home alone
the role of housing in community care
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The Contribution of Housing to Community Care

Housing plays a key role in delivering community care, but significant strains are emerging.

Effective Delivery of the Housing Aspects of Community Care

Authorities are struggling to cope with rising demand and there is an emphasis on crisis response at the expense of prevention.

Improving Performance at the Local Level

Leading edge authorities demonstrate that the planning, deployment and monitoring of resources can be improved.

The Impact of the National Framework

Many of the problems at the local level have their roots in an incoherent national framework.
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© Audit Commission 1998

First published in April 1998 by the Audit Commission for Local Authorities and the National Health Service in England and Wales, 1 Vincent Square, London SW1P 2PN

Printed in the UK for the Audit Commission by

ISBN 1 86240 098 9

Photographs: Paul Doyle (pp52, 66), David Gibson/Photofusion (cover), Gina Glover/Photofusion (p63), Crispin Hughes/Photofusion (pp3, 25, 36, 64), Ulrike Preuss/Format (p4), Brenda Prince/Format (p69), Hilary Shedel (p44), Paula Solloway/Format (p58), Tony Stone (p61), Frank Watson/Photofusion (p15).

Illustration: David Eaton.
Preface

Although not typically associated with care in the community, housing services are, in fact, a vital component of the policy. Suitable housing provides a stable base for independent living and affords access to other services such as health and social care, education and training. Currently, at least 1.3 million tenants and owner-occupiers benefit from housing-related community care services, at an annual cost to the public purse of more than £2 billion. And yet the scale and importance of housing’s role in community care has not received the same recognition as the contribution of health and social services authorities.

The Audit Commission has published a number of reports on community care in the last 12 years, all focusing on the social and healthcare aspects. Making a Reality of Community Care in 1986 argued for a ‘seamless’ provision of services across the various agencies involved, while the most recent report – The Coming of Age – highlighted the need to rationalise the way in which older people are cared for at home and in community settings. The housing dimension has received relatively little attention to date, and this report is an attempt to fill the gap. It examines the performance of housing agencies in identifying current and future need for social housing; adapting properties to sustain independent living; providing vulnerable clients with personal support; offering places in ‘special needs’ projects as appropriate; and co-ordinating efforts with social services and others to achieve the ‘seamless’ service needed by clients. In future, all of these activities will be viewed within the framework of the Best Value regime, which requires councils to demonstrate that they are striving for, and delivering, continuous improvements in performance. The report also examines the national framework of funding mechanisms and policy guidance.

The report is based on fieldwork in 14 housing and five social services authorities, drawing upon interviews, document reviews and samples of case files (Appendix 2). Information has also been collected through four questionnaire surveys of local authorities and providers of supported housing; and four focus groups of tenants with mental health problems.

The study team comprised Nick Ville, Gill Green and Helen Oxtoby from the Commission’s Local Government Studies Directorate, with support from Rohan Thakrar and Bhavin Patel, under the direction of Kate Flannery. Additional help was provided by consultants Lynn Watson, Angie Smith and Dr Jenny Secker from the Centre for Mental Health Services Development.

An Advisory Group of practitioners and other interested parties (see Appendix 2) provided valuable assistance and professional insight. The study benefited from the excellent co-operation of the agencies visited and those completing the questionnaires. The Audit Commission is also grateful to the bodies and individuals who gave advice and commented on drafts of this report. As always, responsibility for the conclusions and recommendations rests with the Commission alone.
The Contribution of Housing to Community Care

The policy of caring for vulnerable people in the community, rather than large, de-personalised institutions, commands widespread support. Local authorities, health agencies and the voluntary sector strive to offer ‘seamless support’ to thousands of people in need. Housing plays a key role in community care, providing ‘bricks and mortar’ together with a range of practical support. But signs of strain are emerging, as the problem of rising demand is compounded by a contraction of suitable stock and significant financial pressures.
Care in the community... commands a degree of support that crosses many boundaries, social and political.

1. ‘Care in the community’ means different things to different people. For some, it represents a progressive and humane approach to the care of needy and vulnerable individuals, rather than consigning them to the de-personalised regimes of large institutions. As such, it commands a degree of support that crosses many boundaries, social and political. But the support is not universal. For example, questions are asked about resources – are we trying to deliver social care on the cheap? And is it safe to close a large number of psychiatric beds without ensuring that appropriate facilities are available in the community for ex-patients who at times still require intensive support?

2. Such questions will continue to be asked as community care policies develop to meet the demands of the new millennium. Their evolution has been gradual; the initial impetus came from the National Health Service (NHS) as new treatments reduced the need for places in long-stay hospitals throughout the 1970s and 1980s. Social services departments made significant contributions, developing a range of community-based services. The culmination of these developments was the 1990 NHS and Community Care Act, which designated social services departments as the lead local agencies for community care.

3. The 1990 Act set out the core principles of community care, as foreshadowed in the 1989 White Paper, Caring for People:
   • to enable people to live as normal a life as possible in their own homes or in a homely environment in the community;
   • to provide sufficient care and support to help people to achieve maximum possible independence and, by acquiring or re-acquiring basic living skills, help them to achieve their full potential as individuals; and
   • to give individuals a ‘say’ in how they live their lives and what services they need.

The principal client groups are frail older people, people with mental health problems, people with learning disabilities and those with physical disabilities [TABLE 1, overleaf]. These categories are only broad groupings; in practice, individual needs can be multiple and overlapping. Many more people are affected indirectly as carers, family and friends.

---

1 A more detailed outline of the development of community care is chronicled in Appendix 3.
Not every individual who falls within one or more of these categories will either need or receive services from the main agencies involved in community care. Most care and support is informal, provided by families and neighbours. If such arrangements break down or are insufficient, people can turn to the NHS or social services to ask for help such as meals on wheels, homecare, day centres, respite care and, as needs increase, residential and nursing care.

The other principal source of support to sustain independent living in the community is the local housing authority and other housing providers (referred to collectively as ‘housing agencies’). Although not typically associated with care in the community, housing services are, in fact, a core component in making the approach work. Suitable housing provides a stable base for independent living and affords access to other services such as health and social care, education and training. The housing service is also an important source of practical assistance for many people, often being their first point of contact with the local authority, as well as being highly accessible, particularly for those who are tenants. Yet the scale and importance of housing’s role in community care has not received the same recognition as the contribution of health and social services authorities.

Currently, at least 1.3 million tenants and owner-occupiers are beneficiaries of housing-related community care services, provided both by council housing departments and registered social landlords\(^1\) [EXHIBIT 1]. The majority are older people living in sheltered housing, people who receive support in specialist housing schemes, and the hundreds of thousands of people benefiting from community alarms (telephone-based technology to provide immediate access to assistance in an emergency).

---

\(^{1}\) Registered social landlords (RSLs) include housing associations, housing companies created under the 1996 Housing Act and voluntary bodies that manage housing properties on behalf of other agencies.
**EXHIBIT 1**

**Housing agencies’ contribution to community care**

Housing authorities and RSLs invest significant resources in helping to deliver community care.

<table>
<thead>
<tr>
<th>What housing services are provided?*</th>
<th>Who is helped?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community alarms</td>
<td>Over 1.1 million older people have a community alarm.</td>
</tr>
<tr>
<td>Aids and adaptations</td>
<td>125,000 Disabled Facilities Grants have been made since 1991; the number of council house adaptations unknown, but significant.</td>
</tr>
<tr>
<td>Home Improvement Agencies</td>
<td>Nearly 200 agencies nationally provide assistance with repairs and grants.</td>
</tr>
<tr>
<td>Vulnerable single homeless</td>
<td>45,000 people with mental health problems, 40,000 physically disabled and 45,000 older people have been accepted as homeless since 1990.</td>
</tr>
<tr>
<td>Specialised housing</td>
<td>450,000 units of sheltered housing with on-site wardens have been built for older people.</td>
</tr>
<tr>
<td>Mainstream housing with support</td>
<td>82,000 units of supported housing for people with mental health problems, physical disabilities, learning disabilities, and other needs.</td>
</tr>
<tr>
<td></td>
<td>Housing agencies provide extra support to enable vulnerable people to manage their tenancy - e.g., helping older people with gardening or regular visits from housing officers; the provision of support is not consistently defined or recorded.</td>
</tr>
</tbody>
</table>

* Some of these services are purchased by social services, the NHS or voluntary organisations.

However, these categories almost certainly underestimate the actual number of people receiving vital support from housing agencies. Many people needing support live in mainstream accommodation and require basic assistance – such as help to sort out their benefit entitlement – in order to sustain independent living. Housing officers can only estimate the number of tenants receiving this ‘low-intensity’ support; only when individual problems escalate and trigger a formal assessment of eligibility for social or healthcare do they enter official statistics [EXHIBIT 2, overleaf].

Sources: DETR, Welsh Office, Housing Corporation, Audit Commission survey on community alarms
Different agencies meet varying levels of need

Housing provides support to a broader group of vulnerable people than social services or health.*

* Excluding GPs, who may come into contact with large numbers of vulnerable people.

Source: Audit Commission

7. The housing service – not just the bricks and mortar of accommodation but practical help from housing officers – is a key element in the ‘seamless’ package of care envisaged by the architects of community care. Surveys of people with support needs confirm the importance of appropriate housing. A recent sample of a thousand elderly people identified aids and adaptations, such as stairlifts and wheelchair ramps, as the most effective means to enable them to remain in their own homes (Ref. 5). Similarly, focus groups of people with mental health problems,1 carried out as part of this study, highlighted housing as the single most important service required to live independently in the community. It is not simply the provision of a roof over people's heads that makes housing's contribution so important, it is the personal support to help vulnerable people cope with everyday living - for example, negotiating the complexities of rent payments or resolving problems with water, gas and electricity suppliers - that makes the difference between life in the community and institutionalisation. This contribution has grown in importance with the increasing concentration of vulnerable people in a declining stock of social housing.

1 The Centre for Mental Health Services Development at King's College, London was commissioned to convene four focus groups in three geographical locations. The groups discussed users' views of the housing and support services that they currently receive and the improvements required.
It is estimated that over £2 billion is spent each year on the housing aspects of community care [EXHIBIT 3]. This is a conservative estimate, as current accounting procedures do not readily identify all relevant expenditure (for example, local authorities’ Housing Revenue Accounts do not show separately the costs of sheltered housing). The majority of the funding is channelled through housing authorities, although substantial sums also come from the Housing Corporation, RSLs, social services departments and health authorities. (A more detailed guide to the main funding mechanisms is set out in Appendix 4.)

EXHIBIT 3
Expenditure on the housing aspects of community care, 1996/97
Over £2 billion was spent last year on the housing-related contribution to community care.

MAIN SPENDING BODIES

<table>
<thead>
<tr>
<th></th>
<th>APPROXIMATE SPEND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE (£m)</strong></td>
<td></td>
</tr>
<tr>
<td>Central government</td>
<td>90</td>
</tr>
<tr>
<td>Local housing</td>
<td>115</td>
</tr>
<tr>
<td>Social services</td>
<td>45</td>
</tr>
<tr>
<td>Housing Corporation</td>
<td>1,105</td>
</tr>
<tr>
<td>RSLs</td>
<td>720</td>
</tr>
<tr>
<td><strong>CAPITAL (£m)</strong></td>
<td></td>
</tr>
<tr>
<td>Community alarms</td>
<td>0</td>
</tr>
<tr>
<td>Aids &amp; adaptations</td>
<td>120</td>
</tr>
<tr>
<td>Homelessness</td>
<td>10</td>
</tr>
<tr>
<td>Sheltered housing</td>
<td>-</td>
</tr>
<tr>
<td>Supported housing</td>
<td>125</td>
</tr>
<tr>
<td><strong>TOTAL (£m)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>235</td>
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<td></td>
<td>55</td>
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<tr>
<td></td>
<td>1,105</td>
</tr>
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<td></td>
<td>845</td>
</tr>
</tbody>
</table>

Sources: DETR, DSS, Dept. of Health, Housing Corporation, and Audit Commission research (see Appendix 5)
The changing role of housing authorities

9. Housing services for people needing extra support have evolved along with the development of community care. But the role of housing authorities in this area is not as defined as it is for social services and health authorities - there is considerable discretion over service levels. Consequently, the contribution of housing to community care varies markedly, reflecting policy choices, custom and practice, the quality of partnership working and the particular needs of individual communities. Nonetheless, it is possible to identify three responsibilities that are essential for success:

• planning strategically to match housing need with resources, and measure what works;
• securing stable home bases for people with support needs; and
• working with other agencies to provide ‘seamless’ support to community care clients.

These responsibilities cover the priority housing and support needs of the local community, regardless of tenure - not just those who are council tenants. Consequently, local housing authorities are required not only to provide housing services directly, but to commission or enable other forms of provision from registered social landlords (RSLs), charities and others.

Planning strategically

10. ‘We are much more than just a landlord.’ (Senior Housing Officer).

Offering effective support to meet day-to-day problems requires more than an operational focus; housing authorities need to act strategically, planning ahead to anticipate changing needs and demographic trends. Aspects of this role are covered by statute: the Housing Act 1985 requires housing authorities to assess housing needs and conditions in their area, while there is a specific requirement under the Chronically Sick and Disabled Persons Act 1970 to consider the housing needs of the sick and people with disabilities. A joint circular in 1992 from the Health and Environment Departments (Circular 10/92) and recent guidance (Ref. 6) highlights the need for housing strategies to address community care issues and be consistent with wider community care plans. Social services authorities are in turn required to consult housing authorities on their plans.

Securing a stable home

11. ‘If you get housing right, everything else follows.’ (Tenant with mental health problems).

Housing authorities secure a stable home base for people needing support by finding or allocating appropriate accommodation, and modifying properties to help those with impaired mobility. Both roles are underpinned by statute. For example, the Housing Act 1996 requires councils to secure accommodation for homeless people who are vulnerable as a result of ‘old age, mental illness or handicap or physical
disability or other special reason’. They must, under the same Act, prioritise allocations to ‘households consisting of someone with a particular need for settled accommodation on medical or welfare grounds’. Adaptations (such as wheelchair ramps) to private homes are mandatory provided that applicants satisfy eligibility criteria, although similar adaptations to council dwellings are discretionary.

Working with others to achieve seamless support

12. ‘Care packages count for nothing without good housing, and the best housing is to no avail without appropriate care.’ (Joint Housing and Community Care Strategy).

People with special needs or vulnerability frequently require a combination of housing, support and care to sustain independent living in the community. This leads housing authorities to work closely with other agencies, both at a service and strategic level, to co-ordinate services and avoid either duplication or gaps in provision. Housing authorities are not required to offer practical support for daily living needs, but the Leasehold Reform, Housing and Urban Development Act 1993 empowers them to provide wardens, community alarms and other support services. There is, however, a statutory duty on social services authorities – where an individual’s assessment reveals a housing need – to notify the relevant housing authority and invite it to participate in the assessment.

13. All of these roles reinforce the importance of appropriate housing to the objective of ‘care in the community’. Yet all is not well. In a number of key respects, the anticipated role for housing services either is not in place or is not achieving the results expected of it; it is time to take stock of performance.

Time to take stock

14. Although the housing dimension of community care is significant, both in terms of the resources devoted to it and the number of people it serves, it has not been subject to the same scrutiny as that applied to health and social services authorities – in practice, if not in theory, it is the ‘junior partner’ in the process. A number of factors make it timely to review progress and problems:

• community care is making ever increasing demands on housing services;
• the stock of social housing available to meet the needs of people with support needs has contracted;
• the role of housing authorities is changing, principally through exposure to competitive tendering and the transfer of local authority stock to RSLs; and
• major changes in funding, in relation to housing benefit, are imminent.
...there have been significant changes in the provision of health and social care.

**Growing demands**

15. The number of people with support needs living in the community, and thus the demand on housing authorities, is increasing. Much of this growth is due to advances in healthcare - people are living longer and rates of survival at birth and for life-threatening conditions are improving. The age structure of the population has changed since 1981, with the number of those aged 85 or over increasing by 80 per cent, and those aged between 75 and 84 increasing by 18 per cent. Moreover, there is a preference among people with support needs to live independently in their own homes.

16. At the same time, there have been significant changes in the provision of health and social care. The role of the NHS has shifted from long-term care towards acute care. This has been due, in part, to the availability of social security funds in the 1980s which sustained a rapid growth in residential and nursing home places for older people; from over 200,000 in 1981 to a historically high level of over 500,000 places in 1997 (Ref. 7). This growth, combined with an increasing emphasis on primary care (community nursing and GP services), encouraged many health authorities to reduce the time spent in hospital and the number of long-stay beds. Then in 1990, the NHS and Community Care Act capped social security funding and transferred it to social services authorities through Special Transitional Grant. Social services authorities became the lead agencies for arranging social care, managing referrals for continuing care and effectively filling the care gap left by the NHS.

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**EXHIBIT 4**

Changes in the provision of long-stay hospital care beds

There has been a significant contraction in long-stay beds for three principal community care groups.

Source: Department of Health, Statistical Bulletin 1997/20, and Welsh Office
These changes have placed additional, cumulative pressures on housing authorities. The rising number of older people wanting to remain in their own homes has increased the demand for adaptations, home improvements and community alarms. A growing number of vulnerable people have sought rehousing after discharge from hospital or a period of homelessness. For example, the number of homeless people with mental health problems who were accepted for rehousing in 1996 was just over 8,000 – nearly double the figure for 1990 (Ref. 8). Even more people needing support are rehoused through the conventional processes of council waiting lists or referrals to RSLs for specialist housing. And there has been a steady rise in the number of vulnerable people already living in social housing who require help with issues such as access to benefits or neighbour relations. A ‘knock-on’ effect is apparent – health services have refocused on acute care; social services have targeted their resources on higher-level needs and continuing care, leaving housing providers to cope with chronic needs that require ongoing support. This shift in emphasis necessitates a re-assessment of the capacity of housing services to meet their expanding role.

**Reducing stock**

At the same time as demand on housing authorities to rehouse people with support needs has increased, the stock of available social housing has contracted. Largely as a result of the Right-to-Buy provisions for council tenants and constraints on capital expenditure, the stock of mainstream social housing has reduced by over a million dwellings since 1981 to the current figure of 4.8 million dwellings [EXHIBIT 5].

---

**EXHIBIT 5**

Decline in the social housing stock in England and Wales, 1981 to 1996

The social housing stock has reduced by over a million dwellings since 1981.

---

Specialised property such as supported housing, some adapted houses and sheltered accommodation was exempted from Right-to-Buy provisions.
Although the amount of social housing has stabilised in recent years, housing authorities have lost much of their high quality housing stock, and now house an increasing concentration of vulnerable and more dependent people in the remaining, often poorer quality, stock (Ref. 9).

Changing role

19. The way in which housing authorities discharge their role has undergone significant and rapid change. Over 60 authorities have transferred their stock to RSLs under the large-scale voluntary transfer (LSVT) programme, and in the process have exchanged their landlord role for that of ‘enabler’. Many authorities have already tendered, or are planning to tender, their housing management services. The consequent need for authorities to re-appraise what services they provide, and how they deliver them, should include their contribution to community care but has not always done so. This will change – the new regime of Best Value will require housing authorities to review how they plan, deliver and monitor the effectiveness of their services, as well as to undertake fundamental reviews of the need for the services that they currently provide.

