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Evaluation of the Independent Living Grant (ILG)

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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Glossary of acronyms

C&R	Care & Repair
DCLG	Department of Communities and Local Government
DFG	Disabled Facilities Grant
FACS	Fair Access to Care Services
ILG	Independent Living Grant
LA	Local Authority
LAS	Level Access Shower
OT	Occupational therapist
RRAP	Rapid Response Adaptations Programme
SL	Stair Lift
TOR	Test of Resources
WG	Welsh Government

1 The introduction of the Independent Living Grant

1.1 The Independent Living Grant (ILG) is an initiative of the Welsh Government and reflects the collaborative relationship that has been established between, at a national level, Welsh Government, Care and Repair Cymru and the representatives of local authorities in Wales. At a local level the initiative sought to utilise the strong partnerships that already existed between Care & Repair agencies and Housing, Health and Social Care in every county in Wales.

1.2 The Independent Living Grant (ILG) was intended to support the aspirations of various national strategies, including "*Improving Lives and Communities-Homes in Wales*" (2010), "*The Strategy for Older People in Wales*" (2003-13), "*Fulfilled Lives, Supportive Communities*" (2007), and "*Still Waiting: Home Maintenance and Adaptations Services for Older People in Wales*" (2009).

1.3 The principal objectives were to help address local government 'waiting lists' for adaptations, to maximise independence, to help relieve pressures on hospital acute admissions, and to help speed up hospital discharge.

1.4 A sum of £1.5 million was allocated to Care & Repair agencies, through Care & Repair Cymru, to assist in the effective targeting of mid level adaptations for older people to achieve these objectives.

1.5 The ILG was available for older people (over 60 years of age), living in their own home or in privately rented accommodation, for adaptations to their homes involving works between £1,000 and £10,000.

1.6 The programme was not intended to compete with the provision made through Disabled Facilities Grants, but is a complementary support to the same objectives.

1.7 It was intended that referral to the ILG should be based on a simple form provided by Care & Repair agencies, and requiring an agreement by Housing/Health/Social Services for the works undertaken. The adaptation should be provided with the following requirements in mind. Provided for older people who:

- are on an adaptations 'waiting list' for mid-level intervention that improves their independence and wellbeing.
- are in hospital or who are ready for/planning discharge from hospital where the circumstances require mid level intervention to facilitate discharge; and
- wish to continue to live at home as independently and safely as possible, and whose homes require mid-level intervention to enable them to do so.

1.8 There was an explicit aspiration that the ILG should demonstrate ways in which the delays sometimes experienced in the DFG system might be overcome:

- Within the ILG framework, payment for additional Occupational Therapy assessment time was allowable, whether private or from in

house teams, if there is a clear indication that identified cases will not proceed quickly due to the local waiting time for an OT assessment, and that such protracted delays can only be addressed by this means.

- The ILG was not means tested, did not require a DFG application form, and did not necessarily require an OT assessment. Whether an OT assessment would be required was for local C&R Agencies to agree with local government Housing and Social Care partners.
- C&R agencies and their partners were at liberty to propose their own innovative solutions that support the aims and objectives of the ILG, and the access and eligibility criteria.

1.9 Care and Repair Agencies were invited to consult with local partners and to put forward proposals by 24th June 2011 for spending the funds provisionally allocated to them. 75% of the funding was released in advance and the balance available to be released from November, reflecting performance at that point.

2 Methodology

2.1 The Welsh Government commissioned Contact Consulting to monitor the effectiveness of the ILG during 2011-12. The study involved the following elements:

- A review of the literature on the role and value of adaptations.
- Collection of data from Care and Repair agencies on each ILG completed.
- Six detailed case studies of Care and Repair agencies.

2.2 In relation to the provision of data on completed ILG cases, Care and Repair agencies collected a range of information to provide a detailed picture of the types of needs addressed and the assistance provided. This information was provided electronically on a standard form designed at the outset of the evaluation in consultation with the Welsh Assembly Government, project steering group members, and Care and Repair representatives.

2.3 A copy of the form used is attached at Appendix A. The form was provided to projects as a Microsoft Word file and returned in this format. After checking, forms were transferred into Excel and subsequently to other analysis packages. This approach was utilised because it was simple and quick to implement in the tight timescale demanded by the project. The timetable did not permit piloting of the form, but in practice relatively little further guidance was required once the system was in operation and there were few problems with it.

2.4 Case study visits were made to six agencies/local authority areas:

- Newport
- Swansea/Neath Port Talbot
- Carmarthen
- Powys
- Flintshire
- Anglesey

2.5 These were chosen to be representative of the twenty-two local authorities of Wales in that they were drawn from large and smaller authorities, from rural and urban authorities, from North, South and Mid-Wales and included authorities where Welsh speaking service users were prevalent.

2.6 In each case study area interviews were undertaken with agency staff, with officers responsible for private sector housing and with occupational therapists. In each of the case study areas, two visits were made to grant recipients in their own homes to discuss the work that had been carried out through the ILG, the difference the work had made and their assessment of the process. In most cases the principal carers were also present.

2.7 Schedules containing standard questions were used to provide a structure to the interviews. These are reproduced as Appendix B.

3 The role and value of adaptations – a review of the literature

3.1 The duty of local authorities to identify the needs of sick, vulnerable and disabled people within their community and to ensure that an appropriate response is made may be traced to the National Assistance Act, 1948[1]. That same general concern is to be found in the NHS and Community Care Act, 1990[2], which requires that those who are to have their needs met within the Community should be assessed to determine the level and nature of their needs. The Chronically Sick and Disabled Persons Act 1970[3] also lays responsibility on the local authority which may be discharged by the provision of an adaptation, often as part of a multi-faceted package of assistance that may include personal care and the supply of equipment alongside the adaptation. Section Two of the Chronically Sick and Disabled Persons Act 1970 states that local authorities have a duty to arrange for an assessment of needs of disabled people for adaptations and to facilitate any works in their home. In intention the facilitation of such works includes those that may not be supported by funding through the grant system, for example where a disabled person's resources exceed the limits set down in the test of resources. In practice many local authorities focus on those who do qualify for assistance through Disabled Facilities Grant (DFG).

3.2 The foundation for the current system of public subsidy for the provision of adaptations in the homes of disabled people was created in the Local Government and Housing Act, 1989[4]. This introduced a new mandatory grant called Disabled Facilities Grant (DFG). Whilst adaptations had been funded through previous grant legislation this was the first legislation to make specific provision. Delivered within the suite of then existing grants for housing repair and renewal the primary responsibility for the administration of DFG lay with teams of Environmental Health Officers and Surveyors. The legislation suggested that in administering the grant the advice of Community Occupational Therapists, generally working within Social Service Departments, should be taken into account. In practice the Occupational Therapy service generally came to be the gatekeepers to this provision, determining what works are "necessary and appropriate" to meet the disabled persons needs, whilst housing colleagues determine whether what is proposed is "reasonable and practical".

3.3 The 1989 Act was replaced by the Housing Grants, Construction and Regeneration Act 1996[5]. The 1996 Act made all housing grants discretionary, except for DFG where mandatory entitlement was retained. Sweeping changes and increased flexibility for all other types of housing grants were made under the Regulatory Reform (Housing Assistance) (England and Wales Order) 2002[6]. However, mandatory entitlement to DFG remained

[1] National Assistance Act, 1948.
[2] NHS & Community Care Act, 1990
[3] The Chronically Sick and Disabled Persons Act 1970
[4] Local Government and Housing Act, 1989
[5] Housing Grants, Construction and Regeneration Act 1996
[6] Regulatory Reform (Housing Assistance) (England and Wales Order) 2002

unchanged and the provisions of the 1996 legislation still apply, with some subsequent upgrading in financial values.

3.4 In 2005 the UK Government published the findings of an inter-departmental review of the operation of the Disabled Facilities Grant[7] which identified a number of problems with the system. Pressure continued to arise as a consequence of the ageing of the population and the associated increase in chronic conditions, the effects of which might be mitigated through provision of a housing adaptation. The Test of Resources was identified as poorly targeted and "seen to treat particular groups harshly". Households containing a disabled child were seen to be especially disadvantaged and the application of the Test of Resources to these households was subsequently removed.

3.5 Following consultation[8] a number of changes to the Disabled Facilities Grant arrangements were implemented[9]. Concerns about the inequalities, cumbersome process, delays and the adequacy of funding for the programme remained and the Buildings Research Establishment was commissioned to assess the allocation process and means testing in more detail.

3.6 The Buildings Research Establishment Report[10] offered a number of suggestions for reallocating resources more fairly amongst local authorities in England. It also considered how the considerable shortfall in resources to cover those who are theoretically eligible for a DFG could be met. This included both using budgets for health and care services and finding ways to tap into the amount of equity locked up in owner-occupied housing. The report stated that "*We need to compile compelling evidence to demonstrate how money spent on adaptations will save money on health and care costs. This needs to take the form of rigorous cost benefit analyses supported by case studies and good practice examples."* The report suggested that the means test could be waived for work under £6,000 to reduce administration costs and speed the process, but indicated that could lead to more people with higher incomes being allocated resources. Although unpopular, the way round this might be to use a test of equity. Many authorities are already registering a charge against the property of home owners who received a DFG.

3.7 Some authorities in England have removed the Test of Resources under the Regulatory Reform Order. For example Bristol has developed a Low Cost Adaptation grant for work under £5,000 after analysis showed that the resources brought in from client contributions were less than the administrative costs of operating the test of resources. Similarly, Bridgend has introduced a specific stairlift grant that does not require a test of resources in order to offer a much faster service.

[7] Reviewing the Disabled Facilities Grant Programme, ODPM 2005
[8] Disabled Facilities Grant Programme: The Government's proposals to improve programme delivery, CLG 2007
[9] The Housing Renewal Grants(Amendment) (England) Regulations, 2008
[10] Disabled Facilities Grant allocation methodology and means test: Final report, DCLG, 2011

3.8 The review of housing adaptations including Disabled Facilities Grants – Wales, undertaken by Chris Jones and reported on in March 2005, drew attention to delay in delivering adaptations as the greatest limitation in the then existing system. The report also identified some local authorities who were utilising a less bureaucratic "minor works" route as a quick and flexible way of providing low cost adaptations. Minor adaptations provide a range of positive and lasting consequences"[11].

3.9 Jones identifies four periods of time that contribute to the period taken from initial referral to the delivery of an adaptations:

- Time taken for assessment of need by the Welfare Authority (in practice by Social Services Occupational Therapy Team) ("Social Services Time")
- Time taken from receiving an assessment, to receiving a visit from a Housing surveyor and being formally invited to make an application for DFG, and after submitting the application, the time taken for the grant to be approved ("Housing Time")
- Time taken to submit a valid application for a DFG ("Client time")
- Time taken to complete building works after receiving grant approval ("Builder Time")

3.10 Of the average time from referral to completion reported by Jones of 85 weeks, 27 were taken up with "Social Services time" and 26 with "Housing Time". "Builder Time" accounted for 20 weeks and "Client time" just 12 weeks, much of this was accounted for by the complexity of the application documentation and the supporting documents to be assembled. The average period required to secure an assessment masked a range from 5 weeks in one authority to 105 in another.

3.11 As a result of the work by Chris Jones and a parallel consultation in England to improve DFG delivery, revisions to the DFG in Wales were introduced in Annex D of the National Assembly for Wales Circular 20/02 in 2007[12]. This had the aim of putting the needs of the disabled person at the heart of the service, improving co-ordination between different service providers and reducing delays. The DFG Review Report also recommended that lower cost adaptations should be streamlined and made less bureaucratic by channelling adaptations up to the value of £3,000 through a fast-track system rather than through the traditional DFG route.

3.12 In June 2002 the Welsh Assembly provided funding, initially for a three year pilot, for the Rapid Response Adaptations Programme (RRAP Scheme) for minor works. This was administered by Care and Repair Cymru and delivered by the national network of Care and Repair Agencies, in partnership with their local authorities and local health service providers. The pilot was reviewed by Care & Repair Cymru. A total of 16,580 jobs were completed within the first three years with an indicative saving of over £41 million for the health service

[11] Jones C (2005) Review of Housing Adaptations Including Disabled Facilities Grants – Wales, Housing Directorate, Welsh Assembly

[12] National Assembly for Wales (2007) Circular 20/02 Annex D – Revision of Disabled Facilities Grant

in Wales by facilitating quicker hospital discharge, keeping older people at home and preventing accidents.

3.13 Funding has continued with the scheme focusing on facilitating hospital discharge (reducing delayed transfer of care) by enabling quick, essential works of minor adaptation and repair. A secondary aim is to work with health, housing and social care professionals to undertake similar works of small repairs and adaptations, to prevent hospital admissions or re-admissions. The key features of the scheme are:

- Older and or disabled home owners/ private tenants are eligible
- Maximum allowable RRAP cost is £350 per job
- Target maximum number of days from referral to completion of works is 15 days
- Scheme is a partnership between local Care and Repair Agency, Health, Social Care and Housing. Referrals must be made by partner agencies, and for the purpose set out under the scheme
- Works are undertaken in the majority of cases by local Care and Repair agency in house handy-person services.

A further review of the service in 2009/10 estimated that if the work for just 10% of the 15,529 RRAP clients helped that year led to quicker hospital discharge and accident prevention it could give a total cost saving to the Health and Social Care sector of around £16 million. This means that every £1 spent on RRAP saves approximately £7.50 in NHS and Social Care costs[13].

3.14 Housing Adaptations for People with Disabilities, Good Practice Guide No 6: Provision of Community Equipment.[14] Although concerned with equipment rather than adaptations this Good Practice Guide articulates principles that are equally relevant to adaptations of the kind provided through ILG. It identifies solutions that allow for innovation, providing scope for service user choice, timeliness, and alternative methods of provision as examples of "Better Practice".

3.15 In 2009 the National Assembly for Wales Equality of Opportunity Committee reviewed the progress made since the completion of the 2005 Review. The Committee identified a number of areas in which there had been little development, particularly the long and complex process people have to navigate. This report made a number of recommendations concerning the administration of the DFG.

3.16 During the inquiry into maintenance and adaptation services for older people in Wales, published in the 'Still Waiting' report in 2009[15], several key themes emerged strongly which included:

- Inequality across Wales and across housing tenure

[13] Care & Repair Cymru (2011) Rapid Response Adaptations Programme Strategic and Operations Customer Satisfaction Survey Report.

[14] Housing Adaptations for People with Disabilities, Good Practice Guide No 6: Provision of Community Equipment (March 2009, WLGA).

[15] National Assembly for Wales, Equality of Opportunity Committee (2009) Still Waiting: Home Maintenance and Adaptations Services for Older People in Wales

- Workforce issues, skills mix and cross sector working
- Performance management data
- Resources
- Bureaucracy
- Identification and sharing of good practice

3.17 A section on partnership working identified that *"A willingness to allow decisions to be made in a more flexible and responsive way is required. In some cases local authority housing departments, social services, the NHS and other agencies work together to provide a 'one stop shop' service, and there is some evidence that suggests this has resulted in reduced waiting times"*. The report also advocated using less bureaucratic approaches to both the DFG and to assessment and noted the very positive responses to the Rapid Response Adaptations Programme. A series of recommendations emerged including: a strategic approach to monitoring and sharing of good practice, better performance indicators, a single adapted housing register, employing more OTs and embedding them in housing departments, developing a less bureaucratic way of providing adaptations up to £3,000 which are currently done through the DFG to increase the speed of the service to those in greatest need and finally for local authorities to properly resource adaptations. Many of these recommendations had already been identified in Annex D of Circular 20/02 in 2007.

3.18 The Living Well at Home Inquiry[16] in England included a section on connecting housing, health and social care. It reflects the changing legislation relating to the National Health Service in England, but gives some good examples of new ways of working that are just as applicable in Wales. In a pilot in Kingston, PCT staff worked alongside GPs to offer early intervention. They found cases that fell just outside the Fair Access to Care Criteria (FACS) and were therefore not known to social services, but where people were vulnerable in various ways. These people were offered practical support. This example was medically based, but could just as easily apply to adaptions and handyperson services. In Blackpool the 'Counter Attack' scheme was launched several years ago in partnership with the NHS. It involved Care and Repair staff working with GPs, social workers and falls matrons from the local hospital to assess safety risks to individuals and to carry out remedial works, including minor adaptations. The success of the scheme in reducing hospital admissions led to increased funding from the NHS and the development of a referral protocol between GPs and Care and Repair.

3.19 There is an extensive literature documenting the benefits that arise for a range of stakeholders from the provision of adaptations in the homes of disabled people. Reporting in 2001[17] Heywood identifies a range of benefits for the disabled person, their carers and family members. These are principally in the area of mental and physical well-being and, for the disabled

[16] All Party Parliamentary Group on Housing and Care for Older People (July 2011) Living Well At Home Inquiry, Editor: Jeremy Porteus, APPG Inquiry Secretary.

[17] Money well spent: the effectiveness and values of housing adaptations, Heywood F, Joseph Rowntree Foundation , 2001

person, improved dignity, privacy, independence, health (both physical and mental), social inclusion, and opportunities for education and employment.

