

**Cambridge** Centre  
for Housing &  
Planning Research

# **FirstStop local partners: costs and potential savings to public budgets of client casework 2014**

**November 2014**

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# 1) Introduction

This report explores the costs and benefits of a sample of cases dealt with by the FirstStop local partners providing housing options services to older people. It focuses on the intense level three casework data provided by the local partners.

It looks at a sample of the client cases they have dealt with to analyse the potential savings to the public purse of the housing options case work. It is part of the independent evaluation of the Department for Communities and Local Government (DCLG) funded FirstStop local partner programme in 2013-15.

## 1.1 FirstStop

FirstStop aims to help older people make informed decisions about their housing and support, maintain independent living in later life and avoid health problems and unplanned care home admissions. It was launched in 2008 as a joint initiative by four national organisations in response to a report by the Office of Fair Trading (OFT) into how well the care homes market served older people, and which recommended the establishment of “a central information source or one-stop-shop for people to get information about care for older people”.

After a short pilot, the Big Lottery Fund offered seed funding for three years from 2008, and DCLG subsequently provided Section 70 funding to enable the project to be rolled out nationally; to expand its remit to include housing, support, care and related financial issues; and to recruit a number of local delivery partners. Following dissolution of its national founding partnership in 2010, the charity the Elderly Accommodation Counsel (EAC) was recognised by DCLG as the lead organisation to carry FirstStop forward.

FirstStop now comprises a network of local and national service delivery partners led by EAC, bringing together different skills, specialisms and ways of operating, but accessible to the public via one phone number and one website. Its service spans the housing and care divide, offering in depth specialist understanding of all aspects of housing, support and care for older people, along with information on financial and legal issues.

## 1.2 The local partners 2013-14

In 2013-14 FirstStop funded housing options services within these organisations:

1. Age UK West Cumbria
2. Age UK Hillingdon
3. Age UK Wigan Borough
4. Age UK Nottingham & Nottinghamshire
5. Age UK Isle of Wight
6. Age UK Norfolk
7. Middlesbrough Staying Put Agency
8. Age UK Horsham District
9. Revival HIA (Staffordshire Housing Association)
10. Age UK Hythe and Lyminge

11. Age UK Salisbury District
12. Orbit East Care & Repair (Suffolk - HIA & Handyperson project)
13. City of York Council, Housing Services
14. Age UK Northumberland
15. Spire Homes Care and Repair

### **1.3 Evaluation of FirstStop**

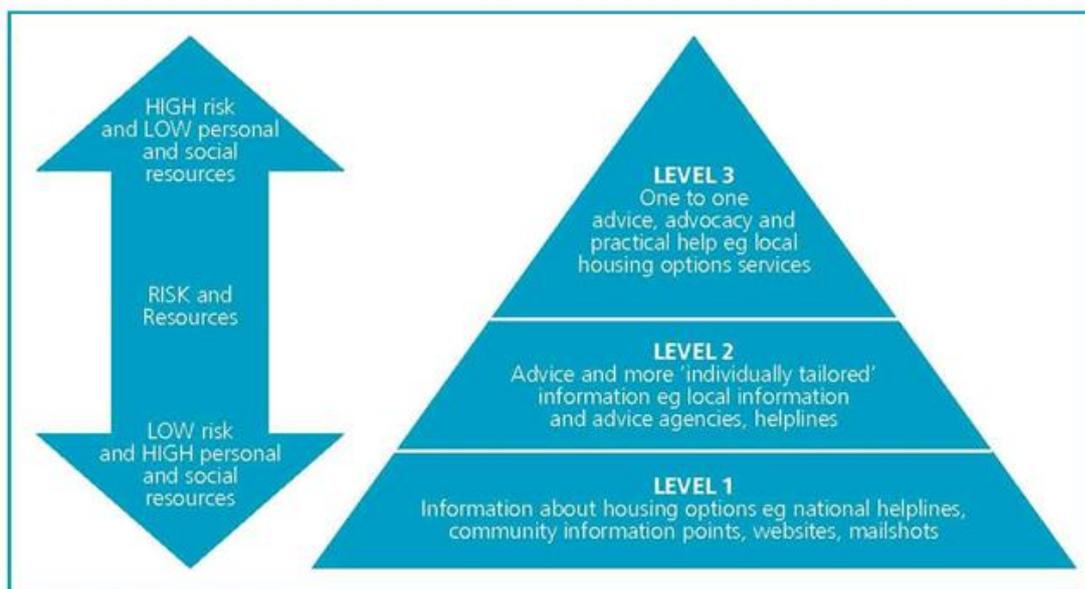
The Cambridge Centre for Housing and Planning Research at the University of Cambridge has been undertaking an independent evaluation of the FirstStop service since November 2009.

Previous reports from the evaluation can be found at:

<http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010>

## 2) Model of local service delivery

FirstStop specified to the local partners that the model of provision should be based on a three level analysis of service user need/assistance, set out in the diagram below.



### Level 1 - Information

This will usually be delivered on a one to many basis to a local group or at a local event. Information may also be provided on a one to one basis by e-mail, letter or phone call. As well as providing older people with general information about their housing and care options, awareness would be raised concerning the availability of the FirstStop website and telephone helpline and the local advice service.

### Level 2 – Advice

One to one, single contact/intervention or provision of information and advice. These lighter-touch cases would be delivered primarily over the phone or at an advice surgery. They may also be delivered by letter or e-mail. They will typically involve some discussion of personal situation and tailored information provision about the enquirer's housing and care options.

### Level 3 – Casework

Individually tailored in-depth casework involving one to one advice, advocacy and practical assistance to enable the person, as far as is practical, to achieve their chosen housing and care outcome. Likely to involve two or more interactions and working in partnership with other agencies to achieve the desired outcome.

### Relationship to the FirstStop national service

There is an expectation that partnership projects will make referrals to FirstStop Advice and that conversely, FirstStop Advice will refer people who need one to one assistance to local partners.

### **3) Monitoring outcomes**

The local partners are required to monitor the cases, outputs and outcomes of the services. In the monitoring framework agreed between EAC First Stop with DCLG there is light touch system focused on output targets with local targets at Level 1, 2 and 3. EAC FirstStop set out a number of outcomes for older people as part of this programme as follows:

1. Older people will be enabled to retain their independence in later life through making informed decisions about their accommodation and care arrangements.
2. Older people will be enabled to maintain good health and avoid accommodation-related acute health problems (e.g. falls); will be enabled to delay or avoid unnecessary care home admission; will be enabled to avoid unnecessary delay in returning home after a period of hospitalisation.
3. Older people who wish to do so will be supported to downsize to more suitable accommodation.
4. Older people who wish to do so will be enabled to release equity safely and financially efficiently through downsizing or through equity release products.
5. More effective use will be made of the supply of family-sized accommodation through supporting older people who wish to do so to move to more appropriately sized accommodation.
6. Older people will have access to expert advice and services to adapt and repair their homes, improving their safety and quality of life, which will also contribute to the maintenance of the housing stock and to the local economy through increased expenditure on building work.
7. Older people will have access to information about local services and networks which will enable them to remain independent and active in their local community.
8. Increased awareness and understanding about housing and care options in later life and the training of older people to provide peer-to-peer information will encourage active citizenship and enable greater self reliance.

