recommendations – local delivery

- **That integrated teams are established in all areas to simplify and speed up customer journeys.**
- **That a Home Independence Transformation Fund equivalent to 1% of the national DFG allocation is provided to develop integrated services in all areas.**

⁸⁸ Local Government Association (2018) Housing Advisors Programme 2018/19.
<https://www.local.gov.uk/topics/housing-and-planning/housing-advisers-programme-201819>.

Chapter 11. Working better together

- 11.1 This chapter looks at the detail of integrated service delivery. It is divided into a number of parts:
- Establishing local need and handling referrals
 - Effective working
 - Delivering health and care outcomes
 - Data collection and reporting

Establishing local need and handling referrals

Finding people needing help with their homes

- 11.2 Most adaptation services do not look in detail at local needs, but simply base forecasts on the previous year's throughput of cases. Research with local authorities across the UK found that most were unaware of unmet need for adaptations. When setting the annual budgets, 78% of local authorities relied on the previous year's spending, and only 14% carried out surveys of need⁸⁹. This was an expedient policy to avoid the build-up of long waiting lists when funding was limited but should not apply now that resources have increased.
- 11.3 A different approach is needed if the aim is to work better with health and social care and be more focussed on preventative policies. There is a need to intervene before people get to crisis point, by targeting people at risk, preventing falls and accidents, and improving health and wellbeing.
- 11.4 Better strategic planning is required with the need for adaptations to be part of Joint Strategic Needs Assessments (JSNAs). Lower income groups are more likely to be disabled, have fewer years in good health in later life and may experience frailty earlier. This requires good local data and mapping to show where resources might be better targeted. It is then possible to work with specific GP surgeries, community health providers, Fire Service home safety check teams and local voluntary groups to find people who have had falls or might be living in poor conditions.
- 11.5 However, people needing help with their homes are also scattered across local authorities and other ways are also required to find those who need help before they get to crisis point. Many will not be known to health and care services, as most people have informal care or just struggle on for as long as they can. Advertising has been minimal up to now. But once services are integrated and able to deliver adaptations quickly and efficiently, there is more scope to

⁸⁹ Zhou, W., Oyegoke, A.S. & Sun, (2017) Service planning and delivery outcomes of home adaptations for ageing in the UK, M. J Hous and the Built Environ. <https://doi.org/10.1007/s10901-017-9580-3>.

publicise the service. The following examples show different approaches to finding people who need the adaptations service.

Oxford - Raising awareness of DFG services

Local authority in-house home improvement agency

Background: The service has a strong commitment to equality of access to a range of services under its local assistance policy which includes support for home adaptations. A broad-based campaign was enacted to raise awareness of available services, both to the public, and a range of organisations and services in health, care and the voluntary and community sectors.

Nationally there has been a reluctance to “advertise” support via Disabled Facilities Grants as, until recently, the level of funding was insufficient to move beyond managing demand for mandatory assistance. Recent increases in budgets through the Better Care Fund has facilitated local service providers, including Oxford, to develop forms of Added Value assistance for older and disabled people that support independence in the home.

Promoting local services: The campaign in Oxford to encourage increased referrals to the expanded range of services included the following:

- Appointment of a caseworker to coordinate the awareness raising programme
- Meetings with key Social Care staff including triage staff in the Independent Living Centre
- Awareness raising with blue light services - especially Fire Services
- Contact with key personnel responsible for hospital discharge and Better Care Fund plus GP consortium groups
- Use of media including local newspapers
- A series of meetings and presentations with a wide range of relevant community groups and their representative organisations
- A portable stand including a banner for promotion events in significant public spaces such as shopping centres. The banner is in a prominent place in the main council office when not used elsewhere
- Presence of an OT at meetings who can directly respond to queries, demonstrate simple items of equipment and initiate referrals immediately.

Key Learning:

- The awareness raising campaign had a very limited budget, but different approaches have been used to maximise impact through low or no cost methods
- Older people reported wanting good quality, easily understandable information in hard copy form so a range of colourful leaflets have been designed and produced that reflect the services potential customers indicated were important to them
- Having a caseworker leading on delivering the programme of events was of critical importance in being effective as is a visual logo for the home improvement agency

- Being viewed as a rapid reliable problem solver for other services especially in the health and care sectors was a key to success (for example in falls prevention and hospital discharge)
- Operating on a basis of accepting self-referrals as well as referrals from a range of partner organisations and services has successfully increased the number of enquiries for assistance
- Local political support can be very useful
- Maintaining a long-term commitment to engage with local people and organisations to identify and respond to existing and emerging priorities in the area

Results: Average DFG referrals rose from 38 in Q1 & Q2 last year, to 51 in Q3, 64 in Q4 and the increase is continuing.

Disseminating Practice: The Oxford City Council experience of advertising and reviewing/broadening a range of assistance services has been shared with other councils in Oxfordshire via its Benchmarking Group. There appears to be an appetite from other local authorities in Oxfordshire to consider how such an approach could be adopted in their respective areas. Oxford's home improvement agency is also keen to share their experience more widely.

Peterborough City Council - Forecasting the need for accessible housing

Background: In 2015 the local authority was keen to demonstrate what their interventions achieved for the local community. This would be used to inform a strategic plan for future service arrangements and resource planning. A key element to meet that challenge was to commission the Building Research Establishment (BRE) to provide an estimate of the amount of accessible housing required in the city, what proportion of homes could be made accessible through DFGs, how much through other funding sources, and how much new build housing would be required.

The Model: The work undertaken by BRE was based on a national model produced for the Ministry of Housing, Communities and Local Government which was then adapted to provide a local model specific to Peterborough, in part using local datasets including population projections. The forecast period was 2015-2030.

The model forecasts both the housing stock at different levels of accessibility, and the expected number of householders broken down by their level of accessibility need: namely wheelchair users, ambulant disabled and ambulant disabled (no aids).

The modelling also took account of stock characteristics (including Wheelchair Homes and Lifetime Homes, plus those meeting or not meeting Approved Document M) as well as funding sources including DFG and Social Care.

Headline findings:

- The model estimates that, based on 1,268 dwellings being built per annum and 1,480 being adapted, 33.8% of the total need of the population will be met in the baseline year (2015).
- Provision is poor for wheelchair homes and lifetime homes with only 4.5% and 16.5% of expected provision being met by the stock respectively.
- A properly administered new build programme makes a major contribution to meeting assessed need over the forecast period.
- Increasing the rate of DFG provision would have to be substantial (multiplier highest for wheelchair needs) to have an impact on the extent to which provision has parity with/is equal to need.

Using the Findings: Whilst the conclusions were not necessarily a total surprise it was useful to have independently derived data that enabled a more prominent position for the DFG service in strategic planning and partnership working. The team used this understanding of the future demand for adaptations to inform the Council's Capital Programme Board and Capital Strategy to ensure that the maximum DFG funding was secured to meet the needs of the city's residents. This ensures that those residents can remain living in their homes safely and independently for longer, giving them a better quality of life and therefore impacting favourably on demand management for other higher cost services provided by the Council.

11.6 Better information about local needs will help services understand what staffing resources are required, where they should be located and what capital resources will be needed. Detailed mapping of current services and analysis of county-wide need was one of the drivers of the Lightbulb project and helped secure buy-in for reorganisation. This type of information-gathering and analysis should be a key responsibility of the new strategic Housing and Health Boards.

Information, advice and routing people down the right pathways

11.7 The 2014 Care Act places a clear duty on local authorities to provide advice and information and to be able to signpost people to appropriate services. Learning from DFG service reorganisation shows that there should be a single access point. That access point needs to be adequately staffed to provide advice and information and to route people effectively towards the right pathways. The front-line service dealing with adaptation calls is a very skilled role and one that should not be underestimated or under-resourced.

11.8 In Scotland, as part of a broader focus on outcomes, the concept of 'good conversations' was introduced at the start of the adaptation process. This incorporated supported self-assessment, raising awareness of housing options, effective signposting and routing to appropriate services.

- 11.9 A number of different pathways are required relating to people's needs and the complexity and urgency of their case. This allows people to have more choice. For example, if someone is asked at the point of first enquiry if they would consider moving, it opens another possible route for help and support. If instead they are automatically put in the queue for a DFG, by the time they are assessed it may be too late to consider the rehousing option.
- 11.10 Online advice is another option to give people more choice. The main expert system is ADL Smartcare which is Care Act compliant. This has been used for several years in East Lanarkshire and is now in use in an increasing number of authorities across England. It gives round the clock access to information and a self-assessment system without having to wait for a therapist. People can identify equipment, adaptations, technology or exercises that will be able to assist them with activities of daily living. It gives people more control, and at the same time can reduce demand for scarce occupational therapy support. If used, this needs to be easy to find and very visible on local authority websites.
- 11.11 A third of older people are not online, so this should not be the sole way for people to get help. For someone who is lonely and struggling, has mental health problems or learning disabilities there is nothing that can replace human contact for assessment, advice and support. However, there is likely to be more staff time to provide support to those who need it most if other customers can do some of the assessment process themselves. A test of the flexibility of new services will be for staff to trust and accept people's own assessments rather reassessing everyone.

Effective working

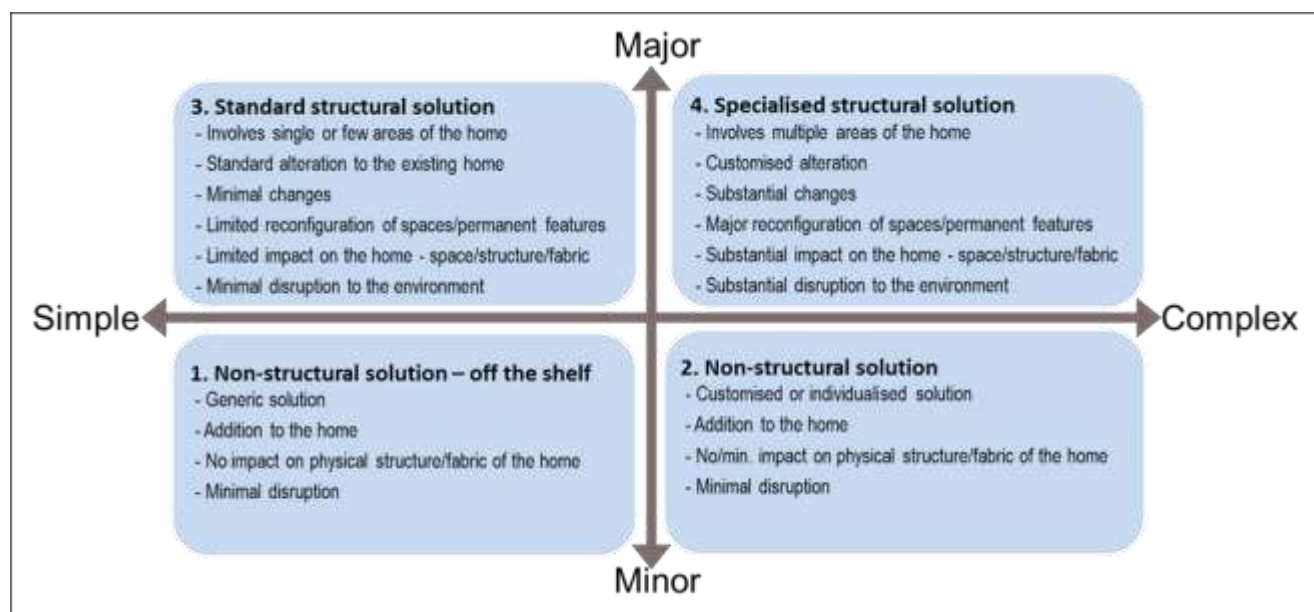
Deciding what is complex and needs occupational therapy input

- 11.12 To effectively route people down different pathways there is a need to understand the potential complexity of the case. Without this understanding, there is a risk that people will be routed along the wrong pathway, causing unnecessary delay and distress.
- 11.13 A complexity framework for home modification services has been developed in Australia to address the skills required to handle a case⁹⁰. This framework, illustrated in Figure 11.1, considers two aspects of complexity:
- Firstly, whether the adaptation is likely to be minor or major. Unlike England, where cost tends to define whether an adaptation is minor or major, in this framework adaptations are defined by the structural changes required to adapt the home environment.

⁹⁰ Ainsworth, E., & de Jonge, D. (2019) Minor modifications: It's not as simple as "Do It Yourself" (DIY). To be published in E. Ainsworth & D. de Jonge (Eds.) An occupational therapist's guide to home modification practice (pp. 381-388). Thorofare, NJ: SLACK Inc.

- Secondly, whether the person’s situation is simple or complex – using 54 different factors. These include the nature of the person’s condition, how urgent the need is, the type of activity the person is wanting to do, and how ready the person is to have their home adapted.

Figure 11.1 Framework for home adaptations service delivery



11.14 Table 11.1 provides an example of how the complexity framework can be used to consider how different types of cases can be managed based on who has the most appropriate skills to support the person through the adaptations process.

Table 11.1 An integrated approach to managing cases based on complexity

The nature of the case	How the case can be managed
The situation is non-complex, and the adaptation is non-complex	With appropriate advice and support (from example for a handyman or trusted assessor) the case could be managed by the person, carer, or family member.
The person’s situation is non-complex but due to the structural of the property it is complex to adapt	Housing professional leads the case but consults with occupational therapist if needs change or arise
The person’s situation is complex, but the home is not complex to adapt	Occupational therapy team leads the case but consults with housing team if advice is required on the design of the adaptation
The situation is complex, and the structural changes required to provide a solution is also complex	Joint management of the case.

11.15 The ‘Adaptation Design Communications Tool Kit’⁹¹, developed in Northern Ireland, is an example of how cross sector collaboration can improve the delivery of adaptation services. Development involved disabled people, occupational therapists, and housing designers/teams. Research was conducted to produce evidence-based design standards for a range of adaptations. Occupational therapists now use these standard designs to recommend adaptations without additional input from the housing team. By standardising the design of adaptations in this way, housing team members and occupational therapists now use their time more effectively to collaborate on complex cases where the standardised solution will not meet the person’s needs, or where the standard adaptation will not structurally fit within the existing layout of the home environment.

Improving the model for assessing what adaptations are necessary, appropriate, reasonable and practicable

11.16 As part of the DFG approval process, the local authority must identify what *‘relevant works are necessary and appropriate to meet the needs of the disabled occupant, and that it is reasonable and practicable to carry out the relevant works’*. In determining what adaptations are necessary and appropriate, the housing authority has a duty under the legislation to consult with the social services authority (unless they are themselves a social services authority).

11.17 Whilst the legislation does not stipulate who in the social services authority should carry out the function of identifying what works are necessary and appropriate, occupational therapists have traditionally carried this out. They are skilled at assessing older and disabled people in their home and identifying ways the home environment can be adapted to improve health and well-being, including the recommendation of equipment and adaptations.

11.18 Previous guidance on the DFG has acknowledged the complexity of determining the needs of older and disabled people and for this reason has provided little direction on what factors occupational therapists (or other professionals involved in the assessment process) should consider when determining what works are necessary and appropriate. The guidance does, however, recognise that adaptation should provide sustainable and effective, individualised solution based on the judgment of the professionals involved with the case.

11.19 From the findings of complaints investigated by the ombudsman service, it is evident that at times sustainable and effective individualised adaptations have

⁹¹ Northern Ireland Housing Executive (2018). Adaptations Design Communications Toolkit [online] https://www.nihe.gov.uk/adaptations_design_communications_toolkit.pdf.

not been installed. The issue in these cases is the initial assessment of need and the narrow focus taken by professionals in understanding what is important to disabled and older people. It has been identified that money is wasted, and potential harm caused when the initial assessment of need focuses on a narrow range of factors such as safety and function, rather than wider aspects valued as important to the person, such as dignity, choice and control.

- 11.20 Whilst it is important for an independent assessment to be made about what works are necessary and appropriate, the lack of guidance on what factors should be considered has hampered professional reasoning and failed to give older and disabled people a voice around what they value. This failure has led to adaptations not providing individualised and sustainable solutions. To reduce the risk of installing inappropriate adaptations and to ensure consistency of practice across England, it is evident that written principles could assist professionals involved in the complex process of identifying what works are necessary and appropriate.
- 11.21 Nine such guiding principles have already been identified by Heywood (2004) in her research on improving the quality of adaptations provided through the DFG system. In this research, she identified the following nine needs older and disabled people consider important when being assessed for what works are necessary and appropriate.

Nine guiding principles for installing adaptations

1. Need to retain (or restore) dignity
2. The need to have values recognised
3. Need for relief from pain, discomfort and danger
4. Need to minimise barriers to independence
5. Need for some element of choice
6. The need for good communication as part of giving choice
7. Need for light
8. Particular needs of children: to provide for growth and change; and the need for space
9. Need of other family members and of the family as a whole

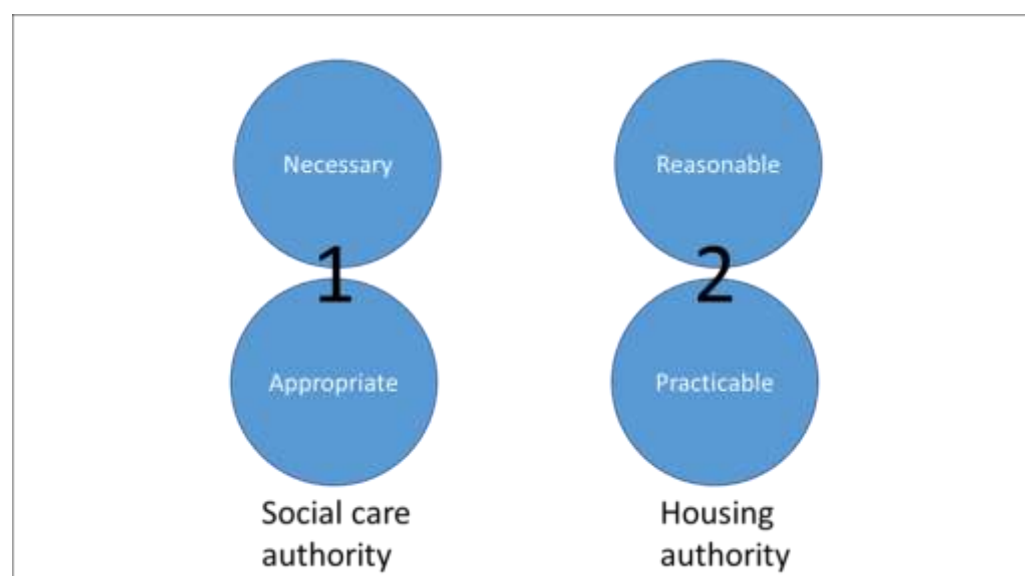
- 11.22 The above principles do not replace the professional judgement of practitioners; instead, it provides a framework to support the decision-making process and to support the communication of what works are necessary and appropriate for improving the health and well-being of older and disabled people.

A collaborative model for the process of determining necessary and appropriate, reasonable and practicable

11.23 In the legislation, and supporting case law, the function of identifying what works are necessary and appropriate must occur before the housing authority decides upon whether the works are reasonable and practicable. The reason the assessment of necessary and appropriate occurs separately and before the assessment of reasonable and practicable is so that the assessment of the older or disabled person’s needs for adaptations is based on need and not on the resources available to fund the works.

11.24 For simple cases, this process (Figure 11.2) is fit for purpose, with the occupational therapist completing an assessment of need with the older or disabled person and identifying and recommending what works are necessary and appropriate. The housing authority then decides whether the recommended works are reasonable and practicable to award the grant. However, where the home environment is structurally more complex to adapt, this model can cause delay and confusion.

Figure 11.2 The traditional way of recommending adaptations



11.25 Whilst most occupational therapists working in social care and housing have a good understanding of what can be done structurally to adapt a person’s home, they are not building experts. Inadvertently, they may recommend an adaptation that is not practicable to install due to the structural limitations of the property. In these situations, after identifying it is necessary to adapt the home, the occupational therapist may require the support of the technical officer to identify what adaptations are practicable. Only then can the occupational therapist decide (in collaboration with the older or disabled person), which solution is appropriate. Resolving issues where an occupational therapist has

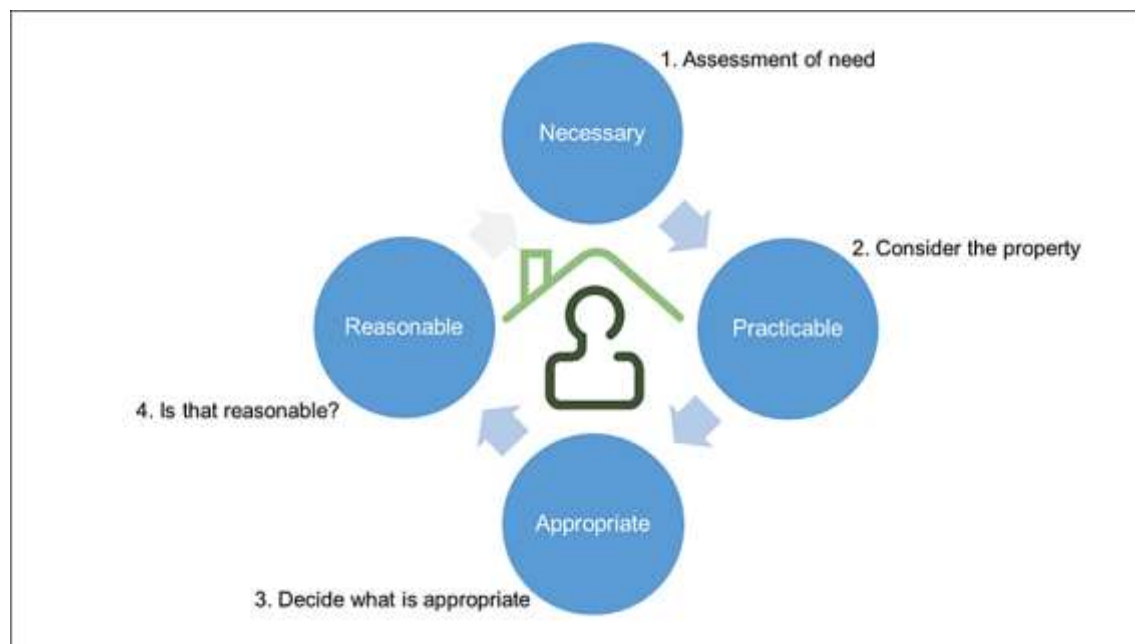
inadvertently recommended an inappropriate solution causes unnecessary delay and confusion, and frustration for the older or disabled person.

11.26 To avoid the consequences associated with recommending inappropriate adaptation, an integrated approach between the occupational therapist and technical officer is recommended. This approach is illustrated in Figure 11.3 and demonstrates that the older or disabled person is at the centre of the process:

- The process begins with the assessment of need and with identifying if it is necessary to adapt the home environment.
- The next step involves considering the home environment and identifying the potential solutions for adapting the home environment and meeting the needs of the person.
- From the range of solutions, the occupational therapist collaborates with the person to identify the most appropriate solution.
- The final stage of the process considers whether it is reasonable to approve the grant.

11.27 Currently, a number of occupational therapy and housing teams routinely conduct these types of joint home visits.

Figure 11.3 A way of developing better adaptation solutions



11.28 These new ways of working underpin the ‘goldilocks’ approach of partnership working and are encouraged by the Royal College of Occupational Therapy who said that occupational therapists must realise that *“your work or role may be integrated into a larger cross-agency service. You may need to adapt your*

*working, learn new skills and share those you have. Working closely with your colleagues can enable a more comprehensive and efficient service*⁹².

Developing a standardised design and construction process for housing adaptations

- 11.29 As with the DFG process, several professional groups are involved in the design and construction of large building projects. For these projects to be completed on time and within financial constraints, the flow of information between these professional groups is crucial. It is also important that each group is aware of how they, and others, contribute to the overall success of the project.
- 11.30 Within the design and construction industry, a number of standardised processes have been developed, such as the RIBA Plan of Work⁹³, to manage this process. By simplifying the process, making transparent the responsibility of each professional group, and identifying where and how information needs to flow through the process, these standardised tools have improved the way major building projects are delivered.
- 11.31 Home adaptations are relatively simple design and construction projects, however the report from the DFG summit in 2015 (organised by the Royal College of Occupational Therapists and Foundations) identified and recommended making it easier for older and disabled people and their carers to understand the process and to improve the flow of information between professionals and teams involved in the delivery of the DFG⁹⁴.
- 11.32 Given the benefits of using a standardised process on large building project, a standardised process for the design and construction of adaptations would address several recommendations from the DFG Summit. The Welsh Audit Office review of the DFG 2018 found that occupational therapists and other professionals *'believe that their work would benefit from standardising assessment approaches and forms across delivery organisations'*⁹⁵.
- 11.33 Recent research on the role of occupational therapists in the adaptations process has led to the development of a standardised process called the Home Modification Process Protocol (HMPP)⁹⁶. The HMPP is based on a design and construction process and describes the role of the occupational therapist at

⁹² Royal College of Occupational Therapists (2016) Care Act 2014 Guidance for Occupational Therapists: Disabled Facilities Grants 2016, p. 19. [online] <https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/care-act-2014-dfg>.

⁹³ RIBA (2013) Plan of Work [online] <https://www.ribaplanofwork.com/>.

⁹⁴ Royal College of Occupational Therapists and Foundations (2015). DFG Summit. [online] London: Royal College of Occupational Therapists and Foundations. <https://www.rcot.co.uk/file/1550/download?token=UJrn-qHx>.

⁹⁵ Wales Audit Office p.40, *ibid*.

⁹⁶ Russell, R., Ormerod, M. and Newton, R., (2018) The development of a design and construction process protocol to support the home modification process delivered by occupational therapists. *Journal of aging research*. <https://doi.org/10.1155/2018/4904379>.

each phase of the project. The process also identifies when occupational therapists need to collaborate with housing colleagues and indicates what information housing colleagues require from the occupational therapist to enable the efficient and timely installation of the adaptations. As the HMPP is based on occupational therapy principles, it takes a person-centred approach and demonstrates how older and disabled person and their carers can be involved in all phases of the process.

11.34 The outcome of using the HMPP in a proof of concept with a team of occupational therapists working in a local authority housing team indicates that it provided therapists with a greater understanding of how their role fits in with the overall design and installation of an adaptation. The occupational therapists indicated the tool had helped them and housing colleagues to develop a deeper appreciation of each other's role, and that they had made changes to the DFG process so that they made better use of time and each other's skills. The HMPP gave the occupational therapists a better appreciation of what type of information housing colleagues needed about the person to help in the design the adaptation, and this then helped the therapists to consider ways in which they could share information in a way that did not breach confidentiality or compromise professional standards.

Communicating with customers, carers and their families

11.35 There is emerging evidence that better visual tools are needed to communicate design plans to customers, carers and their families and to contractors⁹⁷. Most people coming into DFG services know very little about equipment and adaptations, and do not know what is available or how it will fit into their home.

11.36 A research study looked at the role of 3D design in the communication process⁹⁸. A 3D tool helped people better communicate to professionals the nuances of the way they use their home, and it helped practitioners show the home adaptations options available. Users were able to see what these looked like and discuss how those changes might impact on their personal environment. It was a small study with people who were reasonably computer-literate, but it clearly allowed much better communication and joint decision-making and avoided a lot of the mis-understandings that currently occur. A key finding was that people appreciated using these tools alongside the professional rather than on their own.

⁹⁷ Walker, M. (2016) Effective communication methods for Housing OTs <http://ot-magazine.co.uk/effective-communication-methods-for-housing-ots>.

⁹⁸ Money, A. et al. (2015) Using the Technology Acceptance Model to explore community dwelling older adults' perceptions of a 3D interior design application to facilitate pre-discharge home adaptations, BMC Medical Informatics and Decision Making, 15:73. <https://doi.org/10.1186/s12911-015-0190-2>.

11.37 People are getting used to kitchen and bathroom vendors using these 3D tools and will increasingly expect to see them used by adaptations teams. A number of tools have been developed, such as:

- The IDAPT 3D planner⁹⁹. IDAPT is a specialist computer-aided design system used by many local authorities to produce floor plans and 3D visualisations for standard adaptations like showers and ramps. They are currently developing a virtual reality module with photo-realistic renderings of adaptations that would allow a client to be placed into an adapted space and fully understand how it would work for them.
- Glasgow Centre for Inclusive Living online 3D design tool to help people plan their homes¹⁰⁰.
- Australia has developed a sophisticated online tool called My Home Space to help disabled people plan their own designs¹⁰¹.
- A number of apps are being developed to help with design and adaptation planning for people with dementia¹⁰².
- There is also a Home Modify App from Australia¹⁰³.

11.38 Having a design centre or centre for independent living such as in Dorset, Bristol, North Somerset or Knowsley is another option that allows people greater access to practical advice and information where they can see exactly what the options would look like within a room setting.

Working in partnership with contractors

11.39 It is possible to fast-track work directly to contractors provided they are also treated more as partners in the process. The Rutland example below is being piloted and shows how stages in the 'normal' adaptations process can be removed for non-complex cases. This provides a fast and effective service that is much more in keeping with what customers are looking for.

11.40 A few authorities, such as Bristol, fast-track cases to contractors who use the IDAPT planning tool to communicate decisions to the adaptations team. They can also use it to discuss options with customers making communication better all round.

⁹⁹ IDAPT 3D planner <https://www.idaptplanner3d.com/>

¹⁰⁰ Glasgow Independent Living Centre www.home2fit.org.uk, www.adapt2fit.org.uk.

¹⁰¹ My Home Space <https://www.myhomespace.org/>

¹⁰² University of Stirling (2018) App to help improve environments for people living with dementia. <https://www.stir.ac.uk/news/2017/06/newapptohelpimproveenvironmentsforpeoplelivingwithdementia/>.

¹⁰³ <https://www.homemods.info/apps>

Rutland – working in partnership with contractors

Rutland is a small, unitary authority in the East Midlands. It had a very traditional DFG service but is trialling a new approach. The DFG budget (£211,000) was often underspent because Rutland is a relatively affluent area and most clients fail the means test. However, they are still vulnerable and in need of support. The DFG team wants to promote independence and mirror health interventions which are mainly free at the point of contact.

Health Prevention Grant (HPG) delivers rapid outcomes with no means test up to a maximum of £10,000 (£9,000 plus contingencies). A 12-month pilot started in October 2017 across all tenures (the council stock was transferred to a registered provider). By the end of March 2018 49 cases had been opened and 24 completed. More people are coming forward because of the flexible, non-stigmatising approach.

The adaptation service - partnership with local contractors. Specifications are written by the referrer (occupational therapist, occupational therapy aide or physiotherapist) with contractors trusted to take responsibility for the project as they would with any private client. They are asked to personalise the offer, for example, they hold a range of non-white, non-standard size wall tiles to offer clients choice to get away from the ‘medicalised’ grant model. If they wish, clients can use their own contractor and upgrade the specification using their own funding. There is no grant officer or technical officer involvement other than as a ‘facilitator’ to help support clients and contractors. Inevitably there are extras and unforeseen work, but this has not caused major problems.

The average time from application to completion for a level access shower is 12.6 weeks, with stairlifts taking 2.7 weeks through a single supplier contract. stairlifts and ceiling track hoists get a two-year warranty and are replaced if they fail. They have also pre-purchased modular ramps from a company who store them, install, service and remove.

Complex DFGs over £10k are delivered by Peterborough County Council as Rutland has very few each year.

Delivering better health and social care outcomes

Examples of preventative services providing savings to health and care

11.41 There are now a large number of adaptation services providing direct support to health through hospital discharge schemes and falls prevention work. Foundations and the Housing LIN have produced an interactive map that will be regularly updated to show the types and location of different services¹⁰⁴. There are four key categories of service:

¹⁰⁴ Housing LIN (2018) Home from Hospital tool [online] <https://www.housinglin.org.uk/home-from-hospital/tool/>.

- Co-located / embedded caseworkers (often within hospital discharge teams), linked to a community-based handyman's service to deliver practical support in the home.
- Co-located / embedded housing support, focussed on providing assessment and holistic community navigation, based within a hospital discharge team.
- Community-based practical housing support, including handyman's services, focussed on preventing admissions to hospital as well as supporting patients in transition and on their return home.
- Step down beds and apartments provided within a housing setting, to enable prompt hospital discharge before a patient is ready to return home.

West of England Care and Repair hospital discharge service

To enable older patients to return home from hospital more rapidly and safely, West of England Care & Repair (WECR) organises and/or carries out:

- Clutter clearance/deep cleaning to make home sanitary
- Urgent home repairs to make home safe and secure
- Sanitation repairs e.g. broken toilet, washing facility
- Hazards removal e.g. falls risks, electrical wiring dangers
- Heating systems repaired/emergency heating
- Small, essential adaptations e.g. stair rail

Some patients pay for the work themselves but there is charitable funding for those who either have no resources or where it would take too long to organise payment, such as those on low incomes, with dementia or mental health problems.

Service Capacity: 135 patients discharged from hospital per FTE Caseworker per annum. Average cost of works per discharge £273.

Impact: An independent evaluation used case records and interviews with hospital staff to assess how the housing interventions affected length of stay in hospital and examined time savings for hospital and care staff¹⁰⁵. This identified:

- A saving in hospital bed days of £13,526
- A total cost of the housing interventions to achieve @ £948
- A cost-benefit ratio of 14:1
- Savings in hospital staff time amounted to a further £897

Falls prevention: WECR is also piloting and evaluating a falls prevention project. An occupational therapist and a handyman do home safety checks, fix trip and fall hazards, fit minor adaptations and provide people with better strategies to move safely around the home and outside.

¹⁰⁵ Adams, S. (2016) Reducing Delayed Transfer of Care through housing interventions: Evidence of Impact. <http://careandrepair-england.org.uk/wp-content/uploads/2014/12/WE-C-R-Case-Study-Final.pdf>.

Dementia and the DFG

- 11.42 The number of people with dementia in the UK is forecast to increase to over one million by 2023, with the largest increases for people over 80¹⁰⁶. Over 90% of people living with dementia have more than one health condition¹⁰⁷. They are very high users of health services, accounting for 20% of all hospital admissions. They occupy 25% of beds at any one time, are three times more likely to experience a fall in hospital and 20% more likely to die. They tend to stay in hospital 25% longer and are twice as likely to be readmitted¹⁰⁸. Around 40% of people with dementia admitted in an emergency will be discharged to a place other than home¹⁰⁹ and they account for over 70% of those in residential care¹¹⁰.
- 11.43 The home plays an important role as two-thirds of people with dementia live in ordinary housing¹¹¹ and 85% of them express a preference to remain there¹¹². Helping people remain independent at home, and for that home to be fit for them to be discharged after a hospital stay, is therefore vital to reduce pressures on health and care services. Up to now there has been limited use of the DFG to improve homes for people with dementia, but there is scope for it to be used far more as a preventative measure.
- 11.44 Dementia friendly design principles were developed in health and care settings which are not always easily or acceptably transferred to someone's home. There is beginning to be greater understanding of what works in the home supported by the publication of a number of design guides and apps^{113 114}. There has been some evaluation of outcomes, but this needs further research. There also is a need for more dementia specific training for staff delivering the DFG. The following example shows how the DFG is being used in more innovative ways.

¹⁰⁶ <https://www.dementiastatistics.org/statistics/prevalence-by-age-in-the-uk/>

¹⁰⁷ <https://www.dementiastatistics.org/statistics/comorbidities/>

¹⁰⁸ https://www.cqc.org.uk/sites/default/files/documents/cqc_care_update_issue_2.pdf

¹⁰⁹ <https://www.dementiastatistics.org/statistics/hospitals/>

¹¹⁰ <https://www.alzheimers.org.uk/about-us/news-and-media/facts-media>

¹¹¹ Alzheimer's Society (2012) Home Truth. Housing Services and support for people with dementia. London: Alzheimer's Society.

¹¹² Alzheimer's Society (2016) Fix Dementia Care: Homecare, London: Alzheimer's Society.

¹¹³ Dementia Services Development Centre (2013) Improving the design of housing to assist people with dementia, Stirling: University of Stirling.

<http://www.cih.org/resources/PDF/Scotland%20general/Improving%20the%20design%20of%20housing%20to%20assist%20people%20with%20dementia%20-%20FINAL.pdf>.

¹¹⁴ <https://www.scie.org.uk/dementia/supporting-people-with-dementia/dementia-friendly-environments/>.

Design for dementia

Dementia Dwelling Grants - Worcester City Council is leading a joint health, social care and housing project that involves integrated working between six local authorities (Bromsgrove, Malvern Hills, Redditch, Worcester, Wychavon and Wyre Forest District Councils). It uses a top-sliced amount of the DFG allocation to provide non-means tested grants to help people with dementia make changes to their home. People are referred via the community mental health team, GPs and the early intervention dementia team to Age UK Hereford and Worcestershire Dementia Advice Service (DAS). Dementia Advisors provide advice and information and support households to claim the grant. The maximum available is £750 per household.

The project is being evaluated by the University of Worcester¹¹⁵. In 2017-18 over 500 people were assessed and over 380 accepted the grant. Over 86% of recipients are home-owners living in their own home rather than in residential or acute care. People choose their own preferred solution based on the difficulties they are experiencing and feedback about what works and what does not work on evaluation visits.

The average cost of a Dementia Dwelling Grant is only £150 for those living alone and £132 for those living with a partner or family. This evaluation will help inform the design of future equipment and adaptations. Other local authorities are copying the model and writing Dementia Design Grants into their RRO policies. This project demonstrates that a timely, preventative, housing response to a diagnosis of dementia need not be expensive to the public purse. It can make a substantial difference to the lives of people coming to terms with their diagnosis and help them maintain their independence for longer.

BRE demonstrator home

The BRE innovations park at Watford showcases good practice in building design and has around 20,000 visitors a year. In 2018 they opened a demonstrator home aimed at professionals in the health, care and housing sectors involved in helping people live independently in later life, particularly those with dementia.

It originated from collaboration with an architectural partnership and staff from John Moores University in Liverpool who had used a 'living laboratory' approach to see what was important to enable people with dementia to carry on living in their own home¹¹⁶. In collaboration with BRE they developed a set of design principles. As most people live in the existing stock and want to stay in their home BRE have created a typical home, a Victorian terrace house, to demonstrate good practice in how to retrofit a home for later life and how this can help people with dementia.

There is potential to use this as a training location for home adaptations teams.

¹¹⁵ Evans, S., (April 2018) Dementia Dwelling Grants – evaluation of the pilot programme. Interim evaluation report, University of Worcester Association for Dementia Studies.

¹¹⁶ Halsall, B. and MacDonald, R. (2015) Design for dementia – Vols 1 and 2.

http://www.hlpdesign.com/images/case_studies/Vol1.pdf.

http://www.hlpdesign.com/images/case_studies/Vol2.pdf

Making every contact count (MECC)

11.45 There is much more scope for health, care and housing to work better together, particularly to identify people who require adaptations before they reach crisis point, as a lot of need is hidden. There are several services that could potentially identify and refer those who need help if they find that someone is living in a home with potential hazards, has already had a fall, is beginning to struggle with activities of daily living or is in the early stages of dementia. These include:

- GP surgeries
- Community health/care navigators/social prescribing teams
- ‘Staying steady’ exercise classes for people who have experienced falls
- Dementia clinics and memory cafes
- Fire service home safety checks¹¹⁷
- Care providers

11.46 In 2015, Age UK developed a pilot care navigator project in South Warwickshire. They worked with people over 75 who had the greatest health care needs from 31 GP surgeries. It was done in conjunction with the FirstStop advice service. The service raised awareness of housing and care options; gave specific housing and care advice; and provided more extensive help to enable people to move home, get adaptations or otherwise improve their housing situation. Evaluation showed that the potential cost savings of better health outcomes considerably outweighed the revenue costs¹¹⁸. There is potential for DFG teams to work in partnership with care navigator services across the country.

11.47 Other health and housing links are being developed, as is demonstrated by the Cornwall Home Solutions adaptations service. They have a pathway to ensure that that adults and children who are referred for a wheelchair get an assessment to see if they need adaptations to their home. They also consider whether a riser wheelchair would be a more cost-effective solution. If this was a standard service across the country, it could make a huge difference to wheelchair users. The 2015/16 English Housing Survey found that there are 232,000 households with at least one person who uses a wheelchair inside the home. Half (51%) found it very, or fairly, difficult to manoeuvre their wheelchair around their homes, so there is obviously a high level of unmet need¹¹⁹.

¹¹⁷ Public Health England (2016) Evaluation of the impact of Fire and Rescue Service interventions in reducing the risk of harm to vulnerable groups of people from winter-related illnesses. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573558/FRS_winter_pressures_evaluation.pdf.

¹¹⁸ Adams, S. (Mar 2017) Integration in Action: Evaluation of Age UK Warwickshire’s provision of impartial information and advice about housing, care and related finance in later life. <http://careandrepair-england.org.uk/wp-content/uploads/2017/05/AgeUk-W-Evaluation-report-Final.pdf>.

¹¹⁹ Ministry of Housing, Communities and Local Government (2018) English Housing Survey 2015/16, *ibid.*

11.48 There are also a number of well-established hospital discharge schemes being run by home improvement agencies, such as Manchester Care & Repair, but not many have been properly evaluated and written up. There is a need for more research to demonstrate the impact of improving housing on health so that more partnership working can be established.

Data collection and reporting

11.49 Home adaptation services have been good at reporting outputs (number of grants and amount spent) but not as good at measuring outcomes and impact (number of people helped to remain independent and impact on health and wellbeing) as this is much more difficult. It is beginning to change. There is a need for much better evidence to support service reorganisation, and once services are integrated and strategic oversight is stronger, regular performance reporting is expected. There is also a need to collect and evaluate a range of data to demonstrate fair access to services under the Equality Act.

11.50 One important element of service delivery is the end-to-end speed of the service. The 2013 good practice guide gave a table of time targets for three stages of the customer journey: 1) from first enquiry to occupational therapy referral; 2) from referral to approval; and 3) from approval to completion of work. This was further split into urgent and non-urgent work. However, there is often no effective end-to-end reporting system. There is also no contingency fund to deal with backlogs if delays occur.

11.51 Time measurement should reflect the new context that the DFG is operating in. Services have to be faster if they are to be preventative and work effectively with health and social care. Customers need a much quicker service to return from hospital, to prevent their condition worsening, to improve their wellbeing and to stop carers being put under undue strain. This requires fast-track systems which may cut out some stages entirely or new funding packages of which the DFG is only one part.

11.52 What is needed is much better data collection, effective reporting and benchmarking with other authorities, with services accountable to their Housing and Health Partnership Board, the BCF and HWB (or their successor bodies).

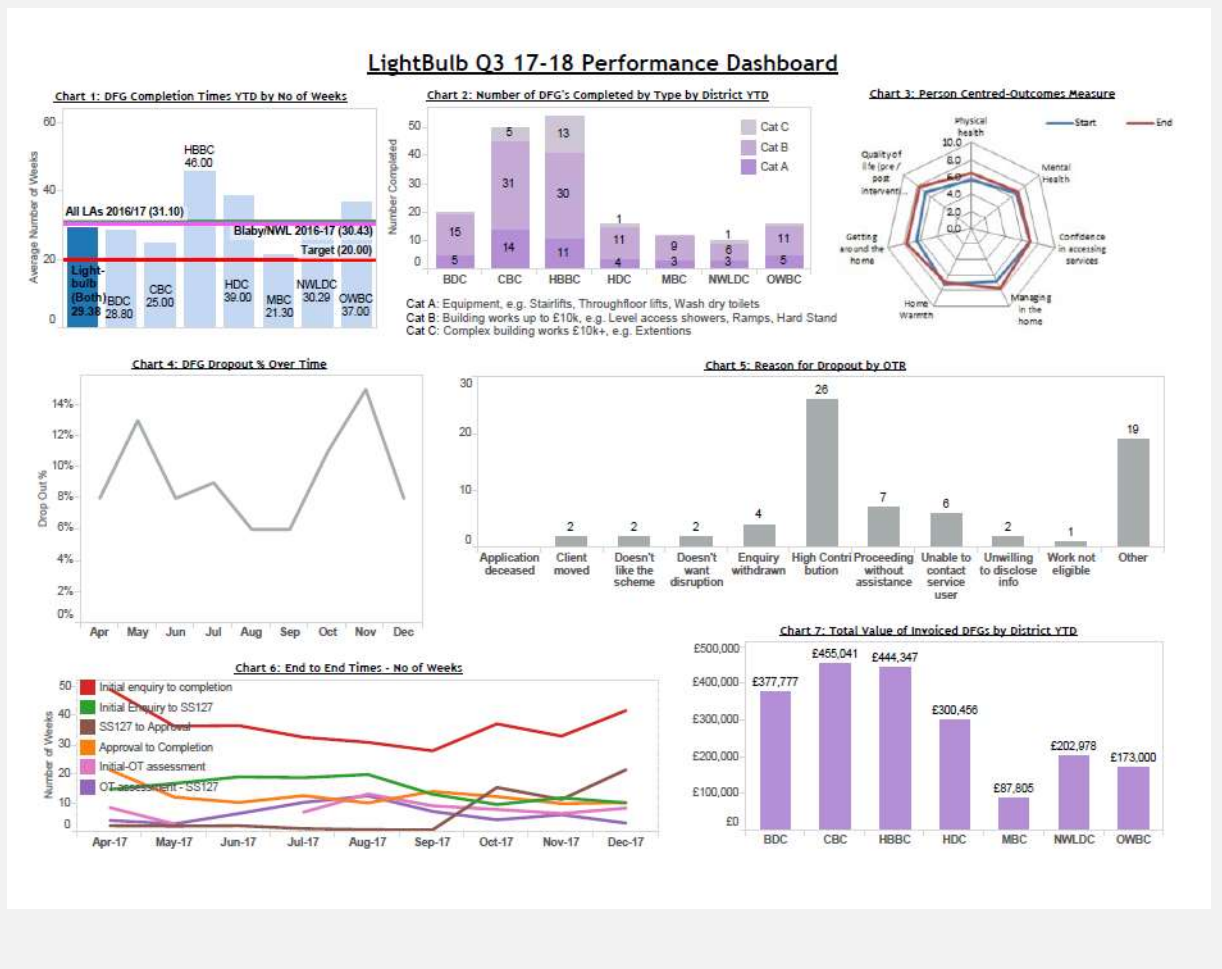
Local reporting

11.53 Use of NHS numbers on case files is still not commonplace, despite being a requirement of the 2014 Care Act and the BCF. There is a need for more data sharing protocols and alignment of IT systems to enable the end to end customer journey to be more effectively managed and monitored than it has up to now.

11.54 Some useful reporting models are developing, as evidenced by the Lightbulb dashboard below. Foundations has also launched a DFG analytics system in partnership with Intel4Housing¹²⁰. This incorporates cost, timescales, outcomes and social value data and allows services to benchmark their performance against others to see how they compare, learn from their approach and measure improvement over time.

Leicestershire Lightbulb project performance dashboard

A performance management system was designed for the Lightbulb Programme when it was established. It provides Management Board and Delivery Group members with a dashboard of tables and charts giving an overview of key areas of performance. A report is produced each quarter and compared to previous figures. A separate dashboard shows results of the Hospital Housing Enabler work. The data is used to improve performance and deliver a more effective service for customers.