3.20 The impact on well-being is further documented in the wide-ranging literature review undertaken by Heywood and Turner in 2007 for their report "Better outcomes, lower costs".[18] Their report also reviews studies that had sought to establish cost savings to the health and social care economy through the provision of adaptations.

3.21 The question of cost benefit from the provision of adaptations relies on an equation which is simpler to state than to specify: how many events requiring high cost health or social care services have been avoided, multiplied by the estimated cost of providing those services. The second part of that equation is less problematic than the first; there are many sources that will provide the cost data.[19]

3.22 The dilemma faced by anyone seeking to ground an evaluation of the cost benefit to health and social care budgets of preventative services, such as those offered by adaptations is well expressed in a briefing paper from Northamptonshire County Council[20]: *"The majority of prevention work and preventive services appear to exist due to the assumption that ultimately they will result in lower use of services, and will consequently prove cost effective in the long run. This assumption is held up in government policy, despite an evidently weak evidence base. ..... there is strong evidence for falls prevention... there is at present no conclusive evidence regarding low level preventative interventions, (or) housing adaptations ..."*

3.23 Whilst the literature provides a large number of assertions of the cost benefit of a range of interventions what has been lacking is evidence from studies that can quantify the degree of risk mitigation through particular interventions. Computations of the costs of alternative scenarios abound but how much of that cost can be mitigated by an adaptation remains a contested question. This is being addressed by more recent work with a focus on falls prevention and delay in transfer to residential care.

3.24 Work by the Lean Enterprise Research Centre at Cardiff University reports a study of people moving to residential care over a five year period[21]. Of the total of 750 people moving to residential care 244 had been identified by OT services for a DFG, 85 had received a DFG and 159 had not. Those who received a DFG entered residential care at an average age of 84 years, whilst those who did not entered at an average age of 80 years. The report suggests that there is a high correlation between receiving a DFG and an average delay in admission of four years.

[18] Better outcomes, lower costs- Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence", Heywood R & Turner L, Office for Disability Issues and University of Bristol, 2007.
[19] See for example: Unit costs of health and social care services 2011, Curtiss L, 2011, PSSRU
[20] Evidence Cluster: Prevention, 2009, Northamptonshire County Council
[21] Lean Enterprise Research Centre, Cardiff Business School (2010) Lean and Systems Thinking in the Public Sector in Wales

3.25 Whilst there are a number of imponderables in making the calculation (whether the person receiving the adaptation also receives home care before transfer to residential care and whether, once there, they meet part of the cost of their care) the gross cost of four years of residential care is in the region of £80k per person to set against the average cost of a DFG of around £7k.

3.26 The second area in which financial benefit is widely asserted is in the prevention of falls and resulting fractures. The cost to public funds of a hip fracture was estimated at £28,665 in 2007.[22]The difficulty here is that the circumstances that lead to a fall are multi-factoral and a single intervention will only have a partial rather than determining impact. Whilst an adaptation may identify and remove tripping hazards, improve accessibility and generally modify the risk inherent in the home environment it will represent only one element in determining a safer outcome. Other factors may include underlying health conditions, medication, nutrition and hydration, chronic joint conditions, balance, and lifestyle.

3.27 A 2010 study estimated that in the course of one year 32% of older people whose housing had not been improved or adapted were at risk of a fall that would result in hospital admission, community health service use and/or a need for social work department funded support. This contrasted with a rate of fall risk of 10% among those whose houses had been improved or adapted by a Care & Repair service.[23]

3.28 The Partnerships for Older People Programme (POPPS)[24] was set up to test and evaluate different models of service delivery through 29 local authority-led pilots. The aim was to shift resources away from institutional and hospital based crisis care for older people towards earlier, targeted interventions within their own homes. The findings indicated that preventative action of many kinds can produce an average saving of around £1.20 in emergency bed days for every extra £1 spent on prevention. These gains are on top of the £1 of additional service benefit from addressing older people's presenting needs. There are also efficiency gains for the Health Service in reducing hospital overnight stays, accident and emergency attendances, clinic or outpatient appointments and physiotherapy/ occupational therapy appointments.

3.29 The Warwick Law School and BRE report 'Linking Housing Conditions and Health,'[25] although about house conditions more generally rather than specifically about adaptations, found that the largest savings are not delivered using traditional grants and loans but small interventions through

[22] Better outcomes, lower costs- Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence", Heywood R & Turner L, Office for Disability Issues and University of Bristol, 2007.

[23] Handyperson Financial benefits Toolkit, O'Leary C, Linney J & Weiss A, 2010, DCLG, also cited in The costs and benefits of preventative support services for older people, Pleace N, 2011, University of York.

[24] Department of Health (2010) Improving care and saving money: Learning the lessons on prevention and early intervention for older people, London: Dept of Health

[25] Warwick Law School and BRE (2010*)* Linking Housing Conditions and Health: A Report of a Pilot Study into the Health Benefits of Housing Interventions

handyperson' services. The most significant impacts are associated with falls prevention as unintentional falls are the most common home injuries treated by the health sector.

3.30 Using the Financial Benefits Toolkit, the national evaluation of the Handypersons Programme[26] in England indicated that the service generated modest cost benefits, with two thirds of those benefits going to social care services in terms of reduced need for sheltered accommodation or care and a third to health due to falls prevention.

3.31 A more recent study for Carmarthenshire's Healthier Homes Project[27] indicates some of the advantages to the health service that result from changes in people's housing. Reductions in use of GP services may be similar in the case of adaptations. The pilot study showed that 23% of those who lived in unimproved properties saw their GP more than 4 times in a three month period compared to 14% in properties where work had been completed.

3.32 The Care and Repair England report 'Time to Adapt'[28] cites a notable example of how really close links between home adaptations providers and the health service can improve services for disabled people considerably. Blackpool Care and Repair has organised their service from the perspective of the user, not the provider and the PCT, home improvement agency and local authority have worked together to bring the time it takes to complete a home adaptation down from a year to an average of 8 weeks - or even less if a case is urgent. John Turner, the Integrated Systems Manager at Blackpool PCT states that *'The links between housing suitability and health are incontrovertible. If we want to improve older people's health, enable their independence at home, prevent falls and reduce other common problems it is absolutely critical that we work effectively with housing colleagues to make older people's homes safe, decent and adapted places to live'.*

3.33 The authors of 'Time to Adapt' state that one of the key factors preventing home adaptations having a higher priority and greater investment is that expenditure in one sector, housing, results in savings in other sectors, health and social care. They note that when the health service started recharging social services for the extra bed day costs where delays to discharge were caused by patients waiting for social care support to be organised it resulted in reductions in delay. They suggest that *"it may be worth considering a similar system for adaptations in order to stimulate improvements in provision".*

3.34 Finally, a more radical model of integrated service provision is being developed in various parts of England based around Centres for Independent Living. In Knowsley, near Liverpool, they have amalgamated all services for

[26] Croucher, K. et. al. (2012) National Evaluation of the Handyperson Programme, Department for Communities and Local Government.
[27] Carmarthenshire County Council (2011) Feeling Fine: Healthier Homes.
[28] Adams, S. and Ellison, M. (2009) Time to Adapt - Home adaptations for older people: The increase in need and future of state provision, Nottingham: Care and Repair England.

older and disabled people in one new centre using pooled budgets from health and the local authority. Everything from the blue badge scheme, wheelchair assessments, displays of equipment and adaptations, the Care and Repair scheme, the handyperson service, health and community OTs, and the adaptations team from the transferred housing association are co-located under a single manager. The equipment store is housed in the adjacent building. It is a total one-stop shop. This was given the top rating in a national study carried out for Scope in 2011[29]. A similar type of service is in development in Dorset where it is planned to amalgamate services into first three, then eventually six hubs, based on the Centres for Independent Living[30]. A further feature of these new initiatives is the involvement of user groups in the planning, design and running of these centres.

Conclusions

3.35 The challenges arising from the administration of the DFG system have long been recognized. At the macro level this is seen in the attempt through successive legislation and guidance to manage the equation between the resources available from public funds and an increasing level of demand.

3.36 Achieving timeliness in the delivery of adaptations is recognized as an appropriate goal for both policy and practice in this area but has proved difficult to achieve.

3.37 Whilst the Test of Resources has been removed for adaptations for the benefit of children and is recognized as securing only a marginal cash contribution in return for the delay and complexity that its administration puts into the system there has been sustained resistance to removing it. Despite repeated calls in Wales for a non means-tested fast track service for work under £3,000 until the advent of the ILG most local authorities were reluctant to offer this.

3.38 Collaborative working and the integration of delivery of adaptations with other health, housing and social care interventions are seen to provide an efficient and accessible service to the benefit of both public authorities and disabled persons and their carers.

3.39 The literature provides extensive evidence of the non-financial benefits of adaptation to the individual and their carers: enhanced independence, dignity, quality of life and mitigation of anxiety are all evidenced.

[29] Wood, C., et. al. (2011) Less money doesn't have to mean a poorer service for disabled people, London: Demos.

[30] THCP (2011) Removing the Barriers: Joining up aids and adaptation services in Dorset, SW Regional Improvement and Efficiency Partnership.

3.40 The evidence of financial benefit to the health and social care economy is building but difficult to attribute to a particular intervention. If assumptions are accepted about the basis for such calculations the financial savings to health and social care services are substantial. Table 3.1 below brings together some comparative information about the costs of health and care versus the average cost of an adaptation.

Table 3.1

Summary of the benefits of adaptations versus the costs of health and care

Comparative costs for older people

The average cost of an adaptation is £7,000

- Almost two thirds of general and acute hospital beds are used by people 65+[31]
- Falls by older people in UK cost over £1,000 million pa[32] (59% borne by NHS)
- Every hip fracture costs about £33k per person[33]
- Residential care for an older person costs £19k - £40k pa[34]
- Residential care for a seriously disabled adult is £42k - £74k pa[35]
- Back injuries cost the NHS alone £602 million per year (often carers)[36]
- Timely adaptations can help prevent pressure sores. One pressure ulcer costs £200 per week (£10,400 in a year)[37]

- Adaptations may reduce entry to residential care by 4 years saving about £80k per person[38]
- Improvements and adaptations may reduce the risk of falls by about 60%[39]
- Improvements to property may reduce the number of GP visits by about 40%[40]
- Every £1 spent on RRAP saves approximately £7.50 in NHS/Social Care costs[41]

Note: Costs adjusted to 2011 levels in line with ONS inflation statistics.

[31] DH (2001) National Service Framework for Older People.
[32] Scuffham, P, Chaplin, S and Legood, R (2003) 'Incidence and costs of unintentional falls in older people in the United Kingdom' Journal of Epidemiology and Community Health 57 740-744.
[33] Parrott, S (2000) The economic cost of hip fracture in the UK.
[34] ODPM (2005) Reviewing the Disabled Facilities Grant: 21.
[35] Curtis, L (2008), Unit Costs of Health and Social Care 2008. PSSRU.
[36] Health and Safety Executive (2002), CRR 441/2002, Initiative evaluation report Prices here adjusted to 2009 levels.
[37] NICE (2005) Pressure ulcer management: National cost impact report
[38] Lean Enterprise Research Centre, Cardiff Business School (2010) Lean and Systems Thinking in the Public Sector in Wales
[39] Handyperson Financial benefits Toolkit, O'Leary C, Linney J & Weiss A, 2010, DCLG, also cited in The costs and benefits of preventative support services for older people, Pleace N, 2011, University of York.
[40] Carmarthenshire County Council (2011) Feeling Fine: Healthier Homes.
[41] Care & Repair Cymru (2011) Rapid Response Adaptations Programme Strategic and Operations Customer Satisfaction Survey Report.

Table 3.2

Comparative costs for children

A ground floor extension providing an accessible bedroom and bathroom for a severely disabled child costs £30-70,000 depending on the site and the need for specialist equipment.

- Keeping a seriously disabled child in hospital costs over £275k per year[42]

Note: Costs adjusted to 2011 levels in line with ONS inflation statistics.

3.41 It is very difficult to show the savings generated by a DFG directly with the current level of information. However, the Welsh Government could start to collect more useful data from local authorities, not just on the number and value of DFGs but on the outcomes. How many DFGs enabled people to return home from hospital and how many days bed occupancy were saved; how many DFGs resulted in a reduction in the cost of a care package and by how much; and how many people who had a DFG would have otherwise gone into residential care? Some of the findings from this study begin to start providing this information. Collection of evidence over a longer period from some of the local authorities already working on these issues would enable a significant data set to be built up over the next few years.

3.42 Among the Case Study agencies Neath Port Talbot collected data on the potential alternative outcomes for clients had they not received an adaptation and the consequent costs to the Health and Social Care economy. Documenting the cost of the ILG and drawing on an interdisciplinary judgement as to the alternative outcome had the ILG not been delivered, and the costs associated with that scenario they have identified the estimated saving.

3.43 We have taken the narrative the agency provided and summarised the information and this is reported in Appendix C. This information arises from a local initiative and does not form part of the formal evaluation but does contribute to the available data on cost benefit from the timely provision of adaptations, such as those delivered through the ILG.

[42] ODPM (2005) Reviewing the disabled facilities grant:21.

4 Case monitoring

Introduction

4.1 This section reports the findings from the returns made by Care and Repair agencies on completed ILG cases. By the deadline for returns (10th February 2012) 281 forms were received and included in the analysis. A small number of duplicate forms were removed. Twenty three forms were also received after the deadline. These are shown in Appendix Table A1 but not in the detailed analysis of returns in this chapter. In most cases, forms were fully completed, but in the latter stages approaching the deadline some forms were submitted without client feedback as there was not time to obtain this. A small number of returns were submitted before work was fully completed.

4.2 The deadline for this report did not permit data to be collected on all ILG cases. The total number of ILGs completed by the end of March 2012 was 374, so the cases on which this chapter is based represent 75% of the total. It is not feasible to draw firm conclusions about the extent to which these cases are representative. It is possible that some more complex ILG cases taking longer to complete were excluded from the analysis because they were not complete but there is no evidence to support this.

Number of returns received

4.3 Appendix Table A1 shows the number of forms returned by each Care and Repair agency. Twenty one out of twenty two agencies submitted returns, the exception being Merthyr Tydfil.

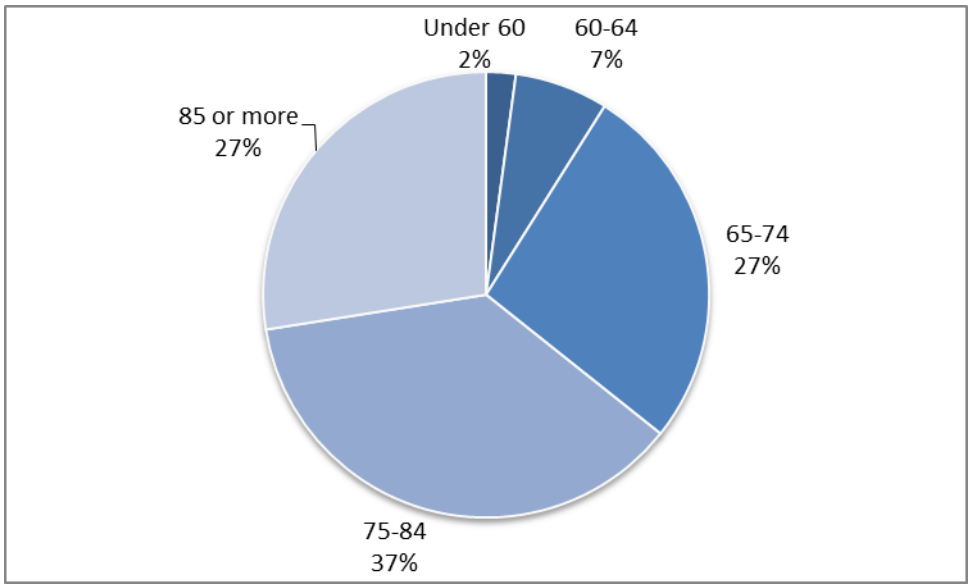
Agreement to participate in case studies

4.4 Appendix Table A2 shows the number of clients agreeing to participate in detailed case studies. Overall, 45% of clients were willing to participate, but in four agencies no clients agreed to this and in two agencies all clients were willing to participate. This suggests that there were differences in the approach taken by agencies to securing co-operation.

Client characteristics

4.5 Agencies collected details of the age, ethnicity and gender of clients and of the type and tenure of their dwellings. Figure 4.1 shows the profile of clients by age. 91% of clients were over 64, 64% over 74, and 28% aged 85 or more. The 75-84 group were the most numerous. It is notable that there were a small number of cases of clients where the client was aged under 60, despite this being outside the ILG eligibility criteria. However clients were overwhelmingly older people.

Figure 4.1 Age of client



4.6 The ethnic mix of clients was almost exclusively white – 99.9%. Clients were almost evenly split between women (51%) and men (49%).

Property type and tenure

4.7 Most adapted dwellings were semi-detached houses (37%) or detached houses (34%) with just over a quarter in terraced houses. Very small numbers of flats, sheltered dwellings and caravans were also represented (Figure 4.2). Nine out of ten clients owned their houses outright, with a further 5% buying and 1% part owning, a feature compatible with the client age profile (Figure 4.3). There were very few clients from the private rented sector.

