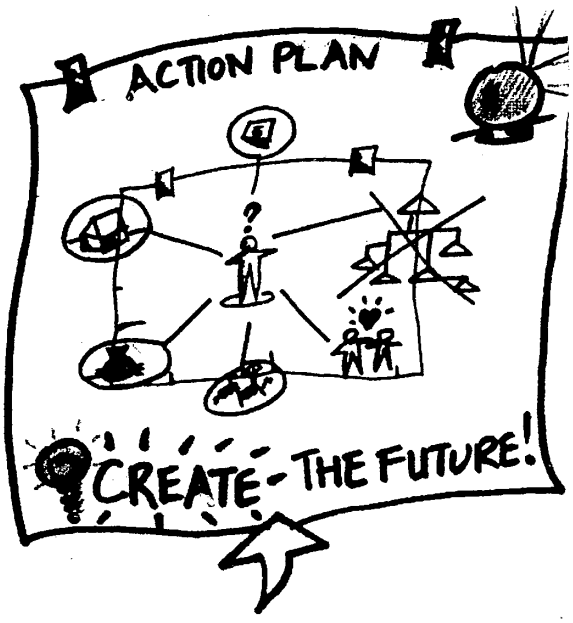
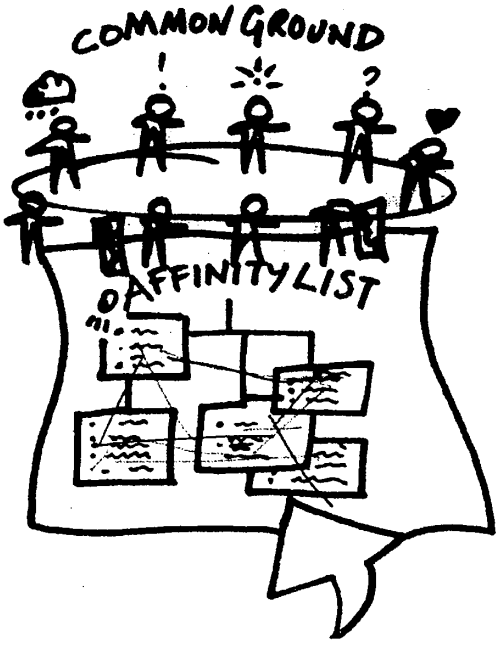
London Health
Partnership

Review of the Provision of Equipment & Adaptations for Older People

Report of a study for the London Health Partnership

Nigel Appleton
Philip Leather





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Introduction

This report focuses on the provision of equipment and adaptations for older people with disabilities. It:

- looks at the problems which older people with disabilities experience in gaining access to the help with equipment and adaptations that they require;
- sets out some examples of ways in which service provision can be improved;
- suggests ways in which both older people themselves and professionals in health, housing and social services can most effectively draw on this information to improve services for older disabled people.

The provision of help to disabled people with equipment and adaptations is a complex field. Regrettably there is no clear and simple legislative framework setting out powers, duties and individual rights. Health providers, social care agencies, housing authorities, and the voluntary sector all have a role to play, but this plethora of organisations often leads to confusion, inconsistency and delay. Rising expectations among disabled people and an increasing determination on their part to secure their rights have combined with technical and design innovations to increase demand, at a time when budgets are more and more restricted. It is not surprising that many users are dissatisfied and many professionals feel under pressure.

Disabled people of all ages have needs but this report focuses on people who develop disabilities in old age, as distinct from disabled people who have reached retirement age and beyond. Many organisations working with older people or representing their interests feel that older people who develop the disabilities associated with old age are often over-looked in the provision of services because they do not make enough fuss about their needs, either as individuals or in an organised way. Some professionals too tend to regard disabilities which emerge in old age as inevitable and a low priority for help. In part this may be because older people far outnumber younger people in the disabled population as a whole, and a full acceptance of their needs would have major cost implications.

Whatever the explanation, the aim of this report is to draw attention to the problems which older people with disabilities experience in getting

access to the services that they need. Chapter 1 summarises the issues which, from discussions with a range of user representatives and services providers, have emerged as most in need of action. But while there are many problems in this field, there are fortunately also many good examples of ways in which services can be delivered effectively and sensitively in response to the demands of users. Chapter 2 reviews a number of interesting and innovative approaches to the provision of equipment and adaptations for older disabled people.

But even good ideas cannot simply be lifted and transplanted to a new context. Chapter 3 looks at ways of building on the resources – both human and financial – already available in local areas, and at ways of identifying which new approaches are most likely to be of value. Chapter 4 briefly describes the legislative framework which sets out the pattern of powers, duties and rights governing the provision of equipment and adaptations. Finally, the Appendix gives details of a range of individuals and organisations who can be contacted for help.

Chapter 1

The issues

From extensive interviews with a range of individuals and agencies involved in the provision of equipment and adaptations for disabled elderly people, numerous issues relating to the provision of equipment and adaptations have been identified. These fall into five main areas:

- the low profile of older people's needs
- the lack of targets and performance criteria
- the role of occupational therapists
- the absence of systems for recycling/reusing equipment and adaptations
- the shortfall of resources.

The low profile of older people's needs

The needs of older people for equipment and adaptations to meet problems arising from disability have a low profile. Older people themselves commonly have little awareness of the options and assistance available to them and few opportunities to make inputs into the development, review or management of services. Older people from minority ethnic communities are particularly disadvantaged in accessing appropriate services. Nationally and locally this is a service area without a champion to protect services levels and budgets.

1 The needs of older people with disabilities have a low profile, even within the disabled movement where radicalisation is led by younger disabled people and older people lose visibility

Nicky Wilkins, of Care & Repair, believes that this low profile is, in part, the outcome of restricted expectations about the conditions and quality of life in old age, a symptom of ageism in both professionals and older people themselves. Paula Jones, of Age Concern London, emphasises that the kinds of disabilities older people have are different from the most frequently occurring disabilities of younger people. As a result, older people with disabilities do not fit within the disability movement very easily, either in their own perception or that of other people. They may not

'feel' disabled, but simply not as able as they used to be. However, this does not mean that their problems are unimportant. The increased levels of referral of older people with disabilities for assessment by occupational therapists, recorded by many social services departments, may obscure the volume of those who do not access services or fail to access them effectively.

Jeremy Porteus, of the RNIB, underlines the problem in relation to people with visual or other sensory impairment whose disability may be classified as part of the ageing process. There are, he says, '200,000 older people with visual impairments in residential/nursing care, many of whom do not need such accommodation but, with an appropriate assessment, could continue to live at home with home help, the necessary aids and adaptations.'

- **Awareness among older people of the options and assistance available to them is very poor**

A recent survey conducted by Age Concern London demonstrated that older people have very limited knowledge of the services and facilities available to assist them in coping with disability. Most do not know what their rights are and are unaware of their entitlement to an assessment of their needs. Peter Archer, Chair of the Chartered Institute of Environmental Health Housing Committee, endorses the view that there is a general absence of information for potential users about the services available. He adds the observation that the dissemination of information would inevitably stimulate demand and this, in turn, might create political pressure to increase resources and improve working methods. Wendy Bourton, of Care & Repair Cymru, provides some evidence from Mid-Glamorgan that where there was local political pressure from people who felt unsupported by existing services, the will emerged to increase collaboration between professionals and to improve the delivery of services through innovative working methods.

Lesley Neville, of the College of Occupational Therapists, makes the point that the Community Care Act identified 'information sharing' as a responsibility of local authorities. One basic example of this is the welfare benefits check-and-advice service. Having access to information about benefits entitlement/availability would improve older people's awareness of their rights, while accessing financial resources would enable them to purchase services appropriate to their needs.

Drawing on national experience, Age Concern England endorses the view that most older people lack information about the resources available to help them meet their disabilities. Age Concern workers spend much of their time correcting the problems caused by inaccurate or misleading information and advice from a variety of sources.

There are many groups within the population of older people who may experience particular difficulties in accessing the information which is available (e.g. those from minority ethnic communities, and those who are blind or partially sighted). Advice-providing agencies should address these needs with material which is either translated into appropriate community languages to meet the needs of people whose first language is not English, or presented in Braille, large print or tape formats.

Ed Murtagh, of Disability West Midlands, sums up quite simply the crucial role of information in providing the foundation for an adequate service: 'If you do not know what is available, how can you choose?'

- **Most current service planning and delivery systems provide very limited opportunities for input by service users and carers**

In the view of Nicky Wilkins, of Care & Repair, the most immediate benefit of increasing the involvement of service users and carers is that it would help to eliminate mistakes. Ian Bradford, also of Care & Repair, believes that service users and carers suffer a sense of alienation from the professionals who assist them, seeing the latters' role as often acting against their interests, especially in the management of budgets. Certainly Age Concern London's survey found evidence that many users felt they had been under-informed and scarcely consulted in relation to the adaptations to be made to their homes and the consequences of having the work done.

Wendy Bourton, of Care and Repair Cymru, sees a brokerage role for some home improvement agencies in helping both users and providers to clearly understand the needs, constraints and expectations of the other.

The Kent Occupational Therapy Bureau has adopted a pattern of user groups for each area of the county. Initially, membership was recruited from interested service clients, including complainants. As response times have

improved and complainant levels have declined, all users are invited to join a user group at the conclusion of the Bureau's intervention.

- **Older people from minority ethnic communities may experience particular difficulties in finding access to appropriate services**

A number of respondents mentioned the failure of current services to meet the needs of elderly people from minority ethnic communities. The insensitivity of some eligibility criteria and service specifications in this area sits uneasily against policy commitments to equality of opportunity.

Lesley Neville, of the College of Occupational Therapists, comments: 'Ongoing work needs to be done with specific ethnic communities to develop appropriate assessments and resources, but it is a *two-way* process and no amount of statutory legislation can *make* people take up employment to provide services if this is viewed by that ethnic group as an undesirable form of employment or demeaning. We have a challenging educational need ahead of us in some aspects of equality of opportunity.'

- **There is insufficient money to meet need, and funding is vulnerable in the present cost-cutting environment, especially as there is no champion for this area**

Age Concern England identifies a lack of money, particularly to finance adaptations, as the principal problem in this area. Many local authorities are operating unofficial moratoria on grant approvals, others are managing demand by delaying the processing of applications. Roy Taylor, of the Association of Directors of Social Services, makes the point that services can fall victim to uncoordinated budget reductions by different agencies leading to famine or feast. Even when expenditure budgets are maintained, budgets for staff to deliver the funding may present an easy target for cuts.

Nicky Wilkins, of Care and Repair, with the benefit of a national perspective drawing upon the practical experience of home improvement agencies, agrees that funding is a difficult problem but one which cannot go unchallenged. Restricted and delayed access to public finance through waiting lists for visits by occupational therapists and grant officers sits uneasily, in her view, with the concept of a mandatory right to assistance.

