Centre for Ageing Better

Home Improvement Services in England: National Evaluation

Final Report

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in partnership with:

Sheffield Hallam University | Centre for Regional Economic and Social Research

bre

UK Collaborative Centre for Housing Evidence

University of Stirling

Foundations

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Acknowledgements

The UK's population is undergoing a massive age shift. In less than 20 years, one in four people will be over 65.

The fact that many of us are living longer is a great achievement. But unless radical action is taken by government, business and others in society, millions of us risk missing out on enjoying those extra years.

At the Centre for Ageing Better we want everyone to enjoy later life. We create change in policy and practice informed by evidence and work with partners across England to improve employment, housing, health and communities.

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Section 1

Introduction

This report presents the main findings from the national evaluation of home improvement services in England.

The Centre for Ageing Better appointed the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University, in partnership with the UK Collaborative Centre for Housing Evidence (CaCHE), the University of Sheffield, the University of Stirling, the Building Research Establishment (BRE), and Foundations, to conduct the evaluation which ran for 18 months between May 2023 and October 2024.

The evaluation builds on the Good Home Inquiry[1] which called for more effective local delivery of home improvement services across England. Better evidence is required to demonstrate the contribution and impact these services make, and to nationally influence for increased prioritisation and investment. The evaluation is central to continuing to evidence the recommendations of the Good Home Inquiry, particularly the key recommendation around the creation of local delivery bodies or Good Home Hubs that provide or signpost to information and advice, finance, home repairs, adaptations and energy retrofit services and operate as a one-stop shop.

[1] The Good Home Inquiry | Centre for Ageing Better (ageing-better.org.uk)

It is hoped that learning from the evaluation will help to inspire local policy makers to improve their home improvement service offer and implement change.

1.1. Aims of the evaluation

This evaluation addresses four main objectives to:

- Fill an evidence gap in research around the availability and impact of home improvement services.
- Provide case studies of areas of best practice which are currently delivering high quality services.
- Demonstrate to national and local policy makers the impact of comprehensive home improvement services on individuals' health and wellbeing, and on wider housing, health, and social care pressures.
- Inspire local policy makers to improve their service offer using learning from case studies about how best to implement change.

And focusses on two key areas:

1. Describing home improvement services.

2. Assessing the quality, impact, and cost of the service.

Detail of the main research questions under each of these areas is included in Chapter 2.

1.2. Background and Context

Home improvements refer to all kinds of physical changes, modifications and assistive devises that can be put in place in a home to support healthy ageing (McCall et al., 2023).[2] They include major and minor adaptations ranging from the provision of level access showers and wet-rooms, alterations to room layouts, toilet replacements and stair lifts, to handrails, ramps, lighting improvements, heating controls, key safes, and monitoring equipment for individuals with health conditions such as dementia (Centre for Ageing Better, 2017).[3] Home improvement services are also often a place to seek information and advice. Services sometimes extend their offer to deal with affordable warmth and energy efficiency issues and include support for dementia and help with creating dementia sensitive environments.

[2] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation*.

[3] Centre for Ageing Better. (2017). Room to improve: *The role of home adaptations in improving later life*.

Home improvement services are vital given the ongoing importance of 'ageing-in-place' and providing support and resources to help people remain living in their own homes and community settings. Many older people often wish to stay put in their homes (Wiles, 2005). Yet, for many older people accessing and managing home improvements that can help them live more comfortably and independently in their homes has been described as a 'fight' (McCall et al, 2023).[4]

BRE analysis of the English Housing Survey (EHS) suggests that the number of households needing at least one adaptation is increasing. In 2014, close to half a million households (475,000) or 40 per cent of households containing at least one adult aged 65 years or over, with a long-term illness or disability, self-reported the need for installation of at least one adaptation. In 2019, figures had risen to 770,000 or 52 per cent of households containing at least one adult aged 55 years or over, with a long-term illness or disability. BRE's latest estimates, undertaken for this evaluation,[5] suggest that 759,000 households, or seven per cent of all households with a person aged 55 years or over across England, need an adaptation and do not have an adaptation. This means that half (49 per cent) of households in England with a person aged 55 who need an adaptation do not have one.

Recent evidence also highlights the extent of poor housing in England more generally. Many homes are in a state of disrepair, with over 3.5 million homes failing to meet the Government's Decent Home Standard. BRE's research for the evaluation indicates that over 50 per cent of the non-decent homes in the owner-occupied sector are headed by someone aged over 55. Older people are also more likely to live in a home with the most serious problems (a Category 1[6] hazard). For example, nearly 60 per cent of all homes that are 'excessively cold' – meaning that the occupants are unable to heat it to a comfortable temperature – are lived in by at least one person aged 55 and over.[7] Older people, particularly those living in the private rented or owner-occupied sector, are more likely to reside in a home that poses a risk to their health and to have their health conditions adversely affected by poor quality homes (Centre for Ageing Better, 2023b).[8]

[4] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation*.

[5] Counting-the-cost-report.pdf

[6] Category 1 hazards are those deemed to pose the most severe risk to the health and safety of occupants. If a local housing authority identifies a Category 1 hazard in a property, they are legally obligated to take action. These hazards can range from structural issues, such as collapsing roofs, to environmental concerns like severe dampness and mould growth.

[7] Counting-the-cost-report.pdf

[8] Centre for Ageing Better (2023b). *Lost Opportunities: A decade of declining national investment in repairing our homes*. Centre for Ageing Better.

Home improvements are therefore crucial for older people to maintain healthy lives and for local and national governments to avoid a health crisis (McCall et al., 2023).[9] It is estimated that the average cost to repair homes where the head is over 55 is just £3,618.[10]

1.3. The Benefits of home improvement services

Arguments for increasing investment in our homes and in home improvement services are increasingly focusing on their potential wider benefits to society. Such investment can boost economic growth, improve health, and save spending in health and social care, and assist with delivery of environmental benefits.[11]

Whilst the evaluation seeks to answer questions around the benefits, costs, value, and impact of home improvement services, existing evidence suggests they can be an effective and cost-effective intervention to prevent falls and injuries for older people (Keall et al., 2015),[12] improve their mental health (Heywood, 2004),[13] and improve their performance of everyday activities (Powell et al., 2017).[14] Adaptations result in older people feeling safer and more comfortable in their homes (Tanner et al., 2008),[15] supporting people to live longer in their communities (Hwang et al., 2011).[16] The contribution of these impacts can result in the saving of monetary and labour costs to the health and social care sectors in the UK (Powell et al., 2017).[17]

[9] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation*.

[10] Counting-the-cost-report.pdf

[11] Home Improvement: A Triple Dividend | Centre for Ageing Better (ageing-better.org.uk)

[12] Keall, M., Pierse, N., Howden-Chapman, P., & al, e. (2015). Home modifications to reduce injuries from falls in the Home Injury Prevention Intervention (HIPI) study: a cluster-randomised controlled trial. *The Lancet,* 385(9964).

[13] Heywood, F. (2004). The health outcomes of housing adaptations. *Disability & Society,* 19(2), 129-143.

[14] Powell, J., Mackintosh, S., Bird, E., et al. (2017). T*he role of home adaptations in improving later life.* Centre for Ageing Better.

[15] Tanner, B., Tilse, C., & de Jonge, D. (2008). Restoring and Sustaining Home: The Impact of Home Modifications on the Meaning of Home for Older People. *Journal of Housing For the Elderly,* 22(3), 195-215.

[16] Hwang, E., Cummings, L., Sixsmith, a., & Sixsmith, J. (2011). Impacts of Home Modifications on Aging-in-Place. *Journal of Housing for the Elderly,* 25(3).

[17] Powell, J., Mackintosh, S., Bird, E., & al, e. (2017). *The role of home adaptations in improving later life.* Centre for Ageing Better.

Home improvement services are found to reduce care home admission rates (Hollinghurst et al., 2020),[18] hours of in-home care needed (Carnemolla and Bridge, 2019),[19] and emergency fall admissions (Keall et al., 2017)[20] at the benefit to monetary and social value.

1.4. Current issues and challenges

Many local authorities across England have introduced home improvement services. However, key challenges and issues remain in the integration of home improvement services. Although there are good examples, the effectiveness of services offered by local councils are often limited due to underfunding (McCall et al., 2022).[21] Over the last decade, funding for home improvements and housing renewal has been cut. A recent report suggests that some £2.3 billion of funding for grants has been withdrawn over this period (Centre for Ageing Better, 2023b).[22] A lack of clear Government guidance to local councils (Mackintosh and Heywood, 2015)[23] also results in a fragmented policy landscape in which available grants and home improvement services remain location dependent, likened to a 'postcode lottery' (McCall et al., 2023).[24]

This patchy landscape and lack of available funding make for an ineffective and inefficient home adaptation service process (Zhou et al., 2019)[25] which can force many residents to self-finance their home improvements (McCall et al., 2023)[26] and act as a deterrent to seeking help for some households (Powell et al., 2017).[27]

[18] Hollighurst, J., Fry, R., Akbari, A., & al, e. (2020). Do home modifications reduce care home admissions for older people? A matched control evaluation of the Care & Repair Cymru service in Wales. *Age and Ageing,* 49(6), 1051-1061.

[19] Carnemolla, P., & Bridge, C. (2019). Housing Design and Community Care: How Home Modifications Reduce Care Needs of Older People and People with Disability. *International Journal of Environmental Research and Public Health,* 16(11).

[20] Keall, M., Pierse, N., Howden-Chapman, P., & al, e. (2015). Home modifications to reduce injuries from falls in the Home Injury Prevention Intervention (HIPI) study: a cluster-randomised controlled trial. *The Lancet,* 385(9964).

[21] McCall, V. (2022). Inclusive Living: ageing, adaptations, and future-proofing homes. *Buildings and Cities*, 3(1).

[22] Centre for Ageing Better (2023b). *Lost Opportunities: A decade of declining national investment in repairing our homes.* Centre for Ageing Better.

[23] Mackintosh, S., & Heywood, F. (2015). The Structural Neglect of Disabled Housing Association Tenants in England: Politics, Economics and Discourse. *Housing Studies,* 30(5).

[24] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation.*

[25] Zhou, W., Oyegoke, A., & Sun, M. (2019). Adaptations for Aging at Home in the UK: An Evaluation of Current Practises. *Journal of Ageing and Social Policy.*

[26] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation.*

[27] Powell, J., Mackintosh, S., Bird, E., et al. (2017). T*he role of home adaptations in improving later life.* Centre for Ageing Better.

Such financial costs coupled with a lack of awareness of services (McCall et al., 2023)[28] and feelings of stigmatisation that are commonly associated with decline and vulnerability mean residents often delay accessing home improvements (Bailey et al., 2019)[29] until they reach crisis. Delays in the installation of home improvements can reduce their effectiveness (Petersson et al, 2009,[30] Powell et al., 2017[31]). The effectiveness of home improvements can also be limited by the poor design of some home adaptations leaving them not-fit-for-purpose and not aesthetically pleasing (McCall et al., 2023).[32] In addition, older homes can be difficult and costly to retrofit (Mallaband et al., 2013).[33] These factors combined with a lack of evaluation and post-adaptation visits (McCall et al., 2023)[34] can result in sub-par performance.

1.5. Models of home improvement services

The fragmented and variable nature of services and the challenges associated with delivering home improvement services indicate a more consistent and coordinated approach by councils is needed. Such an approach will require better funding and must raise awareness of services and highlight the benefits and opportunities available to residents and councils. In July 2023, the Centre for Ageing Better published a report titled *'Building effective local home improvement services'*[35] to advise local areas on how to build an effective and comprehensive one-stop shop service for local areas. The report proposes the 'Good Home Hub' model

[28] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation.*

[29] Bailey, C., Aitken, D., Wilson, G., et al.. (2019). "What? That's for Old People, that." Home Adaptations, Ageing and Stigmatisation: A Qualitative Inquiry. *Environmental Research and Public Health,* 16(24).

[30] Petersson I, Kottorp A, Bergström J, et al. (2009) Longitudinal changes in everyday life after home modifications for people aging with disabilities. Scandinavian Journal of Occupational Therapy, 16(2): 78-87.

[31] Powell, J., Mackintosh, S., Bird, E., et al. (2017). *The role of home adaptations in improving later life.* Centre for Ageing Better.

[32] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation.*

[33] Mallaband, B., Haines, V., & Mitchell, V. (2013). Barriers to domestic retrofit: Learning from past home improvement experiences. *Loughborough University Institutional Repository.*

[34] McCall, V., Gibb, C., & Wang, Y. (2023). The 'fight' for adaptations: Exploring the drivers and barriers to *International Journal of Building Pathology and Adaptation.*

[35] building-effective-local-home.pdf (ageing-better.org.uk)

which highlights five key elements that should be offered for a good service. These are:

- Independent information and advice.
- Independent home assessment.
- Practical support throughout the process.
- Targeted financial support: grants, loans, and other financial products (including DFGs).
- Signposting to trusted traders.

A purpose of the evaluation is to describe current home improvement services and explore models of support to develop an understanding of what works for delivering home improvement services locally. During the evaluation, other issues of consideration were raised including the importance of co-location which benefits good partnership working, the need to lever in more energy efficiency work and extend services/models to include more support for dementia and hoarding. Home improvement services will have to adapt their approaches (as well as workforce training and skillsets) to respond to a range of national and local challenges and to ensure they are meeting the distinct needs of, for example, different tenures and more diverse communities of older and disabled people.

McCall et al. (2022)[36] has proposed an 'Inclusive Living' model which aims to overcome challenges of poor-quality homes, disinvestment in repair and maintenance and the fragmented policy landscape and funding surrounding home improvements. The model has three pillars concerning (1) Physical Space and Design (2) Connections and Relationships and (3) Social Inclusion and Equality. It encourages proactiveness from policymakers to overcome negative stigma and emphasises the importance of framing home adaptations as a public issue rather than a private one, overcoming social inequalities in the process where many older people are unable to maintain or adapt their homes despite a desire to do so.

[36] McCall, V. (2022). Inclusive Living: ageing, adaptations, and future-proofing homes. *Buildings and Cities,* 3(1).

1.6. Report structure

The remainder of the report is structured as follows:

- Chapter 2: Methodology and evaluation activities.
- Chapter 3: Introducing the case studies.
- Chapter 4: The nature and scale of home improvement services.
- Chapter 5: The quality of home improvement services.
- Chapter 6: The value and impact of home improvement services.
- Chapter 7: Economic analysis.
- Chapter 8: Good practice, lessons, and innovation.
- Chapter 9: Conclusion and recommendations.

Section 2

Methodology and evaluation activities

Our evaluation of home improvement services adopts a mixed quantitative-qualitative research approach incorporating elements of process and impact evaluation. It addresses four main objectives:

- Fill an evidence gap in research around the availability and impact of home improvement services.
- Provide case studies of areas of best practice which are currently delivering high quality services.
- Demonstrate to national and local policy makers the impact of comprehensive home improvement services on individuals' health and wellbeing, and on wider housing, health, and social care pressures.
- Inspire local policy makers to improve their service offer using learning from case studies about how best to implement change.

The evaluation is organised under several workstreams headed up by consortium partners. Key components of our approach include updating BRE's cost of poor housing and adaptations models for older households, analysis of decent homes by region by older people, an online survey of home improvement services across England, case studies with eight home improvement services, and an economic evaluation based on Value for Money (VfM) and cost benefit analysis (CBA) frameworks.

Our approach centralises the lived experiences of services users and a whole strand of work is dedicated to embedding lived experience into the evaluation. The stakeholder engagement work package covers a range of different activities including stand-alone engagement and dissemination activities, as well as some research activities which provide an important avenue to substantive stakeholder consultation through the course of the evaluation.

2.1. Scoping phase

The evaluation split into two main phases. A scoping phase to inform the development of the evaluation framework, and the main evaluation phase involving data gathering and fieldwork, stakeholder consultation, data analysis, and the production of a series of outputs.

During the scoping phase we put out an initial call for evidence and undertook a literature review to provide an initial context for the development of the main evaluation framework. We also consulted on case studies for the evaluation. One of the main objectives of the evaluation is to provide case studies of areas of best practice which are currently delivering high quality services.

The selection of good practice case studies for the evaluation was informed by evidence from several sources including:

- Discussions with experts and their views on home improvement services and possible case studies.
- A meeting with Ageing Better to consider suggestions for possible good practice areas.
- Factsheets and initial mapping of a selection of services previously compiled by Ageing Better.
- Consideration of Good Home Hub themes and the types of support that a Good Home Hub could offer including whether a service operates as a one stop shop and offers support such as healthy home assessments, keeping warm/energy efficiency, trusted tradespeople, financial solutions, information and advice, support to commission work, and practical support.
- Evidence from Foundations online directory of home improvement services and analysis of their own database of services.
- Responses to the Call for Evidence issued by the Consortium during the scoping phase of the evaluation.
- A summary analysis of available data for the case study locations including headline figures on population age, health, income, and housing quality for each of these areas compared to England averages.

We held a workshop with consortium partners and Ageing Better on 9th October 2023 to discuss and agree case studies. It should be noted that whilst the case study selection is based on experts' knowledge of the sector and available information and data on a selection of services, there could be other home improvement services we are unaware of that would meet the selection criteria.

The main evaluation phase began in November 2023 and ran for a year. It will culminate with a dissemination event planned for the end of February 2025.

1.2. Main evaluation phase

The focus of the main evaluation covers two key areas:

1. **Describing home improvement services** including questions on:

- The nature and scale of the service provided.
- The number of people/households who use the service, the demographics of who is using the service and what are the referral routes into the service.
- How is the service funded and how much does it cost? How secure is the funding?
- Who makes decisions about the service and what criteria is used to make decisions.
- How closely does the local authority work with related service providers in the area?

2. **Assessing the quality, impact and cost of the service** including questions on:

- The effectiveness of the intervention in delivering a comprehensive offer/ service.
- What impact does the intervention have and on whom, and how and why? (at an individual, service and system level – e.g. housing, NHS and social care, family members and informal carers).
- Whether the service reaches those most in need and those most impacted by social and economic inequalities? What impact does it have on these groups?
- How cost-effective is the service? Does the service provide value for money?
- What are the main constraints on the service, e.g. funding, staffing, outside contractors, management structure, level of integration etc.?

A detailed overview of the suite of research questions against the main evaluation criteria is set out in Appendix 1.

We have analysed and synthesised the findings from these main questions to make some overall conclusions about the impact that home improvement services have on their recipients and to assess the following:

- What the potential impact of services could be if these service models were scaled up across the country.
- What the likely costs would be to scale up a comprehensive service model across the country.
- How should the service(s) be reproduced and implemented in other areas.
- Whether there is a difference in the effectiveness if there are multiple services delivered by different agencies or is a coordinated service more effective.

The different components of the main evaluation and the methods implemented are detailed below.

2.3. BRE analysis

BRE's workstream updates important analysis on the cost of poor housing to the NHS among older people and the costs of adaptations for older people. It examines the incidence of non-decent homes by age, tenure, and region. These nationally representative results inform the national level estimates used in our economic analysis in Chapter 7.

BRE's work was delivered under five main work packages. (Work package 1, detailing the findings of a contextual literature review and analysis of population age, health, income, and housing quality data for the case study locations was part of the scoping phase).

Work package 2 – reporting on and detailing the findings of an analysis of the cost of poor housing to the NHS among older people (using the latest EHS data (2019) and BRE's cost of poor housing model).

Work package 3 – reporting on and detailing the findings of an analysis of the cost of poor housing to the NHS among older people and households with long term illness (using the latest EHS data (2019) and BRE's cost of poor housing model).

Work package 4 – reporting on and detailing the findings of analysis of the latest cost of common home adaptations for older people (by reviewing and updating the Ageing Better Adaptations model created for the Role of Home Adaptations project).

Work package 5 – report containing findings of a 'Decent Homes analysis' - Using EHS data to obtain prevalence of non-decent homes by region by age of Household Reference Person (HRP) and by tenure.

2.4. Online survey

One of the main methods for gathering data about home improvement services was the online survey administered by CRESR. It was sent out to the directory of home improvement service contacts held by Foundations. The survey was publicised through Foundations and a link to the survey sent out in the Foundations newsletter on the 9th of January 2024. Two follow up reminders were sent out in later newsletters (February and April) to encourage participation. We also worked with the selected case studies to maximise the responses from these services.

According to Foundations there are around 200 Home Improvement Agencies (HIAs) in England - which are sometimes known as Care and Repair or Staying Put schemes - covering 82 per cent of local authorities. There will be other types of services too and the total number of home improvement services may be closer to 300. We received twenty-eight responses from a range of home improvement services and local authorities across England. We estimate that the survey response represents around ten per cent of services.

The survey is not a representative sample of home improvement services, responses came from a range of different types of organisations and reflect the variance in service size across the sector, in terms of funding and number of households supported. Organisations were asked to provide information for the last year. Just under half gave us information for the financial year 2022/23 and around a third gave information for the 2023/24 financial year. The other respondents provided figures for other time periods, such as the most recent calendar year, or did not specify which year their response related to.

The survey collected data on the amount and sources of funding, expenditure, types of services provided, number of staff employed, number of households / beneficiaries supported, partner organisations and referrals, the benefits of services/interventions delivered. It also asked if organisations collect and would be willing to share monitoring data or other evaluation findings.

The administrative data gathered by the online survey was utilised as part of the economic analysis of home improvement services. The data also informs case study profiles developed with Ageing Better. The profiles will form part of a suite of resources being developed by Ageing Better, which are designed to advise and support other areas and local authorities wanting to progress home improvement services.

2.5. Case studies

Eight case studies were selected for the evaluation on the basis that they provide examples of good practice. The selection of home improvement services includes areas operating as one stops shops, services offering a range of different types of support, providing good high quality services, and incorporating innovative aspects to the delivery of home improvement services. They cover different parts of the country including a mix of local authorities and covering rural and urban locations.

Case studies help us to describe home improvement services and understand the different approaches used across the sector, the reasons and rationales behind this, as well as the opportunities and challenges for home improvement services of working in these ways. We focus on what is working and areas of good practice but also consider less successful aspects of home improvement services and the challenges and pressures they are likely to face in the future.

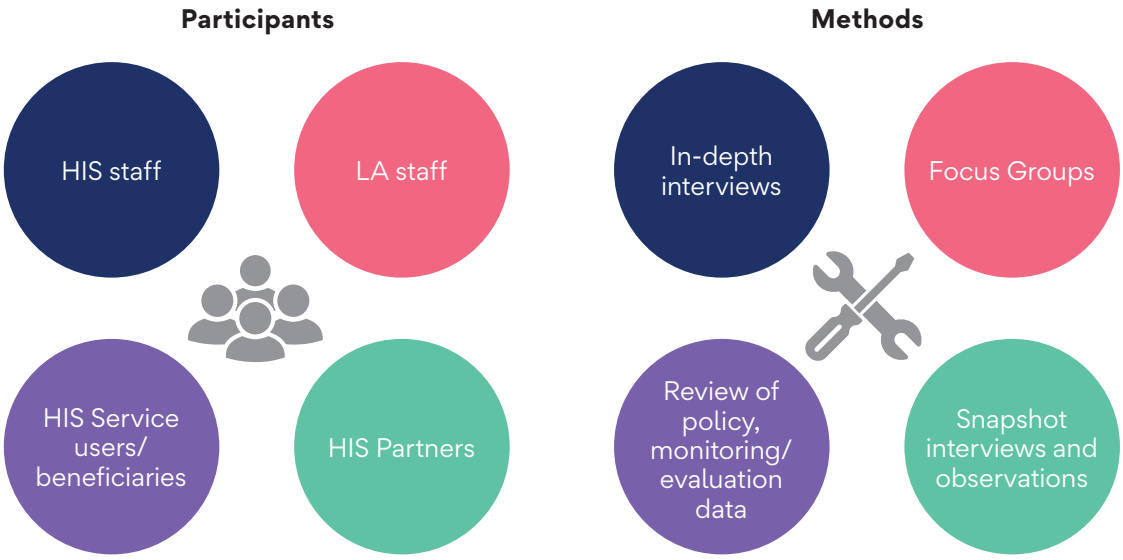
Once initial contact and consent to participate in the evaluation was reached, a scoping meeting or interview was set up with each area, usually with the Head of Service and sometimes including other key staff, to discuss the evaluation, answer any questions and agree how best to proceed with the fieldwork.

This interview gave an overview of each area and helped with understanding the local context within which each individual home improvement service operates. It provided information on the support each service delivers, their model of delivery, the partners and stakeholders they work with including who it was best to speak to during the fieldwork, referral routes into services and eligibility criteria, etc.

At this encounter researchers also asked about relevant policy documents, administrative/monitoring information, and any evaluation data that case studies might hold, checking whether any information could be shared with the evaluation team. Data made available to the evaluation team was reviewed and analysed to support (as appropriate) the economic analysis, providing evidence on the scale of support, who uses the service and on a range of other outputs.

After the initial meeting, a brief outline of our approach summarising what was agreed and setting out the next steps for fieldwork was shared with the case studies, ensuring a degree of consistency across the case study areas. We deployed a suite of methods including interviews, focus groups and workshops, assessment and review of relevant policy, monitoring, and evaluation data (see Figure 2.1, below). Interviews, focus groups and workshops were conducted either face to face, by telephone, or via Teams, with some interviews with beneficiaries of home improvements taking place in their own homes.

Figure 2.1: Overview of a 'typical' case study



And as far as practicable we worked to a target sample of interviews in each case study area and across stakeholder groups (see Table 2.1 below).

Table 2.1: Target Sample (range) for each HIS case study

Stakeholder Group	Number of participants	Inclusion criteria
HIS staff e.g. head of service (CEO), case worker etc.	<=3	– Involved in overall HIS policy/strategy and planning. – Involved in delivery of element(s) of support. – Involved in working with local partners.
LA staff as relevant	<=3	
HIS service users	>=5<=10	In receipt of HIS advice and information / support / intervention.
Local partners e.g. VCS, health, and social care etc.	<=5	– Relationship positive/ supportive. – Relationship challenging to develop/sustain.

Working with the case studies we interviewed 26 people who had used their services. However, we did not manage to engage service users in every case study area. A full breakdown of all the interviews conducted in each area is shown in Table 2.2, below.

Table 2.2: Target Sample (range) for each HIS case study

Case study service	Staff	Other stakeholder	Service user	Total interviews
Case Study A	4	3	5	12
Case Study B	4	3	5	12
Case Study C	3	4	6	13
Case Study D	8	10	2	20
Case Study E	6	1	3	10
Case Study F	6	5	0	11
Case Study G	5	4	0	9
Case Study H	5	3	5	13
Total	**41**	**33**	**26**	**100**

All interviews were recorded, transcribed, and analysed. Analysis of case study data uses a case and theme approach which examines data 'within' 'between' and 'beyond' cases. We seek to understand and assess the impact of home improvement services by developing plausible explanatory accounts about outcomes and identifying elements of good practice. The data from each case study is summarised and assessed in a detailed write up. Each case study write up has been shared with the respective case study head of service to check accuracy, identify any gaps, and to request additional input or clarification.

2.6. Additional interviews

We conducted a handful of additional interviews in different areas of the country with less extensive home improvement services. These interviews were with OTs employed by various NHS Foundation Trusts who were working with housing and home improvement services, and included an interview with a home improvement agency, and a contractor. The interviews provided evidence on perspectives from localities without comprehensive home improvement services. Questions covered what support is available in these areas, how services are delivered, and the issues and challenges currently being faced in relation to delivering DFGs and wider home improvement services.

2.7. Lived experience

Drawing on the lived experience of people who have used home improvement services is a key element in the evaluation framework. This strand of the project led by the University of Stirling involved three elements – individual semi-structured interviews, 'Serious Game' workshops with service users and practitioners, and the development of stories including video stories of people with lived experience.

Four workshops were held between February and June 2024 with people with lived experience of home improvement services in Liverpool, Leeds, London, and Manchester. Many of our workshop participants travelled in from neighbouring local authorities (and sometimes further afield), enabling us to explore experiences across far more than four localities.

Most attendees were older people, although the workshops also involved working-age adults with physical and learning disabilities. Those taking part included a diversity of ethnic backgrounds and participants lived in a mixture of what would be classed as multi-deprived and wealthier areas. Participants were cross-tenure and included owner occupiers, private and social renters, with the majority being urban-based social housing tenants.

The workshops utilised a 'Serious Game' methodology, designed to encourage people to explore issues beyond their own individual experience in an accessible fashion. We used a game called 'Our House,' a new game developed as legacy tool of the DesHCA Project.[37] 'Our House' enables discussions to the level of the home, personalising the ageing process so that individuals can think through the changes that need to be made to homes and how this relates to the personal lived experience in a safe space.

[37] https://www.deshca.co.uk/

A serious game workshop

Participants have a home board in front of them of which they can build their own homes, or a preset home (using cards), and then play real vignettes (based on evidence, and real stories and challenges) into the future. They are given an array of options for adaptations to apply to help improve their home, which helps us see what areas and interventions they see as important. For this evaluation researchers helped people work through real-world based scenarios to discuss the many complex challenges at the heart of home improvement processes – considering the unavoidable trade-offs, not just an ideal vision.

Workshops were followed up with individual interviews with some participants to explore more complex stories. All interviews and workshops were recorded with participants' consent, and the resultant data was analysed to identify the key themes.

A workshop with the same methodology capturing practitioner experiences was undertaken in Sheffield at the Foundations Roadshow in September 2023, exploring lived experience outcomes with those working and connected to delivery of home improvement across local authorities and different agencies.

For more detail on the development of the Serious Game, see our evaluation blog: Serious games for serious issues – using participatory methods to explore home improvement across the life course.[38] The results from the lived experience strand are written up in a separate report (Insert link).

Serious Game practitioner workshop

2.8. Economic analysis

The economic analysis is structured around components of an impact and Value for Money framework including:

- **Inputs:** costs of providing home improvement service/s (HIS/s) including for example source and amounts of funding, costs of home improvements.
- **Outputs:** activity delivered, for example home improvement agencies (HIAs), beneficiary numbers and their characteristics, improvements provided to beneficiaries.
- **Cost Efficiency:** did the project deliver a high volume of activities/outputs in relation to costs?
- **Outcomes:** what difference HIS activity makes such as to physical and mental health, safety, social care, energy usage/efficiency, social isolation etc.

[38] https://housingevidence.ac.uk/serious-games-for-serious-issues-using-participatory-methods-to-explore-home-improvement-across-the-life-course/

- **The additionality of these outcomes:** this is the impact of HIS compared to a counterfactual scenario: in the absence of HISs. To achieve the highest standards of evidence, comprehensive quantitative data is required with an experimental or quasi-experimental design to isolate the additionality of HIS on outcomes.
- **The value of outcomes:** the monetary value, cost savings and return on investment of the outcomes provided by home improvement services.

The economic analysis draws on different data from the online survey, evidence held by Foundations including their directory of HIAs, previous surveys, DELTA data containing information about Disability Facility Grants (DFGs), additional data collected from the case studies on the average cost of individual adaptations or services, and data on outcomes reported by case study service users in qualitative interviews.

More details on the methodology are written up with the findings from the analysis in Chapter 7.

2.9. Stakeholder engagement

There have been several strands to stakeholder engagement throughout the course of the evaluation. We began with a project launch news item which was distributed via the UK Collaborative Centre for Housing Evidence (CaCHE) national newsletter (1369 subscribers). Early activities to build interest and awareness of the project included a call for evidence from external stakeholders and presentations of the project aims and objectives to CaCHE knowledge exchange hubs.

We launched a *Housing and Home Improvement* blog series, with seven blogs to-date, and further blogs and invited commentary to align with the publication of the evaluation. Blogs have featured discussion of innovative methods used in the evaluation, emerging early issues, and critical engagement with wider issues such as the financing of home improvements. We presented the main evaluation activities and early learning to 21 CaCHE knowledge exchange hub members in May 2023.

To engage with wider practice communities, we presented to Foundations Roadshows in Newcastle and Manchester in spring 2024, reaching 216 attendees in total. During these sessions we presented key emerging learning, sought input from practitioners about their own experiences of home improvement service delivery, as well as growing our dissemination network for end of project reporting. Finally, we set up a dedicated *Policy and Practice Forum* to build relationships across the case study organisations, facilitating three online discussion forums. These themed sessions drew in expertise across strategic and service delivery roles, facilitating connections between different organisations and discussing common challenges, ways of working, and good practice.

Section 3

Introducing the case studies

A main objective of the evaluation is to provide case studies of areas of best practice which are currently delivering high quality services. During the evaluation scoping phase, we consulted on case studies (see Chapter 2) and eight areas were chosen.

The areas cover six English regions, including city and unitary authorities with more and less diverse populations. They include rural areas, major urban conurbations, urban with city and town locations, and some urban areas with significant rural parts. The case studies offer a range of services and different types of support incorporating innovative aspects to the delivery of home improvement services. Some of the selected case studies are situated within their local council or organise more arm's length. Some operate like one stop shops and fit more with the Good Home Hub model of simplified access to information and services.[39] All the local authorities where the case studies are situated are part of the Good Home Network.[40] A summary of the location characteristics is presented in Table 3.1, below.

[39] Good-Home-Hub-Booklet.pdf (ageing-better.org.uk)

[40] Following the Good Home Inquiry, Ageing Better in partnership with Foundations set up an active learning hub called the Good Home Network which brings together local authority representatives working to improve poor quality housing so that people in their communities can live independently and safely in their own homes. https://ageing-better.org.uk/good-home-network

Although the selected case studies serve to illustrate examples of good practice, it should be noted that some of them are experiencing significant change, and most are facing ongoing challenges associated with service demand and level of funding. Some services are expanding their offer and moving into neighbouring districts, whilst others are facing changes to their commissioned contract(s) or are restructuring due to recent local government reorganisation. These sorts of pressures were affecting some case studies more than others during the evaluation period and may therefore influence some of our findings and results.

A brief overview introducing each case study home improvement service is detailed in this chapter.

Table 2.1: Target Sample (range) for each HIS case study

Organisation	Type of Local Authority / Organisation	Region	Urban or Rural*	IMD**	Diverse***
Case Study A	District Council/ HIA	North West	Urban / Significant Rural	89	Less diverse
Case Study B	City Council/ Independent non-profit	Yorkshire	Predominantly Urban	55	More diverse
Case Study C	District Council / HIA	South East	Predominantly Urban	182	More diverse
Case Study D	Unitary Authority / Arm's length HIA	North East	Predominantly Urban	5	More diverse
Case Study E	City Council/HIA	North West	Predominantly Urban	6	More diverse
Case Study F	Unitary Authority/ HIA	South West	Urban / Significant Rural	146-265	Less diverse
Case Study G	City Council/CC	East	Predominantly Urban	52	Less diverse
Case Study H	City Council/ Independent non-profit	South West	Predominantly Urban	65	More diverse

*Rural or Urban source - ONS Rural Urban Classification Look up tables
**ONS Index of Multiple Deprivation (1 most deprived)
***ONS Population Profiles for English LAs

3.1. Case Study A: Home improvement agency in the North West

Case Study A is a Home Improvement Agency (HIA) that provides adaptations, minor repairs, and energy efficiency improvements to households within a local authority in the North-West. The HIA is part of a district council and sits within the Health and Housing directorate.

A great proportion of the housing in the area is considered non-decent (23.5 per cent) compared to the England average of 16.7 per cent.

Case Study A provide the following services:

- Handy person services for people of retirement age or people with a disability.
- Disabled adaptations / Disabled Facilities Grants (DFGs).
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Winter Warmth Service - energy efficiency improvements and retrofit assessments.
- Welfare and benefits advice.

Case Study A work with a large range of external partners. As they are part of a district council within a two-tier authority they work closely with their county council partners. In addition to DFGs and minor adaptations, the HIA delivers a hospital discharge service for the county council. The hospital discharge service provides adaptations and small jobs that support timely discharge and patient recovery within an independent setting.

The HIA receive referrals from adult social care, Age UK, Citizens Advice Bureau, and general practitioners.

3.2. Case Study B: Non-profit in Yorkshire and Humber

Case Study B are a non-profit organisation providing home improvement services to people in Yorkshire and the Humber. They exist to help people maintain independence and quality of life within their homes through major and minor adaptations, and energy efficiency works.

In terms of housing quality, 20.8 per cent of dwellings in the local authority are considered ‘non-decent’ as of 2019. This is above the average for England of 16.7 per cent.

They provide the following services:

- Odd jobs / handy person services.
- Disabled adaptations / DFGs.
- Home repair grants.
- Hospital discharge and reablement services.
- Minor home energy efficiency improvements.

Case Study B work with a range of external partners. They are a contractor for the city council and the region's Integrated Care Board, for whom they deliver DFGs, minor adaptations and repairs, and support people discharged from hospital. These services support preventative health outcomes including falls prevention and avoidance of hospital readmission.

The service receives referrals from adult social care, general practitioners, mental health services, and voluntary and community groups. Case Study B also work alongside third sector partners, such as Groundwork, to deliver energy efficiency services.

3.3. Case Study C: Home Improvement Agency in the South East

Case Study C is a Home Improvement Agency (HIA) that provides adaptations, repairs, and energy efficiency and heating services. They are based within a district authority and are part of the council. The HIA's services support people within the district authority to live safely and independently within their home.

There is a lower proportion of dwellings considered 'non-decent' in the authority (12.7 per cent in 2019) than the national average (16.7 per cent).

They provide the following services:

- Healthy Homes Assessment / Home Safety Check.
- Odd jobs / handy person services.
- Disabled adaptations / Disabled Facilities Grants (DFGs).
- Grant assisted home repairs e.g. weatherproofing.
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Energy efficiency improvements and boiler servicing.
- Welfare and benefits advice.
- Information and advice on how to fund home repairs.
- Providing loans to low-income owners.
- Small grants e.g. dementia or assistive technology.

Case Study C work with a range of external partners. They work alongside other teams within the council to improve housing and health outcomes, for example they fund an occupational therapist within Adult Social Care to process DFG cases and undertake small repairs to remove residential hazards for the Residential Regulation team. They also deliver a dementia adaptations and assistive technology service with a local charity.

Case Study C receives referrals from general practitioners, hospital discharge teams, mental health services, and voluntary and community organisations. They also conduct outreach to promote their services in partnership with social services, hospitals, and faith and community groups.

3.4. Case Study D: Home Improvement Agency in the North East

Case Study D is a Home Improvement Agency (HIA) providing home improvements within this unitary authority. They are based in the local authority and provide prevention services through Adult Social Care. They are co-located and work closely with other services, including occupational therapy, reablement and assisted technology teams. A lower proportion of dwellings are considered 'non-decent' (15.3 per cent) as of 2019 than the national average of 16.7 per cent. There is a high level of deprivation within the local authority.