Changes to the funding regime

20. Although housing benefit is primarily intended to pay for the cost of accommodation, many vulnerable people who live in supported or sheltered housing rely on it to finance the additional personal support services that they need to live in the community. The housing benefit bill rose steeply during the 1990s to its current level of almost £11 billion, in part because of its use to fund support services (Ref. 10). In 1996, the then Government sought to contain housing benefit to its ‘core purpose’ of accommodation costs. The proposal generated major concern in the supported housing field, as it threatened the viability of thousands of individual schemes for vulnerable people. In response to this concern, the Government set up an interdepartmental review which is due to report in 1998. Although the future shape of housing benefit provision is unknown, it is likely that some change will be introduced in an attempt to achieve greater consistency and equity across the country. It is therefore timely to ask how well current funding is being used, as this information could usefully inform forthcoming decisions on funding arrangements.

Conclusion

21. Housing makes a major and growing – although not fully recognised – contribution to community care, providing a range of services that have evolved over the last 30 years. But fiscal, legal and social changes raise questions about the relevance of approaches that were developed during the 1990s to meet the demands of the next century. Significant strains are emerging, both at the local level and in the national framework within which authorities operate. The next two chapters examine the problems in delivering services at the local level and point to possible solutions, based primarily on existing good practice, while Chapter 4 considers the national picture.
Effective Delivery of the Housing Aspects of Community Care

The main tasks of housing authorities are to plan strategically, make the best use of resources and monitor performance. Some are successful, others less so. A picture emerges of inadequate identification of needs, inflexible use of stock and insufficient early intervention to prevent vulnerable people reaching crisis point. Some problems stem from constrained resources, but there is evidence of poor collaboration between housing, social services and health authorities that allows too many people in need to ‘fall through the net’.
22. Housing’s key contribution to community care is to secure a suitable and stable home base for people who are vulnerable or who need particular support. This role requires housing authorities to take a long-term, strategic view of the community’s needs, and to work in partnership with other agencies to deliver ‘seamless care’ to clients. In practice, these expectations translate into three key tasks for housing authorities, all of which are highly relevant for Best Value, with its emphasis on reviewing, target-setting and demonstrating improvement in performance [EXHIBIT 6]:

- planning strategically: through analysis and consultation, identify what needs exist in the area, map the provision that is available to meet those needs – commissioning new provision as appropriate – and clarify the demographic or other factors that will influence future needs;
- securing the most effective use of housing resources: review the use of the housing stock and the provision of support services, across all tenures. To achieve the most effective use of resources, authorities must work closely with RSLs, private sector landlords, owner-occupiers and other agencies involved in community care; and
- monitoring performance: build on success and remedy weaknesses, through reviewing services, setting targets and meeting national standards where appropriate, and monitoring outcomes.

EXHIBIT 6
The challenge for housing authorities
To meet the challenges of Best Value and make an effective contribution to community care, authorities need to plan, implement and monitor all aspects of their activities.

Source: Audit Commission
23. How well are housing authorities and other providers working together to meet these challenges at the local level? The issues can be explored by tracing the experience of two particular client groups – frail older people, who are the largest single client group for community care, and people with mental health problems. The difficulties that housing authorities experience in meeting the needs of the latter group illustrate many of the wider problems in this area.

Planning strategically to identify and meet needs

24. One of the key problems affecting the contribution of housing to community care is a lack of information, both on the needs of individual clients and also on the level and nature of current services. None of the 14 fieldwork authorities in the study held a comprehensive database on residents’ needs, although several were in the early stages of developing one. The information available is invariably limited to explicit, previously identified need, and does not include any latent or hidden need. For example, the needs of a young person with learning disabilities who lives in the parental home or in long-stay residential care but who wants to live independently may well be seen as low priority where appropriate alternative accommodation is unavailable, because they are already ‘suitably housed’. They therefore do not appear in demand statistics.

25. Although individual authorities conduct surveys of special needs, the absence of any standard framework or approach makes findings difficult to compare or aggregate. Furthermore, there are no computer-based information systems to combine data on individuals for strategic planning purposes, or to pool information with other agencies involved in joint working. Housing records tend to be property-based rather than tenant-focused, and are not designed to track people with support needs as they move between properties. Tackling this information shortfall is often made more difficult by a lack of shared understanding and knowledge – housing officers and social services staff are often unfamiliar with the objectives, working practices or problems confronting their respective departments. Each needs to learn the vocabulary of the other.
Problems are also apparent on the supply side and in gaining access to appropriate accommodation. Although councils have detailed information on their own stock, few maintain records of current supported and sheltered housing provision in their area that is owned by RSLs and others (to which they often have rights to nominate residents). Only two out of the 14 fieldwork authorities could list all of the local supported and sheltered housing schemes, and none maintained a comprehensive record of adapted properties. Without such information it is impossible fully to evaluate existing provision and proposed new developments. If authorities do not map needs against provision systematically, it is difficult to see how they can plan services effectively - matching the level of support to individual need - or promote independence. Information gaps also pose problems for users. For example, in one area, sheltered housing is provided by the council and six RSLs, but there is no common register or allocations system. Prospective residents must contact each agency separately to obtain information or seek a place.

Joint commissioning

These weaknesses reveal deficiencies in the way that different agencies collaborate in the joint commissioning of services, a key mechanism for delivering client-focused, tailored care packages. Although some authorities do work successfully together, comprehensive joint commissioning is not typical. A lack of integrated planning and decision-making, operating reactively and a tendency to give a low priority to the housing aspects of community care are three common weaknesses:

- Separate and unilateral decision-making

Health, social services and housing authorities may not appreciate the interdependence of their services, especially if they lack shared objectives. For example, health authorities do not always involve housing departments in planning replacement housing and support when closing long-stay hospitals; instead, negotiation is conducted directly with RSLs. This practice undermines the strategic role of local authorities in planning for community needs. Unilateral service adjustments by one agency can have a major impact on others - for example, when social services change the eligibility criteria (gateways to help) or a health trust closes a facility such as rehabilitation units. But the ‘knock-on’ effects of one agency on another are spotted only when problems emerge - they are rarely taken into account at the outset.

Responsibilities are split in two-tier local government – social services is a county-level function while housing is run by district councils. In theory, unitary authorities offer better prospects for joint working and commissioning, especially where housing and social services form a single department.
Reactive approaches
Some joint commissioning is piecemeal and responds to short-term pressures, rather than being systematic and strategic. This means that some provision ‘ossifies’, with schemes lacking flexibility to adjust to changing patterns of need. In the absence of clear commissioning priorities and expectations, a case-by-case approach can prevail at the expense of strategic planning.

Failure to prioritise the housing role in community care
The priority given to this role by housing, social services and health authorities respectively varies across the country, but rarely is it seen as anyone's top priority. For example, some housing authorities that are under pressure to rehouse vulnerable homeless people may concentrate simply on getting a roof over the person's head – ongoing support is not their concern. Without support, many tenants experience difficulties that may lead them to give up the tenancy and thus put even more pressure on homelessness services.

Managing the stock efficiently is a key housing function. Traditionally, the emphasis has been on the direct provision and management of housing stock – the landlord role, as measured by void rates, re-let times, rent arrears and repair targets. But the remit is changing. Government policy initiatives in the last two decades have imposed new challenges and responsibilities that have extended the role of housing authorities. The requirement to offer tenants the opportunity to buy their council homes meant that many of the more affluent tenants, living in the better quality stock, became owner-occupiers. Increasingly, council housing accommodates a higher proportion of the poor and vulnerable, and financial constraints mean that the condition of the remaining stock has sometimes deteriorated. The second major challenge is community care itself, which has placed in council tenancies many more people who, at times, need intensive support. The result is that a significant welfare role has crept up on housing authorities, even those that have transferred their stock through LSVT.

To deliver services effectively within this context requires:
- an adequate supply of housing, both mainstream accommodation and specialised provision, for groups such as people with mental health problems or frail older people;
- the capacity to repair or adapt properties, in both the public and private sector, to enable people with problems such as impaired mobility to remain in their own homes;
- flexibility in the provision of personal support to vulnerable tenants; and
- good joint working arrangements with health and social services staff, and also the voluntary sector.
...making the best use of mainstream stock is the most effective way of accommodating and supporting vulnerable tenants.

**An adequate supply of housing**

30. Mainstream housing, whether the council’s own stock or that owned by RSLs or private landlords, can be a flexible resource to help people with varying levels of need. As circumstances dictate, ordinary homes can be interchanged between people with support needs or other tenants, and the level of support can, over time, be adjusted to suit individual needs. For many housing authorities, making the best use of mainstream stock is the most effective way of accommodating and supporting vulnerable tenants. But there are limits to flexibility, and the circumstances of individual councils vary considerably. There is a dearth of social housing in some areas, while others have a glut of units available for immediate letting, but often of poor quality or a type – such as high-rise flats – which are unsuitable for many community care clients.

31. Focus groups of people with mental health problems were commissioned for this study. Participants indicated that they would prefer to live in mainstream housing rather than be ‘ghettoised’ in special units, but only if certain criteria are met:

- **Suitable location** – ideally, homes should be close to informal care networks (family, neighbours, friends) and with reasonable amenities nearby.
- **Good neighbours** – not surprisingly, considerable importance is attached to living near people who are friendly and helpful, rather than hostile to their support needs (given that people with mental health problems may themselves be difficult neighbours at times). There was a clear preference for living in a neighbourhood with a mix of people, rather than a clustering of similar needs.
- **Fit to live in** – it is essential that the home offered is in a good state of repair and has the necessary facilities such as hot water (and in many cases, furniture). Resolving such practical difficulties with accommodation can be an ordeal for people with support needs, who often find it difficult to express their problems or engage with bureaucracy.
- **Quiet and secure** – people with mental health problems can be particularly sensitive to noise, due, for example, to anxiety states or paranoia. A fear of personal attack or burglary can also compound problems.

32. Housing authorities will not necessarily be able to meet all these requirements – their ability to do so will depend on the stock available to them. A number of authorities cited particular constraints; for example, much of the available accommodation is on high-density, unpopular estates. Consequently, particular streets or tower blocks often have a disproportionate concentration of tenants with mental health problems allocated to them, simply because of the lack of more suitable alternatives. But there are success stories of imaginative responses despite
stock limitations. One fieldwork authority developed a block of flats with closed-circuit television (CCTV) and a concierge system as furnished flats for younger vulnerable tenants— for example, a 19 year old with learning disabilities leaving foster care who was vulnerable to harassment. The scheme has been very successful—so much so that the authority cannot meet the demand for places.

33. Supply of housing is not the only problem. The allocations process in some housing authorities is insufficiently sensitive to the particular needs of community care clients; in extreme cases, applicants receive only one ‘take it or leave it’ offer, or are unable to view the property before accepting it. The time given to consider the offer and make the move can be as little as one week. This approach may keep immediate re-let times to a minimum, but is less likely to ensure that the housing needs of vulnerable tenants are met effectively. One-fifth of a sample of tenants with mental health problems\(^1\) requested a transfer shortly after taking up the tenancy—thus increasing the long-term void rate—often because they had been allocated unsuitable homes in the first place.

34. There is a risk that vulnerable applicants are used as a means of filling difficult-to-let property, rather than property being seen as one means of meeting the needs of vulnerable people. A rethink of the traditional landlord emphasis is necessary; property management objectives should not dominate at the expense of tailoring services to meet tenants’ needs. Given the changing profile of its tenants, social housing is becoming a social welfare service that requires traditional property management skills combined with new approaches to meet the complex needs of current tenants.

**The supply of specialised housing**

35. Some people will require specialised housing such as sheltered units or supported housing schemes (formerly called ‘special needs housing’), some of which is purpose-built. Most supported housing projects are run by RSLs, although local authorities may contribute to capital funding and are often the principal nominators of tenants, while sheltered housing is provided by local authorities, RSLs and the private sector. There are two important questions to consider:

- Is the specialised accommodation in the right place— that is, where the needs are greatest?
- Is the specialised accommodation of suitable quality?

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\(^1\) As part of the fieldwork, a sample of 100 case files of local authority tenants with mental health problems was examined in detail, supplemented by interviews with the relevant estate officers.
36. The need for, and provision of, specialised housing varies between areas and different client groups. A perfect match between need and provision cannot realistically be expected, but a serious degree of mismatch has significant consequences for many vulnerable people [BOX A]. For people with mental health problems, the number of specialised housing places in areas of similar need can vary by a factor of three.¹

**BOX A**

**Local authority research on housing for people with mental health problems**

Leeds City Council examined special needs housing in the area as part of its community care strategy. The project used the Pathways analytical model, which seeks to predict future support and accommodation needs. The main conclusions in relation to people with mental health problems were that:

- a significant number of people are living in hostels for the homeless, where staffing and support regimes are unlikely to be adequate;
- people previously living independently often found themselves unable to cope and made unplanned moves to acute hospitals, hostels or the street;
- there is evidence that discharge from hospitals, both acute and non-acute, is delayed because the required level of support or funding for their care in the community was not available;
- there is a shortage of independent accommodation of a sufficient standard with appropriate levels of floating support; and
- there is a need for expansion of specialist provision to provide medium to high levels of assistance.

Source: A Housing and Community Care Strategy for Leeds (Ref. 11)

¹ Calculation based upon the Mental Illness Needs Index (MINI), which uses regression analysis to identify social and demographic variables that correlate with the occupation of acute psychiatric beds; MINI can be used to predict the relative level of need for mental need for mental health services in a particular area. This level of need was then compared with the number of supported housing places in the relevant areas.
...the development of specialised housing was not the result of a planned, multi-agency approach...

37. Care must be taken when comparing indices of need with particular forms of provision. Those with more severe mental health problems benefit from high levels of support in specialised schemes, but an estimated 80 per cent of mentally ill people live in their own homes, with carers and/or other support such as day centres (Ref. 12). It is possible, therefore, that variations in the provision of specialised accommodation reflect explicit decisions to use other types of provision, or to support people in their own homes as far as practicable. However, fieldwork authorities did not confirm any such rationale; the development of specialised housing was not the result of a planned, multi-agency approach but the ragged inheritance of unco-ordinated historic decisions. Similarly, the combined total of psychiatric beds, residential and nursing care places and specialised housing units also shows wide variation and a poor match with predicted need [EXHIBIT 7].

38. The variation in the availability of specialised housing for people with mental health problems contributes to two problems at a local level: delayed or inappropriate hospital discharges, and a poor use of community care resources. Without somewhere suitable to live, there is a risk that a patient’s discharge from hospital will be delayed or that they will be discharged to an unsatisfactory home environment. A survey in January 1996 revealed that one in ten short-stay psychiatric beds were blocked due to the lack of suitable independent accommodation for people who were ready for discharge (Ref. 13).

EXHIBIT 7
Specialised provision for people with mental health problems
Availability of all forms of mental health provision does not match well with predicted need.

Sources: Supported CORE NHF/Housing Corporation, Department of Health, MINI analysis
Managing the balance of care across agencies

Community-based provision is cheaper and may be more appropriate for some psychiatric patients.

Source: Audit Commission analysis of data (at 1996/97 prices) supplied by Centre for the Economics of Mental Health

Being denied the opportunity to return to the community can be distressing for the individuals concerned – if the estimates of bed-blocking are correct, some 1,500 people are in this position at any one time. It is also a poor use of the resources devoted to care and support. A bed in a short-stay psychiatric unit, with the accompanying care, costs over £800 a week (Ref. 14). A package of care provided to an individual with a similar level of need but housed in a staffed scheme costs around £300 per week [EXHIBIT 8]. The resources saved from reducing bed-blocking could be used to fund the costs of supporting such individuals in the community – suitable accommodation plus a care package as appropriate (floating support, community psychiatric nurse, use of day centre facilities, etc) – for less money overall and better outcomes in terms of enhancing the life experiences of the relevant client group. ‘Win-win’ solutions are possible but require a rebalancing of care across agency boundaries.

Sheltered housing

Mixed success is also the picture in respect of the second ‘tracer group’, frail older people, for whom sheltered housing is a major resource [BOX B]. There are almost 450,000 units with on-site wardens, a figure similar to the total of residential and nursing care places catering for higher levels of need. Sheltered housing averages 11 per cent of all local authority stock and 21 per cent of RSL stock, rising to over 40 per cent in some authorities. But the current pattern of sheltered provision is entirely historic and is not related to any identifiable levels of need or demand. There are significant variations between authorities that cannot be explained by reference to the number of older people living locally, the number who rent rather than own, or their relative poverty and hence increased likelihood of relying on social landlords for help with housing (Ref. 15) [EXHIBIT 9].
EXHIBIT 9

Provision of sheltered housing per 1,000 population aged 65 and over

There are major variations between authorities which cannot be explained by reference to the number of older people living in the area.

Source: HIP returns, DETR

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BOX B

The development of specialised housing for older people

Much of the current stock of specialised housing for older people was built in the 1970s and 1980s, and falls generally into two categories. Category 1 schemes are purpose-built dwellings for relatively independent older people, and do not have a warden on site, although some schemes provide an alarm system and access to a mobile warden. Estimates of provision in England (there are no figures available for Wales) indicate that there are 387,000 Category 1 dwellings.

Category 2 schemes cater for a more vulnerable or dependent group. Typically, they are self-contained dwellings in a single block, with communal facilities such as a common room and laundry room, and an on-site warden. Most places – around 270,000 in England – are in schemes run by local authorities with the balance of 160,000 managed by RSLs. The original purpose of Category 2 housing was ‘to meet the needs of less active elderly people’ (Ref. 16). A further category developed subsequently, known as Category 2½, provides on-site care for those with a greater degree of frailty.

The generic term ‘sheltered housing’ is often applied to all three categories, although technically it relates only to schemes with access to the services of a warden and communal facilities (Housing Act 1985, Schedule 5, paragraph 10). The narrower definition is the one adopted in this report.
Some 87 per cent of local authorities have difficult-to-let sheltered housing...

41. The tension between the demands of stock management and the needs of frail older people is perhaps inevitable. Rather than using sheltered housing as a key community care resource, some councils apply straightforward letting criteria – if there are empty places in sheltered units they will be let to existing older people, irrespective of their degree of frailty. There are sometimes financial and other benefits in releasing under-occupied social housing – it may, for example, allow an authority to take a homeless family out of bed and breakfast accommodation into the property vacated by the elderly person. But placing fit, active older people in sheltered housing can be an expensive option; typically, it costs around £825 per tenant per year for staff and communal services, resources that might be better spent supporting people in their existing homes. Also, there may be people in other tenures, notably the private sector, in greater need of these places. Decisions ought to be driven by community care principles as well as a need to keep down void levels.

42. Some 87 per cent of local authorities have difficult-to-let sheltered housing, although the number of unlet places may be small, and for some authorities the problem is getting worse (Refs. 17 and 18). A fall in demand in many areas has been caused by several factors. The rapid growth of residential care in the late 1980s offered an alternative destination for frail elderly people who may otherwise have entered sheltered housing. Better housing stock and rising expectations mean that some older people will struggle to remain in their own homes rather than move to sheltered accommodation with shared or poor quality facilities (which represents around 16 per cent of the sheltered stock).

43. In response to this trend, many authorities are reviewing and, where practicable, enhancing the standard of their hard-to-let accommodation – but in the short term this often increases the tendency to admit more fit, active older people to fill the voids. Hard-to-let problems are not confined to local authorities; 83 per cent of RSLs also experience them. Unfortunately, authorities sometimes treat RSLs as competitors for a limited pool of potential tenants, rather than collaborating with them to find future solutions. This antipathy affects potential tenants, who are sometimes given little or no information about RSL properties, thereby reducing their choice (Ref. 19).