In the view of at least one social services inspector, resources will not be better targeted on need until health, housing and social services move from service-based to need-based commissioning, identifying which services or combinations of services have most impact on which needs at what cost and redirecting their resources in the light of that knowledge.

- **In many areas service providers are managing difficulties with budgets by reducing the range of services they offer or instituting eligibility criteria which exclude some client groups**

The example most frequently quoted was of those local authorities which refuse to offer a bathing service or equipment or adaptations to facilitate bathing to any, except those who have a 'medical need' for bathing. This is widely condemned and generally considered to be contrary to legislation but is practised in a number of areas. The insensitivity to the needs of all older people for dignity which such a policy demonstrates is difficult to credit.

Limitations of a quite arbitrary kind have been proposed, which would exclude older people from assessment, except in extreme old age or in conditions of terminal illness. Although overturned in those examples cited by respondents, the same proposals seem to emerge as social service departments look for ways of managing their budgets. Examples were provided from authorities where social service departments refused to supply items of equipment costing less than an arbitrary price threshold, without reference to the ability of the client to fund the purchase.

Lesley Neville, of the College of Occupational Therapists, draws attention to the best practice by which many local authorities offer guidelines to their staff to facilitate service delivery. Each case should be seen as unique, and should not be refused services on financial or other restrictive criteria. However, Age Concern England, the British Red Cross, Care and Repair, the Disabled Living Foundation and individual home improvement agency workers all reported examples of arbitrary criteria and exclusions from service. The British Red Cross has experienced a marked increase in demand for supply of equipment to clients whose needs are not being met by the statutory providers. Occasional or short-term users of equipment have particular difficulty in accessing service from health and social service authorities.

The withdrawal of housework services by many local authorities is another area of contention. RADAR makes the point that practical help in the home is the first item in Section 2 of the Chronically Sick and Disabled Persons Act and is considered a key component of good quality community care (*Caring for People*, page 9, para 2.4). This is perhaps the clearest example of divergence between the priority given by users and policy-makers and service providers.

The lack of targets and performance criteria

There are no nationally established standards or criteria for the provision of equipment and adaptations and those established in some localities work against the interests of users. There are many examples of poor co-ordination, or even of conflict, between statutory agencies at a local level.

• There are no nationally acknowledged standards for service delivery or for eligibility criteria, and services are therefore patchy

The lack of consistent service standards across London is identified by Age Concern as a problem for users and carers, leading to confusion and a sense of inequity. Different agencies within the same area frequently operate divergent sets of priorities and eligibility criteria. While the legislation makes this problem a difficult one to tackle, users and potential users are the greatest losers. The Association of Directors of Social Services is currently seeking to generate a model set of standards.

Charging is an area of variation which causes users a great sense of injustice. Policies vary from area to area and between different agencies in the same area. As a result, outcomes can appear random and unfair to the client.

• Existing eligibility criteria seem to be ineffectual and often seem to operate to exclude potential users from services

It can be argued that the intended purpose of eligibility criteria is to match demand to resources by excluding potential users from services. The alternative is total disorder. However, even those who accept this situation

as inescapable, have concerns that eligibility criteria are not rationing resources effectively because they are often service- or people-based as opposed to need-based. It is also argued that criteria are not applied consistently by practitioners and are rarely expressed in terms that can be cost as a basis for budgeting.

In the view of a senior Department of Health official, eligibility and priority criteria can act against the interests of people with relatively low levels of disability or those whose condition is relatively stable. From the voluntary sector too comes the view that the statutory services are failing older people with disabilities. As budgets get tighter, criteria are successively redrawn to exclude older people from service.

Sometimes it is necessary to look beyond the need to deal with urgent problems to direct resources towards the support system rather than the individual. Most assessments do not look at the potential of support systems. A client may be relocated to meet housing need but in the process lose support systems and thus generate a demand for social care services. Ian Bradford, of Care and Repair, expresses the point succinctly: 'Higher dependency may be deflected by the early provision of appropriate help.' The challenge is to balance current resource allocation to those already experiencing high levels of dependency with this investment in containing future demand. But as the pressure on resources increases, such strategic decisions are becoming a thing of the past.

• Gatekeeping to services and budgets is often bureaucratic

Roy Taylor, of the Association of Directors of Social Services, identifies bureaucracy and red tape as a major problem in giving people access to services. More flexible approaches are needed which will, for example, allow people to try equipment before they accept it. By the time the whole process of assessment and prescription has been completed the client's needs may have changed.

Others suggest that for smaller items of equipment a much more flexible approach is needed by which, perhaps, groups of users might provide the major source of advice, and prescriptions or vouchers would allow people to obtain equipment from high street chemists.

- **Conflict arises between social service and housing departments in relation to the funding of disabled facilities grants and this is to the detriment of those who ought to benefit from this provision**

Some housing and grant departments resent meeting what they perceive to be community care costs through disabled facilities grants, while some social services departments resist the provision of funds for adaptations to cover what they believe is a housing rather than a social need. In the general confusion caused by cost-shunting in this area, potential users suffer misinformation, obstruction and delay in exercising their right to services.

On the conflict between social service and housing responsibilities for disabled facilities grant the Department of Health maintains that the position is quite clear. When a social services department accepts a case as meeting the criteria set out in the legislation and refers it to a housing authority for a disabled facilities grant which cannot be provided in the required timescale owing to a lack of resources, then the responsibility to deal with the case rests with the social services department under Section 2 of the Chronically Sick and Disabled Persons Act. The social services department must make arrangements to meet the needs which it has identified in order to fulfil its statutory obligations under the Act. Unfortunately, this clear delineation of responsibility is not always understood by housing and social services departments throughout the country and certainly is not acted upon in many places.

One proposal is that resources from special transitional grant should be used to offset the demands made upon grant budgets by disabled facilities grant, but this source will too soon come to an end. From the social services side it has been suggested that housing authorities should give more priority to disabled facilities grants, but this would of course mean taking limited resources away from other programmes or drawing on reserves.

- **Variations in procedures and impractical procedures for disabled facilities grant can limit access for users or give rise to major differences from one area to another**

Although there is a mandatory right to disabled facilities grant for specified purposes, the availability of this form of assistance varies in practice from authority to authority. Operational rules differ greatly, with some local authorities introducing unrealistic or impractical requirements. Some authorities require work to bring the property to the fitness standard as a condition of making an application for disabled facilities grants, while others do not. However, this requirement will be removed if recent government proposals to change the legislation on disabled facilities grants are enacted.

Both RADAR and home improvement agencies report difficulties for clients in meeting the costs of fees which may be needed at feasibility or application stage. Payments will generally only be made at the completion of works but building regulation fees need to be paid at the outset. Many clients cannot meet these costs, and delay is the result. Where the work involves more complex problems and a structural engineer's report or other fees are required the difficulties are compounded.

An Age Concern London's survey found that individual older people, and those who advise them, experience enormous variation in policy and practice across London, creating difficulties for users, carers and advisers.

- **Some occupational therapists resist the prioritisation of applications for disabled facilities grant and add to waiting list problems generally**

In one area occupational therapists were willing to prioritise cases within local authority stock but not to assign priorities to clients in the private sector. This led to difficulties for the housing authority in managing resources for disabled facilities grant, to ensure that those with the most pressing needs received assistance in an appropriate timeframe. Some grants departments operate methods such as a points system to address this problem.

A senior Department of Health official believes priority criteria should identify those most in need of, and likely to benefit from, skilled

occupational therapist intervention. Simple needs could be addressed by other strategies, thus ensuring those in greatest need get a quick response.

- **The lack of a joint approach by the agencies involved in service delivery and budget holding leads to overlap and vacuum**

Chris Gostick, of the NHS Community Care Branch, identifies the rigidity of disciplinary boundaries as a major problem, and this is endorsed by a wide range of respondents from all disciplines and sectors. Nicky Wilkins, of Care and Repair, identifies a lack of communication and of co-ordination between the statutory agencies with whom home improvement agency staff have to deal on behalf of clients. While there are exceptions, the general rule is that service providers do not act in unison. In one case a social services department employed additional occupational therapists to eliminate a waiting list for assessment but this merely moved the queue, and the pressure, to the grants department. An enhanced level of occupational therapy service undoubtedly brings benefits, but the benefit will be maximised if an increase in service by one agency is co-ordinated with other partners and the inter-agency consequences are thought through.

A social services inspector suggests that all parties must acknowledge that service departments do not have identical agendas. There are large areas of overlap, but much of the problem arises through areas where interests do not coincide (e.g. a client may have high priority for social services but low priority for housing allocation). All agencies need to contribute resources to a common pool to facilitate the resolution of these mismatches. More work is needed to identify where coincidence and divergence of criteria arise. The alternative is cost shunting, trench warfare, and an inefficient use of public funds.

Some respondents mentioned the disruptive effect of getting caught up in what they saw to be unsatisfactory working patterns and relationships between social services management and occupational therapists. One voluntary sector agency manager, for example, referred to the need to bring together two parts of the same department because the internal lines of communication were so poor. A senior officer from a local authority housing department spoke of his difficulty in achieving progress in meetings because of the unhelpful 'private agenda' being pursued by occupational therapists and colleagues from other parts of social services.

The random nature of the access to a service experienced by clients may, in part, be attributed to the uncoordinated nature of service agencies. What is needed are trigger criteria in *every* assessment to know when to process through the receiving agency and when to pass a case on. Social Services Inspectorate monitoring shows that receiving agencies, usually social services, typically have very under-developed systems for identifying and involving other agencies in the assessment process.

Unfortunately, Age Concern London confirms that lack of co-ordination at practical and strategic levels is not necessarily overcome by the linkage of housing and social services under single directorates. This may disappoint those hoping that the arrival of unitary authorities elsewhere in the country will lead to improvements in service.

The difficulties of dealing with the current structure are particularly acute in the area of disabled facilities grants. Age Concern England cites examples of those who have been told, wrongly, that they need to arrange assessment by an occupational therapist before applying for disabled facilities grant. In fact legislation says that the local authority must respond within six months to a full application and must seek the views of the welfare authority as to whether the adaptation is necessary and appropriate. This will normally entail an assessment for a social services department. Examples have been cited of shunting in both directions: social service departments sending clients to the housing authority for financial assessment before accepting them onto a waiting list and housing authorities sending clients to social services for occupational therapy assessment as a pre-condition to registering their enquiry.

The role of occupational therapists

There are a number of problems with the role, training and support of occupational therapists working in the community. The length of waiting lists is a common and perennial area of concern, together with concerns about assessment procedures and the availability of complementary professions in supporting independence in the community.