Data is collected by the local partners to assess how older people have been helped to achieve these outcomes in order to evaluate the benefits of the programme.

## 4) Previous evaluation research

### 4.1 Casework outputs

The evaluation has already identified a number of outputs of the casework for clients. These include:

- Signposting to information or services.
- Information and advice provided.
- Support in decision making.
- Benefits checks.
- Changes to more appropriate care packages.
- Supported to move to more appropriate accommodation.
- Supported to stay in their current home e.g. adaptations (Burgess et al, 2011<sup>1</sup>).

### 4.2 Client outcomes

The research also identified a number of outcomes for the individuals who used the services:

- Feeling more confident in making decisions, feeling more informed and more able to choose between different options.
- Particularly through the local projects clients were supported to stay in or move to the accommodation of their choice, empowering them to live in the housing that they felt suited them best and giving them wider choices.
- Prevention of housing related health problems e.g. falls and unplanned and unwanted moves into care homes.
- Some clients were financially better off through receiving financial advice and/or benefits checks.
- Reduced anxiety.
- Improved wellbeing and quality of life (Burgess et al, 2011).

### 4.3 Progress of the funded local partners 2013/15

As part of the evaluation in 2013-14, the research explored the progress of the local housing options services which are currently funded by FirstStop<sup>2</sup>. It analysed their successes and challenges to date. The report on progress of the funded local partners 2013-14 found that the local projects have empowered older people to make informed decisions, have given them full knowledge of all the options available and have supported them in appraising these options effectively. The case work service has received positive feedback from clients and a range of positive outcomes have been achieved, including continued independent living,

Without the housing options support received, caseworkers said that at best people would have struggled on and endured a lower quality of life and wellbeing, but at worst would have experienced health problems, hospitalisation, or entry into residential care.

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<sup>1</sup> <http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010/FirstStop-Phase2>

<sup>2</sup> Report on progress of the funded local partners 2013/14, July 2014.

<http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010/FirstStop-Report-on-progress-of-funded-local-partners-2013-14>

There is a range of case types, with both support to stay put and to move. People who are supported to move are most commonly downsizing which frees up larger properties, and if moving into the social sector will be likely to move to a one bedroom property. Moving can help to maintain independent living, for example, by moving to an adapted property, and can help to maximise income, for example, because a smaller property is cheaper to heat.

Support to stay put is often related to the provision of adaptations, repairs and heating improvements in order to maintain independent living for longer.

Caseworkers can also support people to maximise their income, particularly through benefits checks, which can have a significant impact on their income and ability to support independent living e.g. by being able to afford gardeners or cleaning support, and to improve their quality of life e.g. through being able to afford transport and heating.

There is clear evidence of demand for the services and caseworkers are dealing with a range of clients and presenting issues. Most caseworkers did report the challenge of coping with the demand for the service, particularly the time intensive level 3 cases, and the wider work around monitoring and promotion. A key challenge, as in previous phases of the evaluation, is the lack of housing supply to enable older people who want or need to move to do so.

#### **4.4 Potential cost savings to the public purse**

Previous phases of the evaluation have looked at the potential savings to the public purse generated by the interventions made by the local housing options and information and advice services. These were based on a sample of client cases from the local partners<sup>3</sup>.

Savings to public budgets may be realised in different ways. For example, many of the vulnerable older people using the casework services had a history of recurrent falls as a result of inappropriate accommodation. Home adaptations and repairs can reduce the risk of falls, saving money from health budgets

The savings to the public purse may be realised over a number of years, for example, where someone is assisted to remain living independently in their own home rather than make a premature move to a residential home.

Prevention of hospital admissions also has potentially significant savings to health budgets. Many of the vulnerable older people using the intense face to face casework services had a history of repeat hospital admissions as a result of living in unsuitable housing, with the knock on effects on their health, anxiety levels and wellbeing. Being assisted to adapt their current home or to move to more suitable housing can reduce the risk of a hospital admission.

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<sup>3</sup> Local Partner Value for Money Case Studies Report, 2012, CCHPR  
<http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010/Evaluation-Findings-2011-12/Local-Partner-Case-Studies-Report/view>

Preventing premature moves to residential care has the potential to generate savings for local authority social care budgets. Some of the older people using the services were already close to crisis point and could no longer manage in their current home. But the assistance the local FirstStop case workers were able to offer enabled clients to either remain at home with adaptations and/or care at home or to move to specialist accommodation.

#### **4.5 Challenges of analysing potential cost savings**

There are a number of challenges in analysing the costs and benefits of the local projects. One is the relatively short time frame of the projects, as to identify savings 'hard' outcomes are needed which may not be achieved during the evaluation time frame, particularly with time consuming cases where clients are assisted to move home. There is intuitively a value to and potential benefits and savings from early preventative work but this is very hard to monitor and quantify as it would require people to be tracked over long periods of time and this has not been possible within the scope of the research.

The monitoring framework adopted for the 2013-15 programme did not attempt to capture outcome data for L1 and L2 so there is no evidence of outcomes for clients receiving these types of support.

The outcomes of the level 3 cases have been monitored as far as possible. However, a difficulty in assessing the impact of the casework is the ability to demonstrate that the outcomes are directly a result of the information, advice and support provided by the FirstStop funded caseworker. The research has collected evidence to explore how the casework leads to outcomes, most importantly through interviews with service users. Interviews with clients were conducted in previous phases of the evaluation and this piece of research builds on the wider ongoing evaluation programme. The likely alternative outcomes if support had not been received were explored through secondary data, through interviews with service providers and through interviews with and data about service users. However, although based in the research findings, these alternatives remain only possibilities and their statistical probability has not been calculated and used in the analysis.

## **5) Aim of this research**

The aim of this research is to report on the costs and benefits of a sample of cases dealt with by the FirstStop local partners providing housing options services to older people. It focuses on the intense level three casework data provided by the local partners.

## **6) Methodology**

In depth telephone interviews were conducted with the caseworkers delivering the housing options services within each organisation (see Appendix 1 for interview schedule). The analysis draws on information collected through the interviews to inform assumptions about costs and benefits.

Data was submitted to FirstStop about every L3 client case (see Appendix 2 for L3 monitoring pro forma). This included demographic information, tenure, referral route, the problems the client was seeking to resolve, the actual outcomes for each client and the likely alternative outcomes for the client if these problems had not been solved, based on caseworker assumptions about each individual's circumstances.

For example, the client may have had a successful benefits check, been assisted to move to alternative housing or to have adaptations fitted. An assumption was made about what would have happened to the client without the help from the caseworker. For example, the client may have been incurring a debt, may have been at risk of a hospital admission caused by living in unsuitable housing or at risk of homelessness.

