Housing Options for Older People service. (HOOP)

An Evaluation of First Stop Manchester.

"Where will I live when I'm older?"

May 2015 – April 2016.

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SUMMARY

As the UK continues to see an ageing population where appropriate housing solutions are scarce and high quality advice and information about these is limited, Manchester Move and Northwards Housing are pleased to present this report about the work that has taken place in North Manchester over the 18 months from April 2015 – September 2016.

The Manchester Move relationship with First Stop began in early 2015 as the service was beginning to look at how it could provide better quality advice and information to older people. Through work with the Housing for an Age Friendly Manchester Board and funding via the Housing Revenue Account and the North Manchester Clinical Commissioning Group the first Housing and Care Options advisor post was established in North Manchester in April 2015. The service has been funded by the North Manchester CCG since April 2016.

Over the first 18 months savings to health and social care services have been conservatively estimated to be in **the region of £1m** for a £60k investment. At this high level **for every £1 that is invested, a minimum of £16 has been saved.** 382 people have received bespoke housing options advice and 97 people have moved into a home that better meets their health and care needs so they can continue to age well and live independently. Many people now have less need to use these services as they feel more confident in their home environment and less isolated in a home that was not meeting their needs in later life.

The service has worked with people aged from 50 – 95 and has taken referrals from a wide range of health and social care professionals. Both the individual people and the professionals have valued having a service that can provide the missing link – good quality and practical housing advice (whether to move or stay put) alongside looking at care needs and signposting to financial advice where necessary.

The partnership with First Stop is crucial if the service is to continue to meets these needs. Their comprehensive website and telephone/live chat service can provide advice that people need to start to think about their choices in later life and the locally based Housing and Care Options Advisor has changed the lives of many people over the past 12 months as the case studies at the end of this report show.

It is very hard to quantify either in words or savings the wider benefits that the service brings to professionals and their patients. Some of the case studies try to go some way towards showing in practise the difference that can be made. More information about the First Stop Service is available at their website www.firststopcareadvice.org.uk and more information about the local service in Manchester can be gained by contacting Anne Duffield, Head of Housing Access at Northwards Housing on anne.duffield@northwardshousing.co.uk.

1. INTRODUCTION

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. The national service 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*".

This work fits well into the strategic direction that Manchester has outlined within "Living Longer, Living Better". This is to ensure that people can get timely information and advice on their housing and care options to stop inappropriate care home admissions and to make the best use of Extra Care and other housing options. For some this will be about remaining independent within their own home.

Undertaking this work in partnership with First Stop gives access to an experienced team and an established service and increases the capacity of the service that can be delivered locally within the City.

While we have also developed the on-line HOOP tool and a booklet regarding Extra Care in Manchester this paper very much concentrates on the referrals that we have received into the service since it has begun.

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.
The North Manchester model works slightly differently to the national model as we are focussed very much on referrals from health professionals who are working with complex cases. Where a service sits in an Age UK or a Care and Repair there is much more of a focus on self-referral. Our model therefore may deal with less people but is probably dealing with more complex cases; with an ability to make considerable savings to the public purse.

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. This also includes work with health, social care and other professionals to raise awareness of the service and to encourage appropriate referrals.

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 OF THE SERVICE.

To enable the service to be evaluated the Elderly Accommodation Council (who run First Stop) have set out a number of useful outcomes – These outcomes are:

1Older 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.

4. VALUE FOR MONEY

The cost for the advisor, including oncosts and such things as mileage, phone etc was approx. £40k for an initial 12 months and £20k for the next 6 months.

This section will evaluate how time has been split between the 3 levels of case

On the previous evaluation work that First Stop carried out they assessed that the average case worker would spend 10% of their time on level 1 cases, 20% on level 2 and 70% on level 3. Over the last year our split has been slightly different:

8% on level 1
12% on level 2
80% on level 3

Over the first 12 months 923 cases were logged.

679 were level 1 cases.
79 were level 2 cases
165 were level 3 cases.

This gives an average cost per case as follows:

Level	Number	Cost per case	Budget (pro rata)
1	761	£4.20	£3,200
2	68	£70.58	£4,800
3	187	£171.12	£30,000

When comparing these figures with those of the other First Stop services around the country our model shows that we are dealing with more level 3 cases than most other services. (The average for other services is 122). These do take up more time and therefore we have adjusted the costings above. However, we also look at overall cost savings at the end of this report

In the first 6 months of 2016/17 there has been a much higher concentration on looking at level 3 cases where there has been complex needs and more difficult cases to resolve. There has been very little time spent on level 1 cases as much of the work is now generating itself through direct referrals from health and social care professionals or from people who contact the service directly (or via a family member) after being told about the service in the past.

Our split of time spent on each level of work has also changed slightly now the service is established and it is estimated that time has been split in the following way:

5% on level 1
10% on level 2
85% on level 3

Over the 6 months from April to September 364 cases were logged.

237 were level 1 cases.
22 were level 2 cases.
105 were level 3 cases.

Level	*Number*	*Cost per case*	*Budget (pro rata)*
1	*237*	*£4.20*	*£1,000*
2	*22*	*£90.90*	*£2,000*
3	*105*	*£161.90*	*£17,000*

While the cost of a level 2 intervention has risen slightly, the cost of a level 3 has reduced as we deal with more cases at this level.