Analysis of financial data from 47 local authorities.
Sheltered housing ... predates care in the community as we now know it.

44. None of the fieldwork authorities conveyed a clear vision of the future role of sheltered housing. There is little evidence of joint working with social services and local RSLs to include sheltered housing in a wider strategic approach to services for older people. Working in isolation from the social services assessment process, housing authorities are less able to identify the needs of older residents across all tenures and develop and allocate sheltered housing accordingly. Social services increasingly concentrate on providing support to people in their own homes, but focus this support on those with relatively high needs. They are less and less involved with older people who are reasonably independent but who could benefit from limited support now in order to reduce or delay their demands on social and healthcare in the future. These are often the people who may be most attracted by sheltered housing.

45. So provision becomes ‘locked in’ to supporting only those elderly people who are known to housing authorities – mainly its own tenants. Consequently, sheltered housing is failing to provide an effective alternative to residential care for non-council tenants who may not need the high level of care provided by residential settings. In view of the current £8 billion bill for residential care and the pressure on social services budgets, this is a significant issue (Ref. 20). In addition, potential economies from sharing staff and facilities (by opening up sheltered housing for wider community use) are not always being realised.

46. These problems, combined with demographic changes and refocusing of the services provided by health and social services, indicate a need to review sheltered housing. Any review should include an examination of the role of the warden, traditionally viewed as a ‘good neighbour’. However, the continuing relevance of this good neighbour role is called into question by two diverging trends. One is the rise in the numbers of fit older people recently admitted to sheltered housing who may need little or no support. At the same time, longer-term residents with rising needs are ‘staying put’, so some wardens are struggling to cope with high levels of dependency among tenants. A particular problem is the rapid increase in the number of older people with dementia and other mental health problems.

47. Sheltered housing was the 1970s/1980s public service response to the issue of caring for older people. It predates care in the community as we now know it. The philosophy of care in the community is to take support to the person at home, rather than move the person to the source of support. Such support services therefore need to be flexible and able to respond to changing and increasing needs. Where authorities can offer this flexible support to older people living in their own homes, the demand for traditional sheltered housing is either likely to decline or to be used to support increasingly frail tenants.
The principle of community care makes it harder to justify tying resources to property rather than to people. Sheltered housing must accordingly re-invent itself as provision for older people who prefer the presence of a supportive community, or it must re-think the levels of need it is able to support. If it does not, it will face serious questions about its relevance in a system which can deliver high levels of support in ordinary housing. Inappropriate sheltered housing could be a lost opportunity for community care but, re-invented, it could be a powerful platform for the success of the policy. In certain circumstances, the best option for an authority which is struggling to use sheltered housing appropriately may be to de-commission some units. Sheltered property now surplus to requirements for older people could be appropriate for other vulnerable groups.

Adapting and improving properties to support independent living

The other ‘bricks and mortar’ contribution that housing makes to community care is to help people remain at home by modifying their property. Many frail older people and people with physical or sensory impairment live in homes which are ill-equipped to cope with their frailty; they may, for example, have difficulty in managing stairs, or getting in and out of the bath. Homes can usually be adapted to help overcome these problems, and the most common adaptations are stairlifts, showers and wheelchair ramps. Less costly works may be funded by social services but housing agencies are typically the main funders for modifications costing more than £350. The source of that funding is, however, linked to the tenure of the occupant as well as individual needs [BOX C].

For some people, independent living requires property improvement rather than (or in addition to) adaptation - their home may lack basic amenities, be cold or damp or generally be in a poor state of repair. In such cases, assistance may be available through other grants, and individuals may be helped by a local Home Improvement Agency.1 Such grants are, though, discretionary whereas DFGs are mandatory. There are also an increasing number of ‘handyperson’ schemes, offering cheap or free labour and materials to undertake small jobs for those who are no longer able to cope for themselves. A key objective of all these schemes is to minimise the risk of older people drifting into more expensive forms of accommodation because of failure to modify properties or meet maintenance concerns. However, authorities are struggling to keep pace with the rising demand for adaptation and repair. Long delays are common - the average time taken from application to completion of a routine adaptation is 14 months [EXHIBIT 10].

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1 Home Improvement Agencies (HIAs) provide independent advice and assist elderly people, people with disabilities and those on low incomes to carry out repairs, improvements and adaptations to their properties. HIAs may be managed by RSLs, local authorities or independent bodies and are often called ‘Care and Repair’ or ‘Staying Put’ agencies.
**BOX C**

**The current system of funding adaptations**

The current system of funding adaptation works is tenure-based. Private sector tenants and owner-occupiers can apply for a Disabled Facilities Grant (DFG), established under the Housing Act 1989. The DFG is a mandatory grant available for adaptations needed by people with frailty or disability, notably improvements to access and ease of movement around the home. The grant is subject to means-testing, with the amount awarded being dependent upon an applicant’s income and savings. The assessment of need for the requested adaptation is carried out by an occupational therapist.

For council tenants, the work is funded by the housing department as part of its landlord role. A council tenant may apply for a DFG, but the work is normally paid for through the Housing Revenue Account. In most authorities there is no requirement for a means test. The main revenue source is rents - in effect, council tenants are paying collectively for their own adaptations and do not benefit from government grant or subsidies.

Tenants in RSL property can apply for DFGs, subject to the standard test of resources. In recent years many RSLs have paid for the work themselves and claimed additional grant from the Housing Corporation. However, in 1996 the Corporation restricted reimbursements to work exceeding £500, and in 1997/98 it halved its total allocation for adaptations to £9 million. In future, RSLs with high levels of reserves will not receive Corporation grants for adaptations work.

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**EXHIBIT 10**

**Average time taken to process adaptations**

Applicants can wait as long as two years for routine adaptations.

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<table>
<thead>
<tr>
<th>Average time from referral to completion (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Council house adaptations</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

Source: Audit Commission fieldwork in eight authorities
...delays in the process are used as a form of hidden rationing.

51. There are a number of reasons for this situation. The first difficulty is a national one – simply, the eligibility criteria for adaptation and improvement grants are not matched by the resources available. Demand for DFGs has risen by over 50 per cent since 1991. But resources are heavily constrained – current funding levels provide for only 25,000 grants annually. This is the ‘tip of an iceberg’ in terms of the scale of potential unmet demand; the DETR estimates that there are 650,000 eligible households in the private sector alone (Ref. 21). However, as well as lobbying for more resources, councils could use existing resources for adaptation work more effectively. They need to address three particular problems:

- resources are not always prioritised to match need;
- systems for processing applications are often inefficient; and
- parochialism in budget management is impeding value for money.

Prioritisation

52. Many authorities attribute delays to a lack of resources, notably insufficient capital funding allocations. Realistically, it is unlikely that the resources allocated will ever meet demand in full, but some authorities are not prioritising needs to match the resources available – instead, delays in the process are used as a form of hidden rationing. What people want often exceeds their needs. It is important that people’s expectations are managed through locally agreed eligibility criteria, consistent with the resources available. Rationing through delay, rather than explicit priorities, means that those with the greatest need may suffer.

Inefficient processes

53. To make the best use of their scarce resources, authorities need to manage services efficiently and effectively. Many are failing to do so. Hence the system is characterised by lengthy delay, which is not only distressing for users and carers but jeopardises independent living and may generate more costly problems in the future [BOX D]. Some housing and social services officers disagree over which adaptations best meet particular types of need, leading to a debate by correspondence. In many authorities the process is over-complicated by the involvement of too many players and protracted decision-making procedures. For example, councils may seek the client’s agreement to the works twice – once each from the two departments involved – entailing multiple visits and inevitable delay.

54. Some authorities cite insufficient staff resources as a cause of delay. Although there is wide variation in expenditure on staff, low staffing does not necessarily correlate with delay [BOX E]. The effective deployment of staff is likely to be of more importance. One authority identified the assessment of need carried out by occupational therapists (OTs) as the main source of delay, and reviewed their tasks and grades. Some tasks were delegated to clerical staff or OT assistants as a result, which
together with amendments to procedures – for example, arranging for some clients to visit an assessment centre rather than staff visiting them at home – led to a significant reduction in the waiting time for an OT assessment.

**BOX E**

**Expenditure on staffing compared to time taken**

Authorities A and B have similar levels of annual expenditure on adaptations and DFGs. Authority B spends significantly more on occupational therapists (OTs), OT assistants, grants officers and surveyors, but this greater investment in staff resources has not led to a speedier processing of adaptations. Authority A processes adaptations more efficiently, aided by the fact that social services and housing staff work together in a single unit, whereas Authority B locates them in different departments.

<table>
<thead>
<tr>
<th>1996/97</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure on adaptations and DFGs</td>
<td>£1.4 m</td>
<td>£1.7 m</td>
</tr>
<tr>
<td>Staff costs</td>
<td>£335,000</td>
<td>£530,000</td>
</tr>
<tr>
<td>Average time taken (routine adaptations)</td>
<td>12 months</td>
<td>16 months</td>
</tr>
</tbody>
</table>

Source: Audit Commission fieldwork

**BOX D**

**Lengthy delays in completing adaptations**

David is wheelchair-dependent and unable to go outside or upstairs without assistance; this condition confined him to his living room. He approached the council for assistance with adaptations. After a visit it was agreed that he needed a ramp and a stairlift, but he had to wait over a year for installation.

Mrs S is 79 and lives on her own in a top-floor maisonette; she wishes to remain in her own home. However, Mrs S recently had a fall and broke her ankle – her social worker now believes that it is only a matter of time before she falls down the stairs. This would obviously be serious for Mrs S, and would almost certainly entail a need for homecare support from social services. The social worker has recommended that a stairlift be installed in her home as a preventative measure, but there is a minimum waiting time of two years.

Source: Audit Commission fieldwork
Inefficient processes and delays entail additional costs or wasted expenditure.

**Poor value for money**

55. Inefficient processes and delays entail additional costs or wasted expenditure. Authorities do not always make the best purchasing decisions, adopting a case-by-case approach to routine adaptations, instead of learning and applying lessons from the cost-effectiveness of previous decisions. (One notable exception was an authority that provided transportable metal ramps instead of building permanent ones; these are cheaper and quicker to install, and can be moved to other properties as appropriate.)

56. Nor do authorities ‘recycle’ equipment and property adaptations to the fullest extent possible – stairlifts, for example, can often be removed and installed elsewhere. Furthermore, none of the fieldwork authorities had a detailed, comprehensive database of adapted properties against which to match people in need when modified properties fell vacant. This would allow authorities to re-use existing adaptations and avoid the need for some new ones. At present, adaptations are generally removed when a property is re-let – this represents poor value for money. Delay also reduces the effective life of an investment; one authority spent £89,000 in a single year on adaptations for users who died before they could obtain any real benefit from them.

57. There is also a degree of ‘cost-shunting’, as social services and housing authorities shift burdens on to each other’s budgets, ignoring overall value for money. For example, applicants for adaptations often require care at home – paid for by social services – pending completion of their requested adaptation. Some 17 per cent of applicants for adaptations in fieldwork sites were receiving care at home, and a year’s delay in providing the adaptations required can cost as much as £4,000 in additional care [BOX F]. Although some of the responsibility for these problems rests with the national financial and legal bases for adaptations and improvements, certain aspects could be dealt with locally.

**BOX F**

**The costs of delay**

In one authority, a door-widening adaptation took seven months and cost £300. The occupant required 4.5 additional homecare hours per week while waiting for the work to be done. The cost of additional homecare over this period was £1,440 (32 weeks x 4.5 hours at £10 per hour).

In a second authority, the installation of a stairlift took 18 months and cost £2,700. The applicant required five additional homecare hours per week while waiting for the work to be completed, at a total cost of £3,850 (77 weeks x five hours at £10 per hour).

Source: Audit Commission fieldwork
While attention to stock management and property adaptation can improve the delivery of community care objectives, care is principally about people. Therefore, effective personal support services are no less critical.

**Flexibility in the provision of personal support**

The essence of community care is that a package of accommodation, support and care is tailored to meet an individual’s particular needs. The packages may change over time, and will usually require input from more than one agency. For housing agencies to fulfill their role, they need to offer a range of housing options – mainstream accommodation, self-contained units, bedsits, shared houses and specialised provision. All of these housing options must be linked to different levels of personal support as appropriate, some of which will be provided by social services. This is a challenging agenda - how effectively are authorities matching the right support with the appropriate roof over the client’s head?

For their part, housing agencies have risen to the challenge by providing a range of specialised housing schemes; for example, by offering community-based care for people with mental health problems, those with learning disabilities and people with HIV/AIDS. Many of these schemes provide intensive support, such as 24-hour cover and high staffing ratios during the day. Other vulnerable people require less support – perhaps help to settle into a new tenancy and then occasional visits from a social worker or estate officer. The current arrangements have two major weaknesses. The first is a mismatch between the level of support needed by particular clients and that provided; in some cases, there is over-provision, which wastes scarce resources, while other clients are not receiving the support that they need to live successfully in the community. The second, linked, weakness is a pattern in which crisis response dominates at the expense of early intervention and prevention.

**Mismatch of support to levels of need**

The mismatch of support to need is illustrated in relation to specialised accommodation for one of the ‘tracer’ groups – people with mental health problems. The needs of this client group can be assessed through what is known as the Care Programme Approach (CPA), in which the assessment generates a care plan specifying the level and type of support that a person requires. Three categories of need are identified; those with serious, long-term mental illness (Category A) are likely to require higher levels of support than those with lesser and often short-term needs (Category C).

Unfortunately, a comprehensive range of provision to meet these varying levels of need is not always available. The Housing Corporation and National Housing Federation have six categories of supported housing, with 90 per cent of schemes falling into three main categories;

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1 Categorisation adapted from work by Patmore and Weaver (Ref. 22).
36 per cent of sampled health authorities reported a lack of accommodation catering for individuals in one or more of these categories. Consequently, some mentally ill people are placed in unsuitable schemes, receiving either too little or too much support – provision is not targeted to need. In a Commission survey of supported housing schemes, only half of the 24-hour, sleep-in schemes – catering for residents with high levels of need – were occupied predominantly by such residents; some schemes had no high-need residents at all [EXHIBIT 11]. Some individuals may be ready to move to schemes offering lower levels of support, and so a degree of flexibility is appropriate, but this needs to be managed carefully to avoid wasteful over-provision.

The existence of mismatches between need levels and provision is confirmed by the fact that 29 per cent of the sample schemes experience pressure to admit people even when the level of support is known to be inappropriate to their needs. Too little support was the reason given for refusal to admit in 26 per cent of cases, with support exceeding that required in 7 per cent of schemes. A basic imbalance between need and supply is a key reason for this mismatch. But the variable quality of referral processes (to identify those who can benefit most from supported housing) is a further significant contributor.¹

¹ Allocations procedures are being examined in a parallel study of the management of supported housing schemes in the RSL sector, due to be published by the Commission later in 1998.

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EXHIBIT 11

Level of support in relation to resident need

Some schemes offering high levels of support contain a high proportion of residents whose needs could be met in less intensive – and thus less expensive – schemes.

Source: Audit Commission survey of 91 schemes housing people with mental health problems, 21 of which cater for high need levels.
64. Placing people in a type of specialised housing that does not match their level of need is frustrating for clients and unlikely to facilitate their return to an independent life in the community. It is also an inefficient use of scarce resources. Although a range of specialised housing options offers valuable flexibility to meet diverse needs, too many resources are locked into accommodation types that do not allow users access to the tailored packages that their circumstances merit. This is partly due to the physical inheritance – some accommodation is now of the wrong type and/or in the wrong place – but it is also the result of the failure to co-ordinate housing’s contribution with input from social services and health authorities. Solutions lie not only in redressing the imbalance between supply and need for different types of specialist housing, but also in using existing stock more flexibly and in the prompt identification of individual support needs.

**Cure rather than prevention – the domination of crisis response**

65. The importance of early identification and intervention is underlined by the effects of the other principal weakness in current provision – the failure to invest in effective prevention. The majority of people with support needs live in ordinary housing, particularly social housing, rather than in specialised projects. Their vulnerability is often less obvious than if they were living in a specialised scheme with on-site support, but their need for support is no less important. Some of them lack the skills needed for everyday living that most people take for granted – budgeting and paying bills, claiming benefits, shopping, etc – and little or no access to informal care networks, such as family or good neighbours. The question of who should provide support with tasks that fall short of typical notions of ‘care’ is a grey area, and at times a point of contention between housing, social services and health agencies.

66. Housing management has traditionally provided practical assistance with problems around rent, housing benefit, neighbour relations and so on. But much of this support is discretionary and not written into any formal agreements. Social services departments concentrate on clients with high levels of need, leaving housing to support the much larger group without formal community care assessments. As the number of tenants needing help increases and intensifies, housing officers are finding it more difficult to sustain support – the ‘grey area’ is fast becoming a vacuum.

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1 One recent study of RSLs in London estimated that up to 60 per cent of their tenants were vulnerable and may need support to help them maintain their tenancy (Ref. 23).
Interviews with estate officers in fieldwork authorities highlighted the difficulty experienced by a number of vulnerable tenants in coping with their situation. Officers cited a number of examples of the sorts of problems that vulnerable people experience, including difficulties in filling out a housing benefit form, struggling to operate the heating system, fear of letting council workers into their home, falling out with their neighbours or not knowing whom to turn to for help in a personal crisis.

To examine the scale and nature of these problems, the files of 100 tenants with mental health problems were reviewed at seven authorities. The sample revealed that in 20 per cent of cases the tenancy had quickly broken down altogether, often with the tenant returning to psychiatric hospital; a further 45 per cent of tenants exhibited signs that they were in difficulty. For example, they were requesting transfers, incurring serious rent arrears (that is, over four weeks in arrears), or were at risk of eviction, or were in and out of hospital. A high proportion had also suffered - or caused - problems with neighbours; unresolved problems affect other tenants and this is a growing problem area for housing officers.

EXHIBIT 12

Experiences of local authority tenants with mental health problems

In a sample of tenancies let to people with mental health problems, a significant proportion were in serious difficulty.

Source: Audit Commission fieldwork, sample of 100 tenancy files
The ‘revolving door’ syndrome

The resultant distress for vulnerable people is substantial and extreme outcomes are not unusual – several of the tenants ended up setting fire to their flats in desperation. The financial price is also high. Although few authorities collect financial data in this way, analysis in one fieldwork authority suggests that each tenancy failure could cost in excess of £2,000 [TABLE 2]. Tenancy failures also result in greater demand on other public services such as accident and emergency units, inpatient psychiatric care, the police or prison services – again, at significant cost to the public purse.

### TABLE 2

<table>
<thead>
<tr>
<th>Costs of tenancy failure</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrecoverable arrears</td>
<td>150</td>
</tr>
<tr>
<td>Legal costs</td>
<td>100</td>
</tr>
<tr>
<td>Cleaning and redecoration</td>
<td>250</td>
</tr>
<tr>
<td>Repairs</td>
<td>500</td>
</tr>
<tr>
<td>Lost rent while property empty</td>
<td>150</td>
</tr>
<tr>
<td>Staff time</td>
<td>500</td>
</tr>
<tr>
<td>Subsequent homelessness application</td>
<td>450</td>
</tr>
<tr>
<td><strong>Total cost to housing authority</strong></td>
<td><strong>2,100</strong></td>
</tr>
</tbody>
</table>

Source: Audit Commission estimates based on national statistics and data from one fieldwork authority

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**BOX G**

Tenancy failure can have simple causes

Richard has mental health problems and struggles to cope with everyday life. He recently received a summons to appear in court because of rent arrears. The council had written to him twice previously; because he had failed to reply, his housing benefit had been stopped and the arrears had mounted up. When the housing officer was finally able to make contact, he discovered that Richard’s mental condition had worsened. He simply could not face dealing with the official letters that came through his door and this had been the cause of his mounting arrears.