Where possible monetary values were ascribed to each actual and likely alternative outcome if support had not been received.

The difference between the cost of providing the actual outcomes for the clients and the cost to the public purse of the potential alternatives if they had received no help, represent a potential saving or cost to the public purse. The cost of the service is deducted to give an indication of the potential savings to the public purse of carrying out these types of housing options case work.

There remain certain immeasurable outputs of the case work that were identified during the research that should be considered alongside the quantitative output in financial terms, such as improvements in overall wellbeing and quality of life.

## 7) Unit costs of local partners

### 7.1 Average unit cost for all cases

The monitoring data recording the number of L1, L2 and L3 cases for each local partner were available up to the end of the first 9 months of the projects. This was extrapolated forward to give estimated case load totals for a 12 month period. The funding that each project received was divided by the number of cases to give an estimated unit cost for all cases, as shown in Table 1.

Unit cost for all level cases 12 months	£
Hillingdon	34
Horsham	16
H & Lyminge	30
Isle of Wight	19
Middlesbrough	22
Norfolk	23
Northants	10
Northumberland	21
Notts	19
Salisbury	21
Staffs	25
Suffolk	17
West Cumbria	25
Wigan	24
York	26

Table 1: Average unit cost for all cases

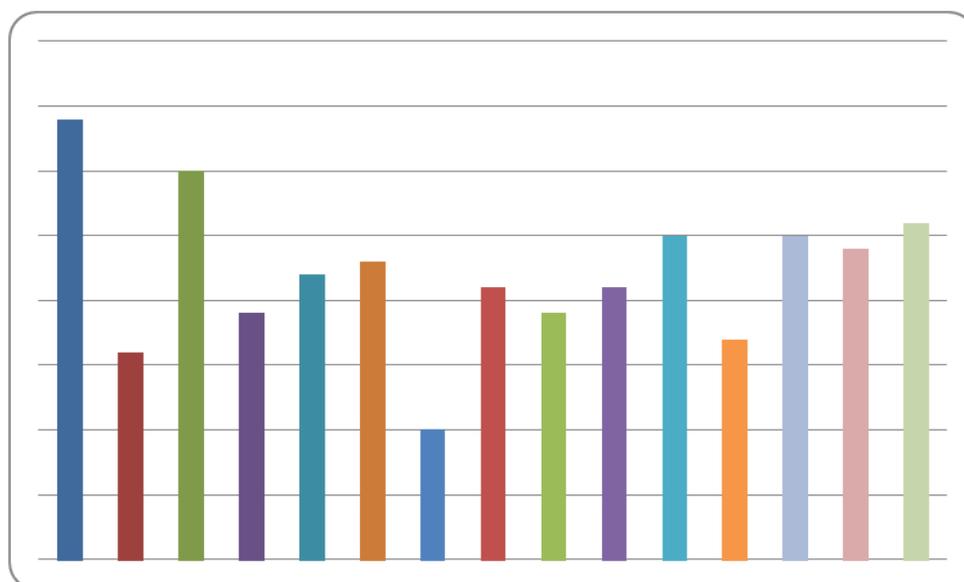


Figure 1: Unit costs for all cases

### 7.2 Unit costs for L1, L2 and L3 cases

However, the caseworkers do not spend equal amounts of time on L1, L2 and L3 cases. The interviews suggest that the ratio is more like 10% of time on L1 cases, 20% on L2 cases and 70% on L3 cases. The estimated unit costs were then calculated for L1, L2 and L3 cases.

Across all 15 partners the average unit cost for a L1 case was £3, £32 for a L2 case and £206 for a L3 case. The unit costs varied between partners as shown in Table 2 below.

The lowest L1 unit cost was £1 and the highest was £5, as shown in Figure 2.

The lowest L2 unit cost was £9 and the highest was £54, as shown in Figure 3.

The lowest L3 unit cost was £85 and the highest was £373, as shown in Figure 4.

Figure 5 shows the unit costs for each case type for all partners.

### **7.3 Cost variations between partners**

These figures do enable comparison but must be treated with a degree of caution. Basing the unit costs on the funding for the service received from FirstStop will not reflect a true picture of the cost of delivering different case types between partners as some of the projects had additional funding from other sources. The unit costs shown here in most cases reflect the grant available rather than actual service costs.

The previous report of progress of the local partners and interviews with caseworkers shed light on some of the reasons for variations in unit costs<sup>4</sup>.

The division of time between case types in the 10/20/70 ratio was based on interview discussions with caseworkers but they did not keep records of time spent on cases so this is likely to vary between partners and also at different stages in the development of the service. For example, when the services were in their early stages it is likely that the L3 case load was smaller and increased as time passed and new cases were opened. Many L3 cases are ongoing and so the L3 caseload tends to increase over time.

The targets for L1, L2 and L3 cases were not the same across all partners which will have led to variations in outputs and therefore unit costs. For example, Suffolk's L2 unit cost is low because they have the highest target for L2 cases so were aiming to achieve the largest volume of L2 cases, and thereby the L2 unit cost is lower. It does not necessarily reflect differences in the way in which cases were dealt with or the support delivered.

Some of the caseworkers also had different types of support from within the wider organisation in which they are based, which can impact on how many cases can be achieved and the unit costs. For example, some partners were receiving administrative support or help to complete the data collection and monitoring from the wider organisation but others were not. Similarly, some organisations were able to use other staff to deliver L1 and L2 cases, freeing up the caseworker to concentrate on L3 cases. Some caseworkers had support from volunteers but others did not. It would be expected that differences in additional support to deliver cases would lead to variations in case numbers and unit costs.

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<sup>4</sup> Report on progress of the funded local partners 2013/14, July 2014.  
<http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010/FirstStop-Report-on-progress-of-funded-local-partners-2013-14>

All of the reasons for the unit cost variations are not clear. It might be expected that for L3 cases fewer people could be seen by a caseworker in a large rural area than in an urban, however, urban Hillingdon has higher unit costs for L3 cases than rural West Cumbria and York and Norfolk have the same unit costs even though Norfolk is a county wide scheme.

It is likely that the degree of experience of the caseworker recruited for the post made a difference. In the interviews some caseworkers described the post as a steep learning curve whilst others said that they had been doing the same sort of work for years and felt that they had encountered all the likely problems and knew how to respond. It would perhaps also be expected that previous experience of delivering such as service within the wider organisation would make a difference, if it was something the wider service was already doing or had delivered in the past, it would be expected that the networks and knowledge would already be in place and that higher case volumes could be delivered more quickly. We also do not know whether the nature of the case makes a difference, for example, whether L3 cases where people are supported to stay put rather than to move, require different inputs of time and effort from caseworkers.

In order to be more accurate about the unit costs for different case types and partners and to analyse the differences by specific partner with greater certainty, more data would be required. All of the additional inputs into providing the casework service would need to be recorded, measured and monitored, for example, the number of hours of volunteer time, or administrative support or hours spent by colleagues delivering parts of the service, for each partner organisation. These inputs would then have to be costed for each service. It would also need more information about how much time caseworkers spend on each type of case and on other activities such as monitoring, networking and general administration. However, previous local partners were asked to record time spent on L3 cases but this did not work very well. All of these data would generate more accurate unit costs between partners and different case types. But they would also increase the monitoring burden for caseworkers and their wider organisations and would require a greater proportion of the evaluation to focus on this.

