CABINET MEMBER FOR ADULT INDEPENDENCE HEALTH AND WELLBEING

Venue: **Town Hall, Moorgate Street, Rotherham S60 2RB**

Date: **Monday, 31st January, 2011**

Time: **10.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Apologies for Absence

4. Transition from Alive Board to Health and Wellbeing Board (Pages 1 - 28)
   - Dr. John Radford to present

5. Rotherham Aids and Adaptations Policy (Pages 29 - 79)

6. Exclusion of the Press and Public
   The following items are likely to be considered in the absence of the press and public as being exempt under those paragraphs, indicated below, of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006).

7. Breastfeeding in Rotherham - UNICEF Baby Friendly Initiative (Pages 80 - 82)
   - Anna Jones, Public Health Specialist (Maternity, Children & Young People)
   (Exempt under Paragraph 3 of the Act - (information relating to the financial or business affairs of any particular individual (including the Council))

8. Action on Infant Mortality in Rotherham (Pages 83 - 117)
   - Anna Jones, Public Health Specialist (Maternity, Children & Young People)
   (Exempt under Paragraph 3 of the Act - (information relating to the financial or business affairs of any particular individual (including the Council))

9. Fee Setting - Independent Sector Residential and Nursing Care 2011/12 (Pages 118 - 120)
   (Exempt under Paragraph 3 of the Act - (information relating to the financial or business affairs of any particular individual (including the Council))

10. Local Authority Circular on the Personal Care at Home Act 2010 and Charging for Re-Ablement LAC (DH) (2010) 7 (Pages 121 - 123)
(Exempt under Paragraph 3 of the Act - (information relating to the financial or business affairs of any particular individual (including the Council))

Healthy Lives, Healthy People

Our strategy for public health in England

The Health Background

- Britain has amongst the worst levels of obesity in the world.
- Smoking claims over 80,000 lives a year.
- 1.6 million people are dependent on alcohol.
- Over half a million new sexually transmitted infections were diagnosed last year, and one in ten people getting an infection will be re-infected within a year.
- Poor mental health is estimated to be responsible for nearly a quarter of the overall burden of long-standing poor health.
- People in the poorest areas can expect to live up to 7 years less than people in richer areas.

The New Approach

- **representative** – owned by communities and shaped by their needs
- **resourced** – with ring-fenced funding and incentives to improve
- **rigorous** – professionally-led, focused on evidence, efficient and effective
- **resilient** – strengthening protection against current and future threats to health.

and will focus on improving the health of the poorest fastest

Health and Wellbeing throughout life

1. Empowering local government and communities
2. Tackling health inequalities
3. Coherent approach to different stages of life
4. Giving every child the best start in life
5. Making it pay to work
6. Designing communities for active aging and sustainability
7. Working collaboratively with business and voluntary sector – the Public Health Responsibility Deal

A New Public Health System

- Public Health England – a national public health service
- A return of public health leadership to Local Government
- Professional leadership nationally and locally
- Dedicated resources for public health at national and local levels
- Focus on outcomes and evidence based practice supported by a strong information & intelligence system
- Maintaining a strong relationship with the NHS, social care and civil society
- Set out in the forthcoming Health and Social Care Bill

Public Health England

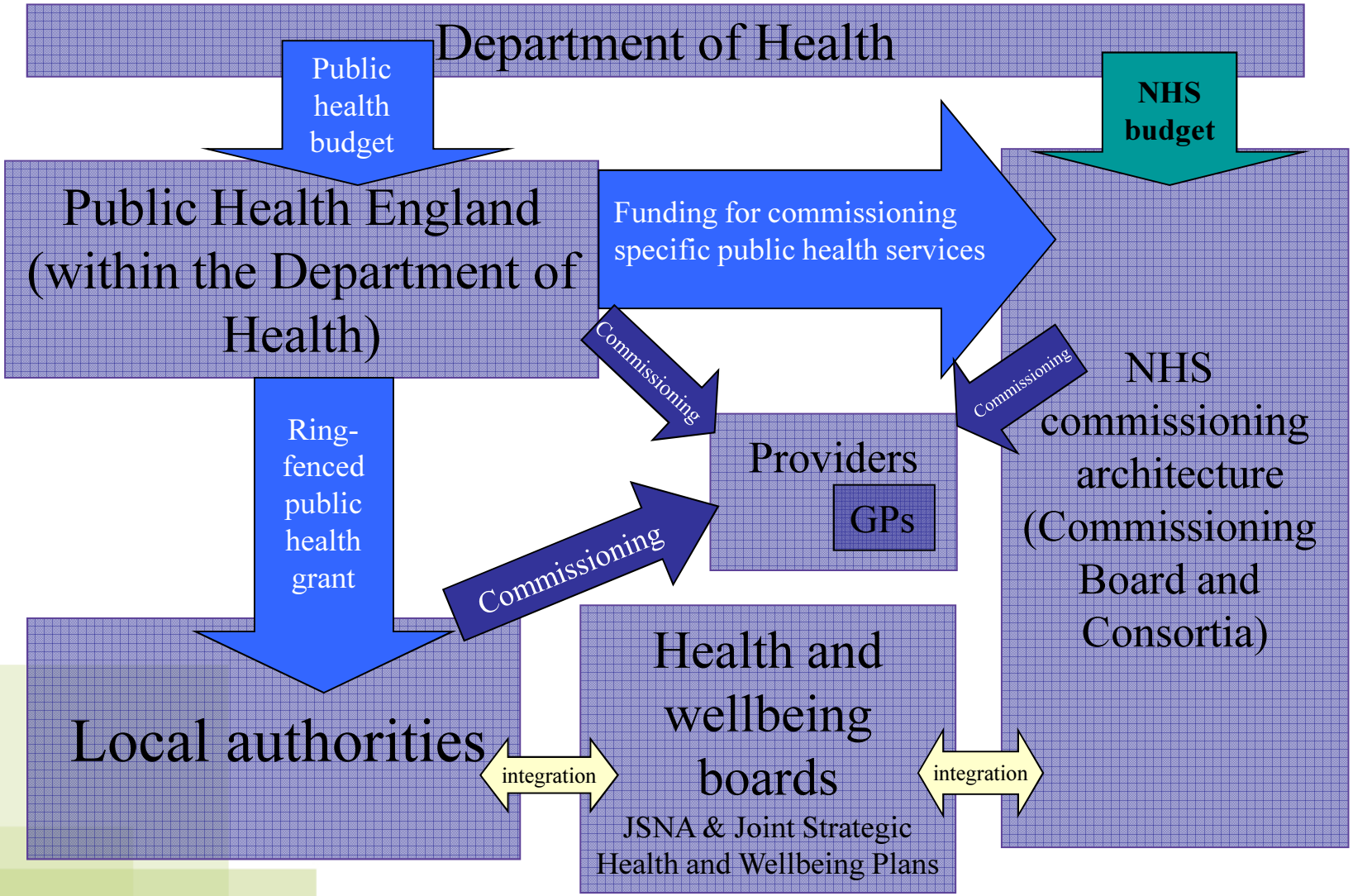
- New public health service directly accountable to the Secretary of State for Health with a clear mission to;
  1. Achieve measurable improvements in public health outcomes; and
  2. Provide effective protection from public health threats

- It will do this by;
  1. Protecting people from infectious disease and biological, chemical and radiological threats;
  2. Helping people and families to be able to take care of their own health and wellbeing; and
  3. Inspiring challenging and commissioning partners from all sectors.

PROPOSED ROLE - The Director of Public Health;

- Will be jointly appointed by the relevant local authority and Public Health England and employed the local authority with accountability to locally elected members and through them to the public.
- Will be the principal adviser on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population
- Will play a key role in the proposed new functions of local authorities in promoting integrated working
- Jointly lead the development of the local Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy (with Directors of Adult Social Services and Directors of Children's Services)
- Will continue to be an advocate for the public's health within the community
- Will produce an authoritative independent annual report on the health of their local population

Public health funding and commissioning



Defining commissioning responsibilities – examples

	Proposed activity to be funded from the new public health budget (provided across all sectors)	Proposed commissioning route/s for activity (including any direct provision)	Examples of proposed associated activity to be funded by the NHS budget (including from all providers)
Infectious disease	Current functions of the Health Protection Activity in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	PHE with supported role by local authorities	Treatment of infectious disease; co-operation with PHE on outbreak control and related activity
All screening	PHE will design, and provide the quality assurance and monitoring for all screening programmes	NHS Commissioning Board (cervical screening is included in GP contract)	-
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the National Child Measurement Programme and commissioning of weight management services	Local authority	NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting, or bariatric surgery

Public Health and the NHS

- The NHS will commission some public health services, with funding passed from Public Health England.
- In addition, the NHS will have an ongoing role in certain services with public health aspects - the Department expects that public health continues to be an integral part of primary care services.
- Public health expertise will inform the commissioning of NHS funded services, facilitating integrated pathways of care for patients. This will be underpinned:
  - locally by ensuring DsPH are able to advise the GP consortia; and
  - nationally via the relationship between the Secretary of State/ Public Health England and the NHS Commissioning Board.

Consultation question

How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

Allocations and the health premium

Department of Health

Allocations

- From April 2013, Public Health England will allocate ring-fenced budgets, weighted for inequalities, to upper-tier and unitary authorities in local government. Shadow allocations will be issued to LAs in 2012/13, providing an opportunity for planning.
- We propose to move to actual allocations from current spend towards the target allocations over a period of time.
- We will take independent advice on how the allocations are made.

Health premium

- Building on the baseline allocation, LAs will receive an incentive payment, or 'health premium', that will depend on the progress made in improving the health of the local population and reducing health inequalities, based on elements of the Public Health Outcomes Framework.
- The premium will be simple and driven by a formula developed with key partners, representatives of local government, public health experts and academics.

We are consulting on Public Health allocations and the health premium in the consultation document

Accountability

- Secretary of State remains accountable for resources allocated to the health and social care system as a whole, for strategy and for the legislative and policy framework and for progress against national outcomes.
- As part of DH, PHE will be accountable to the Secretary of State for the functions it exercises.
- There will also be a relationship between PHE and LAs, which means that local government will be accountable to PHE. The public health grant to LAs, as a ring-fenced grant, will carry some conditions about how it is used.
- The primary accountability for local government will be to their local populations in improving outcomes in health and well-being.
- Locally, Health and Wellbeing Boards will be core to the assessment and agreement of local priorities.
- Data will be published in one place by Public Health England enabling national and local democratic accountability for performance against those outcomes. This will make it easy for local areas to compare themselves with others across the country and incentivise improvements and at a national level to track progress towards health improvements across the board.

Public Health Outcomes Framework: VISION

To improve and protect the nation's health and to improve the health of the poorest, fastest

- **Domain 1 - Health Protection and Resilience:** Protecting the population's health from major emergencies and remain resilient to harm
- **Domain 2 - Tackling the wider determinants of health:** Tackling factors which affect health and wellbeing and health inequalities
- **Domain 3 - Health Improvement:** Helping people to live healthy lifestyles, make healthy choices and reduce health inequalities
- **Domain 4 - Prevention of ill health:** Reducing the number of people living with preventable ill health and reduce health inequalities
- **Domain 5 - Healthy life expectancy and preventable mortality:** Preventing people from dying prematurely and reduce health inequalities

Consultation question:

Do you agree with the overall framework and domains?

The Indicators

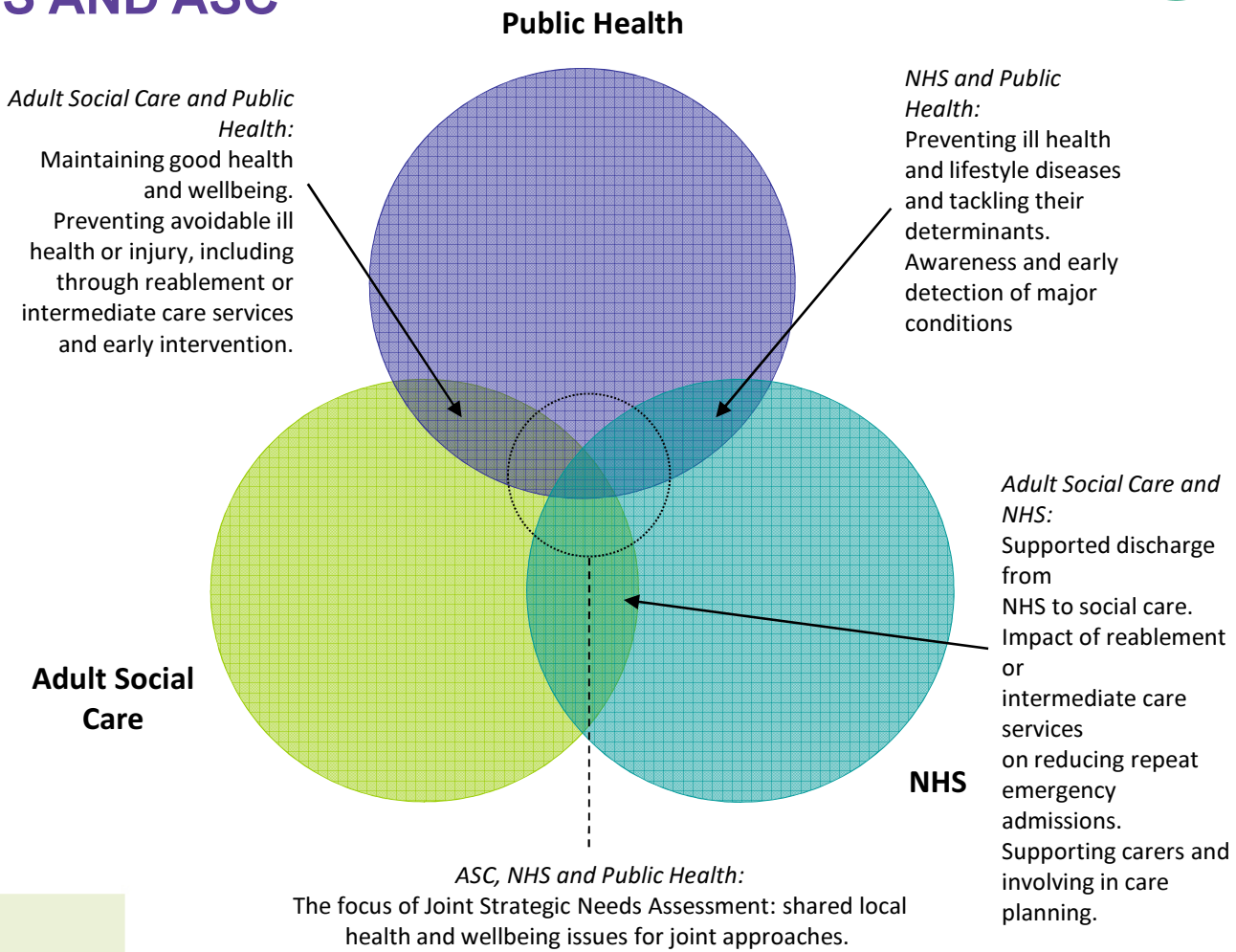
Criteria for how we developed proposed indicator

- Are there evidence-based interventions to support this indicator?
- Does this indicator reflect a major cause of premature mortality or avoidable ill health?
- By improving on this indicator, can you help to reduce inequalities in health?
- Will this indicator be meaningful to the broader public health workforce and to the wider public?
- Is this indicator likely to have a negative / adverse impact on defined groups (groups sharing a characteristic protected by equalities legislation)? (If yes, can this be mitigated against?)
- Is it possible to set measures, SMART objectives against the indicator to monitor progress in both the short and medium term?
- Are there existing systems to collect the data required to monitor this indicator; and
- Is it available at the appropriate spatial level (e.g. Local Authority)?
- Is the time lag for data short, preferably less than one year
- Can data be reported quarterly in order to report progress?

Consultation question

Are these the right criteria to use in determining indicators for public health?

Public Health Outcomes Framework – ALIGNMENT WITH NHS AND ASC



Consultation question:

Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

Summary timetable

Summary timetable (subject to Parliamentary approval of legislation)	**Date**
Consultation on: • specific questions set out in the White Paper; • the public health outcomes framework; and • the funding and commissioning of public health.	Dec 2010–March 2011
Set up a shadow-form Public Health England within the Department of Health Start to set up working arrangements with local authorities, including the matching of PCT Directors of Public Health to local authority areas	During 2011
Develop the public health professional workforce strategy	Autumn 2011
Public Health England will take on full responsibilities, including the functions of the HPA and the NTA. Publish shadow public health ring-fenced allocations to local authorities	April 2012
Grant ring-fenced allocations to local authorities	April 2013

Overall Transition

- Accountability for delivery in 2011/12 will continue to rest with SHAs and PCTs.
- In addition, SHAs will be responsible for the overall transition process in their regions during 2011/12 with co-ordination and leadership for public health from DH.
- As part of this, Regional Directors of Public Health (RDsPH) will lead the transition for the public health system at the regional and local level.

Healthy Lives, Healthy People – A Consultation

- Public Health White Paper

  Role of GPs and GP practices in public health

  Public health evidence

- Professional Regulation
- Outcomes Framework for Public Health
- Funding and Commissioning for Public Health

Find consultation documents at;

www.consultations.dh.gov.uk/healthy-people

Respond to consultations at;

publichealthengland@dh.gsi.gov.uk

HM Government

HEALTHY LIVES, HEALTHY PEOPLE: THE GOVERNMENT'S PLANS FOR PUBLIC HEALTH

This leaflet explains our plans for helping people lead healthier lives, and how you can have your say about them.

What is public health?

Public health is about everything society does to prevent people getting ill, rather than treating sickness. We take for granted the huge advances in public health made in the past. Dirty water, hunger and infection are no longer major killers here.

On average, people in England are healthier and live longer than ever before. Nowadays "diseases of lifestyle" like heart disease, obesity and depression are the issue. Smoking, drinking, lack of exercise and poor diet play a big part.

What is the problem?

Poor health is still a big problem. It shortens and damages people's lives, harms our economy and puts a huge burden on the NHS and taxpayers. Much of it can be prevented, and many of the root causes are social.