Figure 4.2 Property type

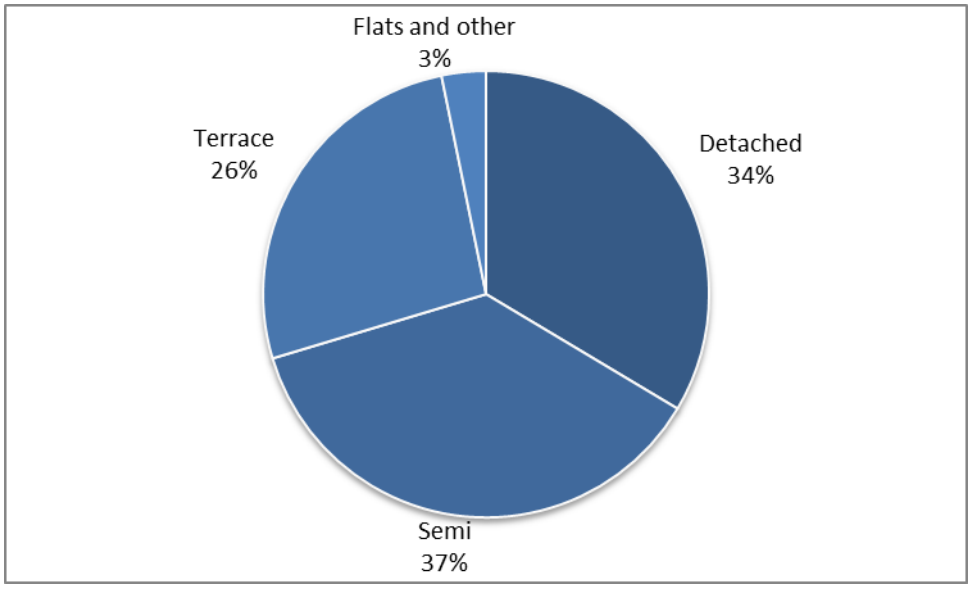
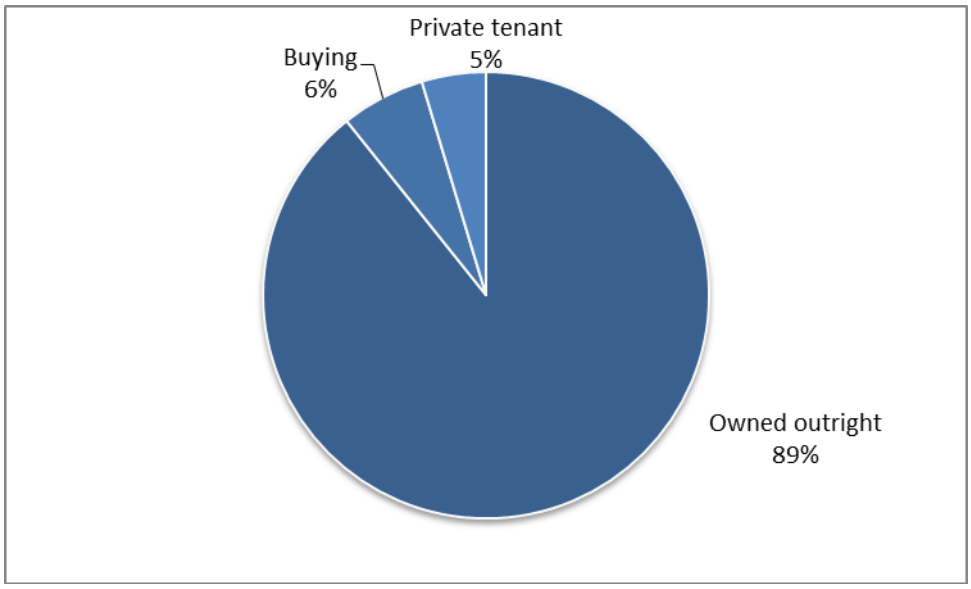


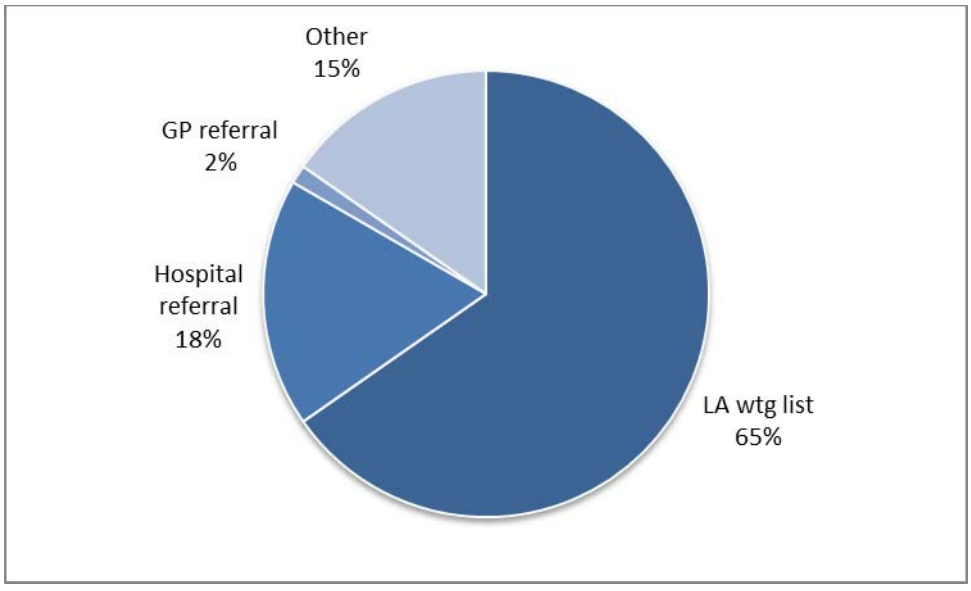
Figure 4.3 Tenure



Referral Process

4.8 Agencies were asked to indicate the main source of referral for the ILG cases which they took forward (Figure 4.4). This information was provided in 80% of cases. The main source was the local authority waiting list for Disabled Facilities Grant (two thirds of valid cases where this information was provided), followed by a hospital referral (18% of cases). The 'other' sources included self-referral by the client or the client's relatives, and falls prevention services.

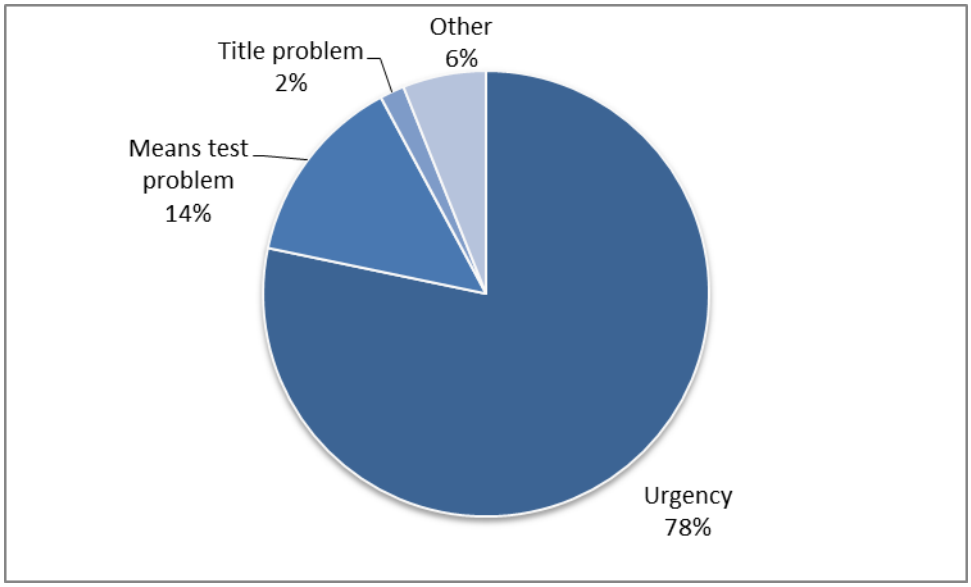
Figure 4.4 Main source of referral



4.9 Figure 4.5 shows the main reason for selection by case. Almost four out of five cases were selected because of the urgency of need. DFG means test problems generated 14% of cases and title problems less than 2%. Few details were given of other reasons for selection (6%) but the examples provided relate to a wide range of complications which had caused delays with DFGs, demonstrating the flexibility provided by ILG.

> Mrs P is a wheelchair user and has a range of mobility difficulties; her husband is her sole carer. She was assessed as needing ramped access to her home and the replacement of the bath with a level access shower. Applied for a DFG and assessed to make a financial contribution. They had already funded a stair lift themselves to avoid twelve month delay. Having considered their housing and living costs they did not feel they could afford the contribution and work would not have proceeded. The provision of the ILG delivered the LAS and ramping within two months, has significantly mitigated the strain on Mr P of caring for his wife and improved the quality of life of both Mr and Mrs P.

Figure 4.5 Main reasons for selection for ILG

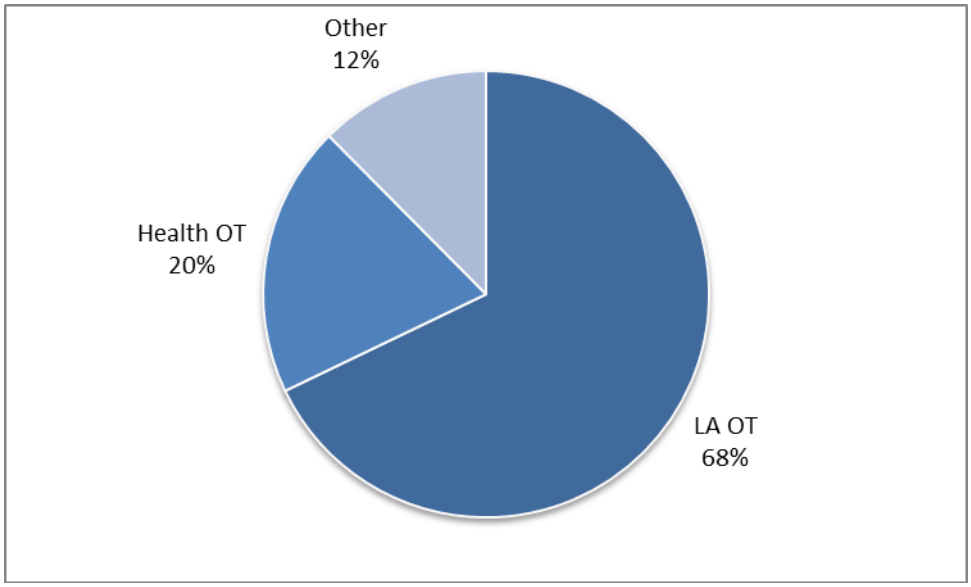


4.10 Almost nine out of ten clients were living in the dwelling adapted. Some 12% of clients were in hospital, with the assistance provided by ILG either contributing to, or securing, their move home.

4.11 Agencies were asked to indicate the source of any assessment of client needs *prior to* referral for ILG (Figure 4.6). A source was indicated in just under 90% of cases. Of these, just over two thirds of clients were assessed by a local authority occupational therapist (OT) prior to referral, and a further 20% were assessed by a health service OT. These were mainly the cases

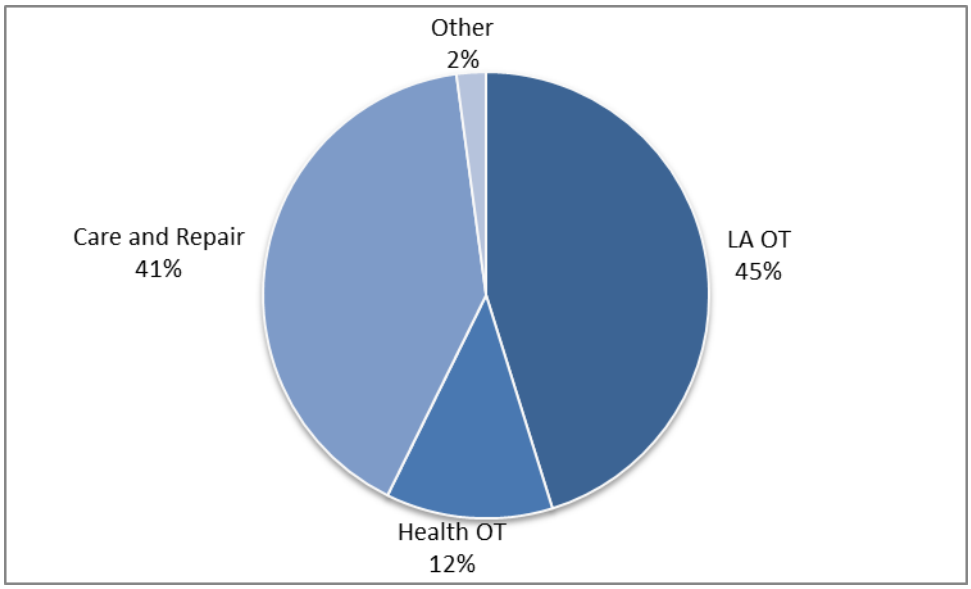
which were hospital referrals. Other sources - mainly Care and Repair staff, or private OTs - were used in 12% of cases.

Figure 4.6 Source of assessment prior to referral for ILG



4.12 Agencies were also asked to indicate the source of any assessment for ILG (Figure 4.7). The sources of assessment for the ILG were equally split between local authority OTs (45% of cases) and Care and Repair staff (41%) with health service OTs accounting for 12%.

Figure 4.7 Source of assessment for ILG

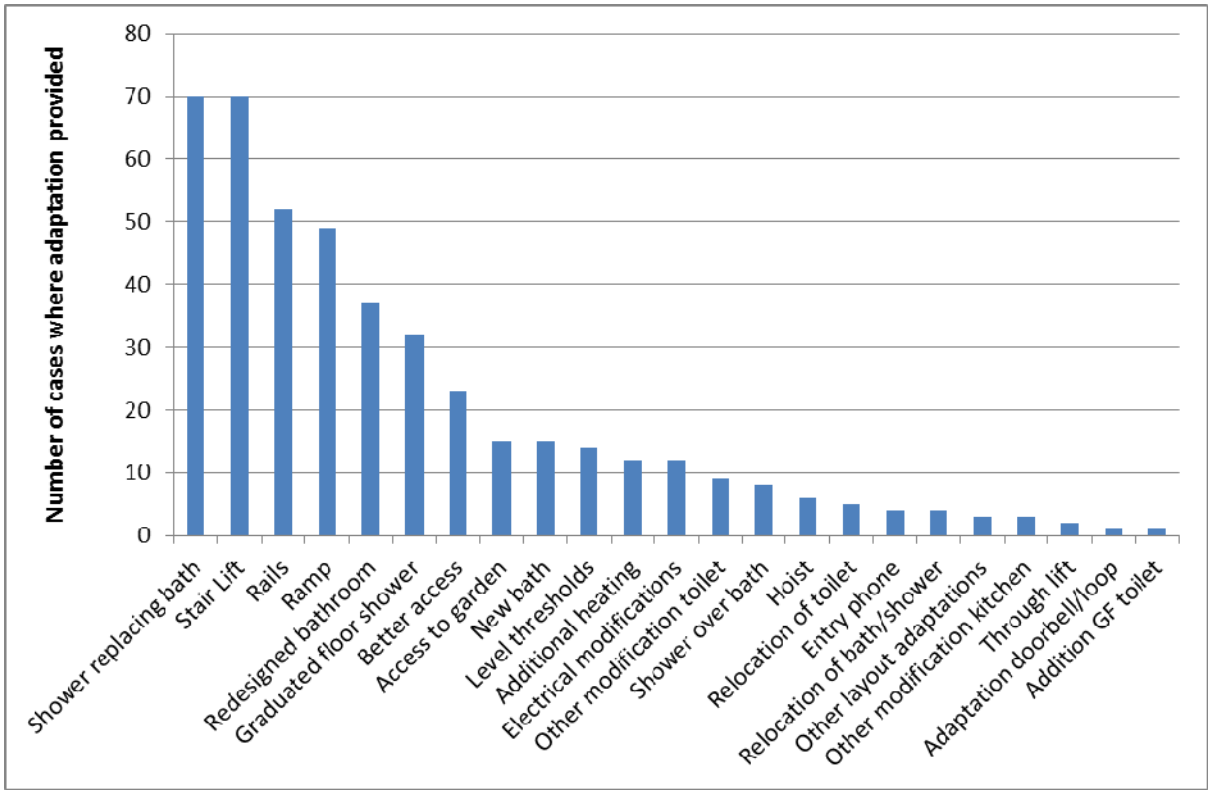


4.13 In the majority of cases (53%) there was OT involvement in the assessment of client needs both *prior to* ILG (for example when clients first came to the attention of the local authority or hospital/GP) and at the stage when the client was referred for ILG. In 24% of cases there was an OT assessment prior to referral for ILG but not again at the stage of referral to Care and Repair. In a few cases (3.6%) an OT was involved at the ILG stage when there had been no OT involvement previously. In the remaining cases (19%) there had been no OT involvement at any stage. Appendix Table A11 shows this in detail.