Case Study D provides the following services:

- Healthy Homes Assessment/Home Safety Check.
- Handyperson services.
- Disabled adaptations/DFGs.
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Making homes warmer/more energy efficient.
- Information and advice on how to fund home repairs.
- Providing loans to low-income owners.
- Small grants, e.g. dementia or assistive technology.
- Social prescribing hub.

They work in conjunction with local health and social care providers, mental health services, the fire service, and other voluntary and community organisations.

3.5. Case Study E: Home Improvement Agency in the North West

Case Study E is an independent charity that primarily operates within and is funded through the city council but provides some services that span across local authority boundaries into neighbouring boroughs. The proportion of non-decent dwellings is higher than the national average 19.2 per cent compared to 16.7 per cent as of 2019. Within the local authority there is a high level of deprivation.

Case Study E provides the following services:

- Healthy Homes Assessment / Home Safety Check.
- Odd jobs / handyperson services.
- Disabled adaptations/DFGs.
- Home Repair Grants.
- Caseworker service.
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Making homes warmer / more energy efficient.
- Welfare and benefits advice.
- Information and advice on how to fund home repairs.
- Providing loans to low-income owners.
- Small grants, e.g. dementia or assistive technology.
- Mental health support.

They work with various external partners, including Local Citizens Advice and other benefits and advice organisations, local GPs, local health and social care providers, Integrated Care Partnerships, and mental health services.

3.6. Case Study F: Home Improvement Agency in the South-West

Case Study F is a home improvement agency (HIA) providing a wide range of services, including adaptations, minor repairs, energy efficiency improvements and hoarding services to households in a local authority in South-West of England. The HIA is run by the local authority and currently sits within the Housing Directorate.

Ranging across the six districts, 13.8 per cent to 20.7 per cent of dwellings are considered 'non-decent.' This range spans the English average of 16.7 per cent.

Case study F provides a wide range of services, which include:

- Healthy Homes Assessment / Home Safety Check.
- Odd jobs / handy person services.
- Disabled adaptations/DFGs.
- Home Repair Grants.
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Making homes warmer / more energy efficient.
- Welfare and benefits advice.
- Information and advice on how to fund home repairs.
- Providing loans to low-income owners.
- Small grants, e.g., dementia or assistive technology.
- Social prescribing hub.

The HIA works with a range of stakeholders across different sectors, reflecting the breadth of its service offer. Within the local authority, key stakeholders include Occupational Therapists working in Housing and Adult Services Directorates and in local Independent Living Centres, and local authority social prescribing practitioners. The Health and Wellbeing Board and Integrated Care Partnership is also a key stakeholder, providing the strategic context and some funding to the HIA. External partners include local third sector organisations providing advice and support (for example Citizens Advice Bureaux, YMCA, and the Centre for Sustainable Energy); housing, health and social care providers (Housing Associations, GPs, adult mental health services, integrated care board); local 'blue light' services (fire service, ambulance service); national sector support, advisory and campaigning bodies (Centre for Ageing Better, Foundations, Empty Homes Network); providers of energy and retrofit services; and organisations involved in the governance and distribution of energy supply (Department for Energy Security and Net Zero, National Grid, UK Power Networks).

3.7. Case Study G: Home Improvement Agency in the East of England

Case Study G provides home improvement services in a city in the East of England. The service is located within the city council. The quality of the housing in the area is in line with the national average (16.7 per cent) as of 2019.

Case Study G provide the following services:

- Healthy Homes Assessment / Home Safety Check.
- Disabled adaptations/DFGs.
- Home Repair Grants.
- Hospital discharge and reablement services.
- Making homes warmer / more energy efficient.
- Welfare and benefits advice.
- Providing loans to low-income owners.
- Small grants, e.g. dementia or assistive technology.
- Social prescribing hub.

Case Study G work with various external partners, including Local Citizens Advice and other benefits and advice organisations, local GPs, local health and social care providers, Integrated Care Partnerships, mental health services, and other voluntary and community organisations.

3.8. Case study H: Home Improvement Agency in the South-West

Case Study H is an independent Home Improvement Agency (HIA) with charitable status operating in the South-West. Case Study H provides adaptations, minor repairs, energy efficiency improvements, home clearances, information and advice, and support moving home.

Case Study H works across three local authorities: Local Authority 1, a unitary authority; Local Authority 2, a unitary authority; and Local Authority 3, a county authority within a two-tier structure. The proportion of non-decent housing is slightly lower than the England average (16.7 per cent) in Authority 1 (16.2 per cent) and Authority 2 (15.8 per cent), but slightly higher in Authority 3 (17.3 per cent).

Case Study H provide the following services:

- Handyperson services for people of retirement age or people with a disability.
- Disabled adaptations / Disabled Facilities Grants (DFGs).
- Lists of trusted contractors to carry out home improvements.
- Hospital discharge and reablement services.
- Winter Warmth Service – energy efficiency improvements and retrofit assessments.
- Hoarding support e.g. property clearances, ongoing group support.
- Support for moving home e.g. identifying suitable properties.
- Lists of trusted contractors to carry out home improvements.

Case Study H work with a range of range of external partners. Their primary stakeholders are the local authorities that commission their services. They receive referrals from adult social care, environmental health, hospital discharge teams, and general practitioners. Case Study H also works alongside third sector partners to deliver complementary services, such as Dementia UK and local community hubs. And they receive funding from philanthropic grant providers and housing associations.

3.9. Funding

Across the case studies the level of funding varies, reflecting the variance in home improvement service size across England more generally. Total funding for the case studies ranges from £1.3 million to £10.1 million. (This compares to an income figure ranging from £538,000 to £18.7 million across the home improvement services responding to the online survey).

The most common funding source is the Disabled Facilities Grant (DFG), with amounts across the case study services ranging from around £500,000 to just over £8 million. Other funding sources include Warm Homes funding, local authority core funding and other pots of local authority money, health service funding, and financial reserves. Some case studies raise additional funding through philanthropic grants, adaptations paid for privately by households, and handy person services for social landlords.

3.10. Staff teams

Staff teams vary in size and make-up. They typically range from around ten to twenty-five staff members, although there are larger teams of thirty and fifty staff members. Staff teams comprise a mix of delivery staff including handy persons, caseworkers, technical officers, and sometimes Occupational Therapists (OTs), as well as managerial and administrative staff. The largest staff team also includes a central customer services team. Home improvement services with larger DFG budgets tend to have more staff, although there are one or two exceptions with the case studies. (The online survey results show that organisations receiving £3million and above generally employ more than 20 staff. Organisations with less than £2million of DFG funding tend to employ ten staff or less).

3.11. Job roles

Caseworker

A caseworker is typically responsible for client triage, liaison, and support, although whether this applies to major or minor adaptations varies between services. Their role is often flexible dependent upon the changing nature of the service, and can include diagnosing minor adaptations, benefits advice, community outreach and signposting to other services. Caseworkers will work closely with stakeholders and other agencies to deliver effective services, for instance social care and third-sector partners.

Responsibilities of the typical caseworker include:

- **Client assessment and triage:** Assessing the client's needs, including medical conditions, mobility requirements, and living environment. Typically conducted in partnership with either occupational therapists or a Technical Officer.
- **Providing and installing equipment:** providing and installing equipment to improve accessibility and health and safety in the home, for example raised toilet seats and perching stools.
- **Client liaison:** liaising with clients throughout and after installations to ensure works are completed in a timely and effective manner, and that clients are satisfied.
- **Signposting:** signposting to other services within the organisation, or to outside agencies, to support client wellbeing.
- **Accessing funds:** accessing grants to fund adaptations and repairs to the clients' homes, especially where the works are not covered by Disabled Facilities Grant (DFG).

- **Stakeholder management:** maintaining relationships with key stakeholders, including the local authority, social care, hospitals, and healthcare services, and third sector partners. Typically conducted in partnership with the Head of Service or a Technical Officer.

Responsibilities of a caseworker that vary between case study locations:

- **DFG applications:** assessing client eligibility for DFG and overseeing subsequent applications, typically if the client has self-referred to the service rather than through social care. This is most common among HIAs within local authorities, whereas independent services will referrals after social care have already completed this process – e.g. delivered in Case Study A and Case study C.
- **Benefit checks and applications:** assessing the eligibility of referrals for benefits such as Attendance Allowance and overseeing subsequent applications –e.g. delivered in Case Study A, B and E.
- **Diagnosing and managing minor adaptations:** diagnosing and prescribing minor adaptations such as grabrails and second handrails, and project managing the adaptation to completion – delivered in Case Study A where caseworkers are trained to Trusted Assessor Level 4.
- **Minor adaptations:** installation of some small adaptations e.g. grabrails – delivered in Case Study B, although caseworkers have to volunteer to be upskilled to provide minor adaptations.
- **Project managing major adaptations or repairs:** project managing some major works, including stairlifts funded by DFG, and window and door replacements – e.g. delivered in Case Study A and Case Study C.
- **Managing heating repairs and servicing:** managing central heating servicing and repairs, including assessing client eligibility for free boiler servicing, client liaison and follow-up, and managing contractors – e.g. delivered in Case Study C.
- **Community outreach:** promotion of the service through campaigns, attendance at local events and community groups, and building networks with third-sector organisations – e.g. delivered by caseworkers in Case Study A, and by a dedicated Outreach Worker in Case Study C and Case Study B.

For example, in Case Study E caseworkers do home visits and provide a range of advice on housing, benefits, living costs, and signposting to other services if needed. Specifically, clients often need help with navigating the benefits system. Caseworkers support with things like Blue Badge applications, council tax reduction applications, signposting to mental health support (e.g. bereavement counselling), etc. At an initial home visit caseworkers spend up to 2-3 hours with the client, introducing themselves and the service and supporting them with completing any forms. They will then schedule a follow-up a couple of weeks later.

In Case Study G, caseworkers are the core of the service. They are a single point of contact for the client throughout their engagement with the home improvement service and provide personalised support. They are also Trusted Assessors. They can refer the client on (e.g. to technical officers) for further support if needed. Caseworkers usually go out with OTs for client assessment visits and will relay information from technical officers to clients.

Handyperson

Responsibilities of the typical handyperson role:

- **Minor adaptations:** Providing minor adaptations and installations to improve home accessibility and safety, including (but not limited to) grabrails, stair handrails, key safes, smoke alarms.
- **Minor repairs:** Undertake minor repairs to remove health and safety hazards and improve wellbeing in the home, including (but not limited to) securing carpets, fitting toilet seats, fitting kitchen drawers and shelves, replacing lightbulbs, and installing chain locks on doors.
- **Making properties suitable following hospital discharge:** Making properties suitable to allow people to recover following hospital discharge e.g. moving or removing items to facilitate living on the ground floor.
- **Responding to customer requests:** Responding to customer requests that may arise during an appointment, either by carrying out minor repairs or adaptations, or signposting customers to appropriate colleagues/services.

Responsibilities of a handyperson that vary between case study locations:

- **Ramps:** Installation of ramps to enable step free access to the home – e.g. this is provided by Case Study A, but by contractors in some other areas elsewhere.
- **Damp prevention:** Small repairs and jobs that may prevent damp ingress to the home e.g. gutter clearances and repairs – provided by Case Study B as part of their asthma alleviation service.
- **Diagnosing need:** Understanding and assessing customer need to diagnose and tailor necessary adaptations e.g. the placement of grabrails – e.g. Case Study A handypersons are trained to Trusted Assessor Level 3, which allows them to make decisions such as where to place grabrails, whereas these decisions are made by the Council's occupational therapists in Case Study B and Case Study H.
- **Assistive technology:** Provision and installation of assistive technology e.g. dementia friendly alarm clocks – provided by handypersons in Case Study C.

For example, in Case Study E the handyperson team undertake DIY jobs, usually taking around 1.5 hours. This can include assembling flat pack furniture, grab rails, curtains, lights – any jobs that the client is unable to do themselves. If the jobs are larger, they are referred to the technical support team who advise on larger jobs and carry out larger home repairs (e.g. roofs, electrics, heating). The handyperson team is managed by a coordinator who manages the day-to-day tasks and weekly planning.

Technical Officer / Surveyor

The Technical Officer / Surveyor typically oversees the delivery of Disabled Facilities Grant (DFG) adaptations and other major repairs and/or adaptations. They work closely with occupational therapists, local councils, and contractors to assess client needs, design, and implement suitable adaptations, and ensure projects are completed on time and within budget. Example adaptations include wet rooms and level access showers, ramps, property extensions, and improvements to the building fabric (e.g. new windows, doors).

Responsibilities of the typical Technical Officer / Surveyor:

- **Client assessment:** Assessing the customer's needs, including medical conditions, mobility requirements, and living environment. Typically conducted in partnership with either occupational therapists or a caseworker.
- **Project planning:** Developing detailed project plans, including technical drawings, architectural plans, and cost estimates.
- **Contractor management:** Source and manage contractors, including tendering or assessing quotes to ensure value for money, and ensuring contractors adhere to project specifications and timelines.
- **Stakeholder communication:** Maintain effective communication with clients, occupational therapists, local councils, and contractors throughout the project lifecycle.
- **Planning application and building compliance:** Ensure all projects comply with building regulations, relevant standards and planning legislation, including the management of planning applications.
- **Post-Project Follow-Up:** Conduct post-project inspections and address any snagging issues.

Responsibilities of a Technical Officer / Surveyor that vary between case study locations:

- **Low-cost finance:** arranging and administering low-cost finance options to fund works above the DFG cap – e.g. delivered in Case Study C.
- **Energy efficiency assessments and implementation:** domestic energy assessments according to PAS 2035 standards and project management of subsequent energy efficiency works e.g. insulation, low-carbon central heating – e.g. delivered in Case Study A.

For example, in Case Study G technical officers conduct a survey with contractors and using the OTs recommendations for works. Technical officers produce a pre-phase construction plan (which includes health and safety information for the contractors and key information about hazards, such as trees and utilities). The contractors then produce a construction phase plan, and then work commences. Technical officers do site visits over the course of the work and inspect it at the end. The admin team keep the client informed of when the caseworkers, OTs and technical officers will visit and about when work will begin.

Technical officers may undertake an options appraisal for more complex cases (at least three options), including drawings and costs for each. This is discussed with other professionals at a panel meeting and the most appropriate option is selected (accounting for what is reasonable and practicable, and considering the impact on the family). The technical officer will visit the client and talk through the chosen option in full. Clients can ask questions and give their feedback. These views will be taken into account as clients know their home and circumstances and may suggest something that has not been considered.

Customer service assistant (CSA) / Administration assistant

Typical responsibilities of a CSA / administration assistant:

- **Client queries:** receiving, handling, and responding to client queries and referrals in a courteous and helpful manner.
- **Receiving referrals:** receiving referrals from outside agencies such as social care or hospital discharge and allocating them to the appropriate team.
- **Complaints handling:** handling and responding to client complaints, including the identification and implementation of a resolution.
- **Scheduling:** scheduling the handypersons service.
- **Administration:** general administration duties as required.

Responsibilities of a CSA / administration assistant that vary between case study locations:

- **Information and advice:** providing information and advice on home improvement schemes, for example available government loans and grants, and compiling and providing lists of trusted contractors in the region – e.g. delivered by Case Study H.

For example, in Case Study D the administration team is key in supporting referrals to different parts of the services (including to occupational therapy). Many people come into the service through self-referral (including family, friends, neighbours as well as themselves). The admin team answer these phone calls and receive a wide spectrum of enquiries (e.g. handyperson requests, chasing up adaptations, hoarding, digital inclusion) and they assess which services a person may require to direct their enquiry within the home improvement agency or to wider services. They receive around 20-30 calls each day.

Occupational therapists

Occupational therapists (OTs) are connected to home improvement services and are sometimes part of in-house teams. An OT's role involves conducting DFG assessments, drawing up, and reviewing plans to ensure the proposed adaptation will meet the individual's needs. OTs work within the DFG process often with a range of external partners. Panel meetings are held to discuss more complex cases that may require major adaptations through DFG funding.

Across the case studies OTs usually assess more complex cases. The roles of OTs differ depending on whether they are, for example, a housing OT or a social care OT. As well as providing support with the DFG process, Housing OTs can assist with advising on the design of new builds, rehousing, and other services.

In some areas (Case Study G) caseworkers tend to go out with OTs for client assessment visits. Typically, referrals for major and minor adaptations often come from OTs (particularly via health OTs and community therapies).

Case Study D has a positive relationship with the council's occupational therapists (OTs) and receive many of their referrals via this route. To ensure OTs are aware of the services available that they can refer in to, new and student OTs spend half a day with the handyperson service and a half a day with other connected teams. There are also rotational OTs (who are on NHS contracts) that work with the reablement team for nine months at a time. This was also felt to support the referral process to the home improvement service as OTs were more aware of the available services.

Section 4

The nature and scale of home improvement services

Home improvement services and agencies are usually commissioned by local authorities and support several strategic objectives for commissioners around for example, prevention, independent living, reducing health inequalities, and minimising exposure to risks such as falls and excess cold.

They often carry out DFG funded home adaptations, and other works and repairs through handyperson schemes. Some organisations deliver a range of other services including hospital discharge and reablement, support to make homes warmer, small grants and loans, and information and advice.

The sector is diverse, and whilst there are still some independent home improvement agencies, many services now sit in local authorities. Some services concentrate on providing statutory grants whilst others are engaged in the wider system and are actively delivering a range of solutions to enable older and disabled people to keep safe, warm, and secure in their home.

We conducted an online survey to find out about home improvement services, the type of services they deliver, who receives these services and benefits from them, and how services are funded.

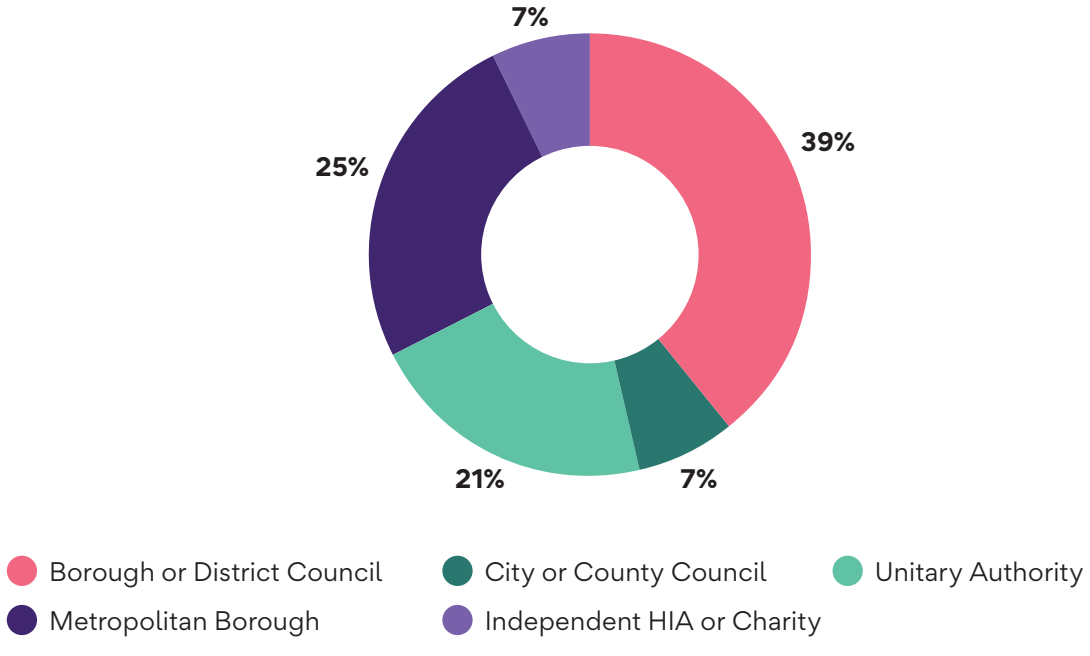
This chapter provides an indication of the nature and scale of home improvement services in England reported in the survey including responses from the case studies. It should be noted that the survey is not a representative sample of home improvement services and is based on 28 responses. Qualitative data from the case studies is also drawn upon to provide further detail and context.

4.1. Who provides services

Evidence gathered during the scoping phase indicates that reductions in funding for housing renewal over the last decade and the loss of ring-fenced Supporting People programme has impacted home improvement services and how they are provided. When the Supporting People programme was introduced in 2003, specific ring-fenced funding meant there was a defined model of what a home improvement agency was. Lots of local authorities and housing associations were able to set up home improvement agencies (HIAs) based on this model because there was a defined funding stream. However, the loss of the ring fence, the financial crash, and increasing pressure on housing associations to generate profits through building new homes has resulted in a reduction in the number of home improvement agencies overall and led to more services moving back in-house to local authorities.

Most responses to the survey were from local authorities providing home improvement services. A small number of independent HIAs or charities also responded. The largest group of local authorities who responded were second tier Borough or District Councils. Figure 4.1 shows the full spread of organisation types.

Figure 4.1: Types of organisations



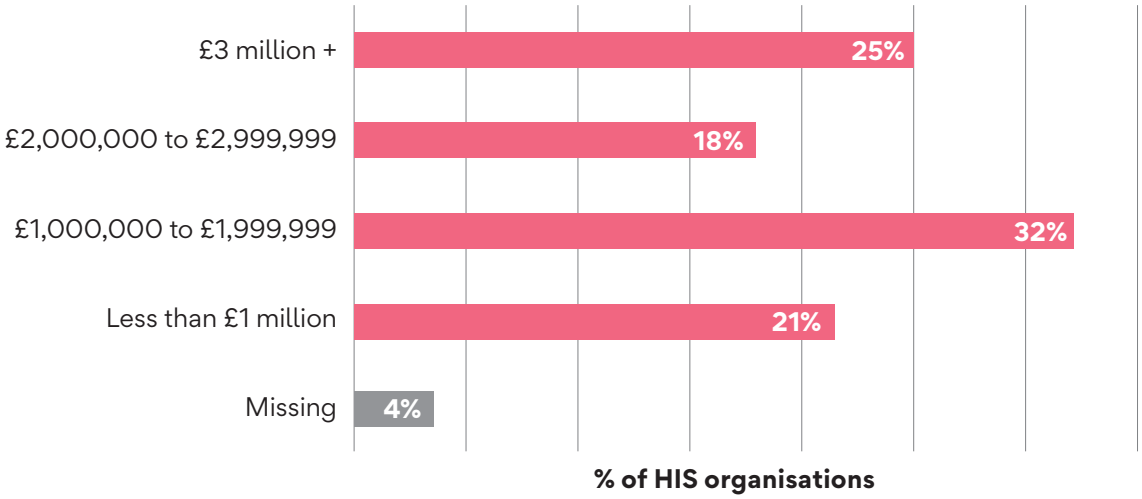
4.2. Funding

Changes in funding mean that many traditional home improvement services focus on Disabled Facilities Grants (DFGs) as this is where most funding is available. DFG funding has been increasing over recent years. According to Foundations the £625 million allocated for DFG in 2024-25 represents a 184 per cent increase in funding for home adaptations since 2015.[41]

Most of the funding received by the organisations responding to the survey came from their DFG allocation. More than 90 per cent of home improvement service organisations in the survey provide disabled adaptations service or DFGs and three quarters of them receive more than £1million in DFG funding.

Figure 4.2 shows that a quarter of home improvement services received more than £3million DFG funding during the previous year that they had records for. Almost a fifth (18 per cent) of organisations received between two and three million pounds in DFG funding and just under a third (32 per cent) received between £1million and £2million. Although a fifth of the organisations report receiving less than £1million in DFG funding, overall, the organisations received substantial amounts of funding with most of their funding often from their DFG allocation.

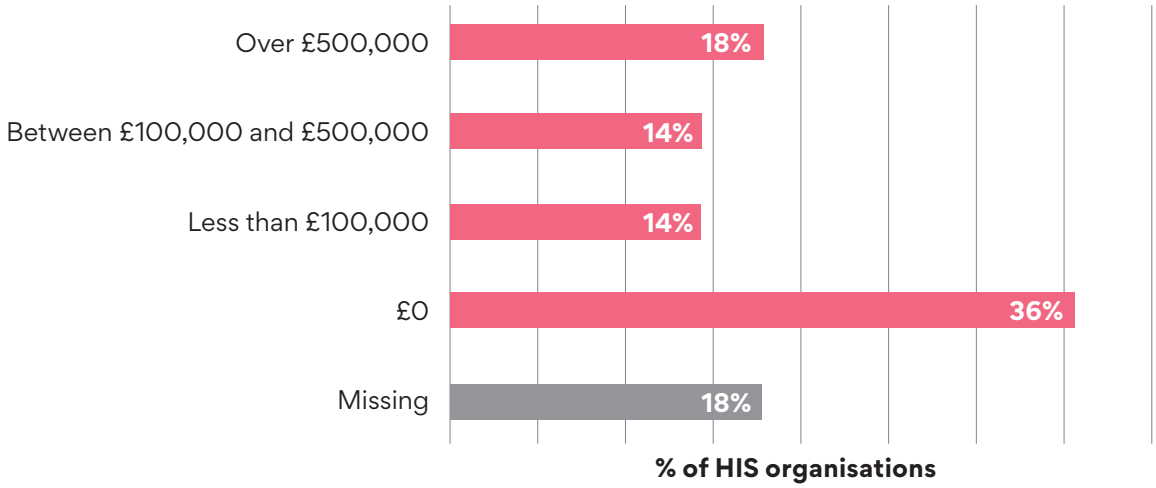
Figure 4.2: DFG Allocation



[41] Performance of Housing Authorities in DFG Delivery (foundations.uk.com)

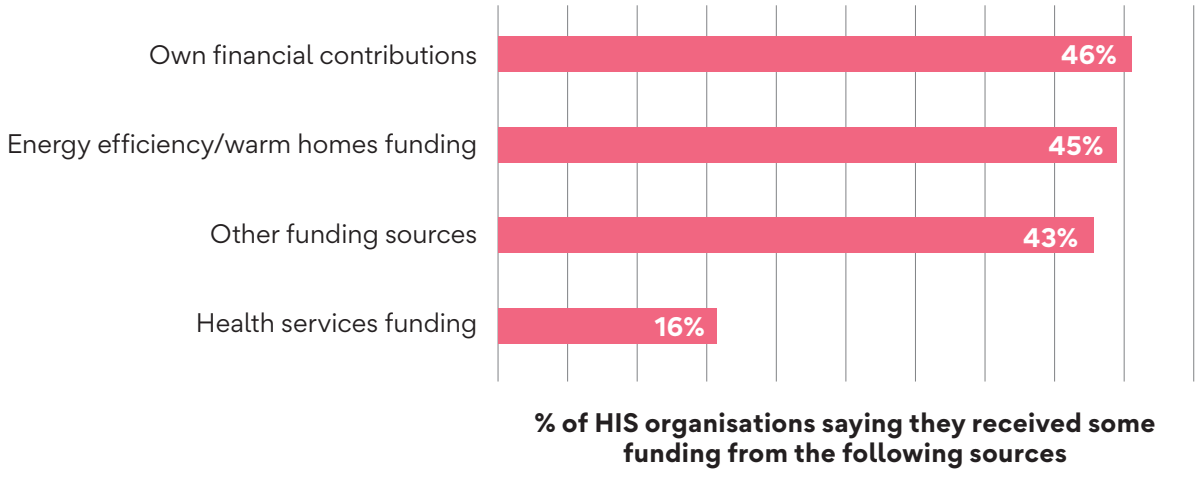
Almost half of home improvement services in the survey also receive funding from other local authority sources excluding DFGs. Whilst other local authority pots of money often make up the second biggest source of funding for home improvement services, the amounts reported are less than DFG funding received, and just over a third of organisations say they receive no funding from other local authority sources (Figure 4.3).

Figure 4.3: Other local authority funding sources (excluding DFGs)



Almost half of the organisations responding to the survey make their own financial contributions to the service and a similar proportion, 45 per cent, receive energy efficiency or warm homes funding. More than two thirds of services receive funding from other sources. A smaller proportion of organisations (16 per cent) say they receive Health Service funding (Figure 4.4).

Figure 4.4: Proportion of Home Improvement Services who receive funding from...



We asked home improvement services whether funding has changed and whether it is likely to change in the future. Most organisations responding to the survey say that their funding has been stable or increasing over the past three years and expect it to stay the same or increase a little over the next three years.

Of the seven case study responses, four reported that their funding has increased over the past three years (three of them by over 20 per cent), one that it has stayed the same and the other that it has decreased a little. Case studies are cautious about what is likely to happen to their funding over the next three years. Online survey responses show that two of the case studies expect funding to increase a little and two that it will stay the same. The other three case studies expect funding to fall (one of them by a lot i.e. over 20 per cent). The case study that did not complete the online survey reported experiencing funding challenges in the past and that it will likely do so in the future.

Figure 4.5: Funding change over the past three years (in real terms)

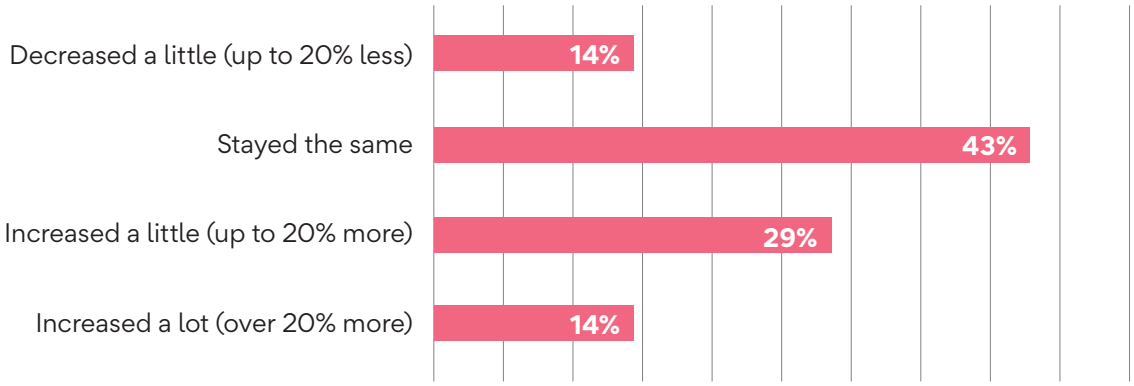
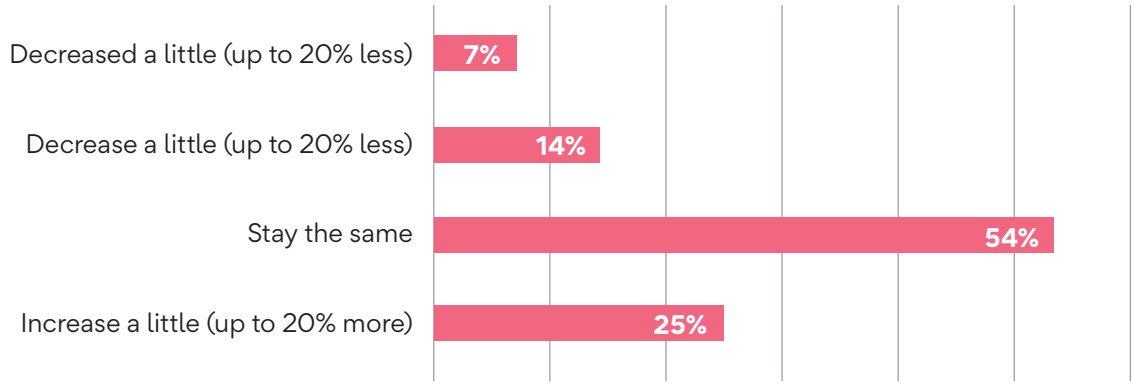


Figure 4.6: Expected funding change over the next three years (in real terms)



The seemingly positive picture of stable funding, however, should be set within a context of the increasing costs of adaptation work, greater need, and a growing demand for services which is outstripping funding that is expected to stay the same, or increase a little (less than 20 per cent) in the next three years.

A fifth of organisations responding to the survey report that funding is likely to decrease in the future, and other evidence from the case studies suggests that services are concerned about funding. Although funding may be stable there is a sense that in real terms funding is not going as far.

Rising costs and increasing demand mean that the DFG allocation is not going as far as it did, and local authorities are beginning to struggle to maintain discretionary grants.

...but local authorities are now beginning to struggle in terms of you know perhaps where they might have used discretion to enhance what they were doing in terms of that HIA model, I think there are now pressures on the budget.

National stakeholder

The DFG review[42] found that despite greater central government investment more adaptations are not being completed. Over recent years the value of grants for adaptations has increased. Latest evidence[43] shows almost half of grants are now between £5,000 to £15,000 in 2022/23 compared to staying around 35 per cent over the whole period between 2009 to 2019/20. This reflects significant and ongoing increases in labour and material costs across the country. For example, one national contractor interviewed for the evaluation told us they have been applying price increases twice per year to keep up with inflation.

Uncertainty around local authority funding is also adding to a sense of insecurity for home improvement services. During the evaluation two of the case studies either had a service that was cut or lost for a reason that was unrelated to performance. Another case study (Case Study E) had to reduce their staffing levels because of funding challenges (despite very high levels of demand and struggles with capacity). Five staff members had taken voluntary redundancy and 17 had reduced their hours.

Cuts to local authority core funding mean some areas have scaled back their home improvement agency offer.

[42] DFG_Review_2018_Summarypdf (publishing.service.gov.uk)

[43] Performance of Housing Authorities in DFG Delivery (foundations.uk.com)

Case Study H reported that their core funding from local authorities has declined in its real value over the past decade. Over time a larger proportion of their income has come from other funding sources, including philanthropic grants, adaptations paid for privately by households, and handy person services for social landlords.

Almost half of the home improvement organisations responding to the survey state they are using their own financial contributions, and one case study is utilising a diminishing pot of funding reserves to support and maintain services. These findings suggest that services across the sector may be making such contributions to plug other funding shortfalls.

... at that point we had some reserves in our home improvement agency funds so we decided we would maintain all the services; we'd carry on exactly as we were and we'd use our reserves up and in the meantime we would look at other options to bring in other funding and generate income with the aim of trying to sustain the services that we had at no cost to the council.

Case Study A

The case studies may demonstrate a possible reason why some services feel like their funding is going to stay broadly consistent. It is evident that case study services are having to take a more proactive approach to identifying alternative or supplementary sources of funding. However, in managing the process of seeking other funding possibilities it is apparent that capacity for other things is being stretched and securing external sources of funding is becoming more challenging.

Making sure there is enough funds to keep us going for another year is a constant battle, but I would say it's getting harder.

Case Study A

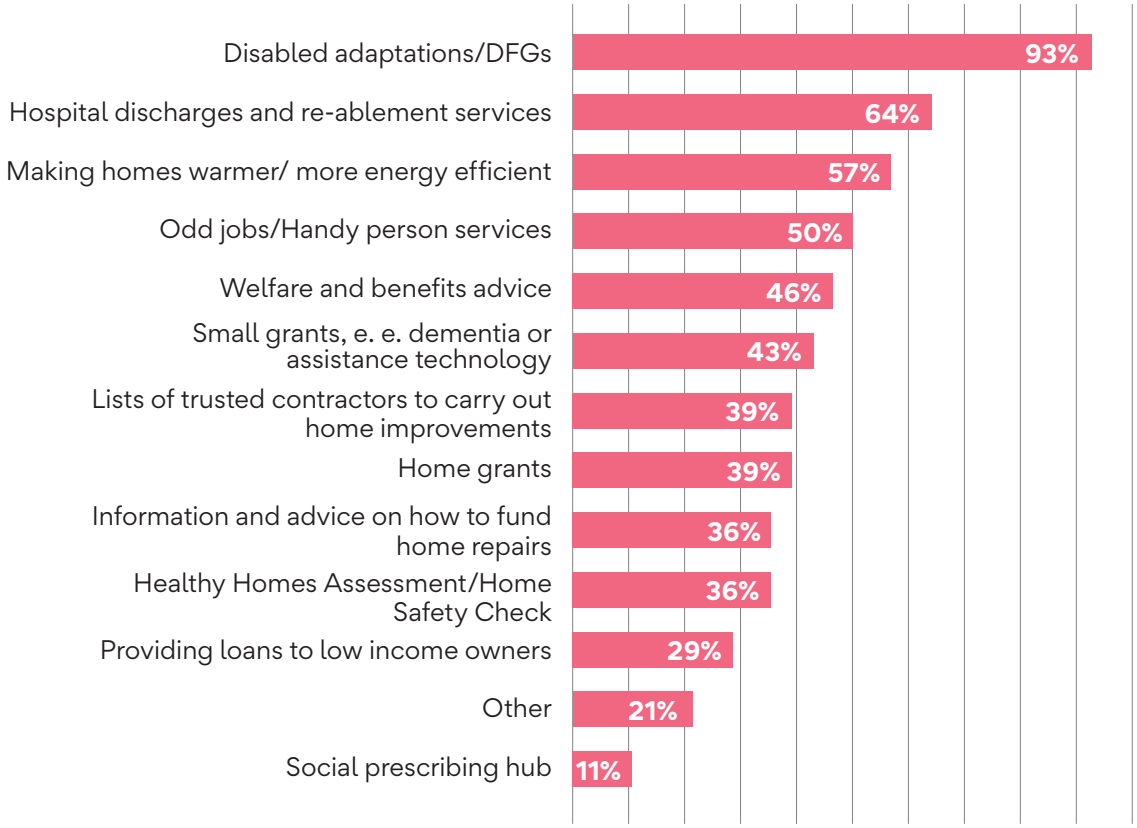
4.3. What services are delivered

Most home improvement service organisations provide disabled adaptations or DFGs to enable residents to carry out adaptations. Just under two thirds (64 per cent) of organisations said that they provide hospital discharge and reablement services, and 57 per cent say they provide services to make homes warmer or more energy efficient. Half of respondents said they provided an odd job or handyperson service. Less common services include providing information and advice on how to fund home improvements, and Healthy Homes Assessments or home safety checks, which are provided by just over a third (36 per cent) of organisations responding to the survey (Figure 4.7).

The significance of hospital discharge services was highlighted by a national contractor performing works to prepare homes for hospital discharge. They stated that this is the main way they now work with local authorities as other funding previously available has been cut so much.

All the services outlined above are provided across the case studies. Results from the survey show that, apart from DFGs which most organisations provide, a larger proportion of the case study organisations are delivering the other services asked about in the survey than the other organisations responding. Compared to other organisations who answered our survey, a greater proportion of case studies provide social prescribing hubs (three case studies), small grants, hospital reablement services and services that help people to make their homes warmer.