This is about how we live our lives, but also about our position in society. Rich people live longer and have better health than poor people. Low income, unemployment, loneliness and discrimination are bad for people's physical and mental health. As a society we have focused a lot on cure and not enough on prevention. We need to do better.

Who should do what?

The health of the nation is everyone's responsibility.

The government must make sure we have high quality health services and that we prepare for health emergencies like flu epidemics and chemical spills. The government is also in charge of other policies that affect health such as housing, jobs, welfare benefits, pensions, transport, environment and education.

The government cannot force people to live healthy lives. People can be helped and encouraged to make healthier choices. Local communities working together, and with a good understanding of human behaviour, will achieve more than extra laws and lectures from the government. Local councils have a critical role to play. Business and industry such as the food

and drink industry has a big responsibility to help us make healthier choices by encouraging healthier eating and sensible drinking.

What will change?

A new service called Public Health England will bring together the things that have to be done at national level, such as preparing for emergencies. From 2012, Public Health England as part of the Department of Health will have responsibility for protecting the health of the population.

From 2013, councils will be responsible for public health in local areas. Their job will be to help improve people's health, particularly those with the worst health. Directors of Public Health will be in charge of this work, in partnership with the NHS, local communities, charities and businesses. It makes sense for councils to have this duty as they are already in charge of many things that affect health.

Councils where people's health is worst will receive more money than other areas where health is better as they have more to do. Councils will be rewarded with extra funds for some of the improvements they make in people's health.

Unlike in the past, funding for public health will be identified as a separate budget so that the government and councils will only use this for public health.

Your GP will also be asked to play a bigger part in preventing ill-health, not just treating sickness.

The Government will work with the business and industry (including food, drink, leisure and lifestyle) through a voluntary Public Health Responsibility Deal. The government will look at a range of ways to encourage business and industry to have a more positive impact on health before considering more laws and regulations.

What will this mean for……?

Parents, children and young people

- A good start in life is vital for health. The government aims to end child poverty by 2020. We will increase the number of health visitors, and provide extra support for families most in need, including through Sure Start Children's Centres.
- We will encourage employers to make it easier for mothers to breast-feed at work.
- There will be a new school sports competition linked to the Olympics.

Older people

- We will continue to offer NHS health checks to people aged 40 to 74.
- There will be local schemes to help and encourage older people stay fit and active, enjoy their environment and live independently at home.
- There will be more support for carers.
- We will improve living standards by increasing pensions in line with inflation or average earnings (whichever is the higher).

Local communities and the environment

- There will be local schemes to encourage more walking and cycling
- There will be new protections for public green spaces to encourage recreation, community activities and food growing.

Smoking

- We will keep the current smoke free laws.
- It will be illegal to sell cigarettes and tobacco from vending machines after 1 October 2011.
- The government is looking at other options, including whether cigarettes should be sold in plain packaging. It will publish a tobacco control plan shortly.

Alcohol

- There will be tougher penalties for clubs, bars and pubs and shops that sell alcohol to children or contribute to alcohol related crime and anti social behaviour.
- There will be tougher controls on selling cut price alcohol.

Have your say

This is only a summary of our plans; you can find more detail at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

We want to hear your views and suggestions. Please make your voice heard and contact us by 8 March 2011.

This leaflet applies to England only. It has been produced by the Department of Health and put into plain English with the help of the health and social care charity National Voices.

LOCAL DEMOCRATIC LEGITIMACY: FACTSHEET
Gateway reference: 15320

1. Introduction

The NHS and Public Health white papers together provide local authorities with an enhanced role in supporting the delivery of health and social care services.

Local authorities will take on the major responsibility of improving the health and life-chances of the local populations they serve, and will lead others to work together to improve health and wellbeing.

Local authorities will lead on public health, using a new ring-fenced budget and health premium, which will reward areas who make the most progress. Directors of Public Health will move from the NHS to local authorities.

2. Mutually respecting partners

Better health and wellbeing will only come from the NHS and local authorities working together, with high quality local leadership and relationships being an essential foundation for achieving better health and wellbeing outcomes.

3. Statutory health and wellbeing boards

There is a need to improve the strategic coordination of commissioning services across NHS, social care, related childrens and public health services. To support this, the Health and Social Care Bill will require the establishment of a health and wellbeing board in every upper tier local authority by April 2013.

Health and wellbeing boards will bring together elected representative and the key NHS, public health, social leaders and patient representatives to work in partnership. This will ensure services are joined up around the needs of people using them, and that resources are invested in the best way to improve outcomes for local communities.

4. Flexible geographical scope

The Health and Social Care Bill will give flexibility for health and wellbeing boards to choose to do their work at whatever level “makes sense locally”. This means they might choose to work together to set up a board covering more than one local authority area, or to carry out some of their work more locally, focussing on the needs of a specific district or neighbourhood.

5. Core membership

To achieve the most effective integration and joint action, core members of the board must include GP consortia, the director of adult social services, the director of children’s services, the director of public health and a representative from local HealthWatch. To increase local democratic legitimacy and to represent the interests of the public the Bill prescribes there must be a minimum of at least one local elected representative.

Local authorities can decide to invite and include other members, for example other groups or stakeholders who can bring in particular skills or perspectives, such as the voluntary sector, clinicians or providers.

By making the boards statutory and specifying a core membership health and wellbeing boards provide the forum for public accountability.

The role of the boards will be to improve joint working and commissioning and increase local democratic engagement with the commissioning of services, alongside patient engagement through local HealthWatch.

6. Enhanced joint strategic needs assessment

The core purpose of health and wellbeing boards is to join-up commissioning across NHS, social care, public health, children's services and other services that the board agrees have an impact on the wider determinants of health – for example leisure or housing.

The aim is to achieve better health and wellbeing outcomes for their whole population and a better quality of care for patients and other people using services.

Through new health and wellbeing boards, local government will lead in bringing together the NHS, social care, public health and children's services to understand local needs through a joint strategic needs assessment (JSNA) and to create a joint health and wellbeing strategy (JHWS) to address them. Local authorities and GP consortia will have an equal responsibility to develop the strategy.

The Bill will place a legal obligation on NHS and local authority commissioners to refer to the JSNA in exercising their commissioning functions.

7. The new joint health and wellbeing strategy

The ambition is for health and wellbeing boards to go further than analysis of common problems to deep and productive partnerships that develop solutions to challenges (rather than just commentating on them).

To support this ambition the Bill specifies boards should develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing. Through the strategy, the council, NHS and other partners will agree, at a high level, how they will address the health and wellbeing needs of their community, giving the overarching framework for developing plans for the NHS, social care, public health and other relevant services.

The Bill will place a legal obligation on NHS and local authority commissioners to have regard to the JHWS in exercising their commissioning functions.

This new way of working is not about one partner on the health and wellbeing board having the power to overrule others' decisions – it's about fundamentally changing the dynamic to one of collaborative leadership. The work of the health and wellbeing boards is about influencing, shaping and driving services.

8. Increased joint commissioning and pooled budgets

Health and wellbeing boards will be able to look at the totality of resources available to support local people's health and wellbeing, across the budgets the NHS, council and other partners hold. The Health and Social Care Bill and health and wellbeing boards are intended to encourage local authorities and their NHS partners to make more use of the flexibilities already available to them – such as pooling budgets or having lead commissioning arrangements – when drawing up the joint health and wellbeing strategy.

Health and wellbeing boards will be expected to consider how the mechanisms for integration already included in the NHS Act, such as pooled budgets or lead commissioning arrangements, could be used to provide more integrated commissioning across health and social care.

9. Health and wellbeing boards as an open-ended vehicle
Local authorities will have freedom to delegate additional functions to the health and wellbeing board. For example, housing or other wider determinants of health could be considered by the board, with the aim of providing better (and more integrated) services to communities

GP consortia will be able to develop voluntary arrangements with a local authority to deliver services on their behalf. For example, local authorities, with their commissioning expertise may be well placed to support GPs in developing new arrangements.

10. Referral and enhanced security
The Department of Health listened to feedback about the importance of having independent scrutiny functions and reconsidered its proposals. We are therefore persuaded that health and wellbeing boards will not have a health scrutiny function.

Rather than placing a duty on the health and wellbeing board, the Bill will place the powers for health overview and scrutiny with the local authority itself. Local authorities can then choose how to exercise these functions, whether through current Health Overview and Scrutiny Committees or alternative arrangements.

11. Implementation framework
Subject to Parliamentary approval, health and wellbeing boards will become a statuary committee of local authorities at the same time GP consortia taken on responsibility for the NHS budget.

Although boards will only formally assume powers and duties in April 2013, the new partnership arrangements are critical to developing the new system for health and care, and need to be hardwired into it from the start. That means developing them alongside other parts of the system like GP consortia, starting now.

Legislating for change is not the same as making it happen. The benefits for local communities cannot be achieved without developing the right local relationships and leadership.

Leaders in local authorities, emerging GP consortia and PCTs need to work together now to consider and establish the right local arrangements.

In the first phase, a network of early implementers – areas who want to start work on new arrangements now – will be supported by DH to share experience and expertise. The outputs of this work will be shared with other councils and GP consortia. We will be writing to all local authorities in January, inviting them to engage in this network.

The second phase of implementation will be the establishment of “shadow” health and wellbeing boards in every upper-tier authority by the end of 2011, with shadow running during 2011/12.

The final phase will be in April 2013 onwards, when statutory duties and powers will take full effect – this will be supported by enhanced scrutiny powers for local authorities

To be successful, it is important that all key partners in a local area take this work forward together, recognising that not everybody is starting from the same point, and that some GP consortia or councils will already be further on with their plans than each other. Partners will need to build learning and share skills together as they go, investing time, effort and commitment in building relationships.

Date issued: 16 December 2010

COMMISSIONING FOR PATIENTS: FACT SHEET

Gateway reference: 15318

1. Introduction

The Government's ambition is for an NHS that puts patients first and continually improves the quality and outcomes of care for everyone. This improvement will come from devolving power to professionals, patients and carers.

By April 2013, there will be a comprehensive system of GP commissioning consortia, supported by and accountable to a new independent NHS Commissioning Board.

2. The principle of GP commissioning

Key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations.

GP commissioning builds on the key role that GP practices already play in coordinating patient care and acting as advocates for patients. It gives groups of GP practices financial accountability for the consequences of their decisions.

3. Granting GP consortia statutory powers and duties

The purpose of consortia being statutory bodies is to ensure that they have a separate identity from that of their member practices.

Being a statutory body means that consortia can have clear powers and duties. This will not affect the status of GPs and GP practices as providers of primary care.

The legislative framework will be designed to make sure that consortia are able to focus on improving quality of care within the resources available to them.

4. Composition of GP consortia

All holders of primary medical contracts will have a duty to be a member of a consortium for each contract they hold, i.e. for each GP practice.

Individual GPs or GP practices will not have to take commissioning and financial decisions on their own. The majority of GPs will continue focusing on providing primary care.

Membership of consortia will be flexible, with consortia able to expand, contract, dissolve or merge.

The precise size of a consortium is less important than the ability to scale up or scale down depending on the nature of the activity being undertaken.

The NHS Commissioning Board will need to be satisfied that prospective consortia, when applying to be established, have made appropriate arrangements to ensure that they can discharge their functions.

5. Robust governance arrangements

Commissioning decisions will need to reflect the healthcare needs of the practice's registered patients together with the needs of unregistered patients for whom the consortium is responsible.

All consortia should have an Accountable Officer who need not be a GP or clinician. However, strong clinical leadership is a critical component of successful commissioning, and clinical experience will be essential in understanding how best to improve quality and outcomes.

The consortium's Accountable Officer will be responsible for ensuring that a consortium promotes continuous improvements in the quality of services it commissions, complies with its financial duties, and provides good value for money.

All consortia will be required to have a published constitution.

Consortia will be required to make remuneration arrangements and commissioning plans public, to hold an open annual general meeting, and to publish an annual report showing the results of patient and public consultations.

6. Partnership working and public involvement

There will be increasing focus given to partnership working and the importance of multi-professional involvement in commissioning.

The NHS Commissioning Board will hold consortia to account for financial performance and outcomes, but there will also be a stronger role for local authorities in helping shape commissioning priorities, and in promoting a joint approach to improving the health and wellbeing of local communities.

There is a commitment to greater patient and public involvement within emerging GP consortia. The Health and Social Care Bill will place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development. Local Healthwatch will strengthen the patient's voice, and the enhanced role of local authorities will increase the democratic legitimacy of NHS commissioning decisions.

7. The NHS Commissioning Board

The NHS Commissioning Board will be established in shadow form as a Special Health Authority in April 2011, and as a full non-departmental public body from April 2012.

The Board will be responsible for establishing GP consortia, and in doing so will ensure that there is a comprehensive system of consortia across England. The Board will hold consortia to account, but will only have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions.

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, and promoting choice and patient and public involvement.

The Board will need to be able to demonstrate good clinical evidence in support of its decisions, maintain effective relationships with professional bodies, and have strong internal professional leadership.

The Board will publish a business plan setting out how it intends to achieve its statutory duties, and the objectives or requirements that have been set for it by the Secretary of State. It will also publish an annual report setting out progress against both its duties and objectives and requirements.

8. Clear accountability

GP consortia will have a stronger focus on improving the quality and outcomes of care for patients. They will be under a statutory obligation to seek to reduce inequalities in access to healthcare.

The NHS Commissioning Board will draw on the national outcome goals in the Outcomes Framework to develop a Commissioning Outcomes Framework, to help hold consortia to account for promoting improvements in quality.

GP consortia will also be required to ensure that their expenditure does not exceed the commissioning budget allocated to them. There will be a clear line of financial accountability from consortia to the NHS Commissioning Board and in turn to the Secretary of State. The Board will have the powers to intervene where there is a significant risk of financial failure.

There is a need to ensure a fair approach to handling current deficits and surpluses. The expectation is that any debt will be fully resolved by the end of 2012/13. Further detail is included in the NHS Operating Framework for 2011/12.

9. Commissioning primary care

The NHS Commissioning Board will commission primary medical care services, but we are planning an explicit duty for all GP consortia to support the Board to improve the quality of these services.

The NHS Commissioning Board will be able to ask GP consortia to carry out some commissioning functions in relation to primary medical care on its behalf. This will mean that consortia have a core role in improving patient care across the system.

The NHS Commissioning Board will retain formal responsibility for ensuring that a practice is meeting its core contractual duties. The Care Quality Commission will be responsible for ensuring that GP practices are meeting standards of safety and quality.

10. Commissioning specialised and complex services

The NHS Commissioning Board will commission national and regional specialised services, drawing on engagement with GP consortia. The specialised services portfolio will be kept under regular review. There will be a criteria-based approach to deciding which services are 'specialised'.

The NHS Commissioning Board will have responsibility for health services for those in prison or custody, high security psychiatric services and the current PCT duties in relation to healthcare for the armed forces and their families.

GP consortia are likely to work collaboratively with each other on particular aspects of commissioning, such as commissioning low volume services. The NHS Commissioning Board will also be able to commission some services on behalf of consortia, where this is agreed by both parties.

Responsibility for commissioning maternity services will lie with GP consortia, but with a strong role for the Board in promoting quality improvement.

11. Autonomy for the NHS with national leadership

The functions of the NHS Commissioning Board will be defined in primary legislation, rather than being at the discretion of the Secretary of State through legal delegation.

Instead, the Secretary of State will set a mandate for the Board, which will include the totality of the Government's requirements and expectations for the NHS over a three year period, updated annually.

Each year the Secretary of State will be obliged to undertake a formal public consultation on the priorities within the mandate for the NHS Commissioning Board.

In the event of emergencies, it is vital for the Government to be able to act decisively. The Board will be under a duty to ensure NHS preparedness and resilience by assuring that clear arrangements are in place.

12. GP pathfinders and managing the transition to consortia

Consortia pathfinders will test out design concepts for GP commissioning and explore how emerging consortia will best be able to undertake their future functions.

Pathfinders and other emerging consortia will work closely with PCTs to deliver the QIPP agenda.

The NHS Commissioning Board will start to establish consortia from April 2012. Once established as statutory bodies, consortia will be able to take on staff from PCTs.

In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable in their own right from April 2013 onwards.

15. Conclusion

Our proposals for GP commissioning and the NHS Commissioning Board are intended to transform the quality of care and health outcomes for patients. Day-to-day decision making will be more sensitive and responsive to their needs and wishes.

A clear framework established and developed by the NHS Commissioning Board will promote quality, choice, patient and public involvement, and effective stewardship of public resources.

The plans are intended to unlock the benefits of GP-led commissioning, focussing on achieving a step-change in the quality of patient care, delivering better value for the taxpayer and improving the health of local communities.

Date issued: 16 December 2010

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Cabinet Member Adult Independence, Health and Wellbeing**
2.	**Date:**	**31st January 2011**
3.	**Title:**	**Rotherham Aids and Adaptations Policy**
4.	**Programme Area:**	**Neighbourhoods and Adult Services**

5. Summary

The purpose of this report details proposals for the Council's Aids and Adaptations Policy within the borough. It highlights key implications for customers living within the borough.

6. Recommendations

THAT THE RECONFIGURATION OF THE ROTHERHAM AIDS AND ADAPTATIONS POLICY BE NOTED.

7. Background and Proposals

7.1 The Aids and Adaptations (A&A) Team currently operate the statutory function of the Council to administer the Disabled Facilities Grant (DFG) and arrange relevant adaptations to properties within the borough.

7.2 This policy is principally aimed to help people remain in their own homes through the provision of equipment and adaptations. However, adaptations are a last resort and as such all alternatives will be reviewed. The Council must therefore decide whether the applicants needs can best be met through:

- Adaptations within reasonable cost boundaries
- Issue of equipment, **or**
- Re-housing to an alternative adapted accommodation

7.3 It is a mandatory duty for the Council to provide assistance with aids and adaptations for vulnerable disabled people and this is done through the Housing Investment Programme (HIP). This covers both public and private sector properties and enables people to stay in their own homes.