- **There are discontinuities between the functions of occupational therapists as defined by their professional body and supported by their training, and the practical circumstances of community-based occupational therapists**

The training of occupational therapists and the formal definitions of their function offered by the College of Occupational Therapists place considerable emphasis upon rehabilitation work with patients. But occupational therapists employed by social services departments have little opportunity and in some instances are expressly excluded from offering long-term rehabilitation.

This difficulty is compounded by changes in the occupational therapy service operated within the NHS. Shorter stays in hospital mean that most patients are fortunate to receive three or four sessions of rehabilitation from a hospital-based occupational therapist. The limited transfer of health service resources from acute to community provision means that, in most areas, there is little likelihood of receiving rehabilitative therapy from a health service occupational therapist once the patient has returned home. The only other occupational therapy intervention will come from a community occupational therapist working for the social services department who will not be able to offer sustained rehabilitation but will assess for aids and adaptations to meet existing levels of disability. The Kent OT Bureau, for example, explicitly identifies rehabilitation and treatment as outside its core purpose. While induction of clients to the use of equipment will involve some rehabilitative work, and certainly draws on those skills, opportunities to provide ongoing support of this kind are rare.

With a more sustained programme of rehabilitation many clients would regain a greater degree of function and have a reduced level of long-term dependency upon aids and adaptations. Any reduction, especially in this latter provision, would generate a considerable saving.

There is a need to rationalise the employment of occupational therapists in the light of the changes in acute health care and to reappraise their role in the provision of equipment and adaptations to make more appropriate and effective use of their professional skills. This extends, in particular, to reviewing the appropriate ratio of occupational therapists to occupational therapy assistants so that the latter undertake all tasks for which trained rehabilitative skills are not required. This might suggest an increase in the

ratio of occupational therapy assistants to fully qualified occupational therapists.

It is interesting to note that even in Northern Ireland, where health and social services are provided from within a single trust body, the same distinction is enforced. Hospital-based occupational therapists may provide therapy both to inpatients and to those in the community, but those working as community occupational therapists with the social services function generally confine themselves to assessing for aids and adaptations.

Many of those from other agencies who collaborate with occupational therapists in installing equipment or carrying out adaptations complain of the limited appreciation of housing and building matters exhibited by many occupational therapists. A lack an appreciation of technical feasibility may lead to delay and a failure to understand that variations after a scheme has been put out to tender add expense and further delay. This criticism may not be entirely fair. Pre-qualifying training must cover such a wide span that some knowledge areas can only be adequately covered in post-qualifying training. The problems are widely recognised and attempts are being made to address them, not least from within the College of Occupational Therapists.

The difficulties experienced by community occupational therapists have been compounded by the rapid rate of change within social service departments bringing restructuring which is not generally sensitive to their professional needs or the service they provide. The dispersal of occupational therapy to generic teams has exacted a high price. In the Department of Health Occupational Therapy Officer's view there is a distinction between dispersal and fragmentation. In many authorities fragmentation has resulted in there being no professional management or leadership above senior practitioner level; no career structure; limited opportunity for professional development; and a general loss of professional group identity.

The Association of Directors of Social Services believes that the increasing demands upon occupational therapy services generated by care in the community are not being met by the current number of trained OTs. They would wish to see an increase in the numbers being trained with some funding diverted from regional health authorities, which currently commission all OT training, to the training support mechanisms operated

by local authorities. Others also identify the need to retain more trained staff within the profession and believe that this can be achieved by addressing some of the problems of career path and professional structure set out above.

• Long waiting lists for assessment continue to be common and have an adverse effect upon the quality of life of older people

A survey of local Age Concern groups found that waiting times for assessment by an occupational therapist varied from nine months to two years. Against this must be set the evidence of those areas which reported no problems or delays and authorities like Kent which are responding within 28 days to most requests for assessment. Waiting lists and delays do seem to be the norm, especially for those cases judged to have lower priority. The impact of this is that those who could be helped by relatively small items of equipment have to wait the longest to get the help they need. As Paula Jones, of Age Concern London, suggests, the quality of life of many older people is compromised for want of relatively small provision.

The Disabled Living Foundation notes that long waiting lists have led to an increase in the number of people approaching the Foundation for advice with a view to purchasing the equipment they need without waiting for assessment.

Waiting times can be further extended in those local authorities where double assessment, firstly by a care manager and subsequently by an occupational therapist, is the normal procedure. Others remarked upon the bureaucracy that is wrapped round assessment with authorisation and endorsement needed from a number of managers before the assessment could be acted upon.

• The assessment of an older person's need for aids or adaptations is a crucial element in the process but is open to manipulation

Age Concern London and many others indicated that at present most people are being assessed for the services which are available rather than the services they need. Ian Bradford, of Care and Repair, believes that the client is generally seen as a consumer of limited resources, with the professional forced to depress expectations and to manage budgets. Are

care managers and occupational therapists genuinely independent assessors of need or guardians of a budget? Their ability to exercise an independent professional judgement of what the client needs is conditional upon the resources available.

Many will still wish to begin from a fully open assessment and not to limit the range of help to be offered. At present, however, it is clear that many professionals are choosing not to assess for services which they do not believe can be resourced. The political impact of this is to support the view that needs are being met from current resources. No demand for an extension in the range or level of service will be generated while professionals collaborate in this containment of expectation by clients.

There is an element of short-termism in the practice of limiting assessment to what can be resourced rather than what may be appropriate. Appropriate assessment and service provision often saves money in the long run. A number of respondents were able to quote cases in which service levels could have been reduced if appropriate equipment had been provided and in which equipment would not have been needed if service levels had been adequate. In all cases the quality of life of the clients involved would have been enhanced.

Lesley Neville, of the College of Occupational Therapists, comments: 'Assessments must be full and needs-led, but where resources are not in existence, for example with day centres for Asian clients where the appropriate language and culturally acceptable food and activities are available, the assessing agency is often left with a need that remains unmet. It will take time in some areas of need to develop the appropriate resources, and it is not a matter of agencies being unwilling to develop resources. It is often that the skills and response to developing services are not available, or are slow to develop. All that can be done initially in these cases is to record unmet need, and highlight areas of priority for future resources, or to encourage the communities to get involved in their resource development.'

In the view of one social services inspector assessments do not conclude with the objectives of intervention that have been agreed or negotiated with the user and carers. Assessment needs to focus more closely on the outcome that the client wants. Often this would be less complex and less expensive than meeting professional concerns.

Paula Jones, of Age Concern London, urges a more thoroughly holistic approach to assessment which looks at a whole system – an aid or adaptation may not only meet a need that would otherwise require other interventions but also helps maintain morale and capacity. Assessment should be about what can be done, and the package of services, equipment and adaptations should aim to support that objective, not reinforce the deficiencies.

This view is further supported by Chris Gostick, of the NHS Community Care Branch, who believes that assessment ought to be focusing on the impact of all interventions upon the client's quality of life. Sometimes the greatest improvement will come from equipment or adaptations, sometimes from additional services or income. Reviewing the input of resources against the total improvement in life quality will give a much better basis for judging cost effectiveness. For many people who have relatively small disabilities their quality of life would be improved by minor interventions but this is thwarted, while the emphasis through existing criteria remains on the most dependent.

Others express reservations about holistic assessment, believing that while this may be satisfying to professionals, the evidence is that users and carers want professionals to concentrate on what they perceive as their needs. Once these requirements are met, users and carers may be willing to expose deeper needs. It is unrealistic to expect users and carers to expose all of their needs in one assessment.

Age Concern England identifies those with seemingly straightforward needs for equipment as being poorly served by the present system. They have evidence of older people being told over the telephone that they will not be eligible for assessment if they are not registrable as disabled. This may be a particular problem for people with temporary disabilities, following an illness or a fall, for example, who have no eligibility for service under current legislation. By being denied access to assessment they are prevented from securing the assistance they need.

Fresh approaches are needed if people with temporary or low levels of dependency are to receive the help they need and which may help them to maintain function and prevent a decline into higher levels of dependency. Some identify a need to put resources back into generalist support and the encouragement of a self-help culture. Others see a role for limited self-

assessment leading to a more focused referral for those who need professional assessment.

This is also an area in which people with visual impairment suffer particular difficulties. Jeremy Porteus, of the RNIB, reports that no specific data have been collected on the number of blind or partially sighted people applying for aids and adaptations in the UK. There is a need to establish indicators that identify the number of visually impaired people applying for aids and adaptations and to conduct further research on their specific needs, how they were assessed, and the outcome of their applications.

A telling comment upon the efficacy of the current assessment system is the statistic, supplied by the Social Services Inspectorate, that 70 per cent of all equipment issued following assessment is never used. While the Department of Health believes this figure is much too high, no recent estimate is available and the concern expressed by Marie Hendry, of Disabled Living in Manchester, remains: 'Clients are often given what the system will allow, not what they want. Consequently, equipment is not used and the money is wasted.'

- **The general absence of a keyworker in this area leaves the client prey to bureaucracy and dislocation between service providers**

With substantial experience of the benefit of the keyworker approach used by home improvement agencies, Nicky Wilkins, of Care and Repair, identifies the absence of such an approach in the provision of equipment and adaptations as a major reason for failures to breach barriers and to release blockages in the system. This view is endorsed by Age Concern London.

- **There is a shortage of physiotherapists and chiropodists working in the community where they might contribute to restoration of function as an alternative to services which meet existing levels of disability**

RADAR reports that the physiotherapy service is generally not available in the community, in spite of many cases where a physiotherapist would enable restoration of function and reduce the long-term cost of care and

adaptations. This judgement is endorsed by the College of Occupational Therapists who feel that a combined approach of occupational and physiotherapy could play a major part in restoring function, citing people who have suffered a stroke as an example of those who would benefit from, but often do not receive, extended therapy to maximise function. The shortage of chiropodists working in the community has a major impact on the mobility of many older people.

The absence of systems for recycling/reusing equipment and adaptations

There is widespread concern that the value of public investment is often lost through the lack of efficient and cost-effective systems for recycling equipment and for encouraging the occupation of adapted properties by those who would benefit from such provision.

• There is no generally acknowledged and implemented system for supply, recall and refurbishment of aids

The Association of Directors of Social Services believes that while good practice exists in some areas, there are no generally accepted systems for the procurement, distribution, reclaim and refurbishment of equipment. Where improvements have been made, then a more efficient service has been possible without any necessary increase in cost.

Numerous examples were offered by respondents of a failure to retrieve expensive equipment and of others in which the expense of retrieval far exceeded the value of the equipment. The current situation seems to be characterised by all-or-nothing systems. At the root of the problem is often the failure to put in place an effective system for tracking equipment once issued and for informing clients of the policy on retrieval. Most clients and their relatives are very keen to see equipment reused and would collaborate with reclamation if they knew who to contact.