¹²⁰ DFG Analytics <http://www.foundations.uk.com/dfg-adaptations/dfg-tools/dfg-analytics/>

Intel4Housing – DFG Analytics

i4H is a specialist consultancy who set-up analytics and benchmarking systems to drive performance improvements in social housing. They recognised the potential to use advanced data analytics techniques with the DFG that would provide valuable business intelligence.

Working with Foundations they have established a large database of DFG performance data that Local Authorities can use to benchmark their own performance and identify key areas for improvement. A number of Councils have now signed up to the system and collaborating through a learning and innovation club.

11.55 It is very important to demonstrate the impact of adaptations to health and social care partners and to provide effective case studies. Case studies are a crucial way of showing how the grant works, its impact on disabled and older people, and potential cost savings. One way of doing this is shown below.

Tower Hamlets Improvement Project

Aim: to capture the impact of the provision of wet floor showers on care packages and the benefits to the person/carers.

Occupational therapists seldom review care needs when adaptation work has been completed, this is left to reablement or social work teams. These teams have waiting lists which delays reviews and there is no feedback to allow assessment of the benefits of adaptations. With support from managers and project specialists, four occupational therapists developed the skills and knowledge to review care packages. It created a more streamlined review process with reduced waiting times and better continuity of care for service users. Four cases were selected on the basis that the care package was only for personal care or that it was a large component of the care package.

Results: In three cases the care package was stopped, and in the other considerably reduced after the adaptations were installed. All participants felt more independent and their dignity and wellbeing had improved. They were also more physically active as they were carrying out their own personal care.

The total care cost saving over a 12-month period: £23,930.

The review procedure has now been rolled out to the whole team and managers are recording the on-going cost savings.

Learning points: cases need to be open for longer than normal and there must be a way of handing cases over to the social work team if care is complex.

- 11.56 It is important to recognise that the shift to measuring outcomes is about “a *different way of seeing and providing public services that starts with people’s lives and what matters to them in their lives*”¹²¹. It is about getting the right information to understand what is happening to the service and what it is delivering, but the real focus should be on how many more people it is reaching and helping to achieve their own housing goals. The outcomes star shown in the top right of the Lightbulb dashboard might be a good way to help staff really listen to customers to find out about their needs, and after work has been completed to see how the service has helped individuals reach their goals.
- 11.57 It is not just about data collection. Having a user scrutiny panel and following up with any customers who were not fully happy with the service will also help to feed into continual service improvement.

National reporting

- 11.58 Up to now, national level data has only been available from LOGASnet, which is an administrative dataset, not one designed for detailed analysis and research. Returns are voluntary and have reduced over the last five years to only 66% completion rate in 2016/17. As part of the review a Better Care Fund lead told us:
- “My surprise came in that the data is retrospective and provided voluntarily, so although the majority of Local Authorities provide the information, some don’t. How can so much money exchange hands and there be no regulated return? Commissioned services be they Local Authority, Clinical Commissioning Group or anything over £15k have to report on activity monthly. This leaves the fund open to a whole raft of inadequate use, and lack of innovative application. Were it monthly or quarterly as part of one BCF report, partners and the Health & Wellbeing Board would be able to scrutinise it justifiably along with the rest of the programme using an integrated lens.”*
- 11.59 This Review has used LOGASnet data but has had to rely on Freedom of Information Requests to fill gaps in the evidence base. This highlights the need to introduce far more robust monitoring arrangements that help us better understand the impact of DFG, and also to allow Local Authorities to benchmark their delivery and drive service improvements.
- 11.60 LOGASnet is due to be replaced. There is scope to add more detail and to make the return a condition of DFG funding so that effect of changes to service delivery can be monitored more effectively.
- 11.61 To support local scrutiny and innovation we recommend that the current annual LOGASnet returns are replaced with quarterly submissions. The aim should be

¹²¹ Jeffs, M. (2018) Moving from outputs to outcomes [online]
<https://goodpracticeexchange.wales/2018/05/15/moving-from-outputs-to-outcomes/>.

to understand the pattern of local delivery and follow progress in delivering the recommendations set out in this report. We recommend a broader set of indicators is used to cover the different elements of integrated adaptation services, including the DFG. The return should be prepared by each Housing and Health partnership board as a required part of future BCF plans (or similar future requirements) and come under the overall metric of ‘the number of people helped to remain independent at home’. A short list of possible variables to be included is shown in Appendix A1.

Recommendations – working better together

- **Better analysis of local need to develop preventative strategies and determine levels of revenue and capital funding.**
- **Better partnerships with health and care to ensure that ‘Making Every Contact Count’ works effectively to refer people earlier, not at crisis point.**
- **A single point of access with ‘good conversations’ at the start so that people are routed down appropriate pathways.**
- **New staff roles combining occupational therapy, technical and casework skills to support customers more effectively.**
- **New decision-making tools to help occupational therapy and technical staff collaborate more effectively.**
- **Use of 3D design and design centres to communicate better with customers and tailor solutions to people’s own goals.**
- **Use of NHS number on all files, data sharing protocols, aligned IT systems and improved local reporting focussed more on outcomes.**
- **National reporting by each Housing and Health Partnership Board as a requirement of future BCF plans**

Chapter 12. The allocation of resources

Current allocations methodology and the need for review

- 12.1 In recognition of the rising need for home adaptations, central government funding for the DFG within the BCF has increased considerably. In 2016/17, provision rose from £220 million to £394 million. In 2018/19, it is £468 million, and it is projected to increase to over £500 million by 2019/20.
- 12.2 The key issue for DFG allocations to local authorities that needs to be understood from the outset is that establishing a method for distributing financial resources relative to need is inherently difficult; there is demand in all areas but the number of people receiving DFG in each local authority is relatively small. In addition, the test of resources for DFG means that determining the number of people potentially eligible for the grant is very complex. Furthermore, a lack of robust data to identify or forecast need for DFG at local level means that any allocations model can currently only incorporate indicators of potential need for the grant.
- 12.3 The last major review of the DFG allocations methodology was undertaken in 2011 by the Building Research Establishment (BRE). At that time, the DFG allocations were determined by using a complex mix of formulae and bids submitted by individual local authorities. The BRE review concluded that the allocation methodology in place was very volatile, lacked transparency and could not represent the relative potential need for adaptations in any one year. The large fluctuations in annual allocations also made it very difficult for local authorities to plan, prioritise and deliver the DFG.
- 12.4 The BRE report proposed two new allocation methodologies. The first of these was a 'full' allocations model using four factors to create an index of potential DFG need for each region and local authority. The four factors were derived from available national statistics and were considered the most appropriate and robust for use in a new allocations model, and were:
- the number of claimants of disability related benefits
 - the proportion of population aged 60 or over
 - the proportion of people on means tested benefits
 - the proportion of the housing stock that is not owned by local authorities.
- 12.5 The 'full' model had a 'weighting' for poverty through the inclusion of means tested benefits and was considered to be appropriate where there is some stringent means testing for DFG, as occurs under the present system. Using a model which reflects relative poverty could also be beneficial should

government policy wish to direct funding to the more deprived regions and local areas.

- 12.6 The second model created by BRE was a 'simplified' model which omitted the means tested benefits. If future DFG eligibility were to involve less stringent or no means testing, there is arguably less need for the allocations model to reflect relative poverty (notwithstanding the benefits of general redistribution of funding to the more deprived areas). Regional building price factors were applied to both models.
- 12.7 Applying either the full or simplified allocation model to the entire DFG budget at the time would have caused some large swings in local funding levels, with some authorities much better off, but some much worse off. To avoid such large swings, a decision was taken by Government that any future uplifts in DFG funding would use a new allocation methodology to allow for a graduated move to the new model. The 'simplified' model was chosen for any future uplifts.
- 12.8 There have been several developments since the new simplified model was adopted that mean a further review is required, and include:
- The incorporation of DFG funding into the BCF in 2015, so that the provision of adaptations could form part of the strategic consideration and planning of services to improve outcomes for service users.
 - Changes in the types of state benefits and the increase in state Pension Age. The indicators of proxy need for adaptations need to be reviewed and if necessary, updated.
 - Possible misalignment between local authority DFG funding allocations versus actual local authority expenditure on DFGs¹²², some local authorities have not spent all their DFG allocations while others have reported being able to approve more DFGs had additional resources been awarded. It is, therefore, important that the review evaluates the extent to which the current or any proposed new methodology can forecast potential need for DFGs at local level.
- 12.9 Without further depth research it is difficult to understand exactly why the current allocations model would not deliver an equitable distribution of resources relative to need, but it is important to examine each element of the formula to assess its impact on grant distribution. Contributory factors to possible misalignment of DFG funding with DFG expenditure and/or need may include:
- Historical factors – the mix of using the new simplified model for the funding uplifts with outcomes from the previous allocations method, which included annual bidding for funds by local authorities.

¹²² Mackintosh, S. and Leather, P. (2016) *ibid*.

- The use of the simplified model for the allocations rather than the full model which includes an 'ability to pay element'; this could mean that more prosperous local areas would benefit from funding arrangements than they would if income (ability to pay) were factored in.
- The way DFG processes operate on the ground for some areas. Any delays for local authorities receiving their DFG allocation, delays in assessing DFG applications and delivery delays may all mean resources are not being spent quickly, although they are needed. There will be variations in efficiencies among authorities through different ways of working.
- Not all those in need of adaptations are applying for DFGs.
- Issues with tenure – there are variations within local authority areas as to whether registered providers and ALMOs use the DFG or their own financial resources to undertake adaptation works for their tenants. It is very hard for an allocations formula to reflect these diverse arrangements.
- The need for DFGs will exceed the money available despite the overall increased DFG budget provided within the BCF i.e. there is demand in all areas for adaptations but the number of people receiving DFGs in each local authority is relatively small.

12.10 Owing to the above developments and concerns about underspending of allocated DFG funds in some local authorities, Government wishes to evaluate whether the allocation methodology is still fit for purpose and, if not, what alternative options may be available. Fair and transparent allocation mechanisms are always important for DFG allocations and arguably more so at present, as local authority contributions to DFG are declining and the level of central government funding is rising.

Our approach to the review of resource allocation

12.11 This section provides details of: our overall approach to the review; the investigation of data sources; and findings on the sensitivity analysis of different indicators or factors related to the need for DFG.

12.12 There are several factors that will be related to the need for DFG:

- The number of people with a limiting disability who require modifications to their home to remain as independent as possible
- How far the above people can afford to do the work themselves without assistance from DFG
- Whether they live in a home where they can apply for DFG (i.e. they are not local authority renters).

12.13 In an ideal world, we would have reliable local level data for each stage of the 'DFG eligibility journey' (from A to B in Figure 12.1 below) that would enable the allocations formula to accurately predict DFG need. Finding reliable proxy

indicators for these is, however, not straightforward. This review of the allocations formula has re-examined data used in the models recommended by the 2011 BRE review and evaluated some potential new sources.

Figure 12.1 Stages of predicting DFG eligibility



12.14 As with the previous BRE review, it was considered imperative that the data available for predicting DFG need should meet specific criteria: simplicity, transparency, be readily accessible, be fair, and provide sustainability over the medium-term (at least 5 years) but be responsive to changes in the population and their circumstances.

12.15 The starting point for this review was to create a baseline of the number of people within the local authority or region who could potentially benefit from adaptations to their home and then add in ‘adjustment’ factors one by one so to examine the cumulative effect of each stage; this would help determine where the greatest shifts in the distribution of allocations may occur. In the analysis described below, all of the adjustment factors have been given equal weight; whether this is the preferred approach needs to be carefully considered.

12.16 Due to the timescales available for this project, we focussed on two regions¹²³: London (which is very diverse) and Yorkshire and Humberside (which has a mix of rural and urban authorities).

¹²³ Formerly known as the *government office regions*

1. The baseline

12.17 Essentially, this is our best estimate of the number of people who are most likely to need adaptations to their home. There is no reliable, easily accessible data at local authority level on whether people require and could benefit from adaptations to their home, so the indicators examined can only be regarded as proxy indicators of need. The options looked at were:

a) DWP data on receipt of benefits

12.18 The main benefits considered were: Disability Living Allowance (DLA); Attendance Allowance (AA); Personal Independence Payment (PIP); Employment and Support Allowance (ESA) and Carers Allowance (CA). We did not include 'temporary' benefits such as Statutory Sick Pay (the latter is paid for a maximum of 26 weeks). Other much more rarely received disability related benefits like Industrial Injuries Disablement Benefit (IIDB) were not included, as the number of recipients would not impact greatly on the baseline, but IIDB could be included in the baseline if considered essential for further baseline analysis.

12.19 The review also decided to exclude ESA from the baseline simply because ESA is an 'earnings replacement benefit' where eligibility is based on capacity to work and take part in work-related activities (e.g. training), rather than specific disability needs. If we included both ESA and PIP, the baseline would also double count the potential 'need' for many working age households giving less weight to those who were over State Pension Age. Also, ESA is most commonly the means tested (rather than contribution-based) variant and may be best dealt with as part of an 'ability to pay' factor to be added later. Similarly, there would be double counting if we included CA, as one of its main conditions of eligibility is that the person cared for is already receiving one of the following: AA; the daily living component of PIP; or at least the middle rate 'care' component of DLA.

12.20 DWP claimant data is updated at least once a year and is readily accessible at local authority level. For PIP, a number of claims are being currently reassessed following the PIP Judicial Review that ruled that the revised guidance unfairly discriminated against those with mental health problems. This DFG allocations review therefore looked at the impact of using data on PIP caseload (the number of 'live claims' which would include those being reassessed) and actual recipients. Although there is a big difference in the absolute numbers, the proportions of cases within each region and within each local authority within the two regions examined are virtually identical. Table 12.1 below illustrates the comparative regional profiles. The review concluded that the use of actual recipients was best for simplicity's sake.

12.21 One key disadvantage of using disability related DWP data is that it will underestimate potential need, because there will be some people who may be eligible for such benefits but who do not apply for them for various reasons. The

reasons include lack of knowledge, uncertainty around entitlement and concern that receipt of certain benefits may impact adversely on other support received. That said, DWP data is probably no less robust than other proxy indicators.

Table 12.1 Distributions of disability related DWP* payments/applications

	DLA payments			AA payments			PIP applications			PIP payments		
	number	%	rank	number	%	rank	number	%	rank	number	%	rank
North East	115,075	6.5	9	69,228	5.7	9	189,628	7.3	9	95,864	7.4	9
North West	298,628	16.9	1	181,182	15.0	2	460,259	17.7	1	238,713	18.3	1
Yorkshire and The Humber	195,696	11.1	4	117,608	9.7	7	290,549	11.1	5	144,492	11.1	5
East Midlands	159,066	9.0	8	108,282	8.9	8	241,746	9.3	6	116,850	9.0	8
West Midlands	195,608	11.1	5	142,768	11.8	3	322,456	12.4	3	153,508	11.8	4
East	163,623	9.3	7	140,004	11.6	4	240,400	9.2	7	120,952	9.3	6
London	230,771	13.1	3	127,710	10.5	6	324,250	12.4	2	160,802	12.3	2
South East	236,290	13.4	2	186,104	15.4	1	308,010	11.8	4	155,360	11.9	3
South West	168,137	9.5	6	138,324	11.4	5	229,504	8.8	8	117,658	9.0	7
Total	1,762,894	100.0		1,211,210	100.0		2,606,802	100.0		1,304,208	100.0	

*DWP data for August 2017

b) Census data

12.22 The census asks whether each person has a long-term illness or disability and whether it affects their day to day activities. The census data proved to be very strongly related to claimants of AA, PIP and DLA. As census data is more difficult to use for this type of analysis and only collected every 10 years, it was felt using the DWP data was, on balance, fairer and simpler.

12.23 Table 12.2 and Table 12.3 show the ranking of the different local authorities within Yorkshire and Humberside and within London for three types of data which may predict need for adaptations: the census data on long-term illness, receipt of AA, DLA and PIP combined and the overall 'health deprivation and disability domain' of IMD (see below). There is a very close correspondence between census data and benefit receipt, but less so with overall IMD.

c) Index of Multiple Deprivation¹²⁴

12.24 This has a separate 'health deprivation and disability' domain which does include receipt of disability related benefits in its construction. Other factors included are: years of potential life lost; acute morbidity; and a comparative illness and disability measure. It is more difficult to use in a formula, as it is an index that ranges from -1.0 to +1.0 and IMD is only updated sporadically. As the domain was again reasonably closely related to DWP benefit receipt, the review decided to omit this from further analysis. Furthermore, we were unable to conclude whether the data sources for the IMD indices are any more robust than DWP or census data.

¹²⁴ The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation

12.25 It is important to remember that all three data sources are only broad-brush indicators of baseline need for adaptations. Not all people with disabilities or claiming relevant benefits will need adaptations, either because they have them already and/or the nature of their disability means that there are no common adaptations to their home that can be made e.g. for someone with severe learning difficulties. Similarly, some people who have significant problems and would benefit from adaptations do not claim the disability related benefits they would qualify for.

12.26 In common with other surveys that include health/mobility related questions, the census is likely to underestimate the number of people with long-term health difficulties, as not all respondents wish their health problems to be recorded.

Table 12.2: Ranking of local authorities by potential need for adaptations, Yorkshire and Humberside

	Rank - IMD health deprivation	census rank (all long term disability - limits a lot)	DWP rank - benefit receipt*
Barnsley	21	15	14
Bradford	15	19	18
Calderdale	13	11	11
Craven	20	3	3
Doncaster	14	16	16
East Riding of Yorkshire UA	4	13	13
Hambleton	9	5	5
Harrogate	5	6	6
Kingston upon Hull, City of UA	17	12	12
Kirklees	12	17	17
Leeds	19	21	20
North East Lincolnshire UA	1	9	9
North Lincolnshire UA	8	10	10
Richmondshire	7	1	1
Rotherham	16	14	15
Ryedale	11	2	2
Scarborough	3	7	7
Selby	6	4	4
Sheffield	10	20	19
Wakefield	18	18	16
York UA	2	8	8

Note: * receiving AA, DLA or PIP at moment – numbers/lowest rank=1

Table 12.3: Ranking of local authorities by potential need for adaptations, London

	Rank - IMD health deprivation	census rank (all long term disability - limits a lot)	DWP rank - benefit receipt*
Barking and Dagenham	30	10	11
Barnet	7	32	31
Bexley	9	15	18
Brent	17	29	27
Bromley	6	27	26
Camden	21	9	12
City of London	4	1	1
Croydon	19	33	32
Ealing	20	31	30
Enfield	14	30	33
Greenwich	24	23	25
Hackney	31	20	22
Hammersmith and Fulham	27	6	5
Haringey	22	16	15
Harrow	5	12	9
Havering	12	24	17
Hillingdon	16	19	20
Hounslow	18	13	13
Islington	32	14	19
Kensington and Chelsea	3	4	4
Kingston upon Thames	2	2	2
Lambeth	25	21	23
Lewisham	26	25	24
Merton	8	5	6
Newham	29	28	29
Redbridge	11	26	16
Richmond upon Thames	1	3	3
Southwark	28	22	28
Sutton	10	7	7
Tower Hamlets	33	17	21
Waltham Forest	23	18	14
Wandsworth	13	11	10
Westminster	15	8	8

Note: * receiving AA, DLA or PIP at moment – numbers/lowest rank=1

2. Adjusting this ‘baseline need’ using factors

12.27 The review examined data sources and the impact of using three different sorts of factors:

- Income/affordability (including housing costs)
- Frail elderly
- Tenure

a) Income/affordability

12.28 Local authorities have the power to devise their own form of means testing to decide whether people get support from DFG to pay for all or part of the cost of their adaptations. Virtually all will ‘passport’ those who are in receipt of the main means tested benefits, which are:

- Income support
- Job seekers allowance (income based only)
- Employment and Support Allowance (income based only)
- Housing Benefit
- Council Tax Support
- Pension Credit (guarantee element only)
- Universal Credit (where rolled out)
- Working Tax Credit and/or Child Tax Credit, provided that the annual income for the purposes of assessing entitlement to the tax credit is less than £15,050 (in areas where Universal Credit still not ‘live’).

12.29 Some other benefits, like Carers Allowance, involve some means testing although this is only of income from employment, and using Carers Allowance will double count disability related benefit receipt. The problem is getting reliable data on whether people receive any of these.

12.30 The DWP data at local authority level do not cover combinations of benefits (there will be a lot of double counting, as people will often be claiming more than one type). The main double counting would be with housing benefit; using this would mean that the allocation model ran the risk of overestimating need amongst renters at the expense of owners (who can’t claim housing benefit). Also, the local level DWP data cannot distinguish between JSA and ESA, which are income based (i.e. means tested), and those which are contribution based (i.e. not means tested).

- 12.31 There does not appear to be any local authority or even regional level data on receipt of tax credits through either DWP or HMRC (who administer this benefit). In future, when Universal Credit (UC) is operating in all areas, it should be a lot simpler to use this data for working age households, as it covers all means tested benefits together with working tax credit. However, at the moment, using this UC data without the data on Tax Credits would result in bias, given that UC has been rolled out on a local authority by local authority basis and there are a large number of areas where it is still not 'live'. We were unable to find any local authority level data on receipt of Council Tax Support.
- 12.32 Given the current problems with establishing the number of households or people in receipt of means tested benefits, we examined the 'income' domain of IMD¹²⁵. The most useful part of this appears to be the number of people in income deprived households (see Appendix 2 for more information on how this domain is calculated). If we standardise this by the population, we can create a very simple low-income factor to adjust the proxy 'need' for DFG. This was done by calculating the proportion of the population who are 'income deprived' and adding 1.
- 12.33 For comparison, we created an 'income' factor using DWP benefit data; in this case the number of households who were claiming IS, JSA, ESA, PC or UC. There will be some double counting in certain households and between both ESA and PIP and between AA and pension credit. The impact of using this rather than IMD is broadly similar, with more variation apparent within London (highlighted in Table 12.5) than within Yorkshire and Humberside (Table 12.4). More detailed investigation would be needed to see how much of these differences may be due to the roll out of Universal Credit in different areas.

¹²⁵ The Income Deprivation Domain measures the proportion of the population in an area experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

Table 12.4: Profile of potential affordability of DFG, Yorkshire and Humberside

	IMD income		Receipt of means tested benefits	
	% income deprived	rank	% households in receipt	rank
East Riding of Yorkshire	10.6%	8	16.2%	8
Kingston upon Hull, City of	25.3%	22	32.3%	22
North East Lincolnshire	20.3%	21	27.3%	20
North Lincolnshire	14.7%	9	21.2%	11
York	8.1%	5	13.0%	2
Craven	7.7%	4	14.4%	6
Hambleton	7.4%	3	13.6%	5
Harrogate	7.1%	2	13.5%	4
Richmondshire	6.9%	1	13.1%	3
Ryedale	8.6%	7	16.0%	7
Scarborough	16.1%	15	24.2%	17
Selby	8.5%	6	13.0%	1
Barnsley	17.9%	17	27.6%	21
Doncaster	18.2%	18	25.9%	19
Rotherham	18.3%	19	25.4%	18
Sheffield	16.5%	16	22.7%	13
Bradford	19.9%	20	23.9%	16
Calderdale	15.8%	14	23.6%	15
Kirklees	14.9%	10	21.0%	10
Leeds	15.3%	11	20.6%	9
Wakefield	16.0%	12	23.1%	14
Total	15.7%	13	21.9%	12

Table 12.5: Profile of potential affordability of DFG, London

	IMD income		Receipt of means tested benefits	
	% income deprived	rank	% households in receipt	rank
Camden	15.2%	18	19.0%	21
City of London	5.0%	1	9.4%	1
Hackney	20.7%	33	23.4%	32
Hammersmith and Fulham	16.2%	21	23.0%	31
Haringey	19.1%	29	21.3%	28
Islington	18.9%	28	24.1%	34
Kensington and Chelsea	13.3%	13	18.9%	19
Lambeth	17.6%	24	20.6%	26
Lewisham	18.0%	27	20.7%	27
Newham	19.2%	30	18.3%	18
Southwark	17.8%	26	24.0%	33
Tower Hamlets	20.7%	32	22.1%	30
Wandsworth	11.9%	9	14.4%	11
Westminster	15.0%	16	17.7%	14
Barking and Dagenham	21.3%	34	20.4%	24
Barnet	12.0%	10	13.9%	9
Bexley	11.6%	7	14.1%	10
Brent	17.4%	23	19.0%	20
Bromley	10.3%	5	12.6%	4
Croydon	15.0%	17	21.9%	29
Ealing	15.9%	20	18.1%	17
Enfield	19.3%	31	19.2%	23
Greenwich	16.9%	22	20.1%	25
Harrow	11.9%	8	13.4%	6
Havering	12.2%	12	14.9%	12
Hillingdon	12.1%	11	13.3%	5
Hounslow	13.5%	14	19.2%	22
Kingston upon Thames	7.8%	3	10.5%	3
Merton	10.9%	6	13.6%	8
Redbridge	13.6%	15	13.5%	7
Richmond upon Thames	6.6%	2	9.9%	2
Sutton	10.2%	4	16.0%	13
Waltham Forest	17.8%	25	17.9%	15
Total	15.2%	19	17.9%	16

Housing costs

- 12.34 The review of the allocations model was also tasked with determining how housing costs could be factored into both the means test and the allocations model. This is especially challenging, not least because what housing costs should comprise is subjective e.g. should it be rental or mortgage costs only or should we include council tax, or should the location, age and type of home be given consideration, given that these housing characteristics influence maintenance and upkeep costs. There will also be costs incurred by owners e.g. maintenance and upkeep and buildings insurance that are not paid directly by renters but which are likely reflected in their rental payments.
- 12.35 The ONS has done some work in this area for owner occupiers, which is explained here:
<https://www.ons.gov.uk/economy/inflationandpriceindices/articles/understandingthedifferentapproachesofmeasuringowneroccupiershousingcosts/apriltojune2017>.
- 12.36 This may be a useful starting point for considering more work in this area if Government wishes to consider more depth analysis into housing costs.
- 12.37 Another important consideration for an allocations model is whether there is comprehensive, comparable and robust data for both private renters and registered provider renters, given that the latter provide statistical data returns to the Homes and Communities Agency¹²⁶ and private landlords have no such obligations.
- 12.38 Data on private rental costs will vary in coverage (i.e. not all can be analysed at local authority level), in completeness (i.e. the quantity and nature of missing data will likely vary) and in data collection methodology. There are several publicly available sources on the private rental market in the UK, although access to national survey data can only be accessed via the UK Data Archive. Main sources include: VOA data¹²⁷, the English Housing Survey and Family Resources Survey (FRS). Using VOA data would seem the most sensible data source, but further work would be required to fully assess how it could be factored in.
- 12.39 While local housing allowances do give an indicator of rents within an area, the allowances are based on the 30th percentile of rents (i.e. the lower end of the market only) and use different geographical boundaries to DFG.
- 12.40 Obtaining data on outstanding mortgage costs and monthly repayments is even more problematic, and we believe that only national survey data (e.g. EHS and FRS) could potentially assist with this at regional level only. We know from our work on the EHS that there are issues with the reliability of respondent data as

¹²⁶ <https://www.gov.uk/government/statistics/statistical-data-return-2016-to-2017>.

¹²⁷ ONS also VOA and other data to produce the Index of Private Housing Rental Prices (IPHRP) which is considered an experimental data source at present

well as a notable amount of missing data that makes robust analysis problematic.

- 12.41 The English Housing Survey Housing costs and affordability 2015-16 report¹²⁸, which BRE helped MHCLG to produce, contains analysis of average weekly housing cost (mortgage/rents) by tenure and by various household characteristics. The report also shows the average proportion of household income required to pay for these costs and how this varies according to the definition of household income e.g. income for the household reference person (HRP) for the survey only or the HRP and partner income or the income for all household members who, in theory, could contribute to such costs.
- 12.42 From the EHS report it is evident that there is both a broad range of average rental/mortgage costs and a broad range for the proportion of income required to meet these costs, by tenure and type of household. The region where people live will, of course, also impact on these averages. The report therefore, seems to give weight to the suggestion that housing costs are an important issue in terms of someone's ability to pay for an adaptation. At the same time, however, the report also demonstrates the complexity of the task e.g. by demonstrating how the definition of income (particularly whose income) can impact on findings; this is a similar issue for the means test.
- 12.43 In view of the above, it is likely very difficult to apply a simple, transparent and fair regional or local authority factor into DFG allocations formula to take account of housing costs.
- 12.44 To summarise, both the DWP benefit receipt data have disadvantages, and we believe that the issue of housing costs is far too complex to include within an allocation formula. However, as it is more regularly updated, transparent and accessible, we feel that the DWP benefit data provides a better indicator of relative 'ability to pay', and that its disadvantages will reduce once Universal Credit is live in all areas of England.

3. 'Frail elderly factor'

- 12.45 The reviewers felt it was sensible to still include something in the allocations model to take account of the age of the local population, given that older people are more likely to need home adaptations, albeit they are also more likely to have a long-term limiting illness included into the baseline indicator of need.
- 12.46 Currently, the simplified allocations model includes a component for the proportion of population aged 60 or over. At minimum, the review recommends that the current allocations model adjusts the age threshold to an age where

¹²⁸ Ministry of Housing, Communities and Local Government (2017b) English Housing Survey: Housing costs and affordability, 2015-16, London: MHCLG.
<https://www.gov.uk/government/statistics/english-housing-survey-2015-to-2016-housing-costs-and-affordability>.

people are eligible for the basic State Pension; although this varies for men and women, a singular threshold would be simpler to model and administer.

- 12.47 Within the BCF formula, there is a component for older people that includes a factor to take account of 'frail elderly'; in this case defined as the percentage of all these aged 65 or over who are 90 years old or more. There are grounds for considering a 'frail elderly' factor in a new DFG allocations model to replace the existing age component; the question is what the age threshold should be. The BCF approach of taking those at least 90 years old is mainly there to account for the need for residential care, as a higher proportion of this age group are no longer living at home.
- 12.48 This review looked at an approach to include a factor to take account of the proportion of people aged 75 or over in the sensitivity testing, but this 'frail elderly' threshold could be changed. This data comes from population age statistics from the census which are regularly updated by projections. For this research we have taken an average of the estimates produced for 2014-2023. We decided to take the percentage of the total population aged 75 or older which was converted into a simple factor by adding 1.0.

a) Tenure

- 12.49 Only people who are home owners, registered provider renters or private renters can apply for a DFG, so the formula needs to take account of the fact that the proportion of local authority stock varies considerably by local authority, with a number having no stock at all following Large Scale Voluntary Transfer (LSVT). It is relatively simple to construct a factor to adjust the proxy 'need' using the proportion of eligible tenure dwellings in the local authority area. This uses MHCLG data on stock by tenure and local authority area and is updated annually.
- 12.50 The data on grant recipients suggests that a disproportionate number of grants go to registered provider tenants, although it is unclear whether a disproportionate amount of the total budget goes to these tenants as well. This is not surprising as the shortage of social housing in most areas means that it is rationed to those most in need (including people with disabilities) and registered provider homes are proactively managed by staff who have a good knowledge of the council services and grants available.
- 12.51 Home owners may not be aware DFG exists unless they find out about it by chance (e.g. after being referred to social services after a fall, from friends/neighbours or advice agencies). Private tenants may be even less likely to be aware of DFG's and require the permission of their landlord to carry out any works. Whether the DFG allocation system should try to address this by accepting the current barriers to private sector occupiers and giving more money to local authorities with a large proportion of registered provider stock or whether it should try to be equitable between tenures and consider measures

to increase awareness and take-up in the private sector is something that needs full and careful consideration.

4. The new baseline and impact of adding each factor

12.52 A new 'baseline' need was created, based on the total number of people receiving DLA, PIP or AA within that area. We looked at how this affected the relative need between regions and within the two selected regions: Yorkshire and Humberside; and London. We then calculated new allocations based on this by splitting the existing pot¹²⁹ (for that region or England as a whole) according to the proportion of all claimants within the local authority/region.

12.53 Looking first at the baseline position for each overall region (Table 12.6), this looks rather different from their current share of the national allocation, with greater need in the North West, East Midlands and North East than suggested by current allocations, and lesser need in Yorkshire and Humber and the South East.

Table 12.6: Baseline 'need' by region and current allocation share

	Baseline need	Proportion of total pot	allocation - baseline need	current 2016 allocation	change in £	% change (as % of current)
North East	280,167	0.065	£25,801,250	£21,738,299	£4,062,951	18.7
North West	718,523	0.168	£66,170,504	£39,216,448	£26,954,056	68.7
Yorkshire and The Humber	457,796	0.107	£42,159,530	£67,931,075	-£25,771,545	-37.9
East Midlands	384,198	0.090	£35,381,714	£27,953,686	£7,428,028	26.6
West Midlands	491,884	0.115	£45,298,776	£48,918,976	-£3,620,200	-7.4
East	424,579	0.099	£39,100,497	£35,533,186	£3,567,311	10.0
London	519,283	0.121	£47,822,015	£51,520,879	-£3,698,864	-7.2
South East	577,754	0.135	£53,206,750	£63,110,289	-£9,903,539	-15.7
South West	424,119	0.099	£39,058,135	£38,077,162	£980,972	2.6
Total	4,278,312	1.000	£394,000,000	£394,000,000	£0	0.0

12.54 The picture within the two regions examined in detail is also rather different. In Yorkshire and Humberside, baseline need is indicated to be much greater in some areas, although there is no pattern of more/less money for metropolitan areas as opposed to more rural authorities (Table 12.7). Baseline need is significantly lower in North East Lincolnshire, North Lincolnshire, Craven, Ryedale and Calderdale and significantly higher in Hambleton, Harrogate, Selby, Doncaster and Sheffield.

¹²⁹ Based on 2016/17 DFG allocations -termed 'current allocation' for ease of reading.

Table 12.7: Yorkshire and Humberside - baseline 'need' by local authority and current allocation share

	Baseline need	Proportion of total pot	allocation - baseline need	current 2016 allocation	change in £	% change (as % of current)
East Riding of Yorkshire	25,467	0.056	£2,181,614	£2,127,454	£54,160	2.546
Kingston upon Hull, City of	24,200	0.053	£2,073,077	£1,968,062	£105,015	5.336
North East Lincolnshire	14,936	0.033	£1,279,483	£2,188,308	-£908,825	-41.531
North Lincolnshire	15,108	0.033	£1,294,217	£1,763,122	-£468,905	-26.595
York	11,032	0.024	£945,049	£1,003,471	-£58,422	-5.822
Craven	3,855	0.008	£330,236	£433,307	-£103,071	-23.787
Hambleton	5,797	0.013	£496,596	£375,828	£120,768	32.134
Harrogate	9,448	0.021	£809,357	£571,343	£238,014	41.659
Richmondshire	2,988	0.007	£255,965	£212,493	£43,472	20.458
Ryedale	3,467	0.008	£296,998	£452,569	-£155,571	-34.375
Scarborough	10,793	0.024	£924,575	£1,145,100	-£220,525	-19.258
Selby	5,647	0.012	£483,747	£346,958	£136,788	39.425
Barnsley	28,974	0.063	£2,482,038	£2,330,936	£151,102	6.482
Doncaster	30,711	0.067	£2,630,837	£1,965,353	£665,485	33.861
Rotherham	29,367	0.064	£2,515,705	£2,119,269	£396,436	18.706
Sheffield	51,263	0.112	£4,391,411	£3,509,204	£882,207	25.140
Bradford	43,685	0.095	£3,742,247	£3,519,468	£222,779	6.330
Calderdale	15,866	0.035	£1,359,150	£2,063,214	-£704,064	-34.125
Kirklees	34,678	0.076	£2,970,668	£2,483,091	£487,577	19.636
Leeds	56,263	0.123	£4,819,733	£5,630,909	-£811,176	-14.406
Wakefield	34,247	0.075	£2,933,747	£3,006,990	-£73,243	-2.436
Total	457,792	1.000	£39,216,448	£39,216,448	£0	0.000

Note: changes of 15% or more highlighted

12.55 For London, there is more of a clear pattern with baseline need tending to be higher than current allocations in inner London and lower in Outer London (Table 12.8).

Table 12.8: London - baseline 'need' by local authority and current allocation share

	Baseline need	Proportion of total pot	allocation - baseline need	current 2016 allocation	change in £	% change (as % of current)
Camden	14,900	0.029	£1,478,278	£727,538	£750,740	103.189
City of London	290	0.001	£28,772	£26,313	£2,459	9.344
Hackney	18,394	0.035	£1,824,930	£1,184,865	£640,065	54.020
Hammersmith and Fulham	10,076	0.019	£999,673	£1,018,510	-£18,837	-1.849
Haringey	16,726	0.032	£1,659,442	£1,818,183	-£158,742	-8.731
Islington	17,097	0.033	£1,696,250	£1,318,486	£377,764	28.651
Kensington and Chelsea	8,033	0.015	£796,981	£666,726	£130,255	19.536
Lambeth	18,701	0.036	£1,855,388	£1,145,265	£710,123	62.005
Lewisham	18,859	0.036	£1,871,064	£1,053,080	£817,984	77.675
Newham	20,000	0.039	£1,984,266	£1,932,506	£51,761	2.678
Southwark	19,726	0.038	£1,957,082	£1,149,371	£807,711	70.274
Tower Hamlets	17,495	0.034	£1,735,737	£1,572,542	£163,195	10.378
Wandsworth	14,584	0.028	£1,446,927	£1,199,531	£247,396	20.624
Westminster	13,647	0.026	£1,353,964	£1,182,326	£171,639	14.517
Barking and Dagenham	14,737	0.028	£1,462,107	£1,264,509	£197,598	15.626
Barnet	20,774	0.040	£2,061,057	£1,971,131	£89,926	4.562
Bexley	17,001	0.033	£1,686,726	£2,023,569	-£336,844	-16.646
Brent	19,578	0.038	£1,942,398	£3,599,500	-£1,657,102	-46.037
Bromley	19,132	0.037	£1,898,149	£1,680,928	£217,222	12.923
Croydon	24,909	0.048	£2,471,304	£2,046,194	£425,110	20.776
Ealing	20,360	0.039	£2,019,983	£2,529,769	-£509,785	-20.151
Enfield	21,301	0.041	£2,113,343	£2,542,222	-£428,880	-16.870
Greenwich	18,935	0.036	£1,878,604	£1,941,443	-£62,838	-3.237
Harrow	14,260	0.027	£1,414,782	£1,180,502	£234,280	19.846
Havering	16,900	0.033	£1,676,705	£1,426,010	£250,695	17.580
Hillingdon	17,401	0.034	£1,726,411	£3,456,593	-£1,730,182	-50.055
Hounslow	15,153	0.029	£1,503,379	£2,033,255	-£529,875	-26.060
Kingston upon Thames	7,655	0.015	£759,478	£1,032,341	-£272,864	-26.432
Merton	10,159	0.020	£1,007,908	£989,719	£18,189	1.838
Redbridge	16,830	0.032	£1,669,760	£1,659,392	£10,368	0.625
Richmond upon Thames	8,004	0.015	£794,103	£1,307,463	-£513,359	-39.264
Sutton	11,820	0.023	£1,172,701	£1,233,241	-£60,539	-4.909
Waltham Forest	15,857	0.031	£1,573,226	£1,607,858	-£34,632	-2.154
Total	519,294	1.000	£51,520,879	£51,520,879	£0	0.000

Note: changes of 15% or more highlighted

12.56 It is interesting that the relative baseline need indicated by receipt of disability related benefits differs so much from the current DFG allocations when the method for existing allocations uses receipt of disability related benefits as its baseline. There are probably two main reasons for this difference:

- The new baseline does not include out of work income replacement benefits for those deemed unable to work due to health and disability – previously invalidity benefit and now ESA.
- The criteria for receiving PIP are subtly different, and in some aspects more stringent, than those for receiving DLA which it replaced. There has been considerable controversy about the face to face assessment process for PIP

and the many perceived harsh decisions that have been made, and the high success rate of mandatory reconsiderations and full appeals against the initial DWP assessments.

12.57 We added each of the 3 factors (low income, frail elderly and tenure) in turn to examine the impact of each stage. All were given equal weight, which may or may not be the best approach, although it does illustrate the direction of any shifts.

Table 12.9: Overall Regions – modelled amounts at each stage

	new allocation with same total pot				current 2016 allocation
	Baseline need	plus income	plus income and elderly	plus income, elderly and tenure	
North East	£25,801,250	£27,510,015	£27,610,168	£27,310,654	£21,738,299
North West	£66,170,504	£69,019,952	£69,009,411	£71,979,448	£39,216,448
Yorkshire and The Humber	£42,159,530	£42,945,336	£42,930,066	£41,512,036	£67,931,075
East Midlands	£35,381,714	£35,017,484	£35,105,520	£34,278,329	£27,953,686
West Midlands	£45,298,776	£45,965,111	£46,045,602	£45,263,348	£48,918,976
East	£39,100,497	£37,684,408	£37,932,538	£38,268,033	£35,533,186
London	£47,822,015	£47,093,071	£45,662,458	£43,341,554	£51,520,879
South East	£53,206,750	£50,575,282	£50,859,031	£52,009,113	£63,110,289
South West	£39,058,135	£38,189,340	£38,845,205	£40,037,485	£38,077,162
Total	£394,000,000	£394,000,000	£394,000,000	£394,000,000	£394,000,000

Table 12.10: Overall Regions – difference from current allocation share

	Change from current allocation			
	Baseline need	plus income	plus income and elderly	plus income, elderly and tenure
North East	£4,062,951	£5,771,716	£5,871,869	£5,572,355
North West	£26,954,056	£29,803,504	£29,792,963	£32,763,000
Yorkshire and The Humber	-£25,771,545	-£24,985,739	-£25,001,009	-£26,419,039
East Midlands	£7,428,028	£7,063,798	£7,151,834	£6,324,643
West Midlands	-£3,620,200	-£2,953,865	-£2,873,373	-£3,655,628
East	£3,567,311	£2,151,222	£2,399,352	£2,734,847
London	-£3,698,864	-£4,427,808	-£5,858,421	-£8,179,325
South East	-£9,903,539	-£12,535,006	-£12,251,257	-£11,101,175
South West	£980,972	£112,178	£768,043	£1,960,323
Total	£0	£0	£0	£0

Note: negative=less money than 2016/17

12.58 Looking at the regions where the estimates show most change, it is clear that different factors are having more effect in different areas. For example, in the

North West, the baseline itself is much higher and gets a big uplift on this compared with the income and, especially, the tenure factors. In the North East, the main uplift to the baseline is from the income factor. For those regions where need is estimated to be significantly lower than the current model, again we can see the different impact of the factors. For Yorkshire and Humberside, the huge change to the baseline is exaggerated further when the tenure factor is added, whereas for the South East, the main reduction to the lower baseline comes with adding the income factor. Applying the tenure factor at the final stage helps to reduce the losses somewhat.

12.59 Table 12.11 and Table 12.12 examine the modelled impacts of each factor for the local authorities within the Yorkshire and Humberside region.

Table 12.11: Yorkshire and Humberside– modelled amounts at each stage

	new allocation with same total pot				current 2016 allocation
	Baseline need	plus income	plus income and elderly	plus income, elderly and tenure	
East Riding of Yorkshire	£2,181,614	£2,079,474	£2,139,202	£2,195,015	£2,127,454
Kingston upon Hull, City of	£2,073,077	£2,248,609	£2,212,070	£1,944,883	£1,968,062
North East Lincolnshire	£1,279,483	£1,335,428	£1,347,573	£1,492,913	£2,188,308
North Lincolnshire	£1,294,217	£1,286,013	£1,297,706	£1,437,671	£1,763,122
York	£945,049	£876,038	£877,235	£886,502	£1,003,471
Craven	£330,236	£309,812	£321,732	£356,480	£433,307
Hambleton	£496,596	£462,819	£478,436	£530,109	£375,828
Harrogate	£809,357	£753,197	£774,317	£811,242	£571,343
Richmondshire	£255,965	£237,494	£239,548	£247,989	£212,493
Ryedale	£296,998	£282,444	£292,039	£323,580	£452,569
Scarborough	£924,575	£941,584	£976,868	£1,082,372	£1,145,100
Selby	£483,747	£448,306	£449,875	£457,905	£346,958
Barnsley	£2,482,038	£2,597,473	£2,598,507	£2,382,801	£2,330,936
Doncaster	£2,630,837	£2,715,339	£2,719,558	£2,554,325	£1,965,353
Rotherham	£2,515,705	£2,587,290	£2,596,968	£2,359,306	£2,119,269
Sheffield	£4,391,411	£4,419,187	£4,388,546	£4,055,712	£3,509,204
Bradford	£3,742,247	£3,802,704	£3,738,680	£4,138,943	£3,519,468
Calderdale	£1,359,150	£1,377,591	£1,372,881	£1,520,833	£2,063,214
Kirklees	£2,970,668	£2,946,672	£2,925,055	£2,839,257	£2,483,091
Leeds	£4,819,733	£4,767,253	£4,707,865	£4,351,946	£5,630,909
Wakefield	£2,933,747	£2,961,554	£2,963,420	£3,282,177	£3,006,990
Total	£39,216,448	£39,216,448	£39,216,448	£39,216,448	£39,216,448

12.60 It appears that the tenure factor is having a greater effect than either low income or frail elderly – this is simply because there is more variation in this factor than in the other two. In some cases, e.g. North East Lincolnshire, the addition of the tenure factor acts to reduce the large losses to some extent, whereas the opposite happens for Leeds, where adding the tenure factor increases the losses further.