7.4 The public sector adaptations budget is funded through the HIP either by Capital Receipts or Revenue Contribution from the Housing Revenue Account (HRA). However, it should be noted that due to the significant decrease in Right to Buy receipts and other pressures on the Housing Revenue Account (HRA), the allocation of resources to fund adaptations must be looked at together with other priorities. The current budget in 2010/11 is £1.8m.

7.5 Historically, private sector adaptations were funded by the Disabled Facilities Grant (60%) and a contribution of 40% from General Fund resources. However, from April 2008 this funding arrangement changed and it was announced that Local Authority's would receive a DFG allocation without a specified requirement to match this funding and that the DFG funding received could also be used in the public sector, if so required. The DCLG did however state that 'Given the importance of providing adaptations, and the beneficial, preventative impact these have on other budgets, such as social care, LA's are expected to continue to prioritise this important area.'

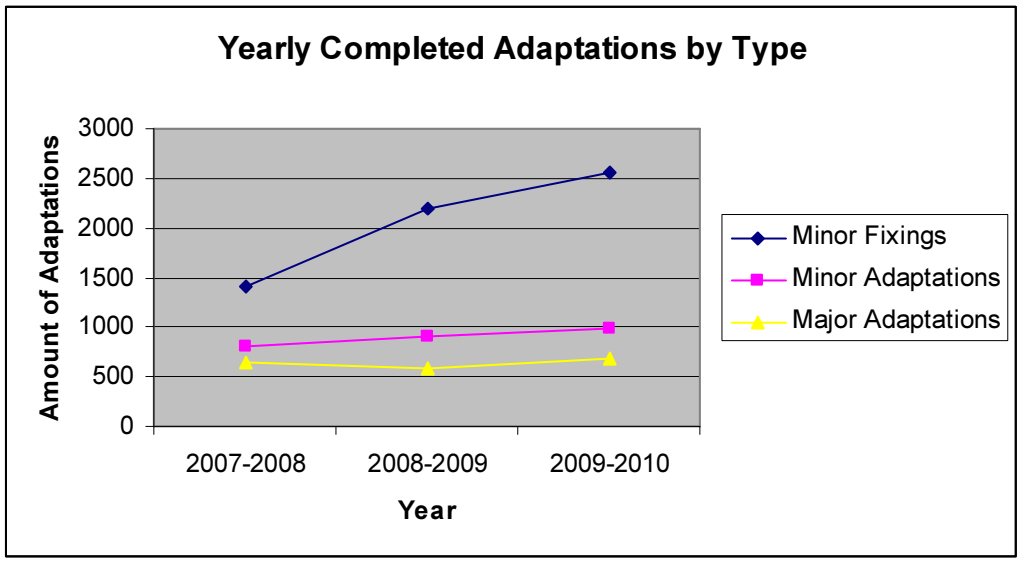
7.6 Adaptations are split into three categories:

- Minor fixings (none means tested and under £1000 in value)
- Minor adaptations (none means tested and under £1000 in value, requiring some structural work)
- Major adaptations (means tested over £1000 in value)

A major adaptation could be made up of several minor adaptations.

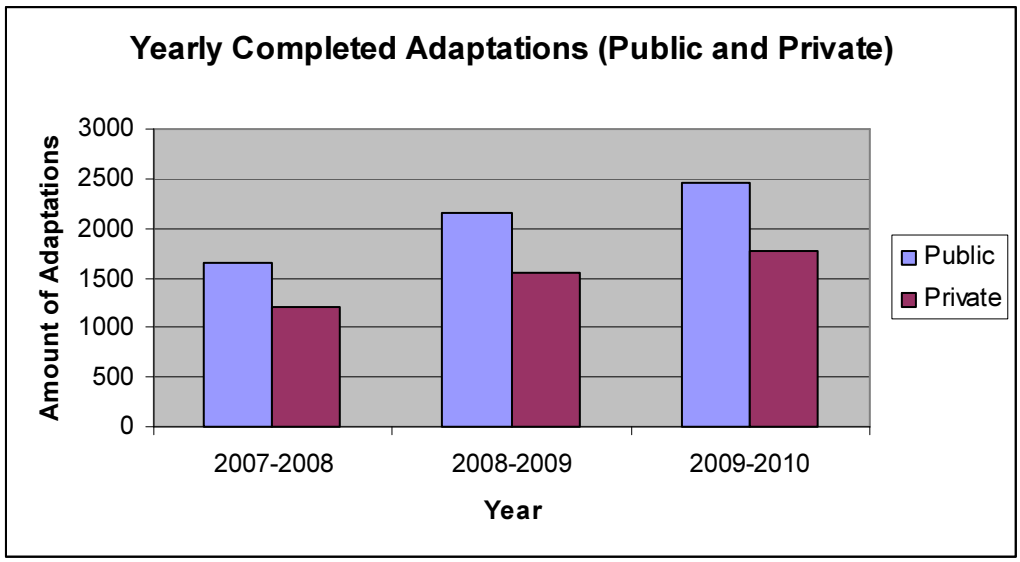
7.5 Although the budget has roughly remained the same, the number of adaptations that the A&A Team have been able to complete has risen over the previous 3 years due to negotiations of costs for specific equipment and jobs. Please see fig. 1

Fig.1



A breakdown of public and private property adaptations can be seen in fig. 2

Fig.2



7.6 *Main Proposals*

The Adaptations Policy document includes both the policy of the Council and the supporting procedures to be implemented by the A&A Team and their relevant partners. The procedures and processes are not highlighted within this report. (see attached policy document – appendix 1)

The statute sets out the legislation for the delivery of adaptations and the qualification for grants. Rotherhams' policy will mirror the statute and give further clarity on areas that are not covered under legislation.

This policy is a reconfiguration of existing practice and policy within RMBC configured to meet current legislation and statute. The purpose of this policy

is to clarify the RMBC position in terms of both legislative and non legislative practice.

7.6.1 *Eligibility for Customers Requesting an Adaptation:*

Eligibility for adaptations is constrained by law.

Often customers may not meet the legal requirements due to a small discrepancy. To ensure those customers are supported, this policy framework will enable the Council to provide a fair and consistent approach to their request whilst easing pressure on existing housing stock.

Generally, customers must either be the named owner or named tenant to be eligible. For children, the parent or guardian must be the named owner or tenant. However, Rotherham does consider that immediate family members who are not named as owner or tenant may also require adaptations. It has been identified that a risk to offering people who are not named would be potential abuse of the system. To combat this, the policy defines immediate family and adds stipulations including:

- The family member must have been in residence at the property for a minimum of 2 years.
- The main carer of the family member must be the qualifying owner/tenant. (For the purpose of the policy, a 'main carer' is also defined).

See Appendix 1: Section 3 (3.6) (Eligibility) Page 2

7.6.2 *Agency Fees:*

For every major adaptation a 10% fee is charged to cover the costs of the A&A team. This fee is to support the project management of the adaptation from design to completion. The 10% is inclusive of the total amount of the adaptation and therefore is inclusive of any grant issued.

Through the personalisation agenda within Rotherham, customers may choose to arrange for works to be conducted themselves through contractors. In such cases there is an expectation that customers would be fully responsible to manage their own adaptation project to meet the recommended specifications by the community occupational therapist. However, initial visits and input will be required from the A&A Team.

Where a customer chooses to arrange works to be conducted themselves and this work is completed, an administration charge of 5% will be applied to ensure costs are covered. This will be deducted directly from any grant that is issued. If the customer requires further input from the A&A Team then the full 10% will be charged.

See Appendix 1: Section 10 (Fees and Finance) Page 14

7.6.3 *Decisions (customer choice):*

Due to the budgetary limitations placed on the service combined with the demand for adaptations, the Adaptations Team will look at all reasonable and practicable solutions to ensure that public monies are spent in a cost effective manner whilst maintaining the adaptation meets the customers' requirements. This is a key factor when reviewing major adaptations.

For non-council properties, if there is more than one adaptation solution that is deemed by the assessing Adaptations Officer as both reasonable and practicable then the most economical will be pursued. If the customer decides that they would prefer an alternative solution, then the cost of the proposed solution can be used toward the cost of the preferred option. However, if there are further costs then these would need to be met by the customer.

For council properties, the A&A Team will pursue the most reasonable and practicable solution. If the applicant refuses the solution, it will be treated as such and the job will be cancelled.

7.6.4 *Grounds for Refusing an Adaptation*

All adaptations are subject to a community occupational therapist assessment. Minor fixings and minor adaptations are seldom refused. There are occasions where major adaptations will be refused. Some of these are determined under legislation.

Where an Occupational Therapist deems that the adaptation is not necessary and appropriate under legislation, a refusal may occur. Where the state of the property is such that an adaptation is not reasonable or practicable, a refusal may also occur.

Any refusals for major adaptations are undertaken by the A&A team jointly with the referring agency i.e. community occupational therapist.

It is proposed that the following refusal proposals be adopted within Rotherham.

Under Occupancy

- If a customer is in a situation where they are under occupying a property, then adaptations will not be considered unless:
    - there are no suitable adapted properties within Council stock, or
    - there are suitable adapted properties within Council stock, but these are minimal and the likelihood of availability becoming apparent within a 12 month period is very low.

- Under occupancy rules are irrespective of what security of tenure the customer currently has and defined within the Allocations Policy.

Mutual exchanges

- A customer who is residing in an adequately adapted property cannot mutually exchange to a property that does not have the specifically assessed adaptive requirements the customer needs.
- Any mutual exchange must be authorised by the Housing Occupational Therapist as suitable, reasonable and appropriate to meet the customers' needs. If it does not, then the mutual exchange will not be allowed.
- If two adapted properties are to be exchanged, then both properties must meet the needs of both households.

Reports not Submitted

- All work needs to fall within the remit of the Housing Grants, Construction and Regeneration Act 1996. Therefore all relevant paperwork is required from all parties. Where adherence to the relevant Act has not occurred, an adaptation will be cancelled..

- If a customer is required to provide proof of ownership or occupation and this proof cannot be provided by the customer, then an adaptation will be refused.

- Where a customer has been means tested and is required to contribute funds but declines to do so, an adaptation will be refused.

- If the property is not owned by the Council, then consent is required by the landlord or owner. If consent is not granted then an adaptation will be refused. Full consent is required and stipulations such added by landlords will not be classed as full consent. The consent is for permanence of fixture and fitting.

Split Households

In the case of a split household where the disabled person is a child (under 16 yrs and a child who is in full time education under 19 yrs), adaptations will only be considered on one property.

The property where the parent with parental control resides will be given consideration for an adaptation. When deciding on who has parental control, the following will be taken into account:

- Who the child resides with primarily
- Any Court Orders in place
- Who child benefit is paid to

See Appendix 1: Section 13 (Adaptation Refusals) Page 30

8. Finance

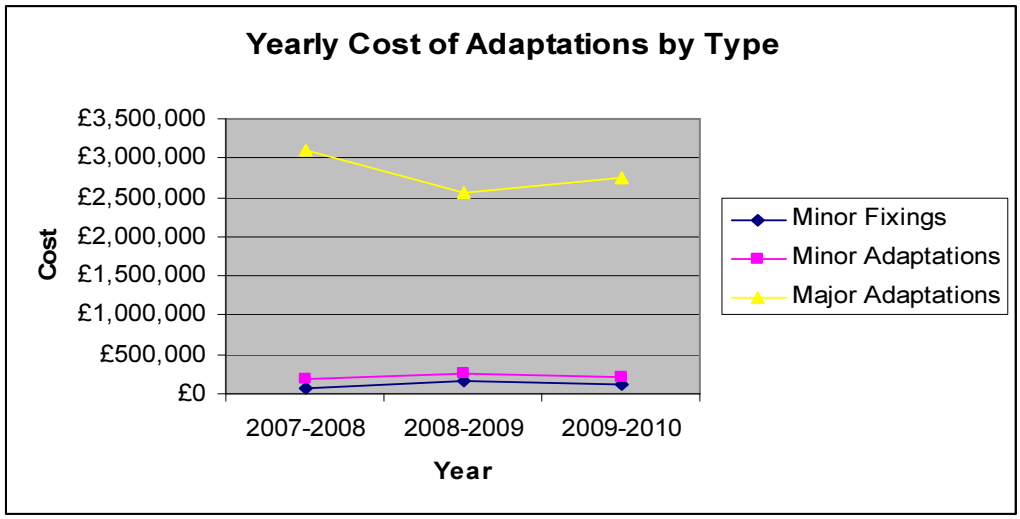
8.1 On a yearly basis, the DFG grant remains roughly the same. The amount is split into public and private. This means that adaptations for Council properties must be done using the public sector grant and the properties that are privately owned must be done using the private sector grant.

The amount for these is split in general terms as:

Public: £1.8 million
Private: £1.4 million

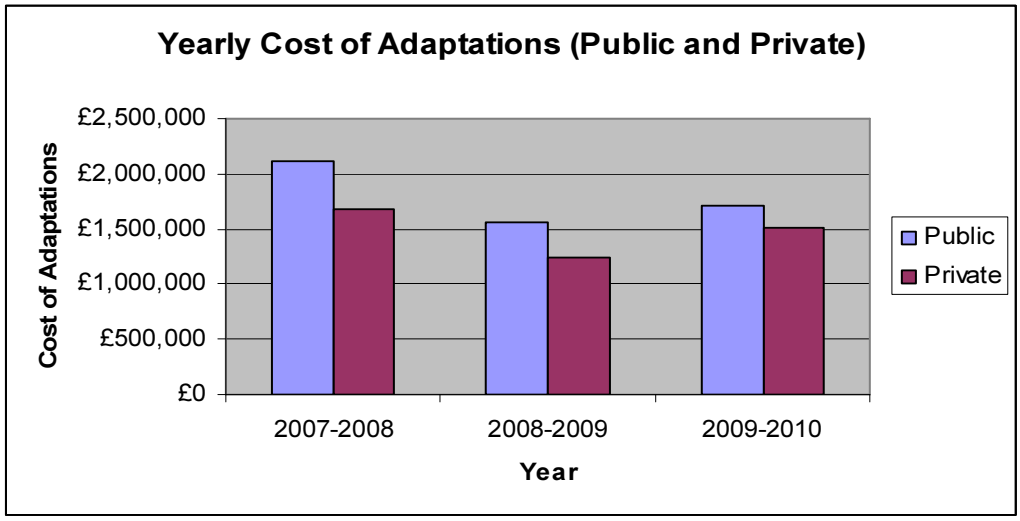
A breakdown of the yearly cost of adaptations by type can be seen in fig.3.

Fig.3



A breakdown of yearly costs by public and private can be seen in fig.4

Fig.4



8.2 In 2010/11 the budget is £1.586m which comprises £866k DFG plus £720k General Fund contribution. Funding from the General Fund of £760k has been confirmed for 2011/12 but not beyond then.

9. Risks and Uncertainties

9.1 Rotherham will be among the few authorities to have a specific A&A policy. Therefore implementation will allow the A&A team to consistently meet the needs of the most vulnerable customer.

9.2 Having a policy in place will ensure that all parties involved in the process are working in line with legislation and policy and also working jointly.

9.3 The A&A Team have responsibility for the DFG budget. By ensuring the A&A policy is in place this will ensure that management of the DFG budget can be achieved and minimise the risk of overspend.

9.4 The A&A team works closely with other key partners and it is important that each department know the limits and boundaries of its remit in terms of A&A work. The policy will enable the DFG to be utilised to it's full capability and ownership of it can be fully justified.

9.5 A Service Level Agreement is in place with the Occupational Therapist service. However, this only defines certain areas and the entire process and linkages with partners is undefined. Such a policy will give clarity to the roles.

9.6 With the potential loss of General Funding from 2012 onwards, it is imperative that the Council has a robust policy to work to inline with the legislation and needs of its Citizens. A lack of policy and direction could lead to overspend.

10. Policy and Performance Agenda Implications

10.1 The A & A team deliver the service at a local level, via home visits, which supports the Council's commitment to providing greater accessibility to services, meeting social needs by helping to ensure a better quality of life, improving fair access and choice, protecting, keeping safe vulnerable people and specifically addresses the diversity agenda, by tailoring services to the needs of hard to reach groups.

10.2 The D54 Indicator measures the time from the date of assessment to the date the adaptation is installed. This is for Minor Fixings only and the target is 7 days.

10.3 The NAS 34 Indicator. This PI measures the waiting time from an application for a major adaptation being received by the Agency and Grants section to approval of a disabled facilities grant. There is no statutory target.

11. Background Papers and Consultation

In particular, background papers are that the service is compliant with current legislation and ensures compatibility through consultation with relevant stakeholders.