The systems needed to record the recovered value of equipment (that is the cost of purchasing a new item discounted by depreciation for age and adjusted for the cost of cleaning and refurbishment) and to set this against a standardised cost of recovery before making a decision about collection are simple to construct. Some scope would need to be built in to allow for equipment not likely to be reissued because it is outdated and for client

returns which involve no collection cost. Clear information should be available to users, carers and the general public, setting out the policy, practice and rationale adopted by the providing agency.

The failure of this area of service involves enormous waste of public money and, no less important, distress to clients and carers. When equipment is not retrieved efficiently, there is distress to a surviving partner or other carer. They resent waste and are distressed by equipment serving as a reminder of loss.

• Public investment in the adaptation of dwellings is not efficiently used, as adaptations are often removed on sale or relet of the property

In some areas housing authorities and social services departments are working together to create special needs housing registers to ensure that adapted properties can at least be identified. A number of housing associations have created databases allowing allocations to be linked to adapted property, maximising the benefit of the initial investment. Where possible, local estate agents also need to be involved so that property in the private sector can be identified and the adaptation sold as a positive feature rather than as an easily removed inconvenience.

The shortfall of resources

The future role of private and voluntary sector service providers, including housing associations, needs to be clarified

• There is only a limited attraction for the private sector to offer services to substitute for the withdrawal of statutory services

The evidence of at least one major commercial provider of housing and care services to older people is that a service which integrates their existing activities with the provision of equipment for older people with disabilities is problematic and offers an inadequate return. Attempts to develop a wide-ranging integrated service did not meet with a sufficient level of demand to justify the organisational costs involved. There are also indications that attempts to directly market dispersed alarms to support

older people to meet their communication and security needs are now declining. The major provider in this field is not currently investing in the marketing of this service directly to the public.

The viability of expanding the provision of equipment through high street chemists may depend upon subsidy to allow these products to compete for shelf space with those showing greater returns. Specialist outlets generally have a low profile and engage in limited marketing. Mail order operations overcome some of the difficulties but the level of inappropriate purchases may be higher when the client must rely upon a photograph or catalogue description. Disabled Living Centres provide an opportunity for clients to try equipment, and some are beginning to move into a more commercial approach to the sale and rent of equipment, but they are few and far between.

The operational difficulties seem to indicate that the market may be occupied predominantly by organisations with a not-for-profit value base operating in a quasi-commercial fashion to sell or rent equipment. The exceptions may be those major commercial organisations who establish facilities to service social service and health authority contracts for equipment and supply directly to the public as an extension of that service.

- **Housing associations now have a major role as providers of social housing with a high proportion of tenants who are elderly or who have a disability**

The National Federation of Housing Associations reports that most housing associations do not have staff to deal with aids and adaptations in anything other than an ad hoc way. Examples of good practice do exist but these are exceptions. In Scotland, housing associations seem to have addressed this area in a more consistent fashion.

The Housing Corporation provides substantial sums of money for aids and adaptations but this is largely random and without a clear strategic objective. There are enormous variations in the funding provided to particular associations and between regions of the Corporation. Procedures for small adaptations are cumbersome, with no streamlined procedure for small jobs. In the view of Tracey Roose, of the NFHA, further work is needed in this area if the potential of the housing managed by housing associations to meet the needs of those being cared for in the community is to be realised.

- **Reductions in funding to voluntary sector organisations decrease their capacity to provide services to complement those of the statutory agencies or to substitute for reductions in service levels**

Age Concern London drew attention to the enormous reduction in the funding made available to the voluntary sector in London and the resulting loss of capacity to play a full part in developing future patterns of service. The financial difficulties experienced by many disabled living centres were mentioned by a number of respondents who fear that this important resource may be lost in many areas. In London the Disabled Living Foundation has found it necessary temporarily to restrict some of the services of its Disabled Living Centre through lack of funding.

Chapter 2

Tackling the issues: examples of good practice

This section provides some illustrations of services which are seeking to face some of the issues examined in Section 1. They provide evidence that change can be achieved and may offer a point of reference for thinking through the operation of services locally.

Disability West Midlands

Since 1977 Disability West Midlands has provided information for people with disabilities, their carers and professionals. The organisation also engages in campaigning activities on behalf of people with disabilities and their carers and is developing a range of training services, principally in the area of disability awareness. Although the advice service offered by correspondence and telephone is well used and their newsletter provides an effective medium of communication, Disability West Midlands is aware of the limited coverage of its target area which can be achieved from one site.

The current model

To extend the range of the service which can be provided from its fixed site Disability West Midlands currently operates two mobile advice-and-information units. The organisation recognises that access to a single fixed service point may be as difficult in a large urban area as in rural areas. One vehicle covers the City of Birmingham, while the other visits the towns within the shire counties of the West Midlands region. Both vehicles visit some locations on a regular basis: shopping centres, pub car parks on housing estates, day centres and similar locations. They also make occasional visits to special events. Both are accessible for people with mobility problems, including those in wheelchairs.

Each unit provides information and advice, carrying a wide range of application forms and literature. This covers equipment and adaptations, welfare rights, personal and specialised services, transport and leisure.

For equipment and adaptations the service sees itself as putting those who need detailed information or casework support in touch with other agencies. These may be specialist regional or national agencies, such as the Disabled Living Centre, or locally based general advice and support agencies, such as CABx. They also provide guidance for those who need to access statutory services.

The benefits

Disability West Midlands sees itself as providing information, which is the basis for informed decision and genuine choice. Their mobile projects provide a point of initial contact, especially for those not accessing services by established routes, and low threshold access for those with low or medium levels of need who would not be priority targets for statutory services.

CAMTAD: The Campaign to Tackle Acquired Deafness, Cambridge

The Campaign operates from a fixed base in NHS hospital premises. In the past, access by users depended largely on their visiting the hospital. It is widely recognised that many people who suffer impaired hearing have difficulty in accepting the presence and extent of their problem. Given that denial is such a major barrier to those with acquired deafness seeking help and advice, workers recognised the need for an outreach service.

In 1987, the Year of the Deaf, CAMTAD was approached by a major charitable foundation with a view to donating a significant amount. The menu of possibilities which CAMTAD developed included an outreach project based in a van. This initiative captured the imagination of the funder: the vehicle was bought and the mobile service launched in September 1988.

The current model

The van is operated by volunteers, many of whom have hearing impairment and offer advice based upon personal experience. The project combines regular visits to fixed sites, such as health centres, with occasional calls to shopping centres, rural carnivals, country shows and other special events.

The van carries information and demonstration equipment such as door alerts, specialised telephone systems, door security systems, specialised smoke and fire alarms, a variety of loop devices for connection to television or audio equipment, personal alarms and pagers, and other aids to hearing. Along with the equipment the van carries a wide range of information on services and facilities in Cambridgeshire for those with hearing impairment together with literature on national organisations and services. The service also carries information on equipment and its correct use, together with price lists and background literature. The project also offers services such fitting new batteries and cleaning aids to hearing which have been supplied by the NHS.

The benefits

The van allows the service to be provided in a range of locations and the volunteers work in a friendly and informal way. This makes the initiative more acceptable to users, especially those still coming to terms with the realities of their hearing problem. The use of volunteers, many of whom are older people with some degree of hearing impairment, is seen to give the service authenticity. There is sufficient time to listen, advise and encourage, and the service provides a route of access for those who would be deterred by a more formal approach.

The initiative has also been useful in building confidence in the service CAMTAD can provide and in some cases has led to the creation of fixed sessions in local health centres on a regular basis. In this way CAMTAD has been able to consolidate and extend its service.

Home improvement agencies

Home improvement agencies, most commonly known as Care and Repair or Staying Put, have been in existence since the early 1980s and have become more widespread since 1991. Their main focus has been on achieving repairs and improvements to the homes of elderly owner-occupiers. Their involvement in adaptations in relation to disability has often been to facilitate major schemes involving substantial building works.

The intention of those who pioneered these schemes was always to support the independence of older people by tackling the widest possible range of problems arising from the design or condition of their property. More recently, care in the community and the availability of funding from social services departments have allowed some local projects to take specific initiatives to provide services to achieve adaptations.

Current models and their benefits

Home improvement agencies have adopted a range of responses according to local circumstances and available funding. Four examples are given here.

- The well established **Staying Put** project in **Oldham** had operated a handyperson scheme since 1989 to provide a low-cost solution to small-repair problems. In early 1994 funding for this scheme was coming to an end, and an opportunity arose to redirect the service. Funding was secured from the social services department for a three-year term, and since 1994 the handyperson has been carrying out the fitting of equipment and a range of minor building works. The caseworker within the Staying Put project screens all clients for entitlement to benefit and any need they may have for further services. The benefits of the project are seen to be in the speed of response, the flexibility of the service, its growing specialist knowledge and the access it provides to other services. Previously such work was carried out by the building services department of the council, and social services felt that they had no control over the timing, cost or quality of the service.

- In **Brighton** the **Staying Put** project had been operating since 1983 and in that time had liaised with occupational therapists in carrying out adaptations but generally only within larger schemes for repair or

improvement. From 1992 a new emphasis was placed upon responding to disability, and closer liaison was established with the local disabilities team within social services. In 1994 the Staying Put project contracted with the social services department to project-manage all adaptations using a dedicated caseworker and technical officer. The scheme manages the financial aspects of each case and supervises the building work from specification (where there is close liaison with the occupational therapist) and tendering to completion. The benefits of the arrangement are perceived to be the growing level of specialisation, which provides the client with a better service, and the degree of control which the social services department can exercise over timing, cost and performance. There have been opportunities for increasing knowledge across disciplinary and agency boundaries, and the project is able to provide preliminary advice to occupational therapists on technical feasibility.

- The neighbouring **Staying Put** project in **Hove** had a similar history of some involvement with adaptations. The area disabilities team of social services had major problems arising from a backlog of approximately 350 unvisited cases. The Staying Put team was approached to provide a limited term service to tackle the backlog. A specialist parallel Staying Put team was created with an occupational therapist, technical officer, caseworker and administrative support workers, under the leadership of the existing project manager. A second, part-time occupational therapist was added later when additional funding had been identified. In the course of the year this team cleared the backlog of cases, with almost 200 moving through the process to receive either equipment or adaptation to meet their difficulties. Around 50 further cases were concluded after the 12 months of the special arrangement. Although the arrangement was for a limited term and concluded after twelve months, inter-agency case reviews continue. These cover not only the backlog cases still in process but mainstream Staying Put cases where disabled facilities grant has been applied for.

  The experience of the initiative has given project staff a good insight into the workings of the social services department. A broader-based alliance of Staying Put, the environmental health department and social services has been forged out leading to some system improvements. The occupational therapists were able to focus on using their professional expertise and not get bogged down in negotiation of grant conditions,

landlords' approvals, and so on. The team are emphatic that the success of the initiative owed much to the presence of the occupational therapist inside the project. This offered an opportunity for informal discussion, mutual learning and understanding and fast decision making: for the professionals, barriers were broken down, and for the clients, the service was effective in delivering a response to their problems.