Figure 4.7: Services provided by HIS Organisations

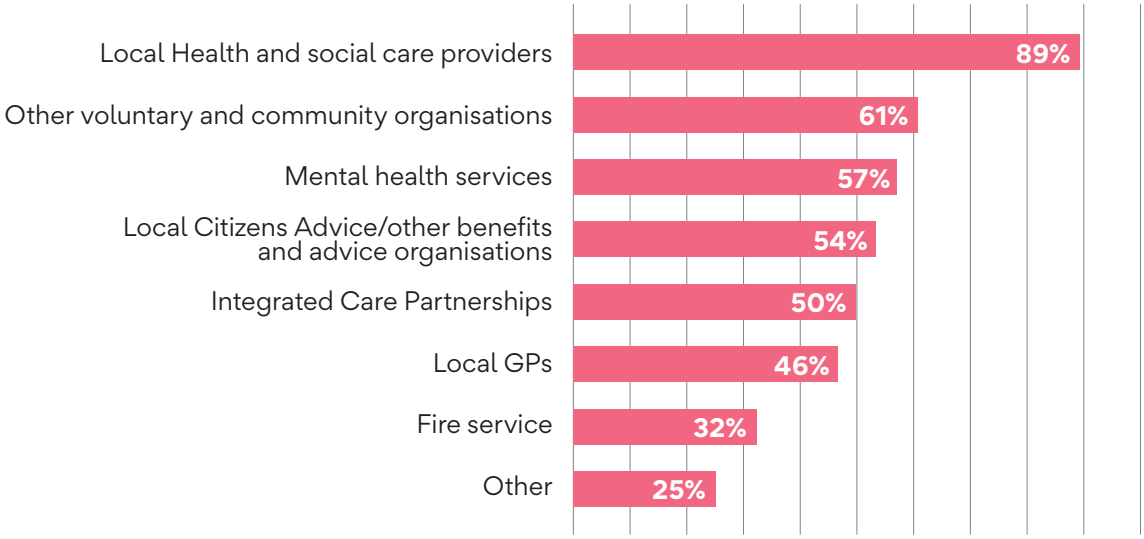


4.4. How closely do the home improvement services work with related service providers

The online survey reveals that home improvement services work with a range of other organisations (see Figure 4.8). Most (89 per cent) have worked with local health and social care providers over the past three years. Sixty-one per cent say they have worked with other voluntary and community organisations, and 57 per cent say they have worked with mental health services. Other organisations include:

- Central government.
- Faith groups and other groups their clients are involved with.
- Hospitals.
- Local authorities and other local authority departments.
- Centre for Ageing Better.
- Foundations.
- YMCA.
- Empty Homes Network.
- ROVI Homes.

Figure 4.8: Other organisations worked with over the past three years



The case studies work closely with a range of partners and stakeholders across different sectors reflecting the breadth of their service offer. They take a proactive approach to developing close working relationships to deliver specific projects and services. For example, three of the case studies are working within multi-disciplinary partnerships to deliver social prescribing hubs aimed at supporting people whose wellbeing is suffering because of something connected with their housing circumstances. Services work with charities to deliver projects e.g. working with Age UK to deliver hoarding intervention projects, and/or signpost to charitable funding if available.

Several of the case study home improvement services are integrated with a wider network of local authority services, health and care providers, and third sector organisations delivering services such as hospital discharge and funding OTs. This includes one case study being co-located with several connected independent living services, such as OTs and reablement, and independent living hubs or centres.

One of Case Study C's key successes has been to fund an OT in the County Council to assess DFG claims which prevents the interface between social care and the HIA from becoming a source of delay. This has reduced the waiting list and allowed the County Council adult social care to focus on higher priority cases. Case Study D is part of the authority's Independent Living Services and works closely with services in this department, including council occupational therapy, assistive technology and reablement.

The service delivered by each case study usually supports several of their respective local authority's strategic objectives across themes such as housing, health, and wellbeing, and may align with Integrated Care Board priorities.

For example, Case Study B works through a specialised housing and health programme, that spans priorities in the council's Housing Assistance policy and Health and Wellbeing strategy, aimed at enabling independent living through improving health at home and preventing falls and cold related health conditions and illness. Commissioned by the council this service has become a single streamlined service requiring Case Study B to work more closely in collaborating with their partner organisations.

Before the council had one service that did hazard repairs, one service that was about hospital discharge, and one service that were doing warmth measures and we thought these are all kind of the same service. What we want to do is have a more streamlined, holistic service.

Case Study B

Each local authority must produce a Better Care Fund Plan that needs to respond to various key lines of inquiry including how strategically the DFG contributes to their Better Care outcome and the wider health and social care system. The main drivers being around prevention and hospital discharge. All the case studies deliver hospital discharge and reablement services and have strong relationships with NHS and voluntary sector service providers. The case study organisations play an important role in partnerships that are working to facilitate more efficient hospital discharges.

Case Study E is part of the voluntary sector hospital discharge group (comprised of funded providers) and have an operational partnership within that group. Similarly, in another area, Case Study B is part of a consortium with a further twelve delivery partners. The home improvement service is the only organisation in the group with a reach across the whole of the city area, and the only organisation with the capacity to deliver home adaptations. They were described as the '*lynchpin*' of the service by one stakeholder. A member of staff from the service explained the process of integration and collaboration.

We've had to jump through a lot of hoops as a HIA to get onto the trusted partnership side of NHS, we even have NHS emails now. So hospital discharges will come to us to say a patient needs to get out of hospital, but they can't go home until they've got grab rails on their front door, or handrails up their staircase. So we'll work closely with the NHS to get a home ready for somebody to be able to leave hospital.

Case Study B

In another area, a stakeholder commented on how the positive approach from Case Study A and the commitment from the home improvement agency's employee, has been key to cementing relationships.

He actually goes and sits in our offices quite regularly and supports the team. [...] He's made himself known. He keeps repeating who he is and what the pilot is about. He's really, really established himself there. He's been really positive, very approachable for staff who can ask him any sort of questions. And again, they've been a big driver in the hospital to get that relationship with the [Name] therapy team.

Case Study A

One stakeholder felt that more mature and developed home improvement services, like the case studies, tend to have better strategic approaches and aligned to those that are described in Chapter 2 of the DFG guidance. This part of the guidance sets out what good local strategic and operational collaboration looks like and how local health, social care, and housing authorities can work well together with housing providers to deliver more personalised support.[44]

> **Where there is that really good strategic understanding around how a HIA can actually support what we're doing as a system in terms of health and social care compared to perhaps the local authority where perhaps there isn't that strategic alignment.**

National stakeholder

It was acknowledged that integration could be hampered by a lack of strategic direction at the local authority level. For example, one interviewee felt that integration between Case Study C and the County Council was hindered by the lack of strategic direction at the county level, despite the county commissioning district home improvement agencies.

> **[The County Council] have no housing strategy, no unifying picture about what the state of their housing is and how their housing serves the needs of residents.... I think county councils can have a tendency to go 'District councils do housing. District councils do that.' So if there's to be a history of better partnership working on those projects and relationships, that's one of the drivers or levers. How is housing viewed and is it a joint project that everyone shares?**

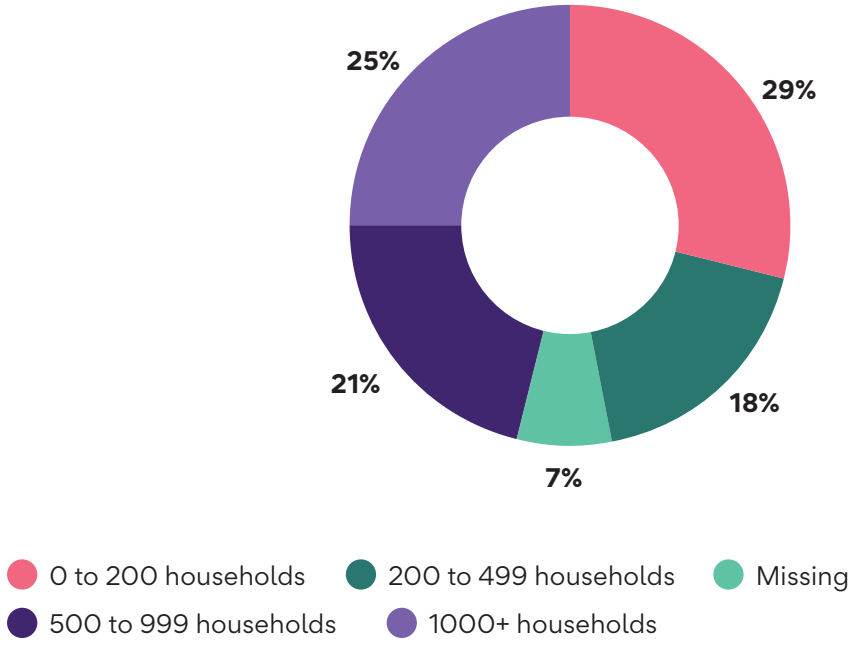
Case Study C

4.5. The number of households supported

There is a wide variation in how many households are supported by each home improvement service. Our survey asked how many households were supported by the home improvement service over the previous year that the service has data for. Almost half of the organisations responding had supported up to 500 households in the space of a year. A fifth of organisations has supported between 500 and 1000 households, while a quarter of organisations reported that they had supported 1,000 or more households (Figure 4.9).

[44] Disabled Facilities Grant (DFG) delivery: Guidance for local authorities in England - GOV.UK (www.gov.uk)

Figure 4.9: Households supported by Home Improvement Services



All the case studies typically support well over 1000 households annually. Figures for the most recent years collected indicate the case studies supported thousands of service users. For example, Case Study E has contact with around 6,000 clients a year (around 10-12,000 contacts overall). In 2022-2023, they helped the following number of people.

- 1919 supported to assess how to improve their home / Healthy Homes Assessment.
- 6702 Home repairs or handyperson visits.
- 164 grants for disabled adaptations/ DFGs.
- 414 grants to make home improvements (in addition to DFG).
- 862 people helped to find a Trusted contractor to carry out home improvements.
- 11956 people helped with hospital discharge and reablement.
- 254 people helped to make their homes warmer / more energy efficient.
- 1335 people who received welfare and benefits advice.
- 1044 people who were given information and advice on how to fund home repairs.
- 23 people supported with loans to low income owners/support to self-funders.

- 19 people helped with Dementia Grants.
- 96 people benefited from other support provided.

Case Study D supported 2,880 people in the financial year 2023-24 via a range of services. The service visits approximately 3000 homes a year (this number does not include visits through telecare support). Most of these visits (around 2,000) are from the handyperson team. These 3,000 individuals often receive several different services following their initial contact.

In 2023-24 they delivered the following:

- 2,400 Home repairs or handyperson visits.
- 262 grants for disabled adaptations/ DFGs.
- 30 people were helped to find a Trusted contractor to carry out home improvements.
- 183 people were helped with hospital discharge and reablement.
- 241 people were helped to make their homes warmer / more energy efficient.
- 146 people were given information and advice on how to fund home repairs.
- 900 people were referred from local health and social care providers.

Home improvement services are supporting more households and most expect demand for their services to continue to rise (Figure 4.10). Over three quarters of organisations responding to the survey said that the number of households they have supported over the past three years has increased, with almost 40 per cent stating that the increase was over 20 per cent. The same proportion of organisations also expect the number of households they support to increase over the next three years (Figure 4.11).

Compared with other organisations who answered the survey, a greater proportion of case studies said the number of households supported over the past three years has increased. Similar proportions of case studies and other organisations said they expected the number of households to increase over the next three years.

Figure 4.10: Change in number of households supported over the past three years

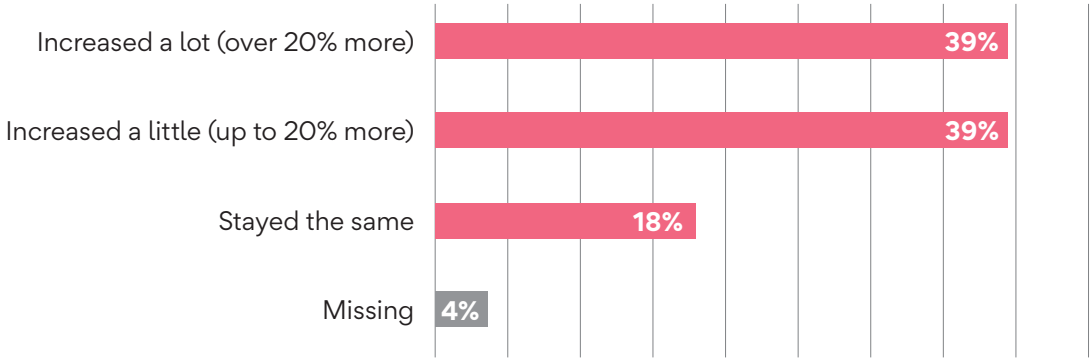
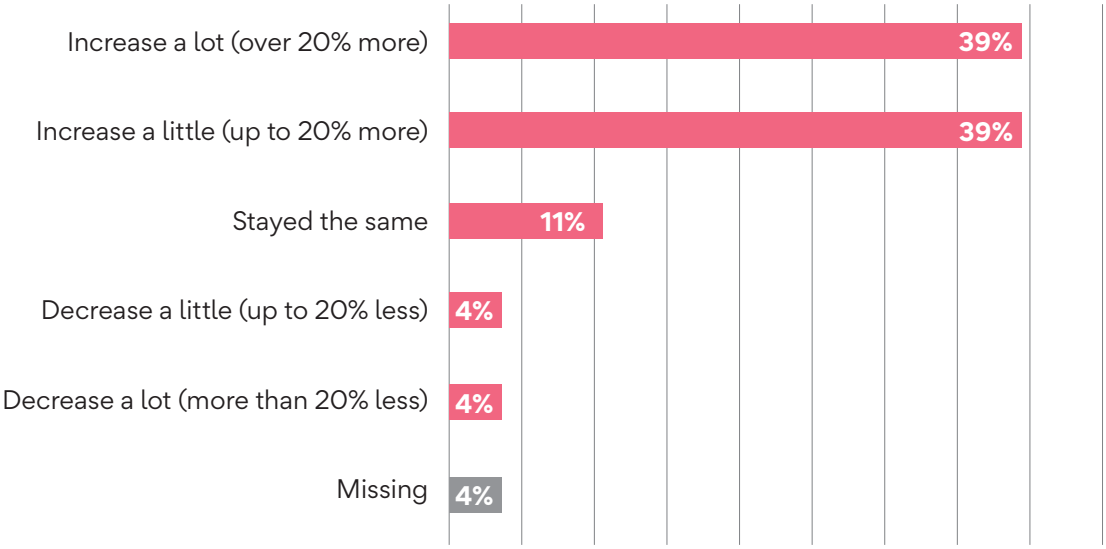


Figure 4.11: Expected change in the number of households supported over the next three years



4.6. Who is being supported

Home improvement service users are mainly older people, people with a disability and/or health condition, owner occupiers, and those on low incomes. The demographic and tenure breakdown may vary slightly with varying emphases across services, but this pattern holds true across different services and areas.

For instance, in Case Study A, 81 per cent of jobs for minor adaptations and repairs are carried out in owner occupied homes, ten per cent in private rented, six per cent in council homes and only three per cent in housing association properties. The tenure composition for DFGs looks slightly different with 62 per cent owner occupiers, 16 per cent housing association and 22 per cent private rented.

In case study C, the Safe and Secure Grant is available to people with a disability or aged 60+, owner-occupiers, and those on low incomes. This is reflective of the HIA's objectives which are to promote independence, health, and security among people with disabilities and older people.

Specific services such as DFGs also support a mix of adults and children. For example, a housing Occupational Therapist and Technical Officer working on DFGs in Case Study F reflected that much of their work supports children and families with complex care needs. Minor adaptations (up to £1,000) are available free to anyone if they require an adaptation to remain in their home.

...everybody's entitled to have a grab rail if that's what they need to keep them safe in their home.

Case Study H

A range of other services also offered by the case studies target support at people who are at risk of fuel poverty, at risk of falling, have a cold related illness, or are returning from hospital.

Eligibility rules for commissioned services often vary by age and between different services. There is evidence that age thresholds are increasing due to funding constraints and the greater needs of older clients. For example, Case Study E recently increased the age cut off from 60 to 65. Clients under 60 can be referred to the service if they are in receipt of a benefit. In Case Study D, means testing is applied to people over 65.

However, there are challenges associated with assessing who needs services most. Having an age eligibility criterion is imperfect and can lead to unfairness. People below these cut offs can obviously be in more vulnerable circumstances and may need the service more.

There's a bit of unfairness in there. Once you're over 66 it's much more and you could be 64 and have to pay a full contribution because you work or whatever, so there's that right across.

Case Study D

Interviewees described looking at each case individually and managing people's expectations. When appropriate, this involved encouraging people who may be less vulnerable to access support elsewhere if they can. Budget cuts mean that staff were having to have these conversations with people more often.

I know we all do the same kind of thing but if you've got family there why are you not asking them first? But then you get 'Well my friend down the road said you'll just pop round and do it'. It's trying to do judgement calls and by asking them appropriate questions to make the judgement call, to not be too hard and fast over it.

Case Study D

Across the case studies there is less information on the ethnic background of people using their services. Annual DFG data returns indicate that many local authorities do not collect data on the number of grants completed for individuals from ethnic minority backgrounds, although this is changing. Some authorities are completing a higher proportion of DFGs for ethnic minorities than the proportion of their local ethnic minority population.[45]

Case Study B provided data on the ethnicity of people using their commissioned services for hospital discharge, and their home independence and warmth programme. Figures showed that well over 10 per cent of these service users are from Black and other minority ethnic backgrounds. For example, commissioners of Case Study B's home independence and warmth programme reported that 18 per cent of their service users are from Black and minority ethnic backgrounds.

Eighteen per cent of the service users are from Black and minority ethnic backgrounds which is up from how it was before, so they are getting there, and I think over the next couple of quarters we'll see a real impact.

Commissioner, Case Study B

[45] Performance of Housing Authorities in DFG Delivery (foundations.uk.com)

Some case studies are trying to make their service more accessible by building connections and increasing their efforts to reach out to under-represented communities through outreach work. Success in increasing the proportion of people from Black and other minority ethnic backgrounds using Case Study B's service was partly due to the efforts of their outreach worker.

They in particular were tasked with going into places like mosques or different faith areas to try and reach some of the people we know need the service. And that was reflected on the monitoring. If she went somewhere we saw it reflected in the referral numbers.

Commissioner, Case Study B

In 2023-2024, Case Study A generated 136 DFG cases without the need for a city council referral, over 40 per cent of their completed cases, demonstrating the effectiveness of outreach and promotion.

As well as people from Black and other ethnic minority backgrounds, case study organisations mentioned asylum seekers and refugees and households affected by issues of in-work poverty and child poverty as being under-represented. Many people are struggling but are unaware of the support available, people who would benefit from support are unknown to the services.

There's a lot of people, and especially in Asian communities where they don't know, some [ ] don't speak English and they don't know what they're entitled to but they're at home and struggling.

Service user, Case Study E

Whilst case studies could provide some data on who is being supported by their service, it is fair to say that data is far from comprehensive. Case studies want to improve the data collection and monitoring of the demographics of their service users to better target their services.

We want to start collecting data so that we can say, 'well what is the need?' Demographics, we don't have great analysis of the demographics. We've got low success of people filling in questionnaires to give us that data.

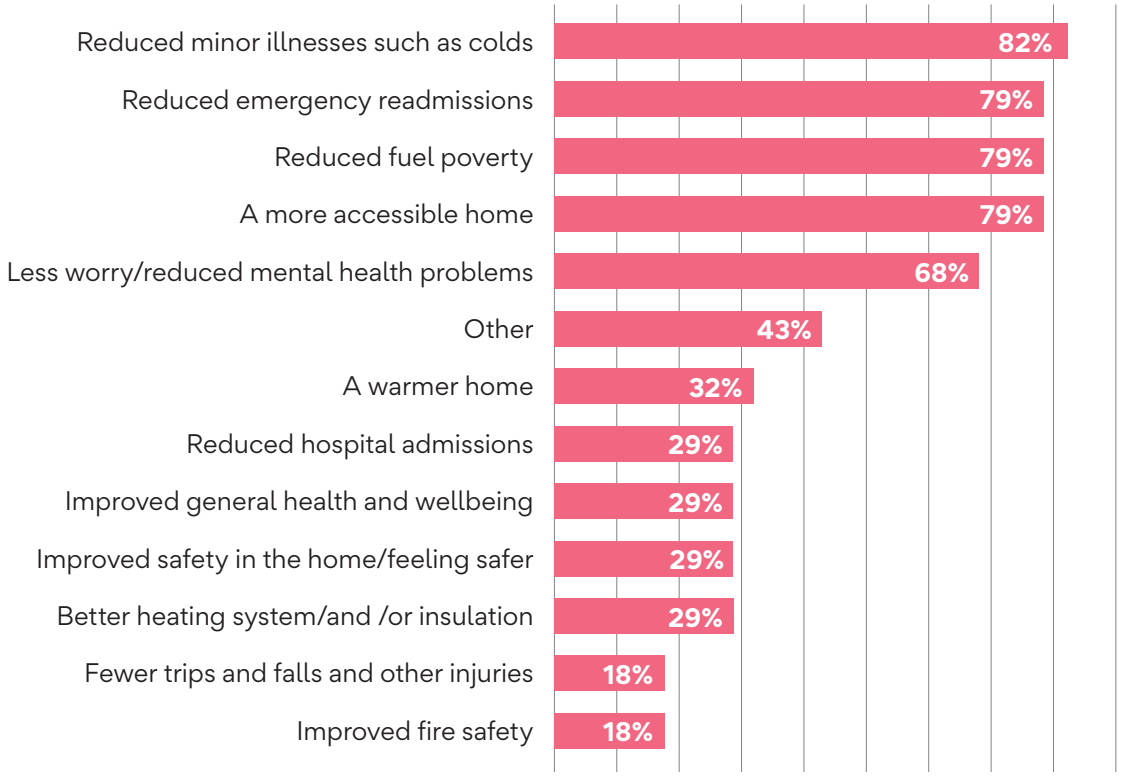
Case Study H

4.7. Main benefits

In the online survey we asked home improvement services what they considered to be the main benefits of the services and interventions they deliver for their clients. We asked them to focus on the main, primary benefits only, ideally listing no more than five (see Figure 4.12). Most organisations (82 per cent) said that one of the main benefits of their service was reducing minor illnesses such as colds, 79 per cent said that reduced emergency admissions were a main primary benefit of their service, and the same proportion said that reducing fuel poverty and creating a more accessible home were main benefits. Two thirds (68 per cent) said that less worry/reduced mental health problems was one of the main benefits. Organisations reported that other benefits, beyond those listed in the survey, were a decrease in home carers needed or fewer hours of home care required. They also told us that there are measured impacts in relation to people remaining independent in their own home.

Findings about the impact that case studies have on people using their services is covered in Chapter 6.

Figure 4.12: Main benefits of the services delivered



Section 5

The quality of home improvement services

The idea for Good Home Hubs emerged from research undertaken for the Good Home Inquiry. Essentially, having a hub or 'one stop shop' offering a comprehensive range of different services around repairing homes is seen as a more effective way for people to access the information, advice, and support they need to tackle poor quality homes. Although there are good services provided by local authorities, currently, the way services are organised is a postcode lottery as to what services are available and their eligibility requirements.[46]

The Good Home Inquiry demonstrated that many people would like to make improvements to their homes, but they are unsure about where to turn for advice, have little knowledge of how to access services, and may not be able to finance improvement works. Having access to a more comprehensive, local service would help overcome these issues and some of the other barriers people typically face when making home improvements.[47]

[46] The only statutory requirement is for local authorities to support disabled people to access aids and adaptations – through Disabled Facilities Grants (DFGs) – but the process can be complex to navigate, and financial support is typically only offered to those with very limited means.

[47] building-effective-local-home.pdf (ageing-better.org.uk)

The expectation is that hubs should build on services already in place and deliver them in partnership with local authorities, charities, and businesses. From a service-user perspective, services must be coordinated to operate as a 'one stop shop.'

The case study home improvement services provide many of the elements that Ageing Better believe make up a Good Home Hub (see Table 5.1).

Table 5.1: Home improvement services

Organisation	One stop shop	Healthy Home Assess	Energy Efficiency	Trusted Trades	DFGs and Grants	Financial support (loans)	Prevent support	Advice (inc. welfare)	Practical support
Case Study A	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes
Case Study B	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes
Case Study C	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Case Study D	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Case Study E	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Case Study F	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Case Study G	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Case Study H	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes

This chapter details evidence from the case studies on how they deliver good quality comprehensive services. It also considers the main constraints on the services and aspects of services that case studies felt could be improved.

5.1. How do services provide a comprehensive service offer

The previous chapter shows that the case studies are providing a diverse range of services beyond DFGs. A greater proportion of the case studies are delivering social prescribing hubs (three case studies), small grants, hospital reablement services, and services that help people to make their homes warmer when compared to other home improvement services that responded to the online survey. The case studies are experiencing increasing demand for their services, with the number of service users typically up by 20 per cent or more in the last three years.

It is noticeable how well connected to the wider system the case study services are. They receive lots of referrals from an extensive range of organisations and partners (e.g. related teams within councils, OTs and Adult and Social Care, GPs, hospitals, third sector organisations, and self-referrals) and have clear referral routes, eligibility criteria and triaging processes for their services.

Most case studies are actively engaged in outreach work to target services on priority demographics specified by commissioners, and to increase referrals from under-represented groups and communities.

We do have an outreach worker who spends a lot of time out there in different settings, within different neighbourhood network groups, in different areas where we may be lacking referrals. They attend events, hold stalls, and provide translation services.

Case Study B

Figure 5.1 below, provides detail of the energy efficiency and warmth services provided by some of the case studies. All the services utilise Affordable Warmth funding to support financially vulnerable people with energy efficiency interventions.

Figure 5.1: Energy efficiency, retrofit and warmth

When undertaking energy efficiency improvements **Case Study A** appoints an Energy Retrofit Technical Officer who is a qualified Domestic Energy Assessor (DEA) & PAS 2035 Trained Energy Assessor. They are responsible for coordinating and managing retrofit and energy efficiency works including insulation, windows, doors, and heating upgrades. The Retrofit Technical Officer is funded by the HIA, and the cost of the works is funded through various sources including the Disabled Facilities Grant, Affordable Warmth funding from the County Council and the UK Shared Prosperity fund.

Case Study B is part of a warmth and independence programme commissioned by the City Council and the ICB. The home improvement service delivers three elements of the service around falls prevention, hazards and repairs, and energy efficiency and heating. This service is delivered in part with the local Groundwork who provide small energy efficiency measures (e.g. LED lightbulbs, reflective radiator panels). The home improvement service's contractors deliver the heating repairs and boiler servicing where appliances have not been serviced for several years or if an appliance is deemed unsafe during a home assessment. Eligibility is restricted

to people aged 60+ with a household income of less than £30,000 and savings of less than £16,000. The programme also provided temporary funding for 'heating on prescription' in the past year, which provided a top-up voucher for energy costs (delivered by Groundwork) and an electric over-blanket delivered by the home improvement service. **Case Study B** also delivers weatherproofing '*aimed at private homeowners. Jobs such as window replacement, roof repairs, pointing... Anything that helps them weatherproof the home and make it warmer.*' Eligibility is according to the DFG criteria. The service is delivered by the HIA's Technical Officers and their contractors.

Case Study C provides heating services and repairs funded by Gas Safe and the City Council's Winter Warmth Grant. The HIA provides free boiler servicing and repairs to owner-occupiers who are considered disabled, low-income, or vulnerable. The funding also includes some measures to improve the energy efficiency of the building e.g. draught-proofing, insulation. **Case Study D** provides winter warmth essentials (e.g. blankets, hats, gloves), boiler servicing and repairs, emergency loan heaters, etc. The service also includes independent advice and support on energy efficiency, including support with applications for grants, payment plans, discounts. **Case Study E** offers interest-free loan products to improve energy efficiency and are piloting a domestic retrofit project via separate funding from Carbon Co-op. This service supports vulnerable people whilst also contributing to other council objectives on carbon reduction.

Case Study F supports a comprehensive energy retrofit service for home owners in partnership with the third sector through various schemes including the Home Upgrade Grant Scheme (HUGs). The case study energy retrofit team receive referrals via the free energy advice line service from their third sector partner, by direct referral via a customer, GP, and other agency or community. In the past year, 200 properties have been retrofitted with microgeneration, insulation and heating measures. **Case Study F** also offers a discretionary form of assistance up to a maximum of £15,000 (subject to available funding) to provide essential property repairs to bring a property up to the Decent Homes standard by removing category 1 hazards. People can receive measures such as repairs, the updating of kitchen and bathrooms, and installation of energy measures to address thermal comfort, and damp and mould. People not in receipt of means tested benefits are directed to the preferred loan provider Lendology for a financial assessment.

Case Study H's larger adaptations and repairs service is set up to support independent living, facilitate hospital discharge, and prevent hospital readmission. It is delivered by Caseworkers who assemble

support packages using the services of the home improvement agency and partners, as well as Technical Officers who act as a project surveyor for larger works. It includes DFG funded adaptations, but also Affordable Warmth grant funded measures and Urgent Repairs. Affordable Warmth provides £4,000 grant funding for energy efficiency measures to improve the thermal fabric of the property, eligibility is restricted to private homeowners or renters with an EPC below C and an annual income under £30,000. Urgent repairs grants are for repairs up to £1,500 to remediate risks to health and safety and restricted to people on passport benefits.

As well as providing a comprehensive service by:

- Offering lots of different services.
- Receiving lots of referrals from a diverse range of organisations and partners – with clear referral routes and eligibility criteria to ensure that the people who can benefit from the service have priority accessing it.

Evidence from the case studies suggests they provide a comprehensive service offer through:

- Developing their services over time and responding to need.
- Their delivery model - e.g. by providing holistic support, streamlining services by operating as 'one stop shops,' and/or adopting more integrated service models.
- Flexible use of funding and good relationships with commissioners and funders.
- Putting caseworkers at the heart of their service.
- Cross referrals within and beyond the service to enable wrap around and personalised support.
- Co-location and/or working closely with other related services.
- Having appropriate systems and strong administrative support to back a comprehensive offer.

These factors are discussed in turn below.

Developing services over time and responding to need

Many home improvement services (including some of the case studies) have been restructured. For instance, services have undergone (or are undergoing) changes to their governance and delivery model, they may have merged with their local authority or another service and been moved into various Directorates. Although some changes and the disruption caused

may have been less than positive, most of the case study home improvement services have operated in their areas in some form for years and have key longstanding staff members.

As mature organisations the case studies are seen as being better able to understand how home improvement services can work to support the wider system, respond to local government priorities, and take better strategic approaches. Over time services have evolved and developed to become more comprehensive. For example, in Case Study B, a home independence and warmth service has grown to include additional work around fuel poverty. The home improvement service has also begun to deliver new related services around air quality and respiratory health and to expand the work they deliver around hospital discharge.

Case Study H benefits from significant *'public and political support'* in the region, due to its longstanding presence, strong connections with related service partners, and record of delivery. This situation had enabled the home improvement service to access philanthropic funding throughout their years of operation. Given its history, the HIA was well placed to know how to help people whatever their circumstances.

They're very well grounded in going to those external agencies to get funding. And I think it's just their presence, that it doesn't matter how challenging an individual that you find in the community can be because of their circumstances, you would always know if you refer them to [HIA Name] they would usually be able to pick them up and deal with the issues that they had, or if they couldn't deal with it they would be able to get them off to another third sector agency who could support them.

External stakeholder, Case Study H

Case Study D is based within Adult Social Care and forms part of the prevention and independent living services provided by the council, alongside other services such as occupational therapy, reablement and assisted technology services. This new service was originally set up to bring services together and be a 'one stop shop.' The first home improvement manager is now the head of service, there is a sense the development of the service has been *'built from the ground up'* and the ensuing benefits in terms of prevention are clear. The case study's service offer is evolving by responding to identified need. For example, they are currently exploring a partnership with a domestic abuse charity to enable survivors to stay in their home safely. This aligns well with the prevention agenda of the organisation and their handypeople are trusted which is particularly important for this project.

Some case studies are key partners in hoarding projects which have evolved out of an identified need. Conversations with the case studies across the evaluation indicate that hoarding is a massive issue. The home improvement services are expanding their offer and working flexibly to respond to such issues where other services might not have capacity, or when referrals are coming from other services such as mental health and the fire service.

For example, Case Study H has a hoarding and support service which is funded by the City Council to support people with hoarding issues and remove fire safety risks for people experiencing hoarding. The home improvement agency has extended the service using additional philanthropic funding to provide a group support network around service users. The support group is intended to provide a more sustainable solution to the issue by providing an empathetic service that understands hoarding as a mental health issue.

One stop shops, holistic support, and integrated service delivery models

All the case studies are offering a breadth of different services to their clients, although when comparing them there are some services that are not provided in every case study, or they are not provided to the same extent in some areas compared to others. Whilst services are predominantly accessed by owner occupiers in all the case studies, and DFG funding cannot be spent on council properties, at least some services offered by the case studies are available to people living in council and private rented properties, as well as owner-occupiers.

However, some services are under pressure due to the level of demand and long waiting lists, at a time when funding reductions are resulting in some services being cut or diminished. For instance, Case Study G reported that austerity meant that unfortunately the services provided have had to be reduced and the service was operating almost exclusively as a *'DFG delivery vehicle.'*

Whilst the delivery model for different services in each case study can vary, case studies strive to provide a holistic offer, and some case studies are adopting more integrated approaches to deliver a comprehensive service. Some services are simplifying access and bringing services together to operate more like a hub or 'one stop shop.'

Case Study A adopts a one-stop-shop model to deliver adaptations, which they refer to as their *'integrated adaptations service.'* Within the one-stop-shop approach, DFG acts as the hub of the service with adjacent services supplementing the DFG process to provide a wraparound service. Additional services include minor adaptations, small repairs, energy efficiency works, and benefits advice. The benefit of this approach is that it provides an easier route to a solution for service users and prevents cases bouncing between the district and county authorities.

Our integrated adaptations service model is what we see as our speciality. It's like that one stop shop so someone can come to us, and they may need a Disabled Facilities Grant but we then can offer all the other services. So rather than keep passing people back to the upper tier authority in a lot of cases we can just deal with the whole thing. We have got all these additional services but a lot of them do link back fundamentally to delivering our DFGs.

Case Study A

Other stakeholders felt having a one stop shop model enabled the HIA to support multiple local authority priorities through a single team. Whereas having a more restrictive service tied to statutory DFGs would limit the City Council and result in them having to find alternative mechanisms to deliver against priorities such as addressing the climate emergency.

For me I think the really critical selling bit of the service is the fact that it has remained that integrated, almost one stop shop for the whole of the home improvement agency service, rather than a fraction of the service, or just the statutory DFG provision being sorted or contracting bits out. I think it just works really, really well.

Case Study A

Case Study D and F are integrated with health and adult social care to provide adaptations, prevention, and home repairs. They streamline existing provision bringing together a multitude of agencies to form collaborative multi-disciplinary teams. Having such a commitment to joint action across local government, health, social care, and housing, encourages more effective joint working. It also establishes the context and framework for cross-sector partnerships, and the development of integrated and effective services that meet the needs of individuals, families, and communities.

More joined up approaches to health, social care and housing support can be supported by a local authority having a Housing Assistance policy using the Regulatory Reform (Housing Assistance) England and Wales Order 2002 (RRO). For example, the wide range of assistance provided by Case Study C targeted at improving living conditions is set out in the city council's Housing Assistance policy. Case Study C has been effective in integration with a wider network of local authority services, health, and care providers, and third sector organisations. To provide a holistic service, this case study has sought to align its services with health. The home improvement agency collaborates with their Health & Wellbeing Board to understand the

priorities of the area. This has informed their service offer by highlighting issues with falls among the elderly and vulnerable, and a growing population with dementia. Furthermore, the case study refers to the Joint Strategic Needs Assessment when designing their services. This process has informed the development of the minor repairs service and the dementia assistance service.

Flexible use of funding and good relationships with commissioners and funders

Good relationships with commissioners and funders are vital enablers to the flexible use of funding and the capacity to offer a more comprehensive home improvement service. Working closely with these parties helps to inform service development and create further opportunities. Case Study B regularly consults with managers and commissioners in stakeholder organisations to align their service offer with changing needs and funding opportunities. Consultation with Health and Housing in the City Council led to the expansion of their weatherproofing service and the inception of a new service around air quality.

For Case Study F, moving back into the local authority was seen as an opportunity to redefine what had previously been a service centred on a 'rigid' contractual arrangement for Disabled Facilities Grant (DFG) provision. An enhanced, and more flexible service, aimed to allow for a greater focus on prevention, in line with the principles of the Care Act (2014). The service benefited from opportunities to bring different funding streams and services together to create efficiencies, and to capitalise on other funding streams in ways that would not have been possible through directly commissioned services. By being closer to the Integrated Care Board it was felt the home improvement agency had more influence.

In my role, I talk to the ICB, I direct the funding. I'm able to take full responsibility for it and apportion it depending on the demands that we need for our service users. So I can 'bespoke' my model how I like, but if it's out in the environment as a contract that's very difficult to do and that means you've got a bit of a one dimensional service.

Case Study F

This is seen as increasingly important in a context where 'black holes' in adult social care budgets can lead to the stripping back of external contracts.

However, other stakeholders in this area expressed concerns that waiting lists for statutory services were long and may be exacerbated by decisions to pivot resources toward innovation funding streams, and there were differing views on how resources were being used to meet local needs.

In some areas, local authorities are implementing their Housing Assistance policy to use the Government funding for the DFG more flexibly. Due to growing pressure to consider alternative funding options for some of their services, Case Study A felt that if their council introduced such a policy this could be used as a way of funding these other services. Some other case studies are supplementing DFG funding with charitable grants or affordable warmth funding, or if the client is a housing association tenant they may seek assistance from the landlord.

> **So, for example, the one case we went to a charity to obtain funding for non-slip flooring.**
>
> **Case Study H**

Putting caseworkers at the heart of the service

To provide a comprehensive service most case studies are putting caseworkers at the heart of what they do. Caseworkers are particularly important for smooth and effective delivery and are the single point of contact for the client. For example, caseworkers are undertaking initial visits and triaging clients, assessing eligibility for the different home improvement services. Caseworkers are pivotal in bringing in other staff such as surveyors and assembling the package of support, tailoring the level of provision to the needs of the client. Caseworkers described their role as helping to navigate the system on the client's behalf and to get the best outcomes possible.

In Case Study G, caseworkers do initial joint visits with OTs. The first visit focuses on general health and issues such as energy. The caseworker can come back for a second visit if needed. Incoming cases are reviewed daily to ascertain whether they are urgent. Technical officers and OTs reported that the caseworker process worked quite efficiently meaning that the client's journey through the service was smooth and they were moved along the process in a logical way whilst maintaining the key point of contact in the caseworker.