- National Assistance Act 1948
- Chronically Sick and Disabled Persons Act, 1970
- Disabled Persons Act 1985
- NHS and Community Care Act 1990
- Disability Discrimination Act 1995
- The Housing Grants, Construction and Regeneration Act 1996
- Housing Act 1996
- Rotherham Allocation Policy
- Rotherham's Housing Strategy

- Adaptations Team
- Assessment Team
- Key Choices Property Shop
- The Occupational Health Service
- Health Services
- Service Quality Team
- 2010 ltd
- Performance and Development
- Assessment Direct

Appendix 1: Aids and Adaptations Policy and Procedures document

Contact Name :
Martin Humphries, *Housing Access Manager, ext. 23770*
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Appendix 1

Aids and Adaptations Procedure and Policy Document

Staff defined as authorised persons concerning Minor Fixings:

Occupational Therapists
Social Services Officers
Technical Officers (Social Care)
Social Workers
Assessment Direct Officers
Sensory Impairment Staff – Rehabilitation Officers

Staff defined as authorised persons concerning Minor Adaptations:

Occupational Therapists
Social Services Officers
Technical Officers (Social Care)
Social Workers
Assessment Direct Officers
Sensory Impairment Staff – Rehabilitation Officers

Staff defined as authorised persons concerning Major Adaptations:

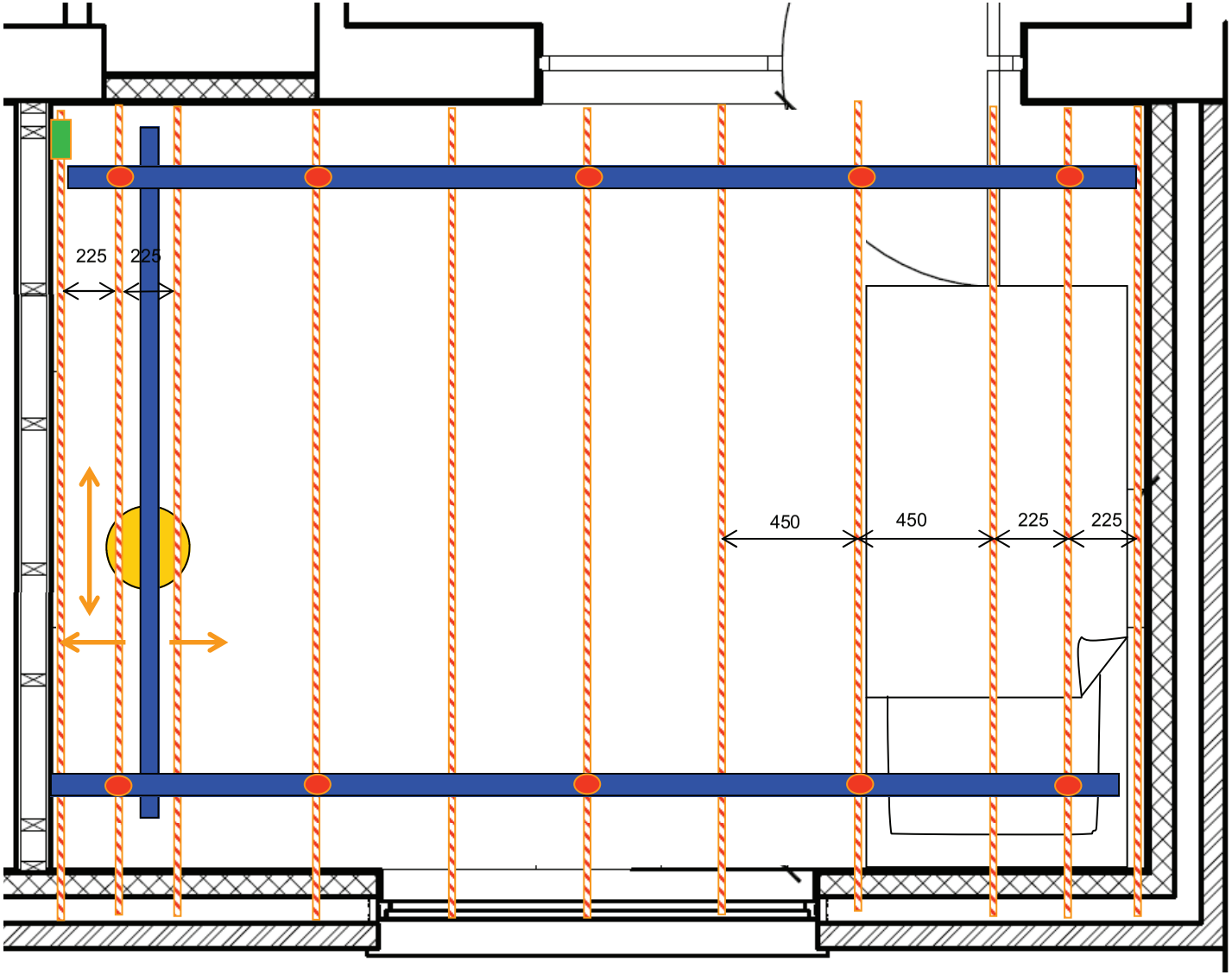
Occupational Therapists
Sensory Impairment Staff – Rehabilitation Officers

Joist Positions for a single Room 'H'-System

- Joist Position
- Bracket Fix Point
- Switched Spur (High Level)
- Hoist Tracking
- Hoist Unit

Notes

1. Joists to be a minimum of 50mm wide and capable of a point load equal to 1.5 times the Hoists SWL ie 130KG hoist requires a joist capable of supporting 195KG.
2. Lights within system to be no deeper than 20mm.

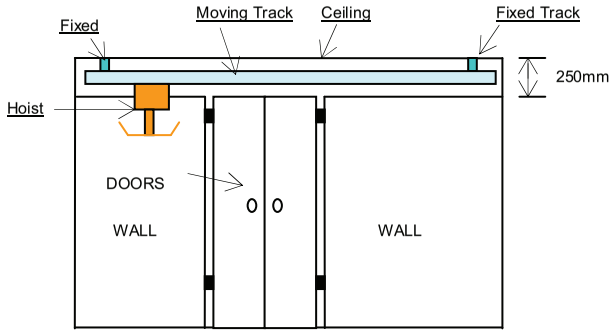


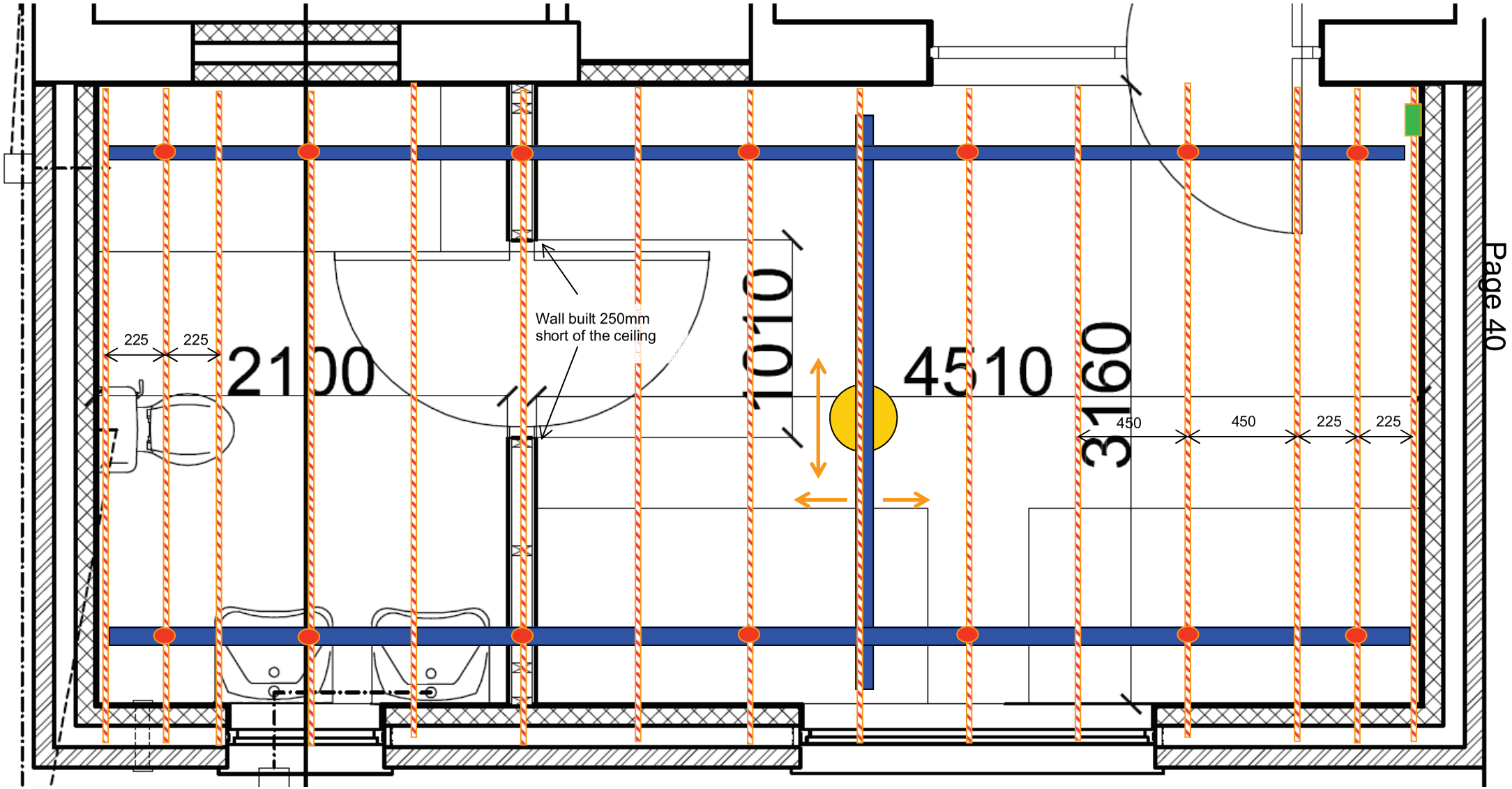
Joist Positions for a 2 – room 'H'-System

- Joist Position
- Bracket Fix Point
- Switched Spur (High Level)
- Hoist Tracking
- Hoist Unit

Notes

1. Joists to be a minimum of 50mm wide and capable of a point load equal to 1.5 times the Hoists SWL ie 130KG hoist requires a joist capable of supporting 195KG.
2. Lights within system to be no deeper than 20mm.





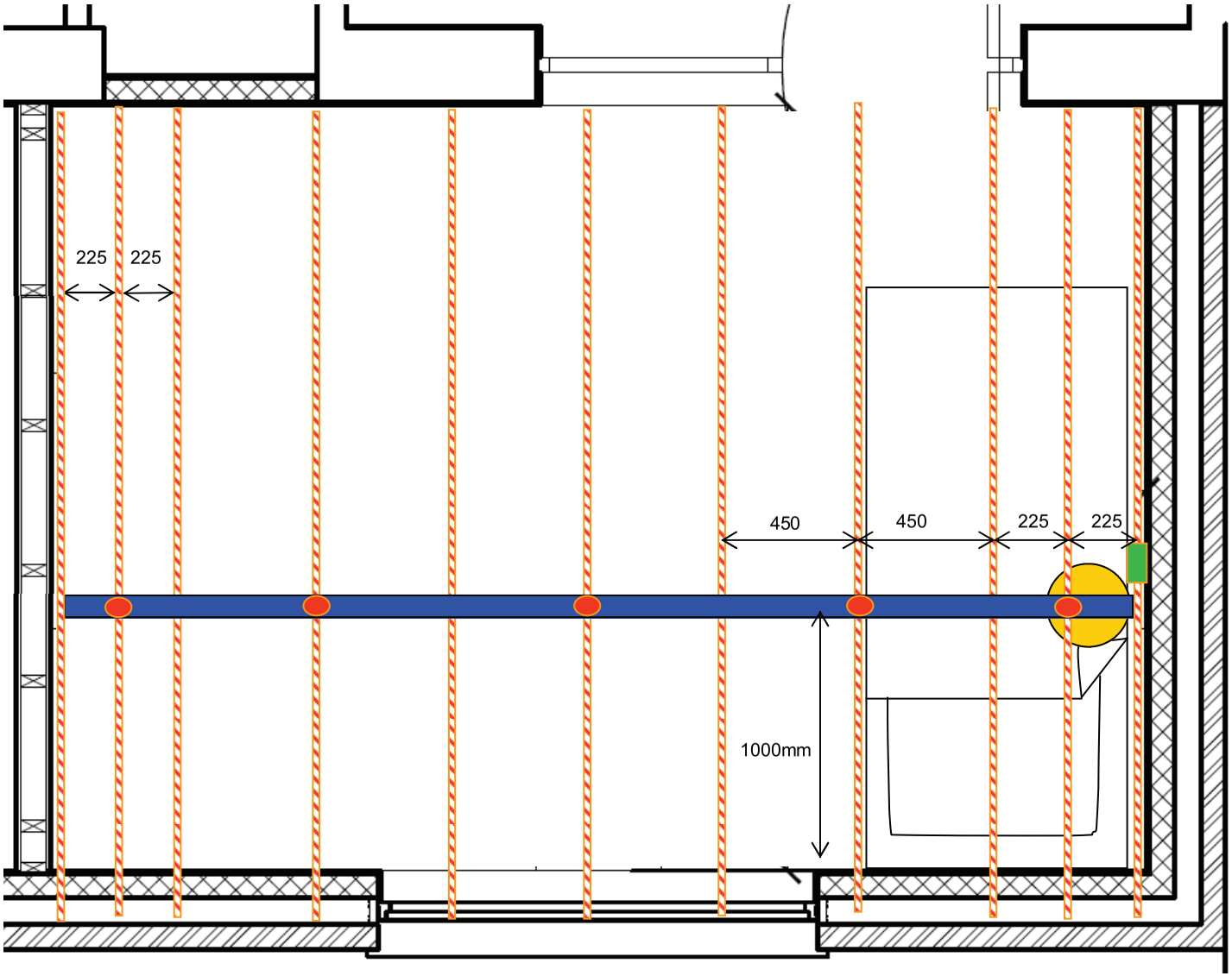
Joist Positions for a Straight track

- Joist Position
- Bracket Fix Point
- Switched Spur (High Level)
- Hoist Tracking
- Hoist Unit

Notes

1. Joists to be a minimum of 50mm wide and capable of a point load equal to 1.5 times the Hoists SWL ie 130KG hoist requires a joist capable of supporting 195KG.

2. Lights to be at least 300mm clear of the track line.

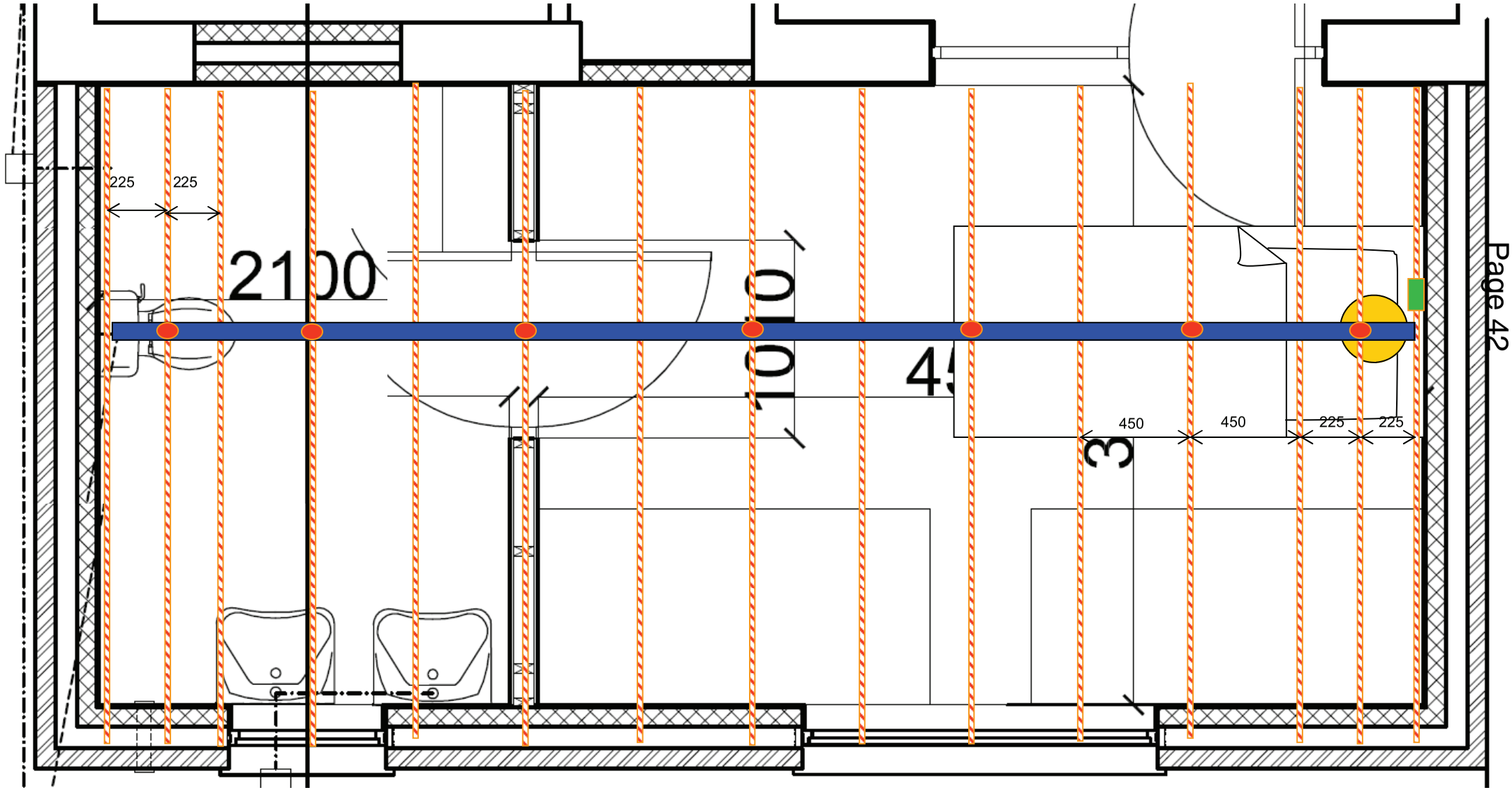


Joist Positions for a Straight track - room to room

- Joist Position
- Bracket Fix Point
- Switched Spur (High Level)
- Hoist Tracking
- Hoist Unit

Notes

1. Joists to be a minimum of 50mm wide and capable of a point load equal to 1.5 times the Hoists SWL ie 130KG hoist requires a joist capable of supporting 195KG.
2. Lights to be at least 300mm clear of the track line.



NAS: Independent Living
Paper: Aids and Adaptations Policy and Procedures

Date: January 2011

1.1 The Council's Adaptations Policy is principally aimed to assist people in living independently through the provision of equipment and adaptations. This can mean remaining in their own homes or re-housing to suitable properties. However, adaptations are a last resort and as such all alternatives will be reviewed.