- In **Bury**, the social services department proposed the creation of a specialist **Staying Put** style of project specifically to provide assistance with adaptations. There was no existing home improvement agency, and this initiative is not linked, as the other examples are, with a home improvement agency providing a broad range of assistance with repairs and improvements. The project commenced in early 1995 with two-year funding. It is managed by an occupational therapist with support from an adaptations and repairs officer, who has a technical background, and an administrative assistant. It was the experience of the social services department that a third of cases where assessment had established the need for an adaptation were not being supported through to completion. Some clients were unable to cope with the paperwork and form filling, others had difficulties finding and appointing a reliable builder, and others still could not find the resources to fund their contribution to the cost of the work. The project has spent its first months of operation seeking to identify clients who are caught in this situation and trying to help them make progress. The adaptations and repairs officer is able to offer advice on the technical feasibility of proposed schemes and to project manage major jobs through to completion.

  Although in its early stages, the initiative has already created an awareness of the need for a common approach between the disciplines and agencies involved in adaptations if an effective service is to be provided to clients.

Oxfordshire centralised procurement, storage, distribution and reclaim arrangements for equipment

(Oxfordshire Health Authority and Oxfordshire County Council Social Services in association with Huntleigh Nesbit Evans Healthcare)

The arrangements for the procurement, storage and distribution of equipment in Oxfordshire reflects the history of the occupational therapy service in the county. Community occupational therapists transferred from Berkshire at local government reorganisation in 1974 were directly employed and used their own equipment store. The majority of the county was served by occupational therapists employed by the health service and, although subsequently transferred to the employment of social services, the equipment store continued to be operated by health.

The delivery of equipment was handled by the ambulance service and fitted in, when space allowed, with routine journeys. In some areas simple equipment could take up to seven or eight weeks to arrive from the stores. Staff in the stores rated the priority for delivery but this did not reflect the situation of the clients and although occupational therapists could try to expedite the process no one set overall priorities.

The budget for equipment was controlled by the stores department, not the occupational therapists, so there was no connection between those specifying work and budget control. Irrational stocking was common because it reflected special offers from suppliers and preferences of individual professionals, rather than a co-ordinated range matched to current usage. The refurbishing of recycled equipment was haphazard and equipment was often retrieved at greater cost than its value. Installation was carried out by direct labour or by social services contractors.

In reviewing this background Nick Kennedy, of Oxfordshire Social Services Department, is clear that the problems did not reflect on the staff, who were doing their best. The coming of 'community care' brought the realisation that to meet standards of service quality and health and safety requirements fundamental changes would be needed

The health authority and social services department jointly commissioned a consultant who recommended the creation of a central store operated by one agency. The two authorities decided to implement the

recommendations by seeking an externally managed service. The project was put out to tender in April 1994 on the basis of a catalogue of equipment and service specification, drawn up in negotiation with the professionals involved. The contract was awarded to Huntleigh Nesbit Evans, a manufacturer and supplier of equipment to the health and social care sector, which created a subsidiary company to manage the contract.

The award of the contract has generated some adverse reaction within the industry on the basis that the company's manufacturing business may gain commercial advantage. However, the Oxfordshire operation is managed at arm's length from other parts of the group, and the stocking and supply of products are specified by Oxfordshire Health Authority and Oxfordshire Social Services Department. The catalogue of stock items was devised and is revised by professionals in the two authorities. Huntleigh Nesbit Evans staff do not offer alternative products but refer to the purchasing professional if the equipment they have specified is not available.

The current model

Huntleigh Nesbit Evans National Care Oxfordshire established its warehouse and distribution centre in Abingdon in September 1994. The operation is managed by a distribution and warehousing specialist who had no previous experience of health care equipment. The staff complement includes an administration manager, a receptionist, two customer care advisers, two order processors, three warehouse persons, three driver/installers and a builder. The driver/installers and the builder undertake the installation and customising of small equipment, the fixing of grabrails, creation of ramps, and other work.

Every potential specifier has a catalogue of 140 of the most commonly specified items which are held in stock by Huntleigh Nesbit Evans. These include bathing and accessories, lifting & handling equipment, toileting and accessories, mobility aids, aids for daily living, beds and accessories, and pressure area management products. Each product is illustrated by a line drawing together with a description, technical specification, fitting and installation requirements and usage limitations. The cost of purchase, weekly hire, installation (where appropriate) and return value are all specified.

For stock items the specifier may stipulate the time scale for delivery. This can be within 24 hours, within three days or within five days, and a sliding

scale of charges for delivery places a premium upon the shorter time scales. In cases of extreme urgency Huntleigh Nesbit Evans will provide an out-of-hours and immediate delivery service. If delivery is not made within the specified timescale, the specifier receives a refund of the delivery charge.

Specifiers are not restricted to the items in the catalogue and can continue to specify other equipment at their own discretion. This will normally be sourced by Huntleigh Nesbit Evans as a special order and is not governed by the delivery time guarantees of stock items. This provides an obvious incentive to stay with the catalogue items where possible.

Budgets are now devolved to service teams. The team, and the individuals within it, are allocated an upper-spend limit per item and per order. Occupational therapists have a higher limit than care managers. As cost and sophistication of equipment tend to go together, this provides a simple restriction on the ability of non-specialists to specify equipment which needs assessment by an occupational therapist. Each person authorised to specify equipment is given a PIN number to identify them, and Huntleigh Nesbit Evans refer orders above an individual's limit for authorisation by the line manager or specialist with an appropriate limit.

Huntleigh Nesbit Evans submits claims for payment to central finance, which matches claims for payment to copy requisitions and confirmation of receipt or installation. The system allows for expenditure to be set against individual budgets and spending patterns by client group, equipment type, or geographical area can be examined.

The system allows for the transfer of cost between health and social services without prior authorisation. Thus a health service-based occupational therapist can specify equipment to assist the patient on discharge and if longer-term use is indicated on reassessment by the community-based occupational therapist, then the cost can be transferred to the appropriate budget. Similarly, equipment originally taken on hire to meet a short-term need can be charged as a purchase with the crediting of hire charges against the cost, if a longer-term need becomes apparent.

The individual receives a credit to their budget on returned equipment, less a depreciation and administration charge, and this provides an incentive to keep track of equipment and arrange return, as appropriate. For stock items the credit is immediate, for non-standard items refund is made when the item is reissued. The catalogue of stock items identifies the

return value of each piece of equipment, and the procedures guard against the expensive collection of items of small value.

Under the previous system there was no proper complaints procedure. In the first four months of operation of the new system, complaints ran at 4 per cent of requisitions, although many of these arose from circumstances before the commissioning of the present arrangements, and only 1 per cent related to stock items. The level of complaints has fallen steeply since the beginning of the current year. The new system is now handling a higher volume of requisitions, and deliveries have increased by 21 per cent. Oxfordshire Health Authority and the social services department have set up a user group of professionals which reviews and verifies the range of equipment included in the stock catalogue. Involvement of service users and carers in the work of this group is now on the agenda.

Benefits

The benefits for people with disabilities in Oxfordshire are seen to be in the operation of a more efficient service in both delivery and installation. For the professionals it removes a good deal of unproductive activity, allowing them to concentrate on the delivery of professional skills, while giving their clients a more rapid and accurate service. It has also provided a means by which non-specialists may directly access the service in a controlled way. If some professionals find the perceived restriction of their freedom to specify irksome, their resistance may also be related to unfamiliar responsibilities for budget management. For the commissioning authorities it provides excellent management information and budgetary control systems, while placing responsibility for the minutiae of service delivery with the contractor.

Southdean Co-operative Housing Association Glasgow

Southdean is a Co-operative Housing Association managing just under 300 properties in the area of Drumchapel, Glasgow. Their stock includes a mixture of new and refurbished property, together with some properties awaiting demolition. Around 20 per cent of their tenants are aged over 60. It was the experience of trying, with great difficulty, to secure temporary adaptations to one of their properties to meet the needs of a particular tenant that motivated them to develop a better system. After persistent attempts to establish contact with the social work department, they eventually managed to arrange an initial meeting to discuss common concerns and talk through particular cases. Both sides found the meeting useful and made a commitment to continue to meet.

The current model

The housing manager and the senior development officer of Southdean hold regular meeting with the social work department occupational therapist covering the neighbourhood. Meetings are generally once a month and on average last an hour to an hour an a half. They will review individual cases, and the occupational therapist will also offer advice on the design of new developments and major programmes of refurbishment. For example, in the case of the refurbishment of a complete block, the occupational therapist assessed all tenants and advised on preferred layout design and equipment to support their independence.

Many of the cases come to the attention of Southdean staff through the work of their welfare benefits adviser in the housing management team. In carrying out assessment for disabled living allowance, the adviser will identify problems with the tasks of daily living and pass these on, through the joint meeting, to the occupational therapist for assessment. Tenants who have learnt of the service through the tenants newsletter will also make direct referrals of themselves and their neighbours. Under the funding system operating in Scotland short-term equipment and adaptations will be paid for by the social work department and long-term adaptations will be funded by Southdean Co-operative Housing Association and reclaimed from Scottish Homes.

Benefits

The system is seen to benefit all parties. The tenants have much better access to the service with an immediate impact on their quality of life. The housing association is able to meet its obligations to tenants and operate in an effective way. The social work department is able to deliver services accurately and cost-effectively. The housing association keeps track of equipment and sees that it is returned when the property is vacated or needs alteration. The professionals involved testify to the benefits of collaborative working in extending their awareness of client needs and available responses. The practice of joint visits has strengthened mutual understanding and confidence.

Canadian Mortgage and Housing Corporation Self-Assessment Guide: Maintaining Seniors' Independence through Home Adaptations

Older people needing equipment or adaptations to maintain their independence within their homes often have little opportunity to contribute to the process of assessment and specification. Too often they are reduced to the level of spectators, responding to the set solutions offered by professionals. This self-assessment tool helps older people look critically at their own level of function and the constraints upon their independence posed by the physical design and facilities of their home, while illustrating constructive solutions.

Instruments for self-assessment have limitations, and need to be supported with professional advice and specialist services. One other concern of professionals is that such self-assessment guides may encourage clients to create wish lists without regard to budgetary constraints. The Canadian example envisages clients meeting costs and thus coping with budget constraints themselves. Any such material designed for use in the UK would need to make clear the circumstances under which work may be publicly funded and the limitations which may apply.

The model

The guide provides a checklist for each of ten areas:

- Getting in and out of the home.
- Using the stairs
- Moving around your home
- Using the kitchen
- Using the bathroom
- Getting out of a bed or chair
- Using closets and storage areas
- Doing laundry
- Using the telephone or answering the door
- Controlling light and ventilation.