Adaptations

4.14 Figure43.8 shows details of the adaptations provided via ILG or other sources. A small number of other forms of assistance were reported in addition to those in the table – mainly the provision of access to various forms of advice/information. Showers to replace baths and stair lifts were the most commonly provided adaptations through ILG (25% of cases each), followed by rails, ramps, the redesign of bathrooms, and graduated floor showers.

Figure 4.8 Adaptations provided through ILG



4.15 Adaptations funded through other sources but provided at the same time as those funded through ILG were also recorded (see Appendix Table A12). These were not common as most ILG cases did not involve additional

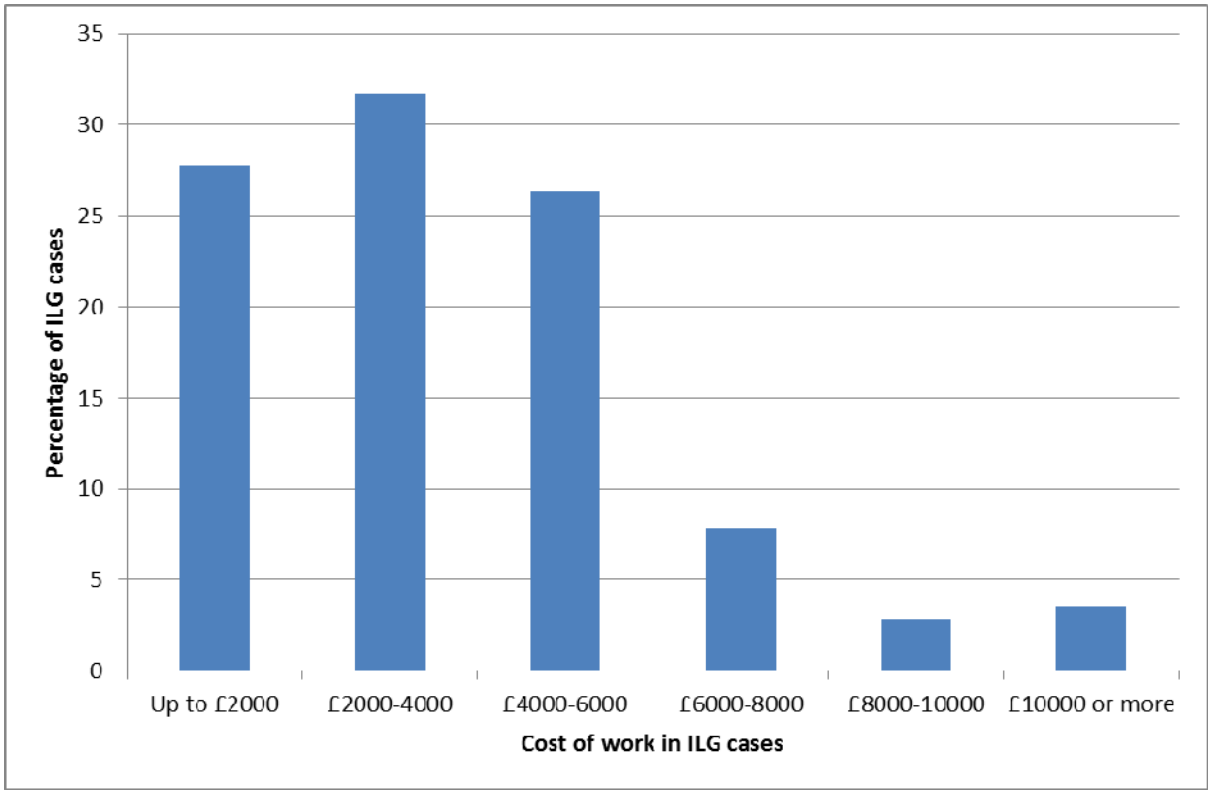
funding. Rails were the only other significant adaption funded from other sources.

4.16 Appendix Table A12 also sets out those adaptations which projects reported to be *required* by clients. In some cases the percentages required exceed provision, implying unmet need, but in others they are less, implying the provision of adaptations which were not required. In some cases, a wide range of adaptations are specified as needed, and in others very few are referred to. This suggests that it would be unsafe to draw detailed conclusions from this data by comparing need and provision on an adaptation by adaptation basis. Broadly, the pattern of need for adaptations is similar to that for adaptations provided, in that the same types of adaptation feature strongly in terms of needs and provision. The main unmet needs would seem to be electrical modifications and access to gardens.

Costings

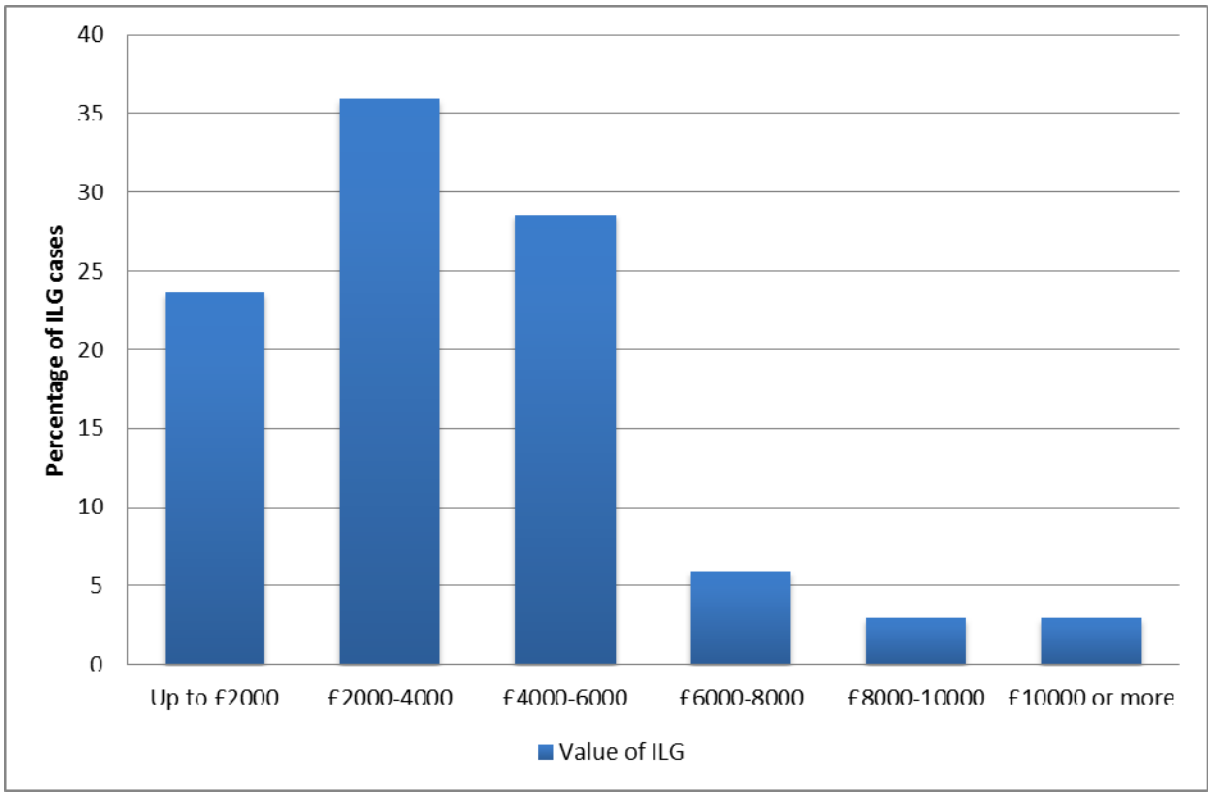
4.17 Figure 4.9 shows the cost of works carried out. About one third of jobs fell in the £2,000-£4,000 band, with the remainder mostly costing under £2,000 (28%) or £4,000-£6,000 (26%). Only 14% cost over £6,000. The average cost of work was £4,148.

Figure 4.9 Total cost of work in ILG cases



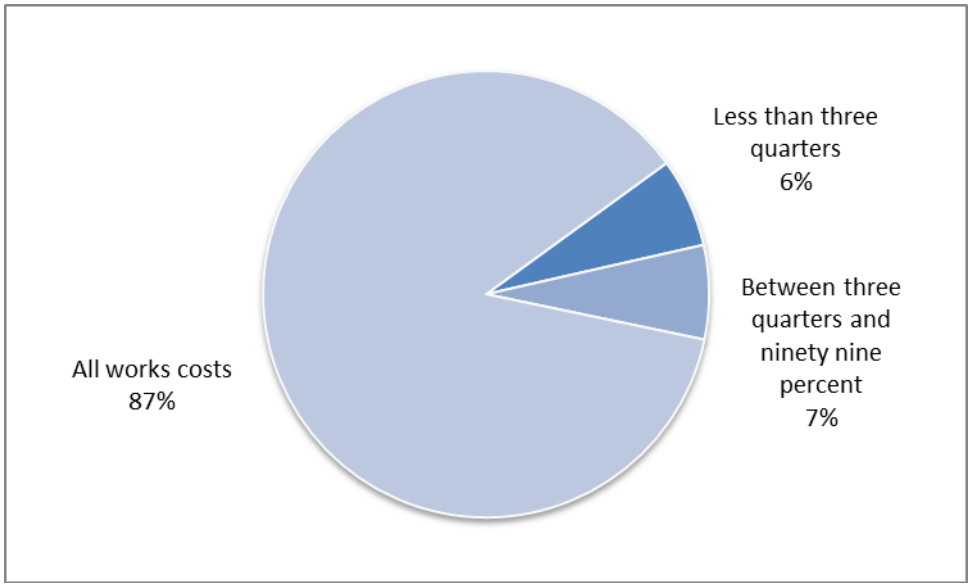
4.18 Figure 4.10 shows the costs met through ILG, which follow a broadly similar pattern to that for total works cost, with 36% of ILGs in the £2,000-£4,000 band, 24% costing under £2,000 and 29% costing £4,000-£6,000. The average ILG value was £3,499.

Figure 4.10 Amount of ILG



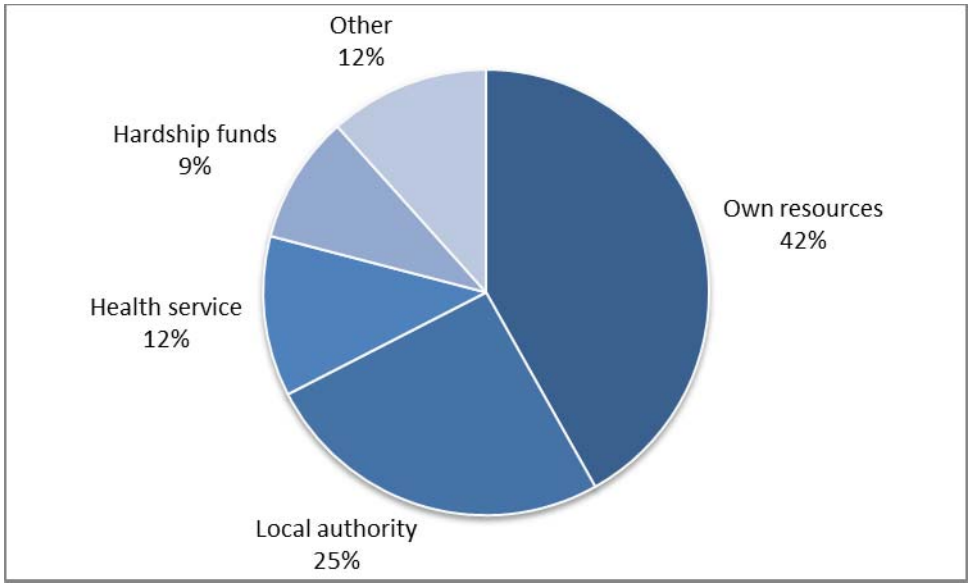
4.19 The difference between the average cost of work and the average ILG is about £650 but this is misleading. In 87% of cases ILG covered 100% of works costs (Figure 4.11). The large difference between the average costs of work and average ILG is accounted for by a small number of cases where ILG formed part of a larger job.

Figure 4.11 ILG as a percentage of total works cost



4.20 Amongst the 37 cases (23% of all cases) where works were partly funded from sources other than ILG, the main sources of additional funds were the client's own resources (42% of the cases involving other funding) or the local authority (26% of these cases). Table 4.12 shows the amount of additional funding on top of ILG. This was mostly under £2,000 (60% of cases) but in a small number of cases was much greater.

Figure 4.12 Sources of additional funding



Note:additional funding was used to meet part of the costs of work in only 23% of cases

Fee charges

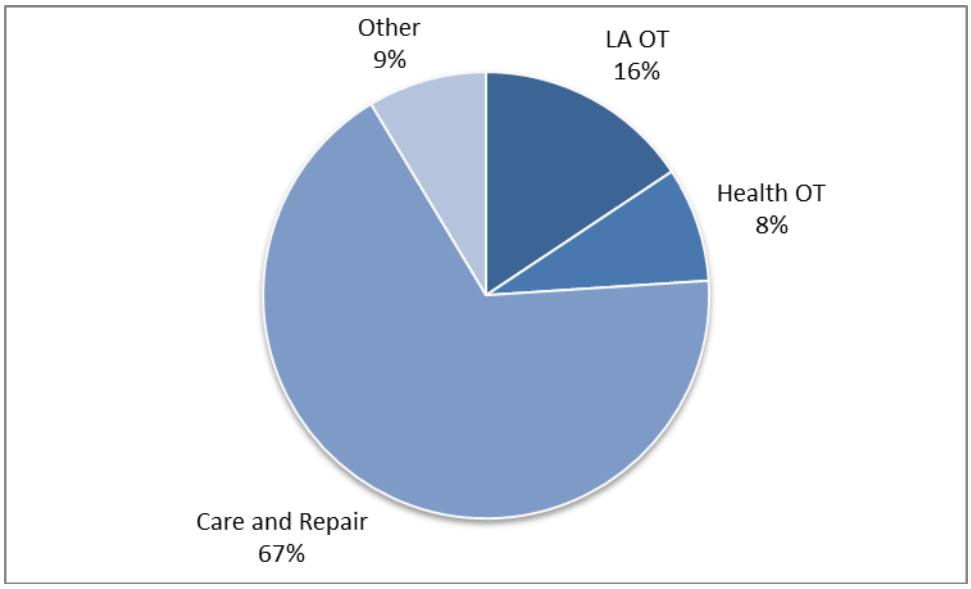
4.21 The costs of any fees charged by Care and Repair agencies and other professionals were eligible for ILG and where applicable are included in the total costs of work and ILG funded costs shown above. Information provided by Care and Repair Cymru indicates that professional fees for ILGs amounted to £123,814 within total expenditure to 31st March 2012 of £1,530,092. Fees thus represented 8.1% of total costs. No individual agency reported fees in excess of the 10% maximum which was agreed at the outset of the initiative.

Benefits of ILG

4.22 On average, Care and Repair agencies identified seven benefits for each completed case, so there was a clear feeling amongst project staff that ILG was an effective tool for securing real benefits for clients. The most frequently cited benefits were the reduction of the risk of injury from falling, and improved safety/well-being (both cited in 95% of cases). These were followed by the reduction of the risk of admission to hospital (87%). The reduction of injury and the risk of hospital admission, and the improvement of safety are clearly major benefits to clients. Reduced waiting time for adaptations was mentioned in 74% of cases, followed by a reduction in the risk of need for home-based social care (49%) or nursing care (45%), or a move to residential care (37%). Improved access to and from the home was cited in 37% of cases. In 12% of cases, earlier discharge from hospital was reported – although the proportion securing this benefit is lower than others, it represents a real gain both for clients and for public sector resources. The adaptations which these cases were more likely than others to include were a ramp, a hoist, and especially, a stairlift.

4.23 The main sources of this assessment of benefits to clients were Care and Repair agencies (Figure 4.13). Local authority OTs assessed the benefits in 17% of cases, health professionals in 9% and other sources in 10% of cases. The ‘other’ sources specified were doctors, the client or the client’s family. There were few differences between the assessments of benefits made by OTs (both local authority and health service based) and those made by Care and Repair agencies. Health service OTs were slightly more likely to stress early hospital release as a benefit, and OTs in general were more likely to cite benefits than Care and Repair staff. Appendix Table A19 shows this in detail.