Source: Audit Commission fieldwork
Nearly half of the tenancy failures ended with the tenant being admitted to hospital, usually a re-admission – this goes some way to explaining the current 37 per cent re-admission rate to psychiatric beds (Ref. 13). A typical stay of four weeks in hospital costs the NHS £3,200. It also places additional pressure on psychiatric wards – occupancy levels in some areas are currently in excess of 100 per cent. Bed shortages often lead to pressure to discharge other patients early or on leave of absence. A prolonged stay in hospital is likely to result in the loss of the tenancy, leaving the patient with nowhere to go when they are ready for discharge.

Many tenancy failures therefore result in homelessness. A significant number of the homeless have mental health problems – one recent study of rough sleepers in London estimated that around 40 per cent were suffering from mental health problems, often linked to substance abuse (Ref. 24). Some cases lead to encounters with the criminal justice system, which adds significant additional costs. For example, identifying and prosecuting a young offender costs £3,700 and a stay in prison costs £450 a week (Ref. 25). People with mental health problems are disproportionately represented in the prison population – a recent study stated that one-third of remand prisoners reported a history of mental health problems (Ref. 26).

A picture emerges of significant resources invested by housing, social services and health authorities in crisis-based services – homelessness, high intensity support in specialised schemes, hospitalisation in short-stay psychiatric beds, etc – in large part because funding is available for these services, but is lacking for more basic (and often less costly) support. There has been considerable investment in outreach and resettlement for rough sleepers, but for all vulnerable groups, the relative absence of low-intensity tenancy support can often be the cause of re-entry into expensive, high-intensity attention. In effect, many people with mental health problems become trapped in the ‘revolving door’ syndrome whereby tenancy crisis leads to hospitalisation and/or homelessness, and then a lack of ongoing support after being rehoused means that these tenants fail to establish a firm foothold in the community (Exhibit 13). Not all such cases can be avoided, but where support does work, money is not only saved, but clients’ quality of life is enhanced.

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I Bed occupancy levels in excess of 100 per cent can occur where patients are on leave, absent without leave or temporarily transferred to secure facilities.

II The costs of processing young offenders, and other issues around youth crime, are discussed in Misspent Youth, published by the Audit Commission in 1996.
**EXHIBIT 13**

**The ‘revolving door’ syndrome**

Many tenants with mental health problems experience a ‘revolving door’ syndrome. Sources: Audit Commission, Department of Health, Sainsbury’s Centre for Mental Health

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**Joint working arrangements**

72. Such tenancy crises are often a complex mix of immediate housing problems compounded by problems with health and social care. More than three-quarters of tenants in the file review were known to, or receiving support from, health, social services or voluntary groups. Many have significant needs - an estimated 40 per cent were diagnosed as schizophrenic or psychotic and/or had been long-stay psychiatric patients. Although housing services can assist with their practical problems, the
Contact between housing and social services or health is frequently limited to letters written in support of rehousing. Planning and delivery of care is the responsibility of social services and health agencies. Consequently, systems need to be established whereby housing officers work closely with their colleagues across the professional divide. Unless all three work well together, the ‘seamless service’ will be more myth than reality.

There is much evidence that joint working does take place – what is questionable is its quality and effectiveness. Although joint working has been consistently promoted through government advice and research into good practice (Ref. 6), debate has centred on the process rather than the outcomes. Too often, effective liaison is a matter of good individual working relationships (that may not survive changes of personnel) rather than a systematic framework of standard procedures and monitored objectives. Contact between housing and social services or health is frequently limited to letters written in support of rehousing. Housing officers reported that they were not routinely involved in assessments with health and social services, a point confirmed by the case file review. Some expressed dissatisfaction on operational matters such as the sharing of information – for example, to resolve confidentiality issues – and regular liaison. This impaired their ability to gauge accurately an individual tenant’s needs or to anticipate and counter problems [BOX H].

**BOX H**

Problems flowing from poor liaison between departments and agencies

A couple who both suffered severe mental health problems were being harassed by neighbours. The local authority’s response was to relocate them, nominating them for a property managed by a local RSL. One member of the couple was admitted to a psychiatric hospital before the move took place, but the relocation nevertheless started with the help of a social fund grant for removal expenses. However, the partner was also admitted to hospital before the move was completed and the tenancy was terminated.

The council continued to treat the couple as council tenants who were entitled to rent rebate in respect of their ‘old’ house, but refused to pay housing benefit on the new home because they had not formally completed the relocation and taken up residence. Nonetheless, the RSL was charging rent, and with no housing benefit to fund it, arrears mounted while the couple were hospitalised. The RSL then instigated eviction proceedings. At the couple’s request, a voluntary group intervened and suggested a meeting between housing benefit staff and social services officers to resolve the situation. The meeting never took place and arrears continued to mount.

A vulnerable couple, forced to move because of harassment by council tenants, therefore faced losing their new home largely because housing and social services failed to explore a simple, commonsense solution.

Source: Information provided by the National Association of CAB.
A critical consequence of these failures is an inadequate safety net which is failing to protect many vulnerable people.

74. Disputes between social workers and healthcare professionals about the provision of support are evident. Social workers or psychiatrists sometimes argue that it is inappropriate for them to become involved or provide support in mental health cases where a tenant does not want help, is aggressive or has an ‘untreatable’ personality disorder. One housing officer reported in his notes:

‘I asked if there was a social worker involved and was told that B had had one in the past but the social worker had closed the case due to B’s aggressiveness.’

The housing service has no such simple choices – it is left ‘holding the baby’ or pushing it back on to the street.

75. These points speak to the need for a review of the role of housing in meeting community care objectives. But, additionally, they convey a deeper concern about the broader role of social housing, and the objectives set for those who manage it. A picture emerges of housing agencies unable to make the best use of specialised and ordinary housing stock for people with support needs, and social services authorities unable to make the everyday working links with housing colleagues to ensure that support is linked to the individual, rather than tied to particular accommodation. A critical consequence of these failures is an inadequate safety net which is failing to protect many vulnerable people. However, this picture is obscured by a relative absence of procedures to evaluate services rigorously, set targets or measure performance – gaps that will be cruelly exposed by the Best Value regime.

76. The housing role in community care is beset by problems of measurement – what does success look like, and how can weaknesses and inefficiency be identified? A common cry is that the nature of the client groups and their problems are not susceptible to quantitative assessment. While acknowledging some of the difficulties of performance measurement in this area, the cost of the current problems in human terms and to the public purse should inject a greater sense of urgency into councils’ efforts to develop performance systems. A relatively easy starting point would be the property adaptations process (see paragraphs 49 to 58).
...the community care dimension often remains unmeasured and at times unmentioned.

Adaptations to people’s homes are an important and growing area of community care. Yet none of the authorities visited monitored how long adaptations were taking to provide – that is, from initial contact with social services to the completion of the adaptation – nor how effectively needs were being met. This is despite the fact that the source of delay typically lies within housing and social services departments, rather than in the clients’ input or in the building works themselves. The stages in the process are therefore subject to measurement which can pinpoint the probable source of inefficiency and delay [EXHIBIT 14]. Councils could improve the adaptations service in a number of ways, even within a context of constrained resources. But without basic information on the length of the process, it is not possible for councils to establish the reasons for delay or to devise appropriate solutions.

The lack of a performance focus is not confined to the area of adaptations. In many authorities there is little measurement of the success of services such as sheltered housing, supported housing or tenancy support. Housing authorities and RSLs are familiar with measuring performance in the core areas of landlord responsibilities – voids, rent arrears, etc – but the community care dimension often remains unmeasured and at times unmentioned. None of the fieldwork authorities had any measures of success of the housing management service specifically in meeting community care objectives; they are thus not well placed to respond to the Best Value requirement to account for their achievement of objectives and local targets.

EXHIBIT 14
Source of delay in adaptations
Most of the delay in completing routine adaptations occurs within housing and social services departments.

Source: Audit Commission fieldwork in eight authorities
Most practitioners are keen to evaluate performance, but they lack a clear framework which specifies service objectives and measures of performance. In most cases, they also lack IT systems to gather the information needed to underpin performance measurement.

**Conclusion**

There are a number of problems at local level with the planning, delivery and monitoring of housing’s contribution to community care [EXHIBIT 15]. Too many authorities do not have a comprehensive and strategic grasp of needs and resources, there are inefficiencies in the use of existing stock and vulnerable people are not always receiving the ‘seamless’ support that is so vital. However, the picture is not one of consistent underperformance; some authorities have had a degree of success in these areas and provide a lead for others. The next chapter outlines how some of the problems can be tackled, illustrated by good practice examples from a number of leading edge authorities.

**EXHIBIT 15**

**Problems and causes**

Authorities need to address a number of problems if performance is to improve.

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>CAUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning strategically</strong></td>
<td>• lack of information on needs and provision</td>
</tr>
<tr>
<td>• poor trend planning</td>
<td></td>
</tr>
<tr>
<td>• needs not mapped to available resources</td>
<td></td>
</tr>
<tr>
<td><strong>Managing existing resources</strong></td>
<td>• inadequate supply/quality of mainstream stock</td>
</tr>
<tr>
<td><strong>Stock</strong></td>
<td>• allocations process not sensitive enough to needs of vulnerable people</td>
</tr>
<tr>
<td>• authorities not making best use of ordinary housing for vulnerable people</td>
<td>• unco-ordinated, historic decisions in development of specialised schemes</td>
</tr>
<tr>
<td>• supply of specialised housing often does not match needs of communities</td>
<td>• lack of a strategic vision for sheltered housing</td>
</tr>
<tr>
<td>• sheltered housing not targeted at frail older people</td>
<td>• role of warden under-developed</td>
</tr>
<tr>
<td>• significant delays in providing adaptations; typically 14 months and up to two years in the worst cases</td>
<td>• process inefficiencies and priorities inconsistent with needs</td>
</tr>
<tr>
<td><strong>Personal support</strong></td>
<td>• national resource levels and eligible need do not match</td>
</tr>
<tr>
<td>• mismatch of support to need in supported housing</td>
<td>• gaps in provision and inflexible schemes</td>
</tr>
<tr>
<td>• tenants with mental health problems struggling to live in the community</td>
<td>• crisis response predominates</td>
</tr>
<tr>
<td><strong>Monitoring performance</strong></td>
<td>• lack of joint working across agencies</td>
</tr>
<tr>
<td>• lack of performance focus</td>
<td>• lack of a clear framework specifying objectives and measures of performance</td>
</tr>
</tbody>
</table>

Source: Audit Commission
Improving Performance at the Local Level

The new Best Value regime will require systematic review and monitoring of performance. The starting point is a sound understanding of local needs, alongside a database of provision. Authorities need a clear vision of the role of sheltered housing - a major resource - to maximise its contribution. Improvements are also possible in processing requests for adaptations. Leading authorities are developing flexible approaches, both in stock management and the provision of personal support such as resettlement - prevention is better than cure.
81. Spreading good practice between authorities is one means of raising overall standards of performance. And early improvement is possible. The advantage of focusing on processes, such as the speed and efficiency of property adaptation, is that improvements can be almost immediate and are not necessarily costly. Indeed, they can usually save resources. The Best Value regime of review and target-setting may stimulate action. This analysis of the deficiencies in the current arrangements indicates that housing services need to focus their review and evaluation activities on the three vital roles of planning, securing the best use of resources and monitoring performance.

82. The starting point must be a sound understanding of the needs that exist within the authority’s area, alongside a database of provision. Such a database is a prerequisite to evaluating the balance of services within and across agencies, developing an effective strategy for housing and community care, and ultimately engaging in joint commissioning with partner agencies to make the best use of resources. This may, in turn, require discussion to ensure that a common vocabulary is used across housing and social services to define and categorise ‘support needs’. Although compiling such a comprehensive and accurate information base is not an easy task, a number of local authorities have successfully completed such exercises and have found them invaluable for planning purposes [BOX I, overleaf].

83. The mapping of needs and provision should not be confined to local authority tenants and stock. The quantity, range and quality of supported and sheltered housing in all tenures requires review, for several reasons. First, to ensure that appropriate packages of accommodation and support are available to those in need; second, to identify any shortfalls in provision; and finally, to avoid duplication or over-supply. Housing agencies would benefit from better information on:

• the precise number of available units and their condition;
• what needs are currently being met and whether admissions criteria require any revision;
• the financial basis of provision – for example, the unit cost of a place in sheltered accommodation; and
• the effectiveness of current provision in relation to identified needs.
A useful starting point would be for housing authorities to gain access to the database on supported housing stock developed by the National Housing Federation and the Housing Corporation – the Continuous Recording (CORE) data set. The Supported CORE data set provides extensive information on schemes including client group, number of bedspaces and support services provided. The Housing Corporation and the DETR could encourage – or require – RSLs and housing authorities respectively to justify bids for supported housing schemes against the current configuration of supported housing in the

**BOX I**

**The Housing Pathways model of mapping needs against provision**

The Housing Pathways model enables local authorities to map housing need and housing supply in their area. The population for the model includes all those who require extra support or community care services, regardless of whether they are currently receiving such support, and is broken down into client groups (for example, mental health, learning disabilities). There are three factors in the model: current housing situation, estimated future need and housing supply.

- **Current situation** – for example, living in one’s own home, living with relatives, in specialist accommodation or homeless;
- **Housing needs factors** – such as a need for more/less support, a desire for independent living or the unsuitability of current residence/location; and
- **Housing supply factors** – notably the extent of planned new accommodation, existing re-lets, moves to specialist accommodation and adaptations to current homes.

The authority gathers information about all three factors to produce a projection of net housing need for each client group. To date, the model has been used as a planning tool in over 20 authorities. In many areas, findings include a lack of emergency accommodation for people needing temporary refuge due to mental health problems; a lack of self-contained supported housing; and difficulties in accessing such accommodation because of the prior demands caused by large-scale hospital closures.

In practice, identifying the initial population is difficult, because the model seeks not only to capture the needs of less ‘visible’ groups such as people with mental health problems, but also extends to identifying latent need. Its application therefore requires considerable resources, including input from experienced researchers. But it represents a considerable advance on many previous approaches to mapping need.

Source: Housing Need and Community Care, Lynn Watson, NHF, 1996

84. A useful starting point would be for housing authorities to gain access to the database on supported housing stock developed by the National Housing Federation and the Housing Corporation - the Continuous Recording (CORE) data set. The Supported CORE data set provides extensive information on schemes including client group, number of bedspaces and support services provided. The Housing Corporation and the DETR could encourage – or require – RSLs and housing authorities respectively to justify bids for supported housing schemes against the current configuration of supported housing in the
area. Although many authorities do not see it as their responsibility to monitor the quality of supported housing schemes managed by RSLs, it is an important part of the strategic process to obtain such information. At the very least, housing managers should establish regular liaison with the regional Housing Corporation staff whose role it is to monitor such schemes.

85. Once the scale and nature of the problems facing housing authorities and their partners in community care are defined and quantified, it should be possible to assess how well resources are currently being deployed. Evaluation of change options then becomes possible. A number of housing authorities, social services departments and health authorities have crystallised this process in the shape of a housing and community care strategy [CASE STUDY 1]. This more comprehensive approach complements ongoing service improvements in the areas of most pressing need.

86. Joint strategies should not only be a means to seek new resources - opportunities exist to make better use of current resources, within and across agencies. In the first instance, the emphasis should be on maximising the benefits of the resources already invested in housing. New services may have to be commissioned as needs change, but in many cases these are likely to adapt current provision, rather than be additions to it.

**CASE STUDY 1**

**Housing with care - Essex County Council**

Essex County Council’s partnership with RSLs and the Housing Corporation was originally designed to provide housing for ‘key’ workers such as teachers. The new responsibilities arising from community care led to an expansion of the partnership to include district councils and health authorities, and to a refocusing of tenancy priorities. Client groups such as older people and those with mental health problems now take precedence.

The partnership has developed specific service standards, including a target response of six months for the processing of Disabled Facilities Grants. A housing and community care strategy has also been developed to provide a framework to improve access to suitable housing for vulnerable people.

A particular innovation has been the creation by the Housing Corporation of the Strategic Reserve, which brings together county council land resources and top-sliced money from Housing Corporation funds, LA HAG and RSL funds. The result has been the development of 315 housing places, with appropriate packages of support, across the county.

Source: Audit Commission fieldwork
Securing the best use of housing resources

Housing agencies often face a difficult challenge in finding the right combination of bricks and mortar and personal support to offer vulnerable people. Some local authorities are heavily constrained by the limitations of their own stock – the quantity or quality or, in some cases, both. In the absence of realisable proposals for a large-scale capital building programme, councils need to scrutinise the extent to which they are maximising what they already have. Some authorities have expanded the options available by working increasingly collaboratively with the private rented sector and with RSLs. There has also been a growth in the use of regeneration funding such as Estate Renewal Challenge Fund (ERCF) to target the needs of vulnerable tenants – for example, by bringing hard-to-let blocks into full use through concierge schemes, which offer greater security and protection.

Allocations policies have also come under review, as housing departments strive to ensure that the particular needs of vulnerable tenants are addressed. Detailed advice for both housing officers and prospective tenants, together with sensitivity on pre-tenancy viewing and the time needed to take up residence, can help to minimise the risk of a tenancy ending prematurely. That flexibility is the key to maximising the effective use of what, to all intents and purposes, is an inflexible resource – building stock – is illustrated by some developments around sheltered housing, the largest resource currently available for assisting older people with support needs. The option of sheltered housing was promoted when the preferred solution was seen to be moving people to a supportive environment. Now that the ideal is to deliver support to where people live, some sheltered housing is losing its sense of direction – its role needs a fundamental review.

In each council, that review should be conducted jointly by housing and social services, drawing on examples of current good practice [CASE STUDY 2]. Authorities need to ask what role they want sheltered housing to play in the overall context of services for older people, and consider whether existing facilities, staffing and policies are adequate [CASE STUDY 3].

The review should cover all local provision – RSLs are frequently as important a provider of sheltered housing as councils. Any review should ask both strategic and operational questions:

- What are the predicted patterns of demand for sheltered housing, and how can it best be integrated with other services for older people? Is there, for example, a need to shift resources between options, tenures or geographical locations?
- What should the basis be for allocating sheltered housing places, setting this provision within a community care context and not simply fulfilling stock-management requirements? For example, can agreement be reached on objective criteria for the degree(s) of frailty for which sheltered housing should cater?

The National Housing Federation's Appraisal Guide for Sheltered Housing, published in 1996, would be a good starting point for review by RSLs and local authorities alike.
CASE STUDY 2

Flexible use of sheltered housing - North Hertfordshire District Council

As part of a pilot scheme, wardens in six sheltered housing schemes have been trained to carry out care assessments, including the financial implications; to conduct care reviews – for example, after discharge from hospital; and to supervise the subsequent delivery of care to residents. (Over one-quarter of tenants in North Hertfordshire’s sheltered housing schemes are in receipt of social services care.)

The training has led to a number of improvements:

• savings have accrued in the time formerly spent by social services officers in assessing, reviewing and supervising care for nearly 60 people;
• the service to clients is faster and more flexible in response to changing needs, especially before and after a stay in hospital; and
• there is less need for wardens to provide ‘stop gap’ care while awaiting an assessment or service to arrive.