The checklist is supported by line drawings. These were found to be particularly helpful in encouraging users to recognise the relevance to their own situation and to envisage the benefit of equipment or adaptations. The publication is part of a suite of supporting literature and assessment instruments for users and professionals.

Benefits

The publication gives older people a means of assessing their own situation. It may be particularly useful in providing those who do not recognise themselves as disabled with a critical insight into their situation and encouraging them to access services. Although it lacks the sophistication and safeguards of a full professional assessment, it does provide a means of giving some immediate remedies and of empowering the user to participate in the assessment process. Those areas where applicants for occupational therapy assessment were judged to have low priority needs may wish to consider whether such a publication would be preferable to an interminable wait or the dispatch of a commercial catalogue of equipment.

Nationale Wonningraad (NWR) experiment with adaptable renovations

Between 1984 and 1991 the NWR, the Dutch Federation of Housing Associations, carried out an experiment on adaptable housing in which 40 housing associations participated. The experiment was aimed at encouraging the building of all new housing in such a way that an adaptation would be easy should the occupant become disabled. The experiment demonstrated that building new adaptable housing was possible within the spatial and financial limits of Dutch social housing. If the requirements are included in the design process from the beginning, then the additional costs compared with building in a non-adaptable way are very small. In the experiment the additional costs proved to be an average of £120 to £130 per dwelling.

The success of this experiment encouraged the development of models for the refurbishment and renovation of property to similar standards of adaptability. In April 1995 SEV, the Dutch Foundation for Housing Experiments, took the initiative to implement the models for adaptable renovation developed by the NWR and find out which choices principals in the building industry will make. In all twenty housing associations and local authorities are participating in this experiment, which will be evaluated and reported on in due course.

The model

Models for the implementation of adaptable housing standards to existing property needed to be more flexible than those provided for new-build housing. Some properties could not be made adaptable for a full range of disabilities. The model therefore distinguishes between three levels of target group: people without specific disability, for whom prevention packages were created; a second group consisting of people with disabilities but excluding wheelchair users; and a third group comprising all disabled people, including wheelchair-users and users of walking aids. These three target groups were matched to three levels of accessibility:

- the approach to the dwelling up to the front door (accessibility);
- access into the dwelling and to its facilities (visitability);
- the ability of the whole interior of the building to provide a context for independent living (usability).

Out of the matching of these three levels of ability and three areas of the dwelling and its surroundings came the definition of nine packages of specifications for improving the existing housing stock. Three packages addressed the need to prevent accidents; three packages were intended to improve housing for people with disabilities but not including the needs of wheelchair-users; and three packages were designed to improve housing for disabled people including wheelchair-users. The term 'adaptable' will remain exclusively reserved for measures to make housing adaptable for people with a wide range of disabilities, including wheelchair-users.

Benefits

For those who occupy dwellings which have been renovated using the packages of specification developed by NWR there is the benefit of not having to move or suffer major disruption in the home if their level of functional ability declines. For those who own and manage such property there is the benefit of avoiding costly one-off adaptations and the ability to offer a range of homes suited to a variety of personal circumstances.

Walbrook Disabled Persons Housing Service, Derby

The inspiration for this service is attributed to one client, formerly a patient in a long-stay hospital for adults with learning difficulties, who was referred to Walbrook Housing Association for housing in 1983. For some years Walbrook had been providing housing designed for severely disabled people. Success in working through the challenge presented by this patient led the housing and social services authorities to offer funding for Walbrook to establish service for all disabled people, regardless of whether they were applying for tenancies with the association or not. The Walbrook Disabled Persons Housing Service (DPHS) was launched in 1985.

The current service

Walbrook Disabled Persons Housing Service employs one full-time and one part-time housing adviser, both occupational therapists. Clients are visited in their own homes, their housing needs assessed, and advice given on aids and equipment. The adviser will prepare DPHS users' functional and environmental assessments for adaptations work. The assessments are developed into plans drawn up in close conjunction with Walbrook Housing Association's architect who works part time for the DPHS. There was also technical support from a consultant who designs specialised equipment and gadgets to solve particular problems. The housing advisers will also discuss rehousing options with clients when appropriate. The DPHS also operates a training flat, and advisers will arrange training for clients in that setting.

Referrals to the service come from a wide variety of sources, clients must be disabled and either living in Derbyshire or moving to the area. An appointment will be made for a first visit, in which the scope of the service will be explained. The basis of the service's casework is to establish what the client wants.

The initial explanations lead into information giving and advice on housing options: to move or to stay and undertake adaptations, the range of possible repairs, improvements and adaptations with the conditions which may attach to each of these, equipment to assist independence, income and finance. The intention is to provide a seamless service which starts from the client and works out through their needs and wishes to a solution.

The model is now being taken up by a range of statutory and voluntary agencies and the National Disabled Persons Housing Service has recently received funding for a development post from Barclays Bank.

The benefits

The DPHS provides clients with a comprehensive range of options, offered in a non-directive style and followed through with supportive assistance. This allows people with disabilities to review their housing options and implement the course of action which best suits their needs and aspirations. For statutory partners it provides a specialist agency which can bring to bear extensive expertise with the resources to spend time working through solutions with clients in a way not often possible in mainstream services.

Chapter 3

Moving into practice

Assessing local need

Existing patterns of service are as likely to be determined by available resources as latent need but they do provide a starting point. The first task for groups who wish to address a concern about the provision of equipment and adaptations for older people with disabilities, is to list local service providers. This will involve some research using Yellow Pages, Thomson's Directory and the Public Library. Key organisations should be contacted first, such as Age Concern, local disability groups and social services. They should be able to provide contacts in other organisations. The aim is to build up a file giving the name, address and contact details of each organisation or agency together with a brief outline of the services, facilities or activities they offer.

Key contacts among professionals and statutory bodies will include the following:

- domiciliary care workers (home helps) and their managers;
- care managers in social services;
- specialist social workers (e.g. for deaf or blind people, and for minority ethnic communities);
- general practitioners;
- community nurses;
- occupational therapists (health service and social services);
- consultant geriatrician;
- housing officers;
- grant officers in housing or environmental health departments.

Within the voluntary sector there are a number of key agencies to contact, including the following:

- Age Concern groups;
- pensioners' forums;
- pensioners' groups from major local employers;
- group of or for people with disabilities;
- British Red Cross;

- Women's Roal Volutnary Service;
- housing associations with a strong local presence.

Neither list is exhaustive. Having listed the local service providers they should be surveyed by questionnaire or interview. In each case it will be necessary to establish:

- the number of referrals each agency receives and if possible the categories into which these fall;
- the number of cases dealt with and the categories of assistance provided;
- the number of items of equipment distributed, differentiated by type;
- the number and type of adaptations carried out and their value;
- the number of people receiving a service or taking part in an activity;
- what estimates they can offer of current need, what length of waiting lists they have and what delays commonly occur in the system.

From this work it will be possible to map the pattern of local services, calculate the numbers receiving services of different types and a preliminary estimate of need. Going beyond this will need survey work with a sample of older people drawn from the general population. Local pensioners' groups or lunch clubs may provide a convenient, if not strictly representative, sample.

It is possible to use a short questionnaire asking for the age of the respondent, the difficulties with daily living they experience and the types of assistance they receive. Respondents are asked to identify any needs they have which remain unmet and to indicate which sources of help or information are known to them. From the returns from this exercise it is possible to extrapolate figures for the total local population of older people and to compare this with the results of the survey of service providers. A more sophisticated self-assessment instrument, such as that developed by the Canadian Mortgage and Housing Corporation, could be administered to a sample of older people. Again the outcomes can be set alongside current service levels and estimates of latent demand from service providers and others.

Securing support for change

The key to any successful change process is to be found in ownership. Unless all the major participants accept the need for change, recognise the relevance of the proposed changes and believe them to be practicable, the

process will not have a successful outcome. The policymakers, the frontline service providers and all those who provide the connections between them, need to own the process and objectives of change if they are to be successfully implemented. Those driving the process of change must have a sound appreciation of the perceptions of all the stakeholders. It is easy for those who grasp the need for change, and who set about implementing it, to be carried along by the momentum of the process and lose contact with others who may not perceive the need for change so clearly or may feel that their position is threatened by any shift in the status quo.

A good starting point is to conduct a stakeholder analysis, seeking to map all those, within and without the organisation(s) involved, who might have some stake in the systems under review. In the area of aids and adaptations for disability in older age this will clearly involve a wide range of professionals from a number of disciplines and agencies, together with service users, their carers and others, such as elected members. For each group of stakeholders it will be necessary, from existing knowledge or by taking soundings, to establish their position in relation to the current arrangement and to any likely changes.

All those involved need an opportunity to share in the definition of the areas of difficulty and to be invited to offer means of addressing them. It is generally safer to resolve any conflicts in perception by deferring to staff nearest to the point of service delivery. The information which is fed back may be handled through the categories of strengths, weaknesses, opportunities and threats, to build a framework for understanding the current situation and beginning to identify areas for change.

In those key areas identified for change participants may be brought together in small task groups to work through the systems and examine possible developments, test their viability in discussion with one another and begin to build new systems and strategies. At regular intervals it is necessary for those in positions of leadership to offer a clear vision of the overall direction of change and to endorse the efforts of those who are doing the detailed work. Regular feedback of the proposals being developed to as wide a range of participants as possible is important with a genuine willingness to hear and evaluate criticism honestly.

To secure the necessary ownership of change the process will need to be well led, provide a clear overall vision and be practicable in its detail.

Proposed changes need to emerge from a process of listening carefully to the experience of those closest to the point of service delivery, offer changes with perceptible benefits to at least the majority of stakeholders. If it is possible to introduce changes incrementally this will ease the process but people will need to know in which overall direction the individual steps are leading them. Any changes will need to be monitored and reviewed in the light of experience.

How to select, adapt and learn from practice in other agencies and locations

If this is not to be perceived as a negative process, implying criticism of those currently delivering the service, the only appropriate starting point must be in the identification of elements of good practice within the existing situation. Evaluate those areas of the local service which are good and are seen to work effectively. Isolate areas where difficulties arise or where the service is acknowledged to be poor, every attempt should be made to do this in a blame free climate. Are there ideas within the team or among users for making improvements? Often those closest to the operation of the system have good ideas about working more effectively but do not feel empowered to offer those insights. Provide a system by which input from users, carers and front-line professionals can be gathered. A wide trawl for ideas will produce some crucial insights which everyone knew but no one articulated.