1.2 The statutory duties of the Local Authority in connection with adaptations are mainly laid down in the following legislation:

- National Assistance Act 1948
- Chronically Sick and Disabled Persons Act, 1970
- Disabled Persons Act 1985
- NHS and Community Care Act 1990
- Disability Discrimination Act 1995
- The Housing Grants, Construction and Regeneration Act 1996
- Housing Act 1996

However, the Council must decide whether the applicants needs can best be met through:

- Adaptations within reasonable cost boundaries
- Issue of equipment, **or**
- Re-housing to an alternative adapted accommodation

The Council can discharge its duties under the Chronically Sick and Disabled Persons Act 1970 by any of these means.

2 Definitions

2.1 Adaptations are split into three categories:

Minor Fixings: Adaptations under £1000.00 in value. An Occupational Therapist or other authorised person (see appendix 1) must recommend the adaptations required. No means test is required. See section 12.4 for types of adaptations. Minor fixings should be completed within 7 working days from assessment.

Minor Adaptations: Adaptations under £1000.00 in value. An Occupational Therapist or other authorised person (see appendix 1) must recommend the adaptations required. No means test is required. Minor adaptations can involve a small amount of construction work. See section 12.2 for types of adaptations.

Major Adaptations: Adaptations over £1000.00 in value. An Occupational Therapist or other authorised person (see appendix 1) must complete an OT35b recommending the adaptations required. A further report maybe required for adaptations over £8,000. A means test is required. Major

adaptations may require a large amount of construction work. See section 12.1 for types of adaptations.

3 Eligibility

3.1 Eligibility is generally governed by legislation and therefore the policy reflects this.

3.2 The Council must be satisfied that the customer has a qualifying owner's interest or is a qualifying tenant.

3.3 A qualifying owner is one who has a freehold of a property or a minimum of 5 years remaining on a leasehold. If the leasehold is less than 5 years in duration, confirmation must be obtained from the freeholder of the property of what is due to happen at the end of the leasehold period.

3.4 A qualifying tenant is one who meets one of the following:

- Who is a secure tenant
- Who is an introductory tenant
- Who is a protected occupier under the Rent Act 1976
- Who is in occupation under an assured agricultural company within the meaning of Part I of the Housing Act 1988.
- Who is an employee who occupies the dwelling or flat concerned for the better performance of their duties.
- An assured tenant of a Housing Association if suitable alternative accommodation cannot be sourced through the Housing Association.
- An assured short hold tenant who has a minimum 5 year tenancy remaining.

In all the above scenarios, the Council must be satisfied that the applicant is either the owner or tenant and therefore will require either proof of ownership or proof of tenancy. If the applicant is under 19, then the parent/guardian is required to be the owner or tenant and will require either proof of ownership or proof of tenancy.

3.5 All applicants must show that the property requiring adaptations is their permanent residence. A permanent residence is one where the likelihood is that the applicant will not move from the accommodation for a minimum of 5 years. It is also accommodation of which the applicant resides at full time.

3.6 Where the applicant is under 19 and the household is split, investigation must occur to see who the legally responsible parent/guardian is. Consideration will be taken of benefits claimed for the applicant and where the applicant resides predominantly.

3.7 There are circumstances where applicants may not meet the legal requirements.

If an applicant is not the owner or they are not named on the tenancy, they may still be eligible if:

- The applicant is a partner of the owner/tenant. A person is treated as a partner if:
    - They are married.
    - They are not married, but are living together as man and wife.
    - They are of the same sex and registered as a civil partner

  - They are of the same sex, but are living together as if they are in a civil partnership.

- The applicants is an immediate family member (parents, grandparents, adult children, grand children and siblings), who have lived with the owner/tenant for a minimum of 2 years continuously immediately prior to the application. **And** the main carer of the applicant is the owner/tenant.
  - A main carer is one who is defined as providing support on a daily basis and assists in daily functions such as personal care and domestic support.
- There are specific regulations surrounding members of the Armed Forces as defined in Housing Grants, Construction and Regeneration Act 1996 as amended in 2008.

Cases outside the above requirements may be reviewed by the Adaptations Review Panel. (See section 8)

4 Adaptations Process

4.1 *Assessment Direct*

First line of contact for applicants is Assessment Direct. The applicant can contact Assessment Direct with details of their specific case. Assessment Direct act as a triage and cascade to the relevant department.

In cases of Adaptations, the assessment could be cascaded to an Occupational Therapist. However, both housing options and a medical assessment (for housing) can be arranged at the same time.

4.2.1 *Occupational Therapist*

Once received, cases are allocated to the relevant team. The current Service Level Agreement states that applicants must be visited within 28 days of receiving a referral.

4.2.2 During the assessment, the Occupational Therapist (OT) should firstly consider any equipment that may meet the applicants' requirements. These may include but are not limited to:

- Bathing equipment
  - Swivel bathers
  - Bath board
  - Bath seats
  - Shower stools
- Raised seats
- Perching stools
- Commodes

4.2.3 If equipment would not meet the applicants' requirements, the OT should then consider any minor fixings that may meet the applicants' requirements.

4.2.4 If minor fixings would not meet the applicants' requirements, the OT should then consider any minor adaptations that may meet the applicants' requirements.

4.2.5 If minor adaptations would not meet the applicants' requirements, the OT should then consider any major adaptations that may meet the applicants' requirements.

4.2.6 The standard procedure would be for the OT to submit an OT35b of their recommendations potential solutions for long term need.

4.2.7 If the potential cost of adaptations totals more than £8,000, then re-housing should be investigated prior to considering major adaptations. All applicants' who may require adaptations totalling more than £8,000 must have a Housing Register Application completed and a referral to the Assessment Team (Housing) completed.

4.2.8 Should the potential cost of adaptations total more than £8,000, it is expected that the OT should fully investigate all options that may relieve the customers' situation. The OT will note all potential solutions and any potential issues related to these solutions. They will also note the applicants' wishes.

For example: An OT may assess an applicant as requiring ground floor bathing and bedroom facilities. Potential solutions to this issue may be re-housing, construction of an extension or conversion of existing rooms

4.2.9 The applicant may not wish to be re-housed and this should be noted as well as any medical and social grounds to support this fact. Recommendations should be made to the requirement of the customer and not specifically to a solution unless the solution is limited to one option.

4.2.10 Once the applicant has been visited, the OT must assess whether the case is high risk or not and complete an Occupational Therapist Report. On cases where the cost of works will potentially exceed £8,000, a full OT report is required. Any equipment that has been identified as required at the visit should be ordered and requests for minor fixings should be made through completion of an OT30 form.

4.2.11 Minor adaptations should be sent through to Adaptations Team by completing an OT31 form. This information is then input into the Flare system. It is given a Flare number and then attributed to be completed. Minor Adaptations should be **started** within 28 days.

4.2.12 Major adaptations should be sent through to the Adaptations Team by completing an OT35b form. An OT35a letter will be sent to the applicant. An OT35a letter is not confirmation that a Disabled Facilities Grant will be granted, it is simply to inform the customer that a referral has been sent through to the Adaptations Team.

4.3 Adaptations Team

4.3.1 The Adaptations Team will write to the customer once they receive a referral verifying the referral has been received and indicating the process as to which is to be followed.

4.3.2 The Adaptations Team will inform applicants no later than 6 months after receipt of referral as to the decision of what work if any will commence.

4.3.3 The legal requirement is for the Adaptations Team to complete adaptations within 6 months of a Disabled Facilities Grant application being submitted.

4.3.4 A Technical Officer will visit the site to look for potential solutions and gather information required for a means test (if necessary).

4.3.5 The Adaptations Team are required to identify if the property is either Housing Association, Owner Occupied, Privately Rented or Council Property.

4.3.6 If the property is not Council, then the customer must provide proof of ownership. This can also include a rental agreement to prove proof of occupation. A consent form will also be required in terms of rented properties.

4.3.7 Technical Officer to investigate potential solutions. The Technical Officer will look at the most cost effective solution whilst maintaining that the solution is both reasonable and practicable.

4.3.8 If an architect is required, the Technical Officer should contact the architect to arrange for drawings to be completed.

4.3.9 An asbestos report is required by the relevant handlers (highlighted within Diagram 1.

4.3.10 If asbestos is found then the following would occur:

- If Council stock, 2010 are informed and the asbestos is removed.
- If not Council stock, then the customer is informed of the cost of removal. If the asbestos is not removed, then the adaptation will be cancelled.

4.3.11 If no asbestos is found a current Edition Electrical Test is completed. Any faults would need to be rectified prior to commencing further work. Fault rectifications for Council properties are done through 2010. All other rectifications must be paid for by the customer. If the rectifications are not made, then the adaptation will be cancelled.

4.3.12 If any financial issues are raised then the Adaptations Team need to be informed. If these issues cannot be resolved then the adaptation will be cancelled. For example, a means test is conducted and it is found that a customer is required to contribute. If the customer disagrees with this then the adaptation will be cancelled.

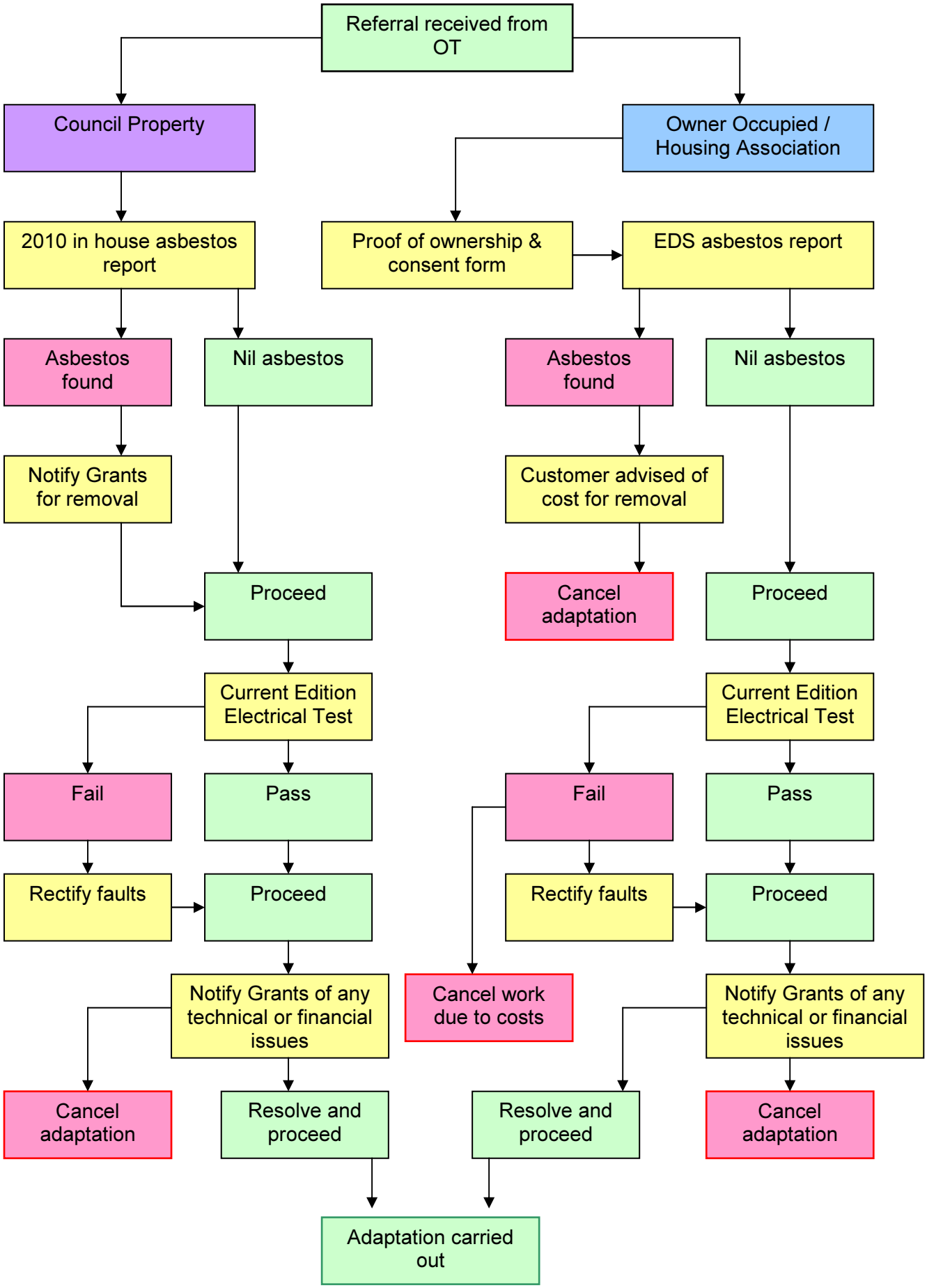
4.3.13 Once any financial issues are resolved or there are no financial issues, the relevant contractor is informed and the job is completed.

4.3.14 Diagram 1 highlights the above process.

4.4 No work can commence until any customer contribution has been paid in full.

4.5 Under no circumstances can any retrospective payments be made. I.E. The customer can not start work on an adaptation and then re-charge it back to the Council.

Adaptations Team *Diagram 1.*



4.6.1 Once the adaptation has been completed, the Technical Officer will check the invoice amount and approves the figure on the Flare system.

4.6.2 If the invoice amount is incorrect then the Technical Officer is required to investigate to why this has occurred.

4.6.3 If the wrong invoice has been issued then the invoice is returned to the contractor and they are required to rectify and issue a correct invoice.

4.6.4 If unauthorised work has been completed then agreement to pay must be sought from the Adaptations Manager. The Technical Officer should gather supporting evidence from the contractor as to why this occurred. If the supporting evidence is not sufficient then any unauthorised work will not be paid for.

4.6.5 Once the correct invoice amount has been input on Flare then a final inspection can occur. Initially this will be in the form of a telephone call. If the customer is happy then an on site visit may not be necessary. If an issue is raised by the customer in terms of the work undertaken, then an on site visit will be conducted.

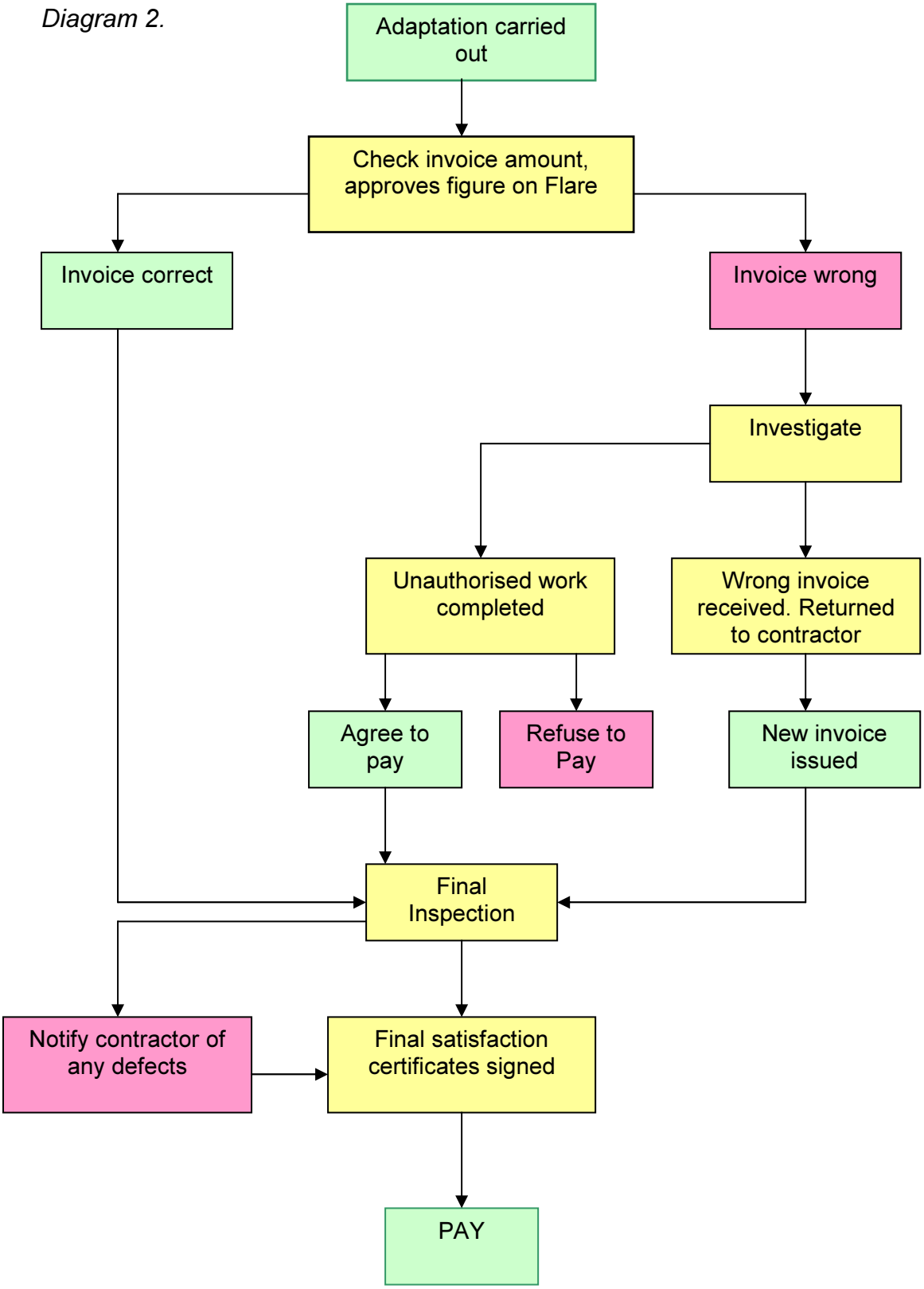
4.6.6 If any issues are raised, then the contractor is contacted by the Technical Officer and notified of any defects. It is the contractors' responsibility to rectify any defects. Payments will not occur until defects are resolved.

4.6.7 If no issues are apparent or the issues have been resolved, then a Final Satisfaction Certificate is signed.

4.6.8 Payment can then be made.

4.6.9 Diagram 2 (overleaf) highlights the above process.

Diagram 2.



5 Further Works and Changes of Circumstances

5.1 Occasions may arise where work is pending and a change in circumstances require a further OT assessment. Should this occur, then the OT should inform the Adaptations Team.