Source: Audit Commission fieldwork

CASE STUDY 3

Developing sheltered housing as part of a joint strategy for older people

Wolverhampton Metropolitan Borough Council submitted a bid for Best Value pilot status which proposes changes to sheltered housing as part of a strategy for an ageing population. The strategy is based on extensive local consultation, covering services provided by leisure, transport and education as well as housing and social services. The resultant strategy, finalised in 1997, emphasises rehabilitative and preventive services, and has a strong community focus. One significant output of the strategy is that some 1,000 ‘very sheltered’ flats will be developed over the next 10 years to replace existing residential home places.

A successful pilot scheme has been running for several years. Care is offered on site to high-dependency tenants at a set charge. Lower-dependency tenants have access to support services if needed, but are not charged for them. Support services and a social club are used by older people in the local community, and the schemes provide opportunities for volunteering and training existing and future care workers. Performance indicators include occupancy levels, community participation, quality of life and independence for tenants, training and employment achievements, and unit cost savings.

Alongside this initiative, the council is developing purpose-built bungalows for older people who do not need or want the services of the very sheltered blocks. These bungalows often allow larger council houses to be made available for families.

Source: Audit Commission fieldwork
How should the role of wardens be developed? For instance, is it a key objective that wardens help to sustain increasing numbers of frail older people in sheltered housing? If so, then the extension of the warden’s role to encompass assessment, key working, monitoring and co-ordinating care delivery needs to be considered. This support should then be targeted on residents most in need.

How can the use of sheltered housing facilities be maximised, where it is appropriate to do so? A fall in demand logically argues for some units to be put to other use; if redundant for elderly persons, can sheltered housing schemes be adapted to provide supported housing for other vulnerable groups? Or can sites be sold and the resources recycled to address more relevant care objectives?

Responding to the demand for adaptations, repairs and community alarms

90. The needs of many community care clients can be met through property-based solutions such as adaptations or the installation of an alarm. Clear potential for improvement exists in the time taken to process property adaptations. The first step in tackling this issue is to monitor the time taken to complete adaptations from the point of initial referral. Other good practice includes:

- matching eligibility criteria to resources available;
- streamlining the process within and between agencies;
- more effective deployment of staff;
- effective local purchasing and re-use of adaptations [BOX J]; and
- pooling budgets across departments/agencies.

91. Several of the fieldwork authorities have reduced waiting times significantly by prioritising referrals to match the available resources [CASE STUDY 4]. Sharing resources across agencies is another approach – pooling budgets can promote their optimal use. Social services authorities could, for example, consider transferring resources from homecare budgets or Special Transitional Grant in anticipation of savings from the speedier processing of adaptations. In addition, appropriate expenditure on equipment can avert the need for expensive adaptations.
Prioritising adaptations to reduce delay - London Borough of Southwark

Before April 1996, Southwark had a complex four-part priority system and long waiting lists for DFGs - waits of two to three years were common. To improve the situation, the Council both streamlined the administration of the adaptations process and reviewed the eligibility criteria. Councillors tightened criteria for new referrals and a simpler two-band priority system was introduced.

The processing of adaptation referrals was improved when the principal occupational therapist instituted regular meetings with the direct labour team, which has the contract for general building works for council stock. The meetings are a forum to monitor ongoing work and to discuss any problems, including delays/quality issues or changes needed on site. Meetings may take only 10 minutes but have greatly improved relationships and the speed of work.

The old ‘priority three’ waiting list has been cleared. In 1996, Southwark’s waiting list stood at 1,556 applications and entailed a wait of up to three years; by December 1997, it had fallen to 437 outstanding applications with a maximum wait of six months.

Source: Audit Commission fieldwork

Re-using adaptations

Stairlifts are among the most common adaptations provided by housing authorities. Analysis of DFG files found that, in some cases, applicants waited up to 22 months for a stairlift to be fitted. As with most adaptations, the reasons for delay are partly operational and partly a matter of financial constraints. With stairlifts, however, there is scope for achieving financial savings through a form of recycling.

Unlike some adaptations, such as bathroom conversions, many stairlifts can be removed when they are no longer required and re-used elsewhere (particularly those on straight flights of stairs). During 1996/97, Nottingham City Council’s adaptations and renewals agency installed 61 stairlifts, 13 of which were second-hand. The cost of removing a stairlift and installing it in a new property is in the region of £360, compared to approximately £2,000 for a new lift. Re-using stairlifts thus generated savings in the city’s adaptations budget in excess of £22,000 for the year.

Source: Audit Commission fieldwork
Community alarms are a cost-effective means of support...

92. Streamlining the process can be achieved in several ways: allocating responsibility for the whole process to one authority or agency and thus reducing the stages in the process; establishing ground rules on priorities; and identifying the most cost-effective way of meeting needs. Involving private sector and/or voluntary bodies in this area of work can also be beneficial. For example, Home Improvement Agencies help users to negotiate their part of the process (for example, the test of resources), leveraging in private finance and assisting owner-occupiers and private tenants who are not eligible for 100 per cent grant aid to identify other sources of support.

**Community alarms**

93. The second property-based solution is of particular help to frail older people. Community alarms are a cost-effective means of support, offering immediate assistance in emergencies. Expansion of the current, very successful, alarm systems could entail:

- extending provision beyond local authority stock – to include owner-occupiers and RSL tenants;
- reaching more client groups – such as people with disabilities or women at risk of domestic violence; and
- meeting short-term needs – such as those of people who are recovering from a hospital stay.
CASE STUDY 5
Extending community alarms to people discharged from hospital

Imaginative use of community alarms is not restricted to authorities that run their own control centres. Waverley Borough Council uses the control centre provided by Guildford Borough Council and the two authorities are collaborating on developments to the service. Waverley has developed good working relationships with the local health authority, and over one-quarter of referrals for community alarms now come from health professionals.

A hospital liaison officer runs seminars on the Careline scheme to inform staff from housing (including wardens from sheltered housing schemes) and social services departments and the local health trust. Alarms may be installed before individuals are admitted to hospital on the recommendation of occupational therapists, district nurses or health visitors. Ward sisters can also alert Careline about existing patients who might benefit, and a ‘rapid response’ agreement ensures that the alarm is in place by the time of discharge, thus supporting safe early discharge.

Users pay a weekly charge for the service, but Careline staff help to find charitable or other funds where necessary. They also carry out benefit checks on all new clients, which may increase income by more than the extra costs of the alarm. The Council is currently planning to expand services to clients with mental health problems, in a joint project with social services and the local community mental health team – ten users will be involved in the first year.

Source: Audit Commission fieldwork
Providing flexible support to needy and vulnerable tenants

94. A critical area for improvement is the capacity to offer tenants with varying support needs flexible assistance to allow them to sustain independent living. All too often the support provided does not match the level of need, or tenants have to relocate to obtain support, which runs counter to the ethos of community care. There is a better way – problems and their attendant costs could be avoided if relatively inexpensive support could be offered, either by a single body or through joint working, to avert the tenancy crises that trigger the ‘revolving door’ syndrome.

95. One key way that the housing service can pre-empt problems is for estate officers to take appropriate action before a new tenancy commences. Nearly three-quarters of clients in the case file review had been offered or received some limited form of additional support or guidance before they took up the tenancy – for example, in obtaining the correct housing benefit. This was particularly true where competitive tendering disciplines had resulted in the specification of more comprehensive checklists for estate officers to use with new tenants. It should also be possible to use pre-tenancy checks to help identify potentially vulnerable tenants – at present, many councils find out about a tenant’s vulnerability only when the tenant’s problems hit crisis point.

96. Both initial and ongoing support are important in overcoming the ‘revolving door’ syndrome of tenancy crisis and hospitalisation. This needs to be reflected in the priorities adopted by housing agencies for staff deployment. Some housing and social services authorities offer resettlement support to help people to re-establish independent living in the community. This is more comprehensive than pre-tenancy support; typically, it comprises help with tasks such as finding appropriate accommodation, assistance with moving in and getting furniture, making benefits claims, managing personal finances and developing life skills. The support is usually time-limited, lasting for a period of between six months and a year. The existence of resettlement services is variable; unfortunately, it is not available in 50 per cent of the authorities sampled, even though many are in areas of high need [EXHIBIT 16]. The principal reason cited for not providing resettlement support is that it is not a statutory service, and many authorities lack the resources to provide it.

97. In practice, the need for such assistance is often not time-limited. In many cases tenancies fail within the first year or two as problems accumulate, rather than at their inception. In recognition of this tendency, some housing agencies are developing ‘early warning’ mechanisms, based around a commitment to visit regularly tenants who are identified as vulnerable [CASE STUDY 6]. In the case of smaller agencies and/or where needs are not so great, dedicated housing support staff may not be feasible; managers should then look to other means of ensuring support – for example, by supplementing paid staff with volunteers or the efforts of local residents [CASE STUDY 7, overleaf]. Whatever form the support takes, it is essential that its success in averting tenancy crises is monitored – for example, through local performance indicators.
Exhibit 16
Resettlement services
Resettlement services are not available in 50 per cent of authorities surveyed, some of which are in areas of high need.

Source: Audit Commission survey of 28 local authorities

Case Study 6
Early intervention to support vulnerable tenants - London Borough of Hammersmith and Fulham, and Julian Housing

Hammersmith and Fulham has recently established mechanisms to support the growing number of tenants with mental health problems, many of whom experience difficulty in living independently. The service aims explicitly to assist those people whose tenancies are threatened because of their vulnerability, and also seeks to attract additional support from local mental health services. The service is provided by the equivalent of 1.5 officers, who help with problems such as resolving rent arrears, neighbour disputes, harassment or self-neglect. In its first year, the service has intervened successfully in over 40 cases of housing crisis.

Another example is the initiative developed by Julian Housing, a Norwich-based voluntary organisation that serves people with mental health problems; it has set up an outreach service for clients whose needs were not being met by existing services. The service supports 24 clients living in independent accommodation, nearly all of whom were isolated, lacking family or other support. As well as improving the quality of life for their clients, the support team has helped to reduce client admissions to hospital by nearly two-thirds, and tenancy crises are now uncommon.

Source: Audit Commission fieldwork
The role of joint working in ensuring flexible provision

As both defects and success stories illustrate, flexible support to people in need can sometimes be provided only where partners in community care work closely together. To achieve the goal of seamless provision of support across housing and other agencies, a clear understanding on respective responsibilities and scope of involvement is needed. In practice, this requires agreement on:

- what services are required to sustain vulnerable people in the community;
- the range and type of need to be met by each agency;
- appropriate involvement of housing officers in assessing care and support need; and
- how information on, for example, care plans is shared.

CASE STUDY 7

A community-based response to supporting vulnerable tenants

The London Borough of Richmond has, over the years, housed some of its vulnerable tenants on an estate in Ham which has suitable accommodation for single people. When some struggled to cope, a small group of tenants set up Ham Friends Club, in partnership with the Council, to befriend them and help them to establish roots in the community.

The club offers a drop-in centre that is open twice a week; the premises are provided by the Council and social services help with administration and promotion of the facility. Vulnerable tenants are given individual support by fellow tenants with issues such as benefits entitlement, as well as recreation activities and meals.

Source: LB of Richmond
More effective liaison could also be secured through joint training, so that housing, social services and health staff develop shared knowledge and skills, agree common objectives and establish regular communication channels [CASE STUDY 8]. Joint training may also lead to more formal arrangements for joint working. For many vulnerable people in the community care system, the plethora of agencies and departments with which they have to deal is daunting and at times frustrating, especially when those agencies act parochially or bureaucratically. Clients can be pushed from pillar to post as officers protecting their own department’s budget deny responsibility for meeting the individual’s total needs. Those in need would undoubtedly find it more helpful to deal with only one person, whose remit covered all the elements of a potential package - housing, support and care. Where unitary authorities cover both social services and housing, it should be possible to create small teams of such posts, embracing both specialisms. These need not be new posts but could be created by redeploying existing staff. In county situations, partnerships and protocols could achieve similar results.

CASE STUDY 8

Joint training for housing and social services staff - Newcastle

A review of how the city council was dealing with the needs of residents with mental health problems led to a joint training initiative for the Council’s social services and housing officers and staff from the City Health Trust. The programme was delivered at locations across the city, and covered:

1. explanations of mental health and housing policies;
2. presentations on housing allocations practices and the roles of mental health social workers and community psychiatric nurses (CPNs); and
3. a case study exercise, focusing on a mentally ill tenant who was causing problems for his neighbours and who refused to co-operate with housing officers or his CPN. Delegates discussed:
   • what resources could be deployed to help the tenant
   • the legal responsibilities of the agencies involved
   • how these related to the service priorities of each agency
   • the most effective way of managing and resolving the situation

Joint training helped to raise awareness of each agency’s roles and responsibilities, and encouraged staff to develop a partnership approach to problem-solving. One output of the sessions has been a resource pack, including explanations of agency structures and procedures, a glossary of specialist terms and a list of contact names.

Source: Audit Commission fieldwork
There is little performance measurement in the field of housing and community care, one exception being the Audit Commission’s required performance indicator (PI) on the time taken to provide social services equipment. This dearth of evaluation and monitoring represents a major obstacle to the demonstration of Best Value. While the most appropriate performance measures are likely to be those that are drawn up locally to reflect local objectives, some general guidance can be offered. Five generic categories would address key objectives and current weaknesses:

- meeting service objectives;
- appropriateness to users’ needs;
- satisfying service users and carers;
- timeliness; and
- cost effectiveness.
**BOX K**

**Key performance measures for the housing aspects of community care***

The following aspects of performance could be measured locally in order to identify where improvement is needed. Information should be recorded and monitored over time. In due course, some of these indicators may be suitable as a basis for comparison with other, similar authorities.

**Access to suitable housing**

- Average wait for permanent rehousing (by vulnerable client group)
- Percentage take-up of first offers: reasons for refusal

**Adaptations**

- Average time taken from initial enquiry to completion, by major adaptation type
- User/carer satisfaction surveys

**Supported housing**

- Is there a map of need and provision for the local area?
- Data by scheme – for example, occupancy level, turnover of tenancies, destination of leavers, number of tenants needing to move on

**Sheltered housing**

- Background data on each scheme and its residents – for example, occupancy rates, average number of offers per vacancy, average age of residents (now and on entry), percentage of residents with a care package
- Residents’ satisfaction survey
- Success of sheltered housing in preventing people from having to move to nursing or residential care

**Sustaining vulnerable tenancies**

- Tenancy failure rates: reasons for failure
- Number and type of neighbour complaints involving vulnerable tenants: housing authority’s response

*The suggested package of measures was formulated during a one-day workshop convened during the study, which brought together a range of practitioners to consider the merits of existing and potential new measures.

Source: Audit Commission
Conclusion

Housing agencies are not fulfilling their role in community care as well as they could. Strategic planning is inadequate; the housing stock is not being used effectively for community care; many people in need are not receiving the practical support that they require to live in the community; the key resource of sheltered housing requires review, and performance is not being evaluated to identify and remedy weaknesses. Many of these problems have local roots which housing authorities can influence, drawing upon existing good practice in a number of progressive councils [EXHIBIT 17]. However, improvement at the local level is a necessary but not sufficient response. For housing agencies to be effective contributors to community care, they must work in collaboration with social services and health authorities within a coherent national framework. The role of central government, and its impact on efficiency and effectiveness at a local level, is discussed in the next chapter.

EXHIBIT 17
Problems, causes and solutions
There are solutions available to many of the problems identified at the local level.

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>CAUSES</th>
<th>SOLUTIONS</th>
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</thead>
<tbody>
<tr>
<td>Planning strategically</td>
<td></td>
<td>• map current needs and provision; develop databases</td>
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<tr>
<td></td>
<td>• poor trend planning</td>
<td>• plan for the future</td>
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<tr>
<td></td>
<td>• needs not mapped to available resources</td>
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<tr>
<td>Managing existing resources</td>
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<td>• more flexible allocations processes and more complete assessments of needs</td>
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<tr>
<td>Stock</td>
<td></td>
<td>• rebalance services in the light of strategic review</td>
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<td></td>
<td>• authorities not making best use of ordinary housing for vulnerable people</td>
<td>• role of sheltered housing to be jointly reviewed by housing and social services, including the role of the warden</td>
</tr>
<tr>
<td></td>
<td>• supply of specialised housing often does not match needs of communities</td>
<td>• monitor time taken to process adaptations and identify causes of delay</td>
</tr>
<tr>
<td></td>
<td>• sheltered housing not targeted at frail older people</td>
<td>• improve the efficiency of adaptations and other repair processes</td>
</tr>
<tr>
<td></td>
<td>• significant delays in providing adaptations; typically 14 months and up to two years in the worst cases</td>
<td>• review floating support and seek more flexibility in supported housing</td>
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<tr>
<td>Personal support</td>
<td></td>
<td>• improve pre-tenancy and resettlement provision; clarify roles and responsibilities for support</td>
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<td></td>
<td>• mismatch of support to need in supported housing</td>
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<td></td>
<td>• tenants with mental health problems struggling to live in the community</td>
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<tr>
<td>Monitoring performance</td>
<td></td>
<td>• develop measures of performance at a local level and identify areas for improvement</td>
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<td></td>
<td>• lack of performance focus</td>
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<td></td>
<td>• lack of information on needs and provision</td>
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<tr>
<td></td>
<td>• inadequate supply/quality of mainstream stock</td>
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<tr>
<td></td>
<td>• allocations process not sensitive enough to needs of vulnerable people</td>
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<tr>
<td></td>
<td>• unco-ordinated, historic decisions in development of specialised schemes</td>
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<tr>
<td></td>
<td>• lack of a strategic vision for sheltered housing</td>
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<td></td>
<td>• role of warden under-developed</td>
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<td></td>
<td>• process inefficiencies and priorities inconsistent with needs</td>
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<td></td>
<td>• national resource levels and eligible need do not match</td>
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<td></td>
<td>• gaps in provision and inflexible schemes</td>
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<td></td>
<td>• crisis response predominates</td>
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<td></td>
<td>• lack of joint working across agencies</td>
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<tr>
<td></td>
<td>• lack of a clear framework specifying objectives and measures of performance</td>
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</tbody>
</table>

Source: Audit Commission
The Impact of the National Framework

The efforts of local authorities may not deliver better standards of housing and support unless there are parallel improvements in the national framework. Policy guidance from the lead government departments needs to be better co-ordinated, and the funding regime is in need of urgent reform. Its complexity and fragmentation lead to perverse incentives to opt for institutional care, undermining community care principles, and there is evidence of significant waste of resources because of inadequate funding for preventive approaches.
Housing authorities have become more and more involved in the provision of community care and, in liaison with other agencies, are striving to overcome weaknesses in the use of the housing stock. The more successful authorities have developed sound information bases and invested their services with a strong user focus. Others can learn from such approaches. Yet housing authorities are not operating in a vacuum—the successful delivery of the housing component of community care depends on an effective partnership between central and local government. Many of the problems experienced locally have their roots in the national framework for community care.

For housing agencies to be effective contributors to community care, they need to make flexible use of the housing stock, tailor support to match individual needs, and work closely with partner agencies such as social services departments to provide ‘seamless’ care. The track record in achieving these objectives is a mixed one, with dramatic improvement needed in some areas to reach the service standards of the best authorities. But efforts at the local level may not feed through into better standards of housing and support unless there are parallel improvements in the national framework for housing and community care. Three pressing needs exist:

- policy guidelines that promote core objectives and define roles and responsibilities;
- a funding regime that contains appropriate levers and incentives to encourage the optimal use of resources; and
- a regulatory framework that encourages high standards of service and affords protection for the most vulnerable clients.