> **From the client perspective I think it is a journey for them, and they do go through each stage, and they know what's going on, which is really important as well.**
>
> **Technical officer, Case Study G**

For OTs, the system worked well in terms of clients having a caseworker as a key point of contact which was consistent for them, but also enabled OTs to focus on the technical side of their role. OTs reflected that this was not the case in other areas of the county, due to a lack of funding for caseworkers. In these areas, OTs would have to respond to a wide range of queries from clients, which a caseworker would be better placed to deal with.

[Other areas are] having to approach it differently. They don't have the structure we have, do they? They don't have the caseworkers we have. They're invaluable. Some areas have caseworkers, but they only have like, one or half of one or something like that.

OT, Case Study G

The importance of caseworkers is also exemplified in another area (Case Study F) where having no caseworkers was impacting negatively on the quality of the service. Here, having no caseworker roles in place, means that other staff (such as Technical Officers and Occupational Therapists) are picking up administrative and client communication responsibilities outside of their core roles.

It is hoped that the introduction of caseworker roles into the service will help improve the quality of the service user journey by overcoming problems with communication and enhancing engagement with service users and other stakeholders.

I would say something that has been missed is that caseworker role a bit really because some of the day-to-day bits could be done with someone that can just keep the, especially from a technical side, they can keep that case moving.

Case Study F

Subsequently, Case Study F has implemented a caseworker pilot project. Several members of staff have been seconded into new caseworker posts to trial the roles, and their impact on allocated cases. An aim of the pilot is to understand the cultural changes required within the organisation and partners to embed the roles. It will also identify required modifications to process and monitor the impact of the roles on efficiencies, technical time, and reducing waiting times.

Cross referrals and wrap around service

Home improvement services aim to ensure that service users are directed to the most appropriate services and receive all the support they need. In the case studies, cross referrals to different parts of their own service and beyond to other agencies happen regularly and are embedded in the way the services work.

Staff reported that clients often have more than one need. For example, people may be referred for one issue initially, such as income maximisation, but caseworkers assess clients for any other issues during their visit to the client's home and through their conversations. An individual might need a benefits check and a key safe, so the caseworker and handyperson team would both receive referrals.

We'll do a home visit, and you can tend to pick up on certain things, or we can send out our small repairs service and say when you're there can you do a home energy efficiency survey, can we do a safety survey, we might speak to the NHS falls team. So there's all manner of things that can come from one referral.

Case Study C

Cross referrals are part of multi-agency working and providing an efficient wrap around service to clients. Staff need to be well-informed of the different services that are available and may be appropriate, allowing them to cross-refer where this could be useful.

Where you're offering smoke alarm check, are you lonely, is your heating done, there's a list of about a dozen things where we refer out to....So I think we're all constantly aware and looking as to what else we can do to go the extra mile beyond what we would normally provide [...] we don't work in our little silos.

Case Study D

So, I think having that multi agency approach as well referring out, help to look at that whole picture (of clients' needs) as opposed to just what you're there for.

Case Study F

This model of working means the service provided is personalised and bespoke to an individual's needs.

Every job that we do is bespoke to the customer. All right, there's a standard template for a level access shower but everyone in terms of if someone's had a stroke and got a right sided weakness or visual impairment, we think about colour contrast and location of grab rails, do they need more, what type of shower, all these things are absolutely bespoke, to a point 'cos you've always got that balance of what the customer needs and what the customer wants.

Case Study D

Being aligned with other key services enabled effective cross referrals. In Case Study G, the specialist housing social prescribing service is managed within the home improvement agency but is a separate (though aligned) service. Both staff teams meet on a weekly basis enabling cross-referrals (e.g. from HIS OTs to the social prescribers). The set up enables Case Study G to connect service users to wider support if needed and provides additional capacity. The social prescribing service supports clients with housing options (e.g. understanding banding, registering on the system), applying for benefits (e.g. Attendance Allowance, Carer's Allowance), small DIY jobs (e.g. hanging curtains), applying for funding for larger household jobs (e.g. flooring), digital inclusion and medical assessments for OT referrals. They work with people who cannot or do not want to stay in their homes, supporting in various ways, e.g. de-cluttering, removals, assisted bidding.

Staff from the social prescribing service described an example of a client who was initially assessed by the HIS for adaptations but was ineligible due to awaiting being allocated a new property as her current one was overcrowded. However, the HIS was able to refer to the social prescribing service to support with her physical and mental health which was being impacted by her current living situation:

So she wasn't eligible for adaptations, but her housing is having a huge impact on her physical and mental health. So in our joint meeting this morning, the assistant practitioner and the caseworker brought the case up. And we said refer to us and we'll get out and see her as soon as possible.

Social prescribing service, Case Study G

Service users value the range of services they receive. Two service users interviewed for Case Study C had used the Handyperson service for small repairs. Both valued the range of works available and consequently were repeat users of the service over multiple years. One of these two interviewees had received grabrails following a fall but had since used the service to fit smoke alarms, fix a leaking tap, and fit a key safe. The interviewee explained:

I was delighted to find out they did key safes. I rang in the morning and by the afternoon I think I had it, the service was absolutely great, I couldn't believe my luck.

Service user, Case Study C

Co-location and working closely with connected services

Several of the case studies benefit from being co-located and/or working closely with other connected services such as OTs and reablement services. This arrangement facilitated a more effective comprehensive service offer. Being co-located or meeting regularly with staff from other aligned services enables cross referrals, and better discussions about cases. Caseworkers in Case Study G agreed, stating that having the whole team co-located in the same office (e.g. technical officers, caseworkers, OTs, etc.) supporting good communication and team working helped the whole home improvement process to be as efficient as possible. They reflected that doing joint visits (e.g. caseworkers and OTs) was beneficial as one person can be focused on talking to the client while the other is observing the home environment.

In Case Study D, staff have noticed a positive difference since the move to co-location with other services. A good example of this is the way in which the handyperson service and Telecare support work together, where those receiving services through this team are automatically referred to Telecare for an assessment. Having close working relationships with occupational therapy is also important to the service as the OTs refer using a prioritisation system. Cases classified as high priority (Level 1) are fairly rare (1-2 cases a month). Level 2 cases are dealt with within 3-6 months, whilst Level 3 cases are less urgent. Each case is added to a waiting list managed by the case study administrative team. A points system based on the level of priority and length of time on the waiting list is continually reviewed and the team works through the list.

Having appropriate systems and strong administrative support

The case studies highlight the importance of having good administrative support and appropriate case management systems. This assistance supports the delivery of an effective holistic service and minimises duplication when making cross referrals. Having a strong administrative team and core staff members who are aware of all the available assistance is crucial to the effectiveness of the service, particularly in terms of making and maintaining connections.

In Case Study D, the administrative team are key in ensuring effective triaging and referrals into the most appropriate services. Although each member of the team has their own areas of the service, they share information using the same system. There is one record for each service user, but they can make referrals to multiple services depending on need, which prevents duplication. They have specialist knowledge (e.g. on processing DFG applications) so they are well-placed to refer effectively. Cross-referrals also happen regularly between different services. This process aims to ensure the service users do not slip through the cracks and aren't *'getting passed from pillar to post.'*

In Case Study B, the recent implementation of the new CRM system is fundamental to providing this holistic and integrated service.

> **The CRM that everyone now uses means that anyone can take a phone call from a client. To ensure that you have a wraparound service, you have to have that core set of staff that understand what everybody does, so when someone comes into the service, they can ask the right questions in order that they get referred to every element of the service.**

Case Study B

A lack of a robust case management system, which would allow for data sharing across internal services and give all stakeholders access to basic data on service user journeys, was creating challenges for Case Study F, although they were looking to address this by procuring a new system.

5.2. What are the main constraints on services

DFG Funding and costs

We asked the case studies about the main constraints affecting their service and it is clear funding is the most pressing concern. The previous chapter touched on issues with the DFG cap and the rising costs of carrying out work which are putting pressure on home improvement service funding. Recent inflationary pressure, particularly on material and labour costs, has made delivering what people need within the DFG cap of £30,000 increasingly challenging.

> **Today it's really difficult to provide what people need within the financial footprint that we're looking at. And I think that's probably the main challenge.**

Case Study H

This is seen (by many interviewees across the case studies) as a major constraint on services, restricting what they can deliver and making larger adaptations like extensions prohibitively expensive. With respect to the DFG cap one interviewee explained:

> **... price increases have been astronomical. Over the last 10 years I think we've gone from just about getting an extension with a bathroom and bedroom done for the maximum grant limit to that at least doubling, sometimes trebling.**

Case Study A

Councils may use top up grants where possible, but even with top up grants extensions are difficult to complete within funding limits. In Case Study C, one interviewee explained that '*extensions are just a nightmare. The maximum grant plus the top up grant still doesn't get anywhere near an extension in [place].*' Another interviewee agreed, explaining that even with the grant available for an extension, *'you could be looking at a shortfall of around £30,000. So that's an issue across the board.'* Another interviewee suggested that the funding cap can make it difficult to meet the expectations of service users in terms of aesthetics and quality of work.

Sometimes staff must have difficult conversations with clients because of these constraints. Caseworkers and OTs try to manage expectations by explaining the limitations of the DFG grant and what is practical at their first contact with clients, giving an indication of what funding they might be entitled to (e.g. full funding or a top-up grant), if the client can provide financial information.

Reliance on top up grants risks the sustainability of home improvement services. DFG allocation for Case Study D has not increased for many years. The increase in more complex cases needing extensions coupled with rising costs made things challenging, and whilst the council currently tops this up where possible, this situation was not sustainable. Case Study E were able to use the discretionary DFG fund in their area for their larger home repairs, however, at the time of the evaluation there was a moratorium on this.

The lack of an uplift in the DFG upper limit effectively means that the DFG is no longer fit for purpose as it is restricting what the services can deliver. It was also mentioned that means testing is not proportionately fair to those who are working. Government guidance should be reviewed to take this into account as sometimes older people might have a lot of savings whereas working people might have no savings but end up contributing more. This was particularly difficult for children's cases as it is quite a burden on family finances.

Some of the other constraints on DFG funding did not make sense.

It's crazy for instance that you can't use DFG to repair a stairlift, but you can buy a new one, you can't repair a shower, but you can buy a new one. It's madness, £120 I can repair a £5000 lift which then will last another seven, eight years.

Case Study D

Local authority funding and commissioning

Local authority funding has declined in real terms and is becoming a strategic risk for home improvement services.

... the reliance on local authority funding is one of the challenges, especially because they in are decline and local authorities are struggling. I think certainly from the funding perspective, with the help and support that we try and provide, it's just not enough money anymore. That's the main challenge. If you go back to when I started there were a lot of different types of grants that were available. And you just see them over the years quietly dissolving.

Case Study H

We won the second contract in October for [name], but the money stayed the same and costs were up. So, in effect we had a funding cut. We got to the point at the beginning of the year where we were possibly going to run out of funding before the end of September. So, we have talked to the funders, and they have managed to find another £50k worth of funding just to plug that gap.

Case Study B

From a commissioner's point of view (Case Study E), it is becoming increasingly challenging to decide which services can be funded, e.g. due to rising costs of labour and materials, higher demand, and changes to legislation. Mandatory adaptations (e.g. stairlifts) are costing more and leaving less available for discretionary adaptations (e.g. heating). This means people are more likely to be living in inadequate housing which increases their chances of falling ill and being admitted to hospital. The commissioner felt that if the DFG grant were not ringfenced this would allow them to use capital DFG to potentially employ more OTs which would be a benefit, but this would mean the rest of the budget could then be used for anything which would lead to other disagreements in the council.

Funding insecurity is also resulting in the services being provided becoming less generous.

I think we feel less like white knights than we did 12 or 15 years ago when the money was flowing in from local authorities and the government really prioritised this and it's free because you're over 60. So that's a challenge really.

Case Study H

During the evaluation, services were cut or were being recommissioned, and the expansion and development of services in some areas was being hindered due to funding limitations. For Case Study A, the recommissioning of the adaptations service under a new model was likely to affect the service's ability to provide an integrated adaptations service, and lead to minor adaptations being delivered by a different provider. In Case Study B, insecurity, and fluctuations in their funding from core local authority contracts meant the team is unlikely to grow in the short-term. Stakeholders explained that the service offer around energy efficiency and fuel poverty could be expanded to generate further impact if funding was available.

I think we'd encourage them to take on some other elements of work around fuel poverty. We could develop that. Probably when we started in 2017 it wasn't a massive thing, but it is now. So we've firmed it up a bit within the new spec but that's definitely an area where we could develop and bid for more funding. Things like insulation, it would be great if we could have that in the service as well.

Case Study B

Similarly, the expansion of the organisation's support for hospital discharge was hindered by the decision not to commission a programme to support patient recovery beyond its three-year pilot. One of the reasons the home improvement service engaged in this programme was to diversify their sources of income because of an over reliance on local authority funding. However, the alternative funding streams may also be uncertain and contingent upon being able to demonstrate impact for stakeholders which can be challenging.

Interviewees in another area felt that some commissioners fail to understand the scope of what home improvement services do. Caseworkers in Case Study E thought that commissioners do not always know what is happening in the community and that funding can sometimes feel '*top-down*' which restricts the service. This lack of awareness contributed to funding levels not being adequate for the services they were expected to deliver. They highlighted that clients often need help with a wide range of issues, including emotional support, which they always tried to help with as clients can be very vulnerable and may not have other support.

The main thing I would be highlighting is that there's a lack of awareness of the actual depth we go into in these services. And that's probably why there's an issue with funding. Funders think they're just funding people to go and do a benefit form but they're not. It's ten times as much as that and that's why I think there's probably lack of resources, lack of funding.

Case Study E

This organisation had already experienced a substantial reduction in staffing levels through voluntary redundancy as a direct result of local authority funding cuts. The caseworker team have reduced from five to four and they felt this would be difficult going forwards as their caseload was already high.

It was already hard as it was [...] we're [going to] have a lot less resources next year which will be tough.

Case Study E

Variation across areas and local authorities

The comprehensiveness of the service offer provided by some case studies varies across geographical and local authority areas and is often dependent on the specification of each locality's commissioned service(s). This variation affects the extent of, and the quality of the service offered, and some people miss out completely.

One interviewee explained that within their county there is significant variation between the districts in terms of home improvement agency provision:

... you end up with someone living in [location] where there is no HIA, they gets nothing at all from an HIA point but is potentially just over the border [from City]. But there must be people in need. There's at least one person that needs it, but that person's not getting anything. Where someone in City is getting an incredible service.

Case StudyC

Variation in contracts can create challenges for referrals, and the staff and customer service teams who manage the service across boundaries. For instance, in Case Study H:

The number of contracts is quite challenging. You could have up to 4.5 metres of galvanised steel handrail down your garden path in [place] and [place], but our staff have to remember that the framework agreement in the [place] local authority area means that we can only do one metre if we're doing works inside the property as well because they've got their own in-house team.

Case Study H

One interviewee argued that the organisational structure has become '*convoluted*' as it has evolved over time and expanded into multiple geographies with varying service offers. Consequently, Case Study H was engaged in a restructuring of the management structure at the time of the research. And was clarifying and simplifying the service offer around the organisation's key principles, namely *'case work, technical work, minor adaptations, along with some customer support and information and advice.'*

In another area (Case Study G) the OT based in the County Council mentioned some geographical complexity relating to her role. She sometimes gets referrals through the locality team (which covers three district councils) which fall outside of the City Council's boundaries so must refer these on or send them back. GP surgery patients and housing association tenants can cross local authority boundaries so this can be a challenge.

Balancing capacity and demand

At a time of growing constraints around funding and costs, balancing capacity and demand is becoming more difficult. Challenges exist among the service user base due to increasing complexity and the reduced ability to pay a top up fee if grants will not fund the entirety of the adaptation.

There are challenges around people's ability to pay, financial circumstances. [...] So our demand is higher, but their needs are much higher and much more complex and the amount of time it takes for our teams to either work with people to try and find solutions for them is really difficult.

Case Study A

Pressures on the wider system can cause issues impacting the ability of home improvement services to undertake preventative work. For example, Case Study D explained that some referrals are categorised as 'urgent' by the time they reach the agency, because of being held on waiting lists elsewhere.

One week we had seven 'urgents' for DFG which is we need to do it straight away, when we looked at them five of them weren't really urgent but because there'd been delays further down the line it's then made them more urgent.

Case Study D

Demand has also increased due to reductions in other support services elsewhere. Interviewees from Case Study D reported that the number of cases had increased over the past few years. They felt this was partly due to voluntary sector services being reduced which was putting more pressure on social care to provide services. At times, technical officers may be unable to implement caseworker recommendations until 9-12 months later, at which point an individual's needs may have changed and their condition may have deteriorated.

The service aims to mitigate this challenge through effective triaging via OT assessments and the administrative team, ensuring that each case is dealt with. Nonetheless, waiting times can be longer than the team would like because of limited capacity and high levels of demand. The team aimed to mitigate this by communicating clearly with the customer to manage their expectations and ensure they are aware of what is happening with their case on a regular basis.

In some areas there is a back log of cases and growing waiting lists. For Case Study G, the COVID-19 pandemic left a legacy of cases and changes to the organisation's remit to include council housing stock resulting in a significant (inherited) backlog and much longer wait-times for clients. People have recently had to wait close to year for an adaptation, whereas they were usually completed within 90 days pre-Covid. Due to the high level of demand and long waiting list the service is not currently publicising itself.

Other interviews from across the sector indicate that capacity concerns are a widespread problem and are contributing to waiting lists. A shortage of home improvement staff and a shortage of OTs is impeding the delivery of DFGs in some areas, leading to an underspend on the DFG budget. In one area an interviewee mentioned that some of the more straightforward cases are being outsourced to external OT agencies, but more complex cases are kept in-house and are taking more time to progress due to a lack of staff.

...the most complex cases are waiting longer because we don't have the staff, enough staff that works with those cases to, you know, to assess and progress the cases and then they have to wait longer on the other side with [the] home improvement agency because...they are the case that you have to wait the longest because you need highly specialist staff aware to work with those cases the same way you need a highly qualified specialist experienced OT.

OT, London borough

A response to this has been to make a business case to use the underspend to create new Trusted Assessor posts so that surveyors can be freed up to process some of the more complex cases, utilising their skills better. However, there remains recruitment challenges in upskilling people to these Trusted Assessor posts and finding the right people who have the potential to do these jobs.

In Case Study F, the complex task of managing demand and resources across its range of services was reflected on by several interviewees. At the time of the evaluation, this home improvement service was facing a significant challenge related to a lack of capacity to manage combined lists of previous authorities when the council became unitary, as well as dealing with the increasing complexity and severity of cases and managing demand across different '*fee paying and statutory services*.' These issues meant that waiting lists for some services have been too long. The introduction of new grants, which are aimed at prevention and bringing down DFG lists has increased the administrative burden for the organisation, as one interviewee reflected.

I think because we've introduced all these new grants, you know, people are entitled to a lot more. Therefore, it generates more referrals and that's all got to be logged. It's all got to be contracted out. It's all got to be financially processed and then you've got to report on it.

Case Study F

Recruiting skilled staff

Case study services are struggling to recruit staff they need with the relevant skills and experience required, including surveyors and technical officers, handy persons, and OTs. This is often due to a lack of applicants and the job roles paying less than similar jobs in the private sector or other opportunities locally.

We tried to recruit a technical officer for seven rounds, and we've had to appoint somebody who's not experienced but has the skills, our handyman seven or eight rounds, because you can earn as much in Aldi as you can being a handyman.

Case Study D

The team reflected that people may also be put off working for a local authority due to fears of instability and cuts.

The inability to recruit staff can limit the ability of some organisations to scale their service or respond effectively to growing waiting lists. In one area (Case Study F), a lack of caseworkers was hampering the service's ability to oversee client journeys and liaise with service stakeholders.

Roles such as caseworkers and technical officers are complex and muti-faceted which can also make them challenging to recruit to.

We've got a pretty steady team at the minute. But if somebody left or retired or got ill, I know I would find it difficult to recruit. Without even looking. I know it will be difficult, especially for technical staff but also for the support workers and the customer service. They have to have the skills, but they also have to be the right person and have empathy.

Case Study B

Services are also limited because case studies are unable to resource the level of staff that is needed to expand. Case Study B aspires to grow its service offer to dementia sufferers, but this is not something they can resource to the extent they would wish to.

I would like to expand the dementia service again, but that would mean recruiting some dementia specialists or taking one of our staff and putting them on some quite significant training.

Case Study B

Supply chain issues

Some case studies mentioned issues with securing qualified supply chains to deliver some of their services. For example, in Case Study A, a lack of qualified suppliers to deliver retrofit within the region constrains the rate at which the energy efficiency service can be expanded. One interviewee explained, *'we've historically had to go out of the district to get the people who've got Trustmark registration.'* The nature of the construction industry in the region makes gaining accreditation quite burdensome.

A lot of the district's contractors are small to medium size enterprises, and they don't have the backroom staff to do all the administration to keep on top of all the accreditations, so how that changes is quite a big job.

Case Study A

Other services also struggled to attract contractors, due to private jobs paying better and more quickly, and being less complex.

Housing association policies

A few case studies mentioned the challenging nature of providing adaptations to housing association tenants due to the length of time and procedural steps involved. The time it takes getting permissions constrains home improvement services from delivering a prompt service, installing an adaptation in a housing association property can cause significant delay.

Something as simple as a level access shower that's taken over a year for a housing association to give permission to is a big problem. [...] They basically didn't know who was responsible for giving permission, so you were just going round the houses.

Case Study C

Interviews with other stakeholders suggest that this is a sector wide issue. There are lots of issues with timeframes when it comes to completing works with housing associations. Other concerns mentioned include inappropriate OT referrals from housing associations about repairs, and housing associations incorrectly advising their tenants.

And it's an easy way out for them to advise clients, saying, oh, you just need a letter from your OT because they have [a] different budget for DFG and then they put it on that budget. However, this is creating an awful lot of work and we're taking stuff away from helping vulnerable residents dealing with clients who have been given the impression that they just need a letter and then the repair will get done.

OT, London borough

Some policies can prohibit tenants from receiving adaptations, an example was given of a housing association refusing permission to install wet rooms other than on ground floor properties.

Changes within housing associations such as staff turnover and the loss of independent living teams make developing stronger partnerships with housing associations more difficult. Case Study H had made some advances in speeding up permissions by developing a joint protocol to handle cases with housing associations, but progress had stalled due to staff turnover within the associations.

Demonstrating impact

The development of services can sometimes be constrained by difficulties associated with demonstrating impact. Funders often want services to evidence the difference they are making, but measuring the preventative effect of services is challenging and there are inherent methodological difficulties in quantifying impact.

In Case Study A, a pilot hospital discharge service was constrained by its ability to demonstrate impact. Stakeholders explained that if they could effectively quantify the preventative savings from the service, one option could be to joint fund the service with the Integrated Care Board (ICB). Furthermore, this additional funding could potentially be used to expand the home improvement agency's services in local districts where currently it was providing a less expansive service.

Other stakeholders suggested that housing and health often struggle to '*talk the same language*.' They elaborated that:

...we [i.e. housing] don't necessarily understand exactly what they [i.e. health] want to evidence. And they want quick wins now but some of the stuff that we're talking about will take years to evidence.

Case Study A
Whilst home improvement services collect qualitative data to understand the impact of their services, there remains a lack of formal evaluations to quantify the impact they have on health and care expenditure.

5.3. Improving services

We asked the case studies about the aspects of their services that could be improved, and they identified a range of factors. Several interviewees felt there was a general **need to raise awareness of home improvement services** among the client group and other stakeholders such as their own council's staff members.

> **There's always people that are surprised that the HIA exists. [...] Even within the council, there's probably people that work in the council that have got family members that would need assistance and probably are oblivious that the HIA exists.**

Case Study C

Some challenges related to the **complexity of the wider health and housing system** such as working across the varying geographical boundaries covered by different parts of the health system. Case Study E reported that where they had been able to develop projects from scratch (e.g. [name], mental health project), this worked more smoothly because they involved more standard funding and a more holistic client pathway.

A lack of provision for hoarding and homelessness support within some district authorities was also preventing successful hospital discharge and making this area of work more challenging. Although there is a limitation to the impact home improvement services can have on issues such as homelessness, other than signposting. Some case studies are increasingly working with Registered Providers who are struggling to manage hoarding incidents in their stock (Case Study F), and have developed more extensive support around hoarding, including the provision of group support networks (Case Study A).

Better sharing of data with external partners like the NHS would also improve client journeys. Some case studies are making advances in the development of their **client management systems to allow for better sharing across internal services**, yet sharing data with health partners remains a challenge. Case Study D explained that the local council and NHS are investigating technical solutions to enable referral data to be stored in a centralised place to ensure service user journeys are efficient and to avoid duplication. However, it is an expensive and lengthy process, and there are complexities around ensuring the system is efficient and works for everyone. Moving such discussions forward is challenging and is sometimes deprioritised due to competing priorities and demands.

As much as you talk about it and go to meetings and discuss it, it then just gets put on the back burner again. Health and social care, as much as we try and give each other the information that we need to, it would be a lot easier if we were all on that one system where we could all get the information we needed.

Case Study D

In Case Study F:

Being in a single local authority has facilitated data sharing – we've got access now to (the social care system). We couldn't do that before because we weren't in the same council and data protection and that. But we've only got read access.

Case Study F

Case studies are looking to **new ways of working to improve their service delivery and enhance the support people receive**. Case Study B is aiming to **cross-skill staff** to support a more integrated approach. It is hoped this new development will enable staff to be competent in a wider range of skills ensuring that new service users receive a holistic package of support.

Cases studies also highlighted the need to **improve responsiveness and communication with clients and other stakeholders particularly where there are delays, long waiting lists, and back logs**. Improving client management is one way of doing this, as is improving relationships with housing associations to prevent prolonged delays in delivering adaptations for social housing tenants. Evidence from the lived experience strand of the evaluation shows that much of the frustration and distress caused by problems such as the length of the process, can be significantly mitigated by good communication. Communication within and between agencies is essential from the point of view of the end user.

Case Study F has undertaken a gap analysis of the literature and support documentation that is available to service users and stakeholders. This has resulted in a new DFG leaflet and guidance notes, a redesigned hoarding leaflet and new hoarding factsheets. These documents were codesigned with service users, stakeholders, and the customer panel to improve communication with clients and stakeholders.

In Case Study F, **adopting a systems approach to service improvement** has also identified where enhancements could be made, highlighting gaps in service provision, and capturing good practice which could be deployed elsewhere in the service. The Case Study has trained a member of staff to be a **systems thinking champion**. One example is the impact of Adult

Social Care waiting lists on the case study's services. The unintended consequence of increasing resources to reduce the list in Adult Social Care being an uplift in the number of referrals to the home improvement service that it was not adequately resourced to address. This work has highlighted the need for **integrated management of resourcing to meet customer need**, which is being addressed through **joint service user journey mapping** (involving Adult Social Care service managers, occupational therapists, and the home improvement service manager) with a view to identifying how processes can be managed more smoothly.

Some case studies would like to **increase the service they offer** to clients. Developing **more work around energy efficiency and fuel poverty** is seen as a potential area for expansion if funding could be made available. Stakeholders at Case Study F felt that potential future income streams (such as carbon offsetting) could also be developed from the energy efficiency and retrofit work. It is recognised that people who could potentially pay for home improvements need better advice and support. Although loans and various funding packages are available, many people are reluctant to borrow money for home improvements or lack sufficient information to make an informed choice. **Closer working relationships between local authorities, home improvement services and trusted local lenders are needed** to improve access to reliable financial support for home improvements (Case Study D).

Current funding constraints on services can also limit choice and the support available to service users. However, offering more choice over the design of minor adaptations would be welcomed by service users.

> **I would have liked it black, because it's white and it's very glaring and everybody says if the burglars see grabrails they know an elderly person lives there, but I can always paint it black I suppose.**
>
> **Service user, Case Study B**

One case study reflected that it can sometimes be **difficult obtaining feedback from service users**. Case Study C were trying to improve responses to surveys to better inform service improvement, but this was an ongoing challenge. In Case Study H, handy person visits are proactively followed up after work is completed with a telephone call to obtain feedback. This approach has generated more detailed qualitative feedback on the service for commissioners.

Section 6

The value and impact of home improvement Services

The Lived Experience report [link] details the difference that adaptations, home repairs and improvements can make to people's lives, and the wider impacts they can have on people's health and wellbeing.

The report highlights the importance of the entire home improvement process when considering outcomes. Benefits from having improved accessibility and functionality in the home can be undermined by a problematic process and a lack of communication. Where home improvement processes work well, they do so by improving the home, not just the house.

In this chapter we report on the impact on service users who have received support from the case studies and examine what aspects of the services are particularly valued by service users. The chapter also covers efforts that the case studies are taking to reach those who are most in need, and the reasons why services are valued by wider stakeholders, other services, and the system.

6.1. For service users

There were a range of key impacts of home improvement services for service users which were reported across the eight case studies.

Independence

A key aim of many home improvement services is to enable service users to continue living **safely and independently** in their own homes. Service users overwhelmingly described improving or maintaining their independence as an important impact of the services they had received. This was achieved through a range of interventions depending on client need.

Service users reflected that sometimes very small interventions had made a big difference to their levels of independence. For example, one service user described how having a perching stool relieved pressure on their joints allowing them to complete household tasks without support:

> **I've got two perching stools now which are high seats where I can, one in the kitchen where I can prepare food and the other that I can sit and do my ironing, so that's been a great relief.**

Service user, Case Study B

Similarly, larger adaptations improved the **accessibility and safety** of the home, enabling service users to continue living independently. Adaptations such as level-access showers, wet rooms, and stairlifts had made a huge difference to a few service users enabling them to move safely around their homes and care for themselves independently. One service user, who had suffered injuries because of previous falls, was struggling to get in and out of the bath and had to rely on her daughter, who lived elsewhere, to help her. She was fearful of having another fall and felt that her situation would have been unsustainable without the help of the home improvement service.

> **I can't really state how much difference it made. Well that, you know, I can actually just get in the shower without worrying about falling. It's so easy. It's a lovely shower. It's just exactly what I needed. If they hadn't have put it in, I don't know what I would have done really.**

Service user, Case Study D

Adaptations often led to feelings of **greater confidence** and **less of a need to rely on others** for support with day-to-day tasks.

I feel so confident. I have things also to hold so I'm confident on my own now. I don't have to ask my children, I'm going in the bathroom, sit and wait, keep the door open in case anything happens so they can come and help me. Now I can go on my own whether there's anybody at home or not, I can go on my own without fear.

Service user, Case Study C

As well as having more independence within their homes, service users also described positive impacts of the service in enabling them to engage with others outside of their home, reducing isolation and loneliness and helping them to maintain or build social connections and be supported by their community. One technical officer described a recent example.

That's one thing I really like about the job is because I see, you know, huge impact from where I first go and do the survey and people struggling to when I go back and do the sign off at the end. You just make a huge difference to everyone's life. But I saw a lady last month and she was, yeah, archetypal grandmother. She was 93 and she hadn't left her home for three years because she couldn't get down the steps. So we've gone in there and we've put some ramps in, put a different door in and now she's up and away and out in the community and all the rest of it.

Technical officer, Case Study G

Small-scale adaptations, such as grab rails were reported to r**educe the risk of trips and falls** and made the home more **accessible**, so people felt more confident in moving around more.

Well I think it's given him confidence to try and move around more and do things for himself. [...] Having the grab rail in that toilet, it's a very small area but he can grab it as he goes in, and I think it's made him more independent.

Service user, Case Study H

Supporting physical health

Aids and adaptations and other interventions enabled people to **manage their health conditions** more effectively and enabled them to **recover safely at home following discharge from hospital** after accidents or treatment. Adaptations were frequently described as making a major difference in terms of service users' quality of life and **reducing their pain and discomfort.**

> **I couldn't walk from here to there without crying. I used to get up from here and cry just to get across there to get to the other side of the room. I couldn't get in and out of the bath. But when they did the wet room, you just walk in, switch it on and switch it off again and it's done, it's so easy.**

Service user, Case Study A

For some service users, minor adaptations, such as grab rails supported them with **regaining their mobility** and being able to implement occupational therapists' recommendations, without having to rely so much on family, friends or carers.

> **[The adaptations are] helping us keeping pace with her progress basically because it's a gradual process, physio exercises and gradually building up her confidence to tackling the stairs.**

Service user, Case Study H

Minor adaptations had a significant impact on **quality of life** and safety. Many participants, service users and staff alike, were confident that these adaptations had prevented falls. One service user, who suffered with arthritis, described the impact of having a second handrail installed on the stairs.

> **If I'm lucky I've got these two fingers and a thumb to grip, so it's better having two handrails. I feel a lot safer, a lot happier, a lot more comfortable.**

Service user, Case Study H

Another service user had previously been unable to use her kitchen effectively, due to it not being fully accessible to her wheelchair. Following adaptations, she was able to independently access her kitchen, giving her greater **control** over what she could cook and having a knock-on impact on her physical health.

> **I assessed her, we identified what she wanted to achieve in the kitchen and adapted the kitchen and basically, she is just over the moon. She's like "It's changing my life. I've lost two stone in weight because I can actually cook what I want to cook, and I've got control over what meals I cook" and not relying on ready meals which are known to be not that great for you.**

Occupational therapist, Case Study G

One service reported that whilst it was not always possible to improve or maintain the physical health of those they support, their services were still hugely valued by service users and their families. They described the importance of their services for giving people **dignity** and maintaining their quality of life, even as their condition deteriorated.

> **We make a hell of a difference to the majority of clients, people with MND, end of life cases, children's cases. People say, "you enabled my husband or wife to live comfortably to the end of their life".**

Caseworker, Case Study G

Improved physical environment

Alongside core services which provide adaptations to make people's homes safe and accessible, the case studies deliver a range of additional services with a focus on providing wider support as needed. Many of these services improve the physical condition and environment of people's homes making them safer to live in, warmer, and enhancing the quality of life of residents.

For example, providing **affordable warmth and energy saving** projects had the impact of improving service users' health and wellbeing by improving the physical environment in which they are living. One service user described the impact of these interventions on her and her family's quality of life.

> **Before, my children and I would be piling things on top of us before we went to bed. But now the house is warm enough that I can even just use a sheet to cover myself, I believe that has improved the quality of my life because I can think better, I can feel human, that's what I wasn't used to.**

Service user, Case Study C

Other services also described the impact of improving **energy efficiency** on **thermal comfort**. The improvements had enabled service users to keep their homes warm (alongside reducing energy consumption and bills). Interventions included installing more efficient boilers, boiler servicing and repairs, insulation, new doors, windows and radiators, winter warmth essentials (e.g. blankets, hats and gloves) and emergency loan heaters. One staff member described an example where a home's EPC rating was improved from E to C due to the improvements to the home.

We put double glazing in, new front door, new back door, loft insulation, cavity wall insulation, new boiler, fixed some radiators. They got the works!

Case Study A

A Sanctuary scheme which involved improving **home security** through the installation of locks, new doors and windows, fire bags on letter boxes, and measures to make gardens more secure, had recently been piloted in one of the home improvement services (Case Study G). It had received extremely positive feedback about the impact it has made for people who have experienced **domestic abuse**, in terms of **feeling safe**. In some cases, this has led to children being able to be returned to the care of their mother by social workers.

Some of the case studies provide support for people with hoarding disorder, which was felt to be an increasing problem. In some cases, improvements to the physical environment needed to be addressed before the service user could be assessed for adaptations, as the environment may be **unsafe or unsuitable to begin other work**. Services improved the physical environment of homes by arranging house clearances and clearing properties, removing hazards, and decluttering. Some services placed a key focus on the **mental health needs** of service users with hoarding disorder, noting the importance of approaching this in a therapeutic way due to the complexity of the issue. One service, who had partnered with Age UK to deliver this service, said:

Traditionally when we very first used to work with environmental health many moons ago, houses just used to be cleared, which is the worst thing that you can possibly do for someone with a recognised hoarding disorder. So now we take a therapeutic approach to the way that we support people. There's no time limit on that level of support that we can give. Sometimes we can move things on quite quickly when the individual is willing, other times it can take over a year to kind of work with somebody and be able to clear the home. But that relationship with Age UK has worked really well actually.

Technical officer, Case Study D

Mental health and wellbeing

Many service users reported improvements in their mental health and wellbeing. They felt **safer, more independent and more confident** in their own home, which r**educed feelings of stress and anxiety**. One participant had a stairlift installed by the home improvement services which enabled her to leave the house more easily, improving her **social connections**. This had a significant impact on her mental health. She said: *'I've had a stairlift installed and that has saved my sanity if you like, reduced my depression.' (Service user, Case Study A).* Another service user emphasised the importance of their **local community** in their wellbeing, and the adaptations would enable them to stay in their home: *'the house isn't perfect but it's really important that we get to stay living here.' (Service user, Case Study B).*

Others experienced improved wellbeing following adaptations which enabled them to contribute to household tasks and activities that they had struggled with before, giving them back a **sense of dignity**.

> **It means I'll finally be able to share in the cooking which I'm quite happy to cook and I'll be able to do that much, much better. [...] It's going to make life so much easier all in all.**

Service user, Case Study B

Home improvement services staff often spoke about the impacts of the service on clients' mental health too. A technical officer described an example of a service user who had received adaptations, and the positive changes he had observed in terms of their mental health.

> **The link to mental health as well, the impact on that guy's mental health was unbelievable, he was having very dark thoughts at the start of the scheme. Just the change in that individual when you go and see him, he's a different man, he says I can go out now with my wife, I can sleep with my partner in the same room.**

Technical officer, Case Study D

The services often also had **wider impacts on the family and friends** of service users, reducing their stress and **improving their relationships**.

That's a side of the job we maybe don't talk as much about in terms of outcomes, as well as the physical side it's the impact on positive mental health for families and carers and the wider family then, cos it makes their burden a bit easier because you're helping the individual become more independent.

Technical officer, Case Study D

Family members of service users agreed. One described that the knowledge that adaptations had been installed had **reduced their stress and anxiety**: *'it's certainly set my mind at rest cos I was a bit anxious about it, having falls at home, but having these bars and help has made a big difference.' (Family member, Case Study H).* Another family member reflected that alongside the worry about the health of their loved one, the **physical demands** of caring for someone before adaptations were installed was a key source of stress and anxiety. The work completed by the home improvement services meant that: '*I'm not breaking my back every time I get him in and out of the bath' (Family member, Case Study A).*

Home improvement services' staff also explained that service users can be hesitant to engage with the service, as they are worried that it is the *'thin end of the wedge'* **fearing losing control** and **having to leave their home**. The services enabled people to stay in their homes and age safely in place. For many, this was important in terms of maintaining their independence, but also as they had an emotional attachment to their homes and had important local social networks, which were important factors in their overall wellbeing.