5.2 If the work pending has not been started then it will not commence until the OT has submitted their further report.

5.3 The new work will then be added to the pending work to be completed as one job.

5.4 If the pending work is a minor adaptation and the new work is also a minor adaptation, but the cost of both works would mean that the work in total would equate to a major adaptation, then the adaptation should be treated as such and therefore means tested if required.

5.5 If the pending work is a major adaptation and the new work either a minor or major adaptation, or indeed vice versa, then the customer would need to be re-assessed in terms of a means test.

5.6 A Technical Officer may ask for a review of the works, if they believe further enhancements may be required. In such circumstances, Assessment Direct will be contacted to arrange a further assessment by the OT. The Head COT's will also be made aware to in turn notify the OT who initially assessed the customer. Alternatively the Housing OT can be contacted to re-assess the situation.

The Technical Officer should also contact the Assessment Team (Housing) to complete a referral if this has not been done previously.

6 Disabled Facilities Grants

6.1 Applicants who feel they may be eligible for a Disabled Facilities Grant can apply through Assessment Direct for an assessment of need. Once a recommendation has been made a financial assessment will be conducted by the Technical Officer. This is an income based 'means' test of resources.

6.2 There is no means testing for families of disabled children under the age of 16 and a young person to the age of 19.

6.3 Means testing will take into account savings above a certain limit. There are also premiums for certain benefits (These are listed later).

6.4 If the applicant has a partner, then their combined income will be assessed jointly. Capital is included in the means test. The first £6,000 of savings is disregarded.

6.5 Depending on the outcome of this assessment the amount of financial assistance offered can vary from 0 to 100 per cent of the cost.

6.6 The award works as follows:

- If the applicants income is less than the applicable amount the applicant will not normally need to contribute to the cost of the works.
- If the applicants' income is more than the applicable amount, a proportion of the applicants' income will be used to calculate how much they could contribute towards the cost of the works.

- The applicable amount is the amount as seen by government as the requirements for the cost of living for the customer or household. Anything highlighted above the applicable amount is subject to a contribution.
- The applicable amount and any associated contributions are calculated through the Ferret system. (see section 7.0 for information on Ferret)

6.7 The maximum amount of grant that a council is required to pay is £30,000.00 in England per application less any assessed contribution from the applicant. If the cost of the eligible works is more, the council can use discretionary powers to increase the amount.

7 Means Testing

7.1 A means test will be carried out by the Adaptations Technical Officer and input into Ferret. It should be noted that a means test is **not** required for applicants under the age of 19.

7.2 Ferret is a Government accredited software programme that is utilised to formulate the outcome of a means test. Information is fed into the software.

7.3 This is an income based test although there are certain pass-porting benefits that would denote a means test as not applicable. These benefits are:

- Income Support
- Income baser Jobseekers Allowance
- Housing Benefit or Council Tax Benefit
- Child Tax Credits (if the household is earning less than £15,050 per annum.)
- Working Tax Credits (if the household is earning less than £15,050 per annum)
- Employment and Support Allowance (income related)
- Guaranteed Pension Credit

7.4 Certain benefits are ignored in the means test. These include:

- Disability Living Allowance
- Attendance Allowance or Constant Attendance Allowance
- Guardian's Allowance
- Any concessionary payment to compensate for the non-payment of Income Support, Disability Living Allowance, Attendance Allowance, Constant Attendance Allowance, Mobility Allowance or War Pensioners Mobility Supplement
- Any social fund payment
- Any benefit-related Christmas Bonus
- Any payment of Housing or Council Tax Benefit or Council Tax Transitional Relief
- Any payment made by the Secretary of Star to compensate for the loss of Housing Benefit or Housing Benefit Supplement.
- Any resettlement benefit (this is arrears of unpaid benefit sometimes payable to people leaving hospital who were inpatients before April 1987)
- Any special War Widows Payment. These payments were introduced with effect from April 1990. The whole of such a payment is ignored. The recipient may also be getting an ordinary War Widows Pension.

7.5 The means test will **not** ignore the following benefits and they **will** be taken into account in the calculation:

- Employment and Support Allowance (contribution)
- Retirement Pension
- Severe Disablement Allowance
- Carer's Allowance (formerly Invalid Care Allowance)
- Incapacity Benefit
- Savings Pension Credit
- Maternity Allowance
- Childs Special Allowance
- Retirement Allowance*
- Disablement Benefit*
- Industrial Death Benefit*
- Unemployability Supplement*
- Reduced Earnings Allowance*
- Widows Pension*

Child Benefit, Statutory Sick Pan and Statutory Maternity Pay are all classed as income.

* Benefits payable under the Industrial Injuries Scheme.

7.6 Once the information has been fed into the Ferret system, a report is generated. The report is verified by a second Technical Officer. If Ferret calculates that the Applicant is required to make a contribution towards costs, the applicant is sent a letter. This letter includes all the relevant information supplied by the applicant in terms of income. It is the applicants' responsibility to review this information and ensure that it is accurate. If it is accurate then the applicant will be asked to confirm their contribution so work can commence. If incorrect, the applicant must inform the Technical Officer so the information can be re-fed through Ferret.

8 Adaptations Review Panel

8.1 The purpose of the ARP is to expedite the evaluation of complex cases where major adaptations and extensions have been proposed. Membership of the ARP is limited to:

- Housing Access Manager (Independent Living)
- Adaptation Manager (Independent Living)
- Assessment Manager (Housing) (Independent Living)
- Professional Lead Community Occupational Therapist Manager (Assessment and Care Management)
- Clinical Lead Community Occupational Therapist Manager (Assessment and Care Management)
- Specialists: including Technical Officers and Occupational Therapists (when required)

8.2 The ARP will not consider cases if housing options have not been exhausted.

8.3 ARP Process

8.3.1 A OT18 form is completed by the relevant OT. Details of the case are then subsequently passed to the Adaptations Team. A full evaluation of the case is undertaken including cost and feasibility studies alongside the OT and other relevant agencies.

8.3.2 The case officer prepares the respective case for submission with the appropriate documentation. The Adaptation Manager is provided with a summary detail of the case prior to presentation at the panel. The case is presented to the panel by the Adaptations Manager. Panel members then consider the information presented and discuss the case in order to facilitate a recommendation. In making its' decision, the ARP will look at all suitable solutions inclusive of re-housing.

8.3.3 The review panel will look at all available solutions to resolve a customers issue and decide on which solution will be used.

8.3.4 If there is not enough information to make a reasonable decision, a request for further information will be made to the relevant source. Timescales for response will be agreed within the ARP.

8.3.5 Customers will be informed by letter of the outcome of the decision from the ARP. Decision letters will be sent to the customer no later than 14 days following the ARP.

8.4 There is no appeals procedure to decisions made by the ARP. If a customer is unhappy with the decision that is made within the ARP, then they should follow the Council's general complaints procedure.

9 Authorisation Thresholds

9.1 The mandatory limit for adaptations is £30,000 in England. The following are the authorisation thresholds per post:

£0 - £8,000	Technical Officer
£8,000 - £15,000	Adaptations Manager
£15,000 - £30,000	Housing Access Manager

9.2 Above and beyond the mandatory limit, the Council is able to use discretionary powers to authorise further payments. However, any payments over the £30,000 limit will still come out of the same pool of funding. There is no additional funding for discretionary payments.

9.3 All discretionary payments require authorisation from the Director of the service. Any payments totalling more than £50,000 will require authorisation from the Cabinet Member for Safer and Attractive Communities. It must be noted that the Council will investigate all other alternatives before considering discretionary payments.

9.4 In the case of discretionary payments, a report will be submitted by the Housing Access Manager / Adaptations Manager highlighting the individual circumstances and also the recommendations from the ARP.

10 Fees and Finance

Facilitation Fees

10.1 The Adaptations Team is self financing and as such charges a fee to facilitate adaptations. Fees are applicable only to major adaptations.

10.2 For every major adaptation a 10% fee is charged to cover the costs of the A&A team. This fee is to support the project management of the adaptation from design to completion. The 10% is inclusive of the total amount of the adaptation and therefore is inclusive of any grant issued.

10.3 If a customer is eligible for a Disabled Facilities Grant, this can be used to cover the fees. It is important to note however, that if the cost of the adaptation is between £27,270 - £30,000, that there will be a requirement for the customer to pay additional monies.

For example:
An adaptation costing £30,000 would incur fees of £3,000 and therefore have a total cost of £33,000. The maximum DFG funding is £30,000 and therefore the customer would need to pay £3,000. This example is dependent on the customer passing a full means test and being awarded a nil payment toward the adaptation.

Architect Fees

10.4 In the circumstance where an extension or modular extension is required, or when complex internal alterations are required, architects will be used in accordance with legislation.

10.5 Where an architect is used, fees will also be incurred. Fees may vary, but the average cost is between £500 - £800. This fee works in the same way to the facilitation fee (see 9.2).

Waiver of Fees

10.6 Through the personalisation agenda within Rotherham, customers may choose to arrange for works to be conducted themselves through contractors. However, initial visits and input will be required from the A&A Team.

10.7 In circumstances where a customer chooses to arrange their own works to be completed an administration charge of 5% will be applicable (rather than the normal 10%).

10.8 Customers who choose this option will be required to manage their own project.

10.9 If the customer has any issue with the contractor, then it is their responsibility to resolve the issue. If the Adaptations Team are required or asked to be involved then the applicable fee will apply.

10.10 Any unforeseen additional costs would need to be met by the customer and would not be met through the DFG.

10.11 Payments will be made directly to the contractor upon completion and will be deducted directly from any grant that is issued.

10.12 Interim payments can be made at the discretion of the Adaptations Manager.

10.13 Under no circumstances will the customer be given the award directly.

Charges on Properties

10.14 The Council are able to add a legal charge to a privately owned property for the cost of the adaptation should the property be disposed of within 5 years

Where the applicant/customer or in the case of a child, their parent/guardian, are no longer the qualifying owner either by sale, donation or repossession, the property will be deemed as disposed of.

10.15 A legal charge will only be considered where the adaptation/s has increased the floor size of the property or added value to the property. Examples would include, loft conversions, extensions, out building conversions, multiple adaptations.

10.16 The Council will only consider adding a charge where the cost of the adaptation/s is more than £8,000.

10.17 Consideration does not mean that this is a blanket policy and every case will be judged on its own merits in terms of adding a charge.

11 How decisions are made on what adaptation will be done

11.1 Due to the budgetary limitations placed on the service combined with the demand for adaptations, the A&A Team will look at all reasonable and practicable solutions to ensure that public monies are spent in a cost effective manner whilst maintaining the adaptation meets the customers' requirements. This is a key factor when reviewing major adaptations.

11.2 For non-council properties, if there is more than one adaptation solution that is deemed by the assessing Adaptations Officer as both reasonable and practicable then the most economical will be pursued. If the customer decides that they would prefer an alternative solution, then the cost of the proposed solution can be used toward the cost of the preferred option. However, if there are further costs then these would need to be met by the customer.

11.3 For council properties, the A&A Team will pursue the most reasonable and practicable solution. If the applicant refuses the solution, it will be treated as such and the job will be cancelled.

12 Types of Adaptation

12.1 Types of Major Adaptation

12.1.1 *Extensions*

Apart from Modular Extensions, extensions are the most costly type of major adaptation. Extensions generally include adding further rooms to an existing property, such as a bathing/washing facilities or bedroom.

Costs can range from £12,000 - £45,000.

12.1.2 *Conversions*

Conversions include the alteration of a specified room or building into a meeting the customers need. Often this would mean converting a garage, loft or parlour room into a bedroom or bathroom or both. This can be a cost effective alternative to building an extension.

Costs can range from £11,000 - £25,000.

12.1.3 *Ramped Access*

This is priced per square meter at £500. Therefore, overall costs are worked out for the areas covered. Ramped access would generally be a minimum of 1:12. Temporary ramps can be used as an alternative and cheaper option.

Ground excavation concluded and paving slabs on end to be used as retainer unless otherwise specified. Hardcore compacted to necessary levels not exceeding 150mm. 20mm aggregate concrete not exceeding 150mm thick brought to a tamped finish with trowelled edges. Finished area to be suitably graded that no ponding of water is apparent.

Ramped access to have a minimum of 100mm up stands. Width of ramp must be a minimum of 1200mm unobstructed. A gradient of 1:12 is acceptable where individual flights are no longer than 5m. For flights greater than 10m a minimum 1200 x 1200 level landing must be provided.

An Aco drainage channel or similar approved to be fitted at head of ramp. The existing DPC must be protected by the provision of a vertical damp proof membrane. Ventilation to the sub floor spaces through the existing air grates must be maintained. Supply and fit galvanised mild steel tubular handrails. Tubular handrail to be 50mm in diameter. Handrail to be 900mm high from ramp with uprights at maximum centres of 2m. Uprights to be placed at every change of direction.

Potentially temporary ramps could be Minor Adaptations. Ramped Access costs (not temporary) can range from £1,000 - £7,000

12.1.4 *Through Floor Lifts*

Through floor lifts are applicable to assist customers reaching upper floors who cannot utilise stair lifts. Space is required on both floors to ensure this option can be done.

Lifts shall comply with all British and European standards such as BS 5776 including all current amendments applicable at the time of manufacture. Through Floor Lifts shall comply with BS 5900. All lifts must comply with the BSEN 8140 standards as and when they are published.

Lift will be a single floor rise, and in case of fire the lift must return to 1st floor, for indoor use only.

The stair lift must be so constructed that they do not cause excessive electromagnetic interference and are not unduly affected by electromagnetic interference, and carry C.E marking in accordance with the E.H.C Directive 89/336/E.E.C. and Amending Directive 92/31 E.E.C.

A lockable ON/OFF switch shall always be supplied and installed either on the machine or on the wall.

Any electrical work which may be required must be carried out in accordance with current legislation and an appropriate certificate to be produced upon completion.

In the case of single access properties, stair lifts must not be installed that could prevent access in the case of emergency.

All lifts must be individually serial numbered and full installation/maintenance records must be maintained.

Costs can range from £10,000 - £16,000

12.1.5 *Stair lifts*

Standard specification must include:

- Manual swivel seat.
- Seatbelt to be fitted as standard.
- Padded upholstery in a neutral colour.
- Minimum safe working Load 120Kg.
- Up to 5000mm of track
- 12 months fully inclusive warranty.

Stair lifts must comply with the BSEN 8140 standards as and when they are published. The stair lift must be so constructed that they do not cause excessive electromagnetic interference and are not unduly affected by electromagnetic interference, and carry C.E marking in accordance with the E.H.C Directive 89/336/E.E.C. and Amending Directive 92/31 E.E.C.

A lockable ON/OFF switch shall always be supplied and installed either on the machine or on the wall. The electrical supply to the appliance shall be a unique dedicated clearly labelled supply and terminate adjacent to the appliance or control unit in a switched fuse connection. When specified a 30 mA sec RCCD shall be installed to protect the 240 V parts of the installation.

Any electrical work which may be required must be carried out in accordance with current legislation and an appropriate certificate to be produced upon completion.

Varying costs apply dependent on if the staircase is straight. Curved stair lifts are available at a higher cost. Space at the top of the stairs is required for transfers on and off the lift.

Costs can range from £2,500 - £7,000

12.1.6 *Ceiling Track Hoists*

Ceiling track hoists are fitted to assist with the transfer of customers in and out of bed, in and out of bathing facilities and on and off toilets. Occupational Therapists individually assess customers for sling requirements.

Install Unit to include connection to a suitable electrical supply. Any electrical work which may be required must be carried out in accordance with current legislation and an appropriate certificate to be produced upon completion. Minimum safe working Load 130Kg.

All hoists must be individually serial numbered and full installation/maintenance records must be maintained.

Tracks can be straight and can offer turning circles. They can transfer through multiple rooms. Joists are required for this to occur.

Appendix 2 outlines the joist requirements on pre-installation.

Costs can range from £1,200 - £6,000

12.1.7 *Internal Alterations*

Internal alterations can include door widening, wall removing/building and sometimes can fall into the minor adaptations category.

Costs can range from £1,000 - £10,000

12.1.8 *Modular Extensions*

These are pre-built extensions that can be moved from one location to another. The initial costs are high, but they are re-usable and can be moved. The cost of moving them is also high and they are of a set format so will not always be relevant. There are currently 3 in the borough.

Costs can range from £25,000 - £100,000

12.1.9 *Hard standings*

Hard standings include drop kerbs (although these on their own fall under Minor Adaptations – see 11.2.13), off road parking for level access to properties for wheelchair use. Hard standings will only be approved for those customers who require them due to mobility issues identified above.

Grounds will be excavated until a suitable sub grade is reached and debris will be removed from site. 50mm thick pre-cast paving slabs to be used as retainer unless otherwise specified. These will provide the formwork into which the hard core and concrete will be placed.

When installed the paving flags will be vertical and plumb on sides, the top edge shall be level, the base shall be set into the ground to a depth of not less than 200mm, held in place with concrete. The top edge of the flag shall be cut with a masonry saw to give a straight clean edge 100 mm above the finished surface of the concrete and shall be consistent along the gradient of the ramp. The cut edge is to be smooth and flat with all sharp arises removed to form a chamfered edge. Paving flags shall comply with current legislation. Hardcore compacted to necessary levels not exceeding 200mm. 20mm aggregate concrete not exceeding 150mm brought to a tamped finish with trowelled edges.

A fair joint will be made at the junction of the ramp and existing hard surface. The platform shall be level with the internal finished floor level. The finished area will be suitably graded to ensure that no ponding of water is apparent.

The existing DPC must be protected by the provision of a vertical damp proof membrane. Sub ventilation to dwelling must be maintained where air bricks are obstructed: installation of 100mm PVC pipe duct from the existing air brick terminating at a new air brick installed within the platform/ramp will be required.

Costs can range from £1,000 - £3,500

12.1.10 *Level Access Shower*

Preformed shower tray forming a wet area; thermostatically controlled shower; approximately 8 sq metres of tiling; shower rail and weighted curtain with between 10ml – 20ml gap from floor; grab rails as necessary; slip resistant floor covering for entire room; moisture resistant lights; extractor fan.