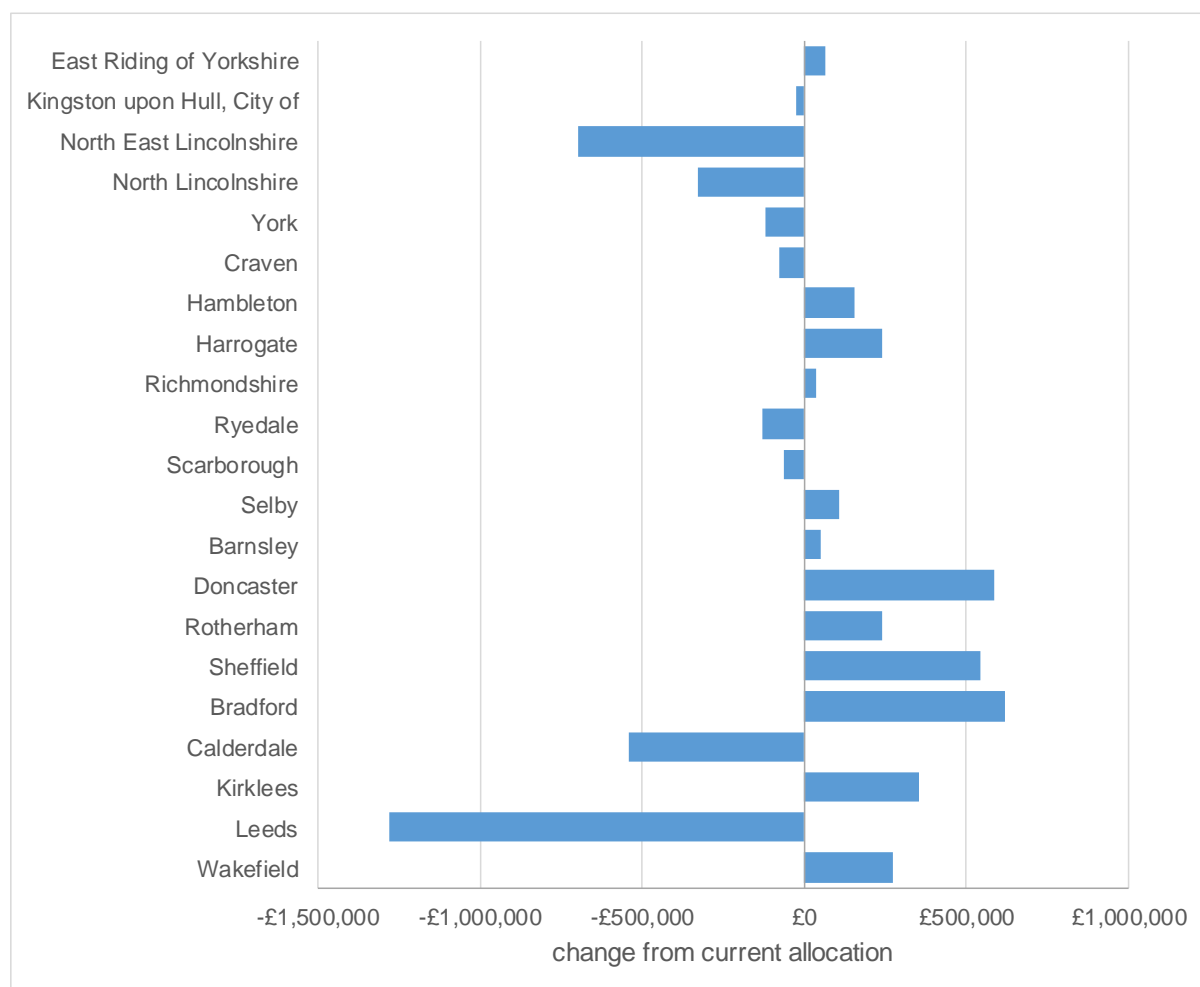
Table 12.12: Yorkshire and Humberside – difference from current allocation share

	Change from current allocation				
	baseline need	plus income	plus income and elderly	plus income, elderly and tenure	
East Riding of Yorkshire	£54,160	-£47,979	£11,748	£67,561	
Kingston upon Hull, City of	£105,015	£280,548	£244,008	-£23,178	
North East Lincolnshire	-£908,825	-£852,880	-£840,735	-£695,395	big loss
North Lincolnshire	-£468,905	-£477,109	-£465,416	-£325,451	moderate loss
York	-£58,422	-£127,432	-£126,235	-£116,969	
Craven	-£103,071	-£123,495	-£111,575	-£76,827	
Hambleton	£120,768	£86,991	£102,608	£154,280	
Harrogate	£238,014	£181,854	£202,974	£239,899	moderate gain
Richmondshire	£43,472	£25,001	£27,055	£35,496	
Ryedale	-£155,571	-£170,125	-£160,530	-£128,989	
Scarborough	-£220,525	-£203,516	-£168,232	-£62,728	
Selby	£136,788	£101,348	£102,916	£110,947	
Barnsley	£151,102	£266,537	£267,571	£51,865	
Doncaster	£665,485	£749,987	£754,206	£588,972	big gain
Rotherham	£396,436	£468,021	£477,699	£240,037	moderate gain
Sheffield	£882,207	£909,983	£879,342	£546,509	big gain
Bradford	£222,779	£283,236	£219,212	£619,475	big gain
Calderdale	-£704,064	-£685,623	-£690,333	-£542,381	big loss
Kirklees	£487,577	£463,581	£441,963	£356,166	moderate gain
Leeds	-£811,176	-£863,656	-£923,044	-£1,278,962	big loss
Wakefield	-£73,243	-£45,436	-£43,569	£275,188	moderate gain
Total	£0	£0	£0	£0	

Note: negative=less money than 2016/17

12.61 The largest overall reduction in allocation applying this method would be for Leeds, where the baseline is estimated to be very much lower and the losses just seem to get bigger as each of the other factors is applied; especially the tenure factor at the end. The largest increases would be for Sheffield and Bradford – it is interesting to note that applying the tenure factor at the end significantly decreases the allocation for the former and increases it for the latter. The findings from Table 12.12 is shown graphically in Figure 12.2.

Figure 12.2: Yorkshire and Humberside – differences from current allocations



12.62 Table 12.13 and Table 12.14 examine the modelled impacts of each factor for the local authorities within London.

12.63 It is interesting to see that the final stage of factoring in the percentage of stock that is not LA owned has a very big impact for some authorities; most notably Southwark where around 30% of stock is still owned by the local authority. Here, and in other boroughs with a high proportion of local authority homes, e.g. Camden, Hackney and Islington the tenure factor acts to ‘dampens down’ to some extent the very significant increases in estimated need.

Table 12.13: London– modelled amounts at each stage

	new allocation with same total pot				current 2016 allocation
	Baseline need	plus income	plus income and elderly	plus income, elderly and tenure	
Camden	£1,478,278	£1,492,031	£1,490,917	£1,302,448	£727,538
City of London	£28,772	£26,704	£26,918	£28,266	£26,313
Hackney	£1,824,930	£1,910,794	£1,869,796	£1,675,795	£1,184,865
Hammersmith and Fulham	£999,673	£1,042,635	£1,035,054	£999,862	£1,018,510
Haringey	£1,659,442	£1,707,438	£1,686,900	£1,631,381	£1,818,183
Islington	£1,696,250	£1,784,916	£1,758,000	£1,480,399	£1,318,486
Kensington and Chelsea	£796,981	£804,148	£814,849	£847,404	£666,726
Lambeth	£1,855,388	£1,897,513	£1,863,715	£1,740,032	£1,145,265
Lewisham	£1,871,064	£1,915,406	£1,893,689	£1,887,293	£1,053,080
Newham	£1,984,266	£1,991,520	£1,946,741	£1,879,336	£1,932,506
Southwark	£1,957,082	£2,059,245	£2,021,057	£1,603,998	£1,149,371
Tower Hamlets	£1,735,737	£1,797,321	£1,749,319	£1,767,349	£1,572,542
Wandsworth	£1,446,927	£1,403,636	£1,387,682	£1,380,518	£1,199,531
Westminster	£1,353,964	£1,351,824	£1,353,035	£1,379,082	£1,182,326
Barking and Dagenham	£1,462,107	£1,492,669	£1,477,594	£1,258,976	£1,264,509
Barnet	£2,061,057	£1,991,650	£2,018,501	£2,116,485	£1,971,131
Bexley	£1,686,726	£1,631,912	£1,674,355	£1,889,977	£2,023,569
Brent	£1,942,398	£1,960,461	£1,959,444	£2,055,353	£3,599,500
Bromley	£1,898,149	£1,812,824	£1,866,566	£2,106,023	£1,680,928
Croydon	£2,471,304	£2,554,534	£2,573,324	£2,645,366	£2,046,194
Ealing	£2,019,983	£2,023,239	£2,027,110	£2,068,846	£2,529,769
Enfield	£2,113,343	£2,136,872	£2,153,260	£2,230,206	£2,542,222
Greenwich	£1,878,604	£1,913,862	£1,900,039	£1,713,411	£1,941,443
Harrow	£1,414,782	£1,361,481	£1,386,258	£1,479,639	£1,180,502
Havering	£1,676,705	£1,633,728	£1,691,620	£1,725,816	£1,426,010
Hillingdon	£1,726,411	£1,659,887	£1,673,265	£1,715,535	£3,456,593
Hounslow	£1,503,379	£1,520,622	£1,515,684	£1,485,445	£2,033,255
Kingston upon Thames	£759,478	£711,957	£720,424	£754,757	£1,032,341
Merton	£1,007,908	£971,044	£973,675	£1,098,272	£989,719
Redbridge	£1,669,760	£1,607,796	£1,612,479	£1,740,743	£1,659,392
Richmond upon Thames	£794,103	£740,387	£750,734	£847,413	£1,307,463
Sutton	£1,172,701	£1,153,700	£1,173,890	£1,227,993	£1,233,241
Waltham Forest	£1,573,226	£1,573,691	£1,565,184	£1,595,272	£1,607,858
Total	£51,520,879	£51,520,879	£51,520,879	£51,520,879	£51,520,879

12.64 Looking at the two biggest ‘losers’ with a new method (Brent and Hillingdon) highlights the inequity of the allocation system used up until 2010 and which still influences allocations today. Between them, they house about 7% of the total population of London but are being allocated 14% of the total DFG funds for London. This can be traced back to the allocations for 2010/11, when both authorities bid for and received allocations at more than double the needs formula in use at the time.

12.65 In contrast, the biggest ‘winners’ with a new method (Lewisham and Camden) received less than half of their ‘need’ due to placing low bids in 2010/11.

Table 12.14: London – difference from current allocation

	Change from current allocation				
	baseline need	plus income	plus income and elderly	plus income, elderly and tenure	
Camden	£750,740	£764,493	£763,379	£574,910	big gain
City of London	£2,459	£391	£605	£1,953	
Hackney	£640,065	£725,929	£684,931	£490,930	big gain
Hammersmith and Fulham	-£18,837	£24,125	£16,543	-£18,648	
Haringey	-£158,742	-£110,745	-£131,283	-£186,803	
Islington	£377,764	£466,430	£439,514	£161,914	
Kensington and Chelsea	£130,255	£137,422	£148,123	£180,678	
Lambeth	£710,123	£752,249	£718,450	£594,767	big gain
Lewisham	£817,984	£862,326	£840,609	£834,213	big gain
Newham	£51,761	£59,015	£14,235	-£53,170	
Southwark	£807,711	£909,874	£871,686	£454,627	big gain
Tower Hamlets	£163,195	£224,780	£176,777	£194,808	
Wandsworth	£247,396	£204,106	£188,151	£180,987	
Westminster	£171,639	£169,498	£170,710	£196,756	
Barking and Dagenham	£197,598	£228,160	£213,085	-£5,533	
Barnet	£89,926	£20,519	£47,370	£145,354	
Bexley	-£336,844	-£391,658	-£349,215	-£133,592	
Brent	-£1,657,102	-£1,639,039	-£1,640,056	-£1,544,147	very big loss
Bromley	£217,222	£131,896	£185,639	£425,096	moderate gain
Croydon	£425,110	£508,339	£527,129	£599,171	big gain
Ealing	-£509,785	-£506,530	-£502,658	-£460,923	moderate loss
Enfield	-£428,880	-£405,350	-£388,963	-£312,016	moderate loss
Greenwich	-£62,838	-£27,581	-£41,403	-£228,032	
Harrow	£234,280	£180,979	£205,756	£299,137	moderate gain
Havering	£250,695	£207,718	£265,610	£299,807	moderate gain
Hillingdon	-£1,730,182	-£1,796,706	-£1,783,329	-£1,741,058	very big loss
Hounslow	-£529,875	-£512,633	-£517,571	-£547,809	big loss
Kingston upon Thames	-£272,864	-£320,384	-£311,917	-£277,584	moderate loss
Merton	£18,189	-£18,675	-£16,044	£108,553	
Redbridge	£10,368	-£51,597	-£46,913	£81,350	
Richmond upon Thames	-£513,359	-£567,076	-£556,729	-£460,050	moderate loss
Sutton	-£60,539	-£79,541	-£59,350	-£5,248	
Waltham Forest	-£34,632	-£34,167	-£42,673	-£12,586	
Total	£0	£0	£0	£0	

Note: negative=less money than 2016/17

12.66 The findings from Table 12.14 are shown graphically below in Figure 12.3 and Figure 12.4 for outer and inner London authorities respectively. Note that the axis scale for the 'change from current allocation' is different for each graph, owing to the far larger values for the outer London authorities.

Figure 12.3: Outer London – differences from current allocations

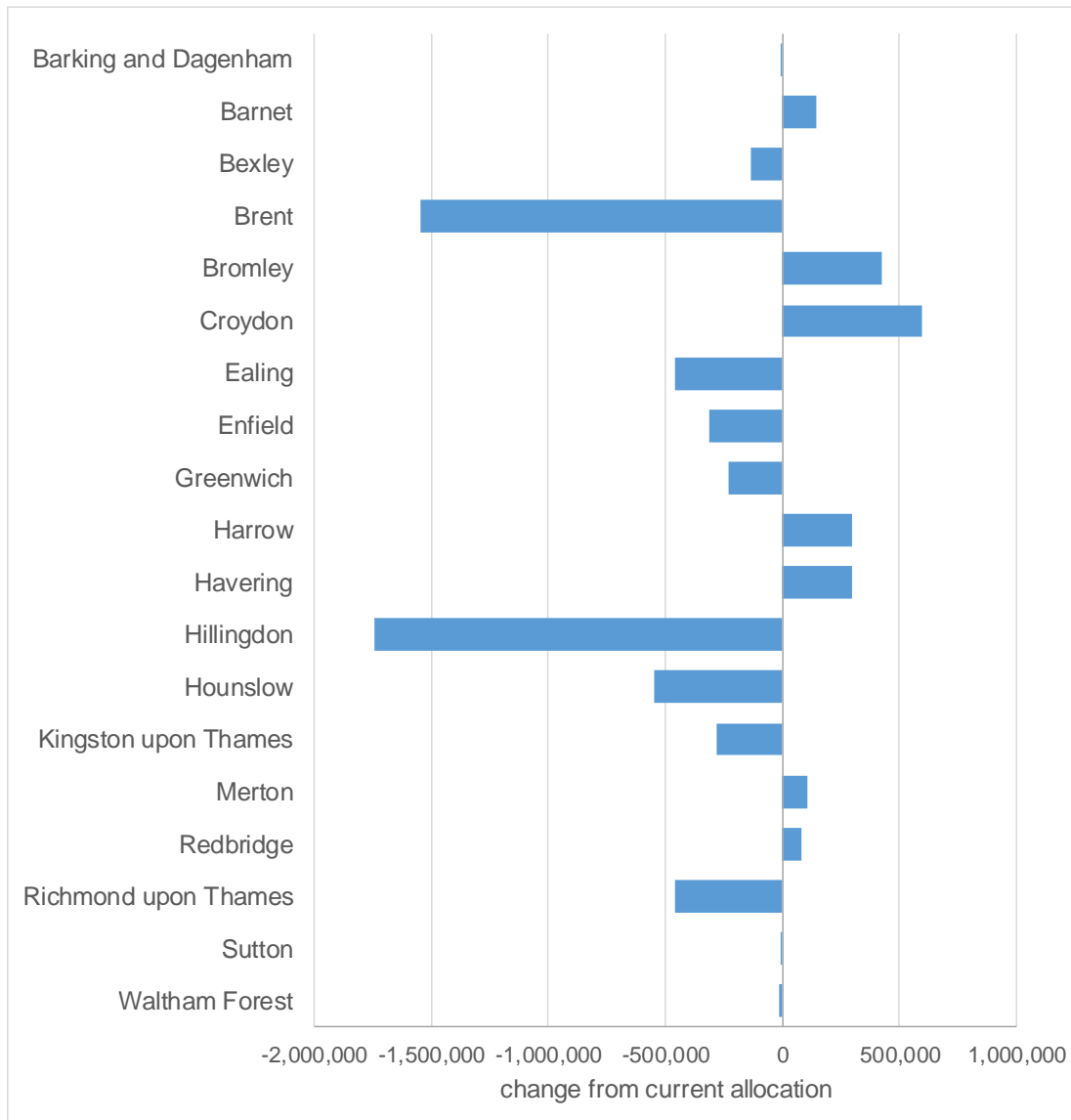
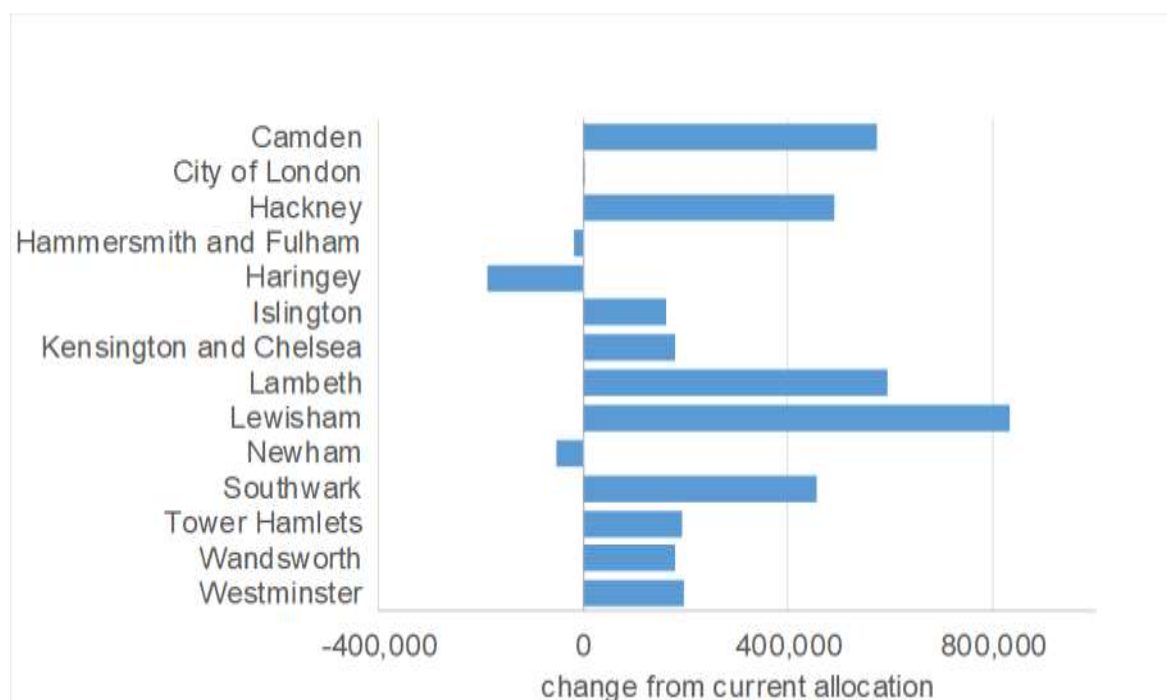


Figure 12.4: Inner London – differences from current allocations



Building costs/cost of adaptations

12.67 The 2011 BRE review found no firm evidence for regional differences in costs of adaptations due to variations in the dwelling profile (age and types of homes) of the housing stock in each region. However, average costs for DFG works examined at the time of the 2011 review and via the data obtained in this review show some variation by region for similar type of work. Both the full and simplified allocation models recommended in the 2011 review included a factor for variations in building costs (BCIS tender price index).

12.68 There are likely to be several sources for data on building cost variation, such as the BCIS which requires a subscription. This review found details of UK Construction Cost Regional Variations via: <https://www.costmodelling.com/regional-variations>. The indices set out in this website are given in Table 12.14

Table 12.14: Building cost variations by region

Region	Index
North East	100
North West	97
Yorkshire and Humberside	95
West Midlands	92
East Midlands	94
East Anglia	100
South West	100
South East	109
Outer London	105
Inner London	111
UK National Average	100

Note: based on 1Q 2018 where Year 2000 = 100

12.69 There are possible other advantages in including a building cost factor:

- If we link the upper limit of the DFG to regional building costs to overcome the disparity in costs for larger extensions, it would probably make sense to reflect this in an allocation formula.
- The use of building cost would likely ‘dampen’ the potential changes in DFG allocations, should the allocations model change using the factors examined in this review. However, it would have little impact on the main ‘winner’ (North West) and would actually reduce the allocation of the main ‘loser’ (Yorkshire and the Humber) further still.

12.70 It is important to note, however, that building prices can be influenced significantly by local market conditions, and by the size, location and specification of the building works. Furthermore, some local authorities may be able to organise their contractual obligations to procure work in cost-effective ways e.g. gaining a discounted fee for work by using one supplier. Consequently, building costs indices can only provide an indicative guide of regional variations.

Summary points – allocation of resources

12.71 These are the main themes highlighted by the review into the DFG allocation methodology.

1. **There are concerns of a possible misalignment between government funding for DFG and actual expenditure on DFG at local level.** This review therefore needed to examine whether the current allocations methodology used for DFG funding uplifts is still fit for purpose.

2. **It is important to recognise that under-spending by some local authorities and overspending by others is not solely due to current allocations being a poor reflection of need.** There are a number of other factors including the efficiency and resourcing of the whole DFG process from initial referral to commissioning of the work which are probably more important determinants of this. For this reason, we suggest that it is important for commissioning groups to monitor underspend and to understand the reasons for this so appropriate action can be taken e.g. extra support for individual local authorities, resource pooling or co-operative working and even re-allocation of funds within an area.
3. **There are no robust data that can accurately predict the need for DFG at regional or local level.** The available data can only act as proxy indicators of that need.
4. **The data used for any allocation formula should be simple, transparent, fair and as robust as possible** while responsive to changes in the population and their circumstances.
5. If a new allocations model were to only include a baseline proxy indicator for potential need for home adaptations, the allocations would likely change markedly at both regional level and local authority level. **The introduction of additional factors for ability to pay and age/frailty would obviously change the distribution of funding further**, but the **introduction of a tenure factor can cause marked changes in relative potential need** due to the large variations in the proportion of local authority owned stock.
6. In view of the marked impact of a tenure factor upon allocations and the varied approach by registered providers in meeting their tenants' need to home adaptations, should the DFG allocation system try to address this by accepting the current barriers to private sector occupiers and giving **more money to local authorities with a large proportion of housing association stock?** Alternatively, **should the allocation try to be equitable between tenures and consider measures to increase awareness and take-up in the private sector?**
7. Given the difficulties in fine tuning allocations to need, our review recommends that there should **consideration of more collaborate DFG funding arrangements among BCF partners** to ensure the most effective use of resources and more cross local authority collaborations. Using joint pots of funds would also assist local authorities to meet the need for expensive adaptations often required for children.
8. **The review used disability related DWP data** to establish a baseline proxy indicator of needs, due to its transparency and regularity of update. Although the DWP data likely underestimates the prevalence of long-term illness (e.g. issues with take-up of benefits), it is probably no less robust than other potential data sources.
9. **The review also introduced other factors of potential DFG need and examined their impact on allocations.** These factors were: ability to pay

(using DWP income-based data), frail elderly (census population – predictive data) and tenure (MHCLG data). These were given equal weight, but this may not be the best approach and requires further consideration and sensitivity testing. **Are the factors considered by the review for the formula sensible?**

- I. **Should the formula include the income indicator?** Working age people with a disability are more likely to have relatively lower incomes but this applies less to older people.
 - II. **Should the formula include an age factor** and if so, what should the threshold be? Including an age factor is likely to take funds away from ‘younger’ regions like London but on the other hand, older people are more likely to need adaptations.
10. **The use of regional building costs should be given serious consideration**, although these will not reflect local market conditions and variations in procurement strategies.
 11. **Including housing costs into a new allocation formula is problematic due to lack of robust data.** Housing costs may be difficult to define (because there is potential for any definition to be unfair) and are incredibly varied by tenure and among different types of households.
 12. **More sensitivity analysis is needed** to look at impact of factors across regions and all local authorities.
 13. Any change in allocation methodology is likely to result in significant ‘winners’ and ‘losers’ due to the impact of bids made in 2010/11 that still influence allocations today. **A new allocation formula would need to be incrementally introduced over a number of years to allow the biggest ‘winners’ and ‘losers’ to compensate.**

Recommendations - allocation of resources

- **That the allocation formula options are explored further using sensitivity analysis.**
- **That a new allocation formula is established for the next Comprehensive Spending Review and is applied incrementally over the implementation period of that Review.**

Chapter 13. Other funding issues

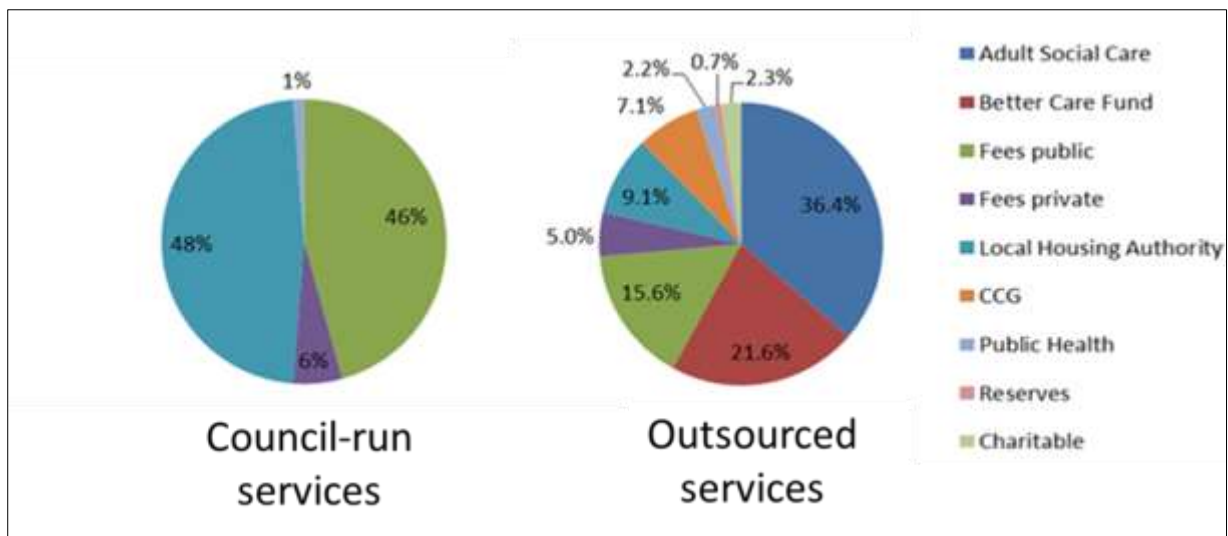
“To shift the thinking from ‘welfare’ to ‘investment’ is part of the strategic challenge”

Heywood (2005)¹³⁰

Local contributions to DFG funding

- 13.1 Local authorities used to contribute around 40% of the capital costs of the DFG, but these contributions have almost disappeared since central government funding increased from 2015/16 onwards. Housing authorities have found it hard to justify putting capital into the DFG when the main benefits are felt by social care and health, especially when housing authorities have been particularly badly affected by austerity measures.
- 13.2 Council-run adaptation services typically have a limited number of funding options. Almost half (48%) comes from housing, 46% from fees levied as part of the DFG, 6% from public health and 1% from private fees (Figure 13.1). Nothing comes from adult social care or the BCF. In comparison, independent home improvement agencies and those managed by registered providers had a wider variety of sources including: adult social care, the BCF, local housing authority, the CCG, public health, charities and fees (DFG and private).

Figure 13.1 Funding for council-run and outsourced services



¹³⁰ Heywood, F., et al. (2005) Reviewing the Disabled Facilities Grant programme, Bristol: School for Policy Studies.

- 13.3 Integration of services can bring together other funding streams such as ICES, wheelchair funding, assistive technology and telecare. Revenue costs can then be shared between health, social care and housing. We have also seen very effective council run services, like HEART in Warwickshire, Dorset Accessible Homes Service and Lightbulb in Leicestershire, that are making a real difference in their communities through using these pooled funding arrangements.
- 13.4 A different solution to the funding issue is for new integrated home independence services to be arms-length from local authorities. This has been done in a few areas such as Sunderland¹³¹. This enables council-run services to bring in funding from a wider range of sources. Being arms-length from the council could also make the service feel more welcoming to home owners, private tenants and private landlords. Evidence is shown in Chapter 16 on 'Developing a market' that these groups do not always think of turning to the council for help with adaptations. If adaptation services were clearly about investment in housing and independence, rather than welfare, it would give them a completely different look and feel from current DFG services. This might be an option to pursue in some areas.

Risk sharing contingency fund

- 13.5 As was discussed in Chapter 12 in relation to national DFG funding allocations, from year to year grant spending is not always even. Across county authorities or regions some districts may have underspend, while others have waiting lists. Given the difficulties in fine tuning allocations to need, there should be consideration of more collaborative DFG funding arrangements among BCF partners.
- 13.6 With a Housing and Health Partnership Board in place, with better strategic oversight and integrated working, it should be possible to set up a partner-wide contingency fund. This can cover:
- Demand over and above the expected level
 - Higher than anticipated numbers of completions
 - More complex and expensive adaptations, such as extensions.
- 13.7 Up until now, many authorities have been loath to share budgets or pay into contingency funds because they worry that the money might be absorbed into general social care funding, especially when social care is under so much financial pressure. Provided DFG funding remains properly ring-fenced in BCF budgets, and the BCF and HWB are required to report on DFG funding separately each year, it should be possible to allay these fears.

¹³¹ Mackintosh, S. and Collingbourne, L. (2015) Home Adaptations for Disabled People Good Practice Case Study: Sunderland, Home Adaptations Consortium.
<https://homeadaptationsconsortium.files.wordpress.com/2013/10/cameo-of-good-practice-sunderland-care-support.pdf>.

- 13.8 It is important that contingency funds are set up to ensure that disabled and older people get access to adaptations when they need them, and do not have to wait when one area has run out of funding while a neighbouring one has underspent resources. It would also allow long-term planning for the disabled person and their family, rather than decisions being budget-driven.
- 13.9 Holding on to funding may have been justified when local authorities were putting in their own capital resources, but not when nearly all of it comes from central government. A more collaborative approach would fit with mandatory RRO policy as it does not fetter discretion, and still allows each decision to be made on its own merits.

Joint decision-making and combined funding

- 13.10 Complex cases, particularly those that are more expensive, need a different approach to decision-making, as was discussed in Chapter 11 ‘Working Better Together’. They also need a different approach to funding.
- 13.11 A housing and health business case should consider the relative costs of different adaptation options, the alternative costs of care if adaptations are not provided and the appropriate mix of funding from different budgets (Table 13.1). Housing providers need to be part of the strategic Health and Housing Partnership Board to ensure the business case can include options to move to alternative accommodation (an existing dwelling, or new adapted property).

Table 13.1 Costs of care for adults and children

Provision Type	Annual Cost
Private sector nursing homes for older people	£41,912
Private sector residential care for older people	£32,864
Residential care homes for adults requiring learning disability support	£69,524
Private sector residential care homes for adults requiring physical support	£46,488
Care home for children — local authority own-provision	£210,444
Voluntary and private sector care homes for children	£171,496
Foster care for children	£33,592

Source: PSSRU Health and Social Care Unit Costs 2017

- 13.12 This type of good practice in the delivery of larger and more complex adaptations is already happening in local authority areas where partnership working and effective RRO policies are already in place.

Personal health budgets

- 13.13 The Department of Health and Social Care, and NHS England may extend the right to personal health budgets as part of a plan to think differently about the links between health, work, housing and disability¹³². Personal health budgets and personal social care budgets could be joined together into a single budget.
- 13.14 There is potential for DFG funding to be included to allow people “a *single, holistic plan that meets both health and wellbeing needs*”. This could improve outcomes and quality of life and reduce admission to hospitals and care homes. As part of this process, there is a programme of work looking at how this might change specifications for wheelchairs. An example is provided below of how joint decision-making about wheelchair funding and DFG funding can provide better solutions.

Personal budgets - a joined up approach

Personalised wheelchair budgets give disabled people more choice over the specification to allow them to get freedom from pain, better posture and achieve their own goals for independence¹³³. This can be effectively combined with decisions about adaptations as the following example demonstrates.

A wheelchair user with a small child needed home adaptations - two options:

1. Adapt both the bathroom and kitchen - this would require lowering the kitchen surfaces which might prove a hazard for the toddler.
2. Only adapt the bathroom and provide a wheelchair with a riser function to allow the current kitchen to be used without adaptation.

Option 2 was preferred as the customer needed a replacement chair. The higher specification would also allow greater independence outside the home, such as being able to go supermarket shopping. Unfortunately, the higher specification chair was not one that was normally provided by that local authority, so the case went to a decision-making panel.

The county council suggested using a number of different budgets to provide the optimal solution. ICES funding could meet the basic wheelchair costs and flexible DFG funding could meet the costs of the higher specification alongside the bathroom adaptation costs. However, there was no agreement in place to allow this to happen quickly. An alternative plan was therefore adopted with ICES paying the basic wheelchair costs, the County Council providing top up funding and the DFG covering the adaptation costs.

This shows the type of pragmatic decision-making and flexible use of budgets that is required to give outcomes that maximise people’s independence.

¹³² Department of Health and Social Care, and NHS England (April 2018) A consultation on extending legal rights to have for personal health budgets and integrated personal budgets, p13. <https://consultations.dh.gov.uk/commissioning-integration-and-transformation/extending-rights-to-personalised-budgets/>.

¹³³ <https://www.england.nhs.uk/personal-health-budgets/personal-wheelchair-budgets/>.

Recommendations – other funding issues

- **That integrated services seek funding from a wider range of sources.**
- **That risk-share funds are set up to deal with uneven demand for grants and that very expensive adaptations are jointly funded by housing, health and social care.**
- **That the DFG is included in personal budgets to provide solutions that meet people's own goals.**

Chapter 14 The means test

- 14.1 The application of means testing for housing grants was introduced at the same time as the Disabled Facilities Grant, in the Local Government and Housing Act 1989. The aim of the “test of resources” was to “target grant aid on the most needy households”¹³⁴.
- 14.2 The test largely mirrors the system of calculating entitlement to Housing Benefit. The assumed weekly needs of the household (the “applicable amount”) is calculated taking into account the number of people, their ages and other circumstances. This is then compared to actual income, and where income is greater than the applicable amount, a “loan generation factor” is applied to the ‘excess income’ to arrive at a notional “affordable loan”. This is the amount by which the grant is reduced, or the contribution expected from the applicant. The reduction in grant caused by this test is lower for tenants because it is assumed that loans will be available on less favourable terms than owner occupiers. The underlying calculation assumes that owners will be able to acquire loans repayable over 10 years, while for tenants the period is assumed to be five years.
- 14.3 The formula used for calculating grant entitlement for those with incomes over their needs level is:
- $$\text{Amount of grant} = \text{cost of work} - (\text{actual income} - \text{applicable amount}) \times \text{loan generation factor}$$
- 14.4 The loan factor makes use of four bands, which ensure that the contribution assessed for those with low excess incomes is lower, for each pound, while for those with higher levels of excess income, the contribution is greater.
- 14.5 The current legislation allows for circumstances where it is assumed that income does not exceed the applicable amount, and in these cases a test of resources is not carried out. This includes applications on behalf of a disabled child and where the disabled person receives one of the “passporting” benefits:
- Income Support
 - Income-based Employment and Support Allowance (not contribution-based ESA)
 - Income-based Jobseeker's Allowance (not contribution-based JSA)
 - Guarantee Pension Credit (not Savings Pension Credit alone)
 - Housing Benefit
 - Working Tax Credit and/or Child Tax Credit provided that the annual income for the purposes of assessing entitlement to the tax credit is less than £15,050

¹³⁴ Wilson, W. (1996) Housing renovation grants, House of Commons Library Research Paper 96/34 596/34. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/RP96-34>.

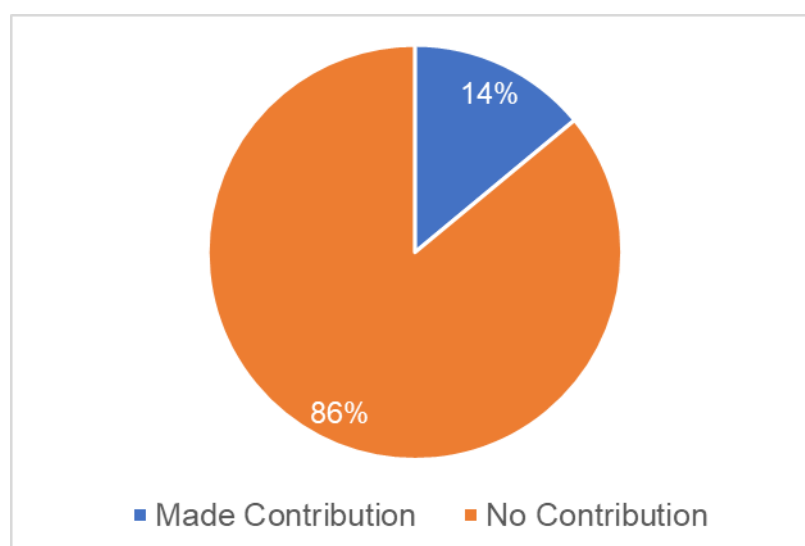
- Universal Credit (this includes any amount of Universal Credit which is being introduced from 2013 onwards as a replacement for working age benefits and tax credits).

14.6 Where an applicant is not passported, then the legislation introduces an alternative “statutory means testing regime” to be used, such as the Care and Support (Charging and Assessment) Regulations 2014.

Means testing in practice

14.7 From data submitted to Government, we know that in 2016/17 only 14% of approved grants were reduced due to means testing (Figure 14.1). Those 14% had their grant reduced by an average of £1,500 – contributing a total of £9.2m or just over 2% of the overall spend.

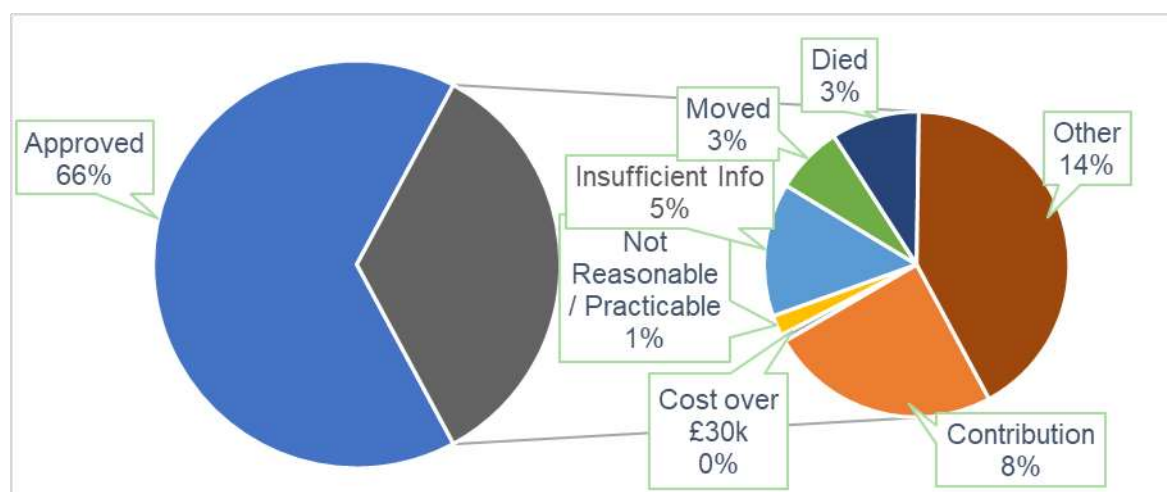
Figure 14.1 Means testing in practice



Source: LOGASnet

14.8 From talking to local authorities, we know that typically the means test is not carried out on 70 to 75% of applications due to passporting benefits or because the works are for disabled children, which make-up about 7% of grants. Further FOI data shows that 34% of grant applications do not proceed, and a quarter of these are due to the result of the means test (Figure 14.2). We do not know how many people are deterred from enquiring entirely by the prospect of a means test.

Figure 14.2 Reason for applications not proceeding



Source: Foundations FOI 2018

The options

14.9 For the purposes of this Review, we have considered 4 options for how the means test could operate in the future. For each we set out the rationale. Where we consider it a viable option we estimate the impact in terms of number of people eligible and the cost to meet that need. The options are:

1. Remove means testing completely
2. Just use passporting
3. Update the existing means test
4. Adopt the Care and Support Charging Regulations

Remove the Means test Completely

14.10 The simplest option would be to do away with means testing entirely. This would clearly have a large impact on potential eligibility – some 340,000 households have not already made adaptations due to financial reasons¹³⁵ - but it is unclear how many would actually apply for a Disabled Facilities Grant. At a time of financial stringency, particularly in social care funding, there are strong

¹³⁵ Ministry of Housing, Communities and Local Government (2016) English housing survey 2014-2015: Adaptations and accessibility of homes report, *ibid*.

arguments against providing funding to those who would be clearly seen to be able to afford their own provision.

- 14.11 Some Local Authorities have experimented with using their discretionary powers to exempt certain additional groups of people (e.g. registered social landlord tenants) or works costing less than a specified amount (e.g. £5,000) from means testing altogether. This usually occurs where a local authority has sufficient budget to meet additional demand in the short-term but is rarely sustained in the longer term as demand increases or budgets are re-allocated.
- 14.12 Several small-scale research projects have shown the investment in adaptations can provide excellent value for money, but these typically report savings in social care costs, which is also means tested. Another difficulty is the current lack of evidence to provide robust estimates of potential cost savings that may arise from the installation of most different types of home adaptations¹³⁶. Therefore, we have rejected this proposal except for stairlifts, where there is a clear return on investment.

Passporting for stairlifts

- 14.13 Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long-term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care¹³⁷. Falls that results in injury can be very serious - approximately 1 in 20 older people living in the community experience a fracture or need hospitalisation after a fall. Falls and fractures in those aged 65 and above account for over 4 million bed days per year in England alone, at an estimated cost of £2 billion¹³⁸.
- 14.14 The location of falls is often unrecorded, but where this information is collected it shows that the most serious injuries are caused by falls from stairs or steps, with more than half of deaths recorded in 2015¹³⁹.
- 14.15 Looking into the return on investment of home adaptations, BRE found that mitigation of hazards on stairs has the best potential payback period of all – quoting an overall payback of 0.61 years¹⁴⁰. Taking into account the cost of a

¹³⁶ Building Research Establishment (2017) Client Report: Cost benefit analysis of home adaptations [online] <https://www.ageing-better.org.uk/sites/default/files/2017-12/Appendices%2C%20the%20role%20of%20home%20adaptations%20in%20improving%20later%20life.pdf>.

¹³⁷ Department of Health (2012) Improving outcomes and supporting transparency. Part2: Summary technical specifications of public health indicators. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358. Last Accessed 03/04/2015.

¹³⁸ Royal College of Physicians (2011), NHS services for falls and fractures in older people are inadequate, finds national clinical audit. <https://www.rcplondon.ac.uk/news/nhs-services-falls-and-fractures-older-people-are-inadequate-finds-national-clinical-audit>. Last Accessed 03/04/2015.

¹³⁹ <https://www.rospa.com/rospaweb/docs/advice-services/home-safety/falls-prevention-factsheet.pdf>.

¹⁴⁰ Building Research Establishment (2017) *ibid*.

stairlift (rather than lower cost handrails), the payback period would still be under two years.

14.16 Traditionally, the purchase of new stairlifts has been funded using the DFG, with ongoing servicing and maintenance provided by Social Care. This split in responsibility has often meant that the whole life cost of a stairlift has not been fully considered under any procurement process and also limited the potential for refurbishment and recycling of existing stairlifts.

14.17 We recommend that the cost benefit of stairlifts is such that a grant should be awarded without being subject to means testing (subject to an application meeting the tests of Necessary, Practicable, Appropriate and Reasonable). We further recommend that this only applies where a Local Authority has established a stairlift refurbishment and recycling scheme as discussed later in Chapter 16.

14.18 Where an applicant wants to guarantee a brand new stairlift, this would fall outside of the eligibility for a DFG.

Passporting for palliative cases

14.19 A small number of local authorities have used the RRO powers to introduce a non-means tested grant for palliative cases. The business case is fairly straightforward: where adaptations can be installed that will enable a person to remain at home for longer at end of life; it can save £280 per day compared to specialist hospital care¹⁴¹. In just one month these savings are equivalent to the average cost of a DFG. However, another study noted that further work is needed to gain a more complete understanding of the costs of palliative care¹⁴².

14.20 We recommend that further consideration is given to grant for palliative cases being awarded without being subject to means testing.

Use of Passporting Only

14.21 As previously described, the majority of DFG applications are already passported due to receipt of certain benefits or the adaptations benefiting a child. We are also recommending that applications for stairlifts, and possibly for palliative care, should also be passported in the future.

¹⁴¹ Marie Curie Cancer Care (2014) Understanding the cost of end of life care in different settings. <https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/publications/understanding-cost-end-life-care-different-settings.pdf>.

¹⁴² Gardiner C, Ryan T and Gott M. (2018) What is the cost of palliative care in the UK? A systematic review BMJ Supportive and Palliative Care, <http://dx.doi.org/10.1136/bmjspcare-2018-001519>.

14.22 However, this would mean that many people with low earned incomes or small private pensions would be unfairly disadvantaged, and so we have rejected using passporting only.

Update the Existing Means test

14.23 Aspects of the existing means test have been criticised since it was introduced in 1989. The Government carried out a review of the operation of the new grant system in 1991/92, where local authority associations described it as “*bureaucratic, difficult to understand and costly to administer*”¹⁴³.

14.24 The review in 2005 stated that “*The Test of Resources, in limiting who is eligible for help, excludes some people in great need, especially ... adults of working age. For these people, it bears no relation to real outgoings and severely discourages those who work by requiring a level of contribution that for many represents an unsustainable burden.*”

14.25 Research carried out by BRE in 2011 listed the key criticisms, including:

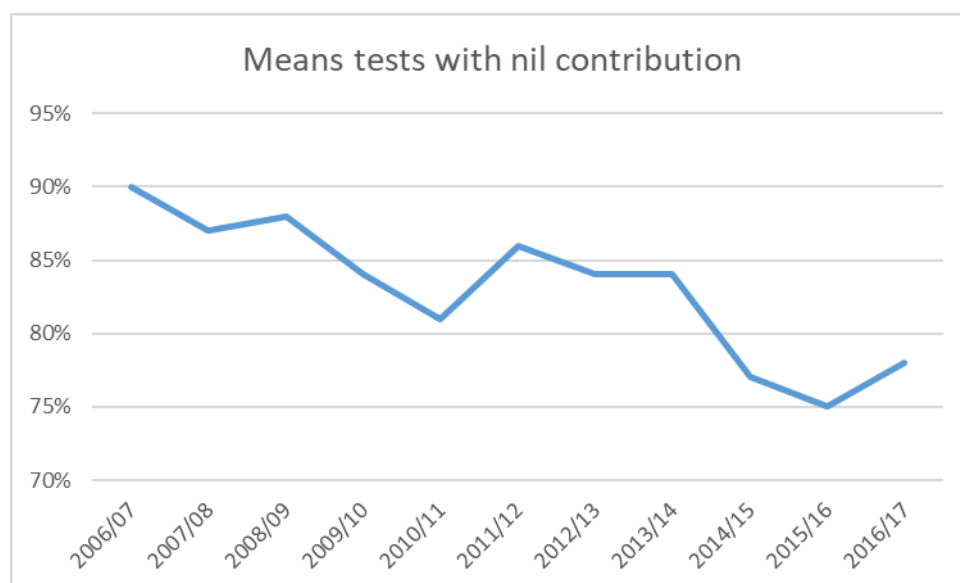
- The use of a standard housing allowance for all households disadvantages those with higher housing costs; particularly those with mortgages.
- The taper system used by the Loan Generation Factor acts as a disincentive to take on paid work or additional hours or move to a better paid job.
- ‘Allowable’ income should be set rather higher than just the basic amounts of income support and pension credit allowances.
- It is very different to means testing for other services (e.g. care) which causes confusion amongst applicants and agencies.