	<b>Unit cost L1</b>	<b>Unit cost L2</b>	<b>Unit cost L3</b>
<b>Hillingdon</b>	5	40	251
<b>Horsham</b>	2	51	202
<b>H &amp; Lyminge</b>	4	51	218
<b>Isle of Wight</b>	2	28	205
<b>Middlesbrough</b>	3	17	183
<b>Norfolk</b>	3	22	181
<b>Northants</b>	1	16	85
<b>Northumberland</b>	3	13	263
<b>Notts</b>	2	26	175
<b>Salisbury</b>	2	54	373
<b>Staffs</b>	4	21	124
<b>Suffolk</b>	3	9	198
<b>West Cumbria</b>	3	54	227
<b>Wigan</b>	3	52	225
<b>York</b>	4	27	181

Table 2: Unit costs for L1, L2 and L3 cases for all partners

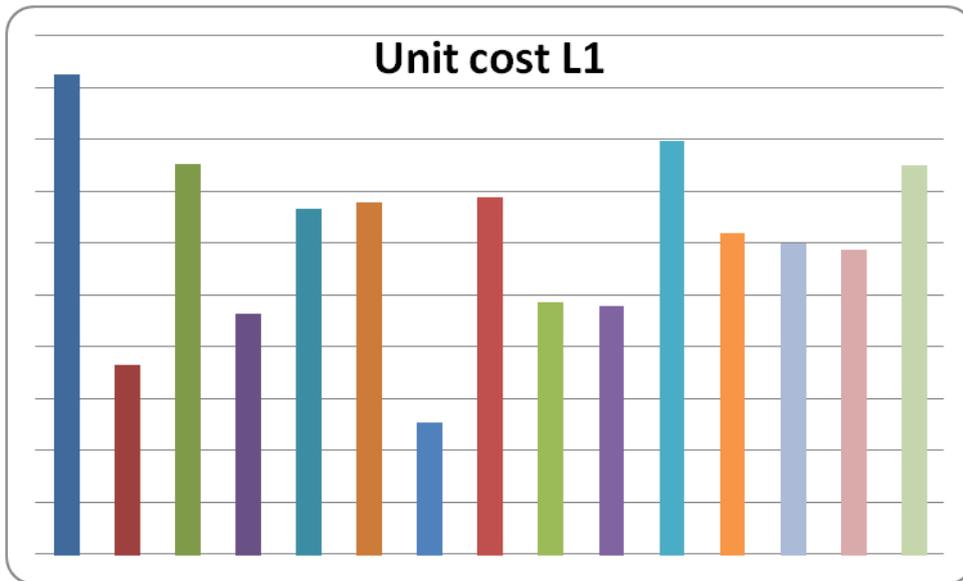


Figure 2: Unit costs for L1 cases

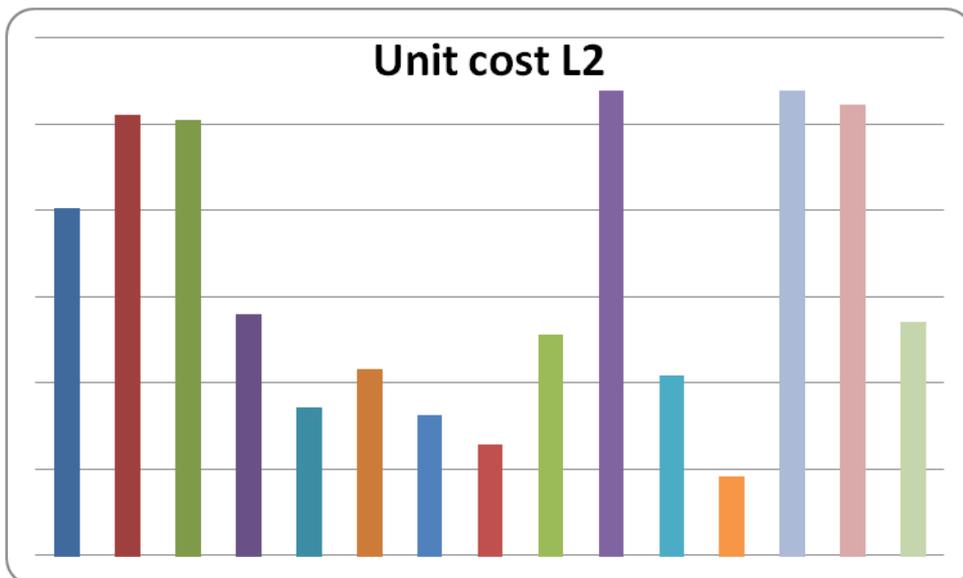


Figure 3: Unit costs for L2 cases

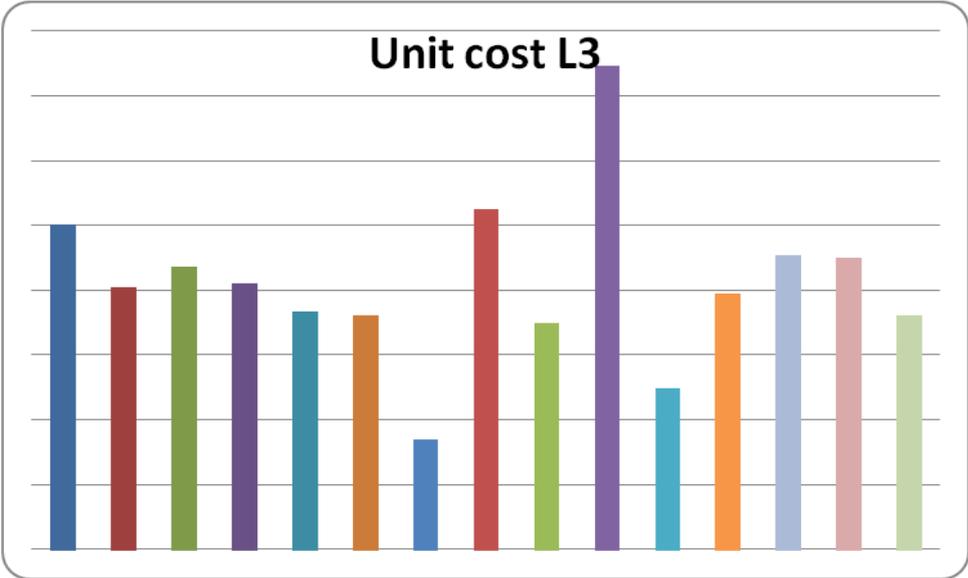


Figure 4: Unit costs for L3 cases

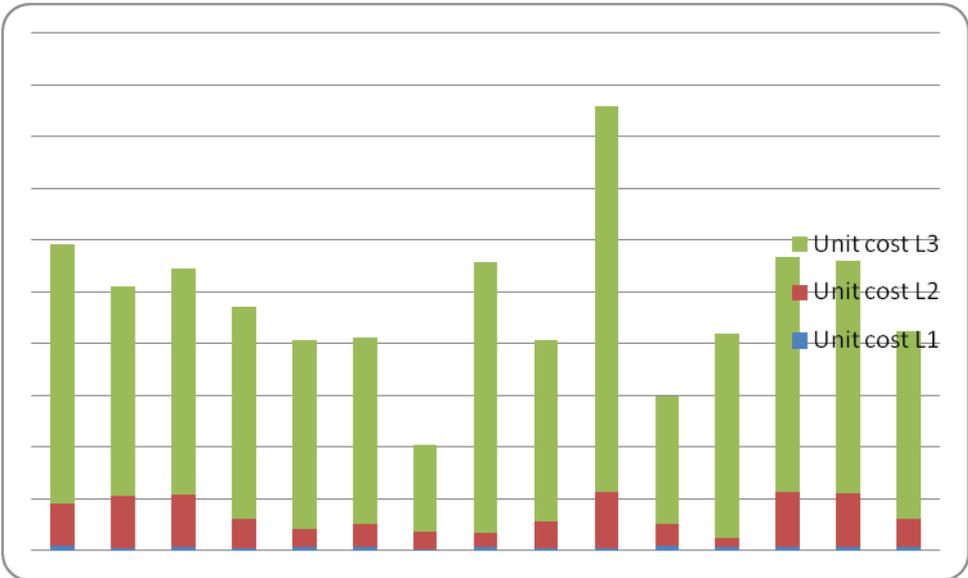


Figure 5: Unit costs for each case type

## 8) Exploring potential savings to the public purse

This section looks at the potential savings to the public purse. It focuses only on the in depth face to face L3 cases, where outcomes are known and recorded. Monetary values have been ascribed to each actual client outcome as far as possible, and then also to each likely alternative outcome if support had not been received, based on the information collected for the research.

### 8.1 Client outcomes – costs to tax payers

#### Helped to stay put - Repairs home safety/security

Some older people were supported to remain in their existing home through repairs to their property e.g. roof repairs or home repairs to improve safety and security. Most people received help through services such as a local handyman service and did not have to pay for small works up to £1000. Most repairs were smaller than the maximum limit and have been estimated at an average of **£100** based on the findings from the interviews with the caseworkers.

#### Helped to stay put - Heating/staying warm

Fuel poverty can be a problem for some older people who may be unable to heat their home, even if they own their property outright without a mortgage. The housing options services provided support to reduce energy bills e.g. by changing providers and by enabling older people to access energy efficiency measures and new boilers. The most expensive intervention was a new boiler system for central heating. The interviews suggested that the average cost was around £2000 and about half of the people who received this help did not pay for it themselves and the cost is estimated at **£1000**.

#### Helped to stay put - Adaptations/Equipment - Major adaptations

The provision of major home adaptations can enable older people to remain living independently in their existing property. The most common major adaptations were stair lifts and walk in level access showers. The average cost of a major housing adaptation was £6,000 in 2007 (Heywood and Turner, 2007<sup>5</sup>). In 2011-12 the £180m DCLG provided for DFG funding was spent on providing around 40,000 individual adaptations at an average cost of £6.7k per applicant. The interviews suggested that the average Disabled Facilities Grant for such works was still about **£6000**.

#### Helped to stay put - Adaptations/Equipment - Minor adaptations

Minor home adaptations can also enable independent living and make the home more secure e.g. the provision of grab rails can reduce the likelihood of a fall in the home. The caseworkers did not record the type of minor adaptation fitted or keep a record of this, but the interviews with caseworkers suggested that grab rails are a common minor adaptation. The mean cost of a grab rail fitted is **£95** (Curtis, PSSRU, 2012, Pg 111<sup>6</sup>).

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<sup>5</sup> <http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-disabilities/officefordisabilityissues/better107.aspx>

<sup>6</sup> <http://www.pssru.ac.uk/project-pages/unit-costs/2012/>