This chapter examines how well this framework supports the housing role in community care, and identifies some policy challenges for government.

Although the focus of the 1989 White Paper, Caring for People, was largely concerned with health and social care, there has been specific policy guidance on the housing aspects of community care (Ref. 27); the DETR and Department of Health have published guidance on developing appropriate strategies (Ref. 6). This advises housing, social services and health authorities on the key issues that they should address, and provides a checklist of key action points for joint planning and working. Visits by staff from regional government offices and the Social Services Inspectorate reinforce this advice. But national guidance on policy and implementation is incomplete; in particular, there are unresolved issues around community-based provision for people leaving long-stay psychiatric units, housing benefit rules, buildings standards for ‘lifetime’ homes and community alarms. Guidance on adaptations, previously set out in one joint circular for both social services and housing, is now split and there are also separate guidelines issued by the Housing Corporation for RSLs.
Planning for the consequences of long-stay hospital bed closures in the NHS is one example where joint working on the ground has been hindered by insufficient co-ordination between government departments. There has been a steady contraction of long-stay psychiatric hospitals in the health service - there are now 110,000 fewer psychiatric beds than there were 40 years ago [EXHIBIT 18]. The NHS and social services authorities have invested in alternative, community-based provision, such as supported housing projects, to replace hospital care. However, this alternative provision amounts in total to around 36,000 places; the rest of the provision for (potentially, up to 70,000) people with mental health problems is presumably in mainstream housing, either as tenants or looked after by carers. The policy challenge for government has been, and remains, to ensure that local agencies can support these vulnerable people, through, for example, floating support, or by making alternative provision for them in supported housing.

Analysis of problems at the local level indicates that local authorities and other housing agencies are struggling to cope with the rising number of people with support needs who are living in the community. There are particular pressures on homelessness services, housing benefit (HB) administration and on estates officers, who are being drawn more and more into welfare and support roles. One answer is to provide more supported housing; the then Department of the Environment acknowledged in early 1996 that ‘up to 19,000 units are needed to care for a population that would previously have been living in psychiatric hospitals’ (Ref. 28).

EXHIBIT 18
Contraction of long-stay psychiatric provision
There are 110,000 fewer psychiatric beds compared to 40 years ago.

Source: London’s Mental Health, King’s Fund, 1997
In the absence of unified guidance on how best to support these vulnerable tenants, councils and RSLs moved into the gap and exploited ambiguity in the rules surrounding HB to establish a range of provision for people with mental health problems. While much of this provision has been innovative and high quality, the significant variation in the availability of HB to accommodate mentally ill people in similar supported housing schemes means that there is inequity in the system; decisions appear to bear little relation to an individual’s need for personal support [EXHIBIT 19].

A series of legal judgements about what can or cannot be funded by HB has further clouded understanding of the rules. In the most recent legal judgement (July 1997), the Divisional Court ruled that HB should be used to fund housing costs only. In the interim, the Department of Social Security (DSS) has agreed, in the short term, to continue funding the costs of supported housing for those residents who would be most affected by a withdrawal of service charge payments. Before determining longer-term arrangements, the DSS is awaiting the recommendations of an interdepartmental working party on the use of HB for supported housing clients; this is due to report by the summer of 1998. If the social housing system is to continue to contribute to care in the community, the Government faces the policy challenge of revising the rules of HB in parallel with other funding streams to ensure that agencies can offer effective support to vulnerable tenants, whether they are living in specialised housing schemes or in mainstream accommodation.

EXHIBIT 19
Use of housing benefit in supported housing for people with mental health problems
There is wide variation in the use of HB to fund supported housing for people with mental health problems, even those who have similar needs and live in similar schemes.

Source: Audit Commission survey of supported housing schemes
A second area of policy challenge concerns the design of homes. A suitable home environment is vital in achieving the objective of remaining in the home, but many people are frustrated by long delays in securing adaptations to their homes, and there are inadequate resources to meet even some high priority applications. One way of reducing the need for expensive adaptations to homes is more sensitive initial design. The ‘Lifetime Homes’ concept, for example, incorporates sixteen design standards, such as wheelchair accessibility and ground floor toilet facilities. Most of the features are relatively low-cost and could result in future savings for government and local authorities.

The third policy challenge concerns community alarms, which provide rapid access to assistance in an emergency and improve personal security. Speed of response in an emergency can significantly affect a person’s recovery chances as confusion, dehydration and pressure sores can start to develop from falls in as little as 30 minutes. Unsurprisingly, many authorities have extended the availability of community alarms beyond older tenants in social housing to include people living in other types of tenure, and to other vulnerable client groups.

However, lingering doubts about the legality of extending provision have inhibited many authorities. The ‘Ealing judgement’ in 1992 stated that community alarms were a social service rather than a housing-related service. This judgment raised doubts about the power of those housing authorities that are not also social services authorities to provide community alarms. As a result, the 1993 Leasehold Reform, Housing and Urban Development Act gave local authorities the power to provide community alarms as part of the landlord function in social housing. But it is still unclear whether district councils can provide services other than to local authority tenants, contributing to the wide variation in the take-up of alarms [EXHIBIT 20, overleaf]. The legal problems have also discouraged sensible co-operation between councils to share set-up and running costs.
An important part of the national framework is to try to guarantee minimum standards of provision, so that an effective safety net exists for the most vulnerable tenants. This goal requires clearly defined roles and responsibilities and shared expectations. Often, these do not exist. A particular cause of friction concerns responsibility for personal support. The pressures on hospital beds and social services imposed by rising demands have led to a retreat away from low-intensity personal support towards acute care. By default, housing agencies are being drawn into the gap, but they cannot always do so comprehensively. Recent high-profile reports into mental healthcare failures highlight the consequences of a failure to ‘own the problems’. For example, the report of an independent inquiry into the care and treatment of Martin Mursell, who was unable to secure housing and support on discharge from psychiatric hospital and ended up killing his stepfather, concluded that:

‘Poor co-ordination between health, social services and housing was in our view a key barrier to the delivery of a good service to Martin Mursell. We believe that the approach to mental health services must be based on the recognition that there has to be collaboration between agencies, cooperation between professionals and participation by users.’
Finding solutions to the policy challenges is harder than identifying them. Clearly, co-ordination is the key to many of the issues. Housing-related community care services cannot be delivered by a single agency – a corporate approach is required which is based on the needs of users. Efforts to overcome fragmentation could point either to a structural solution – creating a lead organisation to take overall responsibility – or to fiscal mechanisms, using financial levers (rewards and sanctions) to bring about change, or elements of both options.

Structural change?

The attractions of the structural option, bringing authorities together into a single body with overall responsibility for both the housing and social services components of community care, are that it could:

• clarify and rationalise current responsibilities;
• promote a holistic view of users’ needs;
• minimise duplication of effort; and
• possibly improve communication (because everyone is working for the same organisation).

There is a precedent at the local level, as some unitary authorities have combined their housing and social services departments under one director. But this development has not always provided the answer. Structural change – even within one authority – can bring disadvantages. It may simply replace explicit and visible organisational boundaries with internal demarcation lines that are just as problematic but less transparent. Moreover, merging housing and social services elements would still leave the interface with health authorities to be addressed. The broader scope of an umbrella housing/community care authority could be unwieldy and difficult to direct. And structural change is invariably both expensive and disruptive to service delivery; in practice, it is likely to take time to devise, implement and bed down. There is thus no guarantee that the structural option will lead to better co-ordination and more effective services, although it should remain an option of last resort if other mechanisms fail to secure improvement.

A less disruptive approach would be to retain the existing managerial/professional separation between housing, social services and health authorities but designate one of them as the ‘lead agency’ for this area, with appropriate legal powers and duties. It could be a different agency in different settings. In theory, this approach could clarify current ambiguity about how personal support to vulnerable tenants and residents is to be funded and managed. The key question is which body would best fill this role. Some practitioners would argue that housing authorities are best placed, in view of their current strategic role in managing the supply of the housing stock and developing preventive services for their community. For housing authorities that have transferred their stock to the voluntary sector, this role would present a challenge – although not an insurmountable one if partnership working is effective.
...housing and community care policies could be better co-ordinated at the national level...

Better co-ordination of policy

118. Whichever structural arrangement is preferred, housing and community care policies could be better co-ordinated at the national level, perhaps through a strategic framework designed to meet the housing needs of vulnerable people. Four areas merit particular consideration:

- explicit recognition of the vital role that personal support plays in sustaining independent living, and the need to ensure that this support is given appropriate priority in local strategies and is adequately funded;
- in the light of the recent government announcement to extend part M of the Building Regulations to include new dwellings (Ref. 29), keep under review the possibility of further moves towards ‘Lifetime Homes’ standards [BOX L];
- empowering authorities to offer community alarm services to all local residents who would benefit from them, and facilitate co-operation with other authorities in providing this service; and
- agreement on national performance indicators – for example, for the time taken to process adaptations to property.

The funding regime

119. Public expenditure in excess of £2 billion is currently invested annually in the housing aspects of community care. Although central government is removed from the immediate provision of local services, its funding regime is a major influence on the way that services are ultimately delivered. To work effectively, the funding mechanisms should align with and promote policy objectives, help to secure value for money, and target resources to where the needs are greatest. Do they achieve these goals?
BOX L

**Design standards for new dwellings**

Incorporating certain low-cost design features into newly built housing can reduce the need for subsequent, expensive adaptations. The Government has recently agreed to amend the Building Regulations to improve access and facilities for disabled people – for example:

- Level entry to the main, or a suitable alternative, entrance
- An entrance door wide enough to allow wheelchair access
- WC provision on the ground or first habitable storey
- Switches and socket outlets at appropriate heights from floor level
- Level or gently sloping approach from car parking space
- Where a lift is to be provided in flats, a minimum lift capacity and dimensions will be recommended

Further amendments to the Building Regulations would be needed to meet the full ‘Lifetime Homes’ standards – for example:

- Walls in bathrooms and toilets should be capable of taking adaptations such as handrails
- Provision for a future stairlift

Sources: Hansard (Ref. 29) and ‘Building Lifetime Homes’, Joseph Rowntree Foundation, 1997
Aligning the funding regime and policy objectives

Current financial arrangements are complex and fragmented [EXHIBIT 21]. The four relevant government departments each use a number of funding routes, which results in at least 25 streams of funding (Appendix 4). Funding reaches front-line services through a variety of mechanisms and is channelled through local authorities, RSLs, the NHS, the probation service, voluntary groups and charities. Such fragmentation has its roots in a legislative and funding framework for housing and community care that has developed piecemeal over 40 years. As each new policy directive or funding mechanism is ‘bolted on’ to the framework, the potential for confusion, incoherence and perverse incentives increases.

EXHIBIT 21
A complex inheritance (simplified version)
The four main government departments use a number of funding routes, resulting in at least 25 streams of funding.

Source: Audit Commission
Four sources dominate the funding of housing-related community care:

- Housing benefit (HB): a benefit payable to cover the housing costs of the unemployed and people on low incomes, regardless of tenure; the bulk of the HB bill is met by the DSS but is administered by local authorities;¹
- Residential care allowance: a benefit payable to people living in independent residential or nursing care, which is funded and administered by the DSS;
- Housing Revenue Account (HRA): a ringfenced account to manage the costs and rental income of local authority housing stock; and
- Supported Housing Management Grant (SHMG): grant payable to RSLs by the Housing Corporation to support designated supported housing schemes.¹¹

In principle, community care enables people to live in their own homes or a community setting, and provides services based on individual need, regardless of tenure (for example, whether council property, owner-occupied, etc). To ensure that the funding regime underpins this objective, its architects must be watchful of countervailing tendencies, and in particular:

- the presence of perverse incentives to use (expensive) residential care or specialised housing, rather than helping people to remain in their own homes;
- a predominance of ‘block’ funding mechanisms that shift emphasis away from individual needs; and
- funding which is so heavily tied to tenure that it impedes the most appropriate use of the housing stock.

¹ The Commission examined the administration of HB and measures to counter HB fraud in studies published in 1993 and 1997: Remote Control (Ref. 30) and Fraud and Lodging (Ref. 31).
¹¹ The effective use of SHMG to run supported housing schemes is examined in a study conducted by the Commission on behalf of the Housing Corporation, to be published later in 1998.
...too often, funding is tied to the property and not to the individual.

123. In fact, these three defects already afflict the housing element of community care. For example, a consequence of the complex charging and allowances system is that the net cost to councils of care for people in their own homes is often considerably higher than the net cost of care in residential homes, even though the gross costs are the same in both cases. This sets up a perverse financial incentive to place people in residential care wherever possible, counter to the community care ethos of care at home cases. The second defect flows from the fact that many supported housing projects are funded on the basis of ‘blocks’ of places – say, four places in a home for people with learning disabilities. This type of funding assumes that residents’ needs will remain stable; the provision ossifies and there is no incentive for the scheme managers to encourage residents to ‘move on’ to a more independent setting when appropriate. And, where vacancies occur, people may be placed in a particular setting even though it may not be wholly appropriate to their needs.

124. The third weakness of the current regime is that, too often, funding is tied to the property and not to the individual. For example, SHMG funds not just the bricks and mortar in schemes for vulnerable tenants but also an element of personal support; it is available only to RSLs. This is a particular problem for one fieldwork authority which has a high proportion of vulnerable people in its area but relatively few RSL properties that could attract SHMG funding for tenancy support. The authority is reluctant to sponsor bids for additional RSL housing as there is already a surplus of local authority housing in the area. Consequently, a number of vulnerable people are not receiving the support that they need.

Securing value for money: cost-shunting

125. Where inflexibility and the existence of perverse incentives mean that would-be tenants remain in institutional settings or specialised housing schemes, there is a net cost to the taxpayer – the system is failing to secure value for money. This failure is often obscured by the phenomenon of cost-shunting, as illustrated by the differential use to which HB has been put in recent years. Although HB is intended primarily to support the costs of ‘bricks and mortar’ rather than personal care and support, recipients in supported housing schemes are eligible for some additional service charges to cover the cost of necessary assistance to sustain their tenancy. Where this provision was exploited to the full, it represented a form of cost-shunting, with the DSS paying for support which in other areas or other schemes is funded by social services or health authorities. But, in many cases, there was no alternative source of funding.

1 Detailed exemplifications of these perverse financial incentives were set out in Balancing the Care Equation: Progress with Community Care, published by the Audit Commission in 1996.
There is in effect, a lottery of funding and provision...

126. The service charge element of HB can be paid only to tenants of specific housing schemes and is not generally available to those in mainstream housing, even though their need for help may be similar. In many cases, vulnerable tenants might be better served if floating support were offered to them in mainstream housing – at a lower overall cost to the public purse. There is, in effect, a lottery of funding and provision, whereby what is offered to a particular individual depends not on their needs but where they happen to live and what funding has been secured locally. The availability of resources for personal support depends more on the source of funding than the degree of need [EXHIBIT 22]. If total costs across all funding sources are compared, health schemes emerge as high cost and benefit-funded schemes represent low-cost provision.

127. Value for money is further impeded by the limited information available on the costs of many housing and support services. Transparency of costs is a prerequisite of value for money, yet current accounting rules do not require the costs of housing and community care to be made explicit or treated consistently; sheltered housing costs, for example, are calculated differently across authorities (where they are calculated at all). The lack of agreed standard definitions for some services, such as community alarms or supported housing, means that, in many areas, there is no agreed basis for obtaining ‘like-for-like’ cost comparisons.

EXHIBIT 22

Cost of supported housing for mental health (24-hour sleep-in schemes)

Cost per bedspace of similar supported housing schemes varies according to the main funding source; most of the high-cost schemes rely heavily on health and social services funding.

Source: Audit Commission survey of 18 supported housing schemes for people with mental health problems

<table>
<thead>
<tr>
<th>Funding source</th>
<th>SHMG</th>
<th>Social services</th>
<th>Health bodies</th>
<th>Housing benefit</th>
<th>Income Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per bedspace per year (£000)</td>
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<td>35</td>
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</table>
Targeting resources to the areas of greatest need

Chapter 2 highlighted the fact that some authorities are not making the best use of specialised or ordinary housing stock to meet community care needs. Although this is a local problem, the method of allocating funds could create stronger incentives for housing agencies to target the needs of the communities that they serve when making bids for resources, rather than bidding for what is available.

For example, until 1995/96, the capital sum allocated to local authorities for Disabled Facilities Grants (DFGs) was based on the condition of private sector housing in their area, not on the number of people likely to need, and be eligible for, adaptations. A needs-based formula has now been introduced but three problems remain. First, there is a backlog of work to be tackled in a number of authorities. Second, the level of capital allocated nationally does not meet the need for DFGs identified by the DETR – there are some 650,000 eligible households in the private sector, but only 125,000 grants were paid in the six years to 1996/97, despite rising council expenditure. Finally, the system is still tenure-based, with government funding not benefiting council tenants, even though the research underpinning the proposed needs-based formula confirms that the need for adaptations is likely to be higher among this group (Ref. 21). Local authorities cannot objectively and effectively target resources to those households most in need when the availability of the necessary funds is linked to tenure.

Another example of untargeted funding is grant aid for Home Improvement Agencies (HIAs). Not every authority has HIAs operating within its boundaries because the pattern of HIA presence is historical, not needs-based. Of the 50 local authorities with the highest needs indicator per 1,000 population, half do not have HIAs funded in their area. New bids have to wait for increased resources – existing agencies do not lose funding when a prospective agency in an area of greater need applies for help.

There are further problems with resource allocation methods for both capital and revenue support. The mismatch between needs and the supply of specialised housing highlighted in Chapter 2 can be traced, in part, to the formula used to allocate capital resources to local authorities and RSLs. The capital allocations of Housing Investment Programme (HIP) funds to local authorities and the Approved Development Programme to RSLs are informed by the Generalised Needs Index and Housing Needs Index respectively. Although these indices incorporate indicators for the number of older and disabled people in need of specialised housing, there are no indicators reflecting the potential housing needs of other community care groups, such as those with mental health problems or learning disabilities.
Thus the provision of revenue-funded services such as resettlement and tenancy support to vulnerable tenants is at the discretion of local authorities – the availability of resources, and the pressure of competing demands, will dictate whether they are provided. Many local authorities use the housing revenue account (HRA) to fund these services, but the personal support needs of local authority tenants are not taken into account in the subsidy calculations for the HRA, even though they influence the costs of providing housing services.

The funding regime should underpin global objectives and effective service delivery. In reality, it is causing some of the gaps in support for people who live in local authority housing, and channelling some people with low levels of need into supported housing which is designed for more vulnerable residents. The complexity of the national funding framework has undermined the achievement of community care objectives and blurred the focus on securing overall value for money for the taxpayer. The framework therefore needs overhaul to:

- provide clear incentives to link funding to client need;
- promote value for money and ensure that benefits, allowances and charging regimes have a neutral or positive impact on decisions about how individual client needs will be met; and
- identify unit costs and mechanisms for the effective control of expenditure.

### Moving towards a coherent, rational funding regime

...the links between funding, processes and outcomes should be more visible.