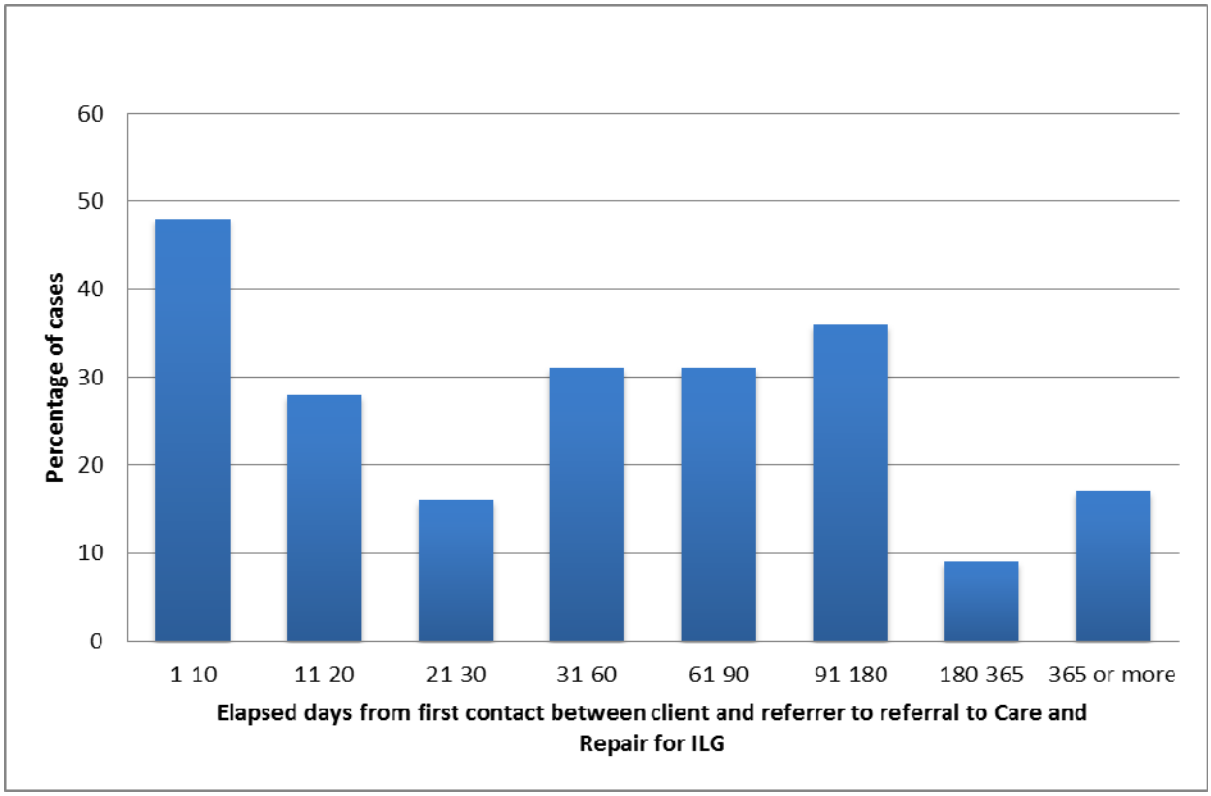
Figure 4.13 Source of assessment of benefits of ILG



Timescale

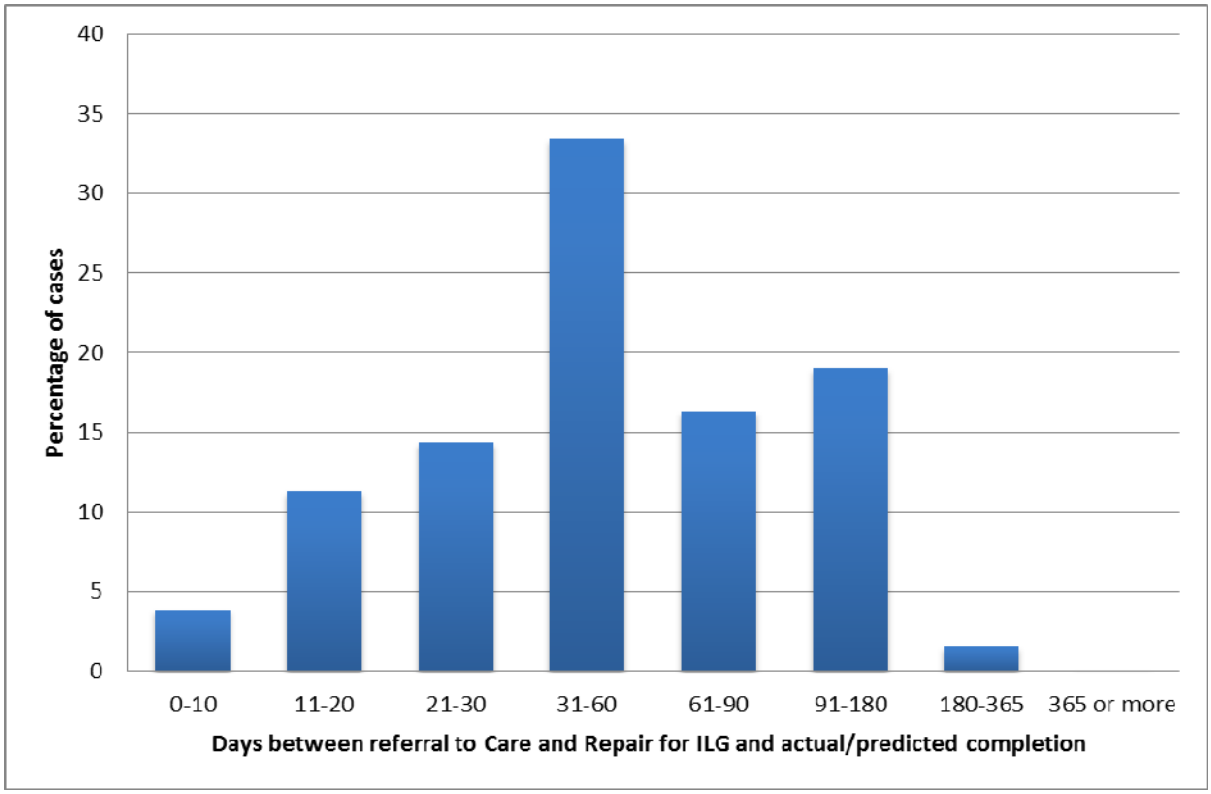
4.24 Figure 4.14 shows the elapsed time from first contact between client and referrer, and referral to Care and Repair for ILG. This was an area where agencies sometimes found it difficult to provide data and there were only 216 valid responses (77%). Some 22% of cases reported ten days or less between first contact with referrer and referral for ILG. This could include cases where clients were referred on instantly because their need was seen as very urgent. The remaining cases were widely spread, but 26% of clients had been waiting for 91 days or more before referral.

Figure 4.14 Elapsed time in days from first contact between client and referrer, and referral to Care and Repair for ILG



4.25 Figure 4.15 shows the elapsed time from referral for ILG to completion of work. There were 257 valid responses (91%). Some 30% of cases were completed within one month and a further third within one to two months of referral, with 16% within two to three months. Only 20% of cases took over 90 days to complete.

Figure 4.15 Elapsed time in days between referral to Care and Repair for ILG and actual/predicted date of completion



In a small number of cases where work was not completed by the deadline for making returns, this calculation is based on the predicted date of completion.

Client Satisfaction

4.26 Response levels for the questions on client satisfaction were lower than for other questions because agencies were required to submit data on some ILG cases before this information could be obtained. It should be borne in mind that information on client satisfaction was collected by Care and Repair staff, as it was impractical to obtain this independently from all clients within the timescale and with the resources available to this study. However the detailed case studies provide independent data on satisfaction with a smaller sample of jobs.

4.27 Reported levels of client satisfaction were very high. Some 99.6% of clients were either very satisfied or satisfied with the overall effectiveness of their adaptation work under ILG and none were dissatisfied. A slightly smaller proportion were very satisfied with the speed at which their adaptation work was carried out (2% were neither satisfied nor dissatisfied), but there was no association between actual length of time taken and the degree of satisfaction, probably because client expectations and the urgency of needs vary. There was a similarly high level of satisfaction with the service provided by Care and Repair. Appendix Tables A22-24 show full details.

4.28 Only 1.2% of clients felt that the work carried out had not been effective in preventing falls and only 0.4% felt that the work had not been effective in improving their ability to live independently (Appendix Tables A25-26).

Conclusions

4.29 Detailed data on ILG was successfully obtained from a large sample of cases processed under this initiative during 2011-12 and from the majority of Care and Repair Agencies. Agencies cooperated fully in providing good quality accurate data on a wide range of issues relating to the ILG.

4.30 The analysis found that the grants provided were for an average of £3,500, although around a quarter were for less than £2,000 and 12% were for £6,000 or more. ILG covered the full cost of work in 87% of cases, and three quarters or more of the cost in 98% of cases, but a small number of grants were provided in combination with client/family contributions, hardship fund payments and other sources.

4.31 Stair lifts and showers to replace a bath were the main types of work carried out, each in 25% of cases. Ramps, rails, access improvements, and floor showers were the other main adaptations provided. The main reason for using ILG as distinct from DFG funding was because of the urgency of work (four out of five cases), but a minority of cases arose because of DFG means test problems. Two thirds of referrals came from local authority DFG waiting lists but a fifth were referred by health service staff.

4.32 Clients were almost exclusively aged over 65 and two thirds were over 75. All were living in private housing, mostly as outright owners. Professionals (OTs and Care and Repair staff) saw the reduction of the risk of injury and hospital admission, and the improvement of safety as major benefits from ILG, together with reduced waiting times for relatively minor adaptations which could be achieved within a limited costs threshold. Clients were extremely satisfied with both the service received and the adaptations provided.

4.33 Overall the analysis of case records shows a very positive outcome from the ILG initiative, although there is a limit to the extent to which more detailed issues relating to the working of the scheme can be explored through this source. A more detailed picture is provided through the in depth case studies.

5 Findings from the case study visits

5.1 Case study visits were made to six agencies/local authority areas:

- Newport
- Swansea/Neath Port Talbot
- Carmarthen
- Powys
- Flintshire
- Anglesey

The introduction of the ILG

5.2 Whilst the majority of those interviewed within local authority housing functions responded positively to the introduction of the ILG there were some expressions of dissatisfaction that the initiative was being delivered through Care & Repair. In one case the concerns were around capacity; the Agency's current role was in the delivery of minor works and handyperson services and they were not geared up for the delivery of more substantial adaptations.

5.3 There was, however, evidence of a more deep-seated concern that this route had been taken, rather than feeding these funds through the local authority. Whilst some would have welcomed more guidance about the setting of criteria most welcomed the flexibility and scope for local discretion that ILG provided.

> "Isn't ILG just a DFG without a Test of Resources? If so shouldn't this be local authority money? Overall I have mixed feelings, I'm very sceptical. OTs and local authority technical staff were taken off normal caseload so others had to wait longer. Priority cases such as hospital discharge and those at risk of going into care get put to the top of the pile anyway. We could have got the same result with DFG"
>
> Service Manager Housing Renewal and Adaptations

> "I would have liked to have seen better guidance: each area put in its own proposals and there was no commonality. Although each area is different they should probably have had a common approach."
>
> "ILG is more flexible, having no Test of Resources. We could do the same with DFG but the issue is how you strike a balance, we could just end up increasing the waiting list. The Test of Resources doesn't actually take that much time as we run it alongside other work so taking it out wouldn't speed cases up significantly. Waiting for OT assessment is the biggest element in time it takes to deliver a grant."
>
> Housing and Community Regeneration Manager & Chair of local Care & Repair Agency

5.4 The extent to which discretion and flexibility were used in framing local plans for the delivery of ILG varied considerably. Some authorities focused on taking cases from the DFG waiting list, working in date order, whilst others focused on those who would not meet DFG eligibility criteria, would be faced with substantial contributions or otherwise might be poorly served by the mainstream process. A number had planned to expedite hospital discharge or the avoidance of admission, and a number prioritised fall prevention. In the majority of cases the ability to by-pass the Test of Resources and to achieve a quicker process were influential in framing intentions for the use of ILG. These intentions contrast to some extent with the outcomes shown in Table A7 where urgency was the determining criterion mentioned in 78% of cases recorded and avoidance of the Test of Resources was mentioned in just under 14% of cases.

> "I was surprised to hear about ILG, we are so used to cut-backs. This was welcome especially as it was not means tested. We are used to such strict criteria and this allowed some creative thinking: you can't be very creative with DFG or you end up breaking the law!"
>
> OT Team Manager

> "DFG is restricted to those who score highly under Fair Access to Care Services criteria and this excludes many where an adaptation would contribute to a preventative package or measures to delay or avoid higher dependency."
>
> Care & Repair Case Worker

5.5 The majority of those interviewed felt that they had learnt of the ILG initiative in a timely way and had been able to participate appropriately in the planning and priority setting process. The only exceptions were some Care & Repair "frontline" staff who felt that the decisions had been made "above their heads" and without the benefit of the insights about deliverability that they might have contributed. In some Care and Repair agencies a senior manager had been involved in negotiation with the statutory partners and the local plan and priorities for use of ILG had been handed down for implementation. Where original intentions proved difficult to deliver, for example in securing early referrals from health based OTs, the frontline staff felt their input would have avoided unrealistic expectations being incorporated into delivery plans.

5.6 All stakeholders spoke of the ways in which existing collaborative structures and relationships had provided a strong foundation for co-operation in this initiative. Unsurprisingly Care & Repair staff were pleased to have been entrusted with leadership in the delivery of ILG and saw it as an opportunity to extend the benefit they could bring to clients.

5.7 Although the existence of the grant had been swiftly communicated to key professional stakeholders, including OTs working in health settings, and there were high levels of collaboration in establishing criteria for selecting cases in each area there were signs that the short time scale worked against those criteria being strongly embedded. In some cases intended priority cases were

slow in coming forward and this was seen to be a consequence of these factors.

The delivery of ILG

5.8 Although the actual service responses were common among the case study sites: stairlifts, level access showers, modular ramps being typical, the strategic intentions varied. Some aimed to remove straight-forward cases from the wait for DFG, for example those whose DFG application was delayed and frustrated by difficulties in proving title. Others provided "enabling" works for those whose total package through DFG would take some time, providing a stairlift, for example, to give access to bedroom and toilet whilst awaiting the provision through DFG of a full wet floor shower room.

> "It has allowed us to offer a realistic service to those who are receiving palliative care. Because we can deliver an ILG in a few weeks, or even a few days, this can make a real contribution to supporting carers and improving the quality of life for people whose prognosis may be short. Taking a year to deliver a DFG for someone whose prognosis is that they have three to six months to live is no help at all, and if we go ahead with it can be a waste of money. The ILG is focused on delivering the adaptation."
>
> OT Team Manager
>
> "Allowed us to experiment with solutions not normally included within DFG by this local authority: modular ramps and shower pods for example which allow quick response to palliative care cases and can also be re-cycled."
>
> Care & Repair Manager

5.9 Achieving an urgent response was the most evident feature and this was demonstrated in palliative care cases, where life expectancy was a few months. Because, in many cases, it would not have been possible to deliver a DFG within the timescale dictated by the prognosis many of these individuals would not have received a substantial adaptation at all.

5.10 Some used ILG to pilot new approaches: modular ramps and, in one case, "shower pods" being examples where an adaptation could be provided quickly. Because these were provided under a limited-term pilot programme there was no sense that these were setting precedents but offered opportunities for a limited term trial. Some provided interventions where what was provided might come back to be re-cycled: modular ramps, some straight-rail stairlifts and the shower pods. This was seen as adding value to the ILG initiative by adding to stock for future development of the service.

5.11 All interventions had been shaped by the opportunity ILG gave for an expedited intervention. The exception was in those sites where there were some inhibitions in the interface with Health based OTs, either in securing their participation or in persuading Local Authority OTs to accept referrals from Health based OTs without re-assessment.

The outcomes achieved through ILG

5.12 The majority of stakeholders interviewed, whether Care & Repair staff or local authority officers saw the primary benefit of the ILG to have been in the absence of a Test of Resources and the form filling and processing that goes with a DFG.

5.13 In a few cases quicker delivery had been secured by not requiring a formal assessment by a Local Authority Occupational Therapist. Others told us that this would have been their aspiration but that OTs employed by the local authority had insisted that they must assess every case. Those OTs we spoke to were unhappy with any other procedure, feeling that each case should receive an assessment by an OT or an OT Aide.

5.14 This was one of the fault lines that divided the case study agencies: those that had required such an assessment and the minority that had used other means, such as employing private OTs, taking referrals directly from Health Service OTs, or relying upon assessment by Care & Repair staff. The evidence that these alternative methods provided faster outcomes is anecdotal and the small numbers involved and variety of arrangements adopted make any further analysis impracticable. Clearly the greatest benefit in using an alternative route to assessment would arise where assessment would otherwise go through the usual local authority OT section where the wait for assessment had not been accelerated for ILG cases.

5.15 The range of adaptations delivered was, in almost every case, broadly what they had expected with most being adaptations "of the middle range": ramps, stairlifts and Level Access Showers. Whilst there were examples of other adaptations being delivered these were the core of the adaptations delivered through ILG and almost all felt that this was appropriate and in line with their expectations. Almost all who were interviewed felt that ILGs had delivered appropriate outcomes to disabled people.

Negative outcomes and concerns

5.16 There were isolated cases in which housing officers of the local authority felt that the ILG had delivered nothing of note that the same money applied through the DFG process would have achieved. Most however had no negative comments. There were also some concerns about the way in which the grant had been administered with OTs being asked to "sign off" grants where they had not carried out an assessment.

> "Were pleased to see fast track and additional money but concerned that we were asked to sign-off work where we hadn't been involved in assessment. However, I am satisfied that work has been done quickly and done well, delivering appropriate assistance to people who needed it."
>
> Local Authority Occupational Therapist

However the concerns were not all on one side

> "I feel frustrated that all cases, including those that came from hospital OTs have had to go through assessment by local authority OTs. Although they have fast tracked these cases it has still added two or three weeks to most cases."
>
> Care and Repair Manager

5.17 The most substantial concern was that around equity of outcome: some people had benefitted from selection for ILG when the majority waiting for a DFG had not, some who were not DFG eligible or not compliant with its conditions on financial contribution had benefitted which some did not see as fair.