### **Helped to stay put - Adaptations/Equipment - Assistive technology**

Assistive technology covers a range of products and types of support. A common type of technology which can be provided to older people is telecare, which is support and assistance provided at a distance using information and communication technology and for example may include a personal alarm to call for help. The mean intervention cost of telecare (both equipment and support package costs) was estimated at **£792** a year (Curtis, PSSRU, 2013, Pg 29, Table 2).

### **Helped to move - Specialist housing - social housing**

Many of the older people who were assisted to move by the FirstStop services entered specialist social housing for older people, most commonly referred to as sheltered housing. The cost to a local authority of providing sheltered housing over one year is **£7923** (Curtis, PSSRU, 2010<sup>7</sup>, Pg 56), this includes the capital and revenue costs but not household expenditure on personal living expenses.

### **Helped to move - Specialist housing - private sector**

Some older people have sufficient income and/or capital to move to specialist retirement housing in the private sector. When people pay for their own accommodation in the private sector, their housing has no cost to the public purse.

### **Helped to move - General needs – owner occupation**

People who already own their own home may move to a more suitable property within the general housing market which they either purchase outright or with a mortgage. When people pay for their own accommodation in the private sector, their housing has no cost to the public purse.

### **Helped to move - General needs - social housing**

Older people may move into general needs social housing, or may already be in the social sector and move to a more suitable property. The cost is estimated at **£4048** per year, based on data from Statistical Data Return Dataset<sup>8</sup> (2012) and assumes receipt of housing benefit, based on the interview findings.

### **Helped to move - Care home**

For some older people independent living is no longer possible so they are supported to move into residential care. The current cost of local authority residential care for older people is estimated as £53,352 per year (Curtis, PSSRU, 2013<sup>9</sup>, Pg 39). However, evidence suggests that about one third of people who enter care homes are self-funders (Leary et al, 2010)<sup>10</sup>. For those who rely on the local authority to meet their costs, this is an estimated average cost of **£35,568** a year.

### **Improved financial situation - Increased income**

One outcome for clients was an increase in their household income. This could be through savings e.g. by changing energy tariffs, but was often through being assisted to claim

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<sup>7</sup> <http://www.pssru.ac.uk/archive/pdf/uc/uc2010/uc2010.pdf>

<sup>8</sup> <https://www.gov.uk/government/statistical-data-sets/local-authority-housing-statistics-data-returns-for-2012-to-2013>

<sup>9</sup> <http://www.pssru.ac.uk/project-pages/unit-costs/2013/>

<sup>10</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/7537/1514533.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7537/1514533.pdf)

benefits to which they were entitled but were not claiming. Previous research found that the average increase in income through benefits checks was **£2045** (Burgess, 2012<sup>11</sup>).

## **8.2 Likely alternative client outcomes without support – costs to tax payers**

### **Continued to live in unsuitable accommodation**

Without support many people would have continued to live in unsuitable accommodation. On its own this has no cost to the public purse, although there may be costs as a result of poor health or falls as discussed below.