Pipe work to run the shortest possible route to unit and to be chrome face fixed. Any new outlets must have means of isolation fitted.

100mm axial extractor fan with a 15 litres per second extraction volume with a pre set factory fitting. Fan to have an isolator fitted outside the bathroom to comply with current legislation.

Tiles to be fixed with water proof adhesive and water proof grout. Tiling. Waterproof adhesive to BS 5980 and BS EN 1347 applied.. The tiles are to be evenly spaced and shall be both plumb in the vertical and level on the horizontal lines and provide a smooth and even surface when fixed. Fit plastic tile edging strips around window apertures and as vertical end stops where required.

Waterproof grout to joints, filling all voids. Joints abutting window frames, door casings, skirtings, shower trays and baths to be sealed using silicone sealant to BS 5889 for use in wet areas. Wipe down all surfaces to remove residue of grout. Leave installation clean, tidy and ready for use.

Replace existing light fitting with moisture resistant lights operated by a new pull cord.

Where a pump is required for drainage purposes an Impey Gulpar pump should be fitted.

Supply and fit fully weighted shower curtain to hang flush with floor shower area in a safe and operational manner. Curtain to be anti-fungal. Rail, curtain runners and rings to be fixed with plugs and screws as per manufacturers instructions.

All pipe boxing required is to be formed from PVC boards and sealed with anti-fungal silicon sealant.

Floor area of bathroom to be covered with SLIP RESISTANT FLOORING. Seams on flooring to be welded and adhesives to be used as per manufacturers instructions. Customers have choice of colour (subject to availability).

In instances where the floor area is too large for one piece of covering, the welded jointing strip **MUST** be away from the showering area.

Floor sheet to be fully sealed and secured. Silicone sealant to BS 5889 for use in wet area.

All installations to be in accordance with the regulations of current legislation. A minor works electrical certificate is to be issued upon completion of the works along with the invoice.

Level Access Showers do not mean that the room will be a wet room, it will just have a wet area and therefore customers must be made aware that water still may run out of the tray area and therefore will sit on any residing tiles.
Costs can range from £3,500 - £5,500

12.1.11 *Shower over bath*

Thermostatically controlled shower; approximately 5 sq metres of tiling; shower rail and weighted curtain with a minimum 200ml hang within the bath; grab rails as necessary; moisture resistant lights; extractor fan.

Supply and fix controlled shower unit with lever control, extra long sliding bar and grab rails to be positioned as per OT's specification

A cord operated, double pole isolating switch or wall mounted switch is to be conveniently located outside the bath/shower room with minimum contact gap of 3mm both poles. The switch must be accessible and clearly identified with neon indicator light. A 30MA residual current device and 40 amp MCB unit is to be sited adjacent to existing consumer unit. Connector block and 2 No. 25mm2 PVC double insulated and sheathed tails to meter.

Pipe work to run the shortest possible route to unit and to be chrome face fixed. Any new outlets must have means of isolation fitted. Grab rails to be PVC grab rails (with a ribbed finish) or similar approved. All cables recessed underneath plasterwork must be protected with PVC capping fixed with non ferrous materials.

Tiles to be fixed with water proof adhesive and water proof grout. Tiling. Waterproof adhesive to BS 5980 and BS EN 1347 applied. The tiles are to be evenly spaced and shall be both plumb in the vertical and level on the horizontal lines and provide a smooth and even surface when fixed. Fit plastic tile edging strips around window apertures and as vertical end stops where required.

Waterproof grout to joints, filling all voids. Joints abutting window frames, door casings, skirtings, shower trays and baths to be sealed using silicone sealant to BS 5889 for use in wet areas. Wipe down all surfaces to remove residue of grout. Leave installation clean, tidy and ready for use.

Replace existing light fitting with moisture resistant lights operated by a new pull cord.

Supply and fit fully weighted shower curtain to hang flush with floor shower area in a safe and operational manner. Curtain to be anti-fungal. Rail, curtain runners and rings to be fixed with plugs and screws as per manufacturers instructions.

All pipe boxing required is to be formed from PVC boards and sealed with anti-fungal silicon sealant.

Supply and fit fully weighted shower curtain to hang within 200mm of bath. Curtain to be anti-fungal. Rail, curtain runners and rings to be fixed with plugs and screws as per manufacturers instructions.

Allow a 25mm lip minimum on wall side of bath for the fitting of equipment if needed and silicon seal bath area with anti-fungal silicon sealant to prevent water penetration.

All pipe boxing required is to be formed from PVC boards and sealed with anti-fungal silicon sealant.

All installations to be in accordance with the regulations of current legislation. A minor works electrical certificate is to be issued upon completion of the works along with the invoice.

Costs can range from £1,000 - £2,000

12.1.12 *'Clos-o-mat' toilet*

Automatic WC/shower toilet (or similar) incorporating flushing, warm-water washing and hot air drying.

Water
15mm cold water service only, water supply can be from high or low level storage or mains.

The Clos-O-Mat will be supplied with 15mm isovalve/flow control filter. No external hot water supply is required. Any new outlets must have means of isolation fitted.

Soil connection
Standard outlets suitable for "P" trap through the wall (180mm floor to centre)
or
"S" trap through the floor (150mm wall to centre).

Electrical
Any electrical work which may be required must be carried out in accordance with current legislation and an appropriate certificate to be produced upon completion. 220/240v single phase AC supply is required (loading 6 to 8 amp, maximum power 1500 watts). A fuse spur outlet should be located adjacent to the unit preferably on R.H.S. facing. This must not have a switch if the unit is in bath or shower area.

Over Flow
Has an internal overflow which discharges into the WC pan through the discharge outlet valve (flush valve). If external overflow is required then the rear of the cistern can be drilled to accommodate a 22mm rear entry overflow; where sited against external or panelled wall, the overflow can be taken straight through. If this is not possible, the wall may have to be chased to accommodate the overflow, or the unit may have to be fitted further toward and then panelled-in.

Costs can range from £2,000 - £4,000

12.1.13 *Central Heating*

The heating systems shall be designed to meet the following internal air temperatures, with an outside air temperature of –3° C.

Room	**Air Temperature**	**Air Change Rate**
Lounge/Living Room	21° C	2
Kitchen	18° C	3
Bathroom	21° C	3
Bedroom	18° C	2
Hall	18° C	2

The new heating systems will be designed with a boiler design flow temperature of 70° C and return temperature of 50° C.

The new heating systems will be designed as a fully pumped, sealed, two pipe system with a difference across the heating circuit of 20° C to maximise the efficiency of the condensing boilers.

Heating and hot water is to be provided via an 'A' rated, condensing combination room sealed boiler installed generally within either the existing cylinder cupboard or kitchen. The boilers selected should meet the following requirements:

- The boiler should be of 28kw output and should be capable of providing a minimum of 12 litres/minutes of hot water @ 35° C rise.
- The boilers will have a 7-day integral time clock to control the heating. Alternatively a remote time clock may be installed in a location agreed by the Contract Administrator.

Radiator outputs and pipe work sizes will be adjusted for the 20°C temperature difference resulting in slightly larger radiators and smaller pipe work.

The systems will be designed with steel panel radiators each having a thermostatic radiator valve and a lock shield return valve.

Radiators will be located under windows wherever possible and with a typical lounge/living room, the heating load should be split between two radiators rather than a single large radiator to distribute the heat across the room.

Radiator valves shall be bottom/bottom connections.

Pressure differential valves are to be installed in a bypass as and where necessary, dependant on the selected boilers' requirements.

Exposed pipe work e.g. vertical pipe drops, or in houses with solid floor, should be contained in performed white melamine faced boxing. Alternatively the exposed pipe work should be boxed in with timber.

All hidden pipe work under ground floor floorboards, and in loft areas will be insulated with 25mm thick insulation. Pipe work behind kitchen units etc. are to be insulated with 22mm thick insulation.

The gas carcass will be totally renewed and the new supply will be sized to meet the new appliances' requirements.

Where gas fires are to be installed the chimney is to be swept by a NACS (National Association of Chimney Sweeps) registered operative and a NACS certificate presented as part of the hand over pack, or where an existing liner is installed the old liner should be removed. In both cases, a new continuous flue liner should be installed, with appropriate flue box, connectors and terminals.

All gas work is to conform to current Gas Safety Regulations and Legislation and must be carried out by a CORGI registered engineer. Appropriate certification must be supplied upon completion of works.

At the design stage each property will be visited and a thorough survey carried out to produce a scaled working drawing and schedule of main materials for each property. The drawing will contain: heat losses for each room, radiator sizes outputs and positions, Boiler position, positions of pipe drops, all pipe work sizes and routes, any trunking/boxing, all flue sizes and routes, note floor construction (Solid or Timber), location of room thermostat and remote time clock if fitted.

All electric fires to be fitted with hearth, backing and surround.

Removal of existing:

The following elements where practical, will be completely removed from the property, existing heating system cylinder; feed and expansion tanks; circulators. All making good is to be carried out to a standard equal or above that of the existing, with the exclusion of any decoration work i.e. painting and wall papering.

Commissioning and manuals

The whole of the system will be commissioned and balanced in accordance with the best-accepted practices, as detailed in relevant Commissioning Codes.

The completed works is to be hot flushed to remove all deposits and flux. Following flushing and inhibitor is to be added to the heating system.
Upon completion the relevant test certificates shall be completed and a pack containing the Operation and Maintenance manual and guarantee for each property provided.

The client will also be provided with training on the use and operation of the new system and controls, which shall be set to the client's requirements.

The contractor shall provide the client with a laminated A4 double sided operation guide, written in plain English summarising the basic operation of the boiler, programmer, room thermostat, thermostatic radiator valves and the selected fire, complete with illustrations or pictures as necessary to provide an easy to follow guide to the heating systems operation.

Costs can range from £3,000 - £6,000

12.1.14 *Kitchens*

Adaptations to kitchens may include lowered work surfaces and access to specific areas.

Kitchen appliances will not be fitted as part of an adaptation. Customers will need to make their own arrangements.

A Minimum 10 standard 13 amp sockets outlets – a mixture of double and single sockets above and below worktops to suit appliance positions, with isolators above worktops and one cooker point.

New 40 mm worktops. All plinths to be fitted with sides behind front section and all edges.

All units backs to be fitted, only exception being where gas meter positions prevent this.

All worktops edges to be fitted with aluminium strips, bedded with silicone, lead edges to be filed to prevent sharp edges. The only exception being splayed edges where Formica is to be fitted.

Isolator valves to hot and cold water to be installed.

All sinks wastes to be renewed in PVCu.

Washing machine outlets to be combined with sink outlet.

All worktops to receive silicone seal to perimeter.

Gas and electrical cooker points are to be fitted with safety chain.

Concealed fully adjustable 180º hinges.

Drawers: metal sides, 15mm bottoms and back.

Side panel/plinth/shelves finish/colour: 15mm white melamine faced high density chipboard. Clip on 15mm plinth in matching colour fixed to legs.

Shelves on plastic covered steel clips.

Adjustable plastic feet on box on legs carcass 4 nr to each single unit, 5 nr to each double unit.

Worktop classification to BS 6222: Part 3 Type 2

All units are pre-drilled and assembled using dowels and confirmat screws at corners and provided with plastic cover caps for confirmat screws.

All wall units 720mm high, 300 deep provided with adjustable fixings.

All base units 875mm high to underside of worktop.

Worktop finish/pattern/colour. 40mm thick with balancing laminate, lipping on exposed faces.

An inset stainless steel sink with single right or left hand drainer to suit the kitchen layout with chrome finish ¼ turn lever taps.

Three rows of 150mm x 150mm ceramic tiles above worktops and between worktops and wall units as appropriate. Tiling will be taken down to floor level behind the cooker space.

An Electrical Completion Certificate must be provided in compliance with the latest addition of the IEE Regulations and to BS 7671:2001.

Costs can range from £2,000 - £3,500

12.2 Types of Minor Adaptations

12.2.1 *Fencing*

To provide a secure are to the rear of the property up to 6m in length and full width of the boundary.

Costs can range from £200 - £1,000

12.2.2 *Door re-hanging / changing (sliding)*

Re-hanging doors so they open on the opposite hand or direction. Or to adapt to sliding doors to make suitable and usable for customers.

Costs can range from £50 - £300

12.2.3 *Door widening*

Widening of doors for wheelchair use. Existing door is removed including casing. Opening enlarged to receive a 926mm internal door leaf. Adequate support provided to brickwork above opening and fit of suitable sized lintel with adequate bearing if required.

New flush door, casing, laths & architraves including all door furniture fitted. In case of a bathroom door; incorporation of a bathroom privacy set which allows emergency access.

Any electrical work which may be required must be carried out in accordance with current legislation and an appropriate certificate to be produced upon completion

Costs can range from £400 - £800

12.2.4 *Tubular steel handrails*

Mild galvanised steel tubular handrail fitted. Rail to be 50mm in diameter. Handrail to be 900mm high from ramp level, with uprights at maximum centres of 2m. Uprights to be placed at every change of direction.

Uprights to be set in plain concrete C20P, 20mm aggregate at a depth of a minimum of 600mm. Ensure the handrail is held in place until the concrete has cured.

All joints to be welded with burrs, snags and uneven areas to be removed with a grinder to provide a smooth and even surface.

Costs can range from £80 - £1,000

12.2.5 *Easy going steps*

Step size will be 600mm x 900mm each. Each step will be formed from pre-cast concrete flags. The sizes of treads & risers will need to be determined. The brick on edge will be used as a riser unless otherwise specified. Bedding to be in cement mortar. All debris to be removed and site left clean and tidy.

Costs can range from £60 - £1,000

12.2.6 *Lever taps*

Either 75mm or 150mm Lever Taps

Existing taps removed and pipe work adjusted as required..

New pair of 22mm (3/4" BSP) Peglar or Similar approved lever taps with 75mm / 150mm reach fitted. Lever taps to comply with current legislation.

Any new outlets must have means of isolation fitted.

Hot tap to be fitted on left and cold tap fitted to right.

Costs can range from £40 - £200

12.2.7 *Strip lights (internal/external)*

Provision of additional strip lights for low light areas both internal and externally.

Costs can range from £80 - £1,000

12.2.8 *Door entry systems*

An automated door system with key fob entry. Intercom system enable for visitors.

Costs can range from £300 - £1,000

12.2.9 *Additional electrical sockets*

Provision of additional electrical sockets for disability equipment.

Costs can range from £40 - £1,000

12.2.10 *Boxing in stairs*

Enclosure of open areas of stairs with solid structures.

Costs can range from £250 - £500

12.2.11 *Composite Doors*

The door will be pre-hung, solid core, featured door of external quality. Weatherboard to be fitted as standard.

Front doors are to be one of 4 styles and colours. The frame shall be 70mm PVCu White Profile with suitable size Aluminium Reinforcement fitted. All frames shall be fitted with a Part M low mobility threshold.

A multi-point locking system is to be used with a minimum of three locking points including the latch. Door furniture to be Gold anodised unless specified.

Front doors to have a door viewer appropriately positioned, security 'T' bar using correct fixing screws, brass numerals and a gold anodised letter plate (including internal flap). Euro cylinder lock shall be fitted with drill resistant hardened pins, with 3 keys provided.

The lock shall have a cylinder guard fitted. Gas vent, min 600mm, to be fitted on top rail of door leaf (If required)

The doors shall be installed strictly in accordance with manufacturer's instructions. Doors shall be sealed to external brickwork using approved low-modulus brown silicone mastic.

Costs can range from £400 - £600.

12.2.12 *Drop Kerbs*

Excavation of existing kerbs and replace with splayed kerbs and at least 3 dropped kerbs.

Excavation of the footway. Reconstruction of the footway with 150mm thick sub-base, 60mm thick base course and 20mm thick wearing course.

A license must be obtained from Streetpride EDS prior to work commencing.

Costs can range from £300 - £500.

12.3 Minor adaptations can be combined and still fall within minor adaptations if the total cost remains under £1000.

12 Types of Minor Fixings

12.4.1 *Grab Rails*

Grab rails are moulded and fluted white PVC. The location will be specified by the OT. Fixings will be secured to the wall in horizontal/vertical/ diagonal position using appropriate fixings.

12.4.2 *Key Safes*

External storage for keys with numbered key access. External size of key safe is H=107mm x W=57mm x D=50mm. Product and installation warranty is 24 months. Position of key safe to be fitted as directed upon order.

12.4.3 *Wooden Stair Rails*

Wooden mopstick rail fitted traversing stairs where required. Additional rails can be provided to existing rails.

12.4.4 *Bed and Chair Raisers*

Feet or brackets added to beds or chairs to enable access to the relevant object.

13 Adaptation Refusals

13.1 All adaptations are subject to a community occupational therapist assessment. Minor fixings and minor adaptations are seldom refused.

13.2 There are occasions where major adaptations will be refused. Some of these are determined under legislation.

13.3 *Under Occupancy*

- The parameters of Under Occupancy are defined within the Allocations Policy.
- If a customer is in a situation where they are under occupied in a property, then adaptations will not be considered unless:
    - there are no suitable adapted properties within Council stock, or
    - there are suitable adapted properties within Council stock, but these are minimal and the likelihood of availability becoming apparent within a 12 month period is very low.

- Under occupancy rules are irrespective of what security of tenure the customer currently has.
- Certain temporary adaptations can be offered to provide a short term solution: However, this would be investigated on a case by case basis and offered only in extreme circumstances.
- In relation to customers who are in Council properties, those who are under occupying will be afforded reasonable preference to local accommodation as per the Allocations Policy.

13.4 *Mutual exchanges*

- A customer who is residing in an adequately adapted property cannot mutually exchange to a property that does not have the specifically assessed adaptive requirements the customer needs.
- Any mutual exchange must be authorised by the Housing Occupational Therapist as suitable, reasonable and appropriate to meet the customers' needs. If it does not, then the mutual exchange will not be allowed.
- If two adapted properties are to be exchanged, then both properties must meet the needs of both households.