14.26 Our online survey echoed these concerns, particularly cases of families where having enough income to sustain a relatively modest mortgage is too much to make them eligible for a grant.

14.27 A more recent criticism is that none of the amounts used to calculate the applicable amount have been updated since May 2008, whereas actual prices have increased by nearly 30% due to inflation. The consequence is that more people will have a weekly income higher than their applicable amount and receive a lower or nil grant. Figure 14.3 below shows the percentage of grant applicants who received a full grant in one Local Authority falling by around 15% over the last decade.

¹⁴³ Wilson, W. (1996) *ibid.*

Figure 14.3 Applicants receiving full grant



Source: Information from one local authority

14.28 The passporting arrangements in the current regulations are also out of date, not taking into account the fundamental changes introduced in the wider benefits system over the last few years including Universal Credit.

14.29 We have looked at the options for updating the current means test by considering four aspects: assessing need, assessing resources, assessing entitlement and passporting.

Assessing need

14.30 The assessment of needs and resources is based on that of the Housing Benefit (HB) scheme, but the rates used in the assessment of need have not been increased in line with the uprating of HB.

14.31 Originally the contribution to cost of works represented the value of a notional loan with weekly payments which was calculated by subtracting ‘allowable income’ (the amount a household needs to live on) from actual income along with a tariff for savings. In the case of owners, the loan period was assumed to be ten years, in the case of tenants five years.

14.32 Prior to the 1996 changes, the main criticism of this method was that low amounts of excess income produced disproportionately high contributions. This placed people on low incomes or those with a limited ability to raise the required amount of contribution at a disadvantage.

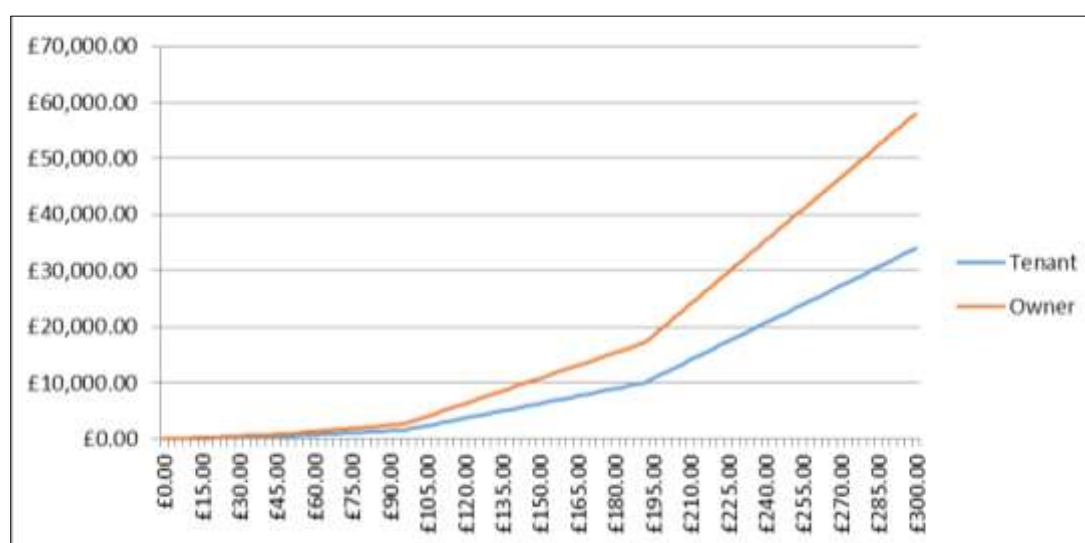
14.33 In 1996, the method of calculation was changed. It still relied on the notional loan principle, but the rates of contribution varied depending on excess income. The “changeover points” were set at £2,500, £5,000, and £10,000 per year of excess income.

14.34 Contributions are initially set fairly low, they increase between £47.95 per week (£2,500 p.a.) and £95.90 (£5,000 p.a.) and sharply between £95.90 per week and £191.80, and again above this amount. The total contribution is made up by adding together individual contributions for each band (where necessary).

14.35 We have understood that the reason for treating tenants differently from owners is that tenants would have to seek an unsecured loan to pay for the works themselves, whilst owners could increase their mortgage and therefore borrow more cheaply. Those who live in caravans or houseboats, pay at the lower, tenant’s multiplier because it is considered difficult to get a mortgage on a caravan or a houseboat.

14.36 The chart below (Figure 14.4) demonstrates the contribution levels under the current means test for excess income, from £0 to £300 a week.

Figure 14.4 Increasing owner and tenant’s contribution under current bands



14.37 It can be seen that relatively modest levels of excess income can reach the current maximum grant level, at least for owners.

14.38 The freezing of the needs rates has had the effect of increasing the amount of excess income in individual cases. As the levels of income taken into account have increased over time, it is more difficult (because of the method by which the notional loan is calculated) to determine what effect continuing indexation would have had on grant levels.

14.39 The means test is applied to the disabled person and partner. There are different rates for those above pension credit age and, unlike most current means tested benefits, an additional pensioner premium for those aged over 60. There is a standard housing allowance of £61.30 which is added to the personal allowances and premiums. Capital rules, for assessing notional income, match those of HB, themselves unchanged for many years.

Re-establishing the link with HB rates

14.40 Table A3.1 in Appendix 3 shows the current rates of allowances and premiums used in the grant scheme and those used for HB.

14.41 In addition to the allowances and premiums, the assessment of needs also includes a fixed housing costs amount, currently £61.30. This is recognised as failing to take account of differing housing costs across local areas and sizes of property.

14.42 Examples 1 to 5, below, and in Appendix 3, show the effect of uprating, in a variety of scenarios, to the current housing benefit rates, including an inflation linked increase to the housing element, bringing it to £79.25.

14.43 We considered ways in which real housing costs could be included as part of the needs assessment. Actual housing costs would be both difficult to determine and would not, in themselves, reflect genuine housing costs on a 'greenfield' basis. Differences between rented and owned properties, those with and without mortgages, those with ground rents or service charges, and other factors make this impractical.

14.44 It would be possible however, and relatively simple, to make use of the Local Housing Allowance (LHA) rates as a comparison factor between different areas and housing sizes. LHAs were calculated using the lowest third of private local market rents for properties with different numbers of bedrooms, although they are now CPI linked. The values are used as part of the HB assessment, so the appropriate tier of local authorities is very used to working with them, and they are simple to find for individual properties using the LHA-Direct website.

14.45 The overall average LHA figure for England (excluding the single room rate) in April 2018 was £159.45. The figures for different room sizes are shown in this table. There is a cap on the LHA figures which affects, in particular, inner London. The figures take no account of the number of properties in each band or in each area.

Table 14.1 Using Local Housing Allowance (LHA) rates

Property size	LHA April 2018			
	1 Bed	2 Bed	3 Bed	4 Bed
Average LHAs England	£113.31	£140.77	£166.69	£217.05
Maximum	£268.46	£311.40	£365.09	£429.53
Minimum	£69.73	£85.00	£97.81	£123.58

14.46 If an LHA linked factor, for example 50%, of the LHA for the size of property and the area (determined by a postcode lookup on the LHA-direct website) then some rough account of a housing cost link for each area could be incorporated into the assessment.

14.47 This would provide a crude average of £79.73, but with a potential range from £39.87, for the smallest property in the least expensive area to £214.77 for the largest property in the most expensive area.

Assessing resources

14.48 Resources rules have been largely unchanged for many years for HB. Consequently, the current DFG scheme differs little from the assessments that would apply under HB. Capital limits and tariff income figures are identical, as are earnings disregards. There is a small difference in the rules applying to income from sub-tenants.

14.49 As excess income is determined solely by the test of whether resources are greater than needs, the effect of uprating the current means test to use the HB figures will reduce the amount which can be assessed as contributing to the cost of works. As each assessment depends upon the circumstances of the individual and their household, it is not possible to make any accurate estimate of the amounts involved.

14.50 Unlike most means tested benefits, there is no capital cut-off in the current grant scheme. Currently Guarantee Pension Credit also has no capital cut-off. There is an argument that adaptations could be paid for from any substantial capital resource, but careful drafting would be needed to ensure that, for example, personal injury awards and monies required for future care were treated appropriately.

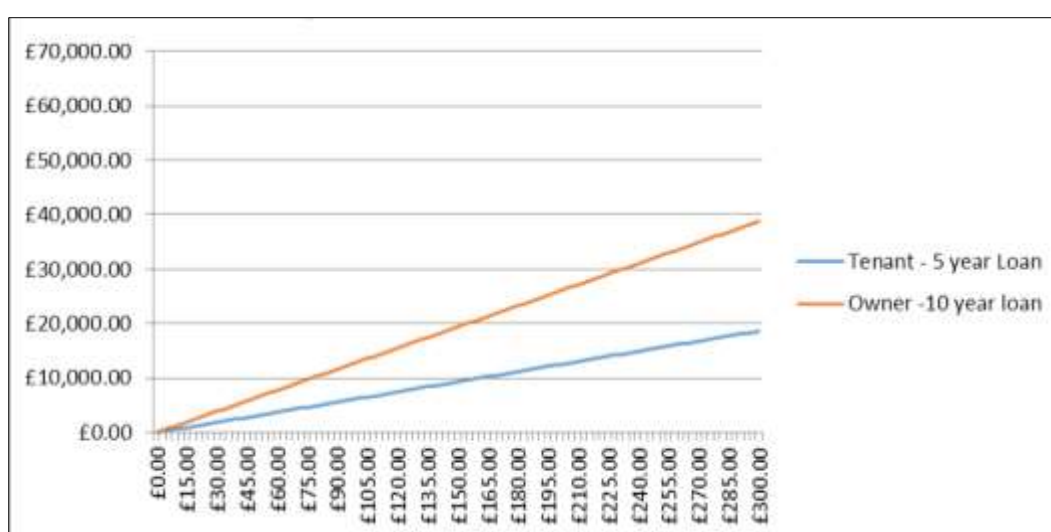
Assessing entitlement

14.51 The four-band calculation of a notional loan value, although complex, seems to be widely accepted as a pragmatic solution. The previous criticism of over-

contribution by those with small amounts of excess income and the smaller contribution of those better-off seem to have been satisfied.

14.52 Other interest linked assessments, such as the new Loan for Mortgage Interest scheme in means tested benefits, and the notional pension's income assessment in the same benefits, make use of the Gilt rate on government bonds. We modelled a fixed Gilt linked contribution system as shown in the chart below (Figure 14.5). The gilt rate used is that of 4th May 2018 – 1.67% – rounded down, as in other existing uses, to the nearest .25%.

Figure 14.5 Increasing owner and tenant's contribution using gilt linked loan value of 1.5%



14.53 It can be seen that a linear Gilt linked system could face the same criticisms of the system that existed pre-banding. People with small amounts of excess income would face higher contributions, while there would be reductions in contribution for those with higher incomes.

14.54 Gilt linking in means tested benefits has the advantage of automatically amending relevant amounts as rates change. This removes any need for frequent amendments of regulations and provides a greater level of administrative simplicity. While a banded Gilt linked assessment would not be difficult to introduce or operate, it is unclear whether there is enough need to reflect day-to-day changes in rates.

Passporting

14.55 Passporting plays an important role in the administration of the current scheme. Passporting is widely used across many assessment schemes in means tested

benefits and other social welfare areas. It permits trusted assessments of need for one scheme to be used in other domains.

- 14.56 The current DFG scheme passports recipients of most means tested benefits to a full grant. A very high proportion of grants are passported, about two thirds, in the current scheme.
- 14.57 Changes in means tested benefits, following the introduction of Universal Credit (UC) would suggest that some changes should now be considered. The rate of introduction of UC and the fact that the bulk of initial claimants have been healthy young single people has meant that an interim decision to passport by any receipt of UC has caused few problems.
- 14.58 As UC rolls out further however, we suggest that it is now appropriate to consider its use in passporting in more detail. UC can be paid to people regardless of their hours of work or health condition. This means that it may be paid to households with relatively high levels of income. Working Tax Credit, the legacy benefit for those in full-time work, and Child Tax Credit passports only where they are awarded on an income of £15,050 or less. UC might seem to be amenable to a similar approach. It should be noted that the Government has chosen to passport UC recipients to an entitlement to free school meals, only where earnings are £7,400 or less. However, UC can vary on a monthly basis which needs to be taken into account.
- 14.59 Another area where passporting might be extended is where domiciliary care is being provided. Only 16% of grant cases are also in receipt of domiciliary care, and passporting could help reduce any instances of the same excess income being used for two assessments.
- 14.60 Receipt of Council Tax Reduction as another passport, as in Wales, may seem to be a logical extension. In England, however, the benefit (or more precisely the charge reduction) has been devolved to local authorities and is increasingly divergent from the original model within different authorities. The maximum reduction varies from 50% to 100% of the Council Tax charge, there are very different treatments of capital and substantially different rule sets which could lead to a postcode lottery.
- 14.61 There are some advantages to maintaining the existing means test structure, one of which is familiarity. It has established eligibility for a DFG for nearly 30 years, and despite its complexity is widely understood by Local Authorities, if not by the public. Any change would necessitate system changes and training needs for staff and create winners and losers in those being assessed.
- 14.62 The link to HB rules, where there will be a great deal of experience in the administering department in the same tier of local government, can help minimise issues of error and fraud.

14.63 Disregarding disability benefits as income allows them to continue to be used for their intended purpose while recognising, from their receipt, the increased need likely to be caused by the claimant's disabilities.

Adopt the Care and Support Charging Regulations (CSCR)

14.64 The Care and Support (Charging and Assessment of Resources) Regulations 2014 were introduced as part of the Care Act 2014; largely mirroring the Fairer Charging regime they replaced. As set out in the statutory guidance¹⁴⁴, the principles are that the approach to charging for care and support needs should:

- Ensure that people are not charged more than it is reasonably practicable for them to pay
- Be comprehensive, to reduce variation in the way people are assessed and charged
- Be clear and transparent, so people know what they will be charged
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control
- Support carers to look after their own health and wellbeing and to care effectively and safely
- Be person-focussed, reflecting the variety of care and caring journeys and the variety of options available to meet their needs
- Apply the charging rules equally, so those with similar needs or services are treated the same and minimise anomalies between different care settings
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so
- Be sustainable for local authorities in the long-term

14.65 These principles could equally apply to “charging” for adaptations, and there are several advantages to aligning the two systems. The CSCR is the mechanism used to assess the level of financial support someone receives towards care provided in their own home. Many DFG applicants do not currently receive care and the adaptations provided should delay the need for this in many cases. The current differences in charging arrangements are difficult to understand. Adopting a similar means test for the DFG would make it simpler for social care staff to understand possible entitlement to a grant. However, the means test would still have to be applied for each application.

14.66 The 2005 Review of Disabled Facilities Grants recognised that the Fairer Charging model addressed two of the key criticisms of the existing test for DFG by (a) disregarding earned income entirely; and (b) incorporating actual housing costs instead of notional costs. The same would apply under the Care and Support Charging Regulations (CSCR) today.

¹⁴⁴ Statutory guidance, Care Act 2014: supporting implementation [online]. <https://www.gov.uk/government/publications/care-act-statutory-guidance>.

14.67 Other key differences between CSCR and the current system are:

- Only the income of the disabled person is taken into consideration, not any belonging to their partner/spouse.
- Allowances are set to income support / pension credit plus a buffer of 25 per cent rather than at the base levels. This buffer level is still in place in the current scheme figures, but it is no longer statutory. This ensures that recipients are left with an individual income above benefit levels.
- Anyone with capital above an upper limit, currently £23,250, does not receive any assistance until/unless the value of their means tested assets subsequently drops below that level through, for example, paying towards their care.
- There is no passporting of entitlement.

14.68 CSCR also makes it clear that certain benefits are intended to help pay for care (Attendance Allowance, Disability Living Allowance - Care, Constant Attendance Allowance, Exceptionally Severe Disablement Allowance and a Severe Disability Premium with Income Support) and therefore should be counted as income.

14.69 In their response to this review, ADASS noted: *“Given that the link is being more directly made for the DFG to support adult social care achieve the outcomes expected through the Care Act, evidenced by it being channelled through the Better Care Fund (BCF) then aligning a means test to the Care Act would be a sensible approach.”*

14.70 The impacts of changing to a CSCR based test were fully explored by the BRE in their 2011 paper. In summary they found that:

- The use of actual housing costs would mean a slight reduction in the number of people eligible for DFG as it impacts negatively on those, mostly older households, who own their home outright. However, it would mean more help to those of working age and in work who are paying at least some of their own rent/mortgage.
- The 25% buffer above income support/pension credit levels would increase the number of people eligible for DFG by around 7.5%. The majority (82%) of the ‘winners’ were aged over 60.

Incentivising Personal Responsibility and Preventative Adaptations

14.71 There is a growing body of evidence and recognition that reducing hazards in the home will lead to fewer accidents and associated injuries and ill health. However, it is often the case that a person only becomes eligible for a DFG after an injury, at the point when they are permanently and substantially disabled.

14.72 Government has said that it wants to improve the risk pooling offer for individuals and signalled that the Social Care Green Paper will include an

absolute limit on the care costs individuals face. If a cap on lifetime care costs is brought forward to meet this commitment, this would offer one opportunity to align the means testing regimes for DFG and social care, while also incentivising individuals to make adaptations.

- 14.73 The inclusion of adaptations within the cap would deliver several key benefits:
- Raise public awareness of the benefits of preparing their home for old age when considering home improvements
 - Encourage people to carry out appropriate adaptations to enhance their independence instead of paying for domiciliary care – limiting their overall spend and reducing the likelihood of ever reaching the capped level
 - Reduced numbers of people reaching the care cap will limit the cost of social care services to the state
 - Adapted homes will present fewer hazards leading to less injuries and calls upon the NHS.
- 14.74 A light touch assessment process would be required to ensure that any adaptation was appropriate and reasonable, but we recommend that this proposal is given consideration within the forthcoming Social Care Green Paper on the care of older people expected to be published in the autumn of 2018.

Further Considerations

- 14.75 CSCR is usually used to calculate a weekly contribution towards ongoing care costs. A mechanism similar to the existing DFG Loan Generation Factor would be required to convert this weekly amount into a one-off contribution towards the cost of an adaptation. The scenarios in Appendix 3 show that levels of excess income under the two tests would be substantially different. We suggest that further modelling is necessary to devise a contribution formula that takes account of this and of the other uses for the assessed excess income.
- 14.76 The need for care and adaptations are unlikely to start at exactly the same time. FOI data shows that only 16% of DFG applicants are already receiving social care funded domiciliary care at the time of their application¹⁴⁵.
- 14.77 Where someone has been means tested for a DFG and made a contribution, we recommend that the contribution is taken into account by social care in any future means testing. Looking at existing local CSCR policies the simplest approach would be to assume the benefit of the adaptation lasts for 500 weeks and divide the contribution by 500 to turn into a weekly amount.
- 14.78 We also recommend that the current passporting arrangements that exist for means tested benefits (revised as suggested previously) as well as disabled

¹⁴⁵ Foundations (2016a) Linking Disabled Facilities Grants to Social Care Data.
<http://foundationsweb.s3.amazonaws.com/4210/foundations-dfg-foi-report-nov-2015.pdf>.

children are incorporated for DFG purposes to minimise the impact of adopting CSCR in terms of administration costs and potential delays.

14.79 During the workshops, a number of delegates raised the issue of assessing Disability Related Expenditure under CSCR for DFG purposes. This aspect of the test can require detailed information about spend on personal items that would not always be appropriate to discuss as part of a housing grant application. This aspect of the test is also open to local discretion, which introduces significant variation across the Country. We recommend that a standard minimum amount is used for assessments under DFG. For example, the Leicestershire CSCR policy¹⁴⁶ allows:

- A standard minimum allowance for 2017/18 for a single person of £20 per week.
- A standard minimum allowance for 2017/18 for a member of a couple of £15 per week.
- A standard minimum allowance for 2017/18 for a couple of £30 per week.

14.80 It has been suggested that existing CSCR capital limits may be increased in the future, which would mitigate the differences with the existing DFG means test. However, this should be taken into consideration in any revised CSCR test.

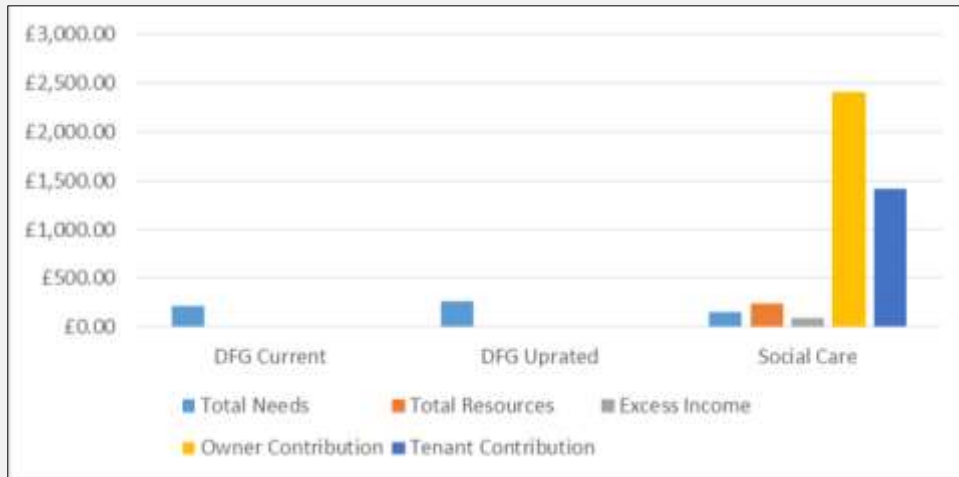
Example scenarios

14.81 These are included to demonstrate the differences between the current and updated schemes and the quite different calculation used in the social care domiciliary support means test. In the DFG means test, there is only a contribution towards the cost of works where the assessment finds an excess of income over needs. The detailed figures, and analyses and notes underlying the charts are in Appendix 3.

¹⁴⁶ Leicester City Council (2017) Adult Social Care Charging Policy [online] <https://www.leicester.gov.uk/media/179202/charging-policy-2017.pdf>.

Scenario 1

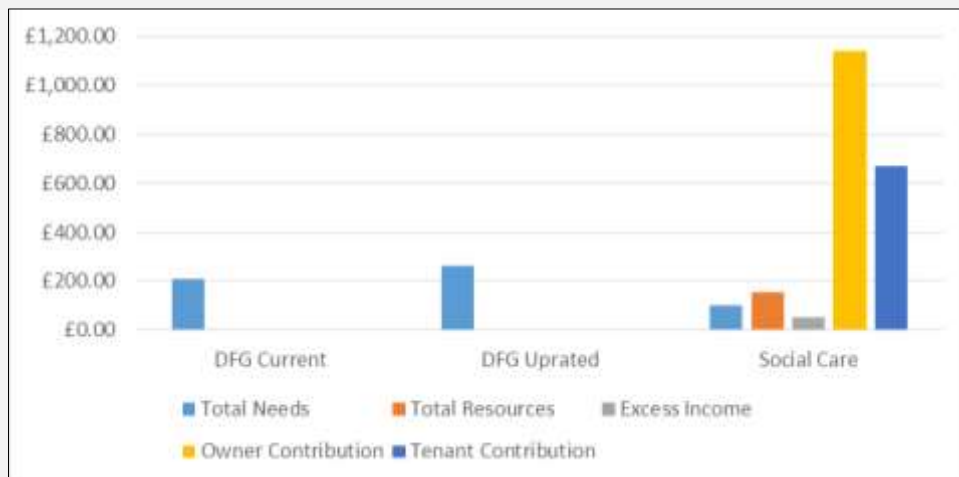
Single, aged 55, disabled, receiving high rate DLA or PIP for care needs. No income other than state benefits



Under the DFG, this applicant is passported to the maximum grant because they are entitled to a relevant means tested benefit. CSCR takes into account the means tested benefits and the disability benefits as income, generating an excess income used to assess a contribution (unless passporting is also applied for means tested benefits - as recommended for DFG applications)

Scenario 2

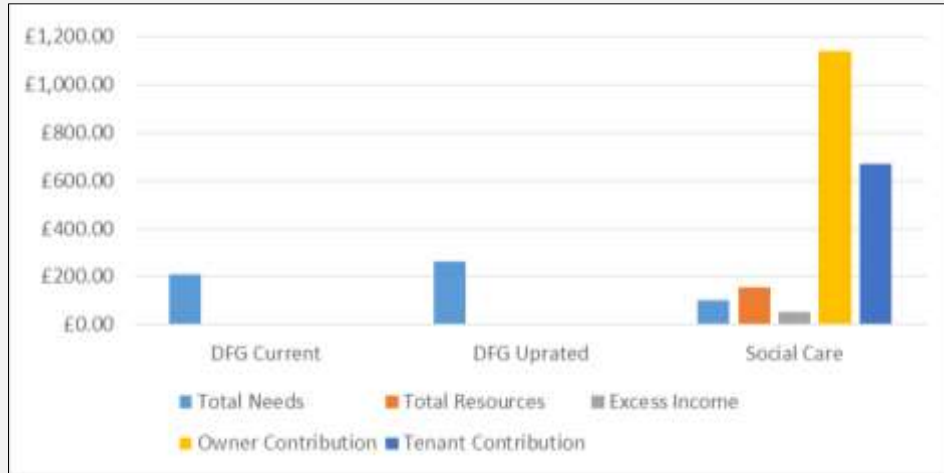
Couple eldest aged 55, one disabled, receiving high rate DLA or PIP for care needs. No income other than state benefits.



Under the DFG scheme this applicant is passported by receipt of a relevant benefit, while CSCR takes that benefit and disability benefits into account as income (unless passporting is maintained for relevant benefits- as recommended for DFG applications). The social care means test is applied only to the individual client. In the case of couples, the personal allowance in the assessment is reduced. Joint income, including means tested benefits, is similarly proportioned.

Scenario 3

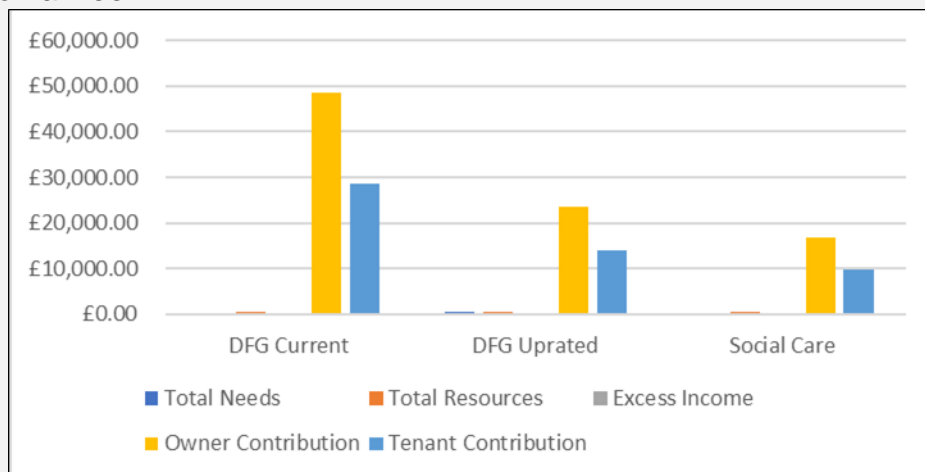
Single, aged 75, disabled, receiving high rate DLA or PIP for care needs. Full Basic State Pension of £125.95 a week plus £200 net private pension a week.



Even though an excess income figure has been calculated in the existing and uprated DFG assessments, they would still be passported by a small amount of housing benefit which has been calculated. CSCR produces a substantially larger amount of excess income, and thus a bigger contribution, than the other assessments (unless passporting is applied for means tested benefits - as recommended for DFG applications).

Scenario 4

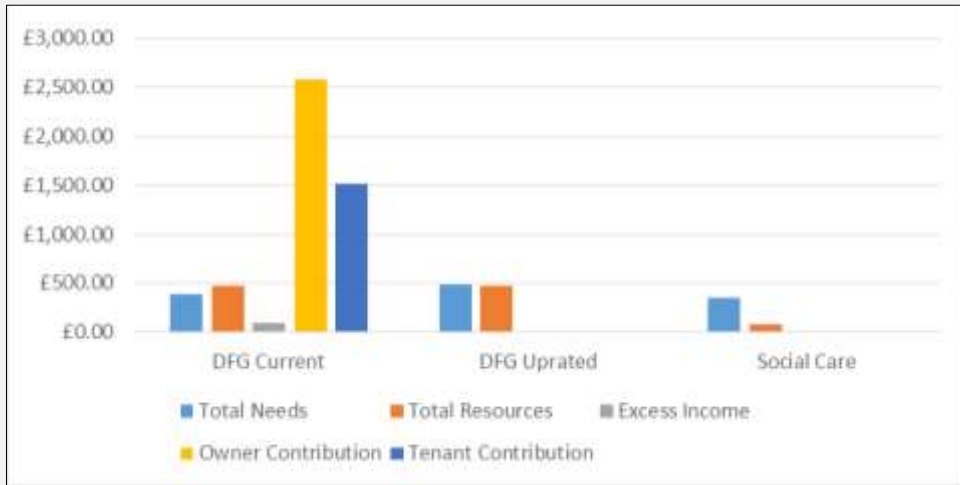
Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week.



The increase in income, coupled with the loss of premiums that would be applicable to a single claimant, has removed entitlement to means tested benefits and therefore to passporting. In this scenario, contributions are higher under the DFG scheme as the social care assessment only takes half of the real income into account for the individual.

Scenario 5

Couple both aged 55, three children aged under 16, one partner disabled, receiving high rate DLA or PIP for care needs, other partner working full-time and earning £400 net a week.



In this scenario, there is no passported entitlement as, although Child Tax Credit is payable, the earnings figure is above the £15,050 annual threshold. Child Tax Credit and Child Benefit are disregarded for social care charging. The complete disregard of earnings and the limiting of assessment to the client alone, in the social care assessment, produces a much lower resources figure in this scenario than for the other examples.

Detailed examples showing the effects of capital are also included in Appendix 3.

Choosing a preferred option

14.82 The final decision between: 1) updating the existing DFG means test; and 2) adopting a modified version of the Care and Support Charging Regulations, will largely depend on how charging for social care is framed within the forthcoming Green Paper on social care for older people. Any significant changes in approach could affect the assumptions on which the options have been based.

14.83 Where an applicant has already been means tested under CSCR and is contributing towards that care, we recommend that they are passported for the purposes of an application for DFG.

14.84 The main differences between the two preferred options are summarised in Table A3.2 in Appendix 3.

Recommendations – the means test

- **That including assessment for DFG within Care and Support Charging Regulations is part of the Social Care Green Paper** – including passporting arrangements and a standard minimum amount for Disability Related Expenditure – and the DFG Regulations are amended accordingly.
- **That alternatively the existing regulations are updated** – re-establishing the link to HB rates, using LHA rates for the Housing Allowance and updating the passporting benefits lists.
- **That stairlifts are removed from means testing** where an authority has set up an effective stairlift refurbishment and recycling scheme.
- **That further work looks at removing the means test for palliative care.**

Chapter 15. Regulation and the upper limit

The legislation

15.1 The primary legislation for the DFG is set out in the Housing Grants, Construction and Regeneration Act 1996, supported by a number of pieces of secondary legislation in the form of regulations, orders and general consents. As revised, the legislation is relatively short and sets out the 20 main requirements:

The Grant

1. Grants are available from local housing authorities.
2. The grant is means tested *as set out in regulations*
3. There is a maximum amount that can be awarded – this is currently set at £30,000 *as set out in regulations*.

The works

4. There are a number of purposes for which a grant ‘must be approved’:
 - Getting in and out of the property
 - Making the property safe(r) for everyone living there
 - Access to the living room
 - Access to a bedroom
 - Access to a toilet
 - Access to a bath or shower
 - Access to a wash basin
 - Preparing and cooking food
 - Improving or providing heating if needed by the disabled person
 - Controlling power, lights and heating
 - Access around the property to care for someone else

Making an application

5. An applicant must be over 18
6. An applicant must already be the owner or tenant of the property, or intend to be (the grant can’t be approved until they are)
7. There must be a disabled person living in the property
8. Disabilities include substantial impairments in sight, hearing or speech, any ‘mental disorder or impairment’ and any substantial physical disability whether from birth or through illness or injury.
9. The applicant must sign a certificate to say the disabled person intends to live there for 5 years or more
10. An application must be in writing and include the address of the property, the proposed adaptations, 2 estimates of cost and **details of any other fees or charges** *as set out in regulations*.

Determining an application

11. The local authority must assess whether the works are 'necessary and appropriate' to meet the needs of the disabled person, and then if those works are 'reasonable and practicable' given the age and condition of the property, e.g. if the property is in a fit state.
12. For district councils, they must ask for the county council's opinion on whether the works are 'necessary and appropriate'.
13. The grant can't be approved if the works have already started – unless there is a good reason why. A grant cannot be approved if the works have already been completed.
14. The council shall approve or refuse an application as soon as they can, but no longer than 6 months after the application was made. For approvals, the council has to say what adaptations it is funding and how much they cost including and fees or charges. These can be revised if circumstances change. For refusals, the council has to say why.

Making payments

15. The council can defer payment by up to 12 months.
16. The works must be carried out within 12 months of the approval date (unless payment has been deferred) – but this can be extended with the council's agreement.
17. The grant can either be paid in instalments as the works progress or in full on completion.
18. The council will only make a payment if they're satisfied with the works and receive an acceptable invoice – that isn't from a member of applicant's family.
19. The works should be done by a contractor who provided one of the estimates for the application – unless the council agrees otherwise.
20. If the grant applicant agrees, the council can pay the contractor directly. If the applicant isn't satisfied with the works, and the council agrees, the council can pay the applicant instead.

15.2 The Secretary of State can also impose other conditions. For example, there is a general consent which allows councils to set a condition that allows them to reclaim specialised equipment like stairlifts if they are no longer needed.

15.3 Another consent from 2008 says that if the applicant is an owner, the council can place a local land charge against the grant – for the portion of the grant that is over £5,000. The charge can be for up to £10,000 and applies if the owner wants to sell the property within 10 years. In that case, the council has to consider if the owner is moving because of their work, wellbeing or caring responsibilities and whether it would cause financial hardship.

The upper limit

- 15.4 The maximum DFG is currently £30,000, but some adaptations cost more than the upper limit, usually the more complex cases, and particularly cases for disabled children and young people. These often involve the building of extensions and/or major reorganisation of the internal layout of the home.
- 15.5 Councils can use discretion to pay extra costs, but the evidence shows that most try to work within the existing limit. When adaptations are budget-driven, they may not provide a person-centre approach that caters effectively for future needs. The Local Government Ombudsman has highlighted cases where this has not resulted in the best decision for the disabled applicant or their family¹⁴⁷. In London, costs appear to be much higher than the limit, at an average of £55,000, reflecting higher building costs.
- 15.6 The Royal College of Occupational Therapists in their guidance for the 2014 Care Act said that they would like to encourage authorities to look imaginatively at their discretionary funding and top-up options, including the options available in the use of the Better Care Fund and under the RRO 2002¹⁴⁸.

The 1996 legislation states:

- The Secretary of State may, if he thinks fit, by order specify a maximum amount or a formula for calculating a maximum amount of grant which a local housing authority may pay in respect of an application for a grant.
- An authority may not pay an amount of grant in excess of a specified maximum amount.

- 15.7 In May 2016, in answer to a parliamentary question, Brandon Lewis, the Minister of State for Communities and Local Government re-affirmed that:

“Local authorities can provide additional top-up funding which can be used to fund adaptations where the cost exceeds the grant limit per applicant”¹⁴⁹.

- 15.8 The upper limit has not been fixed at the same level since it was introduced, as is shown in Figure 15.1. In 1989 there was no limit. Four years later it was set at £50,000 but felt to be too high and reduced to £20,000 the following year. In 2002 it was raised to £25,000. The 2005 review proposed raising it to £50,000

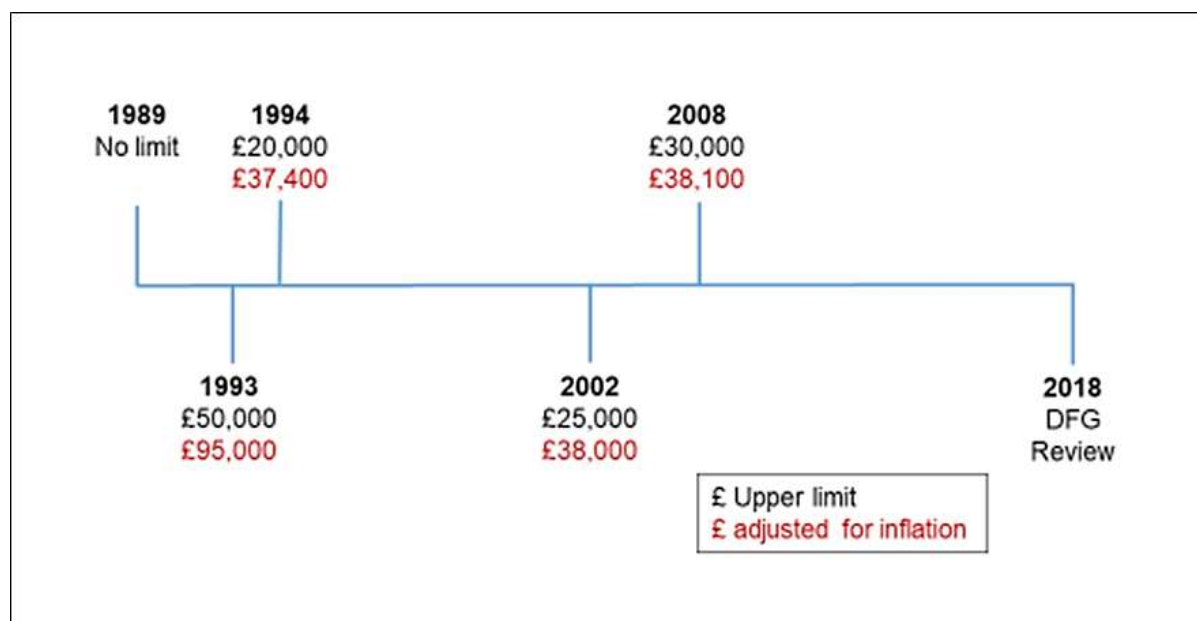
¹⁴⁷ Local Government Ombudsman, *ibid*.

¹⁴⁸ Royal Collage of Occupational Therapists (2016) Care Act 2014: Guidance for Occupational Therapists, The Disabled Facilities Grant, London: RCOT. <https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/care-act-2014-dfg>.

¹⁴⁹ Royal Collage of Occupational Therapists (2016) *ibid*.

and taking away the means test for children. The means test proposal was accepted and the limit raised, but only to £30,000 and it was removed for children. If it had risen with inflation it would be around £38,000 today.

Figure 15.1 Upper limit maximum since 1989



15.9 That the upper limit was a problem was raised in discussions at the workshops for this review, by national organisations and in previous think tanks. It is clearly not covering the cost of work, particularly in London. Some authorities have responded to this by raising the limit in their local area. For example, in Portsmouth, North Kesteven and Rochdale it is £40,000; Dorset and Manchester have raised it to £45,000 and £50,000 respectively. Other places provide top up funding, but in many this is the form of a loan which may not be affordable for people with high mortgage costs.

15.10 Finding the additional funding can lead to long delays for people with some of the most severe impairments or most restricted levels of mobility who are most urgently in need of help. For families with disabled children, already near breaking point, any delays need to be avoided.

Options for change

15.11 The question the review was asked to address was: is £30,000 the correct level to:

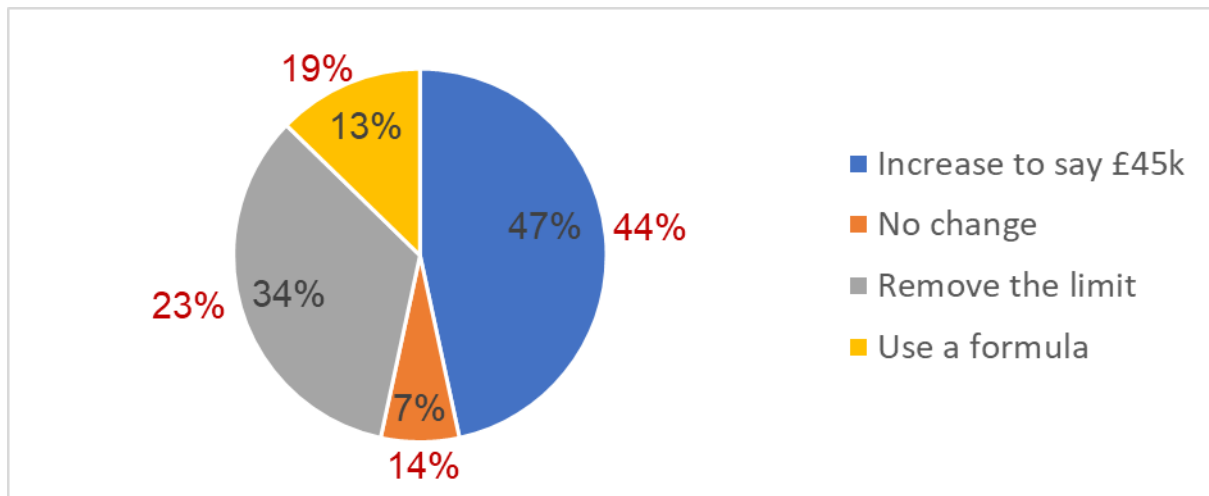
- Deliver value for money to the public sector?
- Support as many people as possible?
- Maintain the financial viability of the grant?

15.12 To find out what people delivering the DFG thought should happen, four options were given to the people attending the consultation events and in the online survey. These included:

- No change
- Raising the limit to, say £45,000
- Removing the limit
- Using a formula.

15.13 The results showed that only a small proportion wanted to keep the limit as it is (Figure 15.2). The majority (47% at the workshops and 44% online) were in favour of keeping a limit but raising it to £45,000 (or an agreed amount). Just over a quarter of the online respondents and a third of the workshop participants wanted to remove the limit entirely. The original legislation stated that the Secretary of State could specify a formula. This option got a more muted response with only 13% of workshop participants and 19% of online respondents in favour.

Figure 15.2 Results of consultation – upper limit

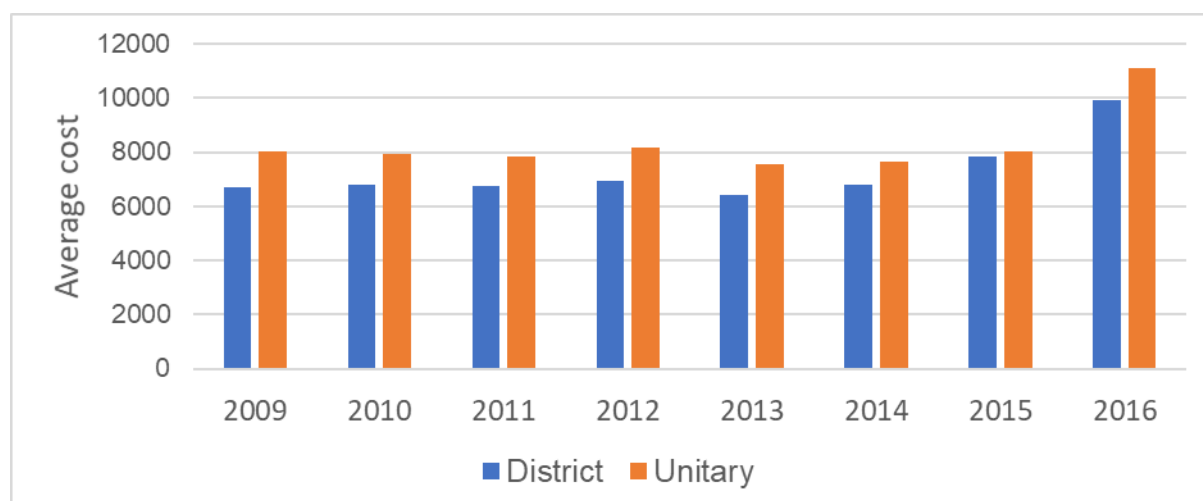


Source: voting at consultation events / [online survey](#)

The evidence for change

15.14 The LOGASnet data show that most grants are quite small. The average was between £6,000-8,000 until 2016/17 when it jumped up to about £9,000. This was probably an adjustment to accommodate rising building costs when additional funding was introduced and the increasing complexity of cases as discussed in Part A. Costs vary between unitary and district authorities, probably because higher costs in London raise the averages for the unitaries (Figure 15.3).

Figure 15.3 Average size of grant by type of authority



Source: LOGASnet

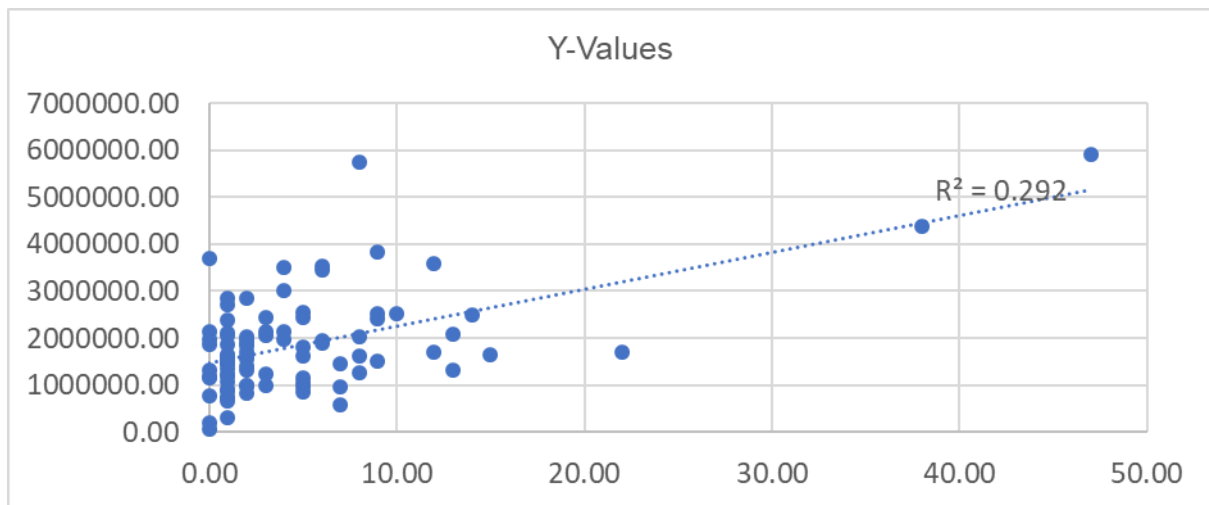
15.15 Table 15.1 reveals that very few maximum grants are approved in any authority (district or unitary) when compared to both allocations and expenditure. Overall unitaries and districts award around 2.5 max grants per £1m spent. Unitaries were more consistent in the numbers of maximum grants given in 2016/17. Only 11% did none, but districts were more varied and almost a third (32%) did none at all. The propensity to give maximum grants does not seem to relate to overall spending levels (Figures 15.4 and 15.5).