### **Enforced move from current accommodation - Homelessness**

Without the case work intervention one alternative outcome was that some clients would have been made homeless, for example, through eviction because of rent arrears. However, official figures show that only three per cent of homeless households who contacted their local authority and were accepted as having a right to be offered housing by the local authority were aged over 60 (Shelter, 2007)<sup>12</sup>. Therefore almost no older people have to be housed through the statutory homelessness system at a cost to the local authority. There are, however, other potential costs of being homeless in older age, such as an increase in health problems, including mental health. However, these are covered separately in the monitoring and analysis so a specific cost of homelessness has not been included to try and reduce the likelihood of double counting.

### **Increased demand for health services - Risk of fall(s)**

The costs (to the state) of falling depend on the severity of the fall, and the degree of medical treatment necessary (Clarke, 2011<sup>13</sup>). A large number of falls are not serious and either require no treatment or involve the victim being checked over at A&E but no further treatment required. A small proportion of falls result in very serious consequences, including death and hip fractures. Some of these serious falls result in very high costs, sometimes in excess of £30,000 to the NHS and to social services if the victim requires a long stay in hospital and a move to residential care, or a very intense care package, as a result.

The most recent study on the costs of falling in the UK comes from 2003 (Scuffham et al, 2003<sup>14</sup>). Overall the data from the Scuffham study suggest that the average cost of a fall requiring A&E attendance was around £1500, which would be about **£2000** at today's prices.

### **Increased demand for health services - Risk of hospital admission**

Living in unsuitable housing has wider health consequences which can result in an admission to hospital. The estimated cost of one hospital admission is **£1739**.

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<sup>11</sup> <http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2010/FirstStop2010/Evaluation-Findings-2011-12/Local-Partner-Case-Studies-Report/view>

<sup>12</sup> [http://england.shelter.org.uk/\\_data/assets/pdf\\_file/0013/41440/factsheet\\_older\\_people\\_and\\_housing\\_may\\_2007.pdf](http://england.shelter.org.uk/_data/assets/pdf_file/0013/41440/factsheet_older_people_and_housing_may_2007.pdf)

<sup>13</sup> <http://www.cchpr.landecon.cam.ac.uk/Projects/Start-Year/2011/Cost-Benefit-Analysis-Lighting-Adaptations/Project-Report/Report>

<sup>14</sup> <http://jech.bmj.com/content/57/9/740.full>

Tian et al found that the total cost of inpatient hospital admissions to the NHS in England in 2009-10 was estimated at £20.5 billion, of which emergency admissions alone cost about £12.2 billion (60 per cent), based on Department of Health data from 2011 and NHS reference costs for 2009-10 (Tian et al, 2012<sup>15</sup>). Ambulatory care-sensitive conditions (ACSCs) are conditions for which effective management and treatment should prevent admission to hospital. The estimated cost to commissioners of emergency admissions in these circumstances is £1.42 billion, which accounts for 11.6 per cent of the total cost of all emergency admissions. This is equivalent to an average cost of £1,739 per ACSCs admission in England.

### **Increased demand for health services - Delayed hospital discharge**

One issue faced when older people are admitted to hospital is that they may not be able to be discharged as their home could potentially no longer be suitable for them to occupy, or because they have to wait for a space in alternate accommodation such as residential care. This can result in delayed discharge from hospital. The average cost of an excess bed day is £264 (Department of Health, 2012<sup>16</sup>). It is difficult to know how much additional time people would have spent in hospital waiting for suitable accommodation without assistance, but in 2009-10, the average length of stay among over 65s varied from approximately seven days to 11 days<sup>17</sup>. We assume here the people delayed from being discharged from hospital stayed the higher average of 11 days, a difference of four additional days at an estimated cost of **£1056**.

### **Increased need for social care - Move to residential care**

For some older people independent living would not have been possible without support and they would have had to move into residential care. The current cost of local authority residential care for older people is estimated as £53,352 per year (Curtis, PSSRU, 2013<sup>18</sup>, Pg 39). However, evidence suggests that about one third of people who enter care homes are self-funders. For those who rely on the local authority to meet their costs, this is an estimated average cost of **£35,568** a year.

### **Increased need for social care - Social care staff involvement**

Without support some people may have continued to live in their current home but would have needed more support from statutory services to enable them to do so. For example, they may have needed support from an adult social care social worker. The average cost of an hour of face to face contact with a social worker is estimated at **£226** (Curtis, PSSRU, Pg 198).

### **Increased need for social care - Social care support at home**

Without support some people may have continued to live in their current home but would have needed more intense support from statutory services to enable them to do so. For

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<sup>15</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf)

<sup>16</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213060/2011-12-reference-costs-publication.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213060/2011-12-reference-costs-publication.pdf)

<sup>17</sup> [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/older-people-and-emergency-bed-use-aug-2012.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf)

<sup>18</sup> <http://www.pssru.ac.uk/project-pages/unit-costs/2013/>

example, they may have needed more care at home. We do not have evidence from the local partners about the care at home received by their clients, whether before or after support was provided. They simply record whether there was likely, in their view, to have been an increase in the amount of social care at home provided if support had not been provided.

The average weekly cost of low cost local authority-organised home care is £141 for four hours a week which is £7332 a year (Curtis, PSSRU, 2013, Pg 126), assuming the cost is covered by the local authority. The median weekly cost of local authority-organised home care is £354 for ten hours a week which is £18,408 in a year (Ibid, Pg 127). If we assume that there is a shift from the low cost to the median average cost care package, this is an increase in cost of **£11,076** a year.

### **Reduction in wellbeing - Social isolation**

Loneliness caused by social isolation is associated with poor quality of life, impaired health, and increased mortality among older individuals. Because of the greater use of health services amongst people suffering from loneliness, one study estimated the costs to the state at about **£780** per person (Kaisu et al, 2009<sup>19</sup>).

### **Reduction in wellbeing - Anxiety/depression**

Without support many people would have experienced anxiety and depression. Although people do not always seek help with anxiety and depression, for those that do the cost was estimated at £2085 in 2007 for people in treatment or where their condition was recognised (McCrone et al, 2008<sup>20</sup>, Pg 22), which is £2538 today. This research estimated that 35 per cent of those with depression are not in contact with services (Page xix). We do not know if the FirstStop clients were in contact with such services so we will assume the same proportion as the national average were and use this as the cost in the analysis. If 65 per cent of people were in contact with services and therefore incurring a cost, the cost is estimated at **£1650**.

### **Financial impact – Debt**

Only about half of all people with debt problems seek advice, and without intervention almost two-thirds of people with unmanageable debt problems will still face such problems 12 months later. Research has demonstrated a link between debt and mental health. However, because anxiety and depression are a separate category, no additional cost has been included for the impact of debt on service use.

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<sup>19</sup> <http://biomedgerontology.oxfordjournals.org/content/64A/7/792.full.pdf>

<sup>20</sup> [http://www.kingsfund.org.uk/sites/files/kf/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf)

## Example

This example shows how the cost information can be used to explore the costs and potential savings of individual case studies.