### Linking funding to clients rather than properties

Fundamental reform is needed to tackle the deep-rooted constraints on the effective use, transfer and pooling of resources across agencies, so that resources follow the client rather than particular tenures or properties. Making the funding regime more client-focused could start with rationalisation to reduce the current bewildering array of funding routes and the (often abortive) costs consumed as agencies bid for funding from different government ‘pots’.

Streamlining would promote clarity and transparency; the links between funding, processes and outcomes should be more visible. Rationalising the funding system could entail allocating a greater share of available resources through direct grants, rather than relying upon the imperfect distributive mechanisms of the benefits system. Because HB is tied to properties and rents, it is unsuitable as a vehicle for funding aspects of community care, which emphasises (or should emphasise) the needs of the individual client.
Reform will need to proceed very carefully...

136. The principle that at least some funding should follow the client across agency boundaries is implicit in current arrangements. Health authorities in England and Wales have discretionary powers to fund community-based services when they close long-stay beds, a power that they have exercised in varying degrees. By contrast, in Scotland there is a clear expectation that the transfer of responsibility for patients from a health board to a local authority will be accompanied by a transfer of resources. Although there have been some problems in implementation, the resource transfer scheme has steadily released savings from hospital bed closures to help finance the development of alternative services. Scheme costs are expected to peak at £200 million per year (Ref. 32). The Government may wish to consider further measures to encourage such transfers, or indeed move towards the pooling of budgets.

137. Allocating more resources through direct government grant to authorities might also increase the proportion of total funding that is cash-limited rather than demand-led, and thus allow more effective control of public expenditure. Objections that channeling funds primarily through councils and RSLs militates against a strong user focus could be offset by greater use of direct payments – giving part of the resource pot to eligible users in the form of cash or vouchers. A limited precedent exists in the system of direct cash payments by local authorities in lieu of direct provision of care services, such as home helps. Current schemes are limited to adults with disabilities and aged under 65, and there would be practical difficulties in extending them to other care groups and to authorities without social services powers. However, aligning the budget to the needs of individual clients could also be achieved by giving assessment agencies control over a significant element of the resources.

138. Reform will need to proceed very carefully as the complexity of the current framework means that sudden changes could have unanticipated side-effects. Radical reform would also entail other problems. Transparency may expose the need for explicit rationing of resources through eligibility criteria – what rationing that takes place is often hidden from view through delay mechanisms. This issue is likely to be contentious, particularly if the right balance is to be struck between meeting crisis need and investing in lower intensity preventive work. Some vulnerable groups, such as those with less severe mental health problems or personality disorders, fall outside current community care criteria; the level of future funding of support for them will need to be agreed and the criteria adjusted accordingly.

Promoting value for money and rewarding efficiency

139. The changes outlined above would help to eliminate some of the perverse incentives and cost-shunting that permeates current funding arrangements. The inter-relationships between benefits, allowances and charging regimes for residential and domiciliary care services need to be reviewed to ensure that clients are not channelled inappropriately into...
institutional and/or high intensity support. Funding should be needs-based and secure overall value for money - that is, the benefit of decisions should accrue to the public purse and not simply to an individual agency or departmental budget. And the needs-based formulae should incorporate some of the demand drivers missing from the current methodology, such as the number of local residents with learning disabilities or the expected incidence of mental health problems.

**Identifying unit costs**

140. Value for money could also be enhanced with the availability of more robust information on comparative costs and their links to performance outcomes; this would require modifications to accounting guidelines for housing authorities and RSLs. If commissioning authorities are to hold providers to account and develop more effective systems for monitoring and controlling expenditure, the costs of services such as sheltered housing, supported housing and community alarms should be identified separately and recorded on a consistent basis.

141. The final weakness in the national framework for guiding and monitoring community care policies is the lack of an effective regulation and inspection regime that covers all settings. There is no statutory system to regulate the standards of care and support provided in many specialised housing schemes such as sheltered accommodation, unless the schemes are registered under the Registered Care Homes Act 1984. Many supported and sheltered housing schemes are not registered. This fact does not in itself mean that there is no monitoring of standards of provision: individual authorities monitor the services provided to them under contract; the Housing Corporation has issued guidance on the achievement of its Performance Standards; and the National Housing Federation has developed comprehensive standards for housing and support services. Nonetheless, none of these bodies can take the overall lead and so regulation is something of a patchwork quilt. The absence of statutory regulation or inspection raises questions about how quality of service and safety standards can be monitored.

142. Registration brings schemes under the aegis of local authority social services inspection units; they are required to meet minimum standards and are inspected at least twice a year. But local authorities’ interpretation of the registration requirement varies between areas. Decisions not to register schemes do not necessarily signal a wish to escape a quality assurance regime; financial considerations often dominate, in that residents are financially worse off in registered schemes because they lose entitlement to housing benefit. On the other hand, non-registration leaves residents without the protection of independent inspection. The increasing evidence of abuse of elderly people (Ref. 33) in sheltered housing and residential care underlines the importance of providing support to protect the most vulnerable.
Government departments have subjected this area to review. For example, the Burgner report was commissioned by the Department of Health in 1996 (Ref. 34) to advise on the regulation and inspection of social services. It highlighted a number of improvements that are needed to the current system for the registration of residential and nursing homes. Many of these measures would, if implemented, bring currently unregistered supported and sheltered housing schemes under a regulatory umbrella. For example, it argues for:

- consideration of the merits of extending statutory regulation to include sheltered housing and hostel accommodation; and
- the need for a national standard on the application of registration – that is, in what circumstances schemes should register.

In particular, clarity is needed in the definition of ‘residential’ schemes which, once defined as such, must be registered. The current pattern of registration is inconsistent and may be inequitable. Alongside this review, consideration should be given to extending the scope of registration to sheltered housing, hostels and most forms of supported housing, to encourage quality standards and offer protection to residents; and also to introducing some regulation of domiciliary services.

Conclusion

This chapter has described key challenges for the Government’s framework for housing and community care. The funding regime does not promote the objectives of community care – its operation is characterised by some perverse incentives, a failure to maximise value for money and inadequate targeting of resources to the areas of greatest need. The policy framework has gaps which can fail the most vulnerable clients, and the perspectives of government departments have not always been well co-ordinated. Problems experienced in delivering services at the local level originate, in part, from the fragmented evolution of funding arrangements and the statutory framework – it is not clear who owns many of the problems, especially in the grey areas of non-statutory provision. The solutions at a national level are elusive and will take time to unfold but, if secured in conjunction with improvements at the local level, could significantly improve the everyday quality of life of vulnerable people [EXHIBIT 23].
**Problems, causes and solutions - the national framework**

The fragmented evolution of the national policy and funding framework is at the heart of current weaknesses, but solutions can be found.

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>CAUSES</th>
<th>SOLUTIONS</th>
</tr>
</thead>
</table>
| **Policy guidelines**
  - Gaps in national policy agenda
  - Impact of closure of long-stay psychiatric beds on housing
  - Lifetime Homes
  - Scope of community alarms provision
  - Roles and responsibilities of agencies unclear | Government's long-range thinking did not fully anticipate the wider impact and importance of these issues |
| **Funding regime**
  - Funding does not always promote community care objectives
  - Cost-shunting between budgets of different agencies: poor VFM
  - Limited information on costs of housing and support services
  - National resources not targeted effectively on areas of need | Current framework results from separate and historic development |
| **Regulation**
  - Lack of a framework of standards for sheltered and supported housing | Funding framework complex and fragmented
  - Historic evolution of funding and responsibilities
  - No requirement to record and report costs in accounts
  - Resource allocation policies not linked to needs of vulnerable people |
| **PROBLEMS** | **CAUSES** | **SOLUTIONS** |
| Government to consider:
  - National objectives for housing and support for vulnerable people
  - Clarification of legal position in respect of community alarms for all those who might benefit |
| Overall funding framework should:
  - Link funding to clients
  - Transfer resources between agencies
  - Streamline funding regime
  - Revise accounting guidelines to facilitate cost-and-value comparisons for key services
  - Introduce community care indicators into resource allocation mechanisms |
| Clarify current registration requirements and consider ways of regulating housing-related care and support |

*Exhibit 23*
Ways Forward

An increasing number of people live independently, but with varying degrees of success. Those who are vulnerable should not be left ‘home alone’, struggling to cope with everyday tasks and the demands of household management as well as their own care needs. The deficiencies in the current arrangements for housing and community care – and possible remedies – are not uniquely national or local, but a combination of the two. At the local level, authorities and agencies must strive to improve strategic planning, emphasise prevention rather than crisis response, and give the service user a stronger voice. Government departments should support these efforts by improving the national framework – clarifying responsibilities, co-ordinating policy initiatives and ensuring that funding mechanisms are properly targeted and promote the best use of resources.

The way forward may not be easy to navigate. Yet the potential rewards are substantial:

- a fuller and more independent life in the community for many people;
- more reliance on prevention rather than cure; and
- better use of public money.

All the agencies involved in the housing aspects of community care share these objectives. The next step is to work through the problems at a local and national level to turn the vision into reality, breaking the vicious circle of crisis response to a virtuous circle that invests resources into preventive work, husbands scarce resources and protects the most vulnerable [EXHIBIT 24].
EXHIBIT 24

From theory to practice - a virtuous circle?

An effective partnership between central government and local agencies could redirect services from crisis response towards prevention and better use of resources: the result could be a virtuous circle.

Source: Audit Commission
Recommendations for action at local level

Improving the delivery of services at the local level will involve housing authorities, social services departments, health bodies, registered social landlords (RSLs), the probation service and the voluntary sector. Recommendations are listed by lead agency but in most cases will also require input from other local agencies.

**Action for local authorities**

1. Establish a shared vision and common objectives for housing and community care services across agencies (para 82).

2. Map current needs and resources to provide information for strategic decision-making (paras 82-4).

3. Ensure that strategies are in place that address housing and community care issues, including:
   - current and future need for housing and support services (para 83)
   - the efficiency and effectiveness of current housing and support services/schemes – how to make the best use of resources across agencies (paras 85-6).

4. Develop effective joint working on a day-to-day basis to eliminate gaps and overlaps in support, establishing:
   - ground rules on day-to-day procedures such as the needs met by each agency and the involvement of housing officers in assessments (para 98)
   - effective regular communications, sharing of information and formal liaison arrangements (paras 98-9)
   - joint training to share knowledge, understanding and skills (para 99).

5. Promote the use of performance measures for housing and community care services, covering cost-effectiveness and quality (para 100).
Ways Forward

**Action for housing authorities**

6. Review mainstream housing services to ensure that they help to meet the needs of vulnerable people, by:
   - making appropriate use of non-council tenures (para 87)
   - improving housing allocations processes for vulnerable people (para 88)
   - enhancing pre-tenancy support, resettlement and ongoing support (paras 95-7).

7. Develop a joint vision (with RSLs) for the future role and use of sheltered housing (para 89).

8. Monitor the time taken to process adaptations from referral to completion of works, and identify reasons for any delay (para 90).

9. Address delays in the adaptations process and improve the matching of demand to resources (paras 90-2).

10. Consider, where appropriate, further extension of the community alarm service to people in all tenures, targeting more client groups and offering the service to those whose needs are short-term (para 93).
Ways Forward

Recommendations for action at national level

Improving the national framework falls mostly within the remits of the Department of the Environment, Transport and the Regions (DETR) and Department of Health (DoH), with the Department of Social Security (DSS) and the Home Office contributing on specific aspects. The DETR and DoH might consider the benefits of one department taking the lead on housing and community care issues. In most cases, the effective implementation of recommendations will require involvement from other departments and agencies such as the Housing Corporation.

**Action for DETR and DoH working together**

11. Develop a national strategy, in conjunction with the Home Office, to meet the housing and support needs of the increasing number of vulnerable people living in the community (para 118).

12. Promote the development and funding of personal support to meet the housing and support needs of vulnerable people (para 118).

13. Clarify the principal roles and responsibilities of the local agencies involved in housing and community care, to ensure more co-ordinated and effective services, and in particular:

   - delivery of seamless personal support (para 112)
   - effective planning of the supply of ordinary and specialist housing for vulnerable people (para 27).

14. Create incentives and/or sanctions to improve joint working at the local level (para 113).

15. Consider the need for a lead authority at local the level to manage the interface between housing and community care (para 116).

16. Consider, in conjunction with the DSS and Home Office, the following reforms of the funding framework:

   - streamlining the number of funding sources (paras 134-5)
   - linking funding to client need and using mechanisms such as resource transfer, budget pooling and direct payments to achieve this (paras 136-7)
Ways Forward

- recognising the need to fund lower intensity preventive work as well as crisis response (para 138)
- abolishing the perverse incentives and cost shunting apparent in the current arrangements (para 139).

17 Require the publication by service providers of the total unit costs of housing and support services on a like-for-like basis (para 140).

18 Consider the development of key national performance indicators for the housing aspects of community care, such as the time taken to complete adaptations (para 118).

**Action for DETR**

19 Promote legislation on community alarms to empower local authorities to offer community alarms to all those who might benefit, and facilitate sensible cooperation between authorities to share set-up and running costs (para 118).

20 Review the impact of the extension of part M of the Building Regulations and consider the feasibility of further moves towards ‘Lifetime Homes’ standards (para 118).

21 Review the allocation of capital and revenue resources for housing and community care to improve targeting to need and value for money overall (para 139). Consider, in particular, the efficacy of resource allocation mechanisms for:
- adaptations (para 129)
- Home Improvement Agencies (para 130)
- specialised housing (para 131)
- resettlement and tenancy support (para 132).

**Action for Department of Health**

22 Consider the introduction of a tighter national standard for the registration of residential care homes (para 144).

23 Consider the merits of regulation of all care and support provided in the community (para 144).
Appendix 1

Checklist for action

(1) Improving services at the local level

<table>
<thead>
<tr>
<th>Strategic planning</th>
<th>Housing Authorities</th>
<th>Social Services</th>
<th>Health Service</th>
<th>RSLs</th>
<th>Probation Service</th>
<th>Voluntary Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a shared vision and common objectives for housing and community care services across agencies.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td>Map current needs and resources to provide information for strategic decision-making.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Ensure that strategies are in place that address housing and community care issues.</td>
<td>✓</td>
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<table>
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<th>Health Service</th>
<th>RSLs</th>
<th>Probation Service</th>
<th>Voluntary Sector</th>
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<tr>
<td>Review mainstream housing services to ensure that they help meet the needs of vulnerable people.</td>
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<tr>
<td>Develop a joint vision (with RSLs) for the future role and use of all sheltered housing.</td>
<td>✓</td>
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<tr>
<td>Address delays in the adaptations process and better match demand to resources.</td>
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<tr>
<td>Consider where appropriate the further extension of community alarm services to people in all tenures.</td>
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<th>Health Service</th>
<th>RSLs</th>
<th>Probation Service</th>
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<tr>
<td>Develop effective joint working on a day-to-day basis to eliminate gaps and overlaps in support.</td>
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<th>Health Service</th>
<th>RSLs</th>
<th>Probation Service</th>
<th>Voluntary Sector</th>
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<tbody>
<tr>
<td>Promote the use of performance measures for housing and community care services.</td>
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</tr>
<tr>
<td>Monitor the time taken to process adaptations from referral to completion of works and identify reasons for delay.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(2) Ensuring the foundations are in place at national level

National policy co-ordination and direction

<table>
<thead>
<tr>
<th>Action</th>
<th>DETR</th>
<th>Department of Health</th>
<th>DSS</th>
<th>Home Office</th>
<th>Housing Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a national strategy to meet the housing and support needs of vulnerable people living in the community.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Promote legislation on community alarms to empower local authorities to offer community alarms to all those who might benefit.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote the development and funding of personal support to meet the housing and support needs of vulnerable people.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rational funding framework

<table>
<thead>
<tr>
<th>Action</th>
<th>DETR</th>
<th>Department of Health</th>
<th>DSS</th>
<th>Home Office</th>
<th>Housing Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider reforms of the funding framework.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Review the allocation of capital and revenue resources for housing and community care.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Require the publication by service providers of the total unit costs of housing and support services on a like-for-like basis.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Clearly defined roles and responsibilities

<table>
<thead>
<tr>
<th>Action</th>
<th>DETR</th>
<th>Department of Health</th>
<th>DSS</th>
<th>Home Office</th>
<th>Housing Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify the principal roles and responsibilities of the local agencies involved in housing and community care.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Create incentives and/or sanctions to improve joint working at local level.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider the need for a lead authority at local level to manage the interface between housing and community care.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regulatory framework and clear accountability

<table>
<thead>
<tr>
<th>Action</th>
<th>DETR</th>
<th>Department of Health</th>
<th>DSS</th>
<th>Home Office</th>
<th>Housing Corporation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider the development of key national performance indicators for the housing aspects of community care.</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider the introduction of a tighter national standard for the registration of residential care homes.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider whether regulation of all care and support provided in the community is needed.</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

Members of the Advisory Group

**Terrie Alafat**  
Assistant Director of Housing  
Royal Borough of Kensington and Chelsea

**Rosy Bowyer**  
Head of Housing and Property Services  
North Wiltshire District Council

**John Critchfield**  
Department of Social Security

**Adrienne Fresko**  
Audit Commissioner

**John Foster**  
Audit Commissioner

**Peter Faherty**  
Department of the Environment, Transport and the Regions

**Peter Fletcher**  
Anchor Housing

**Mary Ney**  
Director of Social Services and Housing  
London Borough of Harrow

**Bridget Ogden**  
Department of Health

**Liz Potter**  
National Housing Federation

**Helena Shovelton**  
Audit Commissioner

**Peter Swain**  
Chair, Department of Health Users Panel

**Lynn Watson**  
Independent researcher

**Jeanette York**  
Local Government Association

Fieldwork sites

**Two-tier authorities: counties and districts**

- Cumbria County Council
- Carlisle District Council
- Eden District Council
- Essex County Council
- Harlow District Council
- Tendring District Council
- Norfolk County Council
- Broadland District Council
- Norwich City Council
- Nottinghamshire County Council
- Nottingham City Council
- Wiltshire County Council
- North Wiltshire District Council
- Salisbury District Council
Unitary authorities

Caerphilly
London Borough of Hounslow
London Borough of Southwark
Knowsley Metropolitan Borough Council
Newcastle City Council

The study team would like to thank staff in these authorities and organisations who assisted during and after the visits.
Appendix 3

What is community care?

‘Community care’ means different things to different people. It is often used as a shorthand term for the closure of large, long-stay hospitals – in particular, psychiatric hospitals – and the resettlement of ex-patients in the community. It is also used to describe a broader policy approach of providing community-based services for all frail and elderly people and people with disabilities, to allow them to live in their own homes rather than an institution. Finally, it refers to the specific system of responsibilities and financial controls established by the NHS and Community Care Act 1990.

The movement away from institutional care for people with severe mental health problems began in the 1930s, was interrupted by the war, then accelerated in the late 1950s. Services for those with learning disabilities followed a similar pattern. In 1971, a government White Paper – Better Services for the Mentally Handicapped – outlined a 20-year shift from hospital-based services to community-based support. It identified the services required to achieve this shift, which entailed a significant expansion in social services provision. Another White Paper, Better Services for the Mentally Ill, was published in 1975 which specified broad policy objectives; it also quantified the services needed from both health and social services per 1,000 population.

In 1970, the Chronically Sick and Disabled Persons Act strengthened care in the community for younger physically disabled people, imposing a duty upon local authorities to provide practical assistance, recreational and educational facilities, help with transport, adaptations to the house, and help with holidays, meals and telephones.

The 1981 White Paper, Growing Older, listed services available for older people but gave no details on levels of provision or on a preferred balance of care.