Table 15.1 The variation in numbers of maximum grants by type of authority

	Districts	Unitaries
Maximum grants per £1m DFG allocation	2.47	2.44
Maximum grants per £1m DFG expenditure	2.56	2.55
Number of maximum grants in 2016/17	32% (44 out of 147)	11% (10 out of 88)

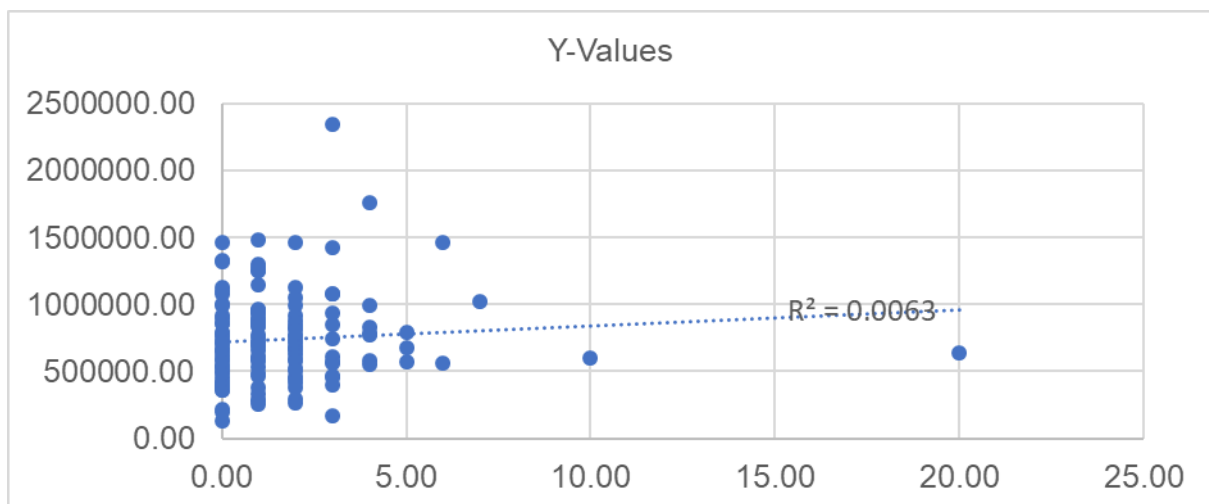
Source: LOGASnet

Figure 15.4 Unitary – spend v max grants 2016/17



Source: LOGASnet

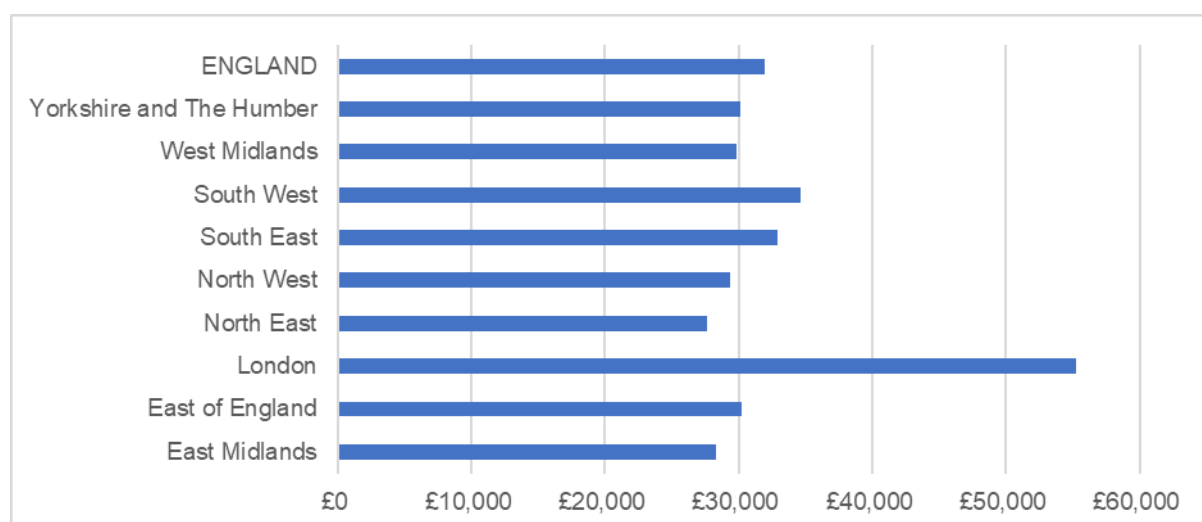
Figure 15.5 District spend v max grants 2016/17



Source: LOGASnet

15.16 As we revealed in Part A, there is significant variation in the cost of bedroom/shower room extensions across the country (particularly in London) (Figure 15.6).

Figure 15.6 Average extension costs by region 2016/17



Source: Foundations FOI 2018

15.17 In the feedback we received from the workshops and online survey, two other issues were highlighted as significant issues:

- VAT** - For most adaptations involving access or bathing, building works are zero rated. But where space is created for a new bedroom, or a kitchen, that proportion of the project is subject to VAT at the standard rate of 20%. For a typical extension it can add over £4,000 to the total cost. We heard examples of different interpretations of the rules taken by different contractors and agreed with inspectors. For example, one ingenious contractor successfully argued that 40% of a bedroom should be zero rated because it was also the access to an en-suite shower room.

An alternative way of dealing with VAT is proposed in the 2018 London Housing Strategy¹⁵⁰. This points out that the VAT on home improvements is charged at the standard rate of 20%, compared with a lower rate of 5% on building a new home. The report suggests that lowering the rate for home improvements to 5% would incentivise homeowners to undertake more building work which would add to employment, economic activity and tax revenues; offsetting losses from the lowered rate.

- Fees** - larger adaptations can be complex construction projects which require knowledge and expertise to deliver successfully. A typical fee for design and project management is around 10%-12%, adding another £3,000+ to an extension costing £30,000. We heard a number of examples of projects proceeding without professional support due to the fees taking costs above the upper limit but suffering from significant delays and other problems as a consequence.

¹⁵⁰ Greater London Authority (May 2018) London Housing Strategy, Section 5.39, p. 145 [online] https://www.london.gov.uk/sites/default/files/2018_lhs_london_housing_strategy.pdf.

The problems of under-specification and lack of professional support

In an online survey of 76 disabled people (74% families with children) in 2017, by the charity Inclusive Home, 52% had experienced problems with the design, building work or equipment installed as part of their adaptation scheme. These are some examples of the comments:

- "Wet-room floor tiles have come up and the bathroom often floods...."
- "Toilet in wrong place windows not fitted properly toilet flooring bubbling."
- "Ramp unsuitable so have to move, so no work can be completed."
- "Toilet needs re-positioning but can't face the upheaval at the moment."
- "Designed wrongly so can't have tracking hoist. Toilet system installed wrong, so waste comes up shower and toilet."
- "3 years later I am still suing the 'professionals' involved for breach of contract and poor workmanship. House ruined, some rooms still unusable. So stressful and upsetting."
- The builder messed up the foundations "so front of extension narrower than back but apparently was too late to sort when building inspector turned up - we didn't find this out until it was built. Shoddy workmanship wet room floor had to be relaid as done incorrectly. He didn't put electric shower in as discussed at pre-build meeting."
- "Back patio laid above damp course of conservatory so we had to pay for drainage."

Source: Inclusive Home

Move away from one size fits all delivery

15.18 Reviewing the evidence, there are few expensive grants, and they seem very different from the main work of adaptation teams which is to provide showers, stairlifts, ramps and other adaptations under £10,000. The nature of expensive cases is usually much more complex. They are often children with complex needs, people who have had strokes, those involved in major accidents or people with long-term conditions such as motor neurone disease, multiple sclerosis or Huntington's disease.

15.19 At the moment, decisions seem to be cost-driven, as so many are around or within the £30,000 upper limit. Raising the limit and changing the way decisions are made could alter the thinking about these grants from 'expenditure' to 'investment'. It would allow a much more person-centre approach which could provide long-term solutions to increase disabled people's independence.

Setting a maximum amount

15.20 Taking an investment approach means that the beneficiaries of the investment must have a meaningful role in the decision-making process. In the case of large and complex adaptations, the beneficiaries will be: 1) the disabled

person, their families and carers; and 2) local health and social care commissioners.

15.21 For commissioners, this means a number of considerations, including:

1. Alternative interventions that may achieve the same or better outcomes, such as specialist equipment or alternative living arrangements
2. The anticipated costs of care and support if suitable adaptations aren't provided
3. An appropriate level of investment in the circumstances.

15.22 We considered developing a standard formula using these factors but didn't consider it viable given the wide range of potential circumstances. We also discarded the option of removing the upper limit completely, as it could negate the need for commissioners to engage and place undue strain on Housing Authorities, particularly on smaller District Councils.

15.23 The remaining option is to increase the maximum limit. However, the variation in building costs across the country means that a one-size-fits-all figure is going to be problematic. We therefore recommend that the maximum amount is raised in line with inflation, with a regional weighting based on building costs.

15.24 Due to the importance of professional expertise on these larger projects, we also recommend that the regional upper limits are increased by a further 10% to ensure that support is provided.

Table 15.2 Maximum Grant Formula

Region	Existing Max	With Inflation	Cost Variation	Net Grant	Upper Limit inc 10% fee
North East	£30,000	£38,500	100%	£38,500	£42,250
North West	£30,000	£38,500	97%	£37,250	£41,000
Yorkshire and Humberside	£30,000	£38,500	95%	£36,500	£40,250
West Midlands	£30,000	£38,500	92%	£35,400	£39,000
East Midlands	£30,000	£38,500	94%	£36,250	£40,000
East Anglia	£30,000	£38,500	100%	£38,500	£42,250
South West	£30,000	£38,500	100%	£38,500	£42,250
South East	£30,000	£38,500	109%	£42,000	£46,250
Outer London	£30,000	£38,500	105%	£40,500	£44,500
Inner London	£30,000	£38,500	111%	£42,750	£47,000

Source: <https://www.costmodelling.com/regional-variations> - Inflation from April 2008 to April 2018

- 15.25 The main beneficiary is the disabled person and their family, and it is essential that they are involved in the decision-making process from the outset.
- 15.26 With the significant discretion that Local Authorities hold to make appropriate decisions around investing in large scale adaptations, it is important to ensure that discretion isn't fettered, and grant applicants know how decisions have been reached. We therefore recommend that, in cases where the cost of meeting an assessed need exceeds the new upper limits, a notice must be issued explaining the decision.
- 15.27 To ensure that potential applicants know the maximum amount for their area, this should be stated on the Local Authority website. It will also be listed on the national www.adaptmyhome.org.uk website which also includes the contact details of every local authority in England for DFG.
- 15.28 As noted previously, a number of local authorities already routinely fund applications in excess of the current upper limit, and not all cases would necessarily increase in cost if the limit were raised. **This makes it difficult to estimate the cost of these recommendation but in the worst-case scenario the additional annual cost would be around £25m.**

Joint funding, risk sharing and joint decision-making

- 15.29 In Chapter 13 'Other funding issues' we discussed the need for risk sharing using contingency funds held by county authorities or a regional grouping of authorities, so that smaller authorities are not overburden by the financial costs of providing expensive grants. As highlighted in Part A, the number of grants awarded in excess of £15,000 is relatively small, but they are often the cases that are subject to the longest delays, as alternative sources of funding are sought. A risk sharing arrangement would ensure that the risk is shared, rather than falling on a single district with a limited budget to ensure:
- Funding is always available.
 - To allow longer term planning for the disabled person and their family, rather than decisions being budget-driven.
 - In some cases - to enable the right specialist expertise to be provided, which might not otherwise be available in a relatively small authority.
- 15.30 The funding chapter also showed that different decisions that are of more benefit to the disabled or older person may be possible if funding is combined in different ways. For example, instead of adapting a kitchen, a riser wheelchair could be provided which would not only give independence in the home but would also allow more freedom in other setting such as shops and supermarkets. It is also possible to bring in resources from other budgets if there is a business case for savings to health and care services.

Moving rather than adapting

- 15.31 Rehousing is an alternative to providing adaptations where it would provide a better solution, where the household is willing to move and if costs are likely to be very high. Adapting an alternative property is allowed under an RRO and the costs of moving can be included.
- 15.32 Change management work in Bristol showed that it was possible to ask people if they would consider moving at the point of initial assessment in social care. Bristol employed a rehousing officer which allowed 26 households to move and saved £477,000 in adaptation costs in the first 9 months it was in operation. Incentives to move, such as removal costs and new carpets and curtains, were seldom needed. The cost of DFG adaptations in the new dwellings was very much lower than improving the existing home, and it provided better solutions to people's needs¹⁵¹.
- 15.33 Rehousing requires close collaboration with registered providers, council stock providers, other local landlords and estate agents to ensure that people can be helped to move within reasonable timeframes. It is also necessary to keep people on the DFG waiting list in case a move proves to be impossible to achieve.
- 15.34 Housing options advice and rehousing services require added revenue funding on top of that for DFG delivery. With pressures on local authority resources, many of these non-mandatory services have been discontinued. In 2015/16 only 20% of authorities provided support for people to move rather than adapting, and only 268 people were helped to move that year across the whole country (Foundations FOI, 2016). Given the savings to DFG budgets, these services could pay for themselves in a relatively short period of time, but again it needs better strategic management at local level to enable this to happen and the engagement of social housing providers and development planners on those boards.
- 15.35 People also need time to think about moving. The current national advice service, FirstStop, has a housing options tool and information about moving. This web and telephone help facility needs to be updated so that more people can get access to advice and information and begin the process of considering their housing options. It also needs to address the needs of younger disabled households who are more likely to want to move.
- 15.36 There is also scope to use volunteers. Evaluation of Care & Repair England's 'Silverlinks' service showed that older people are looking for trustworthy, impartial information and advice on housing options, plus the interconnected

¹⁵¹ Mackintosh, S. (2012) From Home Adaptations to Accessible Homes: Putting people at the heart of redesigning the adaptation service in Bristol, Housing LIN Case Study no 62. https://www.housinglin.org.uk/assets/Resources/Housing/Practice_examples/Housing_LIN_case_studies/HLIN_CaseStudy_62_Adaptations.pdf.

issues of care and finance¹⁵². The older volunteers have no agenda - they share their own experiences but are not there to persuade anybody to make a particular choice. A volunteer can allow space for the person to talk through options and reach the decision that's right for them without feeling under pressure. When asked about why the Silverlinks approach works, volunteers said that people find it much easier to relate to another older person who has gone through similar experiences.

Summary about the upper limit

- 15.37 Larger adaptations are very different in nature to the relatively straight-forward showers, ramps and stairlifts that make up the majority of the DFG programme. A traditional one-size-fits all approach to delivery has not necessarily reflected the expertise required to successfully complete a complex project.
- 15.38 Large adaptations have also been hampered by an often inflexible upper limit, resistance to risk sharing and silo working. There should be a shared understanding of the need to invest and the benefits that will accrue, not just from DFG funding, but from the wider housing, health and social care economy.
- 15.39 The disabled person and their family should be party to the decision-making process and understand the rationale for decisions made. They also need to be given help to move where this might provide a better solution.

Regulatory Reform Order (RRO)

- 15.40 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 enables authorities to offer financial assistance tailored to the needs of their area. The Government provided guidance in 2003¹⁵³ and further changes were made in 2008 following the last review of the DFG¹⁵⁴. More recently, Foundations has provided a guide to preparing a policy¹⁵⁵.
- 15.41 The RRO allows authorities to meet people's needs without going through the full DFG process. The financial help provided by an RRO policy must provide at least the same level of assistance as the mandatory DFG and not fetter discretion in decision-making. For example, an authority cannot refuse a full

¹⁵² Care & Repair England (2016) Making the Housing Connections: An interim evaluation of the Silverlinks Programme. <https://silverlinksprogramme.files.wordpress.com/2017/01/silverlinks-interim-report-1.pdf>.

¹⁵³ <http://webarchive.nationalarchives.gov.uk/20120920034634/http://www.communities.gov.uk/documents/corporate/pdf/145088.pdf>

¹⁵⁴ Department of Communities and Local Government (2008) Disabled Facilities Grant – The Package of Changes to Modernise the Programme, London: DCLG.

¹⁵⁵ Foundations (2016c) Preparing a policy under the Regulatory Reform Order (2002) Housing renewal. www.foundations.uk.com/media/4696/preparing-a-policy-under-the-rro.pdf.

DFG to an individual who requests it, neither can they provide a loan to someone who might otherwise be eligible for a grant.

15.42 Using an RRO policy allows more flexibility in the types of work that can be provided. It can also be substantially quicker. Some authorities use the RRO to dispense with the means test for all work under a certain amount to speed the process. This also helps to remove any stigma people associate with means testing to get more people to come forward. They have also reduced the grant paperwork to make any forms much simpler and easy to fill in. The Cerebra research discussed in Part A showed that forms can still be complex, and only a few authorities have forms readily available online.

15.43 To use the freedoms contained in the RRO authorities must develop a policy to set out how they intend to use their powers, what resources are available and how these have been determined. The policy must be strategic and clearly linked to overall objectives such as those for the Better Care Fund. It needs to be equitable and fair, show the eligibility criteria and set out which groups of people it intends to benefit. It must also have clear, measurable outcomes. Once drawn up the policy must be approved, a notice published, a copy made publicly available and a summary provided on request.

15.44 Grants can be given for a range of different types of work, including:

- Relocation grants
- Hospital discharge grants
- Safe and secure grants
- Handyperson services
- Fast provision of ramps or stairlifts
- Palliative care
- Dementia grants
- Adaptations for people with a learning disability

Dorset RRO policy

The Dorset Accessible Homes Service (DAHS) covers four districts and two borough councils (Christchurch, East Dorset, North Dorset, Purbeck, West Dorset and Weymouth & Portland). Their RRO policy has been operating since 2016. It includes four different discretionary grants or services:

Accessible Homes Grant - is a grant similar to the DFG but more flexible and easier to administer. There is no means test for works under £5,000 (including fees and VAT). For work costing more than £5,000 there is a means test (the part under £5,000 is excluded) but passporting is used for people on a wide range of benefits. As with the DFG, families with children are not means tested. Types of work are similar to the DFG but have been extended to include sleeping space for carers and to cover reasonable expenses in helping a disabled person and their family move home. To cover the full cost of works the upper limit is set at £45,000 rather than the statutory £30,000. They charge an agency fee of no more than 10% of the cost of works included in the grant.

Safe and secure grant - helps low income home owners and tenants carry out minor adaptations, small repairs and the installation of assistive technology. Applicants must be aged 50 and over and be disabled or the parent or guardian of someone disabled. Low income is determined by being on at least one of a list of benefits. The aim is to: reduce accidents around the home; allow independent living; and help with discharge or prevent admission to hospital. However, the grant is not available where the works would be considered the legal responsibility of a landlord. Grants range in size from £50 to a maximum of £2,000 and are limited to £6,000 in total over a three-year rolling period, including a 10% agency fee.

Handy Van Service – this is available for disabled people or those over 50 years of age. People pay for the cost of materials: those on benefits pay no labour costs; those who are not pay £20 per hour.

Loans - available from two councils (West Dorset and Weymouth & Portland) to help people to: improve their homes to meet the Decent Homes Standard; remove Category 1 hazards; address fuel poverty; bring an empty property back into use; improve defects in park homes; or assist people where the maximum grant of £45,000 will not meet the cost of works and no other public assistance is available. The current maximum loan is £15,000.

Cheshire East RRO policy

A Regulatory Reform Order policy supports a holistic approach to help people live independently. Key features include:

- Maximum DFG of £50,000 so that expensive/complex adaptations can proceed quickly without delays trying to get funding
- Loans to help people to pay means tested contributions
- Loans to extended family/separated parents so disabled people can be cared for by their family
- Relocation grants to help with the cost of moving
- Grants and loans for foster carers to care for disabled children
- Combining DFGs with other funding streams (including social care and charitable funding) for urgent care needs including hoists and lifts
- Affordable warmth grants to improve wellbeing
- Combined grant and loan funding so people can adapt their homes in a way that is more aspirational than functional

They work closely with occupational therapy teams, the visual impairment service, the independent living centre, vulnerable people champions, hoarding practitioners' group, community agents and local area co-ordinators. There is a Handyperson service for minor adaptations and repairs. Individual partnership agreements enable joint working with housing providers, including three transfer associations.

Early intervention through equipment and adaptations is delivered by a trusted assessor who works across the HIA and the occupational therapy service. Clients are referred by the occupational therapy referral & advice team and holistic assessments are undertaken in the Independent Living Centre or the persons own home. There is a separate priority pathway for urgent cases such as end of life care, transfer of care and risk of injury.

Quicker service: A lean systems approach reduced adaptation timescales by four months, which was reduced further by a framework agreement for level access showers with a target for installation within six weeks.

Outcomes: They measure resident outcomes including: personal dignity, emotional wellbeing, reduced reliance on informal carers and prevention of hospital admissions. A small-scale research project after installation of level access showers showed that, despite worsening health, most individuals had been able to live completely independently in their own homes for the next two years.

15.45 All authorities that have developed integrated adaptation service also have an RRO policy. However, in 2016/17 an FOI showed that overall only half of authorities had an RRO policy. Many appear to be held back by lack of staffing resources, absence of strategic management support or worries about the audit process if they give discretionary rather than mandatory grants. There is a need to encourage every authority to develop an RRO as part of the integration process.

Suitability of the 6-month time limit

- 15.46 The six-month time limit is not working as it was envisaged in the original legislation. This said that the council shall approve or refuse an application ‘*as soon as reasonably practicable, and, in any event, not later than six months after the date of the application*’.¹⁵⁶ It reflects a time when housing authorities controlled the whole process as part of housing renewal work. When the service is split between administrative departments, delays are not just with the housing authority. It does not reflect the customer’s experience as they may have already spent six months or more on a waiting list for an assessment before they get to the application stage.
- 15.47 It is also a rule that people get around as was shown in Part A. When there are waiting lists, authorities manipulate the dates by not allowing the application until they know it can be approved within the timeframe.
- 15.48 As the 6-month time limit is part of the primary legislation, we recognise that it is more difficult to revise and may be appropriate for a small minority of cases where an applicant submits an application without prior consultation with the local authority. However, we recommend that the requirement to approve or refuse an application “*as soon as reasonably practicable*” is stressed within revised guidance and should in most cases take no longer than 4 weeks.

Other regulation

The Services and Charges Order

- 15.49 The 1996 Services and Charges Order lists the services and charges which may be funded using the DFG¹⁵⁶. The current list includes:
- Confirmation, if sought by the local authority, that the applicant has an owner’s interest
 - Technical and structural surveys
 - Design and preparation of plans and drawings
 - Preparation of schedules of relevant works
 - Assistance in completing forms
 - Advice on financing the costs of the relevant works which are not met by grant
 - Applications for building regulations approval (including application fee and preparation of related documents)
 - Applications for planning permission (including application fee and preparation of related documents)
 - Applications for listed building consent (including application fee and preparation of related documents)

¹⁵⁶ The Housing Renewal Grants (Services and Charges) Order 1996.
<http://www.legislation.gov.uk/ukxi/1996/2889/made>

- Applications for conservation area consent (including application fee and preparation of related documents)
- Obtaining of estimates
- Advice on contracts
- Consideration of tenders
- Supervision of the relevant works
- Disconnection and reconnection of electricity, gas, water or drainage utilities where this is necessitated by the relevant works
- Payment of contractors
- The services and charges of an occupational therapist.

15.50 To ensure that housing options are considered during assessment, we recommend that the costs associated with moving home, including the provision of practical support, should be added to the list. The requirement to be 'necessary and appropriate' and 'reasonable and practicable' would still apply, which means that moving would typically be a lower cost option than staying put.

15.51 An omission from the current list is the funding of extending warranties on items like lifts and hoists. It is cited as good practice within the current guidance and therefore we recommend that the regulations are amended accordingly.

Other Funding Considerations

15.52 The guidance circular that accompanied the legislation in 1996 said that it was for '*housing authorities and social services authorities between them to decide how particular adaptations should be funded*' either through what's now the 2014 Care Act or through a DFG.

15.53 The guidance went on to note that it was common practice for equipment which can be installed and removed fairly easily with little or no structural modification to be the responsibility of the social services authority.

15.54 This demarcation between works with or without structural modification has worked well for the most part but has caused issues where it has been rigidly enforced. For example, we heard that in many areas it is common for a shower adaptation to be funded from DFG, but a free-standing shower chair to be funded by social services. In many cases, this means delays between the completion of the adaptations and the delivery of the shower chair, with the result that the disabled person either cannot safely use their new adaptation or that they have to use a patio chair in the interim.

15.55 We also heard of cases where a ceiling track hoist is funded by a DFG but the slings are funded by social services, resulting in separate orders and delays.

15.56 In Staffordshire they recognised this issue, and the housing and social services authority decided that it was sensible for the initial purchase of items like shower seats and slings to be included within the DFG – similar to the way ink is included when you buy a printer. Replacements will be funded by social services.

Need for clearer guidance

15.57 Throughout this review, it has become clear that the application of the legislation, various regulations, general consents and orders, guidance, good practice guides and use of the Regulatory Reform Order have created a complicated system that few people fully understand. Much of the wording, particularly from the legislation and original regulations, is old fashioned and doesn't properly consider issues around learning disabilities, behavioural issues, mental health, and dementia. For anyone new to the delivery of DFG, there is a very steep learning curve.

15.58 This review sets out a new way of approaching DFG, as part of joined up range funding and services that puts the disabled person at the centre of the process. It is recommended that the guidance is fully revised so that it clearly sets out expectations for local authorities and rights of a disabled person making an application.

Recommendations – regulation and the upper limit

- **That the maximum amount of the DFG is raised in line with inflation, with a regional weighting based on building costs and an amount for professional fees.**
- **That the VAT rules are revisited for major adaptations.**
- **Regulatory Reform Order (RRO) Policies have been developed in about half of local authorities and need to be adopted in all areas to provide more flexible use of the grant.**
- **Each area to have simple application forms available on request.**
- **Applications should be determined within four weeks where the Local Authority has had prior involvement with the application.**
- **That the guidance is fully revised to reflect integrated services, the expectations for local authorities and the rights of the disabled person.**
- **That the Services and Charges Order list is updated to include support with moving and the funding of extended warranties.**
- **That the national advice line is updated and improved to give people support with housing options.**

Chapter 16. Developing a market

The current situation

- 16.1 The evidence from the review has been mixed. There are areas that have transformed their services and have fast, flexible integrated delivery but there are more traditional approaches elsewhere. Some areas allow DFG customers to personalise the specification, and upgrade or add products at their own expense, but others do not.
- 16.2 Innovation in design and the introduction of new products and materials is also uneven. Restrictions on expenditure have made it difficult for staff to get to trade shows and training events, research new products and designs, cost them and get them into standard schedules. A focus on value for money has meant that teams go for the lowest tender submission and do not look at the quality of the outcomes that the price will deliver. We know that many people drop out of the DFG process, but we don't know how many never come forward at all because of the stigma attached to out of date designs.
- 16.3 But change is happening, and interesting trends are emerging that could revolutionise the types of adaptations that are delivered. New products are market driven and mainstream which means that everyone can benefit, not just the small proportion of disabled and older people who happen to get a DFG.
- 16.4 The chapter looks at the need to change the way building work and adaptations installation is procured to make it more consistent and efficient and to drive innovation. It looks at the revolution in personal assistive technology and the 'internet of things' that is allowing disabled people to control their home through their smart phones. Finally, it looks at how to help people outside of the DFG and the role played by both the market and the public sector.

Procurement

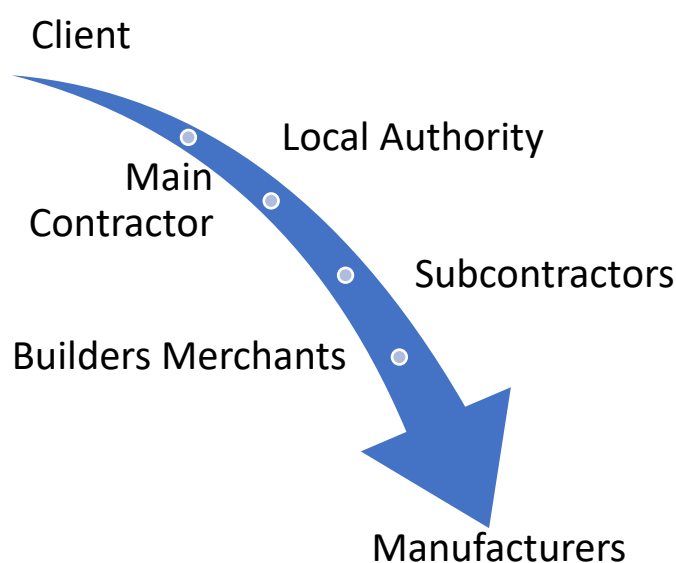
Need for Change

- 16.5 Construction procurement practice is recognised to be poor in the UK, particularly in the public sector. This leads to waste and inefficiency. For DFG, this is made worse by low levels of standardisation in home adaptations and the fragmentation of local authority delivery.
- 16.6 The 2006 Good Practice Guide suggested that Local Authorities set up a schedule of rates for carrying out adaptations works, noting that "*once in place the benefits of such a system are considerable: costings can be calculated*

*directly from the specification, a cost of works fixed and the level of grant assessed without waiting for tenders to be returned and evaluated*¹⁵⁷.

- 16.7 However, research by Foundations found that around two-thirds of DFG funded adaptations are still costed by seeking two or three quotations from local builders based on an ad-hoc specification. In turn, the builders will use local subcontractors and source materials via builders' merchants.

Figure 16.1 Typical DFG Supply Chain



- 16.8 Over 80% of the annual DFG programme is delivered by building firms adapting existing housing. The UK construction industry is highly fragmented, with over 300,000 businesses (of which 99.7% are small and medium-sized enterprises - SMEs)¹⁵⁸. The delivery of DFG is also disjointed, carried out through 326 local housing authorities across England with little collaboration or consistency, particularly around procurement practice.

- 16.9 In their report on the role of local authorities in housing for disabled people, the Equalities and Human Rights Commission found that on average it took 14

¹⁵⁷ Department for Communities and Local Government (2006) Delivering Housing Adaptations for Disabled People: A Good Practice Guide. London: DCLG.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7821/138595.pdf.

¹⁵⁸ HM Government (2018) Industry Strategy: Construction Industry Deal [online]

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731871/construction-sector-deal-print-single.pdf.

weeks to install an adaptation after a DFG had been approved¹⁵⁹. The biggest challenge identified by local authorities was the difficulty in finding reliable contractors to carry out the works. Typically, a local authority will have an approved list of builders that has been built up over several years. There is currently no consistent method of assessing the quality and suitability of builders to carry out home adaptations.

- 16.10 The EU funded Seas-2-Grow project has also investigated the UK market and found that “*there are few mechanisms unifying suppliers of innovations specifically for the elderly*”¹⁶⁰. This often means that equipment meant to help make life easier has been designed more for a hospital rather than a home, such as grey padded shower seats and white plastic support rails. During a roundtable with manufacturers and suppliers we heard that a recent local authority tender had a score profile of 10% for quality, 90% for price. Even for a simple product such as a grab rail, the research and development and subsequent tooling costs can run into thousands of pounds, which has to be recovered in a unit cost “*which LA's are not prepared to pay so where is the incentive to change?*”.
- 16.11 The Latham¹⁶¹ and Egan¹⁶² reports recognise the need for clients and suppliers to improve their collaboration, working with fewer suppliers in a more settled supply chain. In the wider construction industry this has generally been achieved by the creation of frameworks which then stay in place for a fixed period of up to 4 years. However, there can be a tension between the benefits of working with fewer suppliers in a long-term relationship and the benefits of maintaining a market which is accessible to new entrants with associated competition and innovation. Frameworks can also stifle continuous improvement and tend to lock out smaller local companies.
- 16.12 Some local authorities use frameworks and schedules of rates to improve the efficiency of their procurement process, but this is generally done at a local level with the intention of reducing cost rather than developing the market.
- 16.13 The challenge then, is to use the £0.5bn annual DFG budget to improve design, shorten timescales and retain control of costs.

¹⁵⁹ Adams, L., Morris, S., Thomson, D., Rossiter, H., Felton, J., Newbold P. and Hazel, Z. (May 2018) Housing and disabled people: the role of local authorities, London: EHRC.
<https://www.equalityhumanrights.com/sites/default/files/research-report-115-housing-and-disabled-people-the-role-of-local-authorities.pdf>.

¹⁶⁰ Seas 2 Grow (2017) Silver Economy Accelerating Strategies: Market Study.
<https://www.seas2grow.com/wp-content/uploads/2017/06/SEAS-2-Grow-Market-Study-EN.pdf>.

¹⁶¹ Latham, M. (1994) Constructing the Team, London: HMSO.
<http://constructingexcellence.org.uk/resources/constructing-the-team-the-latham-report/>

¹⁶² Construction Task Force (1998) Rethinking Construction, London: Dept of Trade and Industry.
<http://constructingexcellence.org.uk/resources/rethinking-construction-the-egan-report/>.

Procurement Reform

- 16.14 The main barriers to better design and innovation are the lack of integration in the market, and the lack of standardisation and repetition in specification. The traditional procurement processes of seeking multiple quotations has reinforced these barriers. Addressing them calls for both reform of procurement processes and greater efficiency in their operation.
- 16.15 Often, procurement is seen as a standalone process at the start of a construction project. For home adaptations, it is worth considering whether the inclusion of ongoing servicing and maintenance for equipment like lifts and hoists should be included. There is also a question about whether design and construction should be procured and/or provided separately when staffing can cost up to 24% of an average DFG¹⁶³.
- 16.16 From our research into best practice across the sector, we would like to highlight the following as ways in which significant improvements can be achieved at a local level.

Schedule of Rates

- 16.17 Chorley Home Improvement Agency use an online schedule of rates for all their shower adaptations. They have set out a standard specification that has been pre-priced by their list of approved contractors. For each project the HIA select the appropriate items to build up the schedule of works, and in the background the system adds up the rates submitted by each builder to provide instant quotations. They select the successful contractor by looking at price and past performance.
- 16.18 The process is quick and easy to carry out and saves three or four weeks compared to a traditional paper-based approach. It also means that if a contractor is unavailable for some reason, the HIA has alternative quotes already prepared. The online system also allows for fixed price materials from a framework and a series of alternative options to allow for client choice.

Flat-pack extensions

- 16.19 Where a DFG involves an extension, usually to provide a ground floor bedroom with en-suite shower room, the construction will typically be based on a traditional structure of bricks and blocks to match the existing property. This tried and trusted approach has three significant disadvantages: 1) it takes many weeks to build, with all of the inherent disruption; 2) it is very messy, particularly if it rains when the foundations are being excavated; and 3) uncertain ground conditions can lead to significant extra costs.

¹⁶³ Curtis, L. and Beecham, J. (2018) A survey of Local Authorities and Home Improvement Agencies: identifying the hidden costs of providing a home adaptations service. <https://kar.kent.ac.uk/66433/>.

- 16.20 A quicker and cleaner alternative is to use a flat-pack extension. These can be completed in around 1 week by using factory manufactured Structural Insulated Panels (SIP) and screw-pile foundations – an approach used in most episodes of DIY SOS. This means less mess and disruption and much lower risk of unexpected additional costs.
- 16.21 Another advantage with SIPs is thinner, but better insulated walls, which means additional internal floor-space compared to a traditionally built extension of the same external dimensions. In some cases, this could allow an extension to be designed within permitted development limits and negate the need to apply for planning permission.
- 16.22 In the few case studies we have seen, costs have generally been comparable with traditional build, particularly when design and supervision costs are taken into account. However, further development of this market would help to enhance value for money in this area.

Stairlift loans and recycling

- 16.23 From Freedom of Information data, we know that around one third of social services authorities no longer routinely pay for the servicing, maintenance and repair of stairlifts for service users. For those that do, the number of lifts they maintain is increasing year-on-year, with an average servicing cost of £82.50 and an average repair cost of £227.64 per year for lifts outside the manufacturer's warranty period.
- 16.24 Care and Repair Newcastle have an equipment loan scheme that effectively provides disabled clients who have an assessed need with a stairlift on a free loan for the duration that they need it. The scheme was introduced to make better use of funding by recycling stairlifts¹⁶⁴.
- 16.25 For the recipients the benefits include:
- Speed of service – they have no waiting list for this service and a simplified process means clients typically receive a stairlift between 3-6 weeks after their initial enquiry.
 - Increased safety – client's safety is increased as the period from identification of need to installation has been radically reduced from over 12 months to 3-6 weeks.
 - Increased number of recipients – previously some clients would fail a means test for a DFG and have to fund the installation, service and maintenance of a stairlift themselves, or continue to struggle getting up and down stairs at increased risk to their welfare.
- 16.26 The scheme started in June 2016 and they are now, on average, installing three stairlifts each week and removing one stairlift each fortnight, which is then

¹⁶⁴ <http://www.careandrepairnewcastle.co.uk/how-we-help/equipment-loan-scheme/>

recycled through the scheme. It is therefore recommended that stairlifts are delivered through a non-means tested equipment loan service for speed of service, increased safety and to reach more people in need.

Value for money, standards and cost benchmarking

16.27 To go from fragmented delivery to a more settled supply chain will require significant co-ordination and engagement with Government and industry stakeholders. If it is the intent of Government to use the annual DFG budget of £0.5bn to shape the market, then it will need to lead the process, and focussed effort will be required from all parts of the supply chain.

16.28 Improving the certainty of the forward programme by announcing a further five-year funding profile for DFG, including local allocations, would encourage local authorities to take a longer-term view on procurement practice. However, we recommend taking a lead from the UK Construction Strategy, by:

- Establishing by benchmarking a challenging but realistic market price for procurement.
- Setting common standards for typical adaptations and communicating requirements to prospective suppliers in a clear and consistent way.

Benchmarking

16.29 Cost benchmarking is required to establish better consistency of value for money and a baseline for new cost/value-led approaches to procurement. The benchmarking should also include project on-costs (agency fees, administration costs, etc.) so that efficiency of the overall project is also plotted.

16.30 Clearly, where cost is a lead driver, there is a risk that the quest for the lowest initial capital cost will take precedence over judgments made on value – and particularly on the outcomes for the client. A vital part of benchmarking is therefore a clear understanding of how a project will deliver benefits to the wider public sector, so that cost benchmarks are not set at an artificially low level by the inclusion of projects that fail to deliver wider social value.

16.31 The criteria for social value will need to be converted into standards and specifications that can be passed to suppliers as part of the brief that they are required to meet. There should be consistency across the country in how these standards are set, and wherever possible they should be outcome based to maximise the opportunities for innovation.

Common Standards

16.32 A number of frameworks for home adaptations already exist that set-out common standards for materials. Some are set specifically for DFG projects,

typically at a local level, whereas larger scale frameworks are usually targeted at works programmes of housing associations.

- 16.33 Further work is required to assess the effectiveness of these frameworks, to ensure that they do not create a barrier to entry to the market, particularly for SMEs at the local level, with some assurance that longer term relationships and economies of scale will produce greater value for the taxpayer.
- 16.34 For builders, we recommend developing a national accreditation scheme similar to the Certified Ageing in Place Specialists that operates in North America. Builders undertake Trusted Assessor type training to understand the requirements for fitting adaptations correctly as well as mentoring on how to market and promote their services. With appropriate support this would help to encourage more SME builders into the adaptations market for the benefit of both local authorities and people looking for a trusted solution to carry out works themselves. In the UK, this could be associated with the current Trustmark registration scheme.

Assistive technology

Introduction

- 16.35 Technology has always been part of Disabled Facilities Grant – paying for stairlifts, through floor lifts, and ceiling track hoists. The DFG legislation also includes the less common control of power, heat or light as a “*purpose for which ... a grant must be approved*”¹⁶⁵. These all form part of a wide range of electronic assistive technology devices that function to compensate for disabilities or impairments.
- 16.36 Assistive Technology has long been claimed to support independence of service users, reduce unpaid carer ‘burden’ and to save Adult Social Care and the NHS money by reducing need for care, preventing unnecessary hospitalisation and delaying/preventing moves into residential care. For example, early project evaluations generally concluded that telecare could produce positive outcomes for people who used it, but these studies were mostly small scale and used methods that meant their findings could not be regarded as entirely reliable¹⁶⁶. However, they did encourage more rigorous research, including the ‘Whole System Demonstrator’ (WSD) project—a randomised controlled trial that took place at three local authority sites. It concluded that over a 12-month period, and using a wide range of indicators,

¹⁶⁵ Housing Grants, Construction and Regeneration Act 1996

¹⁶⁶ Kings College London, Background to the UTOPIA study [online]
<https://www.kcl.ac.uk/sspp/policy-institute/scwru/res/utopia/background.aspx>.

outcomes were not significantly different between telecare users and a control group who received other services and support but not telecare.

16.37 Part of the problem is the way that businesses innovate for older adults and disabled people generally. Too often these groups are seen as needing solutions to their medical issues, like mobility or medication management. Any concerns about self-image or style – significant concerns for any other sector of society – are often seen as frivolous and only treated as an afterthought¹⁶⁷. As a result, a small-scale German study of telecare users found that only 14% carried their emergency pendant with them at all times¹⁶⁸.

16.38 But with the rise in smart technology, there is a growing range of solutions that can be used to modify the home of a disabled person and increase their independence. Excitingly, most of these solutions are part of the consumer drive towards smarter homes and the emergence of the “Internet of Things” – devices that are connected to the internet, can be controlled remotely and send back data about their environment.

16.39 As the WSD study shows, we need to be aware that technology doesn’t always deliver on its promise and we can’t realistically expect one universally designed holistic solution or seamless integration with existing service delivery and other devices. We’re also unlikely to see a clear reimbursement model based on public health care financing or a clear metric for the specific impact on quality of life at this stage. However, we could reasonably expect to see smarter homes, targeted and personalised support for condition management, rudimentary assessment of behaviour and a positive impact on engaging users.

16.40 When considering the role that Assistive Technology can play in DFG we have considered only options that are:

- Used in the home environment
- Likely to improve the independence of the user
- Available to use now.

Technology for Ageing Well

16.41 Some studies suggest ageing occurs in a predetermined order and can be represented as a ‘curve of functional ability’ shown in Figure 16.2 below, which

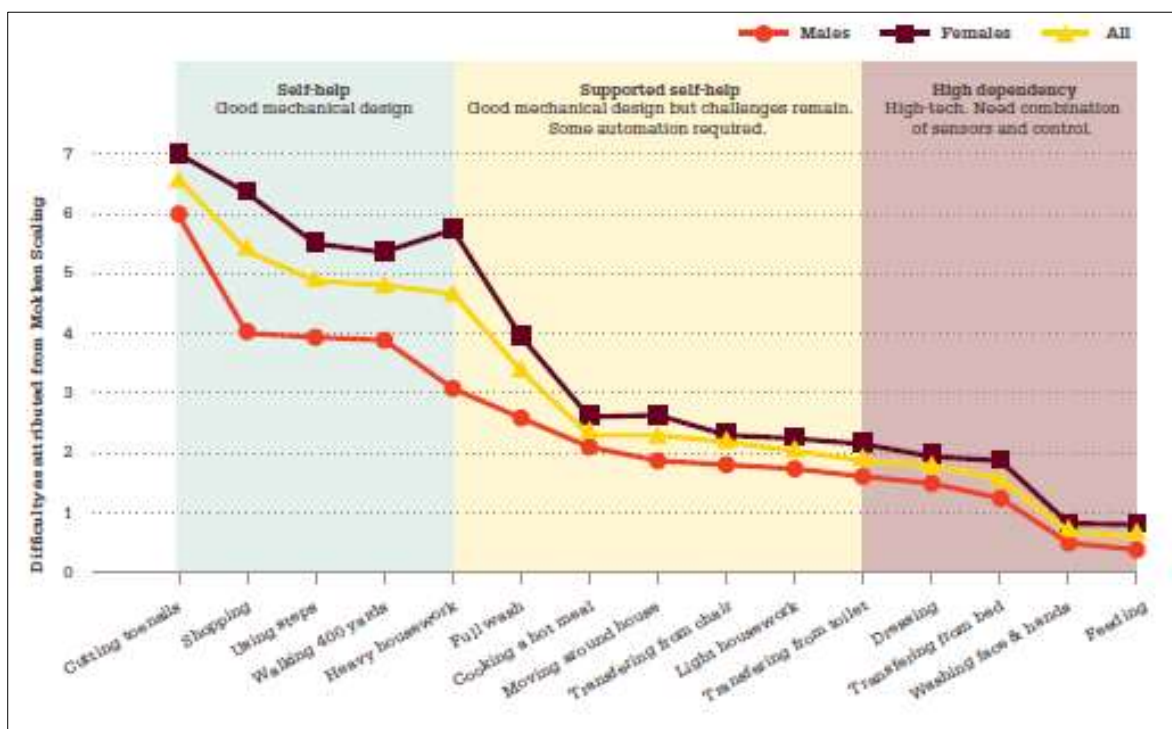
¹⁶⁷ Coughlin, J. F. (2018) *The Longevity Economy: Inside the World's Fastest-Growing, Most Misunderstood Market* by Joseph F. Coughlin, Cambridge, MA: Massachusetts Institute of Technology.

¹⁶⁸ Heinbüchner, B., Hautzinger, M., Becker, C. et al. (2010) Satisfaction and use of personal emergency response systems, *Z Gerontol Geriat* 43: 219. <https://doi.org/10.1007/s00391-010-0127-4>.

presents the level of difficulty the very old (85 years plus) have in performing daily tasks of personal care, household chores and mobility. The Institution of Mechanical Engineers defined a series of criteria for independence at home, where the needs and applications of technology would vary depending on where a person sits on the curve.

16.42 An opportunity exists to encourage greater activity through better home design and adaptive and assistive technology for some tasks, such as shopping, using stairs, housework, moving around the house, and transferring from chair, toilet and bed. Automatic assistance could be made to help maintain maximum activity, only providing what is necessary to encourage the older person to maintain muscle exercise as long as possible, based on health and not age.

Figure 16.2 Curve showing decline in functional ability



Source: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0031665>.

16.43 Eligibility for DFG is based on having a substantial disability and so most current applications are for adaptations below 4 using Mokken scaling. Further developments will require good mechanical design with some automation or higher level of technology.

Mainstreaming Assistive Technology

16.44 With the negative brand value associated with older age and disability¹⁶⁹, the growing market for the ‘Internet of Things’ is aimed at easing the lives of mainstream consumers. It has significant potential to improve the lives of people with disabilities by addressing issues they have identified as being important concerns: being unable to undertake household chores; not wanting to be a burden on family members; fear of being taken ill when alone; and fear of accidents such as falls¹⁷⁰.

Table 16.1 Amazon’s range of products and services as an example:

<p>Amazon launched the Mayday button in 2013 – a simple click on a tablet connects you to a tech adviser in 15 seconds or less</p>	
 <p>House Cleaning</p>	<p>In 2015 they launched Home Services – an online service where you can find and hire vetted, licensed professionals to come to your house and perform services ranging from plumbing, to cleaning, to tech support, and almost everything in between</p>
<p>2016 saw the launch of the Amazon Echo in the UK – a smart speaker that can take voice commands to make calls or control a range of other devices</p>	
	<p>And in 2017 they introduced Amazon Key. A system that includes a smart door lock that people can open and close their doors without a key or give a guest a code to enter their homes.</p>
<p>Combining these services means you could ask the Echo to contact you to the Mayday response, arrange a cleaner through Home Services who could let themselves into your home using Key.</p>	

¹⁶⁹ DePoy, E. and Gilson, S. (2010) Disability Design and Branding: Rethinking Disability within the 21st Century, Disability Studies Quarterly, Vol 30, No 2. <http://dx.doi.org/10.18061/dsq.v30i2.1247>.