Mr D is 89 and owns his own home. After a period of illness he was admitted to hospital. When he was ready to be discharged he was unable to go home as he could no longer manage the stairs to either access the house or get upstairs to the bathroom. He was admitted to a local residential home but was very unhappy and resented being placed with people with dementia and Alzheimer's when he is very sharp and alert. Mr D wanted to return home and remain independent. With support from his daughter he talked to a FirstStop caseworker.

The FirstStop caseworker discussed his options. The case worker liaised with the local authority and advocated on his behalf for him to be placed on the critical list for home adaptations. A stair lift and walk in shower were installed at his home. She also arranged for a benefits check which identified that he qualified for a higher rate of Attendance Allowance.

Mr D was very happy that he was able to return home. He does not need visits from a carer as he can use the stair lift and walk in shower. He said that he is much happier now that he is home. Mr D said that the additional income makes a difference and that he would have struggled without it. He has been able to save and purchase a new bed which he finds much more comfortable.

"The money makes a difference. I would have struggled without it. It has been a big help....I am much happier now that I am home".

A major home adaptation such as this costs the local authority an average of £6000. However, if Mr D had remained in local authority residential accommodation, this would have cost the local authority an average of £53,352 per year.

## 9) Overall average costs of different outcomes

Using the estimated costs of different client outcomes outlined above, it is possible to calculate an estimate of the total cost of the interventions by the local partners. The caseworkers recorded the outcomes for each client and these were collated to make totals across all of the 15 projects.

For example, the data suggest that for people who received L3 support from the projects in one year, there will be 223 major adaptations at an average cost to the local authority of £6000 per adaptation, a total cost of £1,336,000 across all 15 projects, as shown in Appendix 4.

The total estimated cost for all actual outcomes in one year is just over £4 million. This is an average of just under £280,000 per local partner.

The caseworkers also recorded the likely alternative outcomes for each client if they had not been supported. The costs of these alternative outcomes were also estimated for all 15 partners in one year.

For example, it was estimated that 260 people would have been at risk of a fall. These falls could have cost £580,060, as shown in Appendix 3.

The total estimated cost for all likely alternative outcomes in one year is just over £7.5 million. This is an average of just over £500,000 per local partner.

The difference between the estimated cost of the alternative outcomes if no support had been received and the estimated cost of the actual client outcomes with intervention by the caseworkers represents a saving to public budgets. In this case it is estimated at an average saving of around £220,000 per partner.

The average FirstStop funding received by each partner for 12 months was £31,600. Minus this funding, the average estimated saving to public budgets for each partner is around just under £200,000 in a year.

This figure may sound relatively high compared to other types of support, but in part reflects the vulnerable nature of the client group with a high level of complex needs and the types of outcomes e.g. moved to specialist housing with support rather than to a residential home.

## 11) Summary

The research has in previous phases of the evaluation explored how the local projects have empowered older people to make informed decisions, have given them full knowledge of all the options available and have supported them in appraising these options effectively. The casework service has received positive feedback from clients and a range of positive outcomes have been achieved, including continued independent living, higher incomes, reduced isolation, access to housing equity and a better quality of life. Without the support, people would have struggled on and endured a lower quality of life and wellbeing, and many of the people who were level 3 cases would have experienced health problems, hospital discharge or entry into residential care, therefore resulting in a higher cost to the public purse. This research shows that with support from caseworkers, clients had outputs that resulted in costs to the public purse e.g. local authority funded home adaptations, but that on balance these costs are lower than the potential costs to the public purse if no support had been received e.g. more care at home required or entry into residential care.

The evaluation has evidence to demonstrate the impact of the FirstStop local services that is both qualitative and quantitative. This can be used by the partners in their own local contexts. Whilst there are limitations to the approach, there is both evidence of positive outcomes for individuals and evidence of cost savings to public budgets, mainly to health and social care budgets.

## 12) Contacts

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## Appendix 1: Interview schedule for case workers

1. Your role and duties?
2. Time in post?
3. Training?
4. Purpose of project?
5. What is going well?
6. What is more challenging?
7. How have you used the national FirstStop resources in your work?
8. Have you referred people to the national FirstStop resources (phone line/web site)?  
Any feedback on this?
9. How are cases referred to you?
10. Has national FirstStop referred any cases to you?
11. Additionality – was this something the organisation was doing anyway?
12. What is the nature of the case work?
  - a. Client group
  - b. Their problems
  - c. Common solutions/outcomes.
13. Time spent on cases? Time spent on other tasks?
14. How do you record and monitor case work?
15. Case numbers?
16. What would have happened to these people without the project?
17. What difference would it have made to your work without FirstStop? Would you have done the same cases/given the same advice?
18. When the FirstStop funding ends what do you think will happen to the project?
19. Will any of the work continue? If so, what and why? And if not, what and why?
20. What has been the response to the profile raising work, of both FirstStop specifically and of housing options for older people generally?

## Questions about the monitoring data for the VFM analysis:

Helped to stay put:

1. Repairs Home safety/security - type, cost and who pays?
2. Heating/staying warm - type, cost and who pays?
3. Major adaptations – type, cost and who pays?
4. Minor adaptations – type, cost and who pays?
5. Assistive technology – type, cost and who pays?

Moved:

6. Downsize? Size?
7. Relocation costs and who pays?

Helped to move into - type/tenure:

8. Specialist housing - social housing – usually sheltered and who pays?
9. Specialist housing - private sector – extra care/adapted and who pays?
10. General needs - social housing - who pays? Housing benefit?
11. General needs - private rented - who pays? Housing benefit?
12. Care home – who pays?

Improved financial situation:

13. Increased income – amount, benefits check?
14. Enabled to access home equity – downsize or equity release product?
15. Money management – savings?
16. Charitable grant received – amount?
17. Debts – usual amount of debt?

## Appendix 2: Level 3 monitoring return

### A General information

**NB** Other than for Q2 & Q10, all responses relate to the older person about whom the enquiry is being made or, if a couple, the person considered to be most in need of the housing and care options advice service

1 Date of initial contact/enquiry

2 Enquirer

- Older person
- Family member/friend/other informal advocate
- Social care/housing professional
- Health care professional
- Vol sector agency

3 Age

- 50-64
- 65-74
- 75-84
- 85 <

4 Gender

- Male/female

5 Ethnicity

- White
- Mixed/multiple ethnic group
- Asian/Asian British
- Black/African/ Caribbean/Black British
- Other ethnic group
- Information not provided

6 Tenure

- Owner
- Social rented
- Private rented
- Other

7 Accommodation type

- General housing
- Specialist housing for older people (\*see note )
- Care home
- Other (eg living with family; almshouse etc)

8 Long-term health condition/disability

- Yes/No

9 Household type

- single person
- couple
- other

## 10 How did you find out about the Housing & Care Options Advice Service?

- general publicity
- housing/social care professional
- health professional
- other vol sector agency
- FirstStop national advice service
- Other