13.5 *Alternatives*

- The Occupational Therapist will assess whether an adaptation is both necessary and appropriate.
- By doing so, they will look at issues including but not limited to:
    - Under occupancy
    - Overcrowding
    - Medical condition of applicant / household
- Where an adaptation is not necessary and appropriate, the adaptation will be refused.

13.6 *State of the Property*

- The state of the property is important and it must be deemed by the assessing Technical Officer as reasonable and practicable for an adaptation to occur.

- In terms of the state of the property, the Technical Officer will look at issues including but not limited to:
    - Wear and tear
    - Disrepair
    - Electrics
    - Plumbing
    - Heating
    - Environmental Health
    - Structure including roofing
    - Drainage
- Where an adaptation is not reasonable and practicable to occur, the adaptation will be refused.

13.7 *Reports not Submitted*

All work needs to fall within the remit of the Housing Grants, Construction and Regeneration Act 1996. Therefore all relevant paperwork is required from all parties. Where adherence to the relevant Act has not occurred, an adaptation will be cancelled. Such paperwork may include but is not limited to:

- A minimum type 2 asbestos report or equivalent.
- A current Edition Electrical Test report.

13.8 The Adaptations Team will attempt to confirm proof of ownership of accommodation through the Land Registry. If this cannot be done, then the customer is responsible for proving ownership. If proof cannot be provided then an adaptation will be refused.

13.9 If the customer is a tenant, then they are required to provide proof of occupation. If this proof cannot be provided by the customer, then an adaptation will be refused.

13.10 If the property is not owned by the Council, then consent is required by the landlord or owner. If consent is not granted then an adaptation will be refused. Full consent is required and stipulations added by landlords will not be classed as full consent. The consent is for permanence of fixture and fitting.

13.11 Where a customer has been means tested and is required to contribute funds but declines to do so, an adaptation will be refused.

13.12 If a customer withholds information that would normally be taken into account for a means test, an adaptation will be refused.

13.13 In the case of a split household where the disabled person is a child (under 16 yrs and a child who is in full time education under 19 yrs), adaptations will only be considered on one property.

The property where the parent who the child is dependent on resides will be given consideration for an adaptation. When deciding on which parent the child is dependent on, the following will be taken into account but is not limited to:

- Who the child resides with primarily
- Any Court Orders in place

- Who child benefit is paid to
- Agreements between parents
- The individual facts of the case

14. Removal of Adaptations

Void Properties

14.1 Adaptations to void properties will only be removed following approval for its removal by the Housing Access Manager and the Adaptations Team Manager.

14.2 Adaptations will not be removed unless:

- There are no suitable applicants requiring such adaptations on the Housing Register.
- They are not fit for purpose and beyond economical repair.
- Special circumstances

Let Properties

14.3 Consideration for removal of adaptations may occur after succession or assignment of a property unless:

- by either succeeding to the property or being assigned the property, the property will or has become under occupied (see 13.3); and/or
- the equipment can be re-used in another property

14.4 Rules for succession and assignment can be found within the Allocations Policy.

15 Design Brief for New Build Disabled Person's Units (DPUs)

15.1 Introduction and Aims

Inclusive design empowers people to maximise their independence by providing an environment which supports people's occupational performance. The environment where people live has a direct impact on their health and wellbeing. A well designed, supportive environment can help to facilitate physical, mental and psychological wellbeing.

This design brief outlines standards for new build DPU properties. However, the needs of each disabled person are individual and as such this document is for guidance only. Where possible the customer should be given some choice relating to the design of the property. However the aim is to plan for the life of building and therefore each DPU needs a degree of built in adaptability to accommodate the needs of future occupants.

15.2 Legislation and Standards:

- DDA 1995
- BS 8300:2001
- Approved Document to Part M of the Building Regulations
- Lifetime Homes
- Code for Sustainable Homes

15.3 External Environment

Realistic distances to local amenities

- Shops, cash point, schools, doctor, chemist, pub, etc

Fully accessible, safe and secure routes within a development

- Good lighting – all routes are well illuminated
- Clear signage – including dwelling numbers to be large, raised and contrasting with background.
- Crossings – barrier free with dropped kerbs no steeper than 1 in 12
- Minimise cross falls to no more than 1 in 50 on pavements
- Smooth pavement surfaces with a minimum width of 1200mm
- Ensure footpath gradients are no more than 1 in 12 for 2000mm or 1 in 15 for 5000mm, use level landings of 1200mm at the top, bottom and if required intermediate
- Protective footpath edgings where adjacent ground falls away

Minimise distinctiveness of DPU

- Sensitive treatment of parking, common features such as level thresholds, brickwork, roof tiling, etc.

All dwellings accessible to a visitable standard

- Wheelchair users must be able to access neighbours houses

Refuse

- Suitable, usable refuse provision a short distance from the external door.

Gardens

- Gates to have 900mm clear opening, can be operated from both sides and have reachable and easily manipulated fittings.
- Accessible for clothes drying, external storage and planting

Parking

- Covered parking space adjacent to property or designated parking space for communal dwellings.
- Safe, suitable storage for an electric scooter

Entrance

- Smooth, slip resistance level or ramped route to entrance, ramps no steeper than 1 in 15 and no longer than 5000mm.
- Entrance level landing of 1500 x 1500 mm minimum, 1200mm depth of outward swinging door, up-stands provided where ground level is below the path.
- Entrance canopy of minimum 1200 x 1500mm extending beyond door on lock side, maximum height 2300mm.
- Provide accessible, adequate lighting from car to entrance, infra-red detectors are useful in addition to switches.
- Clear door width of 900mm minimum
- Approach space beside leading edge of door, 200mm minimum for a door opening away and 300mm for door opening towards wheelchair user, expending 1800mm from face of door.
- Threshold – Level or height not exceeding 15mm, weather tight, tapered profile externally.

- Provide secure locking, with key at 800 – 900mm high, and contrasting, easy to grip pull or handle at 900 – 1000mm high.
- Opener – if opening pressure is greater than 20 newtons
- Entry system – Entry phone site 300mm clear of internal corner and at 1000mm to buzzer or provide a bell sited at 800 – 900mm high.
- Pull – make provision to fit a closing pull on the outer facing of an inward opening door at 900 – 1000mm high.

15.4 **Entering and leaving Property**

Transfer into internal chair

- Space required in house to transfer to second wheelchair and store the first, if necessary leaving it on charge.

Turning space

- Provide clear space to manoeuvre and turn behind a closed door of 1500mm x 1800mm.

Entry phone

- At front entrance doors to dwelling make suitable provision for future installation of entry phone. For example providing blanked socket outlet, conduit and draw wires with operating pints in living room and bedroom.

Provide secondary door to external space eg gardens

- Entrance level landing of 1500 x 1500 mm minimum, 1200mm depth of outward swinging door, up-stands provided where ground level is below the path.
- Clear door width of 900mm minimum
- Threshold – Level or height not exceeding 15mm, weather tight, tapered profile externally.
- Provide secure locking, with key at 800 – 900mm high, and contrasting, easy to grip pull or handle at 900 – 1000mm high.
- Pull – make provision to fit a closing pull on the outer facing of an inward opening door at 900 – 1000mm high.
- Provide accessible, adequate lighting.

15.5 **Moving around inside and storage**

Straight passages

- 900mm clear width. Ideally a centralised layout should be considered so doors open off a core space rather than passage ways. Ensure doors on opposing sides of passageways are directly opposite.

Turning 90 degrees

- Passage widths or approaches to turn through 90 degrees and 1200mm clear width minimum

Turning 180 degrees

- 1500mm clear turning space

Effective clear widths for doors

- 900mm minimum clear width and open beyond 90 degrees. Doors should open against a wall and not into the centre of the room or preferably be sliding doors where wall space permits.

Storage

- Ensure that depth and width of storage space, in combination with any shelving layout, provides optimum access to space and to stored items. Ensure opening widths of doors suits angled or head-on approach.

Moving between levels

- Where dwellings are designed on more than one level ensure provision for independent movement between floor levels in a wheelchair without needing to transfer and adequate circulation space on each level.

Space in living area

- Ensure enough space to accommodate wheelchair user and space for furniture and transfer to seating. Ensure adequate space to approach and operate doors, windows, equipment and controls. Ensure radiators do not inhibit layout and sockets are not sited within 750mm of an internal room angle.

15.6 **Kitchen**

Layout

- Lay out kitchen for practical use of a wheelchair user, ensuring clear manoeuvring space of 1800mm x 1500mm minimum. Where practicable position windows for ease of control and cleaning.

Worktops

- Provide a length of 600mm deep worktop with clear knee space below and appropriate to size of dwelling. Ideally all worktops, including hobs and sinks to be adjustable in height between 750mm and 910mm.

Sink

- Provide integral shallow sink and drainer to maximise height adjustability, with insulated bowl and clear knee space below. Ensure provision of an accessible easily manipulated mixer tap.

Storage

- Provide storage appropriate to size of dwelling in a position and format usable from a wheelchair, eg trolleys, carousels, pull-out baskets, etc

Controls and lighting

- Provide electrical controls, including sockets, within reach to suit adjustable worktops. Provide general and task lighting

Appliances

- Provide and install hob and built in oven. The hob should have knee space below and oven at an accessible height, with side opening door, adjustable to suit user. Provide a minimum of 3 spaces for appliances/white goods depending on size of property.

Refuse

- Provide suitable internal refuse arrangements manageable from a wheelchair.

15.7 **Bathroom**

Layout

- Provide fully accessible bathroom with WC, basin and installed level access shower, with provision for bath in place of shower, with flexible or easily adapted services. Ensure provision of direct access from disabled person's bedroom into bathroom. Ensure independent approach/transfer to and use of all fittings, including clear manoeuvring space of 1500mm x 1500mm minimum. Ensure walls and ceilings are adequate for subsequent fixings of hoists, seats and supports, etc.

Radiators

- Not to be sited next to toilet as potential for burning for clients with poor sensation unless low temperature radiators are installed. Also not on walls which will affect position of furniture.

WC

- Select and position for a range of transfers and to accommodate drop down support rails. Centre of WC pan should be 500mm from adjacent wall. Allow 1100mm min approach to front of pan to allow transfer.

Shower

- Fully accessible including slip resistant, drained floor, such as installation of Impey Level-Dec 8. Fully tiled bathroom, reachable and usable controls and scope for water containment or enclosure.

Wash Hand Basin

- Wall mounted wash hand basin. Select and position to be approachable in a wheelchair with a shallow but good capacity bowl, reachable lever taps.

15.8 **Bedroom**

Layout

- The bedroom needs to be large enough to provide access to both sides of the bed in the disabled person's room. Ensure walls and ceilings are adequate for subsequent fixings of hoists, seats and supports, etc.

Doors

- Make provision for connection between the disabled persons bedroom and bathroom by means of a door with panel over in full height frame or fully detailed door to accommodate installation of a ceiling track hoist if required. The door should be a minimum of 1000mm clear width either a sliding door or saloon style doors.

15.9 **Other**

Internal Doors

- Ensure doors permit subsequent fixing of pulls and other fittings.
- Provide easily operated handles at a height of 800mm to 1000mm.

- Ensure provision of locking devices manipulated from inside and outside in an emergency.
- Fit sliding doors where space permits.
- Allow minimum clear width of 900mm.

Windows

- Allow approaches for wheelchair user to operate controls for window.
- Ensure glazing line to windows in living, dining and bedrooms is no higher than 600 to 800mm so seated person can see out.

Controlling Services

- Ensure a wheelchair user can reach, control and read main services, heating and radiators.
- Provide isolating stop taps to sink, washing machine, WC and shower.
- Provide flexible plumbing to any adjustable fittings.
- Large rocker light switches at a height of 900mm.
- Sockets set at 700mm to 1000mm high or 100mm above work surfaces, install large rocker switches.
- Ensure provision of telephone line at 700mm high.
- Provision of fire alarms.

Hoists

- Make provision for future hoist installation by preparing ceilings in disabled person's bedroom, bathroom and lounge to allow installation of a ceiling track hoist, provide conduit and fuse spur in roof space over room.

- Joists to be a minimum of 50mm wide and capable of a point load equal to 1.5 times the Hoists SWL i.e. 130KG hoist requires a joist capable of supporting 195KG. Lights and other ceiling fittings to be at least 380mm clear of the track line.

16 Health and Safety

16.1 The Adaptations team deliver the service at a local level, via home visits, which supports the Council's commitment to providing greater accessibility to services, meeting social needs by helping to ensure a better quality of life, improving fair access and choice, protecting, keeping safe vulnerable people and specifically addresses the diversity agenda, by tailoring services to the needs of hard to reach groups.

16.2 To ensure Health and Safety procedures are adhered to, the team work within the provisions of ETAB procedure to ensure staff. A copy of this procedure is available to all Housing Access staff.*

*The ETAB procedure contained personal staff information and is therefore not published or available to non-council members.

16.3 All accidents and incidents should be reported to the Adaptations Manager who will formulate a quarterly report to be submitted to SMT via the Housing Access Manager.

16.4 Any threats of violence or actual violence against staff will be reported to the police and legal action will be pursued against the perpetrator. Staff will work to the policy and

guidelines on work related violence to employees in line with:

- The Health and Safety at Work Act
- The Management of Health and Safety at Work Regulations 1999
- Approved Code of Practice and guidance L 21

17 Safeguarding

17.1 All safeguarding issues will be reported to the Safeguarding Team as per the Council's safeguarding policy.

17.2 Officers will also report all safeguarding issues directly to the Adaptations Manager who will formulate a quarterly report to be submitted to SMT via the Housing Access Manager.

18 Complaints

18.1 All complaints are dealt with under the corporate complaints procedure.

18.2 Advice and guidance for staff dealing with complaints can be found on the intranet.

18.3 Advice for customers wishing to register a complaint can be gathered from:

http://www.rotherham.gov.uk/info/200119/customer_services/1081/making_a_complaint/1

18.4 Complaints can be made by writing in, emailing or telephoning.

19 Data Protection

19.1 The Council will comply with the Data Protection Act 1998 and Article 8 of the Human Rights Act and will show proper regard for the confidentiality of service users and employees personal information.

19.2 The Adaptations Team will work within the guidelines of the Council's Data Protection Policy

20 Equality and Diversity

20.1 The Council will comply with the Equality Act 2010 and related legislation as per below:

- Equal Pay Act 1970
- Sex Discrimination Act 1975
- Race Relations Act 1976
- Disability Discrimination Act 1995
- Employment Equality (Religion and Belief) Regulations 2003
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Age) Regulations 2006
- Equality Act (Sexual Orientation) Regulations 2007

20.2 The Council will comply with all anti-discrimination legislation including:

- Human Rights Act 1998
- Carers (Equal Opportunities) Act 2004
- Civil Partnership Act 2004
- Gender Recognition Act 2004

- Work and Families Act 2006

20.3 The Council operates an Equality and Diversity Policy which the Adaptations Team works within.

21 Allocations of Adapted Properties

Applicants Requesting Re-housing and require some form of adaptations

21.1 Where an applicant has applied for adaptations:

21.1.1 Applicants will need to have been assessed by an Occupational Therapist as requiring adaptations.

21.1.2 Where a customer wants to be re-housed rather than adapt their existing property, the Occupational Therapist should recommend requirements **and** solutions. This is contrary to the normal process highlighted within 4.2.1 - 4.2.10.

21.1.3 The Occupational Therapist must then contact the Assessment Team (Housing) to inform them of the outcome and requirements.

21.2 Where an applicant has not applied for adaptations they will need to be assessed by the Assessment Team (Housing).

21.3 Where the Assessment Officer deems that adaptations are required when moving to a new property, they should update the customers application with the requirements and the correct Medical Priority code:

PSMP	**Priority Single Medical Priority**
PFMP	**Priority Family Medical Priority**
PEMP	**Priority Elderly Medical Priority**

If the applicant is a Council tenant the application will be coded as below:

PSTM	**Priority Single Transfer Medical**
PFTM	**Priority Family Transfer Medical**
PETM	**Priority Elderly Transfer Medical**

The Assessment Officer should ensure the checklist concerning adaptations is completed when updating the housing application.

21.4 If the customer is adequately housed and existing adaptations in the applicants current property meet the customers need, then a Medical Priority will not be awarded.

21.5 Allocations of adapted properties will be to those with an assessed need for those adaptations.

21.6 If no applicant is suitable for the adapted property, but their needs partly meet the adaptations then they will be allocated by in line with the Allocations Policy.

21.7 If an applicant does not require the adaptations within a property, then the Adaptations Team should be contacted prior to an offer to an applicant. The Adaptations Manager may consider removal of adaptations if it is feasible and appropriate under special circumstances, however, it is expected that this would only be in limited cases. If a property that is allocated is let to an applicant and then contact is made with the Adaptation Team to request removal of an adaptation, such a request would be refused.

21.8 In the case of a split household where the disabled person is a child (16 and under or 19 and under if the child is in full time education), Medical Priority cannot be given to both parents.

The parent with parental control will be given Medical Priority due to a child's disability. When deciding on who has parental control, the following will be taken into account:

- Who the child resides with primarily
- Any Court Orders in place
- Who child benefit is paid to

The other parent will not be given Medical Priority if that priority is solely reliant on the child's circumstances. The applicant would remain within the group they are currently in.

If there are special circumstances that mean the applicant requires adaptations, but they are not eligible, then their case maybe considered at the Housing Assessment Panel. (See Allocations Policy for details)

21.9 All adapted properties are advertised in the Key Choices letting Scheme, but the advert will inform the customer that preference will be given to applicants who have made a bid with an assessed need.

21.10 Where adaptations have been refused on a property for one of the reasons listed within Section 13, a report should be submitted to the Housing Assessment Panel. The panel have the authority to consider Priority Plus status under exceptional circumstances.

21.11 Where a Major Adaptation valued over £8,000 has been identified as a potential solution and a further potential solution is for re-housing, a report should be submitted to the Housing Assessment Panel. The panel have the authority to consider Priority Plus status under exceptional circumstances.

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