¹⁷⁰ Doughty, K. (2004) Supporting independence: the emerging role of technology, Housing, Care & Support 7(1), pp11–17. <https://doi.org/10.1108/14608790200400004>.

- 16.45 Local Authorities are starting to pick up on these opportunities. Working directly with Amazon, Hampshire County Council has become the first local authority to use new Amazon Echo technology to help older people live independently in their homes for longer. It is providing 50 adult social care clients with a modified version of the device to remind people when to take medication or check when their carer is due to arrive. It will also connect to other technology in people's homes such as movement sensors, so it can remind people to have a drink when they enter the kitchen.
- 16.46 Other Local Authorities are following suit. Norfolk have also started using Amazon Echos, connected doorbells, sensors that tell if you have fallen, and associated technologies and learning lessons from innovative approaches elsewhere.
- 16.47 Geoff Connell, Norfolk's head of information management and technology said¹⁷¹:
- “We're now poised at a stage where it is about to go mainstream. We're looking at how we can learn lessons from places like Hampshire and target self-funders to keep them out of the system and look at all of our care packages to ask if they are suitable for a combination of tech and people. We are aiming at the consumer tech, stuff that will integrate easily and cheaply.”*
- 16.48 Other “consumer tech” will allow you to remotely govern your heating, turn lights on and off, and control most electrical devices using a mobile phone, a remote control or even by voice commands. New switches are emerging that can also control gas and water feeds which could be essential safety features for people with a diagnosis of dementia or behaviours that challenge. The case study below illustrates the impact of the creative use of existing technology.

¹⁷¹ Norfolk Council looks at Alexa for social care (Mar 2018) [online] <http://www.ukauthority.com/UKA-Local-Digital/entry/8023/norfolk-council-looks-at-alexa-for-social-care>.

LightwaveRF Case Study

Ross Hovey's mobile phone is his lifeline and in connecting LightwaveRF's smart home solutions he has transformed his home and way of life. A Liverpool football fan and banking professional, he has a rare neuromuscular disorder, spinal muscular atrophy – a genetic disease that causes muscle weakness and progressive loss of movement. For 37 year-old Ross this means loss of strength in his arms and legs.



With support from his parents nearby, his specially designed wheelchair, a team of dedicated carers and LightwaveRF smart home solutions, Ross lives independently in his home in Cambridge.

How Ross uses Lightwave

“One of my friends recommended LightwaveRF and I have never looked back,” reflects Ross. *“It’s easy to install and not at all complicated. The retrofit is great.”*

Ross says: *“I sleep with my phone in my hand as it enables me to do everything – it is my lifeline. The advent of smart phones has made tech easier to interconnect. I love that I can control every LightwaveRF device from the free app. When I arrive home I can turn on my outside light, open my front door and light my hallway all from my phone. If I need to alert a carer in the middle of the night I can turn their bedroom lights on at the touch of a button. My hallway has three PIR motion sensors. When a carer gets up in the night to turn me, hall lights come on and go off again once they are back in bed.”*

Ross said: *“I don’t endorse a specialist disabled world. The world should be normal and accessible to everyone. The NHS advocate the Possum electrical assistive technology, it dates back to the 1980s, is noisy, ugly, and powered by an impractical PDA system. I didn’t want a special solution, I wanted stylish in my home which is why I chose LightwaveRF. It is cool, modern, affordable, easy to use and non-intrusive.”*

Cognitive and dementia AT Case Study

- 16.49 There are a plethora of businesses providing consumer tech products and services that can be utilised support independent and healthy living in old age. It is predicted that over 130 million smart home devices were shipped in 2017, and by 2020 the average home will have more than 500 connected devices, ranging from washing machines to light bulbs¹⁷².
- 16.50 However, while the tech is generally quite easy and intuitive to use, it can still be difficult to know what to buy and how to set it up. This is where handyperson services are starting to develop expertise in providing and installing suitable kit¹⁷³.

Using the Data

- 16.51 As well as being easy to control remotely, this consumer tech also collects data which can be sent for remote monitoring. This means that a smart home can catch the 'little things' before they become major issues for the resident, and ultimately a cost burden on the NHS. For example, increased toilet visits can signal urinary infections or incontinence, deviations in gait over time can be the precursor to an impending fall – all of which could, if left unchecked, result in long stays in hospital for treatment. By detecting these signs early, the smart home and its inbuilt technology can warn the resident or a doctor of an imminent episode. With simple interventions such incidents could be mitigated or even avoided.
- 16.52 Over the last 18 months Cascade3d have been using standard sensors to monitor the stair usage of an 80-year old woman who had a hip replacement 10 years ago. They can track the number of times up and down per day, average time, and the standard deviation for fastest/slowest. Further research is required, but alongside listening to and being guided by clients' wishes and ensuring that clients understand the role of equipment and its relevance to their needs, it could provide a diagnostic to identify when a stair-steady¹⁷⁴ or stairlift should be considered.
- 16.53 In America, radar-based systems have been developed that are unobtrusive but can measure body movement and vital signs at a distance, even through walls, detecting falls and automatically raising an alarm. But their ability to remotely sense heart rate and respiration rate (vital signs which can be correlated with physical illnesses) means that this data can also be logged over

¹⁷² Johnson, C. (2016) The Future of Connected Home Health, Saffron Waldon: Plextec.

<https://www.plextek.com/wp-content/uploads/2016/07/The-future-of-connected-home-health.pdf>.

¹⁷³ Coughlin, J. F. (2015) How the Internet of Things & On-Demand Services Will Change Housing in Retirement [online] <http://bigthink.com/disruptive-demographics/how-the-internet-of-things-on-demand-services-will-change-housing-in-retirement>.

¹⁷⁴ <https://stairsteady.net/>

time and used to assess risk of falls, heart failure, Parkinson disease and others¹⁷⁵.

16.54 Another study has used radar sensors to monitor the gait speed of older people as they move around their home¹⁷⁶. A change in gait speed has a high correlation with falls risk, and this system has an algorithm that can track walking speed and alert a carer when the risk of a fall increases.

16.55 These systems show how non-intrusive and non-stigmatising systems can be retrofitted to homes to allow people to live independently and safely.

User Acceptance

16.56 As society ages, more and more older people will be technologically savvy. A recent survey of over 70's by Silk Road¹⁷⁷ found that over 75% thought that technology can make living in their home easier/better and prioritised emergency response, enhanced alarms for visual and hearing impairment, memory aids, medication assistance and video monitoring.

16.57 This suggests that the next generation of retirees will be redrawing Maslow's hierarchy of needs to include the new necessities of Wi-Fi and smart technology¹⁷⁸.

The Downsides

16.58 Most assistive tech makes it easier to perform tasks that a human would otherwise do. A stairlift, for example, replaces the need to climb the stairs and in doing so removes the inherent physical health benefits of the exercise. Kaddour Bouazza-Marouf CEng FIMechE Mechatronics in Medicine Loughborough University believes that user activity should be intrinsically incorporated and encouraged within the living environment. He suggests that when a stairlift is installed, the user would need to cycle using hands and/or feet to move up or down the stairs. The stairlift will be electrically powered and uses feedback from the cycling torque and speed of the user through a control strategy; the restraining torque of cycling would be controlled to suit the ability of the user.

¹⁷⁵ Diraco, G., Leone, A., & Siciliano, P. (2017). A Radar-Based Smart Sensor for Unobtrusive Elderly Monitoring in Ambient Assisted Living Applications. *Biosensors*, 7(4), 55.
<https://doi.org/10.3390/bios7040055>.

¹⁷⁶ Phillips, C., Keller, J., Popescu, M., Skubic, M., Rantz, M., Cuddihy, P. and Yardibi, T. (2012). Radar walk detection in the apartments of elderly. Conference proceedings of Annual International Conference of the IEEE Engineering in Medicine and Biology Society.
<https://doi.org/10.1109/EMBC.2012.6347327>.

¹⁷⁷ Silk Road (Jan 2018) Considerations when moving to a retirement style home [online]
http://www.wearesilkroad.com/pages/news/older_people.php?v3.

¹⁷⁸ Coughlin, J. F. (2015) *ibid*.

16.59 There's also the potential for technology to replace actual human interactions. There's significant research indicating that social isolation and loneliness have a negative effect on health and wellbeing among older people, but contradictory stories on the impact of technology. For example, research into internet use and loneliness in older people¹⁷⁹ found that wellbeing increased where they could get in touch with friends and family but decreased where they were trying to make new friends.

Assistive Technology and the DFG

16.60 The UK Industrial Strategy¹⁸⁰ sets out Grand Challenges to put the UK at the forefront of the industries of the future, ensuring that the UK takes advantage of major global changes, improving people's lives and the country's productivity. One of these Grand Challenges is the ageing society.

16.61 Most of the tech described here is relatively low cost – so unlikely to be part of a DFG in isolation. However, one of the purposes of DFG is facilitating the use by the disabled occupant of a source of power, light or heat by altering the position of one or more means of access to or control of that source or by providing additional means of control.

16.62 Routinely incorporating relatively low-cost consumer technology as part of a DFG funded home modification would create significant potential for widespread adoption, enhancing the UK's potential to be a world leader in assistive technology in accordance with the Industrial Strategy. It would also improve the understanding of the benefits of these systems amongst social care staff, including occupational therapists, with the potential to add further ancillary sensors and devices in the future.

Support for people outside the DFG

16.63 There is a limited amount of information about what home improvement work is done outside the DFG, but it appears to be substantial, with more people in homes with downstairs toilets, showers instead of baths and full central heating. But there is still unmet need, particularly in the older housing stock. In 2014/15, 9% of all households in England (around 1.9 million households) had one or more people with a long-term limiting disability that required adaptations to their

¹⁷⁹ Sum S, Mathews RM, Hughes I, Campbell A. (2008) Internet Use and Loneliness in Older Adults, *Cyberpsychol Behav.* Apr;11(2):208-11. <https://doi.org/10.1089/cpb.2007.0010>.

¹⁸⁰ HM Government (2017) UK Industrial Strategy: Building a Britain fit for the future.

<https://www.gov.uk/government/publications/industrial-strategy-building-a-britain-fit-for-the-future>.

home¹⁸¹. Most (81%) thought their homes were suitable for their needs and over half of households (55%) that required adaptations in their home already had them installed. However, around 45% of households lacked one or more of their required adaptations.

- 16.64 Households with a person aged under 55 who had a long-term limiting disability were more likely (32%) to state their accommodation was unsuitable than those over 75 (12%). This demonstrates that services to help people with adaptations should not be focussed solely on the old, but also on younger age groups. At the moment these are the groups often excluded from the DFG because of the failure to account for housing costs in the means test.
- 16.65 Health and social care are inevitably focussed on older people, as they are the biggest users of services. There are some indications that people only go ahead with adaptations after they had experienced a fall or other incident that made them realise they were becoming less able to cope¹⁸². They may also be deterred by the clinical appearance of adaptations¹⁸³. As Part A of this review indicated, they do not know where to turn for help.
- 16.66 An Age UK survey in 2015 indicated that about 1 in 5 people aged 60 to 69 were making adaptations to their homes to make them suitable for their needs as they age¹⁸⁴. Nearly a third of over-70s had made the changes to make caring for a relative easier. However, a quarter of those interviewed said they would only consider making changes if they had an accident that affected their physical ability and a fifth would only think about adaptations if they were advised by their GP. These findings suggest that people need more encouragement to think ahead and ‘future-proof’ their homes before they get to crisis point. It also indicates that GP surgeries could play a significant role in getting people to think about planning their home and providing initial signposting to advice services if these were available.
- 16.67 How attitudes are changing in the cohort in their 50s just entering later life is difficult to judge. People who have cared for their parents in may be more aware of the need to prepare their home for old age than previous generations. There is a need to understand more about what people are already doing, how effective that is, what holds them back and what might encourage them to do more to ‘future-proof’ their homes. There is also a need to explore what is happening with younger disabled people and what type of services they would like to see.

¹⁸¹ Ministry of Housing, Communities and Local Government (2016) English Housing Survey: Adaptations and Accessibility Report, 2014-15. Ibid.

¹⁸² Powell, et al. (Nov 2017) *ibid*.

¹⁸³ Bailey, C., Hodgson, P., Aitken, D. and Wilson G. (July 2018) Primary research with practitioners and people with lived experience – to understand the role of home adaptations in improving later life. <https://www.ageing-better.org.uk/sites/default/files/2018-07/Primary-research-with-practitioners.pdf>.

¹⁸⁴ Age UK survey 2015 <http://www.ageuk.org.uk/latest-press/archive/1-in-5-older-people-adapting-home-for-later-life/>

16.68 Supporting people outside of the DFG relies on a number of factors:

- Market provision
- Good advice and information
- Reliable tradespeople
- Financial support

Market provision

16.69 The market for technical products is expanding rapidly, as the previous section has shown. There is also considerable innovation in kitchen, bathroom and stairlift design. There are a number of specialist suppliers, and inclusive design is becoming more mainstream. Wet rooms are now aspirational and desirable and found in retail showrooms. Adapted kitchens are also no longer solely the preserve of specialists. Stairlifts are also getting sleeker and take up less space.

16.70 However, the problem is not the availability of age-friendly and inclusive products, it is the lack of specialist sales staff able to advise disabled and older people. Bathroom and kitchen showrooms tend to be male-dominated, sales-driven spaces. Of those over 65, almost half of potential customers are single, and a high proportion are women. Showrooms are not easy environments to talk about disability needs or how to plan ahead for later life.

16.71 The sheer choice of products is bewildering and putting together a package for a bathroom or kitchen that will suite individual needs is not easy, particularly where room sizes are small or awkwardly shaped. Although there are plenty of wet room designs, making sure the configuration is right for future needs, finding easy to use controls, and making sure surfaces are non-slip is not straightforward.

16.72 It is hard to know where to find reliable and knowledgeable information online or to know where to turn for help. It is all too easy to be talked into buying the wrong products. Most people will only have one opportunity to install a new bathroom or kitchen and will not necessarily be able to afford to rectify what can be costly mistakes.

16.73 At the top end of the market there are some innovative companies such as Motionspot who are showing just how beautiful adapted bathrooms can be¹⁸⁵. There is also a lot that can be learnt from the design of hotel bathrooms. Hotel chains are managing to put accessible bathrooms in relatively small spaces and not only making them very attractive but also easy to clean and maintain.

16.74 Some mainstream retailers are becoming more aware of the need to cater more effectively for this market. Bathstore has created an Easy Bathing range in conjunction with specialist bathroom supplier AKW¹⁸⁶. However, other retailers,

¹⁸⁵ <https://www.motionspot.co.uk/>

¹⁸⁶ <https://www.bathstore.com/products/easybathing>.

such as B&Q, have tried displaying inclusive bathroom products before but eventually pulled out. It is still too early to tell whether the Bathstore initiative will have a longer lifespan.

16.75 Better products and services will eventually emerge. Nesta estimates that the spending power of the ‘silver economy’ in the UK will grow from £79 billion to £127 billion by 2030¹⁸⁷. At the moment, most general advertising spending is aimed at younger age groups. There is little sophisticated market analysis of the older demographic with the over 50s, or over 65s categorised as one age group. There seems to be a perception that the older market segment is unattractive and simply populated by low income people in poor health¹⁸⁸. However, the demographic bulge of the “Baby Boom” generation is now entering their later years. They are more ethnically diverse, more educated, more aware of design, used to doing up their homes, and familiar with searching online and comparing ratings. They will eventually drive change, but it has not happened yet.

The role of local authorities

16.76 At the consultation events participants were asked what role councils and national government should play in helping people outside of the DFG or whether it should be left to the market and personal responsibility:

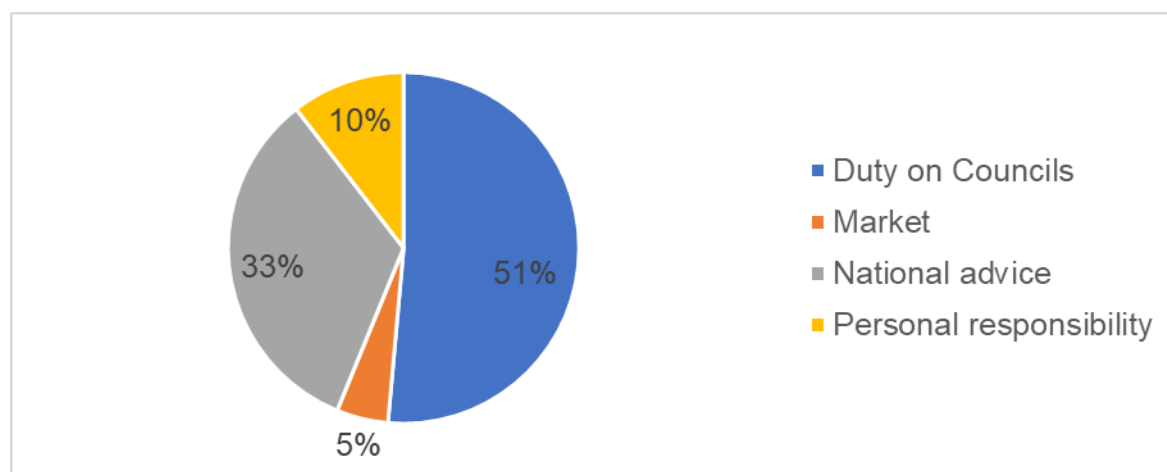
1. Duty on councils - DFG duty should be extended to provide information, advice and support to anyone with a substantial disability
2. Leave it to the market - if there is sufficient demand the market will respond to provide appropriate services
3. National advice - advice and information is available from a national advice centre (web/call centre)
4. Personal responsibility - We should leave people to do what they want in their own homes.

16.77 There was reasonably strong support for councils to have a role in providing information, advice and support (51%). A third of respondents also said there should be some form of national advice website and/or call centre. Only 10% said it was personal responsibility, and even fewer that it should be left solely to the market (Figure 16.3)

¹⁸⁷ <https://www.businessgrowthhub.com/blogs/2017/05/profit-from-the-grey-pound>.

¹⁸⁸ <http://www.ecipartners.com/news-and-insights/insights/the-grey-pound>

Figure 16.3 Options for support for people outside the DFG



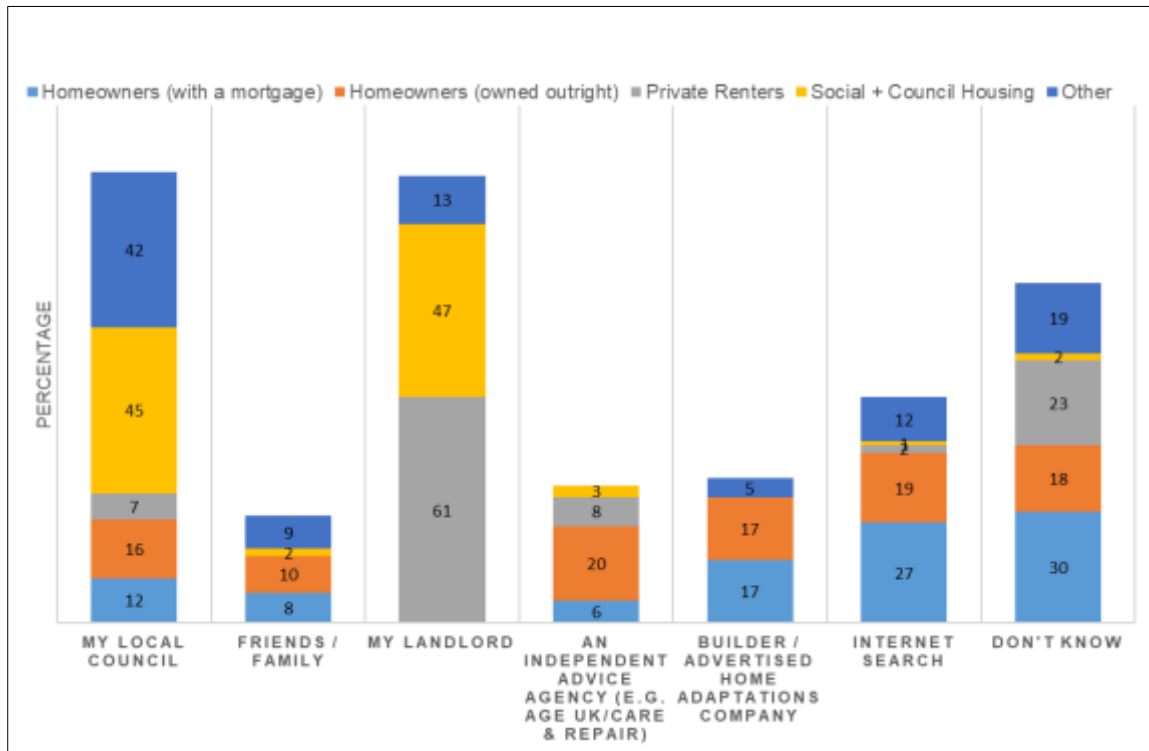
Source: workshop responses

Where people go for information

16.78 The evidence suggests that there is a gap in terms of advice and information, with the market not being able to provide it effectively, at least not at the present time. However, local authorities are not the obvious alternative. In a small-scale survey conducted for Care & Repair England respondents were asked where they would turn for information about adaptations (Figures 16.4 and 16.5). People renting would be most likely to go to their landlord, although social housing tenants would be just as likely to go straight to the council. In comparison, relatively few home owners or tenants in private renting would go to the council.

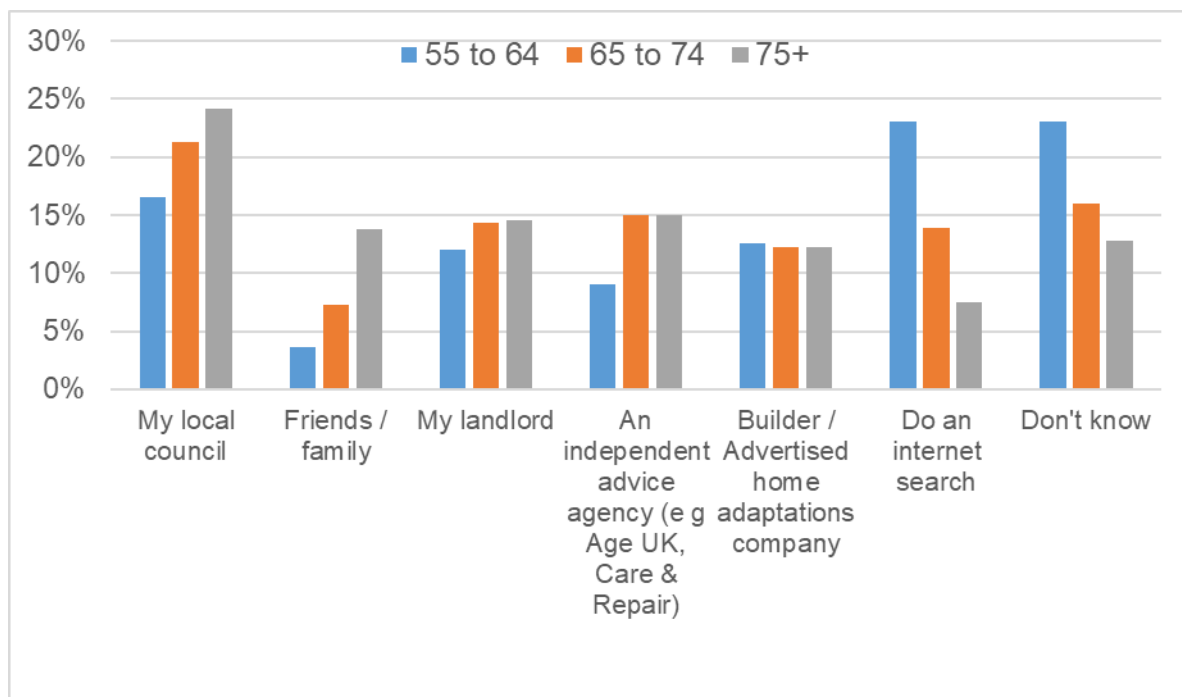
16.79 Home owners (48%), private renters (23%) and people below retirement age were more likely to say they didn't know where to go than other groups. Home owners were more likely than other groups to search the internet (46%) but this was more commonly used by those aged 55-64, rather than older age groups. A third (34%) of owners were as likely to go direct to a builder or advertised home adaptations company as go to an HIA or an organisation like Age UK. Few people in any tenure group who were under 75 said they would turn to friends and family.

Figure 16.4 Where older people go for information by type of organisation and by tenure



Source: BMG Survey for Care & Repair England, July 2017 (481 UK residents aged 55 and over)

Figure 16.5 Where people go for information by type of organisation and by age



Source: BMG Survey for Care & Repair England, July 2017 (481 UK residents aged 55 and over)

16.80 It is a key requirement of the 2014 Care Act to provide good quality information, including housing advice. Areas which have retained a full home improvement agency service are better equipped to provide advice and support to people outside the DFG. However, some areas have lost this function as a result of austerity measures and it needs to be restored as part of developing integrated and holistic services. If councils are going to play a bigger role then some of the ideas suggested earlier in this report, about having a more recognisable name and branding for the service, also need to be implemented. It has to be about 'investment' not 'welfare' and be welcoming for all age groups.

16.81 There is also scope for some home improvement agencies and councils to use their expertise in home adaptations to enter the commercial market as the example of West of England Care & Repair demonstrates. However, it needs to be delivered in a very different way from a traditional adaptations service. It must be market-orientated, fast, efficient and offer attractive and aspirational solutions. It needs to be delivered in a way that would be expected from a mainstream market provider, but with the added advantage of a deep understanding of people's needs and expert adaptations advice.

West of England Care & Repair 'Enterprises' service

WE Care & Repair is a well-established home improvement agency operating across: Bristol; Bath and North East Somerset; North Somerset; and Gloucestershire.

Enterprises is their commercial arm. It provides a specialist design and installation service for easy access bathrooms aimed at people who are not eligible for a DFG, or who prefer to commission the work themselves. The service is designed to help people maintain their quality of life and wellbeing, retain their independence and reduce the risk of falls.

The service works alongside their contractual obligations to support people with minor adaptations and repairs, home security, handyperson services, hospital discharge and other more traditional home improvement agency services.

The development of the service was based on a thorough analysis of the local market for bathroom adaptations and a detailed business plan. It builds on their track record as a trusted local social enterprise. They offer assessment and support from their own occupational therapist and end-to-end project management. The service includes:

- Advice
- Design, visualisation, specification, quotation
- Site supervision and final inspection
- Installation of specialist equipment
- Warranty for building work

To build the service, they had to improve their networks and referral pathways, provide support with financing, develop a different project management and customer support role and work more effectively with the supply chain. There is potential to develop the self-pay service to offer a wider mix of adaptation options.

A brochure is available in print and online which shows a range of design solutions at different price points: <http://www.wecr.org.uk/enterprisesbrochure>.

The Home Independence Centre provides a showroom setting for people to view and try aids and adaptations and have assessments.



Learning points:

- There is substantial opportunity for HIAs to operate more commercial models
- It requires development investment and a higher marketing overhead
- Risk to revenue/reputation if there is a lack of capacity to meet demand promptly
- Competition from the wider market may increase
- It is important to measure outcomes and impact to demonstrate results to funders, future investors and commissioners.

As a not for profit organisation developing a commercial service helps:

- Create profit to be reinvested in services for those on very low incomes
- Delivers preventative services fast to reduce accidents in the home and pressure on statutory services
- Encourages people to take control of their future
- Within WECR it helps drive efficiency in all other parts of their service

Paying for adaptations

Minor adaptations

16.82 Most of the adaptations required may be relatively low cost. The English Housing Survey found that the four most common adaptations that households said they needed were: hand rails inside (40%); a bath or shower seat or other

bathing aids (30%); a specialist toilet seat (25%); or a shower to replace a bath (19%)¹⁸⁹. However, the data needs to be treated with some caution as it is based on self-assessment and lack of knowledge about different types of equipment and adaptations may mean people are not always able to determine what is needed. The evidence in Part A shows that minor adaptations are very cost-effective and have a significant impact on falls and accidents.

- 16.83 There are two ways to deliver minor adaptations using market provision. One is to use some of the new apps and online services to find people willing to do small jobs, and the second, is to use local tradespeople. For these to be effective requires accreditation, as was discussed above, and validated customer rating systems.
- 16.84 There is an important role for a handyman service run by a local authority or home improvement agency. These are still the best way to provide a service to people on low incomes. Handymen are trained as trusted assessors and can not only carry out the work requested but can spot if any other help is required, so they are a very important preventative service. The 2018 CLG Committee report recommended that these are made available in all local authority areas¹⁹⁰.
- 16.85 As a lot of people are not claiming all the benefits they are entitled to, making sure that they get help from a home improvement agency caseworker or are signposted to services such as Citizens Advice is also very important. If benefits income is maximised, it would not only allow people to get minor adaptations, but also to afford to heat their homes, improve their diet, take up hobbies and go out, all of which improves health and wellbeing.

Major adaptations

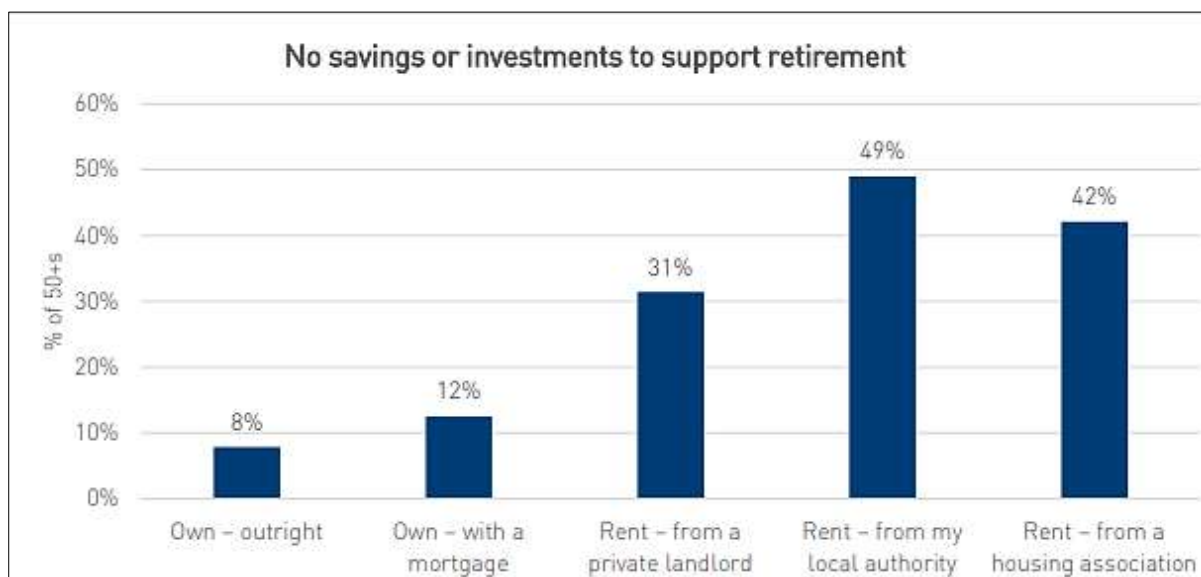
- 16.86 Paying for more expensive work may be more problematic, particularly for people who do not meet the DFG means test but have relatively limited resources. This review has showed that a level access shower costs around £5,000 but a self-funder is likely to have to pay more. The cost depends on local building costs, the quality of the installation and the fact that private work will probably be more expensive than prices negotiated as part of a DFG.
- 16.87 The English Housing Survey indicated that concerns about affordability appear to be diminishing. Households that could not afford to install adaptations decreased from 26% to 21% from 2011/12 to 2014/15. However, there has been a long period of relatively stagnant wages and rising housing costs so whether this remains the case is not clear. There are inevitably going to be people in all areas who will struggle to fund basic bathroom improvements.

¹⁸⁹ Ministry of Housing, Communities and Local Government (2016) English housing survey 2014 to 2015: adaptations and accessibility of homes report, *ibid*.

¹⁹⁰ Communities and local Government Committee (Feb 2018) *ibid*.

16.88 A YouGov survey by the National Housing Federation (NHF) in 2018 found that 8% of outright owners, 12% of those with a mortgage and 31% of those renting privately aged 50+ had no savings or investment to support retirement (Figure 16.6). Proportions were even higher for those in the social rented sector, but they might be more likely to get help from their landlord.

Figure 16.6 People 50+ with no savings or investment to support retirement



Source: NHF (2018) YouGov Omnibus Poll of 3936 adults aged 50+ in England

16.89 There are a number of options for people to obtain funding for major adaptations:

- Loans
- Pension freedoms
- Home equity
- Lifetime mortgages

Local authority loans

16.90 Local authority loans are being used in some areas as part of RRO policies as has been described in some of the case studies in this review. Loans are mostly for larger jobs above the current £30,000 DFG threshold, but some are also used for smaller jobs where work could not otherwise be carried out. Repayment is made when the house is eventually sold. This is an important source of funding for people unable to raise funds any other way.

Pension freedoms

16.91 People over the age of 55 now have greater freedom to withdraw lump sums from their pension pots. Research shows that when this was introduced 700,000 people used those freedoms between October 2015 and December 2016. The majority transferred the money into another pension or bought an annuity, but 28% took their 25% tax free lump sum, and a further 15% took cash in addition to the tax free lump sum, and 43% spent this money on home improvements¹⁹¹. There is little detail of what improvements were carried out, but it shows that people are wanting to invest in their homes as they approach later life. There is some concern that pension drawdown will leave people with insufficient funds to support themselves throughout later life, but people are also working longer and may rely on their pension for a shorter period of time.

16.92 However, spending power will vary. The richest quarter of pensioners earn three to four times more than the bottom quartile and more than one in seven will retire with no pension other than what they get from the state¹⁹². Women in particular have lower levels of pension savings and they predominate in the oldest age groups.

Equity release

16.93 Using some form of equity release is another option. The BRE research into the DFG in 2011 stated that “*virtually all owner occupied households needing adaptations have equity in their home that is estimated to be at least twice the total costs of any adaptations required*”¹⁹³. With the continual rise in house prices since 2011, the costs of adaptations may be a relatively small proportion of equity. Figure 16.7 shows the average equity held by older households. However, a disproportionate amount of housing wealth is held by households in London and the South East, and lower proportions in the North East and North West, which have higher rates of disability¹⁹⁴.

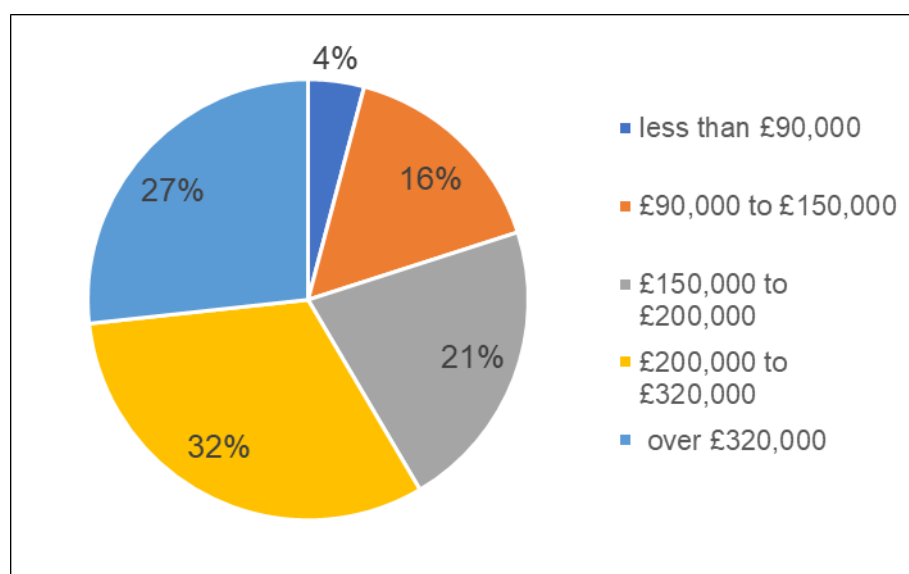
¹⁹¹ Pension and Lifetime Savings Association (2017) Decumulation Decisions: Pension Freedom Journeys. <https://www.plsa.co.uk/Policy-and-Research/Document-library/Decumulation-decisions-pension-freedoms-journeys>.

¹⁹² Wallace, A., Rhodes, D. and Roth, F. (Feb 2018) Home owners and poverty, York: JRF. <https://www.jrf.org.uk/report/home-owners-and-poverty>.

¹⁹³ Building Research Establishment (2011) Disabled Facilities Grant allocation methodology and means test: final report, London: DCLG. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/6335/1850571.pdf.

¹⁹⁴ National Housing Federation (2016) Can our homes pay for the care we need in older age? Asset wealth and an ageing population. http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/Can_our_homes_pay_for_the_care_we_need_in_older_age_-_asset_wealth_and_an_ageing_population_PDF_for_web.pdf.

Figure 16.7 Housing equity held by home owners over 65 years, England 2014/15



Source: English Housing Survey – full interview survey.

Note: based on respondent valuation only

16.94 Equity release products used to have a bad name, but they seem to be becoming more popular, with a greater variety of products, lower interest rates and fewer penalties for making repayments. There are twice as many customers as five years ago. Equity release is catching up with the use of pension lump sums as a source of funding. In 2016, 38p of housing wealth was released for every £1 of flexible payments from pensions, but this reached 56p in Q4 2017. Single older women are an increasing part of this market¹⁹⁵.

Lifetime mortgages

16.95 The lifetime mortgage market is also developing and becoming more accepted. In the future, people may transfer directly from a residential to a lifetime mortgage without ever owning 100% of their property or having a period when they are mortgage-free¹⁹⁶. This is particularly likely in the cohorts approaching retirement who have experienced stagnant wages but still have substantial mortgages. Interest-only mortgages may allow people to take lump sums. Provided interest payments are maintained, there is no roll-up of the interest, meaning it is only the capital that is repaid when the home is sold.

¹⁹⁵ Equity Release Council (2018) Spring 2018 Market Report.

<http://www.equityreleasecouncil.com/document-library/equity-release-market-report-spring-2018/>.

¹⁹⁶ Equity Release Council (2018) *ibid*.

Incentivising home adaptations through the social care cap

- 16.96 There is potentially a lot of demand on equity, principally to pay care costs. It is not an unlimited source of funding, particularly in some parts of the country where house values are low. There is an argument for including spending on adaptations as part of the social care cap, because removing hazards in the home is likely to lead to fewer accidents and injuries, thus reducing costs for health and social care. It would also help to raise awareness of the benefits of preparing the home for later life or as an alternative to paying for domiciliary care, reducing the likelihood of people reaching the care cap.
- 16.97 The previous Health and Social Care Secretary, Jeremy Hunt, in a speech about the principles that will guide the Government’s thinking about the Social Care Green paper, said a sustainable funding model for social care *“will specifically include looking at the role of housing, including how we can replicate the very best models that combine a home environment with quality care and how we can better support people through well-designed aids and adaptations”*¹⁹⁷. Incentivising people through the social care cap might be one way of delivering this support. Any parallel piece of work looking at social care for working age adults also needs to address this issue¹⁹⁸.

Summary – helping people outside the DFG

- 16.98 We don’t know enough about what people are doing to adapt their homes. Home adaptations design is improving and there are some very good products available from mainstream retailers. However, there is an information gap. Local authorities and home improvements agencies could fill that gap, but they need to become more visible and welcoming to people who are able to self-fund. They need to ensure that they do not just focus on an older demographic range, but appeal to younger disabled people, as this is the biggest group requiring help with adaptations.
- 16.99 People with sufficient equity have more options if they wish to use the value of their home to pay for improvements, but there are a lot of demands on that equity. Incentivising adaptations through the social care cap seems a sensible way forward.
- 16.100 People with low, or no equity and on low incomes have fewer choices. Changes to the means test may mean more are eligible for the DFG, but there will always be people who fall outside the criteria. Low cost handyperson services provided by local authorities and home improvement agencies will still be required and they need to be better known. They will also need access to

¹⁹⁷ <https://www.gov.uk/government/speeches/we-need-to-do-better-on-social-care>.

¹⁹⁸ House of Commons Library (Jan 2018) Social care: The forthcoming Green Paper on older people (England), Briefing paper No 8002. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-8002>.

good quality advice to ensure that limited resources are not wasted on inappropriate adaptations.

Recommendations – developing a market

- **A further five-year funding programme for the DFG to improve certainty and enable local authorities to invest in better procurement.**
- **A national accreditation scheme for builders and tradespeople.**
- **Use of an online schedule of rates to increase efficiencies and further work to assess the effectiveness of framework agreements.**
- **Flat-pack extensions to be used to provide a faster service with further research to identify the best solutions.**
- **A smart home starter kit as part of every DFG application.**
- **Local authorities and home improvement agencies to provide advice, information and handyperson services for people outside the DFG.**
- **Further research on what people do outside the DFG to encourage more ‘future-proofing’.**
- **Spending on adaptations outside of the DFG to be included as part of the social care cap and considered in the Social Care Green Paper to incentivise people to prepare their homes for later life.**

Chapter 17. Tenure and equality

“There are inequalities between tenures” “There is a void where policy on the funding of housing association adaptations should be”

Heywood (2005)¹⁹⁹

17.1 Tenure issues were not in the brief and not explored in the consultation events or online survey for this review. However, it is not possible to ignore tenure when looking at the DFG. There are several issues that DHSC and MHCLG will need to consider that may need a separate review. These include:

- The high use of the DFG by registered providers relative to the size of this part of the housing stock;
- The decline in use by home owners despite the increase in numbers of older people with disabilities;
- The difficulties of providing DFGs for disabled people living in the private rented sector who are some of the worst housed
- Whether adaptations in the council stock should continue to be provided through the HRA or brought into the DFG.

17.2 This chapter also addresses adaptations to the common parts of residential properties such as entranceways, hallways, stairwells and emergency exits. These are usually in rented or leasehold properties. Following a report by the House of Lords Select Committee on the Equality Act 2010 and Disability, the Government has made a commitment to review the remaining provisions of Section 36 of the Act. The final section of this chapter looks at the potential impact on the DFG if disabled people request improvements to the accessibility of the common parts of their homes.

Inequality of access to the DFG by tenure

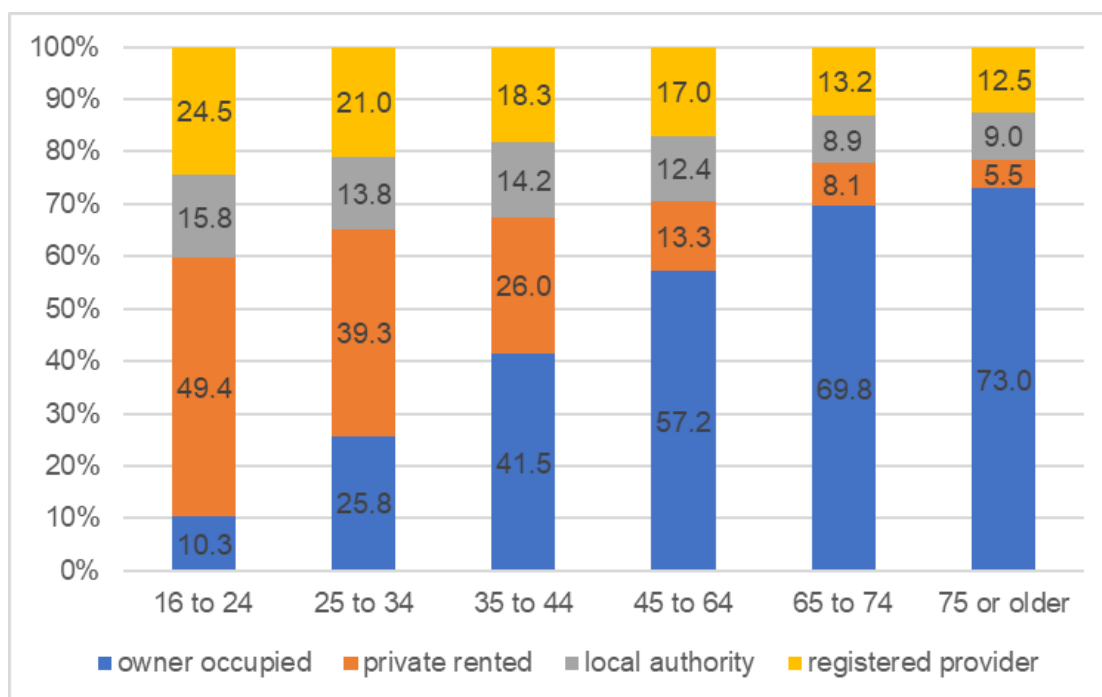
17.3 As Part A demonstrated, there appears to be inequality of access to the DFG. A third of grants (34%) go to registered provider tenants when there are similar numbers of people with long-term illness and impairments in the private rented sector who may be in much poorer housing conditions (Figure 17.1). People in the private rented sector only get 8% of DFGs. There may also be low income home owners missing out on help because their needs are hidden, and few know about the DFG. Registered providers tenants have a much clearer path to get help with adaptations as their landlords will direct them to the council.

17.4 Lack of effective studies at local level mean that it is hard to know the latent demand for adaptations and how this is distributed by tenure. Registered provider usage may reflect the true demand for adaptations. Rather than

¹⁹⁹ Heywood, F.et al. (2005), p.6- 7, ibid.

restricting access for registered provider tenants, ways need to be found to help more people in the other tenures who are missing out on assistance.

Figure 17.1 Distribution of households with a long-term limiting illness by age of HRP and tenure



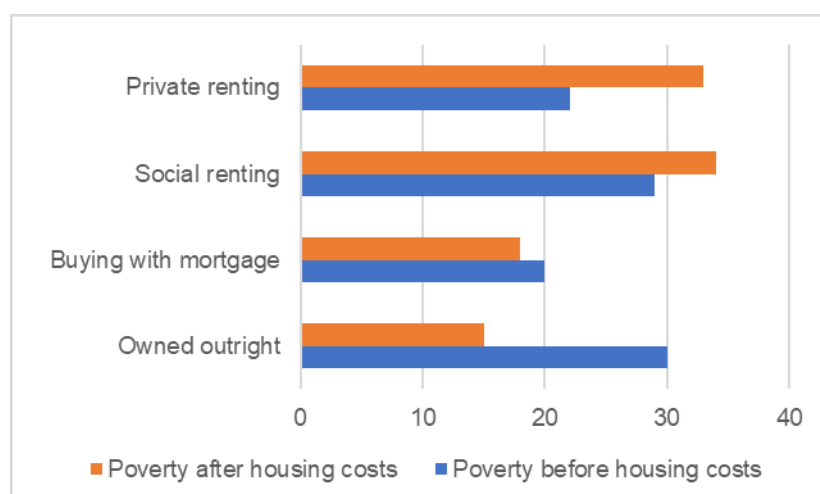
Source: English Housing Survey 2014-15, full household sample

Home owners

17.5 It is often assumed that home owners are wealthier than tenants, but there is still a considerable need for the DFG for people in this tenure. Overall rates of relative poverty are lower for home owners than other tenures, particularly when housing costs are taken into account (Figure 17.2) but looking at those with a long-term illness or disability, home owners are just as likely to be in relative poverty as people in social renting (Figure 17.3)²⁰⁰.