It's a massive thing to put your hand up and ask for help because people can be fearful it's going to agencies or asking for the help because they're scared of being judged that they're failing and they can no longer stay in their own home, no longer be in their own community. [It's reassuring people that it's] not about putting you somewhere else unless you want to be informed of what those somewhere else's are and make your own decision. We're about keeping them in the home. That's the important part. You can see sometimes the relief on somebody's face because they are fearful.

Caseworker, Case Study E

Linked to this, reducing the impact of **isolation and loneliness** was a key outcome of the support provided by services. One participant described how she and her husband had become isolated and struggled with their mental health prior to engaging with the home improvement services.

Support from caseworkers in identifying and applying for relevant benefits (Attendance Allowance) had made a real difference to their mental health and wellbeing.

We got to a point where you don't feel like seeing anybody. Then he got quite depressed. It's helped him a lot, it's just boosted him a little bit. And it's helped me quite a bit, believe it or not. So, we've both benefited from it.

Service user, Case Study E

This couple felt that if the support from the home improvement services had not been available:

We would have spiralled downwards, because we would have not known that there was anybody to help us. I think [his dementia] would have got a lot worse. I think we'd have been a lot more isolated, wouldn't we?'

Service user, Case Study E

Personalised approach

A key element of home improvement services which was universally valued by service users, was the **personalised approach** which was employed by all our case studies. Personalised support provided service users with a **positive and high-quality** service, **tailored** to their needs.

For me personally, it's so bespoke because we're very client-led.

Caseworker, Case Study E

Having a caseworker was highly valued by participants as it gave them a **single point of contact** with the home improvement service and many service users described the important **impact of building positive, trusting relationships with their caseworkers**. The importance of having one individual who acts as the single point of contact throughout the home improvement process was also stressed by participants involved in the lived experience strand of the evaluation. Good communication with a caseworker promotes trust, respect, empowerment, and control over what is being done to a service user's home.

Caseworkers were often described as being **caring and empathetic** and going above and beyond to support service users. This was particularly important as service users may be initially cautious to get involved. Some are concerned that they will **lose control** and not be able to stay in their home

(as described earlier), whilst others had experienced **negative interactions with other services**. For example, one service user felt that they had been *'passed from pillar to post'* when engaging with other services previously. She found the processes overwhelming and confusing and felt she was not listened to or believed. In contrast, she felt her caseworker from Case Study E was *'very approachable. I felt like she was on my side.' (Service user, Case Study E).*

There were many examples from service users of **positive experiences** with the home improvement services which had been crucial in the outcomes they had experienced. These were very often linked to the personalised approach and relationships that they developed with staff.

It is soul destroying when slowly you're losing your mobility and you're having to rely on people to help you all the time. It erodes your confidence something terrible and you no longer feel like the person you were. So that thing of just getting me the stairlift, if she'd given me a million pounds, I wouldn't have felt any better, it was just great and the speed, and she was like a little ray of sunshine that came into our lives.

Service user, Case Study A

They've shown a degree of empathy that we felt was missing on occasions in other organisations. You tend to find this I think with volunteer organisations, they're doing it for different reasons.

Service user, Case Study B

This **high quality of service** went beyond caseworkers, and service users regularly praised the other staff (e.g. OTs and technical officers) and contractors that they encountered.

They'll give you a date, a time and they come round and do the work and clear up, all of them very polite, very professional, they were brilliant.

Service user, Case Study H

Even the workmen that came. Very polite, very caring. You know anything else you need to do with that?

Service user, Case Study E

Home improvement service staff felt that this approach was particularly valuable and unique in the context of **changing models of support** across other services. Caseworkers described the challenges older and more vulnerable people may face in terms of **digital exclusion** and **navigating complex systems**. They highlighted the importance of building trusting relationships face-to-face over time to provide effective and holistic support for these individuals.

> **There's a lot of, you know, go online and do this online, scan this QR code, you know, and it's just the old-fashioned aspect of sitting down with somebody face to face in their environment where they feel comfortable and letting them offload, letting them go off on a tangent and bring them back in a little bit if needed. But more importantly for us and my team is actually hearing what's said and picking out ways in which we can help, not dismissing things.**

Caseworker, Case Study E

A key impact of this personalised service was **raising awareness** of the services that are **available** to service users and helping them to **access** them. Caseworkers reflected that many service users were not aware of the range of services that they could access and were grateful for this support.

> **Because they don't know. I mean, to come back to the same lady again, you know, she didn't know about Attendance Allowance. So, you know, and she was amazed that we could do these things for her, you know, help her and get her funding and we got somebody in to do quite a big clearance for her and she just couldn't believe it.**

Case Study F

Service users agreed, stating that before engaging with the home improvement service they had not been aware of the services and support available to them, and valuing the simplicity of the process of working with a caseworker:

> **Like I say I didn't realise [all the services] were combined like this and it certainly does make a difference once you're assessed and everything, it goes on from there. Everyone knows what each other is doing basically. As I say it's really, really, good.**

Service user, Case Study D

> **If you need to contact someone regarding something, there's always one person that you can directly get in touch with rather than having different departments.**

Service user, Case Study D

Service users often explained that they had struggled with the **complexity of accessing multiple services**, in terms of understanding the processes they needed to go through and accessing relevant services. For one service user, having a caseworker was crucial as they struggled to communicate their needs due to having a learning disability.

> **I think the nicest thing that they did was they kept in contact with all the agencies involved so that there was no miscommunication. I think that was essential because if I've misunderstood something at least they're talking to each other.**

Service user, Case Study D

Financial resilience

A key part of caseworkers' roles is income maximisation. They found that service users were often unaware of the benefits they may be entitled to and found the application processes difficult due to their complexity and sometimes a lack of digital skills. Caseworkers explained that this support can be hugely impactful, describing situations where people had had their benefits cut and were struggling to cope, with some even becoming suicidal.

> **People are always very grateful; you can just tell that it's meant a lot.**

Caseworker, Case Study E

Service users agreed, with one reflecting that they had become isolated due to struggling financially. Following engagement with the home improvement service they had applied for Attendance Allowance and Pension Credit, which had helped them to improve their financial resilience and re-connect with their family and community.

> **It was the actual extra money [from benefits applications] that helped us to be able to think [...] we could go out in the community and see people, take your grandkids out.**

Service user, Case Study E

Service users also noted the impact of other services, such as energy efficiency measures, in terms of improving their financial resilience. One described how the installation and ongoing servicing of a new boiler had made a big difference to their quality of life due to the money they were saving.

> **When she said don't pay, when you have a problem, we will help repair it for you, that brought us back so much money we were giving away and that improved our quality of living also, saving that much money.**

Service user, Case Study C

Some services also offered low-cost finance to service users who may struggle to access mainstream lending services or who are reluctant to take on debt. This had proved very successful for some service users.

> **A charge on the house and that also has given me, my entire family were so happy that that was possible because it was difficult for me to get a loan. This one on the house, no problem.**

Service user, Case Study C

However, some services reflected that people were often unwilling to take up low-cost finance, and these parts of the services tended to be under-utilised. In some cases, service users had an aversion to debt, whilst for others, staff speculated that residents may be reluctant to borrow from the council due to a lack of trust.

6.2. For those most in need and impacted by social and economic inequalities

Home improvement services generally aimed to reach those most in need of their services and those most impacted by social and economic inequalities. However, the extent to which this was a key focus of their work varied between services. Interviewees reflected that DFG work was inherently targeted at those most in need, due to its eligibility criteria and via **means testing**, although they did highlight the limitations of this (described elsewhere). Some home improvement services provided universal services, but all had some level of means-testing or eligibility criteria for certain services to ensure those in most need could access free services.

Interviewees also described the organisational processes via which they prioritise their work. Each service operates a **triaging system** when referrals are received so that those at higher risk or which are more urgent are prioritised.

Some services also had other **strategic priorities** which they used to target individuals with particular needs or conditions. As described earlier some services undertook **outreach work and promotion** of the service to ensure a wider reach. Sometimes this outreach was specifically targeted to engage with people who may be more vulnerable and less likely to be engaged with services already. In some cases, this was linked to particular groups or communities, whereas in other places this was geographically focused. For example, in Case Study C and Case Study B, outreach had focused on building links with faith groups to build trust and reach under-represented groups, such as asylum seekers, refugees and some minority ethnic groups.

> **So we're involved with our faith groups at the moment trying to increase the take up in certain areas. [...] They are often very worried about government and council-type organisations so it's trying to get them to trust us really as well.**
>
> **Case Study C**

Direct outreach work was not always possible due to **lack of resource and capacity** (e.g. Case Study D). However, most services took a **multidisciplinary approach** and had good partnerships with council departments and the voluntary sector, for example. This approach helped to ensure that vulnerable people were not *'bounced around'* the system and received the most **appropriate support** as quickly as possible. In Case Study G, a service is in place working alongside the home improvement services to provide wider support using a social prescribing model. The service is funded by the Department of Health and Social Care and run by voluntary organisations and the council. It is complementary to the work of the home improvement services in that they support people who can't or don't want to stay in their homes, meaning the home improvement service can refer people, who don't quite fit into their remit, to more appropriate support, and vice versa. A member of staff from this service explained:

Lots of our clients need Citizen's Advice, social prescribing and home improvements. I refer into them [name Home Improvement Services] and they refer into us. Our client group are the same. So, social services might refer to us, I might go out and see that they need adaptations. Or the home improvement agency might go out and notice a need for social prescribing.

Case Study G

Home improvement services also **piloted projects or services** based on identified need or available funding for support for particular groups. In some cases, projects were trialled in order to identify if there were needs for specific types of services. This type of innovation and diversification of services was often valued by other stakeholders but sometimes meant that the services provided were **dependent on available funding** for some interventions. Interviewees reflected that their ability to support the most vulnerable is, to some extent, in control of the commissioning local authority. Nonetheless, collaboration between home improvement services and the local authority is common.

However, the extent to which they were able to deliver these complementary services was often limited by **resources and capacity**, with many services experiencing **huge demand** and with some struggling to meet the needs of the service users already coming in.

Although home improvement service staff, particularly caseworkers, highlighted that they were not advocates, they were acutely aware of the vulnerabilities of some of their service users and always tried to ensure that they were aware of their options, rights, and helped them to access all the support available to them. There were many examples of staff going **above and beyond** to support their service users and get the best possible

outcomes for them, even if it went beyond the remit of the home improvement service.

Older people or people in that vulnerable sector will either flee or fight, but most tend to flee and just accept it. We're all a bit like dogs with bones. We never really give up. We always want the best outcome for the client. We're not advocates, we just pretty much tell it like it is and say, "Look, why is this happening?"

Caseworker, Case Study E

Service users also described how the **personalised and caring approach** of the home improvement service was particularly important and was often in contrast to other services. This was particularly valuable for the most marginalised service users as they may be more vulnerable and need extra support and understanding to be able to engage. For example, one service user who had received asylum in the UK described the positive impact their interaction with the home improvement agency had made on their **wellbeing** due to **feeling welcomed and listened to**. They also noted the significant impact of the financial support that they received on their quality of life.

They were good and kind. He talked with me; he listened to me and then if I was saying nonsense he listened to me. [...] I have experienced bad elements elsewhere, people at the council, somebody who was there to deal with the paperwork wasn't dealing with me as a person. But home improvement agency dealt with me as a person so that's the quality of life they've given me.

Service user, Case Study C

Services reflected that unfortunately, despite efforts to engage with those who need the service most, it is likely that **some will be missed**. People struggling with in-work poverty and child poverty may be missed if they do not meet the thresholds linked to home improvement service funds. For example, interviewees in Case Study A explained that their free services were restricted to older people and people with disabilities, which would likely result in people experiencing in-work poverty or child poverty slipping through the net. As a result of this, there were many examples of home improvement services which had **developed specific services** focused on groups who may be u**nderrepresented** amongst service users, including a fuel poverty service for households of working age, and an air quality service for households with children suffering from respiratory conditions.

Case Study B had developed a bespoke home independence and warmth service commissioned by the council and the Integrated Care Board (ICB) to support vulnerable people with falls prevention, hazard repairs, and heating and energy efficiency issues. They focus on service users not covered by core services. For example, the fall prevention service is free for homeowners and those in private rented properties, and includes adaptations such as grabrails, second handrails, and bath steps. They had seen an increase in cases from key demographics who were previously underrepresented due to outreach and targeting.

6.3. For stakeholders, other services, and the system

Home improvement services were generally highly valued across our case studies by wider stakeholders for several reasons. Firstly, they were seen as **high-quality trusted providers**, which frequently **support multiple local authority priorities** via a single team.

For example, in Case Study H, the home improvement service is closely aligned with the local authority's focus and strategies on providing preventative and integrated services, delaying the onset of acute care needs and reducing pressure on health services by facilitating hospital discharge and preventing (re)admission. One staff member explained:

> **That's the sort of thing we get back to the commissioners and this is what they like to hear, that the money they're spending is helping people to stay independent and safe in their homes.**

Case Study H

This was particularly the case for 'one-stop-shop' type services which are providing a **holistic range** of support and **cross-referring** within and beyond their service.

> **They deliver a range of services that no one else does and that kind of holistic approach is really valuable because they can refer within the organisation and there's an economy of scale.**

Commissioner, Case Study E

Similarly, a commissioner from Case Study E's City Council, described how the home improvement service, which is an independent charity, supported the council to deliver on some of their **wider priorities** alongside housing and health. They particularly appreciated that some of this work may be **outside of the standard remit** of a home improvement service. For example, they offer interest-free loan products to improve energy efficiency and are piloting a domestic retrofit project via separate funding from Carbon Co-op.

This service supports vulnerable people whilst also contributing to other council objectives on carbon reduction.

The ability of an independent home improvement service to offer financial products to improve housing (and therefore health) was also particularly valued by stakeholders in this local authority. They felt these were very important in **maximising prevention** and was seen as something that the council may be reluctant to deliver in-house, due to the complexities and requirements linked to providing these services.

Symptoms of health conditions are dealt with through health funding, but the cause of those health conditions might be [a] housing issue which needs to be funding through some housing source and that's kind of the problem really. The financial products that they provide on our behalf are really valuable. They're quite special.

Commissioner, Case Study E

Stakeholders felt that home improvement services were valuable in helping service users to **navigate the system**, supporting them through bureaucratic processes which could be daunting and confusing. This support stops people from bouncing around the system thereby **releasing capacity** in the social care system. The **connections and relationships** that home improvement services have with other delivery partners and complementary services, as well as community groups and target demographics, was felt to be key to their success and impact. Stakeholders reflected that this approach / model facilitated collaboration and cross-referrals meaning that the service is **integrated, accessible and efficient**. Stakeholders described how the home improvement service was valuable to stakeholders in terms of **receiving and disseminating information** across a wide network of health, local authority, and third sector providers because of their established connections and relationships. For example, an interviewee in Case Study C explained that the home improvement agency had disseminated dementia awareness training across relevant teams in the District local authority. Similarly, the home improvement agency and the County Council OT collaborate to ensure training is up to date and disseminated widely.

We have set up a couple of training days jointly, one looking at portable modular ramps. And then the other was looking at a new hinge for fire doors that would make them easier to open and close. So if we spot a new project, then we would try and do some kind of joint training to make people aware of it.

Stakeholder, Case Study C

Stakeholders acknowledged the **high-quality level of service** that the home improvement services provided, going **above and beyond** to support those who need it and not turning people away. The home improvement service helped to raise awareness with the public about the services that are available. Not only do they provide a **comprehensive range** of services themselves, they are also able to meaningfully signpost or refer people to other services if a service user's needs are outside of their remit due to their integration with wider service providers. Many services operated a 'no wrong front door approach' meaning that service users will be given a **holistic assessment** of their needs rather than being offered an intervention in isolation. This often involved going beyond what they were required to do, and this was recognised by stakeholders as the example below illustrates.

[The home improvement service] signposted a person to mental health services and asked questions around, 'do you have a social worker and are you registered with the GP?' And none of that is what they've been commissioned to do.

Commissioner, Case Study B

Stakeholders explained that they often received **positive feedback** from service users and other organisations about the home improvement service. Home improvement service staff are viewed as well-trained, professional and personable. They were also seen by delivery partners as collaborative and flexible, due to their willingness to work together with other services to provide integrated and comprehensive support.

They're a really engaged delivery partner and they're very flexible, I think that's the joy of them really. Their staff are very flexible in terms of the way they work with people.

Stakeholder, Case Study B

Commissioners also echoed the views of staff and service users on the impact that the services have on people's lives.

There's a neighbour of mine who is in her 80s. She's actually housebound. Possibly a bit of, you know, trauma induced agoraphobia, probably. But yeah, she's had a bit of work done that Care and Repair delivered and then did windows and heating and bits and bobs....and it's just massively improved her life in that she's warm and safe and happy. She could easily have died in the last few years or at least been subject to hospital admission. It genuinely improves people's lives.

Commissioner, Case Study E

6.4. Cost effectiveness and value for money

Commissioners, other stakeholders, and service users overwhelmingly describe the case study services as providing **value for money**. Stakeholders and service users see home improvement services as **trusted providers**, they have a **good reputation** built up over their years of operation. They often help to **support wider strategic objectives** (e.g. for local authorities and the NHS).

The positive established reputation enabled them to deliver **complementary services** beyond those commissioned through the local authority and **generate additional funds**. As one service said: *'every pound the council give us we can turn into two in effect because we've got deep roots in the region.' (Case Study H)*. This service generated income from private referrals to cross-subsidise their charitable mission.

It's usually about £550,000 a quarter they're able to generate in their own income, significant amounts just because of the skill of the business that they do.

Case Study H

In some cases, it was highlighted that despite delivering services to a growing number of service users with increasingly constrained budgets, they still maintained this high-quality service and delivered large numbers of DFG cases, which was highly valued by stakeholders and service users alike. The case studies are providing a comprehensive range of services and employing a holistic approach in their support for clients, all of which was perceived to deliver a very cost-effective service.

Many perceived the delivery model of the home improvement services as having the impact of creating a cost-effective service. The **integrated, collaborative and multidisciplinary** way in which the services operated was seen as being **efficient**, and therefore likely to be more cost-effective than if services were provided separately. Home improvement service staff described the effectiveness of the systems they had in place to manage their caseloads:

> **We're very much conveyor belt, sort of service so everyone has their own parts to do, and it just gets passed down the line and it's quite efficient.**

Technical officer, Case Study G

In some cases, stakeholders reported that home improvement services had worked to become more efficient over time by **streamlining** their delivery model to maintain the quality and range of their services despite budget constraints.

> **They're a much more efficient service now than they were five years ago, it's much more streamlined. They've got a much flatter structure now. Before the customer service team would just do that bit whereas people are doing little bits of everything, so everyone can take a phone call now. If the customer service team are all on the phone there'll be another member of staff that can take calls, so they don't need to take messages. So working practices are more streamlined.**

Commissioner, Case Study B

One-stop-shop services were also felt to offer **cost efficiencies** as they supported multiple local authority priorities within a single, integrated team, allowing DFG obligations to be fulfilled alongside other services, e.g. those tackling the climate emergency.

Several of the cases studies felt that their **focus on prevention** represented long-term value for money and cost effectiveness. One home improvement service reflected that the wider local authority had begun to recognise the value in this approach as a result of financial constraints across the local authority.

There's definitely been a change in the thinking from senior management within Case Study D and I think that's partly driven by the need for efficiency savings. Like all authorities, you know we are struggling financially, so prevention is finally seeing how you know myself and [Staying Put team leader] have always seen it, which is it should always be the priority in terms of people coming through that front door.

Case Study D

The case study services were also viewed as good value for money by those receiving them. Even service users who were utilising paid-for services not covered by grant funding felt that they were cost-effective. Some had compared the prices with other contractors and found the home improvement service to be cheaper. In some cases, service users preferred to utilise the home improvement service as it was endorsed by the council and is a not-for-profit rather than a private contractor. Service user **satisfaction ratings** are also very high, where this data is collected (e.g. Case Study A, Case Study D). The fact that **costs for services from the home improvement service are reasonable compared to the private sector** also helped the home improvement service to undertake home improvements for service users living in private rented accommodation, where landlords may challenge costs.

Despite being generally valued highly by stakeholders, home improvement service staff reflected that it is was **challenging to quantify the impact** of their services, due to the focus on prevention meaning that impacts were more **long term and difficult to attribute to the service**. Some felt that this meant that the service was undervalued by stakeholders.

Part of the challenge is that there are not necessarily savings today, it's cutting down the demand tomorrow. Adaptions might not take the direct pressure off of adult care, but it stops more people coming to them subsequently and in the future.

Case Study H

The same interviewee felt that these cost savings were undervalued by the ICB in the region as the work they provided to facilitate hospital discharge (e.g. adaptations and clearances) was funded through the council rather than the ICB, meaning they were reluctant to invest in and support these services.

Bizarrely housing pays for hospital discharge. [...] I think the issue we've got with the ICB and with hospitals is that there is a real reluctance to invest in these services because it's being funded by the council and obviously the councils don't have any money. [...] ICBs and others should be properly funding these services for the work that they do because it isn't just a council's responsibility, this is a cross health sector funding priority.

Case Study H

Although some home improvement services **collect monitoring data and quantitative evidence** on outcomes, it can be difficult to make 'value for money' calculations. Nonetheless, evidence collected from the case studies points to them providing cost effective services and good value for money. For example, Case Study A delivered 94 per cent of DFGs within target time in 2023-24 and they currently operate without a waiting list due to the successful processing of referrals and cases. Accordingly, customer satisfaction with the DFG service and handyperson service was 100 per cent based on responses to surveys.

Case studies identified a key challenge in evidencing value for money and cost effectiveness as it is **difficult to quantify and attribute outcomes** to the service. It is challenging to disentangle impacts of the services from other factors, and many savings are **long-term** due to the preventative nature of many of the interventions. Nevertheless, interviewees felt very confident that the home improvement services were providing value for money via **increasing capacity** and **enabling cost savings** in the health and care system, and some did collect evidence on interventions which supported these conclusions.

Interviewees described a range of services which contributed to these outcomes. **Hospital to Home services** were a key example cited by commissioners and services in terms of cost savings to the wider health and care system. Hospital to Home services enabled service users to be discharged from hospital safely by providing urgent adaptations quickly. This often involved minor adaptations such as grab rails, key boxes (for carers to enter the home) alongside tech-enabled care. These services meant that discharges could happen more quickly, **reducing bed-blocking** and therefore creating cost savings for the NHS. Commissioners believed these services would likely create further preventative savings by reducing

healthcare usage due to service users having a safe environment for recovery, therefore **reducing re-admittance** to hospital, **attendance at GP surgeries** and **delaying the onset of acute care needs**. As one technical officer pointed out, enabling a person to safely stay in their home often has cost saving benefits for the wider system as it was generally cheaper than moving into assisted accommodation or care homes.

> **Ultimately, we do have to bear in mind that it's generally cheaper and nicer for the client for them to stay in their home than to have to move. So when I say cheaper, it's cheaper for society, cause obviously that's generally cheaper to adapt someone's home and keep them there than it is for them to go into assisted accommodation and things like that.**
>
> **Technical officer, Case Study G**

Although evidence to support these views was largely qualitative, some services did collect quantitative evidence on interventions. For example, a pilot programme delivered by the home improvement service and other voluntary organisations in Case Study B which aims to support patient recovery by providing wraparound support with daily tasks and minor adaptations, quantified healthcare usage for six months before and after using the service. They found that attendance at A&E and hospital inpatient admissions were reduced, and they estimated a c.30 per cent reduction in probability of hospital or A&E admission. Average bed days were reduced from 14 to nine days with average costs per hospital day reduced by c.£500 per person.

In Case Study H, interviewees highlighted an example of an evaluation of a tech-enabled care service providing assistive technology (delivered by the council outside of the home improvement service). It was estimated to have made cost-savings of £2.5 million in 2023-24, primarily via delaying future care needs among service users. This evidence had been used to provide a business case to grow the service within the council.

The fact that home improvement services provided these services was identified as cost-effective in some areas, in the sense that it meant that these services were not required to be funded by other parts of the system. From the perspective of local authorities, where funding is often under pressure, the fact that home improvement services can **generate income from other sources**, is beneficial for councils and appreciated by commissioners.

For example, in Case Study A, the county council provides support for hospital discharge across the county, but explained that, in Case Study A, the home improvement service provision meant that they did not need to provide anywhere near as much financial support as in other areas.

The advantage of working with our district colleagues is that they have access to other funding routes. So, they are either already funded to do that work, in which case there isn't a cost to the County authority or the person, or they are very competitive with their pricing. [...] I would say in Case Study A we've barely used the pot of money from our funds we allocated to that district. It's just over £8,000. And we've been active in Case Study A for nearly 18 months. And we've barely used any money because we've been able to use existing funding that are already in place.

Stakeholder, Case Study A

Similarly, stakeholders from other case studies praised the ability of home improvement services to generate income, which enabled cost savings in other parts of the system. As described earlier, case studies deliver a range of services alongside their commissioned services. These are often funded through **grants from other providers or philanthropic funds**. For example, in Case Study B, interviewees described how they had aimed to diversify their income *'constantly looking at different income streams'* to enable them to not have an *'over-reliance on the local authority.'*

In a number of the case study areas, this approach enabled them to **reach more service users** with different needs outside the remit or restrictions of commissioned services. As described earlier, commissioners often appreciated this **proactive and innovative approach** which helped to deliver on other local authority priorities and tested the need and demand for specific services. Some services generated income by taking **private referrals** to subsidise their charitable mission (e.g. Case Study H), although other services had been forced to reduce or stop offering these services because of escalating demand from professional referrals (e.g. Case Study D).

We had our private works offer around your adaptations during which it's almost been kind of shut down in terms of the list of priorities due to the amount of demand that we're getting through from occupational therapy. So that's made it really difficult to do that private stuff.

Case Study D

Section 7

Economic analysis

7.1. Introduction to the economic analysis (inputs and outputs)

This chapter considers an economic evaluation of home improvement services to provide an understanding of their costs as well as the economic, social, and health impact of the outcomes that they provided. The assessment is important to contribute to the following objectives:

- Fill an evidence gap in research around the impact of home improvement services.
- Demonstrate to national and local policy makers the impact of comprehensive home improvement services on individuals' health and wellbeing, and on wider housing, health and social care pressures.

At the outset it is important to note that there is very limited existing data on home improvement services, particularly that which is collected consistently and comprehensively to allow national level analysis. This study has also had limited influence on new data collection by home improvement service organisations within the study's timeframe. As noted later there is a particular gap in terms of quantitative evidence linking

the activities and support provided by home improvement services to outcomes and impact for beneficiaries, agencies, and society as a whole. Consequently, a full joined up economic evaluation is not possible. The study therefore considers individual components of an impact and Value for Money framework using a mixed and multi-method approach. This considers the funding, costs and activities associated with delivering home improvement services. It also addresses the likely outcomes of home improvement services in relation to what difference they make to their beneficiaries as well as the economic, social, and health benefits that are likely to emerge.

The remainder of the chapter is structured in terms of the components of an impact and value for money framework:

- **Inputs:** costs of providing home improvement services including for example source and amounts of funding, costs of home improvements.
- **Outputs:** activity delivered, beneficiary numbers and their characteristics, improvements provided to beneficiaries.
- **Cost Efficiency:** the average cost of home improvement service activity.
- **Outcomes:** what difference home improvement services make such as to physical and mental health, safety, social care, energy usage/efficiency, social isolation etc.
- **The additionality of these outcomes:** this is the impact of home improvement services compared to a counterfactual scenario.
- **The value of outcomes:** the monetary value, cost savings and return on investment of the outcomes provided by home improvement services.

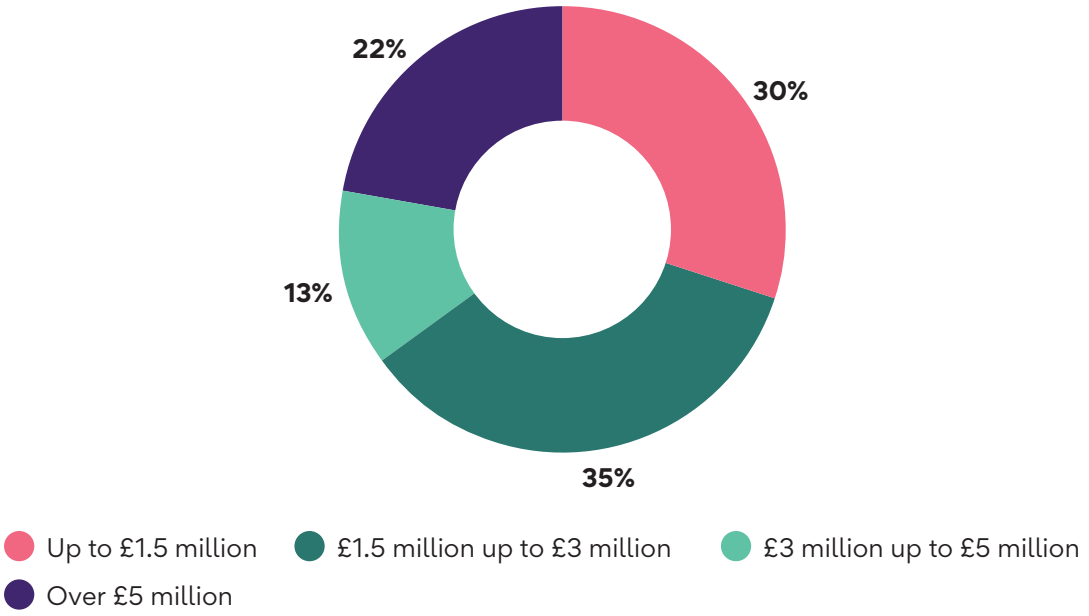
Inputs

This section examines the resources (input) that are used to provide home improvement services. Underpinning this analysis is information on income, expenditure and staffing from the online survey of home improvement services. This asked responding home improvement services to provide information on their: total funding and the sources of this funding; total expenditure and expenditure on broad expenditure categories; and staffing number.

Survey evidence reveals on average home improvement services' total expenditure in the latest financial year was £3,833,257. However total expenditure varied considerably by service. Of the 23 services who provided information, their expenditure ranged from just under £550,000 to £18.7 million. There was also a fairly even distribution across expenditure level bands. Figure 7.1 shows 30 per cent of organisations said they had a total expenditure of up to £1.5 million. A further 35 per cent said they had a total expenditure of £1.5million up to £3million. Of the remainder 13 per

cent reported an expenditure of £3 million to £5 million and another 22 per cent had an expenditure in excess of £5 million.

Figure 7.1: Total expenditure by home improvement services



Composition of expenditure also varied across home improvement services. Across the responding home improvement services, almost three quarters of expenditure (74 per cent) was on grants and a further 13 per cent was on staffing. The remainder (13 per cent) was on other categories such as discretionary payments, materials, grants and office costs which varied by home improvement service.

Analysis of income reveals a similar picture. Across the 27 home improvement services who provided information their average income was £3,846,446. This is similar to the average expenditure. However, income ranged by home improvement service from £538,000 to £18.7 million. DFG allocations accounted for the largest percentage of home improvement service income: 65 per cent. This means that on average across all responding home improvement services, for every £1 of DFG funding a further 54p was levered in from other sources. Other notable income categories were energy efficiency/warm home funding (16 per cent), own contributions (eight per cent) and other LA funding (8 per cent). It is however important to note that seven of the responding home improvement services had no additional funding other than DFG.

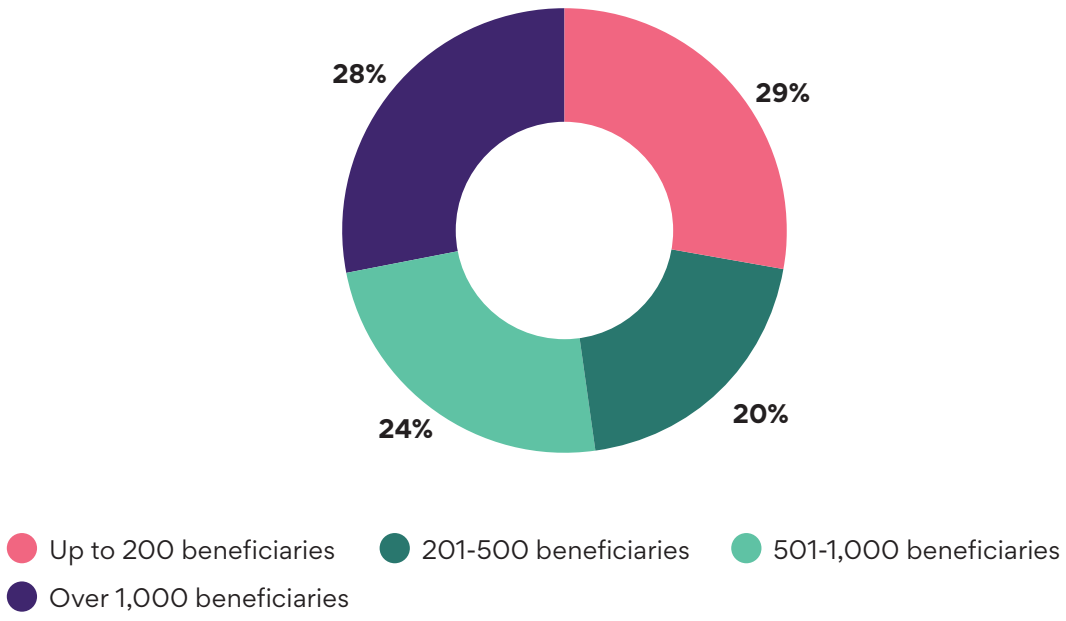
The next two sections consider the support provided by this funding and the average cost of support per beneficiary.

Outputs

Outputs are the activity and actions that home improvement services undertake with their inputs to contribute to outcomes. Within the survey of home improvement services, this study has collected information on the number of households supported as well as the types of support that they provided.

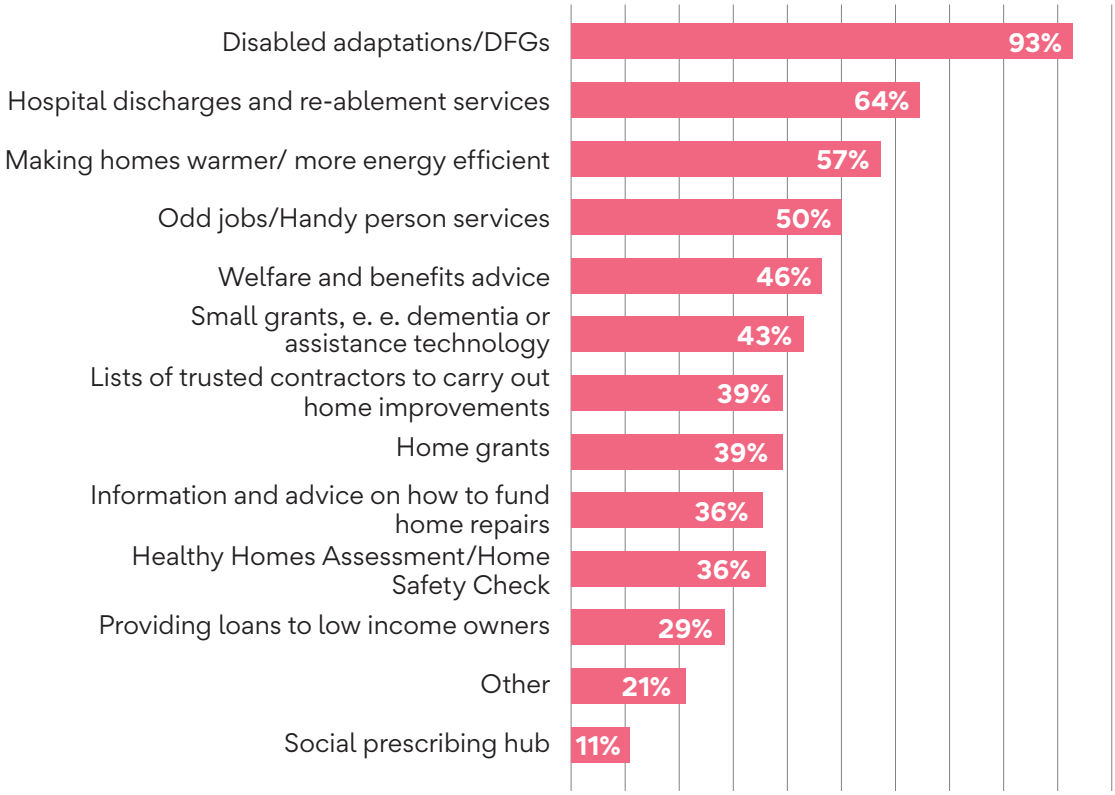
The survey asked how many households were supported by the home improvement service over the latest year that the service had data. Of the 25 home improvement services who responded the average was 1,597 beneficiary households. This average hides a wide variation in how many households were supported by each home improvement service. The average figure is also skewed upwards by a small number of home improvement services with very large numbers of benefiting households. As presented earlier in the report, Figure 7.2 shows 48 per cent of home improvement service organisations had supported up to 500 households in the space of a year. A further 24 per cent of responding organisations had supported between 500 and 1,000 households, while 28 per cent of organisations had supported over 1,000 households.

Figure 7.2: Households supported by home improvement services



As reported previously in Chapter 4, Figure 7.3 shows the proportion of home improvement service organisations reporting that they provide different types of services. Most home improvement services provided disabled adaptations or DFGs to enable residents to carry out adaptations. Just under two thirds (64 per cent) of organisations said that they provide hospital discharge and reablement services, and 57 per cent say they provide services to make homes warmer or more energy efficient. Half of respondents said they provided an odd job or Handyperson service. Less common services include providing information and advice on how to fund home improvement, and Healthy Homes Assessments or home safety checks, which are provided by just over a third (36 per cent) of organisations responding to the survey.

Figure 7.3: Services provided by home improvement service organisations



Analysis of the relationship between beneficiary numbers and the services provided reveals there is a statistically significant positive association between the number of services offered and the number of supported households. This means home improvement service organisations which offer more types of services tended to support higher numbers of households. Focusing on the broad types of services provided, home improvement services that provided information advice and guidance on average supported a higher number of households. Whereas home improvement services who directly undertook works (such as odd jobs or handy person services) or provided hospital discharge/reablement supported on average a lower number of households.

The next section uses this information on households supported (outputs) as well as expenditure (inputs) from above to compute the average cost of support.

7.2. Cost efficiency

This section considers the average expenditure of home improvement services for each household that they support, also known as the cost efficiency. The evidence base for this analysis is the survey of home improvement service organisations. For practical reasons the analysis focuses on 21 responding home improvement services who provided complete information in terms of their expenditure, income and the number of households that they had supported. It also focuses on average cost efficiency across home improvement service organisations. This is due to the aggregate cost efficiency being affected due to the influence of a limited number of home improvement service organisations with very low average cost.