Joint planning and joint finance

The need for co-ordination between health and local authorities in all these areas was seen as vital to success, and joint planning arrangements were introduced under S. 10 of the NHS Reorganisation Act 1973. Joint Consultative Committees were established in 1974, while separate financial resources for health authorities to spend on joint schemes (known as ‘joint finance’) were first agreed in 1977. The principle was that ‘the criterion by which a health authority will use the money allocated to it for joint financing will be that the spending is in the interests of the NHS as well as the local authority, and can be expected to make a better contribution in terms of total care than if it directly applies to the health services’. (Circular HC(77)17/LAC(77)10).
Problems with the system, the Griffiths report and the 1989 White Paper

Despite the arrangements for joint planning and finance, responsibility for introducing and operating community-based services was fragmented across a number of different agencies. The mechanisms for moving resources from hospital-based services to locally based alternatives were deficient. At the same time, supplementary benefit policies allowed a rapid expansion of private residential care. Social services departments had a financial incentive to place people in these homes rather than provide community-based services – the former were paid for by the DSS, the latter by social services. As there was no financial cap on the relevant DSS expenditure, benefit payments escalated rapidly.

These problems were highlighted by the Audit Commission in 1986 in Making a Reality of Community Care. Following the publication of that report, the Government commissioned a review from Sir Roy Griffiths which led to a White Paper in 1989, Caring for People. This proposed major changes to finances and organisation to meet six key objectives:

• promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible;
• ensure that service providers made practical support for carers a high priority;
• ensure that proper assessment of need and good care management became the cornerstone of high quality care;
• promote the development of a flourishing independent sector alongside good quality public services;
• clarify the responsibilities of agencies and so make it easier to hold them to account for their performance; and
• secure better value for taxpayers' money by introducing a new funding structure for social care.

The NHS and Community Care Act 1990

The measures contained in the NHS and Community Care Act 1990 sought to implement many of the Griffiths recommendations, phased in from 1993 and with social services departments as lead agencies for community care.

The Act created a planning framework in which agencies must work together closely. Since 1992, local authorities have had to produce annual Community Care plans showing how local arrangements for the delivery of services meet the six key objectives. There must be consultation on these plans with a wide range of identified partners, including housing authorities and housing associations (now known as Registered Social Landlords).
The Act transferred responsibility for the funding of residential and some nursing home care from social security to local authorities. In 1993/94, the first instalment of special transitional grant (STG) – a ringfenced grant that transferred money from the social security system to local authority social services – was paid over, with a stipulation that 85 per cent must be spent in the private and voluntary sector. Much of the STG money has been used to pay for places in residential and nursing homes. A new Mental Illness Specific Grant was also introduced.

As well as becoming lead agencies and taking on new financial responsibilities, social services authorities had to re-organise their departments, separating responsibilities for assessing needs and commissioning services from those of providing services. Three Commission bulletins have charted the progress made by authorities in these and other areas since 1992:

- Balancing the Care Equation: Progress with Community Care, Bulletin No. 3, Audit Commission, 1996.
- Taking Stock: Progress with Community Care, Bulletin No. 2, 1994
- Taking Care: Progress with Care in the Community, Bulletin No. 1, 1993
Appendix 4

Guide to funding mechanisms

This appendix lists the major sources of funding for the housing aspects of community care; it is by no means exhaustive. Funding sources are listed under the agency which distributes them.

<table>
<thead>
<tr>
<th>Central government direct funding</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td><strong>Capital</strong></td>
</tr>
<tr>
<td>Income Support (preserved benefits from prior to 1993)</td>
<td></td>
</tr>
<tr>
<td>Disability Living Allowance (DLA)</td>
<td></td>
</tr>
<tr>
<td>Residential Care Allowance</td>
<td></td>
</tr>
<tr>
<td>Community Care grants/Social Fund</td>
<td></td>
</tr>
<tr>
<td>Grants from DETR for homelessness projects (under S.180 Housing Act 1996)</td>
<td></td>
</tr>
<tr>
<td>Rough Sleepers Initiative (Phase 2 &amp; 3)</td>
<td></td>
</tr>
<tr>
<td>Homeless and Mentally Ill Initiative (HMII): top-sliced by DoH from Health Authority allocations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing authorities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td><strong>Capital</strong></td>
</tr>
<tr>
<td>Housing benefit and rent rebates, administered by local housing authorities</td>
<td></td>
</tr>
<tr>
<td>Housing Revenue Account (HRA) income from rents and service charges</td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Services and Health Authorities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td><strong>Capital</strong></td>
</tr>
<tr>
<td>Mental Illness Specific Grant (MISG)</td>
<td></td>
</tr>
<tr>
<td>Special Transitional Grant (STG) - social security resources transferred from central government to local authority social services departments under the NHS and Community Care Act 1990</td>
<td></td>
</tr>
<tr>
<td>Social services spending on aids and (usually minor) adaptations</td>
<td></td>
</tr>
<tr>
<td>Joint finance under NHS Act 1977</td>
<td></td>
</tr>
<tr>
<td>Health authority grants to voluntary organisations under S.64 of NHS Act 1977</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Corporation/RSLs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td><strong>Capital</strong></td>
</tr>
<tr>
<td>Supported Housing Management Grant (SHMG)</td>
<td></td>
</tr>
<tr>
<td>RSL income from rents</td>
<td></td>
</tr>
</tbody>
</table>

Some funding also through revenue.

Some funding also through revenue.

Includes Specified Capital Grant for Disabled Facilities Grants (DFGs) and Private Sector Renewal Support Grant.

Supplementary Credit Approvals

Monies transferred from health authorities to other agencies using powers under the S.28a Health Act 1977 (eg, reprovision for patients discharged from long-stay hospitals).

Some funding also through revenue.
Appendix 5

There are no published national estimates of expenditure for a number of areas of housing and community care. To fill these gaps, best estimates have been made using sample information obtained by the Commission. The figures include both capital and revenue expenditure and are for the financial year 1996/97. Data is for England, and Wales where possible.

<table>
<thead>
<tr>
<th>Aids and adaptations</th>
<th>Units</th>
<th>Unit cost £</th>
<th>Total spend £000</th>
<th>Source/methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFGs</td>
<td>25,000</td>
<td>100,000</td>
<td>DETR: HIP2 Section C. Welsh Housing statistics</td>
<td></td>
</tr>
<tr>
<td>HRA-funded</td>
<td>3,708,000</td>
<td>23</td>
<td>85,000</td>
<td>Fieldwork estimate of average spend per local authority (LA) dwelling = £23 x total LA stock</td>
</tr>
<tr>
<td>SS-funded</td>
<td>51,820,000</td>
<td>0.53</td>
<td>27,000</td>
<td>Fieldwork estimate of average spend per head of population, extrapolated for total population</td>
</tr>
<tr>
<td>Housing Corporation</td>
<td></td>
<td>17,000</td>
<td>Housing Corporation (HC) Annual Review 1996/97</td>
<td></td>
</tr>
<tr>
<td>Home Improvement Agencies</td>
<td></td>
<td>4,500</td>
<td>DETR</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td>233,500</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community alarms</th>
<th>Units</th>
<th>Unit cost £</th>
<th>Total spend £000</th>
<th>Source/methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided by local authorities</td>
<td>1,160,000</td>
<td>75.84</td>
<td>88,000</td>
<td>Number of people receiving service estimated from Audit Commission (AC) survey. Unit costs derived from AC survey.</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td>88,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Homelessness and resettlement</th>
<th>Units</th>
<th>Unit cost £</th>
<th>Total spend £000</th>
<th>Source/methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority resettlement schemes</td>
<td>8,400</td>
<td>1,500</td>
<td>13,000</td>
<td>Number of people receiving service estimated from AC survey of 54 LAs. Unit cost from AC analysis of 3 schemes</td>
</tr>
<tr>
<td>Local authority homeless persons unit</td>
<td>20,280</td>
<td>450</td>
<td>9,000</td>
<td>Vulnerable homeless acceptances from DETR. Net spend per homeless household from CIPFA statistics.</td>
</tr>
<tr>
<td>DSS resettlement programme (S.30 Job Seekers Act 1995)</td>
<td></td>
<td></td>
<td>12,000</td>
<td>DSS</td>
</tr>
<tr>
<td>- revenue</td>
<td></td>
<td></td>
<td>13,000</td>
<td>DSS</td>
</tr>
<tr>
<td>- capital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DETR-funded homelessness projects (S.180 Housing Act 1996)</td>
<td></td>
<td></td>
<td>7,000</td>
<td>DETR</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td>54,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Not all aids provided by social services are housing-related. However, as separate figures are not available, total estimated expenditure on aids by social services authorities has been included.

No reliable expenditure figures are available for sheltered housing. Consequently, rents and service charges have been used as a proxy.

Figure does not include expenditure on services provided by health and social services to people living in supported housing as no reliable figures are available.

<table>
<thead>
<tr>
<th>Units</th>
<th>Unit cost £</th>
<th>Total spend £000</th>
<th>Source/methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered housing II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local authorities</td>
<td>285,900</td>
<td>2,150</td>
<td>615,000</td>
</tr>
<tr>
<td>RSLs</td>
<td>163,500</td>
<td>3,005</td>
<td>491,000</td>
</tr>
<tr>
<td>Sub-total</td>
<td></td>
<td></td>
<td>1,106,000</td>
</tr>
<tr>
<td>Supported housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LASHG</td>
<td></td>
<td>26,000</td>
<td>Housing Corporation unpublished figure (estimate assumes 30% schemes joint-funded through ADP).</td>
</tr>
<tr>
<td>Housing Corporation/RSLs - ADP - SNMA/SHMG</td>
<td></td>
<td>98,000 135,800</td>
<td>HC Annual Review 1996/97 HC Annual Review 1996/97</td>
</tr>
<tr>
<td>Joint Finance - revenue - capital</td>
<td></td>
<td>8,000 800</td>
<td>DOH based on HFR20 returns DOH based on HFR20 returns</td>
</tr>
<tr>
<td>Health/Social Services III</td>
<td>19,750</td>
<td>15,049</td>
<td>297,000</td>
</tr>
<tr>
<td>DSS - Housing Benefit/Income Support</td>
<td>59,250</td>
<td>4,536</td>
<td>269,000</td>
</tr>
<tr>
<td>Rough Sleepers Initiative, Phases 2 &amp; 3</td>
<td></td>
<td></td>
<td>11,000</td>
</tr>
<tr>
<td>Sub-total</td>
<td></td>
<td></td>
<td>845,600</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>2,327,100</td>
</tr>
</tbody>
</table>
Glossary

ADP
Approved Development Programme – capital allocation from the Housing Corporation to RSLs

CCT
Compulsory Competitive Tendering. Local authorities are required to subject certain services to external competition.

Care Programme Approach
The Care Programme Approach (CPA) is designed to ensure that people with mental health problems who live in the community receive the health and social care that they need. It covers all patients referred to the specialist psychiatric services and is managed by individual health authorities, in discussion with relevant social services authorities. Applied properly, CPA should provide:

• a systematic approach for assessing whether the patient can be treated appropriately in the community (in the light of available resources and patient/carer views);
• regular review of the health and social care needs of those being treated in the community; and
• effective systems for ensuring that the necessary health and social care services are provided.

The Department of Health requires that all health authorities implement CPA, but not all have done so. CPA depends heavily on successful inter-agency and inter-professional working and full involvement of patients and carers. The Department of Health recommends that a named individual be appointed as the ‘key worker’ for each patient to keep in touch and ensure that the agreed care is given. Patients can be divided into three groups, depending upon the severity of their illness.


CPN
Community Psychiatric Nurse

DETR
Department of Environment, Transport and the Regions – formerly Department of the Environment (DoE)

Disabled Facilities Grant
The Disabled Facilities Grant (DFG) is a mandatory grant available for adaptations that are needed by people with frailty or disability, notably improvements to access and ease of movement around the home. The grant is subject to means-testing, with the amount awarded being dependent upon an applicant’s income and savings. The assessment of need for the requested adaptation is carried out by an occupational therapist.

DOH
Department of Health

DSS
Department of Social Security
Floating support  
Support provided to someone to enable them to live independently in the community. The support is linked to the person rather than the property; people typically live in ordinary housing. The support can be short or long-term and will be ‘floated off’ to others when no longer required.

Handyperson schemes  
Small jobs are carried out for older/disabled people on low incomes (at either a very low cost, or at materials cost only, or for nothing). These schemes may be run entirely separately from HIAs (see below), and may or may not be grant aided.

HIP  
Housing Investment Programme – a submission to central government on capital expenditure incurred, housing needs, and planned future investment. Capital is allocated to local authorities on the basis of the submission.

Home Improvement Agencies (HIAs)  
Provide independent advice and help to assist elderly people, people with disabilities and those on low incomes to carry out repairs, improvements and adaptations to their properties. In many cases this assistance enables people to stay in their own homes. They are usually small schemes, staffed by three or four people, operating on a district-wide basis. HIAs are managed by a variety of organisations, often housing associations but also local authorities and independent bodies such as Age Concern. Many are called ‘Care and Repair’ or ‘Staying Put’.

The assistance provided includes advice on grants and other sources of funding, finding a suitable builder and ensuring that the work is completed satisfactorily. The emphasis is on providing a comprehensive service to help people through the whole process of carrying out the work. The total cost of Government support in 1996/97 for the HIA programme was £4.797m. Grant is channelled through local authorities which are responsible for assessing the need for HIA services in their area and for bidding on behalf of schemes. There are now about 200 HIAs operating in England, of which 70 per cent are in receipt of DETR grant.

Housing Corporation  
The Housing Corporation distributes funding to and regulates registered social landlords (RSLs)

HRA  
Housing Revenue Account – a ring-fenced account of expenditure and rents for local authority housing

LASHG  
Local Authority Social Housing Grant (previously Housing Association Grant). Local authorities may make capital grants (or loans) to housing associations to help them to renovate or acquire new housing stock. Such grants must be financed from the capital resources of the local authority but the government does provide financial incentives to encourage such support.

LSVT  
Large Scale Voluntary Transfer; the complete or partial transfer of local authority housing to a housing association or housing company.

OT  
Occupational Therapist
Reprovision/resettlement

The replacement of places in large institutions contracting or closing with a number of smaller, more flexible schemes based in the community. Resettlement is used to refer to such provision, but can also denote time-limited support to help ex-patients, homeless people and others to establish themselves in mainstream tenancies.

RSI

Rough Sleepers Initiative. In response to growing public concern about the number of people sleeping on the streets, the Rough Sleepers Initiative was set up by the DETR. The initiative comprises a range of special measures including emergency shelters, short term hostels and permanent accommodation.

RSL

Registered Social Landlord. The phrase was introduced in the Housing Act 1996 and now encompasses housing associations, housing companies created under the 1996 Act and voluntary bodies that manage properties on behalf of other agencies.

SHMG

Supported Housing Management Grant (previously Special Needs Management Allowance or SNMA). The grant is made by the Housing Corporation to housing and support schemes.

Supported Lodgings

Supported lodgings may be used by social services for specific groups – often care leavers or people with learning difficulties who need long term support but are able to live in a ‘family’ setting rather than an institution. An individual is placed with a landlord/landlady who supplies an agreed amount of additional support – for example, meals, laundry, etc.

TOR

Test of Resources - means test, used in assessing need for DFG

Vulnerable

In practice there is no one agreed definition of vulnerability. Housing, health and social services work to different pieces of legislation and have different ideas about which groups need additional support. The legal definition of vulnerability for housing professionals is that associated with homelessness legislation:

‘the critical test must be whether the applicant is less able to fend for him/herself so that s/he will suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects’. DoE 1991

S. 189 of the Housing Act 1996 defines the main groups in priority need (apart from families with children or pregnant women) as ‘a person who is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason, or with whom such a person resides or might reasonably be expected to reside’.

Not all vulnerable people require help from statutory agencies – many will be able to rely on their own resources or the help of family and friends.
References

7. Audit Commission The Coming of Age: Improving Care Services for Older People, Audit Commission, 1997.
14. Personal Social Services Research Unit, Unit Costs of Health and Social Care, University of Kent, 1996.
17. Age Concern Institute of Gerontology, Difficult-to Let Sheltered Housing: Results from a National Survey, King’s College London, 1996.

19. Adrian Jones. Can’t N nominate or Won’t N nominate: Local Authority N nominations to Housing Association Sheltered Housing Accommodation, Anchor & Servite Houses, 1997.


21. Providing Indicators of Elderly and Disabled People at District Level, Department of the Environment 1996.


27. Housing and Community Care, Circular 10/92 Department of the Environment and Department of Health; Implementing Caring for People: Housing and Homelessness, Department of Health, 1994.


34. T Burgner. The Regulation and Inspection of Social Services, Department of Health and Welsh Office, 1996.
The Audit Commission has produced a number of reports covering issues related to housing and community care. The following may be of interest to readers of this report:

**The Coming of Age**  
*Improving Care Services for Older People*  

**Take Your Choice**  
*A Commissioning Framework for Community Care*  

**Fraud and Lodging**  
*Tackling Fraud and Error in Housing Benefit*  

**Balancing the Care Equation**  
*Progress with Community Care*  
Bulletin, 1996, 40 pages, 0118864319, £8

**Misspent Youth**  
*Young People and Crime*  
Summary, 1996, 36 pages, 1862400067, £8

**United They Stand**  
*Co-ordinating Care for Elderly Patients with Hip Fracture*  
National Report, 1995, 68 pages, 0118864343, £10

**Finding a Place**  
*A Review of Mental Health Services for Adults*  
National Report, 1994, 96 pages, 0118864335, £11  
Executive Summary, 1994, 20 pages, 0118861447, £6

**Taking Stock**  
*Progress with Community Care*  
Bulletin, 1994, 28 pages, 0118861360, £6

**Taking Care**  
*Progress with Care in the Community*  
Bulletin, 1993, 16 pages, 0118861204, £6

**Seen But Not Heard**  
*Co-ordinating Community Child Health and Social Services for Children in Need*  
National Report, 1994, 98 pages, 0118861737, £11  
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*Personal Social Services and Community Care*  
National Report, 1992, 72 pages, 0118860917, £9.50

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*A New Course for Community Health*  
National Report, 1992, 52 pages, 0118860844, £8.50

**Developing Community Care for Adults with a Mental Handicap**  
Occasional Paper, 1989, 19 pages, 0117014532, £4.25

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National Report, 1986, 132 pages, 0117013234, £9.60

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Housing is a vital source of support for vulnerable people living in the community. It makes a major and growing contribution to community care, and there are many success stories to commend. But fiscal, social and legal changes pose questions about the relevance of approaches developed during the 1980s and 1990s to meet the demands of the next century.

There are a number of problems at the local level with the planning, delivery and monitoring of housing’s contribution to community care, and vulnerable people are not always well served. Too much emphasis is given to dealing with problems after they emerge rather than taking effective preventive action. The result is both distress to users – in particular to frail, older people, those with mental health problems and people with disabilities – and a draining of scarce resources. Weaknesses are not confined to local efforts. The national framework of policy guidance, funding and regulation requires urgent reform to ensure that local authorities are supported effectively in meeting the complex challenges of community care.

The report makes a number of recommendations for improving services, and offers case studies to illustrate good practice. It is essential reading for senior officers in housing and social services departments, and those working in health agencies and other housing providers. The report is also relevant for policy-makers and those who are responsible for the future direction of housing and community care services.