5.18 Others were concerned that when the money was exhausted those who presented in the following week with the same circumstances would have to wait and contribute through the DFG system whereas, a week earlier they might have benefitted from an ILG.

The future of ILG

5.19 Most enthusiastically endorsed the notion that the exercise might be repeated, but with caveats around more time to prepare and the provision of stronger guidance about purpose and process. One or two voices suggested that a repetition would only be acceptable if delivered through the local authority and preferably within the DFG framework.

> "Came at a time when we were looking to review DFG processes to improve 'end to end' time so very welcome. We had some cases where Test of Resources indicated a level of contribution that was unrealistic in the circumstances of the individual. Others were tied up in issues around title that in rural communities can be very complex. ILG allowed us to cut through some knotty situations."
>
> Private Sector Renewal Manager

5.20 The majority view amongst local authority housing officers was that ILG had worked well, that the exercise of local discretion and joint decision making had strengthened local co-operation and secured timely assistance for people who needed a service urgently.

5.21 One or two local authority housing officers and some Care & Repair staff felt that freedom from the requirement for a local OT assessment in every case, as had been practiced in other areas that they knew of, would have further accelerated outcomes for them.

The experience of the grant recipients

5.22 In each of the case study areas two visits were made to grant recipients in their own homes to discuss the work that had been carried out through the ILG, the difference the work had made and their assessment of the process. In most cases the principal carers were also present.

5.23 The benefits in functional capacity, access to facilities and independence were in line with those that one would expect from similar adaptations delivered through a DFG. Level Access Showers allowed the disabled person to manage their own personal hygiene or made the provision of assistance by an informal carer much easier and relieved their anxiety about the risks associated with the solutions they had previously employed.

> Mr B had recently had a stroke and when he was first discharged from hospital he was confined to bed but is now able to use a wheel chair. To facilitate his discharge and support his on-going independence adaptations were provided under ILG to give accessible facilities on the ground floor of his home: a downstairs bathroom has been re-configured with a level access shower and the re-siting of the WC, his bed has been brought downstairs for him and a door entry system has been fitted.
>
> Mr B can stand and manage transfers himself without assistance. With the benefit of the adaptations he is able to manage his own personal care and also does a little cooking.
>
> Referral to Care & Repair came from the hospital OT and adaptation was delivered in less than a month.

5.24 The provision of ramps allowed the disabled person, especially if a wheel-chair user to get in and out of their home more easily, reduced the incidence of risky transfers at the entrance and eased the physical demands made on carers.

> Mrs W is a wheelchair user who is living with a degenerative condition. Mr & Mrs W have undertaken a good deal of work themselves: a stairlift and a level access shower. They are being assisted by Care & Repair but are paying for this work themselves.
>
> Access to the house is difficult with insufficient space for a conventional, concrete ramp. Whenever Mrs W left the house, to attend hospital appointments or for social purposes, her husband and his brother-in-law needed to carry Mrs W in her wheel chair over the threshold and down some steps. This arrangement relies on the availability of the brother-in-law and also poses a risk to Mr W who is waiting for a hip operation.
>
> A modular ramp was installed in four hours, rather than the week that a conventional ramp would have taken had its installation been feasible. The local authority would not have provided a modular ramp under a DFG on grounds of cost (about 25% above that for a concrete ramp.

Mr W is greatly relieved; having been concerned that he might fall when carrying his wife in her wheelchair with risk of injury to them both and the consequent risk that he would not be able to provide her with the care that makes it possible for her to remain at home. The quality of their life is improved in that they can come and go without anxiety and without being dependent on the availability of others. Close family members who also provide elements of care echo Mr & Mrs W's satisfaction:

"The ramp has been so much help, they can now go out on their own without depending on anyone else. If it's a nice day they can just decide: 'let's go out!'"

Mr & Mrs W told us: *"We were over the moon when we saw the ramp. It's made us very happy, it is a Godsend. Another good thing is that when we no longer need it the ramp can be used again somewhere else."*

5.25 The provision of stairlifts offered the opportunity of accessing upstairs bedrooms, bathroom and toilet, contributing to greater privacy and an enhanced sense of normal life.

Mrs J had been discharged from hospital to a Registered Care Home but could not return to her own home because she could not use the stairs to access the bathroom and toilet, nor her own bedroom. She was referred to Care and Repair by the hospital OT and a stairlift was fitted in under a week to allow her to go home where her husband and family provide informal care for her.

Mr & Mrs J, and other members of the family are delighted that she was able to return home so quickly. The hospital OT considered that a safe discharge to home was not possible without the stairlift as the risk of Mrs J falling, and the risk to Mr J as her principal carer, was too great.

5.26 In about half the cases we visited the adaptation under ILG arrangements had been associated with a hospital discharge. In one case a previous hospital discharge without appropriate bathing facilities in place had contributed to a fall and a return to hospital.

5.27 The remainder were people who had attempted to secure an adaptation through the DFG route and represented a range of experience. Some had been assessed as requiring an adaptation, but were put off by the process. Others, when made aware of their likely level of contribution under the Test of Resources, had not entered the DFG system. Some had experienced considerable delay, either because of long waiting times for assessment of grant processing, or because their cases presented complications arising from their condition, the circumstances of their property or difficulties in providing title to the property. Among these there were people who had experienced new incidents of risk whilst waiting.

Mrs E was referred for DFG two years ago after a fall. She has arthritis in her feet which makes getting in and out of the bath very difficult. She had to lean on the hand basin and use her walking stick. She would take her mobile phone with her in case she became stuck and sometimes she had to have a relative present in the house in case she needed help.

When she told her son that she was required to produce the deeds to her house he advised caution and the application did not proceed: "*filling in forms puts you off when you are older – it's a worry."*

Care and Repair called to offer an ILG. Mrs E had her bath replaced with a level access shower, a new toilet, a wash basin and the door to the bathroom re-hung to open outwards. Mrs E reports that she feels more confident in maintaining her independence.

"It's brought my confidence back, I feel more confident about the future. Using the bathroom is a personal thing. I want to be able to go there when I want to. I'm thrilled with it, so proud of it; they (C&R) have been marvellous."

5.28 Grant recipients were generally a little vague about the professions and organisations with whom they had contact in securing the adaptation but all expressed appreciation for the work of Care and Repair and for the contractors. All reported that they felt safer and more confident in living at home since the work was carried out. A number identified risks that had been mitigated, particularly in relation to falls. Most reported an improvement in their general sense of well-being and the quality of their life.

5.29 Perhaps the most striking impact with many of the adaptations was the contribution they had made to the sense of dignity of the recipient: the man who wept in telling us how he was now able to use the toilet upstairs, through the provision of a stairlift, and did not need to use a commode in the dining room and have his daughter empty it for him.

Mr A was discharged from hospital with a history of repeated falls. He has acute respiratory problems and needs to be connected to oxygen at all times. Members of the family would be in attendance morning and evening to supervise him negotiating the stairs. It would generally take between 15 and 30 minutes to negotiate the stairs with stops to regain his breath and with an attendant risk of over-balancing.

During the day it was necessary for him to use a commode sited in the dining room for toileting. The lack of privacy, and the need for a member of the family to take the contents of the commode upstairs to dispose of them, caused him great distress.

Mr A's application for a DFG was, and remains, in process to provide a stairlift and a level access shower on the first floor but delivery of these adaptations is still many months away. Mr A was referred to Care and Repair by the Royal British Legion for an ILG to mitigate the risks to which he was exposed and to improve his quality of life by the installation of the stairlift, providing access to the toilet upstairs. Assessment was carried out by a private OT and the stairlift fitted within a few days.

Mr A reports that he feels more confident about his ability to continue living at home and is pleased that he is able to manage with a reduced level of support from members of his family. His family members report that although they were glad to assist him they were not sure how long the level of support provided could have been maintained or if they would have been able to cope as his requirements for support had increased.

Mr A told us*: "It's made my life happier, easier, and given me more independence; I don't feel anxious and miserable as I did before."*

5.30 Carers too reported positive outcomes in that their ability to provide personal care had been enhanced, and risks to their own health, for example in relation to lifting or a danger of falling, had been reduced. The disabled person's need for care interventions had reduced in most cases: the daughter did not need to come morning and evening to supervise Father's negotiation of the stairs as he could safely use the stairlift, the son-in-law did not need to come and assist with bathing as the level access shower had made it possible for the disabled person to manage their own personal hygiene. We met carers who gave emotional testimony to the desperation they had been experiencing until the adaptation was delivered and their anxiety that they would not have been able to sustain the current situation for much longer.

5.31 As we have observed above, these are benefits that might be attributed to an appropriate adaptation whatever the system under which it was procured and funded. The difference here is in the speed with which the adaptations were delivered. For some of those we visited the adaptation was provided within a few days, allowing a return from hospital or temporary care home placement to a safe environment in which the disabled person and their carers were supported by the provision of the adaptation. For others partial benefit, addressing the most immediate needs and risks, was secured until such time as a full scheme could be implemented.

5.32 All those we visited, disabled people and their carers, expressed appreciation for the speedy way in which the adaptation they needed, and in some cases had been waiting, was delivered through the ILG.

Conclusions from the case study visits

5.33 Most local authority and Care and Repair Agency stakeholders had felt pressured by the short time available to agree criteria for ILG, to consult with colleagues, to plan for its delivery and be ready when the funding became available.

5.34 The majority welcomed the initiative, felt that it had provided appropriate adaptations and that those receiving them had been the "right" people.

5.35 With only one or two exceptions the local authority officers interviewed welcomed the absence of the DFG application form and the Test of Resources,

with the administrative tasks in verifying and processing that go with them. They welcomed too the improved speed of delivery and the flexibility of the ILG. There were some concerns, even among those who approved the simpler ILG processes, about inequity created by parallel systems, especially when one was only available for a short while.

5.36 Two Care and Repair agencies had used their own staff to carry out some assessments and also used private OTs to carry out assessments; another routinely uses an OT working within the agency. One other had wished to use their own staff for some assessments but found statutory partners would not agree this arrangement.

5.37 Some agencies had used the grant to pioneer new approaches or to work in innovative ways, others focused on clearing backlogs or on diverting applicants so that they did not join an existing queue.

5.38 Grant recipients were positive about the service they had received and especially appreciated the speed of response in providing their adaptation.

6 Comparison with DFG outcomes for the case study authorities

6.1 To provide some measure of comparison between the mainstream delivery of DFGs and the performance of Care & Repair agencies in delivering ILG we looked for core data on DFG delivery in the six authorities.

6.2 We were concerned not to place additional burdens on the officers of these authorities and so made a preliminary enquiry about the range of data they might have which could be made available to us by drawing on existing reporting frameworks.

6.3 It was apparent that there was no single format and in some authorities elements of the data were held by different officers, rather than in a consolidated form accessible to all. Some authorities do collect and report upon very comprehensive data in relation to DFG administration, others focus on a core data set. From our preliminary work we established a set of information that most of our case study authorities would be able to supply and this is summarised in Table 6.1.

6.4 It is clear that the number of initial referrals, the number of cases passed to Housing for DFG, and the level of spend in local authorities varies enormously. Given the ranges of population size among our sample authorities it is unsurprising that there should be such diversity.

6.5 With the exception of very large adaptations, normally involving extensions to homes or similar major building works, the range of adaptations delivered by DFGs is very similar to that delivered through ILG: stairlifts, level access showers and ramps. Most ILGs have delivered one or two elements whereas DFGs may be providing more elements within a package of adaptation. This, together with the presence in the DFG figures of larger adaptations such as extensions, lies behind the disparity in average costs for the two types of grant shown in Table 6.1

6.6 In all but one of these authorities assessment in relation to provision of a DFG is carried out by Occupational Therapists working within the Authority, generally from a social services base. In Carmarthenshire the Occupational Therapists providing assessment are located within the housing team.

6.7 Among the six case study authorities the time taken from referral to completion of an adaptation under the DFG process ranges from 315 days to 632 days, with a typical average period of 340 days. The time from referral to completion of an ILG ranges from 32 to 78 days with an average of around 58 days.

6.8 The average time for each DFG to be handled by OT services ranges from 32 days to 295 days. The range of variation reflects pressures upon local services and the availability of Occupational Therapists to carry out assessments.

6.9 The time with Housing ranges from 44 days to 337 days and this generally reflects delays and complexities in the process, for example in securing proof of

title or evidence of resources. These are also major factors reported by local authorities as reasons for applications not to proceed.

6.10 As the majority of our case study authorities used assessment from local authority OTs for ILG, exactly as they would have done for a DFG, the dramatic decrease in time from referral to delivery cannot be explained in most cases by a different process in relation to assessment.

6.11 The absence of a Test of Resources and of other requirements to prove eligibility, such as the need to prove title, will have made a substantial difference when compared with the time that Housing would generally need to process a DFG.

6.12 The absence of a Test of Resources or financial contribution will have reduced the likelihood of drop-outs and therefore of abortive work. The short timescale from referral to completion will have reduced the risk that the grant recipient would move, or die, in the period between referral and completion.

6.13 The priority given within local partnerships to delivering the ILG within the time constraints so that those extra resources should be secured within the Authority was undoubtedly a factor in the areas we visited. Even those local authority staff who were agnostic about some features of the initiative were keen to see that the money on offer was secured. There was also, among a number of OTs, an enthusiasm for using this grant to deliver adaptations to those who had difficulty in accessing the DFG system or whose needs were urgent.

6.14 The factors that have contributed to a greatly reduced timescale for the delivery of the ILG will vary from area to area but in all areas this is the most striking feature in the comparison between DFG and ILG. The slowest average ILG delivery in the case study authorities was 78 days and the fastest average DFG delivery reported among these six was 315 days.

Table 6.1 Indicators of comparison between DFGs (2011) and ILGs (2011/2012) in case study areas

	Anglesey	Carmarthenshire	Flintshire	Powys	Newport	Swansea
Number of DFG related referrals into Social Services	377	None, we have our own OTs within our team	Data not available	Data not available	265	882
Numbers making a preliminary DFG enquiry	120	Approx 900	Data not collected	Data not collected	283	1,467 including MAGs[43]
Number of OT recommendations received into Housing grant administration	120	282	429	180	192	378 Excludes MAGs
Number of drop outs and principal reasons	25 Test of Resources, contribution too high, deceased	No number recorded Test of Resources, contribution too high. OT will not support	57 Test of Resources, contribution too high,, moved, gone into care deceased	No number recorded Test of Resources, contribution too high, OT will not support, failed eligibility criteria, moved away	47 Test of Resources, contribution too high, deceased	179 Applicant request, Test of Resources, contribution too high, failed eligibility criteria Moved.
Who provides the assessment	Social Service OTs	OT within our team	LA OTs	Social Service OTs	LA OTs, Health OTs, Private OT	OTs
Number of completed cases	88	200+	307	159	120	525 excludes MAGs
Value of completed cases	£675,707	£1,650,000	£2,290,000	£715,215	£807,908	£4,928,753 excludes MAGs
Average value of completed cases	£7,678	£8,250	£7,459	£4,495	£6,732	£9,388
Main categories of work	LAS, SL, Ramps	LAS, SL, Ramps	LAS, SL, Ramps, extensions	Extensions, lifts, bathroom adaptations, ramps, SL	Extensions, external lifts, LAS, Ramps, SL	Bathroom adaptations, SL, Ramps
Average timescale for delivery of DFG	324 days	315 days	420 days	391 days	632 days	337 days
Average time with OT Services	32 days	85 days	209 days	125 days	295 days	132 days
Average time with Housing	44 days	50 days	205 days	150 days	337 days	205 days
Average ILG value	£2,515	£4,393	£2,912	£2,814	£3,978	£4,603
Average days to deliver ILG – referral to completion	32 days	65 days	30 days	75 days	78 days	72 days

[43] Minor Adaptations Grant (a discretionary grant provided in this Authority)

7 Conclusions and recommendations

Conclusions

7.1 The ILG was stated to have a fourfold purpose:

- help address local government 'waiting lists' for adaptations,
- to maximise independence,
- to help relieve pressures on hospital acute admissions,
- to help speed up hospital discharge.

7.2 In some agencies referrals for ILG were taken largely, or in some cases exclusively, from DFG waiting lists and it is clear from the Case Monitoring report that the initiative has been substantially successful in meeting that objective.

7.3 Both the case studies and the reported outcomes in the Case Monitoring data demonstrate that grant recipients have been able to maximise their independence through the work carried out on their behalf. The evidence available to the evaluation supports the conclusion that this objective has been met.

7.4 It is more difficult to be so categorical about the impact on acute admissions although the assessment of the outcome of adaptations, set out in the Case Monitoring report suggests that this is so. Although limited in number the case study visits to grant recipients also provided evidence of risks mitigated that might otherwise have led to acute hospital admission.

7.5 Although some grant recipients were referred for ILG whilst still in hospital and in the case study visits to grant recipients we met those whose return home from hospital had been facilitated by having the adaptation swiftly completed the evidence is less than completely convincing.