The average, average cost per beneficiary household was £6,707. This again varied considerably across the home improvement services who responded. Six home improvement services had an average expenditure which was greater than £10k per household supported. This included one home improvement service whose average expenditure was £18,000 per beneficiary household. At the other end of the spectrum two home improvement service organisations had an average expenditure per beneficiary household which was under £250.

Reasons for the differences between home improvement service organisations were multifaceted, and often related to the particular characteristics of the service. Therefore, the average £6,707 of expenditure per beneficiary household can be useful within an economic assessment and/or to project an indicative cost of a service. However, it is important to acknowledge that the actual average expenditure of a home improvement service may be very different.

Using the responses to the survey, analysis has identified characteristics of home improvement services that appeared to be associated with their average costs. However, it is important to note that the limited number of home improvement service organisations that responded to the survey means it was not possible to disentangle and isolate the influence of different factors on the average expenditure per beneficiary. The analysis is therefore based on differences in average expenditure per beneficiary based on whether given characteristics were present.

There is a complex relationship between the number of types of service offered by a home improvement service and its average expenditure per beneficiary. Home improvement services offering a limited number of services (four or less types of service) had on average a lower average expenditure per beneficiary (£7,040 per beneficiary) compared to those with a middling number (five to eight services) of services on offer (£7,960 per beneficiary). However, home improvement services which offered the most different types of service (nine or more different services) had on average the lowest average expenditure per beneficiary (£3,390 per beneficiary). This suggests up until a certain point increasing the number of services on offer by home improvement service increases the expenditure required: more services are associated with an enhanced and more expensive offer. Though home improvement services offering the most comprehensive range of services are typically spreading their resources more efficiently. Therefore, on average they have a lower average expenditure per beneficiary. This ties in with the qualitative findings from the case studies. Stakeholders viewed delivering a comprehensive range of services holistically and in an integrated, collaborative and multidisciplinary way as being efficient, and therefore likely to be more cost-effective than if services were provided separately.

There was a statistically significant negative correlation between the number of beneficiaries that a home improvement service supported and their average expenditure per beneficiary household. This suggests home improvement service organisations that supported higher numbers of households had on average a lower average expenditure per household. This is more than likely because they were spreading their resources more thinly. For example, focusing on advice and signposting services which can be provided at lower cost to a larger number of households. Rather than concentrating predominantly on more expensive services (such as providing adaptations) which would limit the number of households that they could support within their funding.

Reinforcing this point there were noticeable differences between home improvement service organisations in terms of their average expenditure per beneficiary based on the types of service that they offered. Home improvement services who directly undertook works or supported hospital discharge/reablement had a noticeably higher average expenditure compared to those who did not: £6,610 and £6,490 per beneficiary respectively.

While the average expenditure per beneficiary is typically lower for home improvement service organisations who provided information, advice and guidance, as well as healthy home assessments (£5,950 per beneficiary).

Finally, the survey results suggest home improvement service organisations who were solely funded by DFG had typically higher average expenditure per beneficiary (£9,680 per beneficiary) compared to those with more diverse funding (£5,910 per beneficiary). Though these home improvement service organisations also had lower numbers of beneficiaries and tended to offer more costly services such as major adaptations. This has likely become starker given findings highlighted earlier that home improvement services reported difficulties in delivering major works and adaptations within the higher DFG cap of £30,000. Consequently, fewer people can be helped even if Councils use top up grants to fund activity. The latest evidence also shows almost half of DFG grants are now between £5,000 to £15,000 in 2022/23 compared to around 35 per cent over the whole period from 2009 to 2019/20.

In order to provide more context to the expenditure of home improvement services, as part of the case study work an additional data collection exercise took place to collate evidence on the average unit cost of individual adaptations or services. Three home improvement services were able to provide this evidence which is summarised below in Table 7.1. To minimise disclosure the responses of the three home improvement service organisations have been provided in terms of the lower and upper unit cost provided.

It important to note that the majority of the lower unit costs came from a home improvement service located in a northern, relatively deprived local authority. Whereas the upper unit costs were from southern home improvement services, where levels of deprivation were relatively lower. Whilst not derived from a comprehensive evidence base this adds support to hypothesis that different geographic areas face very different costs for similar adaptations or support. With northern and more derived areas typically experiencing lower costs for most forms of adaptation and service considered. Case study evidence also point to recent significant increases in labour and material costs that are affecting the delivery of DFGs. These cost increases have been experienced across the country, but the magnitude of increase has been greatest in the south of England.

The data collection also asked case studies to provide the number of each type of adaptation or service that they have provided in their latest year. Interestingly there was only a weak negative correlation between the unit cost of adaptations/services and the number provided in the last year. This means although there is a tendency for more expensive adaptations/ services to be less common this was far from universal, likely reflecting the provision of adaptations being need rather cost-led.

Table 7.1: Illustrative unit cost of adaptations from case studies

	Total unit cost (adaptation and installation)	
	Lower	Upper
Install a property extension	£35,914	£65,771
Lift	£12,459	£17,216
Kitchen modifications	£4,065	£16,182
Walk in shower	£6,085	£10,040
Wide doorways/hallways	£2,894	£10,000
Toilet equipment/commode	£4,372	£6,417
Over bath shower	£3,133	£5,500
Ramps or street level entrances	£1,610	£5,317
Automatic or easy open doors	£4,570	£5,294
Boiler replacement	£1,850	£4,978
Stairlift or stair glide	£3,974	£4,107
Accessible parking/drop-off site	£3,600	
Loft insulation	£1,750	
Bed lever or bed rail	£900	
Window repairs	£700	
Radiator replacement	£528	
Bath or shower seat	£479	
Boiler repair	£196	£400
Hand rails	£99	£371
Install TRVs	£25	£290
Radiator repair	£263	
Alerting devices (e.g. button alarms)	£235	
Gas fire service	£172	
Boiler service	£100	£151
Temporary heating (e.g. portable heater)	£50	£100
Warm pack	£79	

The next section considers outcomes.

Outcomes

Outcomes are what is achieved as a result of the activities of home improvement services. Reflecting on the evidence base the main categories of outcomes likely to emerge from home improvement services are:

- Home accessibility: this includes measures of use of home and satisfaction with home.
- Heating the home: this includes measures of fuel poverty, achieving healthy temperatures and thermal comfort.
- Home safety and condition: this includes measures of fire safety, safety from Carbon Monoxide, trips and falls, and condensation, damp and mould.
- Health and wellbeing: this includes measures of minor illness, general health, mental health and life satisfaction/wellbeing.
- Usage of primary and secondary health care services: this includes GP appointments, prescriptions, hospital admissions, delayed discharge and readmissions.

A central challenge to this economic evaluation of home improvement services has been accessing robust and reliable evidence on outcomes that are experienced by beneficiaries of services. In the main home improvement service organisations collect and monitor activity (output) information, which is often part of reporting to their funders. However, for an economic evaluation there is a requirement for quantifiable evidence on the number of beneficiaries achieving outcomes as well as the scale of the outcome change.

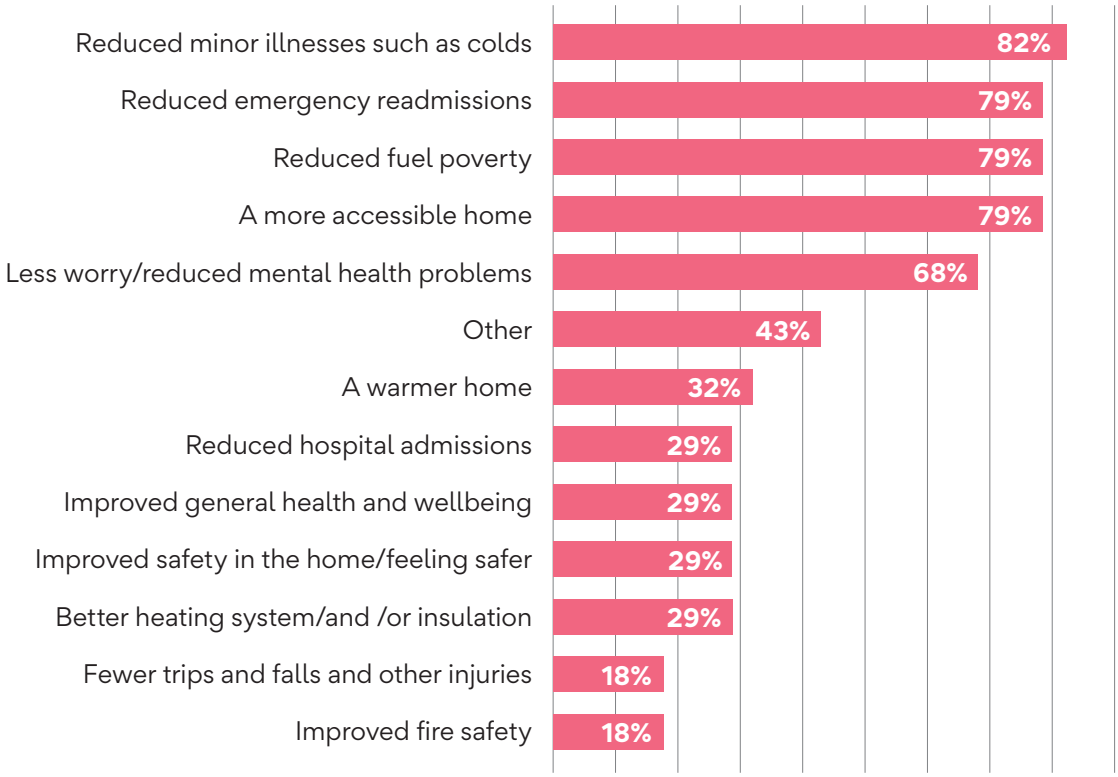
An example is data collected by hospital discharge services. Typically, home improvement services will know and report how many people have been supported to discharge from hospital. However, few have collected, through rigorous methods, the numbers of beneficiaries who would otherwise have caused ‘bed blocking’ and the numbers of hospital ‘bed days’ freed up. Similarly, home improvement services capture data on the number of beneficiaries who have received falls prevention adaptations. However, few, if any services, have evidence on the number of falls prevented as well as the associated outcomes such as reduced A&E admissions as a result of these prevented falls.

It is important to acknowledge that collecting this information will require significant direction (such as demand from funders), investment and support (from data owners) to overcome challenges. In part this explains why the evidence does not already exist. It will also require input from specialists in economic evaluation who can ensure the resulting evidence base, and analysis attain required standards of scientific rigor.

In light of this absence of quantifiable, robust and reliable evidence on client outcomes, this study has considered evidence from the survey of home improvement services on the main outcomes experienced by their beneficiaries. The analysis also identifies the outcomes reported by beneficiaries who took part in detailed qualitative interviews across the case studies.

As shown in Chapter 4 earlier, the survey asked home improvement service organisations what they considered to be the main benefits of the services and interventions they delivered for their clients. Responding organisations were asked to focus on the main, primary benefits only - ideally listing no more than five. The results are listed in Figure 7.4. Most organisations (82 per cent) said that one of the main benefits of their service was reducing minor illnesses such as colds. 79 per cent of home improvement services said that reduced emergency admissions was a main primary benefit of their service, and the same proportion said that reducing fuel poverty and creating a more accessible home were main benefits. Two thirds (68 per cent) said that less worry/reduced mental health problems was one of the main benefits. Organisations reported that other benefits, beyond those listed in the survey, were a decrease in home carers needed or fewer hours of home care required. They also told us that there are measured impacts in relation to people remaining independent in their own home.

Figure 7.4: Main benefits of the services identified by home improvement services



The range of outcomes identified in the survey broadly overlapped with the evidence from qualitative interviews with home improvement service beneficiaries as part of the case studies. Of the 26 beneficiary interviews analysed the most common outcomes experienced related to: improved confidence and independence (20 interviewees), falls prevention (19 interviewees), improved mental health and wellbeing (15 interviewees), reduced pain/improved pain management (11 interviewees), financial (four interviewees) improved comfort/warmth (four interviewees) and improved safety (four interviewees). More detail on these outcomes and explanation of how home improvement services contributed to them can be found in Chapter 6.

The next section considers the extent to which outcomes provided by home improvement services are likely to be additional. This includes exploratory work on the net additional impact of adaptations on wellbeing, applying a quasi-experimental approach using responses to the English Longitudinal Survey of Aging (ELSA).

Additionality

Additionality is an assessment of the extent to which outcomes identified can be attributed to home improvement services, or whether they would have been achieved in their absence. This can involve considering the scale, timing, coverage and quality of the outcomes which occur. When assessing additionality, it is important to acknowledge that scales have been developed which prioritise and rank different methodological approaches. These typically preference experimental and quasi-experimental methods highest. Whereas theory-based and qualitative approaches are viewed to offer lower scientific rigor. As other authors have identified, the available evidence base on home improvement services means there is limited scope to adopt the most scientific method approaches. Therefore, our primary approach has been to assess outcomes that can be attributed to the home improvement services via beneficiary interviews as part of a qualitative assessment of additionality. To extend this and provide more scientific rigor, exploratory work has been completed to assess evidence on the net additional impact of adaptations on wellbeing. This applies a quasi-experimental approach using responses to the English Longitudinal Survey of Aging (ELSA).

The qualitative assessment of additionality comprised the following three stages with the result being an additionality ratio that can be applied to convert gross to net additional outcomes attributable to home improvement services:

- Firstly, specific impact and additionality focused questions were asked during the in-depth interviews with beneficiaries of home improvement services. These questions covered: the outcomes beneficiaries achieved; the types of support that they received or were signposted to; alternative types of support being received; and the relative contribution of support that they received from home improvement services to their outcomes compared to other factors.
- Secondly an impact evaluation proforma was completed during analysis of the interviews which collated specific evidence to inform an assessment of additionality.
- Thirdly, using the interview evidence, a review panel made an independent assessment of the level of additionality provided by home improvement services to the outcomes achieved by the beneficiary. This included to what extent the outcomes would have been achieved without home improvement services and how important their support was to the given outcomes over and above the influence of other factors, interventions, or changes.

The final assessment of additionality was based on 26 in-depth beneficiary interviews undertaken during the evaluation. This number is relatively sizable for a qualitative study. However, it limits the robustness of the estimated level of additionality and the reliability of comparisons between different factors. For example, differences in additionality between beneficiaries who

received different forms of support. It is likely that those who received advice and guidance support will have a lower level of additionality compared to those who received significant works and adaptations to their home.

Overall, the qualitative assessment suggested home improvement services provided a very high level of additionality to the outcomes experienced by beneficiaries: potentially as high as 70 per cent. Underpinning this is evidence that in many cases the only other option would have been to pay privately for services, which for most recipients would likely be unaffordable. Also, for some beneficiaries without their interaction with a home improvement service it is likely that their need would remain hidden, therefore their outcomes would not be attained.

To strengthen the evidence base future work is required to quantify the net additional outcomes that can be attributed to home improvement services using more scientifically rigorous methods. This means adopting experimental (including random controlled trials) or quasi experimental designs to assess the impact of home improvement services on a range of outcomes. Such as how many actual falls have been prevented due to the activities of home improvement services and how many of these falls that have been prevented would have led to a hospitalisation.

As an exemplar this study used the English Longitudinal Survey of Aging (ELSA) to assess the impact of adaptations on wellbeing using a quasi-experimental method. This analysis compares wellbeing levels for those who have adaptations against a matched sample of respondents who do not. The matching process (propensity score matching) used statistical modelling to match each respondent with an adaptation to a nearest neighbour who is statistically the closest to them across a range of key factors other than whether they had an adaptation. The analysis took place on three samples:

- A longitudinal sample allowing for a differences-in-differences analysis for respondents who gained an adaptation between wave 9 and 10 of ELSA and a matched sample who did not.
- Two cross-sectional samples which considered differences in life satisfaction for respondents who had an adaptation in wave 9 and wave 10 of ELSA, separately, compared to matched samples who did not.

The advantage of such an approach is that is quantifies the net additional outcomes that can be attributed to activities with a higher degree of methodological rigour and robustness (achieving Level 4 on the Maryland Scientific Methods Scale). This is important when engaging key stakeholders such as the Treasury and many commissioners. The net additional outcomes from this analysis can also be valued using WELLBY.[48] This additionality analysis is appropriate in the context of evaluating home improvement services since the adaptations considered are reflective of the interventions that they provide. However, it was not possible to determine whether home improvement services had provided the adaptations for the ELSA respondent. Therefore, an implicit assumption of the analysis is that the impact of adaptations is equivalent regardless of who provided and funded them, including if they were self-funded.

Table 7.2 identifies a statistically significant positive impact of adaptations on wellbeing when any form of adaptation is considered. This net additional impact on wellbeing is similar in magnitude across the three samples. The results imply adaptations were associated with approximately 0.19 to 0.21 higher life satisfaction when compared to the situation for otherwise similar matched respondents who do not have adaptations.

The table also considers net additional impact for three broad types of adaptations:

- Falls prevention adaptations.[49]
- Structural adaptations[50] which improve access around the home.
- Non-structural adaptations/features[51] which improve access around the home.

Of these three types only structural adaptations which improve access around the home were identified as having a statistically significant net additional impact. For each of the three samples considered these adaptations were associated with a statistically significantly higher life satisfaction of between 0.21 and 0.32 life satisfaction points.

[48] HM Treasury (2021). Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance. London: HM Treasury. https://assets.publishing.service.gov.uk/media/60fa9169d3bf7f0448719daf/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

[49] These include assistive technology alarms, hand grab rails, stair lifts and ramps.

[50] These include walk in showers, widening doorways.

[51] These include hoists, bed levers/rails, commodes, bath/shower seats and kitchen modifications/features.

Table 7.2: Estimated net additional impact of adaptations on life satisfaction

	Sample					
	DiD: Wave 9 to 10		Wave 9		Wave 10	
	Mean diff	Sig	Mean diff	Sig	Mean diff	Sig
Adaptations all	0.22	0.009	0.19	0.000	0.19	0.000
Falls prevention	0.15	0.317	-0.02	0.809	-0.01	0.908
Access structural	0.21	0.019	0.32	0.000	0.32	0.000
Access features	-0.09	0.755	-0.15	0.180	-0.17	0.225

The next section considers the value of outcomes provided by home improvement services.

Value of outcomes

The valuation of outcomes in money terms is an integral part of economic evaluation. Placing outcomes in money terms facilitates a deeper understanding of an outcome to those that it affects. It provides a consistent measure to compare outcomes and costs. Doing so supports a more effective allocation of resources because it provides a consistent framework to identify the relative importance of outcomes to those affected. This supports an improved and simplified communication about the relative outcomes that are provided.

Valuation techniques can involve different levels of rigour and involve three broad approaches:

- Cost-based approach, these take into account the monetary saving a stakeholder incurs as a result of a change.
- Revealed preferences, use observed behaviour to determine consumer preferences making inferences from trade-offs that people make.
- Stated preferences, by contrast, are based on what people say rather than do; these ask stakeholders to benchmark the value of the outcome compared to tangible things that can be monetised.

The limited information on quantifiable additional outcomes from home improvement services constrains efforts to value the outcomes provided. Therefore, this study provides three illustrative examples of the value of outcomes provided by home improvement services. First a cost-based approach that provides estimates of the likely outcomes associated with providing falls prevention adaptations. This is based on a quantitative model underpinned by work of BRE and the London School of Economics (LSE). Second a revealed preference approach that uses WELLBYs to value the social wellbeing benefits of adaptions. This takes forward the analysis using ELSA provided earlier. Finally, also using a cost-based approach, the value of hospital discharge is explored.

Cost based approach: valuing falls preventions adaptations

Combining evidence from BRE (presented in the Work Packages report undertaken for Ageing Better INSERT LINK) and the LSE,[52] it is possible to develop a quantitative model that provides estimates of the likely outcomes associated providing adaptations to people with unmet equipment and adaptation needs. Reworking BRE's work suggests:

- The expected benefit of a prevented fall on stairs incident is a £9,590 cost saving to the NHS or £53,710 cost saving to society.
- The expected benefit of a prevented fall on the level incident is a £8,550 cost saving to the NHS or £17,040 cost saving to society.
- The expected benefit of a prevented fall between levels incident is a £3,750 cost saving to the NHS or £15,510 cost saving to society.

Using BRE's estimates of the number of households with these category 1 hazards, as well as the probability of an incident, suggests the cost saving of a fall is £7,050 to the NHS or a £29,140 cost saving to society. Conversely the estimated mean cost of adaptations required to prevent falls is £1,600 (combining the mean cost to address the three individual types of fall).

Applying estimates to the 12 months pathways model developed by the LSE suggests a quarter of those supported with an adaptation would be prevented from having an additional fall. In their pathway model, half of recipients who receive a preventative falls adaptation would not have a fall, and a further quarter would have a fall regardless of whether they received a preventative falls adaptation or not. This means the expected return on investment for every £1 spent on adaptations required to prevent falls is £1.10 of cost saving to the NHS or £4.56 to society. Therefore, based on this model the cost savings from falls prevention measures are predicted to exceed costs within the 12-month period.

[52] Snell, T., Fernandez, J-L., & Forder, J. (2012). *Building a business case for investing in adaptive technologies in England*, PSSRU Discussion Paper 2831. London School of Economics.

Table 7.3 provides an illustration of the potential value created from a home improvement service by applying these estimates to activity data provided by Case study B. This shows in 2022/23 Case study B supported 3,444 beneficiaries with adaptations that reduced their risk of falls in their home. The estimated total cost of these, based on BRE evidence, is just over £5.5 million. Based on LSE's likely pathways for beneficiaries, 861 falls would be prevented. Using BRE's work the estimated cost savings from these falls is £6.1million to the NHS or £25.1 million to society. Note this does not include additional value created in terms of for example greater independence and reduced fear of falls which means the full return on investment will likely be greater.

Table 7.3: Illustration of the potential value created by Case study Bs falls prevention activity

Case study B	Number / value
Reduced risk of falls preventions (22/23)	3,443
Mean cost to falls prevention interventions	£1,599
Total cost of falls prevention interventions	£5,505,802
Addition falls prevented	860.75
Expected cost saving of a fall to the NHS	£7,049
Total value of falls prevented to the NHS	£6,067,016
Return on Investment (saving to NHS)	**£1: £1.10**
Expected cost saving of a fall to society	£29,143
Total value of falls prevented to society	£25,084,682
Return on Investment (saving to society)	**£1: £4.56**

Revealed preference approach: WELLBY valuation of adaptations

A more innovative way of valuing the benefits of adaptions is to consider the benefits to the beneficiaries themselves. This has been done using a WELLBY approach which is a form of revealed preference. WELLBY - or 'Wellbeing-adjusted Life Year' - is a methodology to measure and value improvements in wellbeing (HMT, 2021).[53] It is used to refer to the total amount of well-being experienced by an individual over one year. One WELLBY is defined

[53] HM Treasury (2021). Wellbeing Guidance for Appraisal: Supplementary Green Book Guidance. London: HM Treasury. https://assets.publishing.service.gov.uk/media/60fa9169d3bf7f0448719daf/Wellbeing_guidance_for_appraisal_-_supplementary_Green_Book_guidance.pdf

as a change in life satisfaction of one point on a scale of 0-10, per person per year (ONS4 measure). WELLBYs equate wellbeing to personal income (i.e., as income increases so does wellbeing) and estimate the increase in income required to achieve an equivalent increase in wellbeing.

WELLBYs are an appropriate measure of value where it is considered that the concept of wellbeing fully captures all the outcomes created by a project or programme. HM Treasury guidance indicates that WELLBYs can be particularly relevant when the direct aim of the policy is to improve the wellbeing of a certain group. As such the WELLBY approach was deemed to be an appropriate valuation approach given improved mental health and wellbeing is a commonly identified benefit of home improvement service support (see Chapter 6). Many service users reported improvements to their mental health and wellbeing. As a result of improvements and the installation of adaptations service users felt safer, more independent and more confident in their own home which reduced their feelings of stress and anxiety.

The analysis presented earlier of the net additional impact of adaptations using ELSA identified that respondents with adaptations had on average 0.19 to 0.21 more WELLBYs compared to matched respondents who did not have adaptations. Based on the current value of a WELLBY the average expected social value from the increase in WELLBYs due to adaptations is worth approximately £2,790 to £3,230 per beneficiary. Using the same approach but focusing only on the net additional impact of structural adaptations suggests a WELLBY gain of between £3,090 and £4,700 per beneficiary.

It is important to acknowledge that this value is not additional 'real' money that beneficiaries receive. Rather it is the expected equivalent value of household income that would be required to produce an equivalent improvement in life satisfaction than that induced by adaptations. It is also worth stating that this improvement in life satisfaction has been supported by multiple aspects such as improvements in confidence, independence and control as well as improved satisfaction with the living environment. Service users also valued the personalised approach adopted by the case studies which is key in delivering a high-quality service tailored to their needs. Having a positive experience will enhance levels of satisfaction and contribute to the outcomes achieved.

Cost based approach: valuing hospital discharge

As another illustration of the potential value provided by home improvement services, we used evidence from a previous CRESR study on the impact of the British Red Cross's First Call Service in Bristol. The First Call service provided its users a range of support including supporting hospital discharge. The evaluation estimated the impact of the service on secondary health care usage outcomes by comparing outcome change for First Call

service users against a matched comparator. Working with the local CCG, the evaluation accesses average service use data from First Call service users who gave their permission. The analysis compared usage in a baseline period (two years before receiving First Call support) and a post intervention period (six months after receiving support). It also accessed data for an equivalent - anonymised - matched control sample of non-First Call service users (the counterfactual). This sample was matched based on similar characteristics to the First Call service user population.

Based on this evidence base, First Call beneficiaries who received a tier of support that included hospital discharge were found to have 6.9 fewer days in hospital. This impact can be valued using the latest figures from NHS on the average cost of a standard bed with no treatment £390 in 2023/24 prices. This suggests average savings to the NHS of £2,690 per supported hospital discharge before including further direct and indirect costs/benefits such as the costs incurred through cancelled elective operations. (These results are in line with a pilot programme delivered by the home improvement service and other voluntary organisations in Case Study B which aims to support patient recovery and quantified healthcare usage for six months before and after using the service. Average bed days were reduced by five days - from 14 to 9 days - with average costs per hospital day reduced by c.£500 per person).

Cost based approach: valuing interventions to prevent harm from excess cold

Adopting a similar approach, it is possible to provide estimates of the likely costs and return on investment from interventions to prevent harm from excess cold. This uses evidence from BRE (presented in the Work Packages report undertaken for Ageing Better) and McKenzie et al (2019) – who use multiple other sources to estimate the impact of Northern Ireland's Affordable Warmth Programme (AWP) from 2014 to 2018. Due to the available evidence the proposed approach uses a relatively 'blunt' binary measure of excess cold. This is based on whether interventions are likely to increase room temperature to healthy levels (18 - 24 degrees Celsius). An implication of this being an intervention that raised a household temperature from a very low temperature but not to above the health threshold - say 10 degrees Celsius to 17 degrees Celsius - would not have had an impact on harm from excess cold. Even though this increase would likely have a sizable effect on health. Whereas an intervention increasing temperature from 17 degrees Celsius to 18 degrees Celsius would have had an impact, even though the material difference on health is likely to be small.

[54] McKenzie, P., Green, G., Gilbertson, J., Stafford, B., & Cook, S. (2019). *A Health Impact Analysis of the Affordable Warmth Programme: 2014-2018*. Department for Communities.

Using BRE estimates:

- The expected cost of interventions to address harm from excess cold is £8,106 per household, in 2023/24 prices.
- The expected benefit of a prevented harm from excess cold is a £52,230 cost saving to the NHS or £728,182 cost saving to society: both in 2023/24 prices.

Using the impact estimates implied in McKenzie et al (2019):

- With relatively limited targeting for fuel poverty and risk of harm from excess cold, interventions to address excess cold will lead to 2.5 per cent of beneficiary households no longer experiencing harms from excess cold.
- With targeting for fuel poverty but not risk of harm from excess cold, interventions to address excess cold will lead to 3.4 per cent of beneficiary households no longer experiencing harms from excess cold.
- With targeting for fuel poverty and risk of harm from excess cold, interventions to address excess cold will lead to 11.3 per cent of beneficiary households no longer experiencing harms from excess cold.

Table 7.4 applies these estimates to provide an illustration of the potential value created from a home improvement service which provides 1,000 households with interventions to address excess cold. The estimated total cost of these interventions, based on BRE evidence, is just over £8.1 million. Using evidence from McKenzie et al (2019), based on the most cautious assumption of relatively limited targeting, it is estimated that the interventions would prevent excess cold harms for 25 individuals. This would provide a cost saving of £1.3 million to the NHS, a return on investment of £0.16 for every £1 spent on interventions to address excess cold. The estimated cost saving to society is £18.4 million, a return on investment of £2.27 for every £1 spent on interventions to address excess cold.

With targeting for fuel poor households, it is estimated that the interventions would prevent excess cold harms for 34 individuals. This would provide a cost saving of £1.8 million to the NHS, a return on investment of £0.22 for every £1 spent on interventions to address excess cold. The estimated cost saving to society is £24.7 million, a return on investment of £3.04 for every £1 spent on interventions to address excess cold.

Finally with a high degree of targeting (for fuel poverty and risk of harm from excess cold), it is estimated that the interventions would prevent excess cold harms for 113 individuals. This would provide a cost saving of just under £5.9 million to the NHS, a return on investment of £0.73 for every £1 spent on interventions to address excess cold. The estimated cost saving to society is £82.0 million, a return on investment of £10.12 for every £1 spent on interventions to address excess cold.

Table 7.4: Illustration of the potential value created by support to 1,000 households with interventions to prevent harm from excess cold

	Limited targeting	Targeting fuel poor	Targeting fuel poor and risk of harm from excess cold
Households supported to prevent harm from excess cold	1,000 households		
Mean cost of interventions for excess cold	£8,106		
Total cost of interventions for excess cold	£8,105,627		
Estimated harms from excess cold prevented	25	34	113
Cost saving of a prevented harm from excess cold to NHS	£52,230		
Value of prevented harms from excess cold to NHS	£1,318,258	£1,765,524	£5,885,080
RoI NHS	**£1 : £0.16**	**£1 : £0.22**	**£1 : £0.73**
Cost saving of a prevented harm from excess cold to society	£728,182		
Value of prevented harms from excess cold to society	£18,378,914	£24,614,617	£82,048,723
RoI society	**£1 : £2.27**	**£1 : £3.04**	**£1 : £10.12**

Note columns may not sum due to rounding

For information cost to society include the following, which cannot be individually isolated:

- Higher energy costs
- Higher insurance premiums
- Higher maintenance costs
- Higher policing costs
- Higher fire service costs
- Higher paramedic costs
- Cost of enforcement activity by local authorities
- Additional cost pressure on housing services
- Pressure on charities.

Note: the cost saving to the NHS and society are based on different types of financial metrics and therefore should not be summed.

7.3. Summary

This chapter considered an economic evaluation of home improvement services to provide an understanding of their costs as well as the economic, social, and health impacts of the outcomes that they provided. The key findings and messages to emerge are:

- There are important **evidence gaps that need to be filled** to enable more complete, robust, and rigorous economic evaluation of home improvement services. This specifically concerns quantitative evidence on the scale, magnitude and additionality of outcomes. Development of this evidence should prioritise experimental and quasi-experimental design studies and ensure analysis can account for the heterogeneity in home improvement services.
- There is **considerable variation (heterogeneity) in the scale and focus of home improvement services;** as shown in Sections 7.1 and 7.2 by differences in expenditure, the numbers of services offered, and the number of beneficiaries supported. This challenges the development of a singular economic assessment. When considering evidence on home improvement services, or seeking to develop a particular service, it is therefore necessary to adjust for differences in, for example beneficiary numbers and the types of service that will be offered.
- **The average cost of supporting beneficiaries (the cost efficiency**

of home improvement services) is £6,610. However, the amount varies relating to specific characteristics of the home improvement service. For example, the average cost is typically lower when the number of services and beneficiary numbers is greater. This may indicate that services are trying to do more with their funding, perhaps by joining services together or acting as a pathway into other support. Future studies should explore what effect this has on the effectiveness of services in providing additional outcomes and their Return on Investment.

- **Home improvement services are likely to provide a range of key outcomes for their beneficiaries directly as well as for other services and wider society. Most of these outcomes are likely to be additional:** that is they would not have occurred in the absence of the home improvement service. This is supported by qualitative evidence from interviews with beneficiaries as well as quasi-experimental evidence which identified a statistically significant net additional impact of adaptations on well-being.
- The evidence base prohibits a comprehensive assessment of the economic returns and Return on Investment from home improvement services. However, **the study has set out illustrations of the value provided by the activity of home improvement services**. This included:
  - **costs saving and a positive return on investment for the NHS and society from falls prevention adaptation;** the expected return on investment for every £1 spent on adaptations required to prevent falls is £1.10 of cost saving to the NHS or £4.56 to society.
  - **the value of wellbeing benefits from adaptations; £2,790 to £3,230 per beneficiary** applying a WELLBY approach.
  - **basic cost saving to NHS from hospital discharge due to freeing up beds; average savings to the NHS of £2,690 per supported hospital discharge** before including further direct and indirect costs/benefits.

- **Adopting a similar approach, it is possible to provide estimates of the likely costs and return on investment from interventions to prevent harm from excess cold.**
  - based on the most cautious assumption of relatively limited targeting, it is estimated that the interventions in 1,000 households would prevent excess cold harms for 25 individuals. **This would provide a cost saving of £1.3 million to the NHS, a return on investment of £0.16 for every £1 spent on interventions to address excess cold**. The estimated cost saving to society is £18.4 million, a return on investment of £2.27 for every £1 spent on interventions to address excess cold.
  - with targeting for fuel poor households, it is estimated that the interventions would prevent excess cold harms for 34 individuals. **This would provide a cost saving of £1.8 million to the NHS, a return on investment of £0.22 for every £1 spent on interventions to address excess cold**. The estimated cost saving to society is £24.7 million, a return on investment of £3.04 for every £1 spent on interventions to address excess cold.
  - with a high degree of targeting (for fuel poverty and risk of harm from excess cold), it is estimated that the interventions would prevent excess cold harms for 113 individuals. **This would provide a cost saving of just under £5.9 million to the NHS, a return on investment of £0.73 for every £1 spent on interventions to address excess cold**. The estimated cost saving to society is £82.0 million, a return on investment of £10.12 for every £1 spent on interventions to address excess cold.

Section 8

Good practice, lessons, and innovation

In this chapter we focus on the aspects of the case study home improvement services that represent good practice and examine what the case studies do that might provide lessons for other areas and services.

We asked the case studies about the future development of their services and issues around longer-term sustainability. During the evaluation we ran a Policy and Practice Forum with the case studies. These discussions provided an opportunity to share experiences, ideas and good practice, identify common challenges, and build learning across the case study services.

8.1. What features of the case studies represent good practice?

Strong leadership and values underpin the services, and this is central to delivering a good service. Case studies have a mission to promote dignity, independence, control, and quality of life for clients. Service managers drive a proactive ethos, with an outward-facing mentality and ability to see past obstacles – this is a central driver of a good service and has allowed the case studies to maintain and grow services in challenging contexts. Morale is high and staff take accountability for achieving good outcomes for clients.

Case studies take a **holistic and person-centred approach**. Many services are comprehensive, proactively assessing for multiple needs in one visit. Whilst some services were more integrated or co-located alongside aligned services, strong local knowledge, clear referral pathways and good communication were also used to signpost clients. Services support clients to make decisions, ensure that their voices are heard, and have choice in the process. Caseworkers are particularly valued for building trust with clients and managing complex cases.

All case studies provide **preventative support**. This means having the mindset to look at cases holistically and identify potential issues before they arise. Hospital discharge services have been a growing area, with clear evidence of avoiding hospital readmissions.

Most case studies had relatively **low-threshold access** to some services. This supports the delivery of preventative services by getting a foot in the door to pick up other issues in homes. Service access is supported by effective **triage and administration** to ensure a positive customer journey.

The mix of services delivered in case study areas varied but delivered **locally relevant services supporting strategic objectives**. Service offers were designed in conjunction with local strategic partners, and with reference to changing needs, demographics, and population risks.

Developing trust in relationships with key stakeholders and service-users was key. Strategic partners trusted services to deliver, including in complex cases. Service-users trusted services to undertake work, including essential but small jobs, and were comfortable with staff and contractors.

Investment in staff training and upskilling meant that many services could undertake a range of assessments in one home visit. To meet skills gaps, services were developing new in-house training roles.

There were some benefits to **integration**, including flexibility, cross-referrals, and joint working. However, services outside a local government framework also offered integrated services by virtue of strong local connections, partnerships, strategic relationships, and a commitment to a person-centred approach.

Services invested in **building partnerships** at strategic and delivery levels. Many interventions involved collaboration with a range of partners to deliver a streamlined service for clients.

Leadership and values underpinning the service

The case study services have a clear mission and set of values that run through the services and inform how staff work day-to-day. Strong leadership within services is important in driving an ethos throughout all levels that focuses holistically on positive outcomes for service-users – proactive leadership is a key element underpinning a good service as it enables many other dimensions to flow from it. Whilst there are technical dimensions to many roles, services do not view themselves as simply facilitating access to grants or completing forms and assessments, but on a broader understanding of client needs and wants. The focus was on achieving dignity, independence, control, and quality of life for clients, through whatever means available.

Services managers drive a proactive approach, which has enabled the maintenance – and in many cases growth – of services despite a challenging financial context. There is evidence of problem-solving and an outward-looking mentality, which has facilitated the delivery of new services and the development of new multi-stakeholder partnerships in the face of financial challenges. This is enabled by an ability to look past obstacles and proactively address these to deliver for those in need. Most services were *'constantly looking at different income streams'* (Case Study B), especially to reduce reliance on Local Authority funding. Others strategically used reserves to maintain services during Local Authority cuts, whilst looking at *'other options to bring in funding and generate income'* (Case Study A). This resulted in the introduction of a paid-for service to bring in income and a new partnership on hospital discharge, exemplifying a problem-solving attitude such that *'when services are in difficulty you grow your way out of it'* (Case Study A, council stakeholder). Similarly, Case Study H supplemented commissioned services with highly successful income-generating private referrals, including for larger works; this enabled cross-subsidising of other activities.