Do not get bogged down in the resolution of particular examples of problems but try to construct categories of difficulty. Is the issue one of lack of planning and co-ordination, or is it one of delivery problems? From this analysis it is possible to classify the areas in which inspiration is needed: examples of good joint planning and management, improvements in service delivery, and other key issues. It may be necessary to address more than one of these but separate them out and deal with one at a time. Then review examples of good practice or innovation from elsewhere and try to classify them in the same way: which areas of good practice or innovation do they illustrate? Identify elements which match the particular needs. An example of improved service delivery may be interesting and inspiring but will be a distraction if the primary need is to improve joint resource management.

Try to identify the key success factors in the example and then look for the parallel developments which would be needed to achieve a similar result.

Every situation is different and it is rarely possible simply to clone an example of good practice in another location. Its key elements must be identified, equivalent features found in the new situation and a fresh model be constructed.

Having carried out this process for one category of concern repeat the process for the next. Inspiration for that may come from an entirely different example. When all the areas have been addressed there should be a draft model which can be looked at as a whole and internal inconsistencies identified. The process of evaluation and reconstruction should be as participative as possible.

Getting feedback

Feedback from professionals and service users is important in order to judge the impact of change and the appropriateness of services. There are at least four measures which can be taken:

- At the conclusion of each intervention every service user can be provided with a short questionnaire, together with a reply-paid envelope. The questionnaire should ask about the service received, whether it was appropriate, what needs remain outstanding and the overall impact of the intervention on the client's confidence, independence and well-being. Ideally the survey should cover a range of services and providers but all be returned to a single point for analysis.

- The second technique is to recruit a panel of older people drawn from a range of organisations. They may regularly feed back impressions of the services received and discuss policy and service delivery issues with professionals and providing agencies.

- A quarterly interdisciplinary meeting allowing a common review of the feedback from a postal questionnaire or pensioners' panel.

- Most providing organisations practise formal systems for supervision and assessment. The outputs from these may be shared on a confidential basis between senior staff in agencies providing services to a common client group or within a focused locality.

Chapter 4

Obtaining assistance with equipment and adaptations – legislation and official guidance

Which organisation is responsible for providing equipment and adaptations for older disabled people?

Equipment and adaptations are a complex area, and there is no single clear piece of legislation setting out what rights disabled people have, and which organisations should meet their needs. Social services departments (or more accurately, welfare authorities) play an important part and ultimately have a duty to provide assistance with equipment and adaptations to people with disabilities, but local housing authorities also have duties to give grants towards the costs of adaptations in some circumstances. Health authorities, and increasingly the voluntary sector, also have a role to play. To users and their families, to carers, and indeed to many providers, the complexity of this situation is highly confusing. More seriously, it may also seem designed to provide all the organisations involved with an excuse for delay and the opportunity to pass needs on to someone else.

What duties do these organisations have to provide help?

The most important legislation setting out the rights of people with disabilities is the Chronically Sick and Disabled Persons Act 1970. Sections 1-3 of the Act are concerned with welfare and housing. The Act gives *welfare authorities* (in London, the borough councils) the following duties:

- to determine the number of disabled people in their area and to provide disabled people with information on the services and help available to them from various sources (Section 1);

- to arrange for disabled people who need services: practical assistance in the home; assistance with adaptations or the provision of additional facilities to secure safety, comfort or convenience; and a range of other

forms of help relating to recreational activity, travelling, meals, and access to telephone services (Section 2).

The Act has been subsequently amended several times to extend or clarify some of its provisions. The Disabled Persons (Services, Consultation and Representation) Act 1986 added the following duties relevant to the provision of equipment or adaptations:

- when requested to do so by a disabled person (or an authorised representative or carer) the welfare authority must assess the needs of that person for the services specified under Section 2 of the Chronically Sick and Disabled Persons Act 1970. The NHS and Community Care Act 1990 broadened this duty of assessment to cover all cases where it appears to be needed, rather than those cases where help is requested.

These duties are very comprehensive, but in practice the main role of welfare authorities is to assess the needs of people with disabilities, and to provide items of equipment to assist them with daily living. Responsibility for adaptations to dwellings lies in most cases with local housing authorities. In London, confusingly, these are the same organisation, but frequently the welfare and housing functions are handled by different departments. Even when they are not, many problems of co-ordination still occur.

What are the responsibilities of housing authorities?

Although the Chronically Sick and Disabled Persons Act 1970 makes it clear that welfare authorities have the ultimate responsibility for arranging the provision of equipment and adaptations for disabled people, *local housing authorities* have parallel powers and duties to meet housing needs. Section 3 of the Chronically Sick and Disabled Persons Act 1970 reminded local housing authorities of the need to assess and make provision for the housing needs of disabled people, and from 1974 onwards, the pre-existing system of *improvement grants to owner occupiers and private landlords* was amended to allow grants to be given to assist owners with the cost of adaptation work to meet the needs of disabled people. However, this was not entirely satisfactory, and in 1989, the Local Government and Housing Act introduced grants aimed specifically at providing financial help with adaptations. This was amended in 1996 by the Housing Grants, Construction and Regeneration Act. The provision of equipment by welfare authorities was not affected. The grants available are:

- ***disabled facilities grant*** – financial assistance, available as of right to owner occupiers, tenants and private landlords (including housing associations) for adaptations to meet basic housing requirements, and at the discretion of the local housing authority for a wide range of other works. Applicants must be registered or registrable as disabled. The amount of grant is determined by a test of resources applied to the disabled person and in some circumstances other persons with an ownership interest in the dwelling in which the disabled person lives. Grants available as of right are subject to a maximum of £20,000 in England;

- ***home repair assistance*** – this replaced minor works assistance in 1996. The grant (or assistance with materials) is available at the discretion of the local housing authority for works of repair, improvement or adaptation to help owner occupiers and private tenants who are elderly or disabled or who are in receipt of a means-tested benefit (including income support or housing benefit) with works to enable them to remain living in their existing home, up to a limit of £2000 per application and a maximum limit of assistance of £4000 for the same dwelling in a three-year period.

What is covered by grant aid from housing authorities, and what is the responsibility of the welfare authority?

Disabled facilities grant covers adaptations, that is alterations to dwellings to assist disabled people with daily living activities (e.g. the provision of an accessible WC), or the provision of permanently fixed equipment (e.g. a stair lift). Other forms of equipment which can be installed or removed with relatively little or no structural modifications are not covered by the grant and are the responsibility of the welfare authority to arrange. Often, voluntary sector organisations such as the Red Cross are involved in providing equipment, but arrangements vary from one area to another. Welfare authorities often provide equipment free of charge, but are permitted to make charges, if they wish to do so, under Section 17 of the Health and Social Services and Social Security Adjudications Act 1983.

What about tenants of local authorities or housing associations?

Tenants of local authorities and housing associations are eligible for disabled facilities grant, but local authority tenants are not eligible for home repair assistance. Local authority practice on the provision of help with adaptations to their own stock varies. Some authorities fund part of all of this work through the Housing Revenue Account – that is from the rents and other income collected from tenants, but others direct applications for adaptations through the disabled facilities grant channel, leading some applicants to make a contribution to the costs. Sometimes local housing authorities, rather than the welfare authority, also meet the costs of providing the more major items of equipment in the local authority stock. Confusingly, practice varies from area to area.

Housing association tenants, or housing associations themselves as landlords, can apply for disabled facilities grants. However, only housing association tenants, not their landlords, can apply for home repair assistance. Housing associations can also bid to the Housing Corporation (which allocates public money for new housing association building or renovation work) for funding to support major adaptations costing over £500.

What role do health authorities play?

Health authorities are primarily responsible for health care. When a disabled person remains in the community or returns home from hospital, the duty to provide equipment (except certain highly specialised forms of medical equipment) lies not with them but with the welfare and housing authorities. Health professionals such as hospital-based specialists and consultants, general practitioners, occupational therapists and nurses often play an important part in assessing the need for equipment or adaptations, and health authorities may provide equipment to those returning to the community after a stay in hospital, but this is usually on a short-term basis only.

What if someone in need cannot afford the costs?

In relation to equipment, welfare authorities have a duty to arrange for needs to be met but they may make a charge for this, provided that they consider the disabled person is able to meet the cost. Again practice varies locally. Some welfare authorities charge for small, inexpensive, commercially available items of equipment which they acquire through bulk purchase arrangements, passing on the reduction in cost to the user. Others will not supply items below a cost threshold, requiring potential users to purchase these items directly from shops or other suppliers. There are also areas where there is an upper limit on the cost of items of equipment, above which the item is regarded as being the responsibility of the housing authority, especially if the disabled person is a local authority tenant.

Other difficulties arise if a disabled person cannot afford to pay the assessed contribution to the cost of works funded through a disabled facilities grant, or if the grant is discretionary and the housing authority decides not to provide help. Under these circumstances, welfare authorities still have a responsibility to arrange for the necessary services to be provided (Department of the Environment/Department of Health Joint Circular 10/90). Government advice suggests that the welfare authority could meet the extra costs (often referred to as 'top-up' costs) but that for consistency, and because the applicant's contribution has been assessed by a test of resources, they should aim to recover these costs in cases where they consider that the applicant can afford to pay without undue hardship, perhaps through instalment repayments, or by a charge on the applicant's property. The Government also suggests that recovery of any costs met by the welfare authority could be waived in cases where it can be shown that additional costs (for example, the costs of residential or nursing care) would be incurred if the adaptation work did not go ahead.