7.6 The suitability of housing arrangements are rarely a significant reason for delay in discharge from hospital, with access to personal care being a much more prominent reason. Difficulties with accessing upper floors of a property are generally addressed by the suggestion that a bed can be brought downstairs, inability to access the toilet compensated for by the provision of a commode and inaccessible bathing facilities by the suggestion of a "strip wash".

7.7 That more adequate provision, that respects the dignity, privacy and life-style choices of the individual ought to be a factor in unarguable but seems rarely to be the case under the pressure of making an early discharge.

7.8 What may be asserted with some confidence is that for those returning home from hospital the ILG has delivered adaptations in a timely way that have met those needs for access into and within the home, and allowed for needs in relation to transfer, bathing and toileting to be made in a way which is appropriate and sustainable.

7.9 A further aspiration for the initiative: that it should demonstrate ways in which the delays associated with the DFG process might be overcome was met in part. Some agencies were more radical than others in relation to assessment following referral; the majority relied substantially on assessment by a local authority OT as the portal through which all cases should pass, even extending this to cases where referral had been from a Health service or private OT.

7.10 The absence of a Test of Resources and of the other requirements documented in the DFG application form and processes were welcomed by most professionals and seen by them as a factor in achieving a faster outcome. While the current requirements for DFG remain unaltered the simpler system for ILG is seen, by some, as introducing an element of inequity into the provision of adaptations.

7.11 That the works completed delivered the non-financial benefits identified in the literature is clear: from the assessments summarised in the Case Monitoring Report and in the testimony of grant recipients and carers in the case study interviews.

7.12 As the literature review makes clear the debate around the calculation of precise financial benefits to the health and social care economy continues but it is clear that the benefits accruing from this initiative are entirely comparable with those that arise from all appropriate adaptations delivered in a timely way. The ability to remain living independently is enhanced and the transfer to residential care delayed with a consequent cost saving for the individual and the public purse. The mitigation of the risk of falling carries direct cash saving to health, although putting a figure on that requires some assumptions about the attribution of the contribution of the adaptation alongside other interventions.

7.13 The additional benefit achieved by adaptations delivered through ILG, rather than DFG, is that they arrive sooner, up to eighteen months sooner in one of our case study authorities.

7.14 The aspiration that the ILG should foster closer collaboration between the agencies and professions involved was delivered in part. In the case study areas all spoke of existing close co-operation which had been further enhanced by the experience of working to bring forward proposals and deliver the grant against a testing timescale. The area of difficulty appeared to be in engaging OTs within the health service. Whilst referrals had been achieved these were slow to come through and the engagement was not generally as strong as between the other partners.

7.15 There are clearly issues still to be addressed about the interface between health service and community based OTs in relation to referral, the validity of assessments and the integration of effort.

7.16 A further aspiration for the initiative was that ILG should be used to explore innovative ways of working and a number of agencies embraced that opportunity. Modular ramps and shower pods were among the innovations

trialled using ILG. At least one agency that is working on the recycling of adaptations, deliberately chose solutions that might be re-cycled for future use, extending the value achieved through the ILG initiative.

7.17 Some local partnerships included in the case studies were already reviewing their experience of delivering the ILG and looking to draw on that to modify their delivery of DFG.

7.18 Whilst the majority would favour the continuation of the ILG, alongside the DFG system as a means of addressing urgent and “irregular” cases others would be opposed to this, preferring that any additional resource should be directed through the local authority toward the existing DFG system.

7.19 There was an awareness among the agencies included in the case studies that there was now a wealth of experience across Wales arising from the different ways in which local partnerships had deployed ILG. Both agencies and local authority officers showed an appetite to have opportunities to share that experience.

7.20 Should resources be available in the future to renew the offer of ILG we would conclude that this should follow opportunities for the partners to reflect on experience across Wales, to receive some guidance on more focused arrangements and guidelines for the use of the grant, and with sufficient time for appropriate consultation and planning ahead of the release of funds.

Recommendations

7.21 Arising out of our evaluation of the pilot programme for the Independent Living Grant we offer the following recommendations:

1 That noting the success of the Independent Living Grant trial, Welsh Government should seek to identify resources, additional to those allocated for DFG, that would allow the ILG to be provided in future years, preferably by establishing a further pilot operation of the ILG over a minimum of three years.

2 That any extension of ILG should be delivered through local partnerships led by the Care & Repair agency and involving local authority housing and adult social care agencies (including the community based OT service) and health bodies (including health based OTs).

3 That the experience of agencies and their partners in operating ILG should be shared through the provision of regional workshops that will give particular prominence to applications of ILG that adopted innovative responses to the need for adaptation.

4 That Welsh Government commissions further dialogue between interested parties to review the benefits and risks arising from alternative arrangements for assessment for adaptations.

5 That Welsh Government should prepare guidance in advance of any continuation of the ILG that will respond to some of the concerns about purpose, priority and boundaries to practice identified in the evaluation.

6 That Welsh Government should consider commissioning further work to study the impact of adaptations on health and social care budgets through a longitudinal study.

Appendix A: ILG grant case return and detailed tables

Contents

ILG case return form

	See note		
Version date	1	Enter date (dd-mm-yy)	
Contact for queries: Name Email Telephone			
Care and Repair Agency Name			
Client ID	2	Enter number in box	
Service Request No.		Enter number in box	
Consent to participate in the case study	3	Tick box if consent obtained	
About the client			
Age	4	Under 60	
		60-64	
		65-74	
		75-84	
		85 or over	
		Not stated	
Ethnic Group	5	White	
		Mixed	
		Asian or Asian British	
		Black or Black British	
		Chinese or other	
		Not stated	
Gender	6	Male	
		Female	
		Other	
Housing type	7	Detached house/bungalow	
		Semi-detached house/bungalow	
		Terraced house/bungalow	
		Purpose-built flat/maisonette/apartment	
		Converted flat/maisonette/apartment	
		Flat/bungalow designated as sheltered dwelling	
		Caravan/mobile/temporary structure	

Tenure	8	Owning outright	
		Buying with mortgage/loan	
		Part owning/part renting	
		Private tenant	
		Tenant living rent free	
Case details	9		
Source		Local authority waiting list for DFG adaptations	
		Hospital referral	
		GP referral	
		Other – write in details	
Referring Agency	10	Write in details	
Reason for selection	11	Needs too urgent to wait	
		Problem with DFG means test	
		Problem establishing title	
		Other – write in details	
Residence at point of referral to C&R	12	In the dwelling to be adapted	
		In hospital	
		In residential care	
		In nursing care	
		With relatives/friend	
		Other – write in details	
Source of any assessment prior to referral	13	LA OT	
		Health OT	
		None	
		Other – write in details	

Source of assessment for ILG-funded adaptations	14	LA OT	
		Health OT	
		Care and Repair	
		None	
		Other – write in details	
What was the presenting condition or functional impairment prompting the need for adaptation?	15	Write in details	
Assessor Name Organisation Email Telephone	16		

Adaptations	17	Tick boxes below as applicable	
	Required	Provided, funded through ILG	Provided, funded through other sources
Ramp			
Rail(s)			
Alterations for better access eg doors/frames			
Electrical modifications			
Additional heating			
Entry phone			
Individual alarm system			
Hoist			
Stair Lift			
Through Lift			
Graduated floor shower			
Low level bath			
Shower over bath			
Shower replacing bath			
New bath/shower room			
Redesigned bathroom			
Redesigned kitchen			
Relocation of bath or shower			
Relocation of toilet			
Additional toilet on living floor			
Other modification of toilet			
Other modification of kitchen			
Extension to meet disabled person's needs			
Level thresholds			
Alarm system modification			
Adaptation to doorbell or telephone inc loop system			
Other changes to layout			
Access to garden			
Other – write in details			

Costs

Total cost of work including VAT	18	£
Amount of ILG including VAT	19	£

Other sources of funding	20	Source	Tick if used	Amt (£)
		Client's own resources including friends/family		
		Health Service		
		Local Authority		
		Care and Repair Hardship fund		
		Other charitable source		
		Other – write in details		

Predicted Outcomes

Benefits of adaptations funded through ILG	21	Earlier discharge from hospital	
		Reduction of risk of admission to hospital	
		Reduction of risk of move to nursing care	
		Reduction of risk of move to residential care	
		Reduction of risk of injury from falling	
		Reduction of risk of need for home-based social care	
		Reduction of risk of need for home-based informal care	
		Reduced waiting time for delivery of adaptation(s)	
		Improved safety/well-being	
		Improved access to and from home	
		Use of bathroom facilitated	
		Use of kitchen facilitated	
		Use of other rooms facilitated	
		Other cost savings	

Source of assessment of predicted benefits	22	LA OT	
		Health OT	
		Care and Repair	
		Other – write in details	

Assessor Name Organisation Email Telephone	23	
Timetable	24	
Date of first contact between client and referrer		Enter date (dd-mm-yy)
Date of referral to Care and Repair for ILG		Enter date (dd-mm-yy)
Actual/predicted date of completion of ILG-funded work		Enter date (dd-mm-yy)
Client satisfaction	25	
Overall effectiveness of adaptations in meeting needs		Very satisfied
		Satisfied
		Neither satisfied nor dissatisfied
		Dissatisfied
		Very dissatisfied
Speed of delivery of adaptation(s)		Very satisfied
		Satisfied
		Neither satisfied nor dissatisfied
		Dissatisfied
		Very dissatisfied
Service provided by the Care and Repair agency		Very satisfied
		Satisfied
		Neither satisfied nor dissatisfied
		Dissatisfied
		Very dissatisfied

In the client's view, did the ILG funded work...		
Prevent or reduce the likelihood of falling	Yes	
	No	
	Don't know/Not able to say	
Improve their ability to live independently	Yes	
	No	
	Don't know/Not able to say	

Notes

The notes below give guidance on the completion of this form.

1 Enter date when the latest entry on this form was made. Please ensure this is updated if the form is completed in stages.

2 These should match Care and Repair database numbers in each case.

3 We need to identify clients who might be willing to participate in one of six detailed case studies which will be carried out at a later stage. Participants will be contacted through Care and Repair and involvement will involve a short interview to discuss their views on the adaptation(s) and other help and support which they have received.

4 Tick only one category

5 Tick only one category

6 Tick only one category

7 Tick only one category.

8 Tick only one category

9 Tick only one category – tick main if more than one applies

10 Enter name of referring local authority/heath board/hospital/GP practice

11 Tick all that apply

12 Tick only one category.

13 Tick all that apply.

14 Tick only one category.

15 Write in details.

16 These details are required for the case studies.

17 Tick all that apply, add short description of any others in space provided. Give details separately of adaptations required (from pre-referral assessment), adaptations carried out through ILG, and any other adaptations carried out at same time as ILG-funded works.

18 Enter cost in £

19 Enter cost in £

20 Tick each source that applies and enter amounts.

21 Tick all that apply. This should be completed before commencement of works.

22 Tick only one category.

23 These details are required for the case studies.

24 Please enter dates in dd/mm/yy format (eg 05/09/11)

25 Care and Repair projects should collect client views on satisfaction when work is completed. Leave blank if work not completed.

Table A1 Case returns received by agency

	Number of completed grants	Number of returns submitted	Percentage share of all returns submitted
Anglesey	22	20	6.6
Blaenau Gwent	16	14	4.6
Bridgend	15	12	3.9
Caerphilly	17	16	5.3
Cardiff	20	10	3.3
Carmarthenshire	13	14	4.6
Ceredigion	27	27	8.9
Conwy	13	8	2.6
Denbighshire	20	19	6.3
Flintshire	20	15	4.9
Gwynedd	20	13	4.3
Merthyr Tydfil	6	0	0.0
Monmouthshire	18	16	5.3
Neath Port Talbot	16	8	2.6
Newport	16	16	5.3
Pembrokeshire	0	14	4.6
Powys	21	16	5.3
RCT	14	12	3.9
Swansea	18	13	4.3
Torfaen	24	20	6.6
Vale of Glamorgan	22	15	4.9
Wrexham	16	6	2.0
Total	374	304	100.0

Data on the number of completed grants is taken from Care & Repair Cymru's *Progress Assessment of the Independent Living Grant*, Reporting Period: 1 August 2011- 31 March 2012

Table A2 Client willingness to participate in case studies

	Client willing to participate in case study		
	No	Yes	Total
Anglesey	9	11	20
Blaenau Gwent	9	3	12
Bridgend	0	12	12
Caerphilly	3	12	15
Cardiff	5	5	10
Carmarthenshire	5	9	14
Ceredigion	27	0	27
Conwy	1	7	8
Denbighshire	19	0	19
Gwynedd	1	12	13
Monmouthshire	5	11	16
Neath Port Talbot	8	0	8
Newport	10	6	16
Pembrokeshire	0	14	14
Powys	6	5	11
RCT	5	7	12
Swansea	4	9	13
Torfaen	17	3	20
Vale of Glamorgan	15	0	15
Wrexham	5	1	6
Total	154	127	281

Table A3 Age of client

		No	Percent
Age of client	Under 60	6	2.1%
	60-64	19	6.8%
	65-74	75	26.8%
	75-84	103	36.8%
	85 or more	77	27.5%
	Total	280	100.0%

Table A4 Property type

		No	Percent
Type of dwelling occupied by client	Detached	94	33.6%
	Semi	103	36.8%
	Terrace	74	26.4%
	Purpose built flat	4	1.4%
	Converted flat	1	.4%
	Sheltered housing	2	.7%
	Caravan	2	.7%
	Total	280	100.0%

Table A5 Tenure

		No	Percent
Tenure of dwelling occupied by client	Own outright	249	89.2%
	Buying	14	5.0%
	Part own	3	1.1%
	Private tenant	7	2.5%
	Rent free	6	2.2%
	Total	279	100.0%

Table A6 Main source of referral

		N	Percent	Valid Percent
Source of client	LA waiting list for Disabled Facilities Grant	145	51.6%	65.3%
	Hospital referral	40	14.2%	18.0%
	GP referral	3	1.1%	1.4%
	Other	34	12.0	15.3%
	None stated	59	21.0	
	Total	281	100.0%	100.0%

Table A7 Reason for selection for ILG

		No	Percent
Reason client selected	Urgency	220	78.3%
	Means test problem	39	13.9%
	Title problem	5	1.8%
	Other	17	6.0%
	Total	281	100.0

Table A8 Client place of residence at referral

		N	Percent
Where client resident at referral	Dwelling to be adapted	243	86.8%
	Hospital	33	11.8%
	Residential care	2	0.7%
	Nursing care	1	0.4%
	Relatives-friends	1	0.4%
	Total	280	100.0

Table A9 Assessment prior to referral

		Responses		
		No	Percent	Valid Percent
	LA OT	169	60.1%	67.9%
	Health OT	49	17.4%	19.7%
	Other	31	11.0%	12.4%
	None stated	32	11.4%	
	Total	281	100.0%	100.0%

'Other' sources were mainly specialist/private OTs and Care and Repair staff

Table A10 Source of assessment for ILG

		N	Percent
Source of assessment for ILG	LA OT	127	45.1%
	Health OT	34	12.1%
	Care and Repair	114	40.6%
	Other	6	2.1%
	Total	281	100.0%

Table A11 Prevalence of OT assessment

		Assessment for ILG		
		Other/none	LA/Health OT	Total
		Number		
Prior assessment	Other/none	53	10	63
	LA/Health OT	68	150	218
	Total	121	160	281
		Percentage		
	Other/none	18.9%	3.6%	22.5%
	LA/Health OT	24.2%	53.4%	77.6%
		43.1%	57.0%	100.0

Table A12 Adaptations required and provided

	Required		Provided via ILG		Provided other source	
	No	Percent	No	Percent	No	Percent
Ramp	44	15.6%	49	17.4%	3	
Rails	61	21.7%	52	18.5%	18	6.4%
Better access	24	8.5%	23	8.2%	4	
Electrical modifications	14	5.0%	12	4.3%	4	
Additional heating	11	3.9%	12	4.3%	1	
Entry phone	4		4		0	
Alarm	0		0		0	
Hoist	6		6		0	
Stair Lift	62	22.0%	70	24.9%	1	
Through lift	2		2		2	
Graduated floor shower	31	11.0%	32	11.4%	1	
Low level bath	0		0		1	
Shower over bath	7		8		3	
Shower replacing bath	61	21.7%	70	24.9%	5	
New bath	19	6.8%	15	5.3%	1	
Redesigned bathroom	33	11.7%	37	13.2%	1	
Redesigned kitchen	1		0		1	
Relocation of bath/shower	3		4		1	
Relocation of toilet	5		5		1	
Addition GF toilet	3		1		1	
Other modification toilet	10	3.6%	9		0	
Other modification kitchen	3		3		0	
Extension to meet disabled person's needs	3		0		3	
Level thresholds	13	4.6%	14	5.0%	2	
Alarm system modification	0		0		0	
Adaptation doorbell/loop	2		1		1	
Other layout adaptations	1		3		1	
Access to garden	17	6.0%	15	5.3%	6	
Total	440		447		62	

Note: some cases involved adaptations of more than one type

Table A13 Costs of work

		No	Percent
Valid	Up to £2000	78	27.8%
	£2000-4000	89	31.7%
	£4000-6000	74	26.3%
	£6000-8000	22	7.8%
	£8000-10000	8	2.8%
	£10000 or more	10	3.6%
	Total	281	100.0%

Table A14 Value of ILG

		No	Percent
Valid	Up to £2000	48	23.6%
	£2000-4000	73	36.0%
	£4000-6000	58	28.6%
	£6000-8000	12	5.9%
	£8000-10000	6	3.0%
	£10000 or more	6	3.0%
	Total	203	100.0%

Table A15 ILG as a percentage of total works cost

		No	Percent
Valid	Up to 25%	6	2.2%
	25-50%	4	1.4%
	50-75%	8	2.9%
	75-100%	19	6.8%
	100%	242	86.7%
	Total	279	100.0%

Table A16 Source of additional funding

		No	Percent
Other source of funding for work	Own resources	18	41.9%
	Local authority	11	25.6%
	Health service	5	11.6%
	Hardship funds	4	9.3%
	Other	5	11.6%
	Total	43	100.0%

Table A17 Predicted benefits of ILG

		No	Percent
Predicted benefits	Earlier discharge from hospital	33	11.7%
	Reduction of risk of admission to hospital	245	87.1%
	Reduction of risk of move to nursing care	125	44.5%
	Reduction of risk of move to residential care	104	37.0%
	Reduction of risk of injury from falling	264	94.0%
	Reduction of risk of need for home-based social care	152	54/1%
	Reduction of risk of need for home-based informal care	137	48.8%
	Reduced waiting time for delivery of adaptation(s)	209	74.4%
	Improved safety/well-being	269	95.7%
	Improved access to-from home	104	37.0%
	Use of bathroom facilitated	179	63.7%
	Use of kitchen facilitated	14	5.0%
	Use of other rooms facilitated	71	25.3%
	Other cost savings	11	3.9%
	Total	281	100.0%

More than one benefit possible

Table A18 Sources of assessment of benefits

		No	Percent
Source of assessment of benefit	LA OT	49	17.4%
	Health OT	26	9.3%
	Care and Repair	211	75.1%
	Other	27	9.6%
	Total	281	100.0%

More than one source possible.