Services sought to access a range of different grants and philanthropic funds, which could help develop new and innovative services. Philanthropic funds often had different eligibility criteria to statutory services, which could help people who would otherwise *'slip through the gaps of legislation'* (Case Study D). Actively pursuing these funding pots could open-up other service areas, for example Gas Safe funding for free boiler servicing frequently led to the identification of other repair needs for vulnerable groups in Case Study C, enabling the service to reach more clients whose needs had been hidden. However, many services also highlighted the *'constant battle'* (Case Study A) of securing funding to keep going (see 'sustainability' section, below). A stakeholder from another home improvement service outside of the case studies also highlighted complexity for Local Authorities in seeking additional funding because they had to secure prior approval from Boards, Councillors and Members, by which time funding calls may have passed.

Service leads were proud of the work they do and sought to build their external reputation, developing key relationships and a brand that was recognised and trusted. As Case Study D explained *'sometimes it's a question of banging the drum loud enough until a reputation is formed... doing good work, working with local media... getting good stories out there.'* Staff members and partners share the mission and values of the service, and are themselves valued within services, building a positive atmosphere and strong working relationships. Despite challenges, staff morale was often described as high, and at all levels staff demonstrate a commitment to positive outcomes for clients. This drives accountability and a focus on the person at the heart of interventions, which is essential in ensuring that cases are not lost in the system. In turn, this means that recruitment needs to focus on achieving alignment with the service mission, seeking *'people who've the passion to support people'* (Case Study D) and *'a certain type of person who sees past all the obstacles and has a focus on helping the person with whatever they need'* (Case Study E). The focus of service managers on building the right team with the right skills and mentality is important in setting up the possibility for delivering a good service. Within organisations, staff were motivated by wanting *'to make a contribution...to feel that the job they do is worthwhile'* (Case Study H). Within services, staff also supported each other through difficult cases with *'reflective practice and supporting each other... encouraged and valued'* (Case Study G). It was also important for contractors to buy-into the wider mission service, for example through frequent sharing of positive feedback so that contractors knew *'you've helped change someone's quality of life here forever'* (Case Study D).

Holistic and person-centred

One of the clearest elements of good practice is that the Case Studies take a holistic and person-centred approach to home improvement, regardless of structure or delivery-model. Most of the Case Studies services are comprehensive, meaning that if someone comes in for one need, they are also assessed for multiple other services. In many cases, the Case Studies could directly *'offer all the other services'* (Case Study A), but even where this was not possible, clear referral pathways, strong local knowledge, and good case management linked clients to other avenues of support (Case Study G). Services had a mindset that *'you don't go to a property just to look at what's been referred...you're doing everything'* (Case Study C). Therefore, a visit for a small repair could also include energy efficiency and safety surveys, or a call to the NHS falls team. This required staff who have *'the training to look at everything,'* spot potential problems before they arise, and triage cases accordingly (Case Study C). However, some services noted that commissioners may not be fully aware of *'the actual depth we go into,'* resulting in under-funding for such a holistic, tailored offer (Case Study E); this was generally less of an issue where the service had been involved in developing projects from scratch.

A holistic offer was not reliant on integration within a Local Authority, although there were some benefits to co-location of staff (see 'integration' section). For example, Case Study H offered information, advice, and signposting to services that they did not deliver, as well as curating and sharing lists of *'trusted tradespeople who do things that we don't.'* Case Study B offered a *'no wrong front door approach'* according to commissioners, conducting holistic assessments, which included links to wider services beyond the remit of the home improvement service, such as social work and GP services. This is like cases in integrated services where someone may be wrongly referred to the home improvement service, with the home improvement service taking accountability to ensure that connections were made to the correct team (Case Study D).

Routes into a holistic service-offer were underpinned by person-centred support. This meant building trust with clients and facilitating them to *'make your own decision'* rather than deciding for them (Case Study E), always remembering *'it is their home'* (Case Study G). One interviewee described seeing the fear on someone's face disappear when they realised that their needs and wishes would be at the heart of the process and that *'we don't have tick boxes'* (Case Study E). Being person-centred could mean thinking outside the box, for example delivering a loft conversion, which *'sounds odd for a disabled adaptation'* but allowed the service to move a child out of a shared room, which then gave the space for their disabled sibling to *'flourish...in that remaining space'* (Case Study G).

Caseworkers were widely valued for building trust with clients, managing the customer journey, taking ownership of complex cases that could otherwise become lost in the system, and delivering a person-centred approach. For example, one service-user contrasted previous experiences in which they were not treated 'as a person'...*But the home improvement agency dealt with me as a person so that's the quality of life they've given me'* (Case Study C). Another service-user explained that a staff member *'was good enough to spend the time just to talk to me about other things as well'* (Case Study B). Investing in building these relationships with clients is essential and could include initial in-person visits of several hours. Person-centred support therefore requires an investment of time, and the right mindset, to not just listen but also *'actually hearing what is said and picking out ways in which we can help, not dismissing things'* (Case Study E). However, this could sometimes leave services compensating for lack of resources elsewhere as with nowhere else to go for some issues *'obviously you do help them'* (Case Study E).

There was good evidence of the practical delivery of person-centred home improvements across the Case Studies as well, with *'bespoke'* models (Case Study D and E). For example, Case Study B enabled service-users to pay an additional fee to receive a higher specification than delivered by a grant alone, and Case Study D offered *'preferred schemes...if they want additional tiling or things like that ... they pay the difference.'* Similarly, Case Study H allowed clients to pay for work beyond the minimum provided by the Council referral, enabling more *'aesthetically pleasing'* options. This aligns with wider work with service-users in the evaluation, which suggests these choices are highly valued. Having choices (within allowable parameters) offered an important mechanism for maximising a sense of control at a time when a client may be experiencing many things that are beyond their control. Wider research with those with lived experience of home improvement services demonstrates that control is fundamental to positive outcomes. Clients need to be involved in the process, not simply having things done to them – in Case Study D, for example, a handyperson fitted a ramp to ensure that a client was able to enter their home and make decisions about works.

Preventative support

All Case Studies were working to provide preventative support. This is fundamentally linked to a holistic and person-centred service, with key staff trained to identify other potential problems before they arise. Whilst preventative impacts could sometimes be hard to evidence quantitatively, services could show that *'the mindset and the thought process is there'* (Case Study D). A successful preventative service requires a particular mindset, technical and communication skills, wider knowledge and

awareness, and staff who take accountability for navigating service-users through different systems. Staff described their roles as *'a vocation'* (Case Study D), and this drives strong service delivery.

Services offer a range of preventative interventions. This was most evidenced in the number of hospital discharge services, linked to achieving preventative savings from avoiding hospital readmission and delaying the need for residential care. In Case Study A, for example, over nine months the service had prevented 17 discharges from failing and saved approximately 119 acute bed-days. Hospital discharge services typically required a high level of flexibility and responsiveness. This could be achieved by new processes, for example allocating straightforward adaptations directly to a contractor, bypassing Support Workers, and Technical Officers, which enabled *'a 24- to 48-hour turnaround...to get people out of hospital'* (Case Study B). However, some services felt that the strategic focus on hospital discharge as a key priority could divert attention from the preventative function of wider home improvement services, beyond making homes safe to facilitate discharge (Case Study E). There were also complexities around who funded housing interventions in which savings primarily flowed to the health service, including some evidence that viewing interventions as primarily housing-related meant that they were under-funded by ICBs (Case Study H).

Triaging low-threshold routes into services

There was some evidence of good practice in facilitating access to services through outreach, for example in Case Study B, an Outreach Worker worked with under-served communities in the most disadvantaged areas, attending events and places of worship. However, for some Case Studies, services, and more widely in the sector, there was greater differentiation in the extent to which proactive outreach occurred. Service pressures and waits for some services, in some areas, precluded greater advertising or awareness-raising (Case Study E and G).

Whilst all Case Study services had limits on access to some services, most also had some relatively open routes with low threshold for access, for example to small repairs services, or handyperson schemes. This supported the delivery of holistic and preventative services, because once in the door a holistic service can identify other needs and refer accordingly. If routes into the service are too restrictive, this limits the opportunity to identify potential issues early on. Case Study C, for example, offered free boiler services to owner-occupiers who were on low incomes, disabled, or vulnerable, which then *'opened up the door to many repairs...If they say, 'I need a boiler service,' nine times out of ten [the home] needs repairs.'* In Case Study G, all DFG-clients had access to a discretionary grant, which universally funded the first £6,500 of adaptations, regardless of means and as set out in the council's Financial Assistance Policy which enabled the use of powers provided in the Regulatory Reform Order. This was viewed as

providing a system-wide benefit by encouraging clients to get the work done, rather than avoiding the cost and reaching a crisis point.

Access to services is supported by effective triage and administration. This is particularly important for self-referrals, as teams typically receive a wide spectrum of enquiries (Case Study E) and must ensure that clients are not *'getting passed from pillar to post'* even when there were multiple needs (Case Study D). Effective administration was also fundamental to the successful triage of clients in services that operated across administrative boundaries, with different criteria (Case Study H).

Delivery of a holistic and integrated service was underpinned by data systems that hold and track data on client needs and interventions. Some services were investing in new systems, recognising its role in supporting customer journeys. For example, Case Study B had recently introduced a customer relationship management system (CRM). Strong data systems and record keeping meant that clients could have one key point of contact (usually a Caseworker), but all the other roles involved in the case could access relevant information and discuss this across the team (Case Study G). Having one key person managing the process is highly valued for customers. For services without Caseworkers or less robust case management systems (Case Study F, partly because of recent restructuring at the local authority), it was acknowledged that other staff were pressured by administration and client communication responsibilities beyond their core roles, with a negative impact on the quality of the service. This service was seeking to move towards a Caseworker-led approach.

Locally relevant services supporting strategic objectives

Case studies generally delivered a core of services such as adaptations and handypersons schemes, alongside a range of other locally relevant programmes. In some areas, the orientation of services to local challenges was aided by setting a Housing Assistance Policy (Case Study B and C) using the powers of the 2002 Regulatory Reform Order. This could provide flexibility to meet local needs or respond to particular pressures, for example in Case Study C there was a discretionary DFG top-up grant of £30,000 (means-tested) and some services were targeted towards groups most likely to be experiencing socio-economic disadvantage.

The mix of services offered by the Case Studies helped to deliver local strategic priorities across multiple sectors. The design of services was informed by engagement with local strategic partners and data relating to local population needs. In Case Study B, for example, the ICB had adopted *'a model of care...based in population need and population risk and tries to be quite proactive rather than reactive.'* This fed through into commissioning a multi-strand service based on an analysis of needs and health evidence for the local area, considering multiple data sources and local demographics. Case study C also worked closely with their local

Health and Wellbeing Board, utilising a local strategic needs assessment to align their service offer to changing needs. This helped to inform service changes, for example implementing dementia support. Whilst local knowledge was strong, some participants highlighted strategic gaps in higher-tied authorities, for example a County Council with *'no housing strategy, no unifying picture about ... the state of their housing ... and how their housing serves the needs of residents'* (Case Study C). This meant it was not clear that housing was *'a joint project that everyone shares'* across all levels of local governance. In another case, a service felt that commissioners were somewhat disconnected from community needs, with funding restrictions preventing those with a deeper understanding of communities from taking a more flexible approach (Case Study E). Recognition of the benefits of flexibility had been one of the drivers of bringing some services in-house, which had facilitated a move away from rigid commissioning contracts (Case Study F).

Developing trust

Building trusting relationships was an important feature of delivering a good service. This applies both to strategic stakeholder and partners, and to service-user relationships. Strategic partners and stakeholders valued being able to trust the Case Study services to deliver a high-quality intervention, even in difficult cases. For example, Local Authority partners valued working with Case Study C because they knew *'the person you're going to contact is going to be reliable and get the work done properly,'* which *'takes a lot of stress away from the officers'* who could be facing an emergency with hazards in homes. Similarly, others described a Case Study as *'a very trusted service, I've never seen the amount of compliments from any other service'* (Case Study A). Case Study H also received strong local support, stemming from *'their presence,'* longstanding engagement in strategic partnerships, and track-record of delivery. As one interviewee noted, even with challenging cases *'if you refer them to Case Study H, they would usually be able to pick them up and deal with the issues that they had, or if they couldn't...they would be able to get them off to another...agency who could support them.'*

For service-users, trust was also crucial. Accessing services often required divulging of financial information, and individuals sometimes also worried that home improvement was the *'thin end of the wedge'* that would ultimately result in a loss of control or being forced to move (Case Study D). Reassuring service-users and enabling them to feel comfortable and in control required a skilled approach and an investment in developing trusted relationships. This could be aided by going in with the mindset of just having a conversation, because *'people can be fearful going to agencies or asking for help'* (Case Study E). One interviewee explained that they continued to use a handyperson service because they felt *'very safe'* with them, whilst another reflected that the tradesman were not like others who *'come in and say, 'I'm in a hurry,' and then make a mess. [The home improvement*

service] couldn't have been nicer, quicker, cleaner, more pleasant' (Case Study C). Trust was also important for small jobs that delivered important benefits for the end-user but for which it could be difficult to source a private contractor. Handypersons service, for example, were viewed as *'reputable'* when delivered through a verified brand (Case Study H).

Staff training and up-skilling

Investing in the training and upskilling of staff was a key strength of the Case Study services. This supported staff to deliver holistic and preventative services, for example with Caseworkers trained to Trusted Assessor Level 4 being able to self-prescribe minor adaptations and handypersons trained to Trusted Assessor Level 2 to identify additional adaptations carrying out minor repairs (Case Study A). This meant that if handypersons *'go into the property and get chatting to the client they can also flag up any issues [to] go to the caseworker'* (Case Study A). The Trusted Assessor model also provided some bounded flexibility to support a person-centred service which put service-users in control. For example, handypersons could adjust the position of grabrails on-site to respond to the preferences of clients (Case Study D).

Whilst all Case Studies reported challenges in recruiting to roles, particularly Technical Officers, there were innovations which sought to address gaps. Some services had invested in in-house upskilling, for example developing *'a role as an Assistant Surveyor with...day release at college to then get the qualifications to be a surveyor'* (Case Study C). Similarly, Case Study F had introduced an innovative apprenticeship route to align technical roles with home energy improvements, responding to the growth of interest in 'green' economy roles, following difficulties in recruiting to Technical Officer roles.

Up-skilling did not solely focus on technical skills, however, but recognised the unique mix of technical and soft skills that were central to the delivery of services to a more vulnerable client group. This meant that it was essential to partner with contractors who understood the needs of service-users, and that in-house staff were skilled in adapting to the needs of specific groups. For example, stakeholders reported regularly receiving praise for handypersons for *'their understanding and their patience with people with dementia, they really, really understand what it's like...and how they can put them at ease'* (Case Study C). This service also trained other teams in the council in dementia awareness. A stakeholder from another home improvement service beyond the case studies reflected that they had seen general builders unable to cope with the emotional demands of the role, breaking down over their first children's case. This demonstrates the need for all staff and delivery partners to have the emotional intelligence and skills to manage challenging cases and deliver the person-centred services that are so valued to service-users.

Integration

There is some evidence that more integrated services provide an easier route for service-users and prevent cases being lost between different areas or administrative boundaries. There were clear opportunities for cross-referral between services that were positioned within a wider structure (Case Study D, F and G), in which staff were aware of what was available across a given authority, and/or co-located with other relevant teams. For example, in Case Study G weekly meetings with an aligned service enabled cross-referrals for social prescribing, housing options, benefit maximisation, and digital inclusion. Services which had moved in-house perceived a benefit in being *'a much more rounded service'* and looking at the whole picture of client needs *'as opposed to just what you're there for'* as well as the ability to cross-subsidise loss-making services with income-generating funding streams (Case Study F). Whilst the latter is more unique to a Local Authority context, services which were contracted and not 'in-house' also demonstrated strong evidence of delivering holistic services and a relatively integrated pathway for service-users. This was in part because they were well connected to other local services, spent time building key strategic relationships, developed strong partnerships, and were committed to a person-centred approach. Aside from co-location with external teams, there were also perceived benefits to co-location within the home improvement service, with Technical Officers, Caseworkers and OTs located alongside each other to facilitate communication and an efficient *'production line'* service, which *'sounds terrible but...works really well'* (Case Study G).

Integration did provide opportunities to insert home improvement services into a wider network of teams, services, and providers, particularly within a Local Authority context. For example, Case Study C worked closely with related teams within the City Council, such as the private sector team, supporting improvements in the private rental sector. Case Study C also funded an OT within the County Council to assess DFG claims, which prevented delays between social care and the home improvement service, reducing waiting lists and freeing-up County Council resources to focus on higher priority or more complex cases. Training and work-shadowing opportunities were used to good effect, with examples of student OTs spending half a day with a handyperson service and digital inclusion team (Case Study D), and social prescribers shadowing home improvement service workers (Case Study G). This training provided insight into the service offer, processes, and resulted in higher-quality referrals. In the wider sector, a housing OT noted systems in which less experienced colleagues could share clinical reasoning on complex cases with colleagues with more experience in complex adaptations. Whilst this would not be replicable across all models of delivery, across the Case Study services there remained a clear focus on inserting the home improvement service within relevant partnerships, either generically or in relation to delivering a specific service or intervention.

Building partnerships

Case study services commonly worked with a range of other providers and partners in developing and delivering services. Stakeholders reported that services were often proactive in developing these key partnerships and relationships. This was important at strategic and delivery levels. For example, the head of service in Case Study C was viewed as well-engaged with wider networks of health, local authority and third sector service providers, which meant the home improvement service could understand and respond to key strategies. In Case Study F, attendance at the Integrated Care Boards meant that funding could be directed to the needs of service-users in a more bespoke way. Other Case Studies reported *'banging on doors'* to get a seat at the table in strategic forums with health and social care; because other partners recognised the value of housing in health outcomes, these forums had been *'open and receptive'* to the home improvement service, developing an equal partnership (Case Study G).

There were many examples of strong partnerships in the delivery of services. In some partnerships, the home improvement service could be *'the lynchpin'* pulling all the other partners to deliver the service effectively (Case Study B). For example, Case Study B worked closely with partner organisations to replace three separate services with one *'more streamlined, holistic service.'* Whilst there were different routes in and a range of partners involved, from the Local Authority perspective, *'once people are in, they're open to all those different services.'* Evidence from the wider evaluation shows that service-users value the ability to access a range of services via one central point. This case also demonstrates the ability to deliver elements of service integration even without necessarily having a comprehensive, one-stop-shop, which may provide lessons for other areas.

In another case, a home improvement agency employee regularly sat in the partner's office (NHS hospital team), ensuring that *'he's made himself known... He's really, really established himself there'* (Case Study A). This was crucial to delivering a hospital discharge service with partners in health in the discharge team. Similarly, services put time into raising awareness of services, for example by giving presentations to key partners. For hospital discharge services, this could mean making several trips to different hospital wards to develop key relationships (Case Study D).

The extent to which positive relationships had developed was evident in the language used by interviewees. For example, a commissioner reported thinking of the home improvement service as *'more like colleagues than a commission...If we ask them to do things, if they can, they will'* (Case Study E), and a Case Study service explained that they worked with contractors *'hand in glove...we don't just see them as contractors, we see them as partners'* (Case Study D).

8.2. What are case studies doing that might provide lessons for other areas and services?

To aid **localism** a number of services had made use of the Regulatory Reform Order to develop a Housing Assistance Policy which provided additional discretionary top-ups for DFG funding or reduced means testing for lower cost work.

Several services undertook community **awareness-raising** to improve **access** to services, particularly focusing on high-need or underserved populations. Setting up facilities in which clients could see and try out home adaptations could reduce some of the barriers to using home improvement services.

There were several examples of new and innovative services which may provide relevant lessons to other areas. All case studies were proactive in seeking a range of supplementary **funding streams** which could fund these services. **Hoarding** interventions had been developed in several areas, with the best services taking a therapeutic approach rather than focusing solely on clearance. Partnerships around **hospital discharge** were another growth area, requiring strong relationships with the NHS, presence to build up awareness and service referrals, and a highly responsive minor adaptations service. Some areas were developing interventions related to **hazards and condition** such as damp and mould, and hazards in the private rented sector. There were also some examples of **support for moving** to more appropriate homes, recognising that moving to adapted or more easily adaptable homes could be beneficial for clients.

Services were investing in **skills and training** to avoid bottlenecks in the system, for example using Trusted Assessors, and developing new specialist technical roles to support the retrofit agenda.

There were several **financing** models, including paid-for services which could subsidies other activities, and a range of loan offers that could help to unlock the funding to undertake home improvements.

Evaluation and data were being used to design services and demonstrate their impact. There were some examples of increasing customer feedback data and building evaluations into pilot programmes.

Localism

Home improvement services are highly differentiated nationally. Whilst there is some desire for greater consistency of core services to reduce geographical inequalities in access to home improvement, Case Study services also valued the ability to be responsive to local needs, which are not uniform across the country. To aid in designing a local offer, some areas had used the Regulatory Reform Order to implement a Housing Assistance Policy, giving flexibility to provide different services. In Case Study C, this meant relaxing the means test for some services (providing up to £10,000 grant for adaptations), and a discretionary top-up grant for DFGs of £30,000 (means tested). Case Study A was considering implementing a Housing Assistance Policy to enable them to be *'more flexible with what we do with our DFG funding.'* This would enable them to *'increase the maximum you can give under a disabled grant and get rid of means testing for certain clients, but you could also fund some of those other services that...we've managed to fund through external funding and charged-for services'* (Case Study A). Whilst there are possible efficiencies to reducing means-testing, there are also trade-offs in making DFG funding more generous, since it is possible that fewer households could be assisted within current budgets.

Awareness-raising and access

Several Case Study services undertook outreach with local communities to raise awareness of the home improvement service 'offer,' including among under-served communities. This could be a generic or specialist role, for example in Case Study A, caseworkers undertook outreach with community organisations and non-profits, which had increased referrals outside institutional pathways. Similarly in Case Study C, local hospitals and GPs were *'plastered with our leaflets and banners...we go in and do talks... and they all refer into us,'* and there was a bus shelter campaign to advertise free boiler servicing. Case Study B used a different model, with a dedicated Outreach Worker funded by the Integrated Care Board to spend time with neighbourhood groups *'in different areas where we may be lacking referrals. They attend events, hold stalls, and provide translation services.'* This role was central to reaching priority demographics specified by Commissioners. For outreach, it was important to design materials in clear and accessible formats, for example Case Study C colour-coded leaflets to aid the identification of specific services.

Several Case Study services had locations in which service-users could see and try out aids and adaptations. These were typically set up as in-house demonstration rooms, for example kitchens and bathrooms (Case Study D and H). This can help to demystify adaptations and enabled individuals to gain a better understanding of what changes may look and feel like in their home. In Case Study E, as well as trying out equipment on-site, clients

could also take home some small items. This could be an important part of building trust with service-users, who were often concerned about maintaining a sense of home and turning the home into an 'institutional' space. Whilst all services face constraints and it can be difficult to balance the 'wants' and 'needs' of service-users, an element of choice can be built into services to help to deliver a sense of ownership and control. This may be enabled by offering choices of colours, styles (including options to self-fund more expensive finishes), or the precise positioning of adaptations (within safe limits).

New and innovative services

Developing funding streams

All Case Study services were proactive in seeking additional funding. This approach, particularly related to hospital discharge services, affordable warmth schemes, and benefit maximisation, could be replicated in other services. Philanthropic funds – including local schemes – were targeted to support pilots of innovative services, which could then develop evidence to underpin the future commissioning of contracts (Case Study H). Some services had developed streams for self-funding clients. This could range from large-scale adaptations (Case Study H) to minor works. For example, Case Study A offers vulnerable residents the ability to pay for their Handyperson to undertake works that are outside the scope of the service. The Handyperson provides written quotes for clients and takes payment on completion of work with a mobile card terminal.

There were also some innovative examples of services using in-house knowledge and expertise to make savings and generate income. In Case Study A, ramps had been redesigned by the home improvement service to provide an effective option that was less costly and quicker to fit than previous prefabricated versions. The service then brought the manufacturing in-house *'through our handyperson, generating some income, getting them done a lot quicker and a third of the price.'* In another case outside the case study services, reusable modular ramps were being used as a rapid, cost-effective, and sustainable option where appropriate.

Hoarding

Several services had reported an increase in issues with hoarding, and there were several examples of innovative interventions. Case Study D, which was part of a Local Authority, worked in partnership with the third sector to deliver their hoarding intervention, in part because separation from the Council could provide a *'friendlier face'* to build trust with clients who may be wary of accessing support in this area. Central to hoarding interventions is moving beyond clearance and taking *'a therapeutic approach…Sometimes we can move things on quite quickly…other times it can take over a year to work with somebody and be able to clear the home'* (Case Study D).

In one service, the City Council only funded the clearance and hazard-removal dimension of the intervention, but the home improvement service was able to supplement this with a therapeutic group support network via philanthropic funding (Case Study H). The support group is staffed by paid employees and volunteers, some of whom have personal experience of hoarding, with the intention of providing an empathetic service that understands hoarding as a mental health issue. Evidence shows that *'people are more likely to relapse if it doesn't go hand-in-hand with ongoing therapeutic support.'* Empathy was at the core of the service:

It's not just chucking all the boxes in the skip; it's about going through that stuff with somebody and helping them on that journey of decluttering their home so it's safer for them. It's incredibly time-intensive which is why volunteers are very important.

Case Study H

The cross-funding from other grants offers an example in which a more limited service was supplemented to deliver a more holistic service for clients, but there were other examples in which stronger pathways into statutory services for mental health support were being developed (Case Study F).

Hospital discharge

Partnerships around hospital discharge were a key growth area for several services. These services typically required strong partnership working with the NHS and a flexible and responsive approach to minor adaptations, which could work to very short timeframes. There were a number of different models in evidence, which could be adapted for other areas.

In Case Study A, patients were accompanied home from hospital following discharge, assessing the suitability of the home for the patient's recovery and wellbeing. If, for example, a client was unable to use the stairs or bathroom, a coordinator arranged services to remediate the property, which may be undertaken by the home improvement service. This could include minor adaptations, repairs, key safe installation, furniture rearrangements, etc. Works were typically carried out within a few hours of referral. The intervention was *'incredible'* because they *'now have this urgent service, that the HIAs support and stop those [discharges] from failing, and the person can stay at home for a matter of hours until the handyperson comes round.'* The County Council funded the pilot service, with additional funding from the Covid Outbreak Measures Fund (the service was originally implemented during the pandemic to ease pressures on hospitals).

In Case Study B, there is a three-year pilot of a community care and hospital discharge service. The intervention involves collaboration between the home improvement service and a consortium of third sector community organisations. The intervention offers a wraparound service for people receiving community healthcare and hospital discharge patients, giving support with daily tasks (e.g. shopping) and minor home adaptations and installations (e.g. grab rails, handrails, raised toilet seats). The home improvement service delivers the minor adaptations element. Developing a strong relationship with NHS partners means that now *'hospital discharge will come to us to say, 'a patient needs to get out of hospital, but they can't go home' [without adaptations].'* Looking across the Case Studies, it can take time, awareness-raising, and a strong presence within hospitals for these services to become a consistent part of the discharge process.

Developing those relationships could be aided by a dedicated role, for example in Case Study D a new Prevention Liaison Officer (PLO) was working with hospitals to support discharges. They are a Trusted Assessor and so can refer clients to other services, such as handyperson services and assistive technology. Whilst there could be competing priorities in these interventions – with the NHS focused on discharge as soon as medically fit – work towards greater integration meant that the PLO was now a part of the checklist for in-patients coming towards the point of discharge. Although the PLO was now *'picking up on patients before they're fit for discharge'* by spending time on wards, as with other hospital discharge services referrals were often urgent and late notice, requiring a rapid response. For example, in Case Study E, work associated with hospital discharge is undertaken within 48 hours.

Hazards and condition

Several interventions were addressing problems of hazards and condition, including related to issues of damp and mould. Whilst some services were oriented towards the private rented sector (PRS) by design, in other areas the prevalence of poor conditions in the PRS was a problem in delivering programmes which could only be funded to improve other tenures.

In Case Study B, a scheme focused on improving air quality for children with respiratory conditions had recently commenced, in which eligible households with poor indoor air quality – such as damp and mould – were able to access remediation and provide goods such as hypoallergenic bedding. This scheme covered all tenures. Although the nature of the service varied between tenures. For example, the home improvement agency would not deliver damp repairs on social housing properties as that is the landlord's responsibility.

Similarly, in Case Study E a pilot scheme to address damp and mould was being funded by the NHS for households in which a child is admitted to hospital with a respiratory condition. The home improvement service visit the home to undertake an assessment for any improvements that could be

made, for example to the heating system. Funding covered all children being admitted with respiratory problems regardless of housing tenure. However, to-date referrals were almost exclusively to homes in the private rented sector, in which work to improve the property was the responsibility of the landlord and there were limitations with what could be done with a small amount of funding. This highlights the prevalence of serious disrepair in the PRS and the relative absence of mechanisms to directly intervene, except via enforcement action. More widely, however, PRS enforcement is highly variable at the Local Authority level and can raise concerns about the potential for retaliatory eviction.

In Case Study C a partnership with the private sector enforcement team supported compliance with the local private landlord licensing scheme. Integration within the City Council means that teams can refer emergency hazards in the PRS to the home improvement service, enabling the Local Authority to *'resolve those cases really quickly'*. The Case Study service had also *'given the HMO team training on adaptations so...they can refer back to us, and our handyperson service can also be used to fit any emergency smoke alarms.'*

Risks in the home come not only from the physical condition of the property but also the relationships that unfold within the home space. Two of the Case Studies were helping to provide sanctuary schemes in order to enable survivors of domestic abuse to remain within their homes. Case Study D partnered with a voluntary organisation to deliver a sanctuary scheme alongside a domestic abuse support service. Prior to the partnership, the scheme had struggled to find contractors who could deliver the kind of jobs required, because they tend to be relatively small. The home improvement service Handyperson has the technical competence to undertake these small jobs, but the key element they provide is in being trusted, with a track record of working with vulnerable clients. Case Study G also provided a sanctuary scheme across tenures to enable people experiencing domestic abuse to stay in their homes. This included fire bags for letterboxes, door security, Ring doorbells, alleyway gates, lights, and trellis fencing.

Support for moving

It is recognised that it is not always possible for someone to remain at home, for example because it cannot be adapted to meet needs. A move may also facilitate a higher quality of life at a lower cost for some complex cases. In Case Study F, 'help to move' grants facilitate moves into new homes for cases in which adaptations to existing properties are not possible or not the best option. Grants help to reduce the barriers to moving, for example providing advance rental payments that may be unaffordable for clients or providing works such as putting in a key safe or curtain rails. This helps clients to move quickly when adaptable properties become available and could save money on complex adaptations. Case Study H also supported

moves for those aged 60+, with one Caseworker able to support clients through every aspect of moving (including outside the city).

Engagement with stakeholders beyond the case studies highlighted significant efforts to develop an accessible housing register, which would categorise homes according to accessibility, facilitating moves into accessible or readily adaptable properties as they become available. In one area, the NHS Foundation Trust was working in collaboration with the largest social housing providers, detailed surveys were being undertaken to classify homes and list an accessibility rating on the home choice-based lettings system. This would enable those looking for accessible homes to have a much more detailed understanding, for example of whether a home has a level-access shower, if the front entrance and corridors are accessible for wheelchairs, etc. Given the lack of fully accessible homes, a more fine-grained classification may also offer future flexibility to allow households to move to homes with lower accessibility ratings, but which could be more easily adapted without the expense and long timeframes associated with extensions.

Skills and training

Developing the skills of staff was an important route to delivering holistic services and could avoid bottlenecks and create efficiencies in provision. As well as Trusted Assessor models, which were commonly used, Case Study A had supported Technical Officers to deliver more surveying and procurement. Technical Officers discovered that *'there was an opportunity for a lot of value engineering if we took on the responsibility... of procuring the bathroom,'* resulting in cost efficiencies. Case Study A had also used reserves to pay the salary of a Retrofit Technical Officer and train an in-house OT to expedite assessments and reduce waiting lists. The Retrofit Technical Officer enabled DFGs to be used towards energy efficiency improvements in some severe cases because *'it falls under making the property safe as there are... health risks associated with a cold home... The vulnerable resident is more at risk of harm in a colder property.'* Similarly, Case Study F used innovation funding to cross-subsidise additional staffing for core work and reserves could be used to fund agency staff to respond to demand for services – this flexibility enabled a nimbler approach within a Local Authority context, although this would not be possible for directly commissioned services.

Financing

As noted earlier, several services offered charge-for works self-funded by clients (Case Study A, E and H). In Case Study E, these clients received free technical advice, and for some handyperson adaptations the client paid for the materials with labour provided free. For self-funders, several services had loan products on offer. For example, Case Study C provides a low-cost loan to fund adaptations via a charge levied on the property that is

recovered upon sale of the property. One service-user explained that *'me, my entire family were so happy that that was possible, because it was difficult for me to get a loan.'* However, in general there could still be reluctance to use such financing because of an aversion to debt, concerns about borrowing via Council-services, and leaving debt to children. Similarly other services offered loan and equity release packages (Case Study D, E and G), and Case Study F worked closely with Lendology to provide home improvement loans. Having a holistic offer, enabling access to financial products that would assist with home improvements, and being FCA-approved was viewed as *'really valuable...quite special'* by Commissioners in Case Study E.

Evaluation and data

Data could be useful in designing and targeting services and demonstrating their impact in an increasingly tight financial context. In Case Study B, analysis undertaken by the ICB helped to inform the design and targeting of a multi-strand intervention including falls prevention, hazard repair, and affordable warmth. By using data on housing condition, falls incidence, and demographics, service priorities were developed to target key demographics who were particularly vulnerable or under-served. This included people from minority ethnic backgrounds, those with long-term health conditions, and living in the most disadvantaged areas, as well as recognition that there was a need to *'reach younger people, families, especially around warmth and fuel poverty.'*

To improve understanding of the impact of their service, Case Study H had worked to increase response rates to feedback surveys. Every two weeks, the Area Lead accompanied Handypersons on appointments to contact service users, following-up with a call after the work to seek feedback. Whilst time intensive, this improved response rates and generated more detailed feedback, resulting in strong qualitative evidence of impact that could be provided to commissioners. Beyond the case studies, a home improvement service reported using the BRE cost of poor housing model to calculate preventative savings for the removal of category one hazards (in this case, particularly stemming from falls on stairs). This could be used to evidence savings for some interventions.

There is a recognised need to build evaluation into pilot schemes and other time-limited programmes. For example, the evaluation of hospital discharge schemes must be able to evidence preventative savings, which could help support a business case to roll out such services more widely (Case Study A). Similarly, Case Study B was working with partners to improve the quantitative evidence base for some service impacts, including discussions with the ICB's internal evaluation team to discuss possible methodological approaches. However, even where robust data did exist, this did not necessarily lead to stability of delivery. For example, the pilot programme

of community healthcare and hospital discharge in Case Study B benefited from a quantitative evaluation of impact on healthcare usage, using data from NHS England's Secondary Use Services dataset. The analysis demonstrated reductions in the probability of A&E and in-patient admissions, and reduced bed days, quantitative evidence of impact that is rare in the sector. However, the pilot has not been recommissioned. Nevertheless, Case Study B still plan to use a new Customer Relationship Management system to *'control... and use data more effectively'* in order to develop a similar evidence base for other services.

8.3. Future development

Looking to the **future** for their services, the case studies were focused on a number of core issues. There was a need for **consistency of service with local flexibility**, recognising the value of locally designed services but acknowledging the inequalities that arose from a patchwork of provision nationally.

Several case studies saw potential to undertake **energy efficiency, retrofit and fuel poverty** work. This may generate income, draw on and sustain existing expertise within services, and work with a broader demographic including younger families.

Hoarding was viewed as a growing problem in need of tailored interventions.

Whilst beyond the remit of home improvement services, it was also important to consider **new development** and its role in providing a diverse mix of adaptable housing for the future.

Although there were a range of measures, **evidencing impact** was high on the agenda for some services in the future, including qualitative and quantitative approaches.

Considering the future **sustainability** of services, a number of common challenges were evident. Many services were concerned about increasing **demand** and more complex cases alongside funding pressures. **Demographic change** was projected to increase demand significantly among older populations.

The need for home improvements in the private rented sector is likely to expand, as more people in this **tenure** are **ageing**. There were several reports of challenges in adapting housing association homes.

Funding and inflation are major constraints on some of the services delivered by case studies. The cap for DFG funding made it

increasingly difficult to undertake some adaptations, with extensions particularly challenging. Whilst the value of capped grants had already been eroded, the recent context of high inflation had caused significant challenges. Funding pressures were ever-present, and services were vulnerable to the non-renewal of discretionary programmes. Access to funding was predicted to remain a major challenge.

The **staffing** of services is a key constraint, with common challenges in the recruitment of technical roles. The balance of technical and soft skills is important to the delivery of good services, but ultimately it is challenging to achieve.

Consistency of service with local flexibility

In the future, some services were hoping for the long-term development of home improvement services nationally that would deliver a stronger baseline of consistent core services, whilst retaining the flexibility to innovate and deliver supplementary services relevant to local needs. As Case Study A reflected:

Having that reliable funding ideally direct from Government to deliver a home improvement agency-type service on a long-term basis and not...year after year...constantly looking for funding... There's talk of a duty on Local Authorities to have Good Homes agencies in all areas and to me that seems logical.

Case Study A

Even within some local areas, there was recognition of inequalities, since someone could be *'just over the border...but that person's not getting anything, where someone in the city is getting an incredible service'* (Case Study C). Whilst responsiveness to local needs was important, it is also important in the future to reduce variation, and the inequalities that arise from the patchwork of provision. This has also been highlighted by wider work among those with lived experience of home improvement services during the evaluation. Whilst there was vulnerability of some services due to funding constraints, Case Studies recognised the value of retaining some low-threshold services. These could be high-impact for service-users and were a useful route into the service, and it was a priority to retain and grow these services (Case Study C).

Energy efficiency, retrofit and fuel poverty

Several services perceived future opportunities in retrofit and energy efficiency work, for example training staff as PAS domestic energy assessors to *'generate some income'* and promote retrofit to private households (Case Study A) and delivering a new Technical Apprentice role focused on the green economy to expand opportunities in this area (Case Study F). In Case Study A, the future included the home improvement service potentially developing into *'an impartial body you could turn to get contractors and work done to your property that is going to...make a real benefit'* in terms of energy efficiency. Similarly, stakeholders working with Case Study B saw opportunities to *'encourage them to take on some other elements of work around fuel poverty.'* The service agreed that work on fuel poverty brought into view *'a massive amount of younger families who are in real need...an untapped area that could benefit from the holistic approach'* including the building fabric, fuel poverty, and advice. Some services suggested there needed to be a widening of how home improvement services were seen, moving from perceptions of delivery solely to older people, in order to address home improvements among other vulnerable groups.