\* **Note:** Specialist housing for older people includes sheltered, extra care, retirement schemes etc but not residential care homes)

### **B Reason for enquiry (same as for Level 2)**

- Problem perceived with current accommodation – eg repairs, heating, home safety/security
- Increased disability &/or difficulty in access (eg using the bathroom, toilet or kitchen, managing the stairs) / need for adaptations
- Risk of being made homeless
- Want to move
- Concern about housing-related health or social care issue – eg discharge from hospital, stroke, fall, depression/mental ill health
- Need help managing at home
- Concerns about housing-related money issues eg housing benefit, housing-related debt, mortgage)
- Loneliness & isolation
- Seeking practical help - eg gardening, shopping
- Other

### **Ci) Outcome (what has been achieved for/by the older person as a result of casework)**

#### **1 Helped to stay put**

- Repairs/home safety/security
- Improvements to heating/ability to keep warm
- Major adaptations >£1,000 – bath/shower/wc
- Minor adaptations <£1,000 – equipment/grab rails/improving access to and within the home
- Assistive technology

#### **2 Helped to avoid being made homeless**

- Retained existing accommodation

#### **3a Helped to move - identify primary reason**

- Down-size (accommodation too large/no longer meets needs)
- Relocate (e.g. to be near family/friends)
- Specialist housing for older people (better meets housing needs) \*see note
- Care home (no longer able to live independently)
- Other (including as a result of risk of being made homeless)

#### **3b Helped to move – type/tenure**

- Specialist housing for older people - social housing \*see note
  - Specialist housing for older people - private sector \*see note
  - General needs - owner
  - General needs - social housing
  - General needs - private rented sector
  - Care home
  - Other
- 4     **Improved health**
- Reduced risk of falls
  - Reduced risk of hospitalisation
  - Speedier/better managed hospital discharge
  - Better able to manage long-term health condition
- 5     **Improved wellbeing**
- Reduced social isolation (e.g. befriending scheme/ regular telephone contact)
  - Increase in social engagement/activities
  - Reduced anxiety
  - Practical help arranged (e.g.gardening, shopping)
  - Other – narrative box
- 6     **Improved financial situation**
- Increased income – welfare benefits
  - Enabled to access home equity (equity release product or downsizing)
  - Better able to manage money/reduction of or reduced risk of debt
  - Charitable grant received (e.g. to meet costs such as furniture, white goods, heating)

\* **Note:** Specialist housing for older people includes sheltered, extra care, retirement schemes etc but not residential care homes)

**Cii) Alternative outcome (what might have been the outcome for the older person without the intervention)**

- 1     **Continue to live in unsuitable accommodation**
- too large/costly to maintain/expensive to heat
  - increasing difficulty with access to the property and in using amenities within the property
  - lack of safety/continued insecurity
- 2     **Enforced move from current accommodation**
- as a result of being made homeless (eg rent/mortgage arrears/other)
  - as a result of disrepair/insecurity
  - as a result of lack of accessibility/adaptation
- 3     **Increased demand for health services**
- Risk of fall(s)
  - Risk of hospital admission
  - Delayed hospital discharge
  - Exacerbation of long-term health condition
- 4     **Increased need for social care**
- Move to residential care

- Ongoing need for professional social care involvement (e.g. Occupational Therapist)
- Provision of/ increase in social care support at home

**5 Reduction in wellbeing**

- Social isolation/loneliness
- Anxiety/depression
- Loss of independence/increase in dependency

**6 Financial impact**

- Failure to maximise income
- Risk of/continuation of debt

**Ciii) Case closed**

Provide date

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## Appendix 4

### Actual outcomes estimated for 12 months for all partners with estimated total costs

	Outcome	Number of outcomes 9 months	Estimated number of outcomes 12 months	Estimated cost of outcome (£)	Cost by number of outcomes (£)
<b>Helped to stay put</b>	1. Repairs Home safety/security	207	276	100	27600
	2. Heating/staying warm	54	72	1000	72000
<b>Helped to stay put - Adaptations/Equipment</b>	1. Major adaptations	167	223	6000	1336000
	2. Minor adaptations	97	129	95	12286.66667
	3. Assistive technology	42	56	792	44352
<b>Helped to avoid being made homeless</b>	1. Prevented	84	112		
<b>Helped to move - identify primary reason</b>	1. Down-size	60	80		
	2. Relocation	89	119		
	3. Specialist housing	95	127		
	4. Care Home	18	24		
	5. Other	47	63		
<b>Helped to move into - type/tenure</b>	1. Specialist housing - social housing	130	173	7923	1373320
	2. Specialist housing - private sector	22	29	0	
	3. General needs - owner	26	35	0	
	4. General needs - social housing	42	56	4040	226240
	5. General needs - private rented	15	20		
	6. Care home	18	24	35568	853632
	7. Other	14	19		
<b>Improved health</b>	1. Reduced risk of falls	250	333		
	2. Reduced risk of hospitalisation	107	143		
	3. Hospital discharge	34	45		

	4. Long-term health condition(s)	126	168		
<b>Improved wellbeing</b>	1. Reduced social isolation	46	61		
	2. Increase in social engagement	28	37		
	3. Reduced anxiety	239	319		
	4. Independence enhanced	328	437		
	5. Other	26	35		
<b>Improved financial situation</b>	1. Increased income	77	103	2045	209953.3333
	2. Enabled to access home equity	19	25		
	3. Money management	69	92		
	4. Charitable grant received	51	68		
<b>Other</b>	other	115	153		
<b>Total estimated cost of actual outcomes</b>					<b>£4155384</b>

## Appendix 5

### Alternative outcomes estimated for 12 months for all partners with estimated total costs

	Outcome	Number of outcomes 9 months	Estimated number of outcomes 12 months	Estimated cost of outcome (£)	Cost by number of outcomes (£)
<b>Continued to live in unsuitable accommodation</b>	1. Repairs and heating	93	124		
	2. Access and amenities	151	201		
	3. Safety and insecurity	190	253		
<b>Enforced move from current accommodation</b>	1. Homelessness	84	112	0	0
	2. Disrepair/insecurity	43	57		
	3. Accessibility/adaptation	152	203		
<b>Increased demand for health services</b>	1. Risk of fall(s)	195	260	2231	580060
	2. Risk of hospital admission	188	251	1739	435909.3333
	3. Delayed hospital discharge	34	45	1056	47872
	4. Long-term health condition	123	164		
<b>Increased need for social care</b>	1. Move to residential care	85	113	35568	4031040
	2. Social care staff involvement	107	143	226	32242.66667
	3. Social care support at home	131	175	11076	1934608
<b>Reduction in wellbeing</b>	1. Social isolation	56	75	780	58240
	2. Anxiety/depression	214	285	1650	470800
	3. Dependency	128	171		
<b>Financial impact</b>	1. Continued low income	71	95		
	2. Debt	114	152		0
<b>Total estimated cost of potential alternative outcomes</b>					<b>£7590772</b>