Table A19 Predicted benefits by source of assessment

	LA OT	Health OT	LA/Health OT	Care and Repair	Other	All
	Percentage by source of assessment					
Earlier discharge from hospital	8	42	20	9	4	11
Reduction of risk of admission to hospital	86	73	81	90	48	84
Reduction of risk of move to nursing care	49	35	44	46	33	44
Reduction of risk of move to residential care	47	31	41	35	30	36
Reduction of risk of injury from falling	96	96	96	93	52	90
Reduction of risk of need for home-based social care	43	46	44	0	22	13
Reduction of risk of need for home-based informal care	45	35	41	52	22	47
Reduced waiting time for delivery of adaptation(s)	88	77	84	73	41	73
Improved safety/well-being	92	96	93	97	0	88
Improved access to-from home	43	42	43	38	4	36
Use of bathroom facilitated	59	58	59	64	52	61
Use of kitchen facilitated	4	15	8	5	4	5
Use of other rooms facilitated	27	42	32	25	15	26
Other cost savings	2	12	5	5	0	4
All	100	100	100	100	100	100
Base	49	26	75	211	27	313

Table A20 Elapsed time from first contact between client and referrer and referral to Care and Repair for ILG

Days	No	Percent	Valid percent
1-10	48	17.1%	22.2%
11-20	28	10.0%	13.0%
21-30	16	5.7%	7.4%
31-60	31	11.0%	14.4%
61-90	31	11.0%	14.4%
91-180	36	12.8%	16.7%
180-365	9	3.2%	1.5%
365 or more	17	6.0%	7.9%
Missing	65	23.1%	
Total	281	100.0%	100.0%

Table A21 Elapsed time between referral to Care and Repair for ILG and actual/predicted completion

Days	Frequency	Percent	Valid Percent
0-10	10	3.6%	3.9%
11-20	29	10.3%	11.3%
21-30	37	13.1%	14.4%
31-60	86	30.6%	33.5%
61-90	42	14.9%	16.3%
91-180	49	17.4%	19.1%
180-365	4	1.4%	1.6%
365 or more	0	0.0%	0.0%
Missing	24	8.5%	
Total	281	100.0%	100.0%

Table A22 Satisfaction with overall effectiveness of adaptations

		No	Percent
Overall client satisfaction	Very satisfied	226	91.5%
	Satisfied	20	8.1%
	Neither	1	0.4%
	Total	247	100.0%

No dissatisfaction was reported

Table A23 Satisfaction with speed of delivery of adaptations

		No	Percent
Client with speed of service	Very satisfied	215	86.3%
	Satisfied	29	11.6%
	Neither	5	2.0%
	Total	249	100.0%

No dissatisfaction reported

Table A24 Satisfaction with service provided by Care and Repair

		No	Percent
Client satisfaction with CR service	Very satisfied	237	96.0%
	Satisfied	9	3.6%
	Neither	1	0.4%
	Total	247	100.0%

No dissatisfaction reported

Table A25 Client view of effectiveness of work in preventing falls

		No	Percent
Work reduced prevented fall	Yes	234	96.3%
	No	3	1.2%
	Don't know	6	2.5%
	Total	243	100.0%

Table A26 Client view of effectiveness of work in improving ability to live independently

		No	Percent
Work improved ability to live independently	Yes	238	97.9%
	No	1	0.4%
	Don't know	4	1.6%
	Total	243	100.0%

Appendix B Schedule of questions for interviews in case study agencies.

Questions to professional stakeholders

1. Introduce yourself and explain the project, why we are talking to them.

2. The introduction of the ILG
    a. When did they first hear of the proposal?
    b. What was their immediate reaction?
    c. Were they involved in developing the local proposals?
    d. If yes, what priorities were set for the use of the grant?
    e. Did they feel that they (and their organisation/profession) were appropriately involved in the planning?
    f. Were any concerns they had appropriately taken into account?
    g. What were those concerns?
    h. Did the preparation for the ILG have a beneficial effect on collaborative working locally?

3. The operation of the ILG
    a. How quickly was the availability of the grant made known to relevant professionals?
    b. With hindsight could that have been improved, and if so, how?
    c. What were the key local priorities for the use of the grant?
    d. How was that communicated?
    e. Has the level of take-up been in line with your expectations?
    f. What issues have arisen in the management of the delivery of ILG?
    g. How have they been addressed?
    h. What lessons would you identify to improve the delivery of the ILG?

4. The outcomes of the ILG
    a. Has the pattern of referrals been as you expected and if not how has it varied from your expectation?
    b. In your judgement has the ILG been able to offer appropriate assistance to people who might otherwise not have received it?
    c. What are the characteristics of those who have been helped in that way?
    d. In your judgement have cases been dealt with more speedily than would otherwise have been the case?
    e. In your judgement has the ILG delivered the appropriate range of adaptations to meet the needs identified?
    f. Would you judge this initiative to have been cost-effective in its outcomes?
    g. Have the results of the initiative exceeded your expectations, met your expectations or fallen below your expectations?
    h. Please explain your answer.

5. Generally
    a. Will the partnership working that has supported the ILG delivery influence future patterns of local collaboration?
    b. Are there lessons from the referral and assessment processes involved in ILG that you will look to apply, for example in delivery of DFGs?
    c. What overall benefits would you identify from the ILG initiative?
    d. Do you have any concerns about negative outcomes from the way ILG has been delivered locally?
    e. Would you support the ILG initiative being repeated if funds were available?

Could I now talk to you about the mainstream DFG arrangements?

6. Firstly about the route by which people come into the system
    a. Is there a single first point of entry – an intake team for example?
    b. If so are OTs based in this intake team, who does the triage?
    c. What eligibility criteria used – critical, substantial, moderate, low? How are cases categorised when passed to area teams – urgent/standard
    d. What use made of fast-tracking (equipment/minor works/manual handling) at intake stage?
    e. Are all assessments done on home visits – any use of DLC/assessment centres/'mobile bath bus' type service?
    f. Are cases dealt with in date order or is any attempt made to break them up by e.g. by type of adaptation work required? Do all OT/OTAs deal with mix of cases or do they specialise?
    g. If waiting list starts to build do you ever bring in outside staff to clear it?
7. May I ask you about the ways you evaluate the passage of cases through the system?
    a. Do you measure end to end times – i.e. first enquiry to Care Direct through to completion of major adaptation work?
    b. Do you measure outcomes for the customer after an adaptation? Can we have results?
    c. Who does the final inspection of completed adaptation work?
    d. On completion of adaptation work do you liaise with social work teams about levels of on-going care?
    e. Are there any local factors that make adaptations more difficult in this area?

Questions for interviews with service users and carers

1. Introduce yourself – explain the project, why we are talking to them

2. Background - Begin by asking them to talk about the work has been done to their home:
   - What was done with the grant and the help of C&R?
   - What difficulties were you experiencing getting around the home or using the facilities before you had the adaptations done?
   - Did you ever fall – if so how often?
   - Had you been in hospital before the work was done?
   - How did you first find out that you could get adaptations to your home?
   - Did you know there was a grant?

3. If they had been waiting for a DFG – ask them about what happened:
   - Did you see an occupational therapist from the local authority? How long did it take before they visited?
   - Did you see a surveyor? How long did it take for them to visit?
   - Did anyone from the local authority keep you informed about what was happening?
   - Did you know how long you would have to wait?
   - Did you have any difficulties while you were waiting? Falls/accidents?
   - Who put you in touch with C&R?
   - How long did you wait before they visited you?
   - Did you feel the service you got from C&R was the same as the local authority or was if different – or can't you say?
   - If it was different - in what way?

4. If they had been in hospital before the work was done:
   - Who put you in touch with C&R – was someone in the hospital?
   - Did you know about C&R and the grant before you left hospital?
   - Was the work completed before you left hospital – if not, do you feel it could have been co-ordinated any better?

5. What do think of the work that has been done?
   - Did you make a contribution to the cost of the work?
   - In your opinion was the work done well or not?

- Were there any problems – before, during or after the work was finished?
- Would you recommend C&R to other people?

6. What difference has the work made? (this section will have to be tailored to the type of work that has been carried out and the nature of the person's disability or illness)
   - Can you do more on your own now without help?
   - What can you do now that you couldn't do before?
   - Are there areas of the house that you can reach that you couldn't get to before?
   - Were you able to bath or shower on your own before?
   - Are you able to bath or shower on your own now?
   - If other adaptations – ask what difference these have made
   - Do you have outside carers (i.e. paid for - not family or friends)?
   - Have you been able to reduce the amount of help you need from outside carers – if so what reduction in hours, what reduction in the tasks they perform?
   - Do you have care from family and friends?
   - Have you been able to reduce the amount of help you need from them - if so what reduction in hours, or what reduction in the tasks they perform?
   - What do you feel about your safety – do you feel less afraid of falling?
   - If you used to fall - do you think you now fall less than before?
   - What do you feel in yourself – has it made you feel any more or less happier, or optimistic?
   - If you hadn't had the work done what would have happened?
   - Do you think you would have had to move out of this home?
   - If you could sum up in one sentence the difference the adaptations have made to your life what would you say?

7. If a carer is present - ask them about any difference the work has made
   - Do you feel the work has made your life easier or has there been no difference?
   - Do you feel x has improved in any way as a result of the adaptation work that was done or has there been no change?
   - Do you think you would have continued to cope without the adaptations?
   - Do you think you would have had to move?
   - If you could sum up in one sentence the difference the adaptations have made to <u>you</u> and your life what would you say?

8. Thank the participants for their time – talk about what happens now – analysis/report/decisions about future funding. Assure that all information will be treated confidentially and that no names will be used in the report.

Appendix C
The health/care benefits of ILG – Neath Port Talbot cases

Drawing on the expertise of the disciplines contributing to the local partnership the Care & Repair agency in Neath Port Talbot has documented the cost benefits that may be attributed to the ILG interventions they made. For each intervention they have documented the cost, drawing on an interdisciplinary judgement as to the alternative outcome had the ILG not been delivered, and the costs associated with that scenario. They have identified the estimated saving and it is also expressed it as a ratio to the cost of the ILG in the first year following the intervention.

We have taken the narrative the agency provided and summarised the information in the following figure. This information arises from a local initiative and does not form part of the formal evaluation but does contribute to the available data on cost benefit from the timely provision of adaptations, such as those delivered through the ILG.

In Neath Port Talbot details of ILG costs and actual and potential savings in care costs were given for 16 cases. In one case spend of £7,919 on an ILG resulted in an actual saving in reduced care costs of £13,206. Overall spend on ILG (and in one case a supplementary DFG) came to £82k. The ILG delivery team estimated that in 10 of the 16 cases there were actual or potential savings in care costs. These savings amounted to £126k, not including the cost savings to health in the two cases where ILG allowed faster discharge.

In one year alone this would amount to a saving in care costs of £2.38 for every £1 spent on an ILG. In only six cases were there no direct cost savings, but in five cases the work allowed the client to stay in their own home for longer. However, in one case the client died shortly after work was completed.

Figure C.1 Summary of interventions, costs and cost benefits for ILGs delivered by Care & Repair Neath Port Talbot

	ILG solution and costs	**Health/care benefits**	**Actual/ potential savings in care costs pa**	**Benefit per £1 spent on ILG in year one**
1.	Convert ground floor room into wet room with WC and provide level threshold at front door. **ILG cost = £7,919**	Current: 4 care visits per day £465 pw **= £24,158 pa** **Following ILG – care was reduced to a net cost of £58 pw = £3,033 pa**	**£21,125 (Actual saving)**	**£2.67**

2.	Remove threshold to door from kitchen to rear lobby, provide level threshold at front door, and provide elongated steps to both front and rear doors. **ILG cost = £2,219**	Current: Unable to leave hospital without ILG – cost of bed space? Future without ILG: 10 hrs pw £200 pw = **£10,400 pa**	**£10,400 (not including hospital costs)**	**£4.69**
3.	Improve ground floor bathroom to provide shower and maximise circulation space **ILG cost = £6,065**	Current: no care Without adaptations care required: net cost £465 pw **= £24,158 pa**	**£24,158**	**£3.98**
4.	Provide a wash and dry toilet facility. (Clos o Mat WC) **ILG cost = £3,528**	Current: 10 hrs p, cost £250 pw = **£13,000 pa** Future without ILG: 4 visits pd. Net cost £515 pw = **£26,758 pa**	**£13,758**	**£3.90**
5.	Curved SL and rails to existing shower area. **ILG cost = £4,291**	Current: no home care Future without ILG: 10 hrs pw £200 pw = **£10,400 pa**	**£10,400**	**£2.42**
6.	Improve g/fl bathroom to provide shower and maximise circulation space **ILG total cost = £5,660**	Current: no care Without adaptations care required net cost £200 pw **= £10,400 pa**	**£10,400**	**£1.84**
7.	Remove bath and provide LAS on first floor. Ramp and level access to front door. **ILG cost £7,538**	Current: No formal care Future without ILG: 10 hrs pw £200 pw = **£10,400 pa**	**£10,400**	**£1.38**
8.	Gas CH (using NEST), rewire. Convert bathroom for LAS	Current: no home care Future without ILG: 10 hrs pw £200 pw = **£10,400 pa**	**£10,400**	**1.28**

	ILG cost = £8,147			
9.	DFG fast-tracked for thro floor lift ILG for LAS in first floor bathroom. ILG = £3,000 DFG = £8,300 **Total cost £11,300**	Current: no formal care – provided by family Future without ILG/DFG: 10 hrs pw £200 pw = **£10,400 pa**	**£10,400**	**£0.92**
10.	Provide new heating and renew kitchen sink. **ILG cost = £6,460**	Current: 10 hrs pw Cost £250 pw = £13,000 pa Without ILG: will need care home **= £18,000 pa**	**£5,000**	**£0.77**
11.	Dropped kerb, level door threshold, ramp, rail. **ILG cost = £2,841**	Current: 4 care visits per day net cost £515 pw **=** £26,758 pa Without ILG will require nursing home care **= £18,000 pa**	**No direct saving but client able to remain at home**	-
12.	Ramped access to rear door **ILG cost = £1,054**	Current: 10 hrs per week Net cost £200 pw = **£13,000 pa**	**No direct saving but client able to remain at home**	-
13.	Level threshold rear door and ramp down to path **ILG cost = £2,537**	Current: 4 care visits per day net cost £515 pw **=** £26,758 pa Without ILG will require nursing home care **= £18,000 pa**	**No direct saving but client able to remain at home**	-
14.	Provide g/fl WC and level access to rear door and ramp to clothes line. **ILG cost = £6,858**	Current: 4 care visits per day net cost £515 **pw = £26,758 pa**	**No direct saving but client able to remain at home**	-
15.	Hand rails to outside steps, level threshold. **ILG cost = £3,221**	Will allow him to leave hospital – cost of bed space? Will have to move to more suitable home.	?	?
16.	Tracking hoist	Current: 4 care visits per	***Sadly***	-

	system to bedroom **ILG cost = £2,112**	day net cost £515 pw **=** £26,758 pa Without ILG nursing home care **= £18,000 pa**	***passed away***	
	Total ILG costs £82k	**10 cases with actual or potential savings**	**Total savings £126k**	**Av £2.38**