Hoarding

Several Case Study services offered hoarding services, and others viewed this as a growing problem in their locality – particularly since COVID-19 – but with an absence of referral routes (Case Study E). This indicates that hoarding support services could be a future growth area. In Case Study F, which did provide a support service, it is notable that referrals for hoarding were usually made following referral for a different service, highlighting the importance of other services gaining access to homes to identify issues. However, due to increased demand and growing waiting lists Case Study F had raised the threshold at which referrals could be made, limited to the worst cases. Developing future services in this area requires a multi-agency response. Property clearance alone is not sufficient to address underlying problems, and attention to mental health needs – which is not the specialism of home improvement services – is also needed (Case Study C).

New development

Whilst beyond the remit of home improvement services, a housing OT working in another area beyond the case studies highlighted the importance of attending to the quality and accessibility of newly developed homes. One stakeholder provided a technical access consultancy for local plans in their area, filling gaps in some of the technical competency related to accessibility standards. This resulted in a strategic push for more measurable and specific targets in local plans for wheelchair accessible housing and lifetime homes standards, which would – over the long-term – feed back into home improvement services by reducing the need for

adaptations and extensions. Data on the cost of extensions – into six figures – could be used to feed into local plans to call for delivery of more accessible new homes.

Evidencing impact

Whilst all services were measuring the impact of their services, there were some areas that services were seeking to develop in the future. For example, Case Study H had high-quality case studies and qualitative insights, but would also like to develop wider measures, including quantitatively capturing the impact of falls prevention and keeping people safe at home. However, there was recognition that this could be methodologically challenging. More broadly, the service also wanted to improve data collection and monitoring of demographics to better target services.

8.4. Sustainability issues

Demand and demographic change

Many services were concerned that *'funding is going down rather than up'* despite a context of increasing demand (Case Study E). One stakeholder (Housing OT) outside the case studies highlighted projections in which the biggest population increase over the next 20 years would be in the 85+ age bracket, bringing significant demands. Limits to funding and service pressures meant that some Case Studies were considering limiting services. This was already in evidence for some programmes, for example with limited referral routes and a range of eligibility criteria. Case Study E, for example, had recently reduced eligibility for commissioned services from over 60 to over 65 due to funding constraints, although professional referrals for younger clients are still accepted. Case Study F had been forced to reinstate means testing for stairlifts due to spiralling costs. Case Study D had been unable to continue provision of a paid-for service for those ineligible for adaptations because of high demand for core services via OT referrals. In Case Study B, a falls prevention, hazard removal and warmth service had experienced referrals increasing 20-25 per cent in one year, despite a real-terms decline in funding. This led to the consideration of making falls prevention a paid-for service for residents in less disadvantaged areas (IMD deciles three and above). Whilst this measure was not taken forward, it highlights the potential for demand management as needs increase without corresponding funding increases.

In general, most services expected demand to increase considerably in the coming years, alongside likely funding decreases. Increased demand may in part be due to perceptions among multiple Case Studies of voluntary sector and other services being reduced, and many other services or processes moving fully online. This puts more pressure on the few remaining services,

as well as potentially delaying preventative interventions as issues remained hidden until crisis-point. This reduces the efficacy of interventions and undermines the benefits (social and economic) associated with prevention. Several services highlighted not only increased demand, but also increased complexity of cases, including more younger people with disabilities who may be more likely to be being cared for at home rather than hospital. These cases required joint-working with other services, more time in understanding needs and how these may be met, and typically were not well-resourced within DFG funding caps.

Tenure and ageing

The need for home improvements in the private rented sector is likely to expand, reflecting a growing ageing population in this sector and the poorer condition of stock, but there are complexities in PRS service-delivery. As well as individuals being less likely to request services, permissions were challenging, and landlords could be concerned about the cost of changing properties back at the end of tenancies (Case Study D).

Several Case Study services and many practitioners involved in wider engagement through the course of the evaluation also highlighted challenges in working with Housing Associations. This could be difficult because of staff turnover, cut backs in some areas, procedures, and the length of time involved. For example, Case Study C noted one case for a level-access shower that had *'taken over a year for a housing association to give permission.'* Similarly, Case Study H reported that housing associations could be *'extremely difficult, and a lot of the delays are because we're...hanging around, waiting for consent.'* There were also examples of blanket refusals for wet rooms above the ground floor, installing level-access showers in properties which were under-occupied, adaptations in newly built homes (due to warranties), and for tenants within the first year of a tenancy, as well as inappropriate referrals into OT services. However, some wider stakeholders also had positive stories, particularly a larger provider which could resource their own adaptations surveyors and in-house OTs.

Funding and inflation

In all Case Study services, there were significant impacts from high inflation and DFG-cap constraints. Case Study A reported that *'price increases have been astronomical,'* with most services finding challenges with delivering extensions in particular. Extensions were commonly viewed as *'just a nightmare'* where you could be *'looking at a shortfall of around £30,000'* even with a discretionary top-up grant available in this area (Case Study C). Similarly, Case Study D had been able to provide some top-up funding for extensions, but demand was becoming unsustainable and there was a shift towards more means testing. There were also complexities around means testing, with one service noting that this sometimes resulted in working families with no savings contributing more than older people with substantial savings. This could particularly be seen in children's cases which

are usually more complex, placing a burden on family finances (Case Study G) due to costs being much higher. Beyond the case studies, there were also examples of following a model of applying DFG caps per need, for example a shower would be capped separately to bedroom adaptations.

All services were vulnerable to funding cuts, but services which relied substantially on the provision of discretionary improvements were inevitably at high risk. There was evidence during the evaluation of a moratorium on discretionary DFG top-ups (Case Study E). Being part of a Local Authority structure did not insulate services to funding pressures, for example Case Study G had previously been a comprehensive service, but austerity and funding cuts had stripped back provision to focus much more centrally on delivery of DFGs.

Whilst Case Study services had been proactive in seeking additional pots of funding, there was an inherent vulnerability in the model. Case Study H noted that they had already seen many different types of grants, including philanthropic funding, *'over the years quietly dissolving.'* Stakeholders reflected that *'if all the grants dried up and we didn't have sufficient income coming in then I think it would be quite difficult to sustain the amount of HIA staff'* (Case Study A), demonstrating the extent of future challenges for services. During the evaluation, there were examples of services not being recommissioned, for example a pilot of a community healthcare and hospital discharge support service delivered by Case Study B and partners. Other services had seen staffing levels reduced to stay afloat after funding cuts (Case Study E). This meant that there would be fewer resources to meet increasing demand.

Staffing

Longstanding, skilled, and dedicated staff are at the heart of services and central to the delivery of good services. Indeed, many dimensions of high-quality services and innovations stem from having highly qualified, long-term staff who have worked in services for a number of years. Retention of staff, particularly including Technical Officers and Handypersons, are therefore key to maintaining the quality of services in the future. Whilst staff are passionate about their vocation, there were concerns in some services about workloads, pressures, burnout, and maintaining work-life balance. As one participant explained *'I've had numerous opportunities to go to different places on more money, but I really believe in what we do. That's getting harder...because...the pressures...are getting more'* (Case Study D).

Staff retention was crucial, because it was difficult to balance the skills needed for home improvement roles. However, to grow – and even to maintain services without over-work and long waiting times in some areas – it was also necessary to recruit new staff. There were particular constraints across multiple Case Study services in recruiting Technical Officers with *'the right skills, but they also have to be the right person and have empathy. It's no good being great on the phone system but not being able to talk*

to somebody who wants to feel listened to' (Case Study B). The ability to recruit the right staff will ultimately constrain the ability of services to meet population needs locally, as well as pointing to future challenges in the development of more consistent and comprehensive services in other places.

Sustainable adaptations

Going forward more consideration needs to be given to sustainable adaptations. Although this issue was not widely raised in the evaluation, local authorities and home improvement services will need to rethink the way that accessibility is designed. Many adaptations like grab rails, shower trays, and stairlifts are functional and designed to meet immediate needs but are ultimately disposable. Moving away from 'single use' adaptations would help reduce waste and costs. Sustainable upgrades and universal design can benefit the environment and help support the development of more accessible homes.

Section 9

Conclusion and recommendations

Housing is one of the main social determinants of health affecting physical and mental health throughout people's lives. Inadequate housing contributes to poor health outcomes and is a cause of health inequalities.

BRE estimates suggest that unsafe homes headed by someone aged over 55 are costing the NHS £595 million per year. This is over half the cost to the NHS across all ages – despite the over 55s living in just under a third of non-decent homes in England.[55]

Housing and health related inequalities can be tackled by improving homes. Good homes[56] are central to our health. They contribute to prevention by supporting people's health, wellbeing, and independence, which ultimately helps to delay or reduce the need for health and care services in the future.

[55] Counting-the-cost-report.pdf

[56] That are safe, warm, accessible, and affordable.

The new labour government has called for a **'revolution in prevention.'** We are likely to see a redoubling of efforts around prevention and more action to tackle health inequalities over this Parliament, and an even greater emphasis on the closer integration of community and health services at a local level.

The focus for the delivery of health care and other prevention services is shifting to homes and communities. Improving the condition and accessibility of people's homes must become an integral part of this development. There needs to be greater awareness and recognition of how home repairs and improvements and reablement services, can support older people and improve later life. Home improvement services directly support health and social care services in multiple ways by enabling people to live more independently at home for longer, facilitating hospital discharge, and enhancing health and wellbeing. Housing needs to be a joint project that everyone shares across at all levels of local governance. Our findings demonstrate the important role home improvement services can play.

9.1. Conclusion

The evaluation has demonstrated how home improvement services can be an important part of the delivery of locally relevant policies that are supporting local strategic objectives. In some cases this was supported by local authorities having a Housing Assistance Policy which align objectives with existing local social care, health, and older people related strategies, enabling the development of strategic partnerships.

Existing comprehensive home improvement services can act as a hub for collaboration between these local partnerships and services. Comprehensive home improvement services can be the *'lynchpin'* in key partnerships pulling all the other partners together to deliver services effectively. Some home improvement services are also developing their service offer to become more comprehensive providing support for energy efficiency, fuel poverty, and hoarding which bring many health benefits for their service users.

The evaluation presents evidence on the value of local services integrating a range of resources for repair, reablement, and adaptation into service design and delivery. Home improvement services can provide good quality holistic and person-centred support, but they need better resourcing and greater stability of funding to do it.

Funding for home improvement services comes predominantly from the DFG budget. Whilst the recent Budget announcement of an additional £86million of DFG funding is welcome, challenges remain, and longer-term stability is needed.

Ongoing cuts to local authority funding are a strategic risk for home improvement services. Rising costs, increasing demand, and more complex cases mean the lack of an uplift to the DFG cap is no longer sustainable. It is restricting what services can deliver, making larger adaptations like extensions prohibitively expensive, and increasing the barriers to making existing homes more accessible for older people and people with disabilities.

The shortcomings of the DFG system were highlighted by the House of Commons Select Committee Report on Disabled people in the housing sector.[57] Evidence from our evaluation adds further support for the report's recommendations to:

- Review the £30,000 upper limit on individual DFGs and set new regional upper limits which take account of inflation and construction costs.
- Simplify the DFG means test and ensure it does not disproportionately penalise working disabled people.
- Expand DFG guidance and self-assessment tools, to improve public awareness of the DFG and to support applicants as they navigate the process.

Whilst there is more funding for DFGs, there is no defined funding stream for home improvement agencies and services more generally. The loss of ring-fenced funding under the Supporting People Programme and the removal of Private Sector Housing Renewal funding in 2010 has reduced funding for home repairs and other improvements. Funding for staffing to support services other than DFGs has also been lost and has contributed to the lack of staffing capacity within local authority teams. Local authorities have less discretion in how they can use DFG funding which restricts their ability to expand staffing roles, supervision, and training outside of DFG work, compared to external contracted home improvement services.

Across the sector, these changes in funding have led to a reduction in the range of services offered. Over the last decade or so, many former independent home improvement agencies have moved in-house and become primarily *'DFG vehicles.'* If we are to tackle the poor condition of England's homes, specific ring-fenced funding for the provision of comprehensive home improvement services, as well as for DFGs, is needed.

The case for specific funding for home improvement services is reinforced by our findings on how highly valued they are, and by the numerous ways home improvement services contribute benefits to the wider system.

[57] Disabled people in the housing sector - Levelling Up, Housing and Communities Committee

The evaluation presents extensive evidence of the difference that comprehensive home improvement services make to people's lives, and the expertise employed in providing high quality holistic and personalised support. Overall service users felt safer, more independent, and more confident in their own home. However, these benefits can be undermined by issues related to a problematic home improvement process. Good communication is key and can help to mitigate service users' frustrations and distress that can be caused by problems such as delays and the length of the process.

The case studies provided value for money and were seen as cost effective. Services offered cost efficiencies by supporting multiple local strategic priorities within a single integrated team, generating additional funds, offering complementary services and providing services at reasonable cost. Our economic analysis provides illustrations of value from home improvement services. This included wellbeing benefits from adaptations, and costs savings to the NHS and society from falls prevention adaptations, hospital discharge schemes, and interventions to prevent excess cold. However, the challenge of quantifying impact requires much better data. There is a particular gap in terms of quantitative evidence linking the activities and support provided by home improvement services to outcomes and impact for beneficiaries, agencies, and society as a whole.

The evaluation also highlighted numerous features of good practice in providing more comprehensive services and the real difference that good leadership makes. *Strong leadership within services are important in driving an ethos throughout all levels that focuses holistically on positive outcomes for service-users.*

Looking to the future, a reduction in the variation of home improvement services across the country is needed to address inequalities that arise from the existing patchwork of provision. Longer term funding to nurture home improvement services across local authority areas would establish greater certainty and help remove the postcode lottery inherent to current provision.

From a service user's point of view navigating a complex, multi-agency system is inevitably a challenge when looking for help with a home improvement – those needing support with adaptations, retrofitting and general home improvement should be given a single point of contact who stays with them throughout the process. This would make the process simpler, more efficient, and clearer for service users.

However, there remains a lack of awareness of home improvement services amongst potential service users and even within local councils. Local authorities and home improvement agencies should have clear and consistent information and advice around the availability of home improvement interventions and a clear process on who to contact for information.

We hope that our findings around good practice will help to inspire other local services and policy makers, funders, and commissioners to see what is possible.

Finally, our lived experience findings emphasise the **importance of home**. Where home improvement processes work well, they do so by improving the home, not just the *house*. For this to happen, all those involved at **every stage of the process** need to remember this core point. Policy and practice therefore need to use the language of *'home'* and focus on what this means for people going through the home improvement process, remembering that physical adaptations to the house can have emotional impacts.

9.2. Recommendations at a local and sector level

Data and evidence

Whilst all the case studies are assessing the impact of their services, several identified that they needed more support gathering data and evidencing the impact their services make. Services do not routinely benchmark the demographic breakdown of their service users against local population statistics to ascertain whether they are reaching households in greatest socio-economic need and ensuring equity of access. Whilst services are engaged in outreach work to reach underrepresented communities, improving monitoring of demographics will aid better targeting of services.

Some services are using data and analysis undertaken by ICBs to help design, target, and implement services, but several of the case studies stated that it would be helpful if the interventions they were involved in delivering could be formally evaluated to understand the impact.

Evaluating the impact home improvement services have on health outcomes and preventative health expenditure (e.g. on hospital discharge and admission avoidance) with a view to considering how this may support the case for further funding from ICBs is crucial. Evidence is also needed to share good practice with other home improvement services and local authorities.

Sharing data with external parties such as the NHS remains an issue. Wherever possible it is important that technical solutions for the centralised storage of referral data are pursued to ensure service user journeys are efficient and to avoid duplication. Investing in case management systems helps to support the delivery of a wraparound service.

Home improvement services, local authorities, and ICBs should:

- Improve data collection on the characteristics of home improvement service users and benchmark this data against local population statistics to ensure they are reaching those in need and equity of access.
- Work together to improve the quantitative evidence base for service impacts considering how this support can help to make the case for further funding. Specific projects must collect better data on service user outcomes including validated health outcome measures, and ideally linking this to health service use. Ways of improving data include routinely building evaluation into pilot projects, meeting with ICB evaluation teams to discuss methodological approaches and strategies for data collection and analysis, utilising available models such as BRE's cost of poor housing to calculate preventative savings, and commissioning formal evaluations of interventions.
- Look to procure efficient case management systems to support customer journeys and invest in good administrative support ensuring core staff understand the available assistance and can refer to every part of the service.

At a sector level:

- Best practice in monitoring and evaluation, including strategies to engage service users and improve response rates to feedback surveys, should be shared to help build evidence of the impact of the sector at an aggregate scale.
- Support to enable home improvement services to demonstrate their impact and 'make the case' for their services should be enhanced. This could include the development of new and existing toolkits to assess financial benefits of services, introducing training to better support the development of research and evaluation skills within staff teams etc.

Staffing and skills

Many case study services in the study recounted difficulties with recruiting handyperson staff, case workers, and technical officers, and mentioned a shortage of OTs to carry out assessments. Staff shortages and the ability to recruit the right skilled staff is constraining the delivery of home improvement services. Part of the problem is to do with a lack of applicants for these roles and the level of pay offered, which is typically less than similar jobs in the private sector or than other local job opportunities. Until pay levels are addressed recruiting staff, particularly to more technical roles, is likely to remain a challenge.

However, investing in and developing the skills of existing staff teams to deliver a more holistic person-centred support service is of vital importance. Staff trained as Trusted Assessors can assess people and their home environment for home adaptations in simple cases, expediting the customer journey time and reducing waiting lists for DFGs.

Case studies were responding to challenges in recruiting staff such as technical officers by upskilling and introducing assistant surveyor roles or innovative apprenticeship routes to align technical roles with home energy improvements. Others are using reserves or other pots of funding to cross subsidise staff roles or fund posts such as OTs.

It can be desirable to have OTs within teams if possible. Integrating teams and/or developing innovative ways to work in partnership with OTs, rather than seeking to bypass OT assessments completely, was seen to offer the most benefits. It is good practice for Trusted Assessors to be supervised by an occupational therapist. However, the exact structures and processes that support recruitment and upskilling will be locally determined and will be more applicable to some contexts than others.

The increasing number of complex cases and the development of specialist services around for example mental health and hoarding means there is also growing demand for more specialist staff and caseworkers and trauma informed practitioners. Specialised training is likely to be needed to respond to the growing number of hoarding incidents which were consistently reported by all the case study areas.

Local authorities and home improvement services should consider:

- The benefits of implementing a Trusted Assessor programme and discuss and work with all involved partners to implement schemes where possible. Clear collaboration is needed from all parties including the local authority, home improvement agency/service and assessment teams to make the system work. Efficient assessment systems often have occupational therapists and Trusted Assessors working together within multidisciplinary teams.
- Expanding training and work shadowing opportunities between roles such as OTs and handyperson teams. These occasions can be used to good effect and provide valuable sharing and insight into the home improvement service offer and processes, resulting in higher-quality referrals.
- Utilising funding flexibly to resource staff roles that can support the customer journey and improve the response to the demand for services. More specialist roles and training are likely to be needed as services expand and new services are developed. For example, some areas have made a business case to utilise underspend on their DFG budget to create new Trusted Assessor posts in order for surveyors to be freed up to process more complex cases.

At a sector level:

- Support is needed to promote working in technical roles within home improvement services and agencies as a career path, which could be targeted at both younger apprentices looking for experience and older tradespeople looking for a career change.

Control, communication, impact, and choice

Having open routes of access to home improvement services, and a single point of contact for service users to help navigate a complex, multi-agency system and who can bring support packages together were consistent messages across the evaluation. Many of the case studies put caseworkers at the heart of their service, to aid the customer journey and improve communication with service users and between other stakeholders involved in providing adaptations and home repairs.

Recommendations from the lived experience strand of the evaluation concentrate on three key areas **control, communication, and impact**. In addition, offering **choice** to service users, where possible, can help give back a sense of control at a time when people using the service may be experiencing many things that are beyond their control. Previous studies[58] have shown that adaptations and repairs work best when people are fully involved.

Local authorities and home improvement services should therefore:

- Make sure that everyone involved in the entire home improvement process recognises the importance of home.
- Draw on the expertise of those with lived experience of home improvement to map and address barriers in the entire process.
- Give those needing support with adaptations, retrofitting and general home improvement **a single point of contact** who stays with them throughout the process. This would make the process simpler, more efficient, and clearer for service users.
- Ensure that service users are given the opportunity to try out aids and adaptations if they want to. Allowing people to take home some small items and/or providing facilities that people can visit to test out and see what larger changes may look and feel like in their home can help build trust.
- Offer choice to service-users within the home improvement process, for example enhancing optionality within design choices, or enabling enhanced or additional works on a self-funded basis. This can provide a feeling of control.

[58] The role of home adaptations in improving later life.pdf

- Think about the aesthetics of products, and aids and adaptations that are being installed in a person's home to avoid the home from looking clinical. This can help convey a more dignified feeling to service users.
- Explore the idea of specialist contractors for home improvements, who are trained in understanding and communicating with older clients, as well as having the technical skills to deliver adaptations.
- Consider the needs of everyone in the household, especially those of carers. Changes to homes impact the whole household, so it is important that adaptations assist carers and do not detract from how other members of the household use the home.
- Ideally have a longer-term focus to account for future needs, rather than simply reacting to the current situation. Think about shifting to more sustainable adaptations and enhancing a home's longer-term accessibility.
- Proactively utilise skills and agency of older people themselves and organisations they are involved in, to raise awareness of home improvement options and support smoother processes.

Rented properties

Barriers to the implementation of DFG adaptions in rented properties are a problem. Landlord permissions for most types of works and how Registered Providers contribute to works varies nationally and across regions, as does the tenancy support offered to tenants.

The House of Commons Select Committee Report on Disabled people in the housing sector highlighted the issue with some landlords in the Private Rented Sector refusing to grant permission for DFG adaptations to properties. It stated that *'it is unacceptable that any landlords should refuse disabled tenants' permission for reasonable accessibility adaptations.'*

We support the Committee's recommendation that:

- The new Private Rented Sector Landlord Ombudsman must consider all complaints involving a landlord's refusal to grant permission for accessibility adaptations, so that landlords are required to agree to all reasonable accessibility adaptations.

The Committee also stressed how essential it is *'that the Government, local authorities, and the housing sector work together to prioritise disability inclusion and address the barriers that disabled people are currently facing.'*

In this study, we heard about the challenges of working with housing associations, such as long delays in housing associations granting permissions for adaptations, and examples of blanket refusals. Whilst there were more positive stories, case studies were experiencing difficulties in delivering a prompt service to their clients due to the procedural steps involved. Detailed recommendations on housing adaptations and housing associations can be found in a recent report which examines how funding arrangements might be improved and the delivery process made quicker and more effective.[59]

Our evidence suggests that:

- Tenants need more support to adapt their homes as they age. Housing associations and Arms-Length Management Organisations should help to ensure that their tenants have access to advice about the repairs and adaptations they need, and that the assessment for and delivery of these measures is facilitated in a timely manner.
- Registered Social Landlords (RSLs) should have a named officer to lead on home adaptations, to ensure relevant expertise and facilitate communication with other partner services and clients.
- There is a role for strategic sector leaders such as the National Housing Federation to understand the prevalence and implications of RSL policies such as blanket refusals for some types of adaptation or related to some tenancies or property types (e.g. new builds, probationary tenancies, wet rooms above the ground floor).
- There is a role for the Regulator of Social Housing to ensure that RSLs are meeting their obligations under the Consumer Quality and Safety Standard.

At a local level, local authorities, home improvement services, and housing associations need to develop and improve their relationships to:

- Develop joint working protocols between local housing associations and home improvement services to better manage adaptations cases and remove barriers which are holding up DFG cases. There are also opportunities for local authorities and housing associations to work together taking a greater role in improving homes under new Consumer Quality and Safety Standard duties.

[59] THOUSING-ASSOCIATIONS-HOME-ADAPTATIONS-AND-INDEPENDENT-LIVES-v2-small.pdf

Prioritising disability inclusion and tackling the barriers that people are facing when trying to access adaptations and home improvements must also include support for moving. Many local areas provide grants to assist with relocation, but working in collaboration with social landlords to develop an accessible housing register may also be an option for some areas. We would recommend that working in partnership local areas:

- Consider the feasibility of developing an accessible housing register, which would categorise homes according to accessibility, facilitating moves into accessible or readily adaptable properties as they become available.

9.3. Recommendations at a national level

National government focus on improving the housing stock that is currently unfit and does not meeting needs of our ageing population is crucial. We support Ageing Better's call for a national strategy to fix cold and dangerous homes that are damaging people's health.

Addressing the shortage of accessible housing and greater consideration of the housing needs of older and disabled people must become a national priority that is also translated into local plans for housing. Minimum accessibility standard for all new build homes, the 'M4(2)' standard of building regulations must also be implemented. Consideration of data on the cost of extensions – which are often into six figures – could be used to feed into local plans to call for delivery of more accessible new homes and make the case for more measurable and specific targets in local plans for wheelchair accessible housing and lifetime homes standards.

Our study highlights the extent of the need and demand for home improvement services. Demand is expected to continue to rise. Managing waiting lists and demands from across a range of agencies and disciplines is increasing the pressure on some home improvement services. The sector is facing several future challenges relating to the growth in more complex cases, an ageing population, and an increase in the number of older people living in the private rented sector. This situation is becoming unsustainable, and unless there is specific funding and investment in the infrastructure and delivery of home improvement services the sector will not be able to meet these needs.

Funding and consistency

At a national level, our recommendations relate to funding and improving the consistency of home improvement services across local authorities, whilst retaining flexibility to innovate and deliver supplementary services relevant to local needs.

Defined funding is needed to support the growth and development of broader home improvement services, with specific discretionary capital funding for home repairs and interventions like energy efficiency improvements. Any funding arrangement must include sufficient revenue funding to support multi-disciplinary staffing teams – ideally with caseworkers acting as a single point of contact – as well as supervision and training.

Although there is some desire for greater consistency of core services to reduce geographical inequalities in access to home improvement services, case study services valued the ability to be responsive to local needs, which are not uniform across the country.

I think having that long-term funding would be ideal. There's talk of a duty on local authorities to have Good Homes agencies in all areas and to me that seems logical, to have that consistency across all areas where they have a minimum level of home improvement agency type services would be ideal.

Case Study A

Suggestions include creating a franchise for an umbrella organisation so that key services could be recreated across different areas to provide a more seamless service whilst still retaining flexibility.

As stated, we strongly support the DFG recommendations made by the House of Commons Select Committee Report on Disabled people in the housing sector, particularly in relation to the review of the £30,000 upper limit on individual DFGs. The Government has committed to reviewing the cap and the way DFG funding is allocated to local authorities; more flexibility and discretion is needed in how local authorities can use their DFG fees.

We would also like to see:

- National commitment to secure longer term funding specifically for home improvement services, as well as for DFGs, and encouragement for local authorities to fund and develop a Good Home Hub in their area. Such action could help remove much of the uncertainty in planning for home improvement services, reducing some of the variation and the inequalities that arise from piecemeal provision. More stable funding would also help to release some much needed capacity across the home improvement services sector that is currently absorbed in trying to secure external funding.
- Existing comprehensive services (in some local areas) are already well placed to form the basis of such a collaboration or hub and should be developed and funded accordingly. The growth of these services provides useful good practice lessons for the development of Good Home Hubs in other areas.
- Review of the current funding cap of £1,000 for non-statutory services such as for minor repairs and adaptations. The current cap only allows for a basic minor adaptations service and does not adequately consider the aesthetics of products. This can contribute to the known issue for service users of adaptations appearing too clinical.
- To accompany additional funding, we would like to see national commitment to raising awareness and promoting the work home improvement services do. This recommendation **must** be delivered alongside our call for further funding and support. Raising awareness without resourcing services to meet increased demand could overwhelm the sector and damage the trust and goodwill services have worked so hard to build.
- Any future funding for the retrofitting of private sector housing must also consider how it can partner with existing local home improvement agencies to act as a 'one-stop-shop' for sourcing trusted contractors and project managing installations.
- Our evidence shows that hoarding is a major concern. Some case studies in the evaluation are responding and developing specialist support around this issue. More evidence is needed to indicate the demand for hoarding services across tenures, and a national strategy to manage the rise in incidents. Demand for hoarding services is likely to increase, and support for hoarding become a key part of a comprehensive home improvement service offer. More funding is needed to support decluttering and clearance, ongoing therapeutic support for hoarding, and encourage collaboration with other services.

9.4. Creating more collaborative and connected services

Housing needs to be a strategic priority that is shared across local government, the NHS, and Public Health. Although things are changing, health and care services do not always recognise the benefit of investing in housing. The renewed emphasis on prevention and the shift in the delivery of health and social care and prevention services to our homes and communities means that it makes sense for local services to focus on the home environment. To support this shift at a strategic level Health and Wellbeing Boards, the Better Care Fund, and ICBs must increase their focus on housing to aid greater integration and collaboration.

For two tier authorities the development of a *'unifying vision and strategy'* for housing at the County level that strengthens and supplements, rather than duplicates, the strategy at District level could help to aid collaboration and connection, particularly if strategies are developed in partnership with Districts to avoid the imposition of a County level structure upon lower levels of governance.

Our evaluation has also highlighted the benefits and value of local services that integrate repairs, reablement, and adaptations into their local service design and delivery. Greater integration with health and social care can help to create the environment for more collaborative and connected local services.

Home improvement services can be proactive in developing key partnerships and relationships and aligning with strategic objectives. In the evaluation there are examples of how home improvement services are embedded in a wider network of teams, services, and providers, particularly within a local authority context. Having integrated services offers easier routes of access, better cross referrals, and improved joint working, although services outside a local authority context can also offer holistic services and integrated pathways to service users. Being deeply connected with the wider system of health, care, and third sector providers that are working with service users in an area, enables home improvement organisations to provide a complementary service, and a service that can adapt as the nature of funding and needs change.

Having a strategic focus on a key priority such as hospital discharge may also be beneficial. It is apparent that home improvement services are shifting towards hospital discharge to align with the objectives and funding of Integrated Care Boards. However, this can divert attention away from the preventative function of wider home improvement services. Conversations with the NHS and other health partners often focus on hospital discharge rather than appreciating all the other things that home improvement services do. There are issues around housing funding and the complexities of demonstrating preventative cost savings that primarily benefit the health service which, it is argued, mean that home improvement services do not always receive sufficient funding from ICBs.

- We support the DFG Review's recommendation for a new Home Independence Transformation Fund to be set up to help areas develop more integrated services. Resources are needed to help local care, health, and housing partners work together to deliver housing which enables older people and other people with health and care needs to live independently.
- At a local level, strategic decision-making forums such as ICBs, Health and Wellbeing Boards, etc. should ensure that home improvement services are represented.
- Local partners should explore opportunities for work shadowing and placement opportunities, including as part of training for some roles, to enhance awareness, partnerships, and joint-working related to preventative agendas and home improvement.
- Data sharing protocols should be built into hospital discharge programmes to enhance the ability of programmes to demonstrate preventative impacts via analysis of health outcomes data.
- Opportunities should be taken to build preventive support pathways into standard processes, for example within hospital discharge checklists.
- Joint service user mapping between partners such as Adult Social Care, occupational therapists and home improvement service managers can facilitate integrated management of resources to meet client need. Such approaches aid collaboration and identify how processes can be managed more smoothly.

Appendix 1
Evaluation Criteria

Table A1: HIS Evaluation Criteria Question 'library'

Evaluation Criteria	Library of Evaluation Questions
1. Nature, scale and reach of HIS	– What geographic areas (e.g. Local Authorities) does your organisation provide HIS? – What are the needs that are being addressed by HIS: within individual case studies and across HIS as a whole? How does this vary across the local authorities/areas covered by services? – How well are different communities of place and interest across case study areas served by HIS? How does the reach of the HIS vary? Why does it vary? – What services are provided by HIS and how and why do these vary? How are services delivered? What is the model of delivery of services? (Partners/ in house/OSS etc.) – How might the service offer be improved / enhanced or become more consistent across areas. – How do people find out about the HIS? What are the referral routes into the service? Why do people use the service /what are the main reasons for using HIS? – How many people/households use the HIS, what are the characteristics of those who use the service? Who doesn't use the service, and why? – Are those who use the service those who would benefit most? (consider gender, ethnicity, disability, housing tenures, socio-economic groups, health conditions, age etc) – What organisations do HIS work with and why? How closely does the local authority work/HIS with related service providers in the area? – What strategies do HIS use to 'reach' into the community? How effective are they? What can explain better or worse 'reach'? How might 'reach' be improved, or made more consistent across the sector – What other types of services, activities, opportunities, and resources are available in different areas and how do these affect the HIS in terms of their offer, patterns of service, ways of working and outcomes?

Evaluation Criteria	Library of Evaluation Questions
2. Operations and resources, and sustainability	– Who makes decisions about the HIS and what criteria is used to make decisions? How is the service commissioned? Have there been any changes over recent times? What changes/why/etc. – What are the important things that LAs, managers, staff and partners do as part of governance and operation of the HIS? – How is the service funded? Where does the funding come from? What is the breakdown of funding and expenditure? How many staff does your HIS employ? Does the HIS have sufficient resources to meet demand/need? – What additional strategies does the HIS employ to secure additional funding and resources? – What are the hallmarks of quality in the operational running of the HIS? What does it mean for an HIS to 'succeed'? – Are some HIS performing well whilst others are struggling? What aspects of any variations are explained by differences in 'strategy' and capabilities, the nature of the service offer, and what is better explained with reference to contextual factors (such as resource inputs, local authority, model of delivery, neighbourhood type, housing condition, geographical issues, contractors, available health and other services and facilities, etc.)? – What is the extent and nature of HIS relationships with other service providers (public, voluntary and private sector) at a neighbourhood/city level/wider LA area, and how do they vary? How are these relationships managed and how successful are different arrangements? What sorts of partnerships have HIS evolved and how are these serving operations, growth, and financial sustainability? – To what extent are HIS working with each other across areas/LA boundaries? What are the benefits of a more joined-up approach (i.e. in terms of minimising unequal access to resources, or maximising efficiency)? What co-ordination is there across the HIS around service provision? Should all services be provided within a LA or is there scope for cross boundary referrals where there isn't resource for a specific activity or service within one area? – How do HIS develop and evolve their service offer? What is the role of LAs, staff, partners in this process? How does this vary across the HIS? What are the issues faced in service development? What does a comprehensive service offer look like? Does this vary? Should there be a more consistent offer across LA areas? What does a consistent offer look like? How could this be achieved?

Evaluation Criteria	Library of Evaluation Questions
2. Operations and resources, and sustainability	– How is the quality and outcomes of HIS work assessed as part of service monitoring? How well does the data and metrics developed to monitor and evaluate HIS (as set out in the contract and monitoring criteria) align with what service users value about HIS? How is monitoring data used by LAs and HIS to inform service development and improvement? If/where it isn't, why not and how can the data be used more effectively? – Which HIS are expanding / growing (in terms of resourcing, service provision and/or scale of delivery)? Why are some growing/ expanding and others not? – What are the different approaches to business planning across HIS? How successful are different approaches to business planning? What are the strategies of HIS and how successful are these? – How are HIS responding to the opportunities and challenges discussed in chapter 1? How does this vary across HIS? What support do they need to respond effectively? – What is the strategy for learning and improvement – by individual HIS and the sector as a whole? How are HIS being supported to learn adapt and improve? By whom? How is this helping? – What other opportunities are HIS taking up and how are these helping with sustainability? – What are the key outstanding risks and challenges across HIS?
3. Relevance, range and quality of HIS / opportunities and engagement	– What is the range of services and opportunities available within and across HIS? How does it vary and why? – How do HIS differ in terms of referrals to and from other services? What explains that? – How closely aligned are HIS offer and opportunities aligned to key local/national agendas and recommendations from Good Home Inquiry? – What do individuals/service users, staff, partners, and other providers (e.g. public, VCS and private) value about HIS? How closely aligned are these to what people need and want? – What are the principles associated with 'quality' activities, services, and opportunities from HIS? What other factors influence their perception of quality?

Evaluation Criteria	Library of Evaluation Questions
3. Relevance, range and quality of HIS / opportunities and engagement	– (If measurable/measured) how does 'quality' (including perceptions of quality) vary across HIS? What explains differences in quality? For example what influence do features of operations and resourcing have on service quality and what influence do external or contextual factors (neighbourhood/city/LA type, delivery model, geographical issues, housing factors/conditions, local contractors/tradespeople, available health and other services and facilities,) have on quality?
4. Outcomes and impacts	– What are the outcomes of HIS work for key 'sub-groups': individuals (service users), communities/housing, health, and care system, and wider? (e.g. home accessibility/satisfaction with the home, warmth and thermal comfort, home safety, health and wellbeing, use of health and social care etc.). – Do outcomes vary across the local areas in which HIS are working? Do outcomes vary according to age, illness/disability, gender or ethnicity and other population characteristics? – Do the different ways in which service users engage with services affect or contribute to outcomes? What are some of the more common routes and pathways from interventions and support through to achieving better outcomes? What are some of the more common routes and pathways to less desirable outcomes? – What are the most important mechanisms (visible and invisible) that contribute to outcome change (drawing on evidence uncovered under points 1-3 above)? Do these vary across the neighbourhoods, population groups and wider contexts in which HIS are working? Are there any common mechanisms that can be identified across local areas, population groups or contexts? How do key mechanisms work in practice? – To what extent do differences in individuals' needs and circumstances; HIS context and operations and wider local/area factors and / or service characteristics; influence and/or explain any relative differences in outcomes or outcome 'pathways' for key 'sub-groups'?

Evaluation Criteria	Library of Evaluation Questions
5. Costs, benefits, and value for money	– What are the costs and benefits of HIS? – How do costs and benefits vary across different areas, population groups and contexts? – Considering the evidence about costs and benefits, and outcomes (see point 4 above), how can the wider value for money /cost benefit of the HIS be articulated? – How do these costs and benefits compare with other similar provision? What explains these differences?
6. Good Practice and Overall Conclusions	– (Summarising points 1-5) What does a good home improvement service look like? What are the key features etc. – What could the potential impact of services be if these service models were scaled up across the country? – What would the likely costs be to scale up a comprehensive service model across the country? – How should the service(s) be reproduced and implemented in other areas? What are the key lessons/recommendations for doing this? – Is there a difference in the effectiveness if there are multiple services delivered by different agencies or is a coordinated service more effective?

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Let's take action today for all our tomorrows.
Let's make ageing better.

The Centre for Ageing Better is pioneering ways to make ageing better a reality for everyone, including challenging ageism and building an Age-friendly Movement, creating Age-friendly Employment and Age-friendly Homes. It is a charitable foundation funded by The National Lottery Community Fund and part of the government's What Works Network.