Checklist of legislation and official guidance *

Chronically Sick and Disabled Persons Act 1970
Disabled Persons Act 1981
Health and Social Services and Social Security Adjudications Act 1983
Disabled Persons (Services, Consultation and Representation) Act 1986
Local Government and Housing Act 1989
National Health Service and Community Care Act 1990
Housing Grants, Construction and Regeneration Act 1996
Department of the Environment Circular 16/88 Improvements to private housing
Department of the Environment Circular 4/90 Assistance with minor works
Department of the Environment Circular 10/90/Department of Health Circular LAC(90)7 House adaptations for people with disabilities
Department of the Environment Circular 7/93 Local Government and Housing Act 1989: changes to Parts VII and VIII
Department of the Environment Circular 8/94 Changes to the house renovation grant system
Department of the Environment Circular 17/96 Private Sector Renewal: a strategic approach

* *All published by HMSO*

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Ageing with a disability – What do they expect after all these years? Zarb & Oliver, University of Greenwich, 1993

Advice for Older People, British Gas

The Building Regulations 1991 – Access and facilities for disabled people. Draft, HMSO, 1995

Building Sight – A handbook of building and interior design solutions to include the needs of visually impaired people, Barker Barrick & Wilson, RNIB, 1995

Community Care Appliance Stock Catalogue, Down Lisburn Health and Social Service Trust, 1994

Community Care: Making it happen, Scottish CVO/Scottish Federation of Housing Associations/CA Scotland

Cracking Housing Problems, Walbrook Housing Association, 1992

DLF Services, The Disabled Living Foundation

Designing for People with Disabilities, Northern Ireland Housing Executive, 1995

Disability Rights and the Local Government Ombudsman – A study of English social services reports, 3rd Edition, Age Concern England, 1995

The Disabled Facilities Grant: 'Necessary and appropriate?' 'Reasonable and practicable?', RADAR

Disabled Living Allowance, Benefits Agency, 1993

Disabled Living Foundation Annual Report 1993/94

Disabled People Have Rights, John Keep and Jill Clarkson, RADAR, 1994

Ending Discrimination against Disabled People, CM2729, HMSO, 1995

Enhancing Independence – Guidance for home improvement agencies working with people with disabilities, Care and Repair, 1994

Equipment and Services for People with Disabilities, DoH/HMSO, 1992

Equipped for Independence? Meeting the equipment needs of disabled people, DoH, 1992

European Approaches to Accessibility and Housing Adaptation (2nd draft) (Prepublication) EU-HELIOS II, 1995

Good Care – A guide to the good care of people with disabilities, Kent County Council, 1991

A Guide to Products and Services, HNE National Care Oxfordshire, 1994

Home for Good – Information & training pack, Bradford, Mores & Wilkins, Care and Repair, 1994

Home Comforts: Home support for disabled older people, Age Concern London, 1995

The Housing Needs of People with a Visual Impairment. A report from the RNIB to the Housing Corporation , Cooper *et al.*, Housing Corporation, 1995

How to Get Help from Social Services, RADAR, 1995

Improving Disability Services, Nasa Begum and Sheila Fletcher, King's Fund, 1995

Integrated Health and Social Care, Down Lisburn Health and Social Services Trust, 1994

Kent Social Services Department, Occupational Therapy Bureau Business Plan 1995/96

Maintaining Seniors Independence through Home Adaptations: A self-assessment guide, Canadian Mortgage & Housing Corporation, 1989

Measuring Disablement in Society: A research programme, PSI, 1994

Medical Loan Service Standards Document, British Red Cross, 1995

Meeting the Challenge:The technological approach to care in the community, Tunstall Telecom, 1994

More to Life than Gadgetry, Clark, Housing Associations Weekly,12.5.1995
Motor Neurone Disease: The Role of the Occupational Therapist, Motor Neurone Disease Association

Occupational Therapy: The community contribution, SSI/DoH, 1994

Occupational Therapy Workload Survey, Provisional Report (Confidential), ACC/ADSS/AMA/LGMB, 1995

Our Commitment to Older or Disabled Customers, British Gas

Partnerships in Practice: Development of multi-agency partnerships to provide home adaptations for disabled people, Bourton, Care and Repair Cymru, 1994

Planning for Life, SSI/DoH, 1995

The Power to Change – Commissioning health and social services with disabled people, Jenny Morris, King's Fund, 1995

Providing Quality Accommodation, Care and Service for Elderly People, Haven Services Ltd, 1995

Pulling Together – Developing effective partnerships, Care and Repair & College of Occupational Therapists, 1994

Quality Occupational Therapy Services, SSI/DoH, 1994

R & D Project on Developing Health Services for Ageing Disabled People – Project outline, PSI, 1995

A Review of Physically Disabled People in London according to Community Care Plans 1994/95, Bill Murray London Branch CIoH, 1995

The Role of Housing Agency Services in Helping Disabled People, Mackintosh, Leather & McCafferty HMSO, 1993

Scottish Federation of Housing Associations Adaptations Survey, SFHA, 1995

Social Services Departments Complaints Procedure – A guide for service users, RADAR, 1994

Appendix

Contacts and sources of information

Making contact

Within a local area there are a number of possible starting points for establishing contact and gathering information about organisations active in the field of responding to disability among older people. Yellow Pages has a number of headings which may be relevant:

- counselling & advice
- disabled information services
- information services
- social services and welfare organisations.

Be aware that Yellow Pages entries are not comprehensive and some key local agencies may not appear. The telephone directory should also yield contact details for local Age Concern groups, organisations of and for people with disabilities and citizens' advice bureaux.

Local public libraries, information centres and the citizens' advice bureau should all be able to provide contact details for local organisations. Many of the national organisations listed below will provide specialist literature and advice services, some will have local or regional groups.

The housing or grants department of the local authority and the social services department should all be able to offer information and advice on the services which they have available to respond to disabilities experienced by older people and of any conditions which attach to accessing those services.

Bodies concerned with policy issues and national specialist organisations

Access Committee for England
25 Mortimer Street
London W1N 8AB
Tel: 0171 637 5315

ADSS Disability Policy Committee
c/o Director of Social Services
London Borough of Kingston-upon-Thames
Guildhall
Kingston-upon-Thames
KT1 1EU
Tel: 0181 547 6000

Age Concern England
Astral House
1268 London Road
London SW16 4ER
Tel: 0181 679 8000

Can provide some literature, general advice and contact with local groups

British Council of Organisations of Disabled People
Litchurch Plaza
Litchurch Lane
Derby
Derbyshire DE24 8AA
Tel: 01332 295551

Care & Repair Ltd
Castle House
Kirtley Drive
Nottingham NG7 1LD
Tel: 0115 9799091

Can provide some literature, specialist advice and local contacts

Centre for Accessible Environments
60 Gainsford Street
London SE1 2NY
0171 357 8182

Provides specialist information and training services

Centre for Policy on Ageing
25 Ironmonger Row
London EC1V 3QR
Tel: 0171 253 1787

College of Occupational Therapists
6-8 Marshalsea Rd
London SE1 1HL
Tel: 0171 357 6480

Disability Alliance

Universal House
88-94 Wentworth Street
London E1 7SA
Tel: 0171 247 8776

Disabled Information and Advice Line (DIAL UK)
Park Lodge St Catherine's Hospital
Tickhill Road
Doncaster Sth Yorkshire DN4 8QN
Tel: 01302 310123

Disabled Living Centres Council
286 Camden Road
London N7 0BJ
Tel: 0171 700 1707

Can provide details of local and regional disabled living centres

Disabled Living Foundation
380 Harrow Road
London W9 2HU
Tel: 0171 289 6111

Can provide specialist information and advice. Also houses disabled living centre for London where equipment can be viewed/tried

Housing Associations Charitable Trust
168 Old Street
London EC1V 9BT
0171 336 7774

Royal Association for Disability & Rehabilitation (RADAR)
250 City Road
London EC1V 2AS
0171 250 3222

Royal National Institute for the Blind Housing Service
190 Kensal Roadon
North Kensington
London W10 5BT
0181 969 2380

Provides specialist advice equipment and adaptations for those with visual impairment

Royal National Institute for the Deaf
105 Gower Street
London WC1E 6AH
0171 387 8033

Provides specialist information on meeting the needs of those with hearing impairment

Walbrook Disabled Persons Housing Service
Walbrook Housing Association Ltd
66/68 Curzon Street
Derby DE1 1LP
01332 372141

Provides specialist information and contact with local DPHS groups or services

Organisations focusing on Greater London

Age Concern Greater London
54 Knatchbull Road
London SE5 9QY
Tel: 0171 737 3456

Asian People with Disabilities Alliance
Ground Floor, Willesden Community Hospital
Harlesden Road
London NW10 3 RY

Brent Black Disabled People's Association
Dollis Hill Day Centre
105A Brook Road
London NW2
Tel: 0181 450 1281

Disability Advocacy Project
Dame Colet House
Ben Johnson Road
London E1 3NH
Tel: 0171 702 7173

Disability Information Service Westminster Council Ltd
24 Greencoat Place
London SW1P 1DX
Tel: 0171 630 5994

Disability Information Services in Hospital
St Mary's Hospital
Winsland Street
London W2 1HW
Tel: 0171 706 0543

Disability Resource Team
3rd Floor Bedford House
125-133 Camden High Street
London NW1 7JR
Tel: 0171 482 5299

Disability & Information Advice Centre
16 Dalston Lane
London E8 1LB
Tel: 0171 275 8485

Organisations focusing on Merseyside

There are a large number of organisations operating in Merseyside for the benefit of older people and people with disabilities. This list gives only some primary contacts.

Action for Independence
25 Hope Street
Liverpool L1 9BQ
Tel: 0151 709 2366
(Offers advice in relation to people with mental health problems)

Age Concern Liverpool
5 Sir Thomas Street
Liverpool L1 6BW
Tel: 0151 236 4440

Citizens' Advice Bureau
3rd Floor Hepworth Chambers
(and many local offices throughout Merseyside)
2 Church Street
Liverpool L1
Tel: 0151 709 8989

Disabled Information & Advice Line (DIAL) West Lancs
79 Westgate
Skelmersdale
Tel: 01695 51819

MIH Care & Repair Service
46 Wavertree Road
Liverpool L7 1PH
Tel: 0151 709 9375

Organisations operating in Tyneside

There are a large number of organisations operating in Tyneside for the benefit of older people and people with disabilities. This list gives only some primary contacts.

Age Concern Newcastle
Mea House
Ellison Terrace
Newcastle
Tel: 0191 232 6488

Citizens' Advice Bureau
Westgate House
46 Westgate Road
Newcastle
Tel: 0191 232 0832

Disability Action North East
John Haswell House
Gladstone Terrace
Gateshead
Tel: 0191 490 1099

Housing Advice Centre
112–114 Pilgrim Street
Newcastle
Tel: 0191 261 0074

Staying Put – Newcastle
The Shafto Centre
Shafto Court
Ferguson's Lane
Benwell
Newcastle
Tel: 0191 274 2643
Fax: 0191 274 2668

This review was commissioned in 1995 by the London Health Partnership for use by groups who wish to address a concern about the provision of equipment and adaptations for older people with disabilities.

- Chapter 1 looks at the key problems which older people with disabilities experience in gaining access to the help with equipment and adaptations that they require
- Chapter 2 sets out some examples drawn from across the country of ways in which service provision can be improved
- Chapter 3 suggests ways in which both older people themselves and professionals in health, housing and social services can most effectively draw on this information to improve services for older disabled people.
- Chapter 4 briefly describes the legislation and official guidance governing the provision of equipment and adaptations.

The London Health Partnership is an alliance of charitable foundations, business interests and government, formed to generate a distinctive programme of work which will promote the development of urban primary health care. The focus of its work is the well-being of elders in cities, particularly through the delivery of services in and close to their homes. The London Health Partnership has brought together, in a series of 'Whole System Events', a rich mix of people concerned to improve the well-being of elders – including elders themselves, carers and people working in the statutory, voluntary and private sectors. At these events people have worked together and explored the common ground, the areas of shared concern around which they are prepared to work to create the future. After the events people have chosen to continue to meet together, as self-organising groups, to work in new ways and take the concerns forward in their locality.

About the authors

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