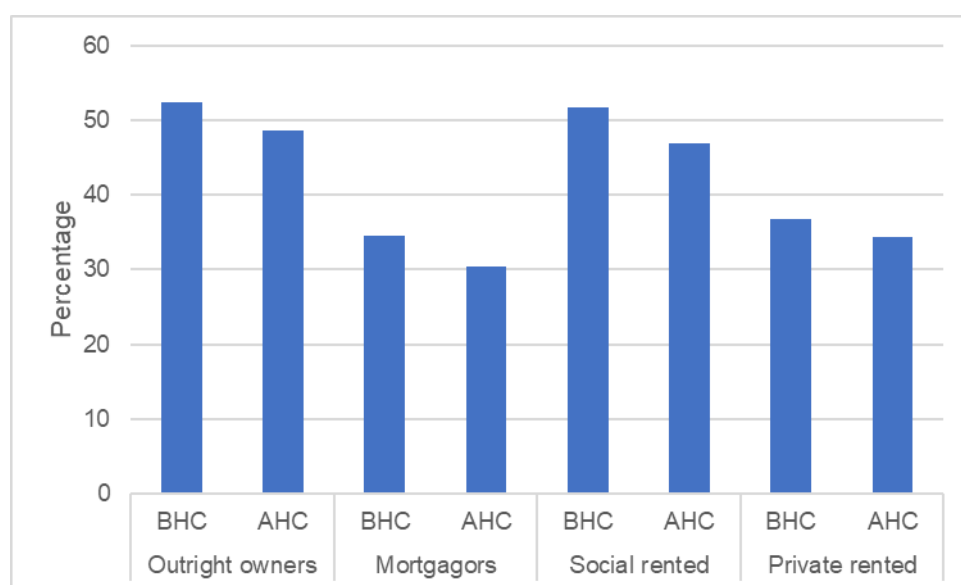
²⁰⁰ Wallace, A., Rhodes, D. and Roth, F. (Feb 2018) Home owners and poverty, York: JRF. <https://www.jrf.org.uk/report/home-owners-and-poverty>.

Figure 17.2 Relative poverty by tenure 2013/14



Source: Wallace, A., Rhodes, D. and Roth, F. (Feb 2018). Note: figures for United Kingdom. Poverty defined as below 60% of median equivalised income.

Figure 17.3 Households with long standing illness or disability by poverty status and tenure 2014



Source: Wallace, A., Rhodes, D. and Roth, F. (Feb 2018), Table 13. Note: figures for United Kingdom. Poverty defined as below 60% of median equivalised income.

17.6 Most people over 65 live in pre-1980 properties not built to current accessibility standards. Category 1 hazards, which include excess cold and risks from falls, affect 13-14% of homes occupied by older people²⁰¹. The homes of older homeowners in relative poverty (before housing costs) require significant investment (£2 billion) to bring them up to the Decent Homes Standard²⁰². The amounts

²⁰¹ Ministry of Housing, Communities and Local Government (2016b) *ibid.*

²⁰² Wallace et al. (2018) *ibid.*

needed per property are only a small proportion of the level of housing equity, however, equity varies both within and between regions and is not always easy to tap into, as was discussed in the previous chapter. Home owners therefore need continued access to the DFG and need to be made aware that this help is available.

Registered providers

- 17.7 Guidance from 2008 states that it is expected that registered providers contribute to the costs of adaptations in their own properties, but this '*needs to be negotiated and established through formal agreement*'^{203,204}. The diverse nature of this sector makes it difficult to develop effective partnership agreements as it ranges from national organisations with 50,000 properties which operate across many authorities, to local organisations with less than 100 homes.
- 17.8 Where there are local adaptation agreements, some of the costs of work to registered provider properties may be claimed back by local authorities, either after work has been completed, or at the end of the financial year. Payments from housing associations or transfer organisations are not included as a separate item in LOGASnet returns so it is difficult to know how much gets returned.
- 17.9 Local funding agreements appear to have become less common, as registered providers have been dealing with uncertainty about income levels due to a 1% cut in rents, a cap on housing benefit and the loss of direct rent payments due to the transfer of tenants to Universal Credit. Contributions are therefore likely to have reduced.
- 17.10 Major repairs expenditure has fallen by 11.3% from £524.5m in 2015/16 to £465.5m in 2016/17 among the top 100 registered providers²⁰⁵. One provider in its annual report said: "*The budget decreases were achieved by reducing planned expenditure on boundary works and environmental programmes, **disabled adaptations**, external wall insulation and slowing down expenditure on various planned maintenance schemes where lifetimes of components may*

²⁰³ Heywood, F. and Mackintosh, S. (2008) Housing Associations and Home Adaptations: Making it Work Smoothly, London: Habinteg.

<https://www.habinteg.org.uk/download.cfm?doc=docm93jjm4n432.pdf&ver=519>.

²⁰⁴ Wilson, W. and Fears, C. (Dec 2016) *ibid*.

²⁰⁵ Hilditch, M. (May 2018) Repairs and maintenance spend tracker: what did your association do in 2016/17? Inside Housing Insight. https://www.insidehousing.co.uk/insight/repairs-and-maintenance-spend-tracker-what-did-your-association-do-in-201617-56310?utm_source=Ocean%20Media%20Group&utm_medium=email&utm_campaign=9493587_IH-THE-FRIDAY-LONG-READ-18-5-2018-GR&dm_i=1HH2,5NHAR,L7J0AM,LZEN1,1

*be extended without breaking Decent Homes requirements*²⁰⁶ (bold type added for the purposes of this report).

- 17.11 Adaptation agreements do not just deal with the payment for adaptations. They also help with the flow of information about the needs of disabled and older people in the locality, the type of new adapted homes required, and ensure that home choice and transfer systems work effectively for disabled people. This helps people relocate if they are in homes that are unsuitable for adaptation. Adaptation agreements therefore need to be a key part of the DFG process.
- 17.12 Registered providers are increasingly developing agreements with health²⁰⁷. Some have hospital discharge schemes or do preventative work with tenants, such as identifying those with dementia or working to combat loneliness²⁰⁸. Some are doing more to support vulnerable people with their tenancies, particularly as Universal Credit is introduced. Some also have very good development policies and are trying to build as many accessible homes as possible. But home adaptation issues seldom appear on the agenda because cases are passed to local authorities for the DFG²⁰⁹.
- 17.13 The situation is further complicated by the changing designation of registered providers. They are sometimes considered public bodies, such as in 2016 when the ONS said their borrowing was on the Government balance sheet, but in 2017 they were again deemed to be private organisations²¹⁰. Many are becoming much more commercial and market-driven.
- 17.14 Local authorities can often get agreements with local registered provider landlords but find it hard to get the big regional and national organisations round the table. It is unrealistic to expect organisations working across numerous authorities to sign up to different agreements in each area. In order to make agreements work, they need to be standardised.
- 17.15 The London Housing Strategy says that “*The Mayor will work with councils and housing associations to agree a protocol to ensure that housing associations*

²⁰⁶ Thirteen Group Annual Report 2016/17 (2017) [online] <https://www.thirteengroup.co.uk/uploaded/thirteen/files/Thirteen%20Financial%20Annual%20Report%2016-17.pdf>

²⁰⁷ Buck, D., Simpson M. and Ross S. (2016) The economics of housing and health: The role of housing associations, London: Kings Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Economics_housing_and_health_Kings_Fund_Sep_2016.pdf.

²⁰⁸ Andrews, J. and Molyneux, P. (2013) Dementia: Finding housing solutions, London: National Housing Federation. <https://www.housing.org.uk/resource-library/browse/dementia-finding-housing-solutions/>

²⁰⁹ Mackintosh, S. and Heywood, F. (2015) The Structural Neglect of Disabled Housing Association Tenants in England: Politics, Economics and Discourse, *Housing Studies*, 30:5, 770-791, <https://doi.org/10.1080/02673037.2015.1044947>.

²¹⁰ <https://www.ons.gov.uk/news/statementsandletters/statementonclassificationofenglishhousingassociationsnovember2017>.

*contribute to the cost of adaptations*²¹¹. But local agreements take a long time to develop. A national agreement would be a better solution, but there needs to be more research about how this might be developed.

Council stock

17.16 The council stock has not been looked at in any detail in this report since adaptations in this stock sit outside the DFG. The 2005 review recommended a single funding pot covering all tenures. We are unable to make any recommendations without doing further work to look in more detail at Housing Revenue Account funding and whether this is working effectively. Council landlords are under the same pressures as registered providers due to rent cuts and welfare reform. How this has affected adaptation budgets is unknown. The same teams often deliver both the DFG and council stock adaptations. It might make sense to bring it all into one funding pot, but it needs further research.

Social housing generally

17.17 Further research is required across the social housing sector to see if access to adaptation services are tenure-neutral. Anecdotal evidence presented to the review team indicates that social housing tenants are sometimes given little choice about adapting or moving. If they are under-occupying, or in a 'general needs' property, they may be expected to move. This may be a good solution for some younger people, but it is unknown whether this is also used for the very old, those with dementia, or people with learning difficulties. It is also unknown how much support people get and the effect a move has on those tenants.

17.18 Only 22% of local authorities have an accessible housing register and some home choice and home swap systems are not very good at recording adapted and accessible homes or matching disabled people to suitable properties²¹². Some landlords are better than others at giving adequate time to view properties and make decisions, and not penalising people for turning down properties that are not suitable. Co-production techniques should be used to involve disabled tenants in changes to the system.

17.19 Heywood said in the 2005 review "*there are no rewards for good housing association policies*"²¹³. Perhaps there should be an annual award to give adaptations and accessible housing policies in social housing greater

²¹¹ Greater London Authority (May 2018) London Housing Strategy, Section 5.39, p. 145.
https://www.london.gov.uk/sites/default/files/2018_lhs_london_housing_strategy.pdf.

²¹² Adams, L., Morris, S., Thomson, D., Rossiter, H., Felton, J., Newbold P. and Hazel, Z. (May 2018) Housing and disabled people: the role of local authorities, London: EHRC.
<https://www.equalityhumanrights.com/en/publication-download/housing-and-disabled-people-role-local-authorities>

²¹³ Heywood, F., et al. (2005) *ibid*.

prominence. The Equalities and Human Rights Commission might be interested in taking this forward following their report on housing for disabled people²¹⁴.

Private rented sector

- 17.20 Figures from Part A show that the number of disabled people in the private rented sector is increasing. Couples with children are now the most common household type in this sector and half a million (510,000) children live in privately rented homes that are unsafe. One in three disabled people in private renting feel their home is not suitable for their needs. However, tenants may be reluctant to come forward to get adaptations if their tenancy is insecure. We also know that permission to adapt the property is refused in 10% of cases.
- 17.21 There is an urgent need for longer and more secure tenancies. The DFG currently requires a tenant to state that they will remain in the property for five years, when the average length of a tenancy is usually much shorter. There may also need to be discussions with mortgage providers as some buy-to-let mortgages specify a 12-month maximum tenancy²¹⁵.
- 17.22 In a survey of 2,517 private landlords across the UK, 93% owned fewer than 5 properties, although the other 7% accounted for 38% of the stock. Dealing with so many small landlords makes it very difficult for local authorities to have much control over this sector²¹⁶. The Homes (Fitness for Human Habitation and Liability for Housing Standards) Bill 2017–19, may help to resolve some the worst house condition problems for tenants.
- 17.23 There is potential for local authority licensing of private landlords to include clauses about allowing permission for adaptations. However, authorities will also need active strategies to deal effectively with landlords if they refuse permission.
- 17.24 The CLG committee report on Housing for Older People recommend that discretionary grants are given to private landlords for the costs of reinstatement or removal of adaptations once a tenancy ends²¹⁷. An alternative approach would be to improve the design of modification solutions to encourage more landlords to allow adaptations that do not need removal.
- 17.25 Housing and Health Partnership Boards could play an important role in co-ordinating a local approach to private landlords. It would also provide a way to rehouse people into the social housing sector where a privately rented home would be difficult to adapt or is in poor condition.

²¹⁴ Equalities and Human Rights Commission (May 2018) *ibid.*

²¹⁵ Equalities and Human Rights Commission (May 2018) *ibid.*

²¹⁶ Council of Mortgage Lenders (Dec 2016) *The Profile of UK private landlords.*
[file:///C:/Users/white/Downloads/the-profile-of-uk-private-landlords-08.05.17%20\(1\).pdf](file:///C:/Users/white/Downloads/the-profile-of-uk-private-landlords-08.05.17%20(1).pdf).

²¹⁷ Communities and local Government Committee (Feb 2018) *ibid.*

17.26 Foundations has a good practice guide on adaptations in the private rented sector which could be updated to provide local authorities with ideas about how to deal with this sector²¹⁸. However, without central government legislation to give tenants better security of tenure and prevent ‘retaliatory eviction’, it is difficult to see how some of the issues relating to adaptations in this sector will be resolved.

Adaptations without delay

17.27 The Royal College of Occupational Therapists publication ‘Minor Adaptations Without Delay’²¹⁹ provided guidance to landlords about minor adaptations. This publication aimed to reduce unnecessary referrals to occupational therapy teams and provide tenants with a quick pathway to adaptations. The publication is currently being revised and updated and needs to be made widely available to all landlords²²⁰.

Common parts grants and the Equality Act

DFG for adaptations to communal areas

17.28 Following a report by the House of Lords Select Committee on the Equality Act 2010 and Disability, Government has made a commitment to review the remaining provisions of Section 36 of the Act. These provisions would enable disabled people to request disability related adaptations to the common parts of residential properties such as entranceways, hallways, stairwells and emergency exits to improve the accessibility of their homes.

17.29 As well as improving the quality of life for people with disabilities, adaptations to common parts have the potential to reduce care costs and NHS expenditure, through fewer hospital admissions from falls, less bed blocking and/or use residential care. Inaccessible common areas can leave a disabled person isolated within their home.

17.30 As stated in the Government response to the Women and Equalities Committee inquiry into disability and the built environment²²¹,

²¹⁸ Foundations (2016b) Supporting people in private rented sector housing: A good practice guide, Glossop: Foundations. <http://www-foundations-uk-com/media/4441/prs-good-practice-guide.pdf>.

²¹⁹ Royal College of Occupational Therapists (2006) Minor Adaptations without Delay [online] <https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/minor-adaptations-without-delay>.

²²⁰ Royal College of Occupational Therapists (in press) *ibid*.

²²¹ Minister for Women and Equalities (2016) Government Response to the House of Lords Select Committee Report on The Equality Act 2010: The impact on disabled people, London: HMSO.

“The Government Equalities Office, Ministry of Housing, Communities and Local Government and the Department of Health and Social Care have been closely engaged on this review. In light of this work, Government intends to commence Section 36, subject to Parliamentary passage of any regulations, should these prove necessary. Further work on identifying and assessing any additional burdens on local authorities is first required, after which an announcement on timing of the commencement will be made”.

- 17.31 This review of the DFG is, therefore, required to consider how the future commencement of Section 36 of the Equality Act could impact on DFG demand and potential funding requirements.
- 17.32 The Impact Assessment on the Equality Act 2010 (Annex H)²²² estimates that there would be increased demand for DFGs to carry out adjustments to commons parts resulting in around 8,000 being paid at an annual cost of up to £27m. It also estimates that half of the 57,000 disabled people it cites as facing difficulties because of inaccessible common parts (29,000 people), will make adjustments in the first year following the legislative change. This assumption is based on 50% awareness of disability legislation among disabled people.
- 17.33 Regrettably, there is little available data that can help inform this aspect of the DFG review. The following analysis mainly uses English Housing Survey (EHS) data to provide contextual information regarding the potential demand for DFGs in common parts and broad estimates of ‘worst case scenario’ potential costs²²³. It also uses data provided through FOI requests to local authorities to provide further information.
- 17.34 Of the 210 local authorities who responded to the FOI request, 193 had not approved any DFGs to common parts in the 2016-17 financial year. Of those 17 local authorities that had, 11 had approved one DFG, while one local authority had approved nine such applications (Table 17.1).

<https://www.parliament.uk/documents/lords-committees/equality-act/Govt-Response-to-HoL-SC-Report-on-the-EA2010.pdf>.

²²² Equality Bill Impact Assessment Version 3 (House of Commons Report Stage) (2009)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/243602/9780108508677.pdf

²²³ The analysis uses 2014 and 2015 EHS datasets which provide a reference point of April 2015.

Table 17.1: DFGs to common parts, 2016-17

Count of Common Parts Applications	Number of local authorities
0	193
1	11
2	0
3	1
4	3
5	1
6	0
7	0
8	0

Source: Foundations FOI request 2018

17.35 The EHS²²⁴ collects information about whether flats have any common parts such as shared entrances, lifts, corridors or staircases. It also records whether flats have any shared facilities such as parking, as well as recording the accessibility from the pavement to the main entrance used to access the flat.

17.36 The EHS estimates that there are around 4.7 million flats in England; 3.5 million of these have common parts and 4 million have shared facilities. Table 17.2 and Table 17.3 show the regional distribution of flats with common parts and shared facilities respectively. Not surprisingly, flats with common parts and/or shared facilities are most commonly located in London.

Table 17.2: Flats with common parts by region, 2015

	Frequency (000s)	Percentage distribution
North East	88	2.5
North West	318	9.0
Yorkshire and the Humber	200	5.7
East Midlands	129	3.7
West Midlands	222	6.3
East	329	9.3
London	1,370	38.8
South East	575	16.3
South West	304	8.6
Total	3,533	100.0

Source: English Housing Survey, 2015

²²⁴ The EHS is unable to provide analysis for dwellings and households at local authority level due to sample sizes.

Table 17.3: Flats with shared facilities by region, 2015

	Frequency (000s)	Percentage distribution
North East	143	3.6
North West	443	11.2
Yorkshire and the Humber	282	7.1
East Midlands	169	4.3
West Midlands	298	7.5
East	350	8.8
London	1,301	32.9
South East	652	16.5
South West	320	8.1
Total	3,958	100.0

Source: English Housing Survey, 2015

17.37 As highlighted in the previous research into predicting need for DFG in common areas²²⁵ only very limited EHS data is collected that might indicate whether households with disabilities who live in flats might require adaptations to these areas or facilities. The indicators are:

- Whether there is level access, and if not, whether it is possible to provide a ramp.
- Whether lifts are present and whether these are large enough to accommodate a wheelchair.
- The assessment of whether there are significantly higher than average risks of harm from falls in common areas. This is the best proxy indicator of whether the stairs are particularly steep or dangerous, or where corridors have uneven surfaces/trip steps etc.

Level access in flats with shared facilities

17.38 Where applicable, the EHS records the number of steps from the pavement to the main entrance used to access the flat. If steps are present, the survey indicates whether there is space for a permanent ramp of 1:20 or shallower to be installed. It is therefore possible to provide estimates of dwellings which already have level access and those where a ramp could be installed relatively easily.

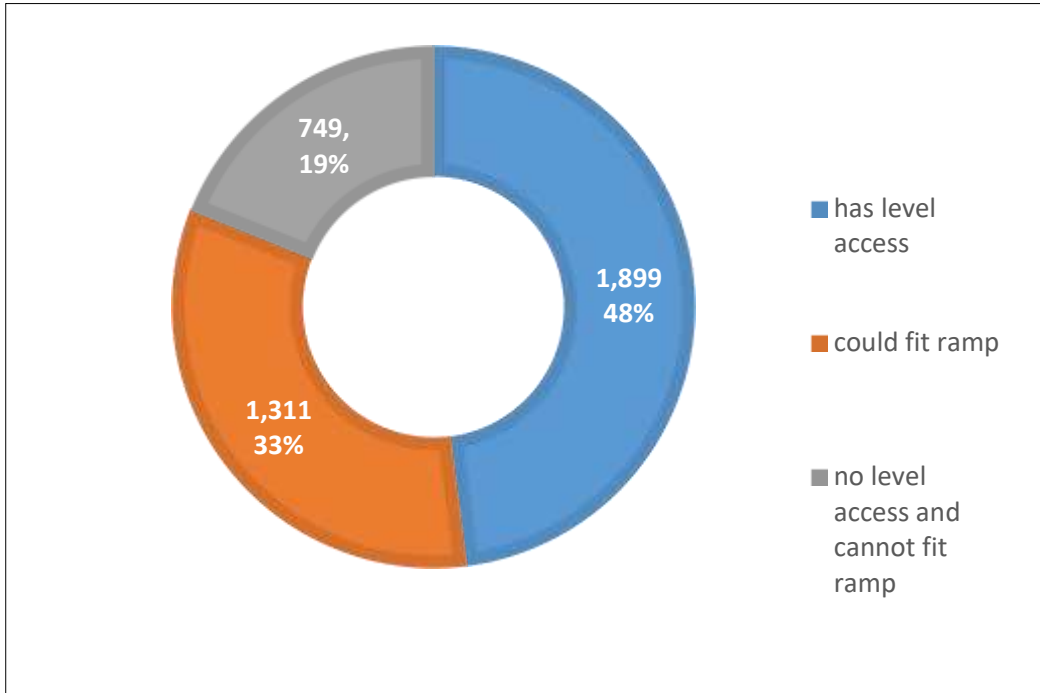
17.39 Almost half (48%, 1.9 million) of flats with shared facilities already have level access and it would be possible to provide this for a further 33% (1.3 million) of

²²⁵ Building Research Establishment (2011) Disabled Facilities Grant allocation methodology and means test: final report, London: DCLG.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/6335/1850571.pdf.

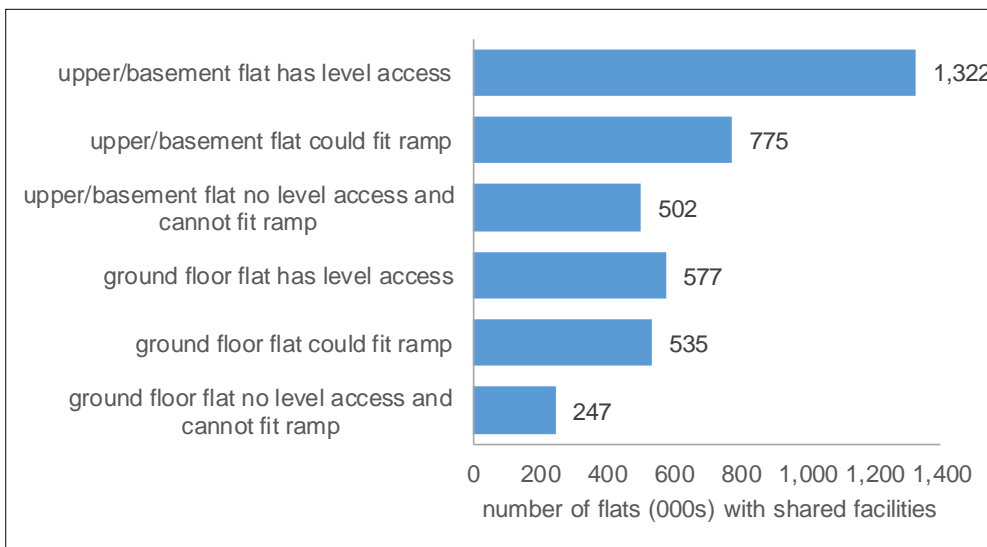
these homes by installing a straight ramp (Figures 17.4 and 17.5). This leaves around 19% (749,000) of these flats where providing level access would be more problematic, prohibitively expensive or simply not feasible.

Figure 17.4: Accessibility of flats with shared facilities, 2015



Note: dwelling numbers are thousands of dwellings
Source: English Housing Survey, 2015

Figure 17.5: Accessibility of flats, by flat level, with shared facilities, 2015



Source: English Housing Survey, 2015

17.40 The presence of level access and the ability to create it varies by tenure (Table 17.4). Private sector homes, especially those in the private rented sector, are less likely to already have level access. Registered provider homes are generally easier to adapt.

Table 17.4: Accessibility of flats with shared facilities by tenure, 2015

	no level access and cannot fit ramp	could fit ramp	has level access	all dwellings
<i>thousands of dwellings</i>				
owner occupied	213	286	460	959
private rented	308	570	546	1424
local authority	93	211	355	659
registered provider	134	244	537	916
all dwellings	749	1311	1899	3958
<i>percentage of dwellings</i>				
owner occupied	22.2	29.8	48.0	100.0
private rented	21.6	40.0	38.4	100.0
local authority	14.2	32.0	53.8	100.0
registered provider	14.7	26.6	58.7	100.0
all dwellings	18.9	33.1	48.0	100.0

Source: English Housing Survey, 2015

17.41 There are also likely regional variations (Table 17.5 and Table 17.6), although the findings should be regarded as indicative only due to small sample sizes for some regions.

Table 17.5: Accessibility of flats with shared facilities by region, 2015

	No level access and cannot fit ramp	Could fit ramp	Has level access	All flats with shared facilities
<i>thousands of dwellings</i>				
North East	38	51	54	143
North West	66	186	191	443
Yorkshire and the Humber	65	92	125	282
East Midlands	23	60	86	169
West Midlands	56	121	121	298
East	49	131	170	350
London	271	318	712	1,301
South East	116	270	267	652
South West	66	81	173	320
Total	749	1,311	1,899	3,958

Source: English Housing Survey, 2015

Table 17.6: Profile of the accessibility of flats with shared facilities by region, 2015

	No level access and cannot fit ramp	Could fit ramp	Has level access	All flats with shared facilities
North East	26.8	35.5	37.7	100.0
North West	14.9	42.1	43.1	100.0
Yorkshire and the Humber	22.9	32.7	44.4	100.0
East Midlands	13.6	35.4	50.9	100.0
West Midlands	18.6	40.8	40.6	100.0
East	14.0	37.3	48.7	100.0
London	20.8	24.5	54.7	100.0
South East	17.7	41.4	40.9	100.0
South West	20.7	25.3	54.0	100.0
Total	18.9	33.1	48.0	100.0

Source: English Housing Survey, 2015

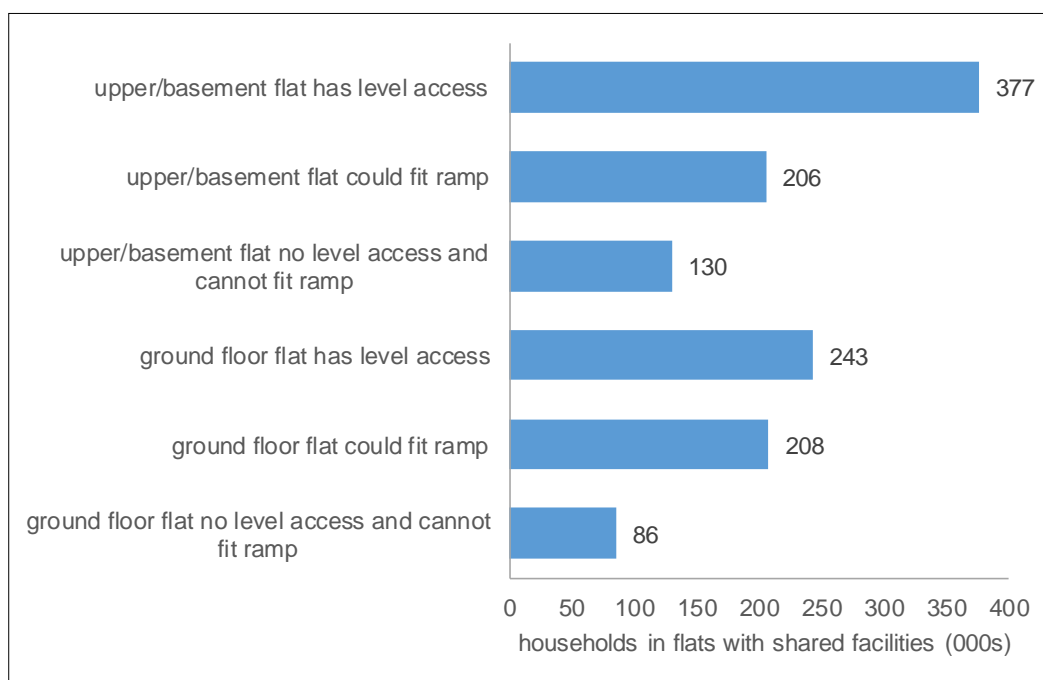
17.42 This review also examined level access in flats with shared facilities for those households where at least one of the following were reported for any household member: a long-term illness or disability²²⁶, registered disabled or a wheelchair user (outside their home or all the time). The EHS estimates that there are around 1.2 million households²²⁷ with these health issues living in flats with shared facilities; these households are more likely to require some form of adaptation. Over half of these 1.2 million households (57% / 712,000) live in basement or upper floor flats.

17.43 Overall, around half of these 1.2 million households already have level access (49% / 620,000) and it would be possible to create this for a further 33% (414,000 households). Figure 17.6 breaks down these figures by households living in ground floor/non-ground floor flats.

²²⁶ This may be a physical or non-physical illness or disability.

²²⁷ We need to bear in mind that illness, disability and wheelchair use are likely to be under-reported in the EHS.

Figure 17.6: Accessibility of flats with shared facilities for households with illness or disability, 2015



Source: English Housing Survey, 2015, household sub sample.

17.44 Due to small sample sizes, it is not possible to analyse the level access findings in Figure 17.6 by tenure, region or other household characteristics. However, for those households living in flats with shared areas who potentially need assistance in accessing their home²²⁸, 34% are registered provider renters, 27% are private renters, 23% are local authority renters and the remaining 15% are owner occupiers (Table 17.7).

17.45 The vast majority of these owner occupiers (87%) reported that they are leaseholders. The tenure of some blocks can be very mixed, particularly in council-owned blocks in London where, due to Right to Buy, there is often a mix of local authority tenants, owner occupiers and private renters in the same block. Many registered provider and privately owned blocks will also contain a mix of owners and renters. Consideration of any adaptations needs to balance the needs and interests of all concerned (the disabled person, other occupiers, the freeholder and any leasehold owners). This involves having strategies and policies on consultation and deciding how the works will be funded.

²²⁸ Households with either a family member with a long-term illness/disability, or a family member who is registered disabled, or who uses a wheelchair outside their home or all the time.

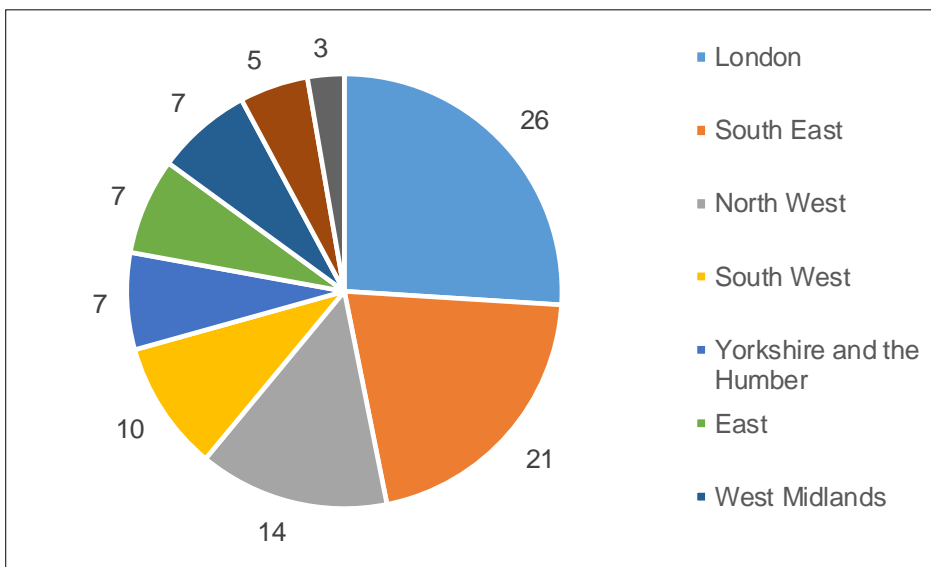
Table 17.7 Households with illness or disability in flats with shared facilities, 2015

	registered disabled, long term illness or wheelchair user all the time or outside the home (000s)	percentage of all applicable households
owner occupier	193	15.4
private renter	336	26.9
local authority	292	23.3
registered provider	429	34.3
all households	1,250	100.0

Source: English Housing Survey, 2015

17.46 Figure 17.7 shows the estimated regional distribution of the 1.2 million households living in flats with shared areas who potentially need assistance in accessing their home. The EHS estimates that around one quarter of these households live in London, while one fifth live in the South East of England.

Figure 17.7: Profile of households with illness or disability living in flats with shared facilities by region, 2015



Source: English Housing Survey, 2015

Potential cost of providing level access to flats with shared facilities

- 17.47 The FOI data suggests that the typical cost of installing a ramp and undertaking some path widening in flats with common areas is around £5,150.
- 17.48 If we use the EHS data for households in non-local authority owned homes that have a potential need for level access (Table 17.7) and the overall proportion of homes in each tenure that can be made more accessible by installing a ramp (percentages in Table 17.4), it is possible to give a very rough and simplistic estimate of the total monies potentially needed to install a ramp/undertake path widening.
- 17.49 Critically, however, the estimate in Table 17.8 is unable to consider the ability of the household to pay for the work and assumes that the cost of the work would be the same irrespective of tenure and other issues that can impact on costs such as any regional building costs variations. The estimate can only be considered, therefore, as a ‘worst case scenario’ for funding needs. The estimated monies required for the potential work is £1.6 billion pounds, roughly four times the amount of the current DFG allocations to local authorities.

Table 17.8 Estimated budget required to provide level access for those with potential need

	registered disabled, long term illness or wheelchair user all the time or outside the home (000s)	could install ramp where one doesn't exist	cost per adaptation (£)	total estimated costs (£000s)
owner occupied	193	0.30	5,150	295,621
private rented	336	0.40	5,150	693,207
registered provider	429	0.27	5,150	588,660
				1,577,488

- 17.50 We need to bear in mind that, for all tenures, this would still leave around 216,000 households, with long-term illness or disability, living in flats with shared facilities where it would simply not be feasible to install a ramp.

Lifts

- 17.51 The EHS classifies the size of lifts available in flats with common parts into three categories: spacious, average and tight. Although exact dimensions are not recorded, it is likely that only a spacious lift would be able to comfortably accommodate a wheelchair user and another person, while an average sized lift may be able to accommodate a wheelchair, but with difficulty. The EHS

Potential Stock Improvements Report 2015-16²²⁹ indicates that in 2015 there were 3 million flats within the housing stock where the entrance level was not on the ground floor, but only 91,000 (3%) of these had a spacious sized lift. An average sized lift was present in 17% of these flats, 6% had a tight lift, leaving 74% with no lift available.

- 17.52 Any work involved to adapt a lift would be very major undertaking e.g. constructing a new lift tower and installing a new lift. Irrespective of the huge costs involved, in many cases it would simply not be feasible to do this work because of lack of space to either fit an additional lift tower or install a lift or a larger lift within the existing structure of the block of flats. Work to lifts is, therefore, not the most realistic way of dealing with people with disabilities who are unable to leave their flat and reach the main entrance due to lack of lift access.
- 17.53 Solutions may include the installation of stairlifts²³⁰ or platform lifts. The FOI information suggests that typical costs for these two adaptations are £4,250 and £13,180 respectively. It is very difficult to provide any estimate for the potential need for these types of DFGs, not least because we do not have any data on the feasibility of undertaking work in various types of flats.
- 17.54 We can, however, make a very rough and simplistic estimate of improving accessibility for some wheelchair users; once again this estimate can only be considered as a worst-case scenario for potential funding requirements.
- 17.55 The EHS estimates that there are roughly 41,000 households living in upper floor or basements flats where a member of the household uses a wheelchair either outside their home or all the time. Although it is not possible to reliably report on the floor level of the flat by tenure for these households, the EHS also estimates that 74% of wheelchair users (outside the home or all the time) are not local authority renters. Applying this percentage gives an estimated 31,000 households who would benefit from some form of lift provided under DFGs if feasible to install - a cost of roughly £129 - £400 million.

²²⁹ Ministry of Housing, Communities and Local Government (2017a) English Housing Survey 2015-2016: potential for stock improvements, London: MHCLG. <https://www.gov.uk/government/statistics/english-housing-survey-2015-to-2016-potential-for-stock-improvements>.

²³⁰ Installing a stairlift can make stairs more dangerous for other non-disabled users as stairs are effectively narrower and obstructed so that trip hazards may be created. In common areas, stairlifts may also be more likely to be vandalised/misused.

Housing Health and Safety Rating System (HHSRS) hazards

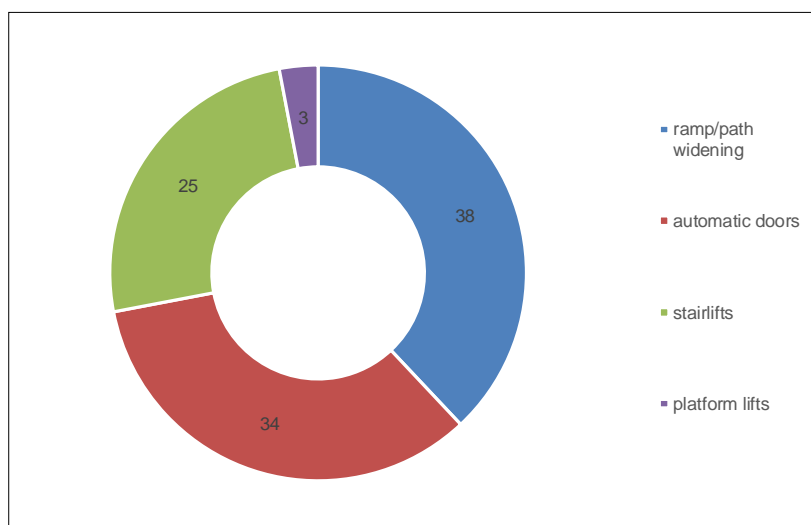
- 17.56 The EHS undertakes HHSRS²³¹ assessments on the prevalence of the risk of falls that are significantly higher than average, and these are a good indicator of serious barriers and hazards for people with mobility problems or other disabilities. These risks are assessed for the individual dwelling and the main rear and front routes to it but not to the whole access way system in flats with common parts.
- 17.57 Among the 3.5 million flats with common parts, it is estimated that 4% (148,000) have significant hazards related to falls (on stairs, between levels or on the level). The EHS estimates that around a third (32%/46,000) of these 148,000 flats are occupied by households with a disability/illness.
- 17.58 As the estimate for significant hazards represents the worst risks only, it likely underestimates the number of flats requiring improvements to accessibility of common entrances, stairs and corridors. We currently have, however, no way of knowing how great the difference may be.
- 17.59 Estimating the cost of work required to common parts is problematic because there is limited data available. The EHS can model potential costs, but these would represent the costs of reducing the hazard to an 'acceptable' level which may not be good enough to ensure improved accessibility. For example, many falls on stairs hazards could be simply reduced by providing an extra handrail to the stairs and/or improving the lighting whereas improvements to accessibility will generally require more extensive works.

FOI data

- 17.60 For those 17 local authorities that provided information on the adaptations they approved to common parts in 2016-17, we have a breakdown of the type of adaptation and the associated costs, Figure 17.8 and Table 17.9.

²³¹ The HHSRS is the government's evidence-based risk assessment procedure for residential properties. It is a means of identifying defects in dwellings and of evaluating the potential effect of any defects on the health and safety of occupants, visitors, neighbours and passers-by. The system provides a means of rating the seriousness of any hazard so that it is possible to differentiate between minor hazards and those where there is an imminent threat of major harm or even death. Potential hazards are assessed in relation to the most vulnerable class of person who might typically occupy or visit the dwelling. For example, for falls on stairs and falls on the level, the vulnerable group is defined as persons over 60 years.

Figure 17.8: Profile of types of DFG adaptations undertaken by local authorities, 2016-17



Source: Foundations FOI 2018

Table 17.9 Cost of DFG to common parts, 2016-17

Type of DFG	Cost (£)
External PlatformLift	£13,180
Wheelchair Access and ramping/ path widening	£12,000
Wheelchair Access and ramping/ path widening	£9,000
Automatic doors and ramps	£8,654
Automatic doors and ramp	£6,560
Ramping	£6,000
Electrical door access & ramping	£5,300
Stairlift	£5,225
Ramping/ path widening	£5,000
Curved Stairlift	£4,640
Stairlift to communal entrance stairs	£4,485
Automation of main door to block and internal door	£4,250
Reconfigure steps on communal access	£3,749
External stairlift to shared access steps	£3,725
Stairlift in communal stairwell	£3,549
Automated Door opener	£3,443
Ramping/ path widening	£3,300
External stairlift on communal steps	£3,175
Ramping/ path widening	£3,000
Automation of main communal front door	£2,814
Door Entry System	£2,420
Widen shared access path	£2,300
Door opening and intercom system	£2,240
Automatic entrance door	£2,140
Wheelchair Access and ramping/ path widening	£2,000
Electrical door access	£2,000
Communal door alterations	£1,882

Summary points – Section 36 of the Equality Act

- This review seeks to better understand how the future commencement of Section 36 of the Equality Act could impact on DFG demand and its potential funding requirements. **Regrettably there is little available data** that can help inform this, although the FOI requests have provided an insight into the DFG work approved for common areas in 2016/17; 40 such DFGs approved by 17 local authorities. **The most common types of DFG works to common areas were installing ramps and widening paths, followed by installing automatic doors.**
- **We were only able to produce ‘worse case’ scenario estimates of potential DFG costs for installing ramps and stairlifts/platform lifts to common parts** for households who reported long-term illness or disability (for the EHS). These estimates could not factor in people’s ability to pay for the work.
- The BRE 2011 review, which tried to predict DFG demand for common areas, concluded that **works to common parts should be dealt with strategically by local housing authorities and registered providers rather than in a one-off piecemeal manner using DFG.** At the present time, it seems this conclusion still holds, although we should add that this is another area of the DFG where **consideration should be given to more resourcing from commissioning bodies, given the potential savings to care and hospital budgets.**
- **The DFG could be used to facilitate a move to more appropriate accommodation.** This would be particularly relevant where adaptations to common parts are simply not feasible to undertake or prohibitively expensive (for the local authority or for household where a contribution is required).

Recommendations – tenure and equality

- **Further research is needed on the role of social landlords in providing adaptations and the feasibility of a national adaptations protocol for registered providers**
- **More research is also needed on ways to engage with private landlords and deliver adaptations more effectively in the private rented stock.**
- **Social housing providers to be included on Housing and Health Partnership Boards to develop a local strategy for adaptations and accessible housing.**
- **A national award for landlords with effective adaptation and accessible homes policies.**
- **Works to common parts should be dealt with by the local Housing and Health Partnership Board rather than in a one-off piecemeal manner using the DFG.**

Chapter 18. Summary, conclusions and recommendations

- 18.1 This has been a practical review to suggest, not just *what* should change in DFG delivery, but *how* it should change. It provides examples to show how transformation has been undertaken in areas that are pioneering new ways of working. It shows how far those areas have come in joining up housing with health and social care to provide wrap-around services for disabled and older people. It demonstrates the need for areas with traditional DFG policies to develop much more integrated ways of working.
- 18.2 At the centre of new integrated services is the disabled or older person, their family and carers. The home is the hub of most people's lives, but for people who are impaired it takes on greater significance as it is often the place where they spend most of their time. Research is beginning to indicate the negative effect of delays in installing adaptations on health, wellbeing and fear of falling. To ensure that people remain independent customer pathways need to be less complex and faster.
- 18.3 Disabled and older people want an efficient, seamless service, where they are fully consulted and given choices about the changes made to their home. It is important to provide adaptations that are effective, well designed, fit with their personal style and are not stigmatising by making the home look like a hospital.

Housing and Health Partnership Board

- 18.4 The way the delivery of adaptations has been split between social care and housing has been an obstacle to the development of effective services for almost 30 years. A single Housing and Health Partnership Board is needed for each county and unitary authority to oversee home adaptations services which will report to the BCF and HWB (or any successor bodies). This approach was endorsed by most of the contributors to the review. To ensure that mandatory DFG funds are protected, the BCF will have to report on DFG spending separately each year.

Making the service more visible

- 18.5 The grant needs renaming to bring it up to date and to reflect that it is part of a broader set interventions to help people remain independent. The rebranding needs to portray a youthful image and be immediately recognisable. Disabled and older people, their families and carers need to know where to turn for help throughout the country. It should also be easy for other professionals (outside of adaptation teams) to know exactly where to refer people who need support with adapting their home.

Integrating services

- 18.6 Several examples are provided of places that have developed integrated services. The Dorset Accessible Homes Service, Warwickshire’s HEART service and Leicestershire’s Lightbulb service demonstrate that integration is possible even in big county authorities and those with scattered rural populations. Some of these services are now more integrated than urban unitary authorities. As health and social care integration progresses, Salford provides an example of an alternative way of organising services in an urban unitary by co-locating the adaptation team with health staff to provide more holistic services focussed on the home.
- 18.7 Each service is tailored to local circumstances and is therefore slightly different, but common themes emerged:
- A strategic partnership board and a strategic plan
 - Linked services using ICES and DFG budgets often including additional funding
 - A single access point
 - Integrated teams under a single manager
 - Effective routing to staff with the right skills
 - Cross-trained staff able to support customers through the process
 - An RRO policy
 - Preventative and wrap-around services
 - Effective end-to-end IT systems
 - Effective reporting on outputs, outcomes and impact and continual feedback and learning
- 18.8 The results show that fewer people drop out, there are less steps in the customer pathway, handovers are minimised, and services are much quicker. Customers don’t get lost in the system but have a single point of access and a contact person to call if they have a query.
- 18.9 However, developing integrated services is not easy. Setting up a strategic partnership board and having the right policies in place is just the beginning. It is as much about cultural change and fully involving staff in the process.
- 18.10 The DFG is such a small budget in comparison to those in health and social care that it has been largely ignored. Strategic managers need to appreciate the transformative results home adaptations can bring for disabled people. To emphasise the importance of safe and accessible housing a new metric should be added to the reporting structure of the BCF (or successor body) on ‘the number of people helped to remain independent at home’.

Transformation funding

18.11 To enable change to happen across the country it is recommended that a Home Independence Transformation Fund is established, which is equivalent to 1% of the overall budget. This would provide advisors to help each authority that needs external support to transform services. There is also scope for secondments to areas that already have integrated services to ensure the learning is passed on.

Working better together

18.12 The review gives practical ways of solving some of the problems inherent in current ways of working. It starts with the beginning of the process and making sure that good conversations are had with customers to fully understand their needs before routing them into the right part of the service. By working out how complex the case is likely to be, they can be directed to teams with appropriate skills.

18.13 New staff posts which combine the skills of trusted assessor, casework and grant officer seem to be a very effective way of dealing with straightforward cases and provide a single point of contact for the service user. More complex cases need occupational therapists and technical staff to work together. The review provides a new set of tools and ways of thinking that will make this process easier.

18.14 Nine principles for installing adaptations are given that should guide the process of working with customers, which include: the need to retain (or restore) dignity; the need to have values recognised; the need for relief from pain, discomfort and danger; the need to minimise barriers to independence; the need for some element of choice; the need for good communication as part of giving choice; and the needs of other family members and of the family as a whole. In addition, there should be awareness of the need for light and the needs of children to growth and change and have enough space. To improve collaboration and communication with customers, there should be more use of 3D visual representation and design centres so that they can clearly see what is proposed and how it will affect their use of the home.

18.15 There is also the potential to work in a much more preventative way. This requires better liaison with health and social care to identify people earlier using the principal of 'making every contact count' so that problems with the home are picked up well before people get to crisis stage. New integrated adaptation services are also more likely to provide help with falls prevention and hospital discharge. There is also scope to use the DFG to provide dementia grants to help people remain independent at home for longer.

Data collection and reporting

18.16 A focus on outcomes and impact is vital as part of service redesign. This means alignment of IT systems, use of NHS numbers on all files and protocols for data

sharing. There are new reporting dashboards that can show results each quarter, benchmark against other authorities and help with continual service improvement. It is proposed that the old LOGASnet annual returns are replaced with a quarterly reporting system based on the local returns to the Housing and Health Board and the HWB. But at the heart of reporting systems should be ways of showing how the home situation has improved for each customer and the impact of adaptations on their health and wellbeing and their ability to meet their own goals.

Resources

National allocation

- 18.17 A previous report indicated that there might be a possible misalignment of allocations to local need, however, there are no robust data that can accurately predict the need for DFG at regional or local level. It is further complicated by the fact that under-spending by some local authorities and overspending by others are not solely due to current allocations but may relate to the efficiency of the local DFG process and the way that it is resourced.
- 18.18 Any change in allocations has to be based on a formula that is simple, transparent, fair and robust. The review used disability related DWP data to establish a baseline proxy indicator of needs, due to its transparency and regularity of update. It then introduced other factors of potential DFG need and examined their impact on allocations. These included: ability to pay, frail elderly data and tenure. It also raised the question of whether further factors relating to age and income should be included. Housing costs and regional building cost data could also be introduced.
- 18.19 The initial results show that any change in allocation methodology is likely to result in significant 'winners' and 'losers'. This because the impact of bids made in 2010/11 still influences allocations today. A new allocation formula would need to be incrementally introduced over a number of years to prevent a sudden, large change in resource levels.
- 18.20 More sensitivity analysis is needed to look at impact of factors across regions and all local authorities to further refine a new allocations formula. It is recommended that a new formula is established in time for the next Comprehensive Spending Review and is applied incrementally over the implementation period of that Review.

Other funding issues

- 18.21 The funding of adaptations used to be more of a partnership between local and central government, with 40% coming from local sources. The combination of austerity and the rise in central government funding has meant that local capital funding provision has declined to very low levels in most areas. Fees taken from

that capital pot have had to be used to cover a large proportion of revenue costs.

- 18.22 To underpin funding and staffing decisions at local level there has to be much greater understanding of the level of need for adaptations through detailed data analysis, working closely with housing and care providers or advertising the service more widely. This would help staff present a case for further local funding to match central government resources. The development of new integrated services should include exploration of ways to bring in a broader mix of funding options.
- 18.23 Given the difficulties in fine tuning allocations to need, there should be consideration of more collaborative DFG funding arrangements among BCF partners. Demand can vary from year to year, and the number of high-cost cases can also fluctuate. For small authorities, major adaptations over the upper limit are very difficult to deal with as they potentially absorb a high proportion of the overall budget. A risk-sharing arrangement is recommended, controlled by the Housing and Health Board, to ensure that disabled people can get equal access to resources when they are needed.
- 18.24 The Housing and Health Partnership Boards and integrated working arrangements should allow funding decisions for more expensive cases to be made differently. A fundamental problem with the existing arrangements is that in most areas the DFG must absorb all the costs of more complex adaptations. However, if that adaptation work: helps to keep a family together; prevents a disabled son or daughter becoming a 'looked after child'; allows someone with a major injury or impairment to leave hospital; reduces care requirements; or has a significant effect on health and wellbeing, there is a business case for joint funding from a number of different housing, health and social care budgets. There is also scope for adaptation funding to be provided as part of new personal health and care budgets to help people better achieve their own goals.

The means test

18.25 Three main options were considered to update the means test:

- 1) The first option is to remove the test completely, or for certain cases, say those under £5,000. In a time of austerity there are arguments against providing funding to those who can afford their own provision and removing it for certain cases was thought to be unsustainable longer term. There is a lack of robust evidence about the savings major adaptations bring to health and social care. The best potential payback comes from the mitigation of falls on stairs. The review therefore recommends that stairlifts are removed from means testing, subject to certain caveats, but only where an authority has set up an effective stairlift refurbishment and recycling scheme. There is also a case to give a grant without means testing for palliative care.

- 2) The second option is to update the present test as it is complex, has not been updated since 2008 and the passporting arrangements are out of date. However, it is not a straightforward process. A number of different ways were considered: including ways of assessing need, re-establishing the links with housing benefit rates, assessing resources and entitlement and passporting.
- 3) The final option considered is to adopt the Care and Support Charging Regulations. This was favoured by people who took part in the consultation for this review as it would remove the confusion about having two different tests, but again it is not a straightforward solution.

18.26 The recommendation is that assessment for DFG within Care and Support Charging Regulations is included in the Social Care Green Paper but there should be provision for passporting arrangements and a standard minimum amount for Disability Related Expenditure. If this is not possible, the alternative is to update the existing means testing regulations. This will require re-establishing the link to housing benefit rates, using LHA rates for the Housing Allowance and updating the passporting benefits lists.

The upper limit

18.27 The upper limit of the grant has not changed since 2008 and has not been adjusted to account for inflation. It is clearly too low to cover the costs of more complex adaptations, particularly in areas with high building costs. As a result, many authorities have set their own level.

18.28 The review recommends moving away from a 'one size fits all' model. The maximum amount should be raised in line with inflation, with a regional weighting based on building costs. Due to the importance of professional expertise on larger projects it is also recommended that the regional upper limits are increased by a further 10% to ensure that the right support is provided. This local maximum amount should be clearly stated on each local authority website.

18.29 Raising the limit and changing the way decisions are made could alter the thinking about these grants from 'expenditure' to 'investment'. It would allow a much more person-centre approach which could provide long-term solutions to increase disabled people's independence.

18.30 There is also a need to look at the way VAT is paid on adaptations as bedrooms and kitchens extensions are subject to VAT while bathrooms are not.

Regulation

- 18.31 A number of other aspects of the regulation were looked at. Given the need for a broader range of services delivered in a more flexible way it was recommended that every authority has an RRO policy.
- 18.32 The 6-month time limit to approve an application is part of the primary legislation but one that is often circumvented. It does not reflect the end to end customer journey and the waits at other stages. As a result, future guidance should stress the requirement to approve or refuse an application “*as soon as reasonably practicable*” where the Local Authority has had prior involvement with the application. In most cases this should take no longer than 4 weeks.
- 18.33 The legislation, regulations, consents and orders, guidance, good practice guides and the Regulatory Reform Order have created a complicated system that few people fully understand. It is recommended that all the guidance is brought together and fully revised so that it clearly sets out expectations for local authorities and rights of a disabled person making an application.

Developing a market

- 18.34 The main barriers to better design and innovation are the lack of integration in the market, and the lack of standardisation and repetition in specification. The traditional procurement processes of seeking multiple quotations has reinforced these barriers. Addressing them calls for both reform of procurement processes and greater efficiency in their operation. The review calls for services to use an online schedule of rates, to make much more use of flat-pack extensions, to have a stairlift recycling scheme, and for there to be some common standards for materials.
- 18.35 There also needs to be better training of builders and tradespeople to give them trusted assessor skills. If this was included in the Trustmark rating system, it would help both adaptation service providers and people aiming to do their own adaptations.
- 18.36 There are some interesting developments in assistive technology field using already available items such as smart phones, speaker systems and low-cost sensors. These can potentially give disabled people much more control over their home environment. They also allow unobtrusive and effective monitoring where someone might fall or has dementia. There is scope to use technology in diagnostics, for example to work out when someone needs a stairlift by monitoring their movement up and down stairs.
- 18.37 The average cost of installing voice-controlled smart heating, lighting and electrical control systems is only about £250 per home. If this was routinely included in the DFG it would cost around £12.5m a year. Customers are already

getting used to these types of systems which are non-intrusive and non-stigmatising. Use of low-cost consumer technology as part of DFG-funded home modifications would encourage more widespread adoption, enhancing the UK's potential to be a world leader in assistive technology in line with the Industrial Strategy.

Helping people outside the DFG

- 18.38 The market for stairlifts and adapted bathroom and kitchen products is steadily developing with more choice on offer in mainstream retailers and online. Many people are choosing to put in wet rooms and to install downstairs bathrooms. But we do not know that much about what people are already doing, how effective it is, what holds people back and what might encourage them to do more to 'future-proof' their homes. Statutory services tend to focus on older people, but most unmet need for adaptations may be amongst younger households.
- 18.39 Relying on the market to solve all the problem is unrealistic as there is an information gap. Showrooms are not good settings to discuss personal problems and retail staff are not trained to give appropriate advice. There are a bewildering array of products and it is all too easy to make mistakes which are hard to rectify, especially for people with more limited resources.
- 18.40 There is clearly a role for the public sector to provide more advice, information and signposting. The problem is that home owners and people in the private rented sector do not naturally turn to the local council for advice. Better branding and advertising would make services better known. There is scope for more online advice produced at national level and closer working with existing online providers.
- 18.41 If designs used in the DFG, or delivered by ICES, were more aspirational it would be possible to 'shape the market' and this could help drive what is shown in mainstream retailers. There is also potential for local authorities to develop their own service for retail customers outside of the DFG.
- 18.42 There are clearly a lot of people able to self-fund. For older people, in addition to using income, there is an expanding range of options available, including: pension freedoms, equity release, life-time mortgages, and in some place, local authority loans. There also seems to greater willingness to use these options.
- 18.43 But there is a group who do not qualify for the DFG who find it hard to raise the required funding. Particularly problematic is the situation for younger disabled people who have low levels of equity, high mortgage costs and little spare income. Altering the means test or bringing it into line with the test for social care, may bring some of this group into the DFG, but there are others who will still fall outside the requirements. Advice and information will be crucial to help

them spend their limited resources widely. Adaptation services and home improvement agencies need to be aware of the needs of this cohort and make sure that services are not overly geared to an older demographic.

- 18.44 There is also an argument for including spending on adaptations as part of the social care cap, as removing hazards in the home is likely to lead to fewer accidents and injuries thus reducing costs for health and social care. It would also help to raise awareness of the benefits of preparing the home for later life or as an alternative to paying for domiciliary care, reducing the likelihood of people reaching the care cap. It is something that needs to be considered in the Social Care Green Paper.

Tenure and equality issues

- 18.45 Tenure was not included as part of this review, but it is impossible to ignore. A third of grants (34%) go to registered provider tenants as they have a clearly signposted route to the DFG via their landlord. However, there are similar numbers of people with long-term illness and impairments in the private rented sector who may be in much poorer housing conditions and many home owners are unaware of the grant and may also be excluded. Adaptations in the council stock are delivered using the HRA budget and so sit outside the DFG making it hard to develop local adaptation strategies.
- 18.46 Tenure issues need a separate review to see if services between tenures are equitable and to determine if the DFG allocation formula needs to be adjusted to give areas with higher levels of registered providers more funding. But it is a complicated picture. Registered landlords may contribute money to the DFG but it is not recorded in LOGASnet returns. Others are more like council landlords and have their own budget and staff to deliver adaptations. Some also fund home improvement agencies and so contribute in other ways to private sector home improvement. However, other registered providers make considerable demands on the DFG budget but give little in return.
- 18.47 It is important to include local providers on Housing and Health Partnership Boards. However, it is sometimes more difficult to engage with national and regional providers who operate across large numbers of authorities. A national protocol would be the most effective way to get housing associations to contribute to DFG funding, have more consistent policies for their disabled tenants and ensure that home choice systems work effectively. This needs to be explored to see if it is feasible.
- 18.48 Private renting is becoming a much bigger issue as more disabled people are likely to be in this tenure from now on. Conditions are very variable and one in three disabled people in this sector said that their home does not meet their needs. Barriers to adaptation include: short term tenancies and landlords refusing permission to change the home. Local authorities could encourage

more adaptations through licensing agreements or grant funding to remove the adaptations at the end of the tenancy. More research is needed to understand the barriers to adaptations in the private rented sector.

Common parts grants and the Equality Act

- 18.49 The Government has made a commitment to review the remaining provisions of Section 36 of the Act which includes adaptations to the common parts of residential properties. There is little available data to determine the likely effect on DFG demand and funding requirements. The review was only able to give 'worst case' scenarios based on what little data is available. These estimates are unable factor in people's ability to pay for the work.
- 18.50 The typical cost of installing a ramp and undertaking some path widening in flats with common areas appears to be around £5,150 which might cost £1.6 billion pounds, roughly four times the amount of the current DFG allocations to local authorities. To provide a lift (if feasible to install) would cost roughly £129 - £400 million. In addition, it is estimated that 4% (148,000) of flats with common parts have significant hazards related to falls (on stairs, between levels or on the level) with around a third occupied by households with a disability or long-term illness. However, the work required might be anything from fitting a handrail to major improvement, so it is impossible estimate the likely cost.
- 18.51 Current DFG data is not helpful in arriving at cost figures as there is very little of this work taking place. All we know is that DFG works to common areas most frequently include installing ramps and widening paths, followed by installing automatic doors.
- 18.52 The recommendation is that works to common parts should be dealt with strategically by local housing authorities and registered providers rather than in a one-off piecemeal manner using DFG, and consideration should be given to more resourcing from strategic partnership bodies given the potential savings to care and hospital budgets. Alternatively, the DFG could be used to facilitate a move to more appropriate accommodation, particularly where adaptations are not feasible to undertake or prohibitively expensive.

Conclusions

- 18.53 This review has been wide ranging. It has provided an assessment of how the DFG is currently being used and made detailed, evidence-based recommendations about how the DFG and the wider housing environment should change. It has sought to give Government a way of developing more effective ways to enable more people to live in suitable housing so they can stay independent for longer. It has also made the case for more joined-up action across housing, health and social care.

- 18.54 We set out a more person-centred and integrated way of delivering home adaptations but recognise that this will need strong leadership and transformation funding to enable change to happen. Better information and advice is also recommended, both locally and nationally. This will lead to more collaboration between housing and social care, innovation and robust data that shows the true benefits of a safe and suitable home environment.
- 18.55 The current formula for allocating funding does not properly reflect need from authority to authority, but it is not just a case of redistribution. There should be an element of risk sharing which reflects fluctuations in demand and exceptional cases which require significant investment over and above maximum limit – which we are recommending should be increased in line with inflation and regional building costs.
- 18.56 Joining up DFG delivery with health and social care is inconsistent with maintaining an entirely separate means testing regime and so we recommend ways in which the Care and Support Charging Regulation could be used. However, we also recognise that social care charging is due to be reviewed and so have included recommendations for also updating the current DFG means test. Either way, we think there is a great opportunity for adaptation costs to count towards a possible care cap, so that people are encouraged to make changes to their home that would reduce future care costs, and thereby decrease the chance of them ever reaching the cap which would mean savings for Social Care.
- 18.57 All of this means that the current DFG Guidance would be out of date and need completely revising.
- 18.58 The annual spend of nearly £0.5bn could be better co-ordinated to help shape the market for home adaptations – encouraging more contractors to enter and manufacturers to innovate more. The potential to adopt smart home technology as part of the UK Industrial Strategy is also advocated.
- 18.59 Finally, we highlight some of the issues faced by different types of tenant when they need to make adaptations to their home and the costs and difficulties of making adaptations to common parts.
- 18.60 The following section brings together all the recommendations from throughout the report. Although the review was based on evidence from a wide range of sources, there is still a need for more research and development. The final section identifies some key areas for further work.

Recommendations - overview

Recommendations - strategic oversight

- A Housing and Health Partnership Board in each area as a requirement of DFG funding with representatives from housing, health and social care.
- Each BCF and HWB to report separately on DFG funding and on a new metric ‘the number of people helped to remain independent at home’.
- Housing and Health Partnership Boards to have a similar structure to Local Safeguarding Children’s Boards.
- The DFG and ICES budgets to be in the same funding pot (the BCF or its successor) to join up DFG services with equipment provision and minor adaptations.
- A single adaptations policy to be developed for each area, based on the needs of the locality, reviewed annually and signed off by the HWB.
- A new name for the grant, the services that provide it and the national advice organisation, and for that name to be used consistently across the country.

Recommendations – local delivery

- Integrated teams in all areas to simplify and speed up customer journeys.
- A Home Independence Transformation Fund equivalent to 1% of the national DFG allocation to help develop integrated services in all areas.

Recommendations – working better together

- Better analysis of local need to develop preventative strategies and determine levels of revenue and capital funding.
- Better partnerships with health and care to ensure that ‘Making Every Contact Count’ works effectively to refer people earlier, not at crisis point.
- A single point of access with ‘good conversations’ at the start so that people are routed down appropriate pathways.
- New staff roles combining occupational therapy, technical and casework skills developed to support customers more effectively.

- **New decision-making tools to help occupational therapy and technical staff collaborate more effectively.**
- **Use of 3D design and design centres to communicate better with customers and tailor solutions to people's own goals.**
- **Use of NHS number on all files, data sharing protocols, aligned IT systems and improved local reporting focussed more on outcomes.**
- **National reporting by each Housing and Health Partnership Board as a requirement of future BCF plans.**

Recommendations - allocation of resources and other funding issues

- **That the allocation formula options are explored further using sensitivity analysis.**
- **That a new allocation formula is established for the next Comprehensive Spending Review and is applied incrementally over the implementation period of that Review.**
- **That integrated services seek capital and revenue funding from a wider range of sources.**
- **That risk-share funds are set up to deal with uneven demand for grants and that very expensive adaptations are jointly funded by housing, health and social care.**
- **That the DFG is included in personal budgets to provide solutions that meet people's own goals.**

Recommendations – the means test

- **That including assessment for the DFG within Care and Support Charging Regulations is part of the Social Care Green Paper.**
- **That alternatively the existing means testing regulations are updated.**
- **That stairlifts are removed from means testing where an authority has set up an effective stairlift refurbishment and recycling scheme.**
- **That further work looks at removing the means test for palliative care.**

Recommendations – regulation and the upper limit

- That the maximum amount of the DFG is raised in line with inflation, with a regional weighting based on building costs and an amount for professional fees.
- That the VAT rules are revisited for major adaptations.
- Regulatory Reform Order (RRO) Policies have been developed in about half of local authorities and need to be adopted in all areas to provide more flexible use of the grant.
- Each area to have simple application forms available on request.
- Applications should be determined within four weeks where the Local Authority has had prior involvement with the application.
- That the guidance is fully revised to reflect integrated services, the expectations for local authorities and the rights of the disabled person.
- That the Services and Charges Order list is updated to include support with moving and the funding of extended warranties.
- That the national advice line is updated and improved to give people support with housing options.

Recommendations – developing a market

- A further five-year funding programme for the DFG to improve certainty and enable local authorities to invest in better procurement.
- A national accreditation scheme for builders and tradespeople.
- Use of an online schedule of rates to increase efficiencies and further work to assess the effectiveness of framework agreements.
- Flat-pack extensions to be used to provide a faster service with further research to identify the best solutions.
- A smart home starter kit as part of every DFG application.
- Local authorities and home improvement agencies to provide advice, information and handyman services for people outside the DFG.
- Further research on what people do outside the DFG to encourage more 'future-proofing'.

- **Spending on adaptations outside of the DFG to be included as part of the social care cap and considered in the Social Care Green Paper to incentivise people to prepare their homes for later life.**

Recommendations – tenure and equality

- **Further research is needed on the role of social landlords in providing adaptations and the feasibility of a national adaptations protocol for registered providers.**
- **More research is also needed on ways to engage with private landlords and deliver adaptations more effectively in the private rented stock.**
- **Social housing providers to be included on Housing and Health Partnership Boards to develop a local strategy for adaptations and accessible housing.**
- **A national award for landlords with effective adaptation and accessible homes policies.**
- **Works to common parts should be dealt with by the local Housing and Health Partnership Board rather than in a one-off piecemeal manner using the DFG.**

Further research and development work

Some of the issues discussed in both Parts A and B of the report, and in the recommendations listed above, include the need for more research and development. These issues are brought together below:

- **More research to explore Local Safeguarding Children’s Boards and work with local authorities, and their representative bodies, to develop a suitable structure for Housing and Health Partnership Boards.**
- **Further sensitivity analysis to test the options for the allocation formula.**
- **Once the details of the Social Care Green Paper are published, more work will be needed on the means test to see if it can be aligned with the test for social care. If not, the current test needs to be updated. Passporting for stairlifts and palliative care needs to be further developed.**
- **Research with disabled and older people and their representative organisations to explore the barriers and facilitators to getting adaptations and how more future-proofing work could be encouraged.**

- Home Independence Transformation Fund – develop learning tools and materials and train advisors.
- Work with RCOT, CIEH, Foundations and university and college training programme providers to develop courses to prepare staff for new integrated roles that cross traditional professional boundaries.
- Work with Foundations, Trustmark, training programme providers and others to develop better training, accreditation and rating systems for the construction industry.
- Research procurement issues including the effectiveness of framework agreements, use of online schedules of rates, and the design of flat-pack extensions to establish best practice.
- Work with industry, retail suppliers, designers and others to develop new adaptation designs: that will fit the small spaces in most people's homes; that are robust; that are easy to clean and maintain; that are low cost or reasonably priced; but that are also desirable and fit with today's lifestyles.
- Work with authorities and home improvement agencies in areas with large BAME populations to better understand the needs of different groups and how the DFG could be provided more effectively and in ways that are culturally sensitive.
- Cases are becoming more complex, there are increasing numbers of customers with multimorbidity, frailty or mental health issues and there are rising numbers of children with social and behavioural problems. There are also more specialised grants for dementia or visual impairment. More staff training will be required (both online and off-line) by Foundations, RCOT and specialist providers.
- New tools for effective working need to be more fully developed, piloted in a small number of local authorities before roll-out nationally:
 - System for 'good conversations' and effective routing
 - Complexity Framework to show what occupational therapy and technical skills are required for each case
 - Adaptations Design Communications Toolkit to provide a guide for standard designs
 - Home Modification Process Protocol to ensure better communication in building projects
 - New complex decision-making process: necessary → practicable → appropriate → reasonable.
 - 3D design tools to encourage better communication with customers.

- The guidance needs to be fully revised so that it reflects integrated services and clearly sets out the expectations for local authorities and the rights of the disabled person making an application.
- A new, national data collection system needs to be developed to take advantage of the introduction of a replacement to LOGASnet. There will be a need to work with BCF and HWBB policy makers to ensure that data is collected and returned on a quarterly basis and that this addresses the new BCF metric of ‘the number of people helped to remain independent at home’.
- Tenure issues need a separate review to look at: the role of different landlords and the barriers and facilitators to getting adaptations carried out. The feasibility of a national registered provider protocol needs to be explored and whether adaptations in the council stock should be brought under the DFG umbrella.

The Review Team

- **BRE** conducted the previous review of the DFG means test and allocation formula and manages the English Housing Survey. Helen Garrett and Maggie Davidson provided the expertise to re-evaluate the allocation formula and provide options for new mechanisms to distribute DFG resources. They also contributed to other parts of the review, including the section on Common Parts and the Equality Act.
- **Ferret Information Systems** provides software for the DFG means test, trains staff in its operation and runs a helpline for practitioners. Gareth Morgan (CEO) carried out the analysis and modelling of options for revising the means test and contributed his expertise to other aspects of the review.
- **Foundations** provides support to adaptation teams, home improvement agencies and handyman services. The organisation was given the brief in 2015 to improve the operation of the DFG. They set up the DFG Champions service, deliver training, run an information website, and provide the secretariat for the Memorandum of Understanding for Improving Health and Care Through the Home. Paul Smith (CEO), Francis Philippa (Strategy Lead) and the rest of the Foundations team played a key role in the review. They carried out Freedom of information requests, conducted consultation events, analysed the LOGASnet data and obtained much of the case study material. Their depth of understanding of the operation of the DFG enabled this review to be completed within a very tight time frame.
- **Rachel Russell** is a practicing occupational therapist who has written widely about assessment for home adaptations. She is also an occupational therapy lecturer and manages the international genHOME database about adaptation outcomes. She provided expert advice about the role of occupational therapists in the DFG process and how services could be delivered more effectively.
- **Sheila Mackintosh**, Research Fellow at the University of the West of England, has carried out change management projects with local authority adaptation teams, evaluated new services run by home improvement agencies, worked on local adaptations agreements with housing associations, and done interviews and focus groups with many people who have received the DFG. She produced a previous report on the operation of the DFG in 2016 and various good practice reports. She was also part of a team which did a recent review of the evidence of the impact and outcomes of home adaptations. She was responsible for pulling together the information provided by the rest of the team into this report.

List of organisations contributing to the review

We received a very high response to the consultation over the short period of time of this review. There have also been many other people we have spoken to, or worked with, over the last few years who have helped influence our thinking about the DFG. Apologies to anyone who we have inadvertently left off the following list.

The 212 people who attended consultation workshops in Leeds, London and Wolverhampton.

The 234 people/organisations who completed the online survey.

The 350+ members of the DFG Champions Facebook group.

All the local authorities who have responded to Foundations' Freedom of Information Requests over the last two years.

The Social Change Agency for facilitating "Rethinking DFG" workshops with support from West of England Care & Repair, Millbrook Healthcare, Revival HIA, Shropshire Council, London Borough of Tower Hamlets, Durham County Council and Bedford Borough Council.

Foundations' Commercial Partners: Abacus, AKW, Altro, Contour, Impey, NRS Healthcare, ProCare, Promoting Independence, Safespaces, Solon Security, Stannah and The OT Practice.

Foundations Advisory Board

Kate Curran from Worcestershire Care & Repair and Nina Warrington from Worcester City Council.

All the Home Improvement Agencies who provided information on their costs and income.

Ian Copeman, Marney Walker and Rachel Russell from the Housing LIN and RCOT

Jeremy Porteous from the Housing LIN

Additional case studies kindly provided by Care & Repair England / Centre for Ageing Better.

Phillip Whitehead, originally at the University of Nottingham and now at Northumbria University, for his work on the BATH-OUT study.

Luke Clements, Sorcha McCormack and students from CEREBRA, University of Leeds, who provided information on children and young people's DFG cases and the accessibility of DFG application forms.

David Everatt and Tim McSharry, Access Committee for Leeds, initiated the research on DFG's for children and young people and contributed to the later study on application forms.

Vaila Morrison from the charity Inclusive Home for sharing her survey of families.

We received detailed written responses from:

The Local Government Association (LGA)

The Association of Directors of Adult Social Services (ADASS)

The County Councils Network (CCN)

The District Councils Network (DCN)

Councils in Dorset / Dorset Accessible Homes Service (DAHS)

North East Adaptations Group (NEAG)

We spoke to:

Angus Cleary of the Equalities and Human Rights Commission

Dave Anderson of the Social Care Institute for Excellence (SCIE)

Dawn Stobbs of NHS England

Dr Helen Meese of the Institution of Mechanical Engineers

Dr Lorraine Morley of Allia / Seas2Grow

Dr Richard Curry of the Smart Homes and Buildings Association (SH&BA)

Ed Warner of Motionspot

Gerry Hodgson of Cascade3D

Gursh Lail of Intel 4 Housing

Jane Lord of NHS England

Jane Mold and Sarah Jane Sharman of Rutland Council

Jim Ellam and Juliet Williams of Staffordshire County Council

John Shermer and Toby Shermer of LightwaveRF

Julia Skelton and Paul Cooper of the Royal College of Occupational Therapists

Karen Sawyer of Cornwall Council

Katherine Stevenson of Arthritis Research UK

Lee Davies of Millbrook Healthcare

Neil Revely of ADASS

Paul Coopey of Warwickshire HEART

Quin Quiney of Blaby District Council

Rachael Docking and Catherine Foot of the Centre for Ageing Better

Rachael Martin-Smith of the Motor Neurone Disease Association (MNDA)

Rachel Shimmin of Buckinghamshire County Council

Robert Thompson of Care & Repair Scotland

Sarah Davis of the Chartered Institute of Housing

Sarah Hillcoat-Nallétamby of Swansea University

Sue Adams and Martin Hodges of Care & Repair England

Vicky Whittle and Madeleine Bell of the Chartered Institute of Environmental Health

Will Prochaska of Baxendales

Appendix

Appendix 1 - Proposed DFG Metrics

These will need further development

Inputs:

Person: Age, Gender, Impairment (by category)

Property: Tenure, Type (by category)

Outputs:

Grant Approvals (categorised by level of contribution)

Drop Outs (categorised by reason)

Timescales (calendar days for main stages)

Types of Adaptation (by category)

Grant Amount (by category)

Outcomes

TBC

Programme

Use of RRO Powers (by category)

Programme Budget

Programme Design (elements included)

Appendix 2 Allocation formula

A2.1 Income Deprivation Domain

The Income Deprivation Domain measures the proportion of the population in an area experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests). It is calculated using the following six non-overlapping indicators;

- Adults and children in Income Support families
- Adults and children in income-based Jobseeker's Allowance families
- Adults and children in income-based Employment and Support Allowance families
- Adults and children in Pension Credit (Guarantee) families
- Adults and children in Working Tax Credit and Child Tax Credit families not already counted, that is those who are not in receipt of Income Support, income-based Jobseeker's Allowance, income-based Employment and Support Allowance or Pension Credit (Guarantee) and whose equivalised income (excluding housing benefit) is below 60 per cent of the median before housing costs
- Asylum seekers in England in receipt of subsistence support, accommodation support, or both.

Note: families=benefit units

A2.2 Other data sources investigated but not included in the allocations formula modelling

1. Annual Population Survey. The number of working age disabled people by disability type, economic activity (employed, unemployed and inactive) at a local authority level for England and Wales 2015 to 2016 based on the (Table 2). Selection of certain health issues would be required for a formula and therefore the data is potentially less objective. Also incomplete covered for some regions and local authorities.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/adhocs/006231thenumberofworkingageddisabledpeoplebydisabilitytypeeconomicactivityemployedunemployedandinactiveatalocalauthoritylevelforenglandandwales2015to2016basedontheannualpopulationsurvey>

2. NHS - Children and Young People's Health Services Monthly Statistics, England - August and September 2017, Experimental statistics.

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets>

The CYPHS is a patient-level dataset providing information relating to NHS-funded community services for children and young people aged 18 years or under. The data collected includes personal and demographic information, diagnoses including long-term conditions and childhood disabilities and care events plus screening activities. These statistics are classified as experimental and should be used with caution. More information about experimental statistics can be found on the UK Statistics Authority website.

3. Housing for Older People Supply – used data from Elderly Accommodation Counsel – for data on older persons accommodation e.g. care – homes, residential care, extra care housing and other data that were modelled.
4. HMRC. Data from HMRC's personal income statistics which are updated annually and based on a large (over 700,000 sample) of records on their PAYE, National Insurance, Self-Assessment and Tax refunds databases. Unfortunately, the data excludes those who don't pay tax and National Insurance (i.e. the majority of people on means tested benefits). As the methodology section notes:

However, as HMRC does not hold information for all people with personal incomes below this level, the SPI is not a representative data source for this part of the population and no attempt has been made to estimate the numbers of cases below the tax threshold or the amount of their incomes. Therefore the National Statistics in this and our earlier publication - with the exception of Tables 3.9 and 3.10 - only cover individuals liable to UK income tax (taxpayers) and their incomes.

For this reason we would not recommend using this data as a reliable indicator of income differentials between regions or authorities.

Appendix 3 Means Testing

A3.1 Current rates of allowances and premiums

Table A3.1 shows the current rates of allowances and premiums used in the grant scheme and those used for HB.

	Current Disabled Facilities Grant Scheme	Housing Benefit
Personal Allowances		
Single person - 65 or over	£143.80	£176.40
Single person - aged 60 to 64	£124.05	£163.00 ²³²
Single person - 25 to 59	£60.50	£73.10
Single person - under 25	£47.95	£57.90
Single person - in receipt of main phase ESA	£64.30	£73.10
Lone parent - 18 to 59	£60.50	
Lone parent - under 18	£47.95	£57.90
Couple - elder aged 65 or over	£215.50	£263.80
Couple - elder aged 60 to 64	£189.35	£248.00 ⁹
Couple - one or both aged 18 to 59	£94.95	£114.85
Couple - both under 18	£72.35	£87.50
Dependent children or young people	£52.59	£66.90
Premiums		
Family Premium		²³³
Couple	£16.75	£17.45
Lone parent	£22.20	£22.20
Baby-under-one addition	£10.50	-
Disability Premium		
Single person	£25.85	£33.55
Couple	£36.85	£47.80
Enhanced Disability Premium		
Single person	£12.60	£16.40
Disabled child	£19.60	£25.48

²³² Over Qualifying Age for State Pension Credit

²³³ Only for pre-2016 claims

A3.2 Example scenarios - details

The scenarios are purely illustrative and do not represent real cases nor relate to any representation of typical situations. They are chosen to demonstrate points of interest in the comparison.

All figures in the scenarios are weekly and assume a continuity of circumstances.

Scenario 1

Single aged 55, disabled, receiving high rate DLA or PIP for care needs. No income other than state benefits.

	DFG Current	DFG Upated	Social Care
Personal allowances and premiums			
Adult allowances	£60.50	£73.10	£91.40
Child allowances	£0.00	£0.00	£0.00
Premiums	£88.80	£114.25	£60.05
Housing Allowance	£61.30	£79.25	£0.00
Total Needs	£210.60	£266.60	£151.45
Income			
Earned Income			
Net Earnings	£0.00	£0.00	£0.00
Earnings disregard	£20.00	£20.00	
Assessable earnings	£0.00	£0.00	£0.00
Net Unearned Income	£0.00	£0.00	£0.00
Benefits Income	£0.00	£0.00	£153.80
Disability benefits			
Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£0.00	£0.00	£0.00
Total Resources	£0.00	£0.00	£239.40
Excess Income	£0.00	£0.00	£87.95
Passported?	Yes	Yes	
Current banding for contribution			
Owner	£0.00	£0.00	£2,411.46
Tenant	£0.00	£0.00	£1,412.97

Gilt rate linked	Gilt rate 1.5%			
Owner - 10 year		£0.00	£0.00	£11,379.00
Tenant -5 year		£0.00	£0.00	£5,476.38

Notes: In this example the claimant would qualify for means tested benefits and therefore be passported under the current DFG rules.

In the social care assessment, there is no equivalent to the housing allowance in the DFG calculation. Instead, net housing costs, offset by any benefit for them, is taken into account. Benefits received, in this case an Income Support entitlement has been assumed, is taken into account as available income. The higher rate disability entitlement is also treated as being available. The social care needs figure ensures that the equivalent of Income Support, or Guarantee Pension Credit, plus 25% remains before any excess income is assumed. In this example, because these incomes are taken into account, there is only an excess income figure under the social care test.

The application of an assessment of Disability Related Expenditure (DRE) could reduce, or eliminate, the level of excess income. DRE is intended to reflect the reality of disability that are additional to those normally required. In practice, it is discretionary in application, practice varies from local authority to local authority and may vary greatly between individuals. It is often criticised as a postcode lottery.

Scenario 2

Couple eldest aged 55, one disabled, receiving high rate DLA or PIP for care needs. No income other than state benefits.

	DFG Current	DFG Uprated	Social Care
Personal allowances and premiums			
Adult allowances	£94.95	£114.85	£71.80
Child allowances	£0.00	£0.00	£0.00
Premiums	£55.00	£71.35	£28.75
Housing Allowance	£61.30	£79.25	£0.00
Total Needs	£211.25	£265.45	£100.55
Income			
Earned Income			
Net Earnings	£0.00	£0.00	£0.00
Earnings disregard	£20.00	£20.00	
Assessable earnings	£0.00	£0.00	£0.00
Net Unearned Income	£0.00	£0.00	£0.00
Benefits Income	£0.00	£0.00	£69.20
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£0.00	£0.00	£0.00
Total Resources	£0.00	£0.00	£154.80
Excess Income	£0.00	£0.00	£54.25
Passported?	Yes	Yes	
Current banding for contribution			
Owner	£0.00	£0.00	£1,141.30
Tenant	£0.00	£0.00	£668.54
Gilt rate linked			
	Gilt rate		
	1.5%		
Owner - 10 year	£0.00	£0.00	£7,018.88
Tenant -5 year	£0.00	£0.00	£3,377.98

Notes: The social care means test is applied only to the individual client. In the case of couples, the personal allowance in the assessment is reduced to half of the equivalent benefits allowance (+25%). Joint income, including means tested benefits, is similarly proportioned. Again, in this scenario, only under the social care means test would a contribution be payable.

Scenario 3

Single aged 75, disabled, receiving high rate DLA or PIP for care needs. Full Basic State Pension of £125.95 a week plus £200 net private pension a week.

	DFG Current	DFG Upated	Social Care
Personal allowances and premiums			
Adult allowances	£143.80	£176.40	£189.00
Child allowances	£0.00	£0.00	£0.00
Premiums	£50.35	£64.30	£60.05
Housing Allowance	£61.30	£79.25	£0.00
Total Needs	£255.45	£319.95	£249.05
Income			
Earned Income			
Net Earnings	£0.00	£0.00	£0.00
Earnings disregard	£20.00	£20.00	
Assessable earnings	£0.00	£0.00	£0.00
Net Unearned Income	£325.95	£325.95	£325.95
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£0.00	£0.00	£0.00
Total Resources	£325.95	£325.95	£411.55
Excess Income	£70.50	£6.00	£162.50
Passported?	Yes	Yes	
Current banding for contribution			
Owner	£1,753.77	£113.10	£12,752.38
Tenant	£1,027.50	£66.24	£7,472.03
Gilt rate linked	Gilt rate 1.5%		
Owner - 10 year	£9,121.31	£776.28	£21,024.30
Tenant -5 year	£4,389.82	£373.60	£10,118.38

Notes: Even though an excess income figure has been calculated in the existing and uprated DFG assessments, they are still passported by a small amount of housing benefit which has been calculated. The social care assessment, although leaving 25% over the Guarantee Pension Credit needs figure, still produces a substantially larger amount of excess income, and their contribution, than the other assessments.

Scenario 4

Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week.

	DFG Current	DFG Upated	Social Care
Personal allowances and premiums			
Adult allowances	£215.50	£263.80	£144.30
Child allowances	£0.00	£0.00	£0.00
Premiums	£0.00	£0.00	£28.75
Housing Allowance	£61.30	£79.25	£0.00
Total Needs	£276.80	£343.05	£173.05
Income			
Earned Income			
Net Earnings	£0.00	£0.00	£0.00
Earnings disregard	£10.00	£10.00	
Assessable earnings	£0.00	£0.00	£0.00
Net Unearned Income	£551.90	£551.90	£275.95
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£0.00	£0.00	£0.00
Total Resources	£551.90	£551.90	£361.55
Excess Income	£275.10	£208.85	£188.50
Passported?	No	No	
Current banding for contribution			
Owner	£48,568.21	£23,596.59	£16,672.40
Tenant	£28,458.03	£13,826.05	£9,768.87
Gilt rate linked	Gilt rate 1.5%		
Owner - 10 year	£35,592.53	£27,021.08	£24,388.19
Tenant -5 year	£17,129.63	£13,004.45	£11,737.32

Notes: The increase in income, coupled with the loss of premiums applicable to a single claimant, has removed entitlement to means tested benefits and therefore to passporting. In this scenario, contributions are more equal as the social care assessment is only taking half of the real income into account for the individual.

Scenario 5

Couple both aged 55, three children aged under 16, one partner disabled, receiving high rate DLA or PIP for care needs. Other partner working full-time and earning £400 net a week.

	DFG Current	DFG Upated	Social Care
Personal allowances and premiums			
Adult allowances	£94.95	£114.85	£71.80
Child allowances	£157.77	£200.70	£250.95
Premiums	£71.75	£88.80	£28.75
Housing Allowance	£61.30	£79.25	£0.00
Total Needs	£385.77	£483.60	£351.50
Income			
Earned Income			
Net Earnings	£450.00	£450.00	£0.00
Earnings disregard	£20.00	£20.00	
Assessable earnings	£430.00	£430.00	£0.00
Net Unearned Income	£0.00	£0.00	£0.00
Benefits Income	£48.10	£48.10	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£0.00	£0.00	£0.00
Total Resources	£478.10	£478.10	£85.60
Excess Income	£92.33	£0.00	£0.00
Passported?	No	No	
Current banding for contribution			
Owner	£2,576.54	£0.00	£0.00
Tenant	£1,509.72	£0.00	£0.00
Gilt rate linked	Gilt rate 1.5%		
Owner - 10 year	£11,945.69	£0.00	£0.00
Tenant -5 year	£5,749.11	£0.00	£0.00

Notes: in this scenario, there is no passported entitlement as, although Child Tax Credit is payable, the earnings figure is above the £15,050 annual threshold. Child Tax Credit and Child Benefit are disregarded for social care charging. The complete disregard of earnings and the limit of assessment to the client alone, in the social care assessment, produces a much lower resources figure in this scenario than for the other examples.

Scenario 6 - Capital

A) Single aged 55, severely disabled, receiving high rate DLA or PIP for care needs. (as scenario 1). Capital £10,000

		DFG Current	DFG Upated	Social Care
Personal allowances and premiums				
Adult allowances		£60.50	£73.10	£91.40
Child allowances		£0.00	£0.00	£0.00
Premiums		£88.80	£114.25	£60.05
Housing Allowance		£61.30	£79.25	£0.00
Total Needs		£210.60	£266.60	£151.45
Income				
Earned Income				
	Net Earnings	£0.00	£0.00	£0.00
	Earnings disregard	£20.00	£20.00	
Assessable earnings		£0.00	£0.00	£0.00
Net Unearned Income		£0.00	£0.00	£0.00
Benefits Income		£0.00	£0.00	£137.80
Disability benefits Income - AA, PP, DLA		£0.00	£0.00	£85.60
Tariff Income from Capital		£16.00	£16.00	£0.00
Total Resources		£16.00	£16.00	£223.40
Excess Income				
		£0.00	£0.00	£71.95
Passported?		Yes	Yes	
Capital Barred?		No	No	No
Current banding for contribution				
Owner		£0.00	£0.00	£1,808.42
Tenant		£0.00	£0.00	£1,059.53
Gilt rate linked Gilt rate 1.5%				
Owner - 10 year		£0.00	£0.00	£9,308.91
Tenant -5 year		£0.00	£0.00	£4,480.11

B) Single aged 55, severely disabled, receiving high rate DLA or PIP for care needs. (as scenario 1). Capital £20,000

	DFG Current	DFG Uprated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£56.00	£56.00	£23.00
Total Resources	£56.00	£56.00	£108.60
Excess Income	£0.00	£0.00	£0.00
Passported?	No	No	
Capital Barred?	No	No	No
Current banding for contribution			
Owner	£0.00	£0.00	£0.00

C) Single aged 55, severely disabled, receiving high rate DLA or PIP for care needs. (as scenario 1). Capital £30,000

	DFG Current	DFG Uprated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£96.00	£96.00	£63.00
Total Resources	£96.00	£96.00	£148.60
Excess Income	£0.00	£0.00	£0.00
Passported?	No	No	
Capital Barred?	No	No	Yes
Current banding for contribution			
Owner	£0.00	£0.00	£0.00

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D) Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week. (as scenario 4). Capital £10,000

	DFG Current	DFG Upated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£8.00	£8.00	£0.00
Total Resources	£559.90	£559.90	£361.55
Excess Income	£283.10	£216.85	£188.50
Passported?	No	No	
Capital Barred?	No	No	No
Current banding for contribution			

E) Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week. (as scenario 4). Capital £20,000

	DFG Current	DFG Upated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£28.00	£28.00	£0.00
Total Resources	£579.90	£579.90	£361.55
Excess Income	£303.10	£236.85	£188.50
Passported?	No	No	
Capital Barred?	No	No	No
Current banding for contribution			

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F) Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week. (as scenario 4). Capital £30,000

+	DFG Current	DFG Uprated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£48.00	£48.00	£3.00
Total Resources	£599.90	£599.90	£364.55
Excess Income	£323.10	£256.85	£191.50
Passported?	No	No	
Capital Barred?	No	No	No
Current banding for contribution			

G) Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week. (as scenario 4). Capital £40,000

	DFG Current	DFG Uprated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£68.00	£68.00	£23.00
Total Resources	£619.90	£619.90	£384.55
Excess Income	£343.10	£276.85	£211.50
Passported?	No	No	
Capital Barred?	No	No	No
Current banding for contribution			

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H) Couple both aged 75, one disabled, receiving high rate AA for care needs. Full Basic State Pension of £125.95 a week each plus £300 net private pension a week. (as scenario 4). Capital £50,000

	DFG Current	DFG Upated	Social Care
Benefits Income	£0.00	£0.00	£0.00
Disability benefits Income - AA, PP, DLA	£0.00	£0.00	£85.60
Tariff Income from Capital	£88.00	£88.00	£43.00
Total Resources	£639.90	£639.90	£404.55
Excess Income	£363.10	£296.85	£231.50
Passported?	No	No	
Capital Barred?	No	No	Yes
Current banding for contribution			

Notes: Couple capital is shared for social care unless specifically attributable.

A3.3 Summary of main differences between the two preferred options

Items	Current DFG Test	Social Care
Qualification for application		Different tests for residential and domiciliary care
Applicant need not be part of household	Yes	No
Older people	Start at 60	Womens state pension age for older person.
Assessment period	previous 52 weeks	
Later recovery	Various circumstances	
Deprivation		Important issue
Needs		
Children included	Yes	Yes
Additional amount included for disability benefits received	Severe Disability Premium, Enhanced Disability Premium, Disability Premium	Enhanced Disability Premium, Disability Premium
Carer's premium	Yes	Yes
Housing costs	Fixed allowance	Housing cost disregard
Capital cut off and tariff income	No cut-off, Tariff income above £6,000 or £10,000 for > 60	£23,250 cut-off. Tariff income above £14,250
Resources		
Disability benefits	Disregarded	Only Mobility disregarded. Care amounts included in income.
Notional contribution from non-dependants	Yes	No
Income from boarders and sub-tenants	Yes	No
Earnings net after tax & NI	Yes	Earnings completely disregarded
Pension contributions disregard	50%	No
Earnings disregard	Partial, follows most MTBs for different family circumstances	Complete
Income from capital	Common rules	Common type of assessment
War Pensions	£10 disregard	Full disregard, except CAA, from 2017 to meet Armed Forces Covenant requirements
Only income of individual used	No	Yes
Housing related costs	Fixed allowance in needs assessment	Disregarded from income

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Disability related expenditure		DRE elements and scheme is at discretion of individual local authorities.
Pension paid to absent partner		50% if at least 50% paid to partner
Assessment		
Passporting	By receipt of MTBs and tax credits	None
Difference between owners & tenants	Yes	No
Leave a minimum amount of income after assessment.	Only excess income used	Residential care PEA of £24.90. MIG for non-residential care calculated similarly to MTBs. Includes partner amounts.
Loan calculation	4 bands	Deferred payments possible
Family type	Disabled person and family	Disabled individual only
Changes of circumstance	Relevant date circumstances	Weekly

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