5. REFFERALS

The advisor has taken on 255 level 2 and 3 referrals over the first 12 month period. *A further 127 cases have been dealt with between April and September 2016.*

These can be broken down by tenure, referral route, main issue and outcome.

This data is as follows:

Referral from:

Referral agency	**Number (Y1)**	**% of cases**	**Number (Apr – Sept 16)**	**% of cases**
Social workers	58	23%	27	21%
Active Case Managers	51	20%	15	12%
Housing application	35	14%	1	1%
First Stop	24	9%	7	6%
PAT manager	19	7.5%	10	8%

Other professional	19	7.5%	26	20%
Self-referral/family referral	14	5.5%	23	18%
District Nurse	7	3%	1	1%
GP/ Practice Manager	7	3%	2	2%
Mental health team	6	2.5%	2	2%
CASS	5	2%	12	9%
Housing Connect	5	2%	0	0
Age UK/C&R	2	1%	0	0
Crisis team	0	0	1	1%
Total	**255**	**100%**	**127**	**100%**

By the end of the year referrals were being received from a wide range of health professionals (in part to the large amount of work that the advisor has done raising awareness of the service). A number of sessions have taken place at team meetings etc of health and social care professionals and these are refreshed when it is thought necessary. The referrals from Active Case Managers and social workers show that this awareness raising has worked and there is no doubt that for those professionals that use the service it can resolve issues and make a difference in the advice and information that a person is receiving at an earlier stage. This is borne out in case studies that are attached at the end of this report.

There are also some two way referrals happening with the national First Stop service and there is a good pathway for those applying for housing and already thinking of moving to be given extra advice and information to aid their decision making.

The same number of referrals are being made to the service as Year 1, albeit from slightly different routes. The self-referral route has increased however this is often after a person has picked up a leaflet or been told about the service by a professional, but then contacted the advisor themselves. The vast majority of these cases it is then discovered are known to at least one service. There is also an increase from CASS teams and other professionals. We will continue to promote the service with Active Case Managers and PAT teams where there have been slightly less referrals from in this period.

Tenure:

Tenure	Number (Y1)	% of cases	Number (April – Sept)	% of cases
Council tenant (HRA)	77	28%	44	35%
HA tenant	64	25%	24	19%
Home owners	64	25%	27	21%
Private rented	28	11%	20	16%
Living with family/friends	6	2.5%	7	6%
Hospital discharge	5	2%	1	1%
B&B	2	1%	0	0
Supported housing	2	1%	1	1%
Shared Ownership	2	1%	0	0
Homeless	4	1.5%	2	2%
Residential Care	1	0.5%	0	0
Total	**255**	**100%**	**127**	**100%**

53% of cases are from council and HA tenants. There has been an increase in referrals from home owners and people living in the private rented sector over the past 6 months which was one of the targets that was set at the 5 month evaluation stage.

It's good to see a number of referrals for older home owners; however it can be difficult to meet some of their needs and aspirations around either purchasing another property or renting from Northwards or a HA. Often as well, people wish to remain in their own homes for as long as possible and at this stage may just be starting to think about the future and not be necessarily looking to move at this stage.

The service is seeing approximately the same amount of social tenants but a healthy increase in referrals for private tenants and lodgers. Many of these people will be living in unsuitable conditions to meet and manage their health needs and therefore this will be critical advice and assistance to help them look at more suitable housing options as they get older.

This report will also look at the tenure of those people that have moved over the past year after involvement with this service.

Main issues:

Main Issue	Number (Y1)	% of cases	Number (April – Sept 16)	% of cases
Heath issues – needs more suitable accommodation	134	52.5%	80	63%
Planning for the future	77	30%	15	12%
Move closer to family	24	9.5%	18	14%
Safeguarding/homelessness	8	3.1%	5	4%
Hospital discharge	5	2%	4	3%
Advocacy needs	2	1%	0	1%
Family breakdown	3	1%	1	1%
Carer breakdown	1	0.5%	0	0
Issues with Private landlord	1	0.5%	4	3%
Total:	**255**	**100%**	**127**	**100%**

There are a wide range of issues and concerns that people wish to talk about – although for the vast majority it is health issues that has led them to seek advice about housing and/or care options.

The two main issues/concerns are unsurprising – those needing more suitable accommodation and others just thinking about planning for future.

A number of cases could have fallen into more than one category and many are complex with dementia and capacity issues playing an ever larger part in many cases. However we have tried to use the main issue of using the service for this monitoring.

Advice could be in the form of many different things and includes such things as:

- Repairs/disrepair
- Housing options
- Local activities
- Visits to retirement/EC schemes
- Money advice referral

- Monitoring/pendant services (Care Call).

The casework service is dealing with more cases where advice is needed quickly (be that to move or stay put) and less cases where someone is looking to plan for the future. It is hoped that for those that need general advice they are able to look at the First Stop website or use the telephone service and we continue to promote that as often as possible.

There is a slight increase in dealing with hospital discharge cases and the service can play an important role here in helping to look at options where someone cannot go home or is in a transitional/intermediate bed. There have been some good successes here in ensuring that a sustainable longer term solution is found.

Outcomes:

Outcome	Number (Y1)	% of cases	Number (Apr-sept 16)	% of cases
Advice given	112	44%	66	52%
Moved home	64	25%	33	26%
On offer for a new home	3	1%	11	9%
Staying put	57	22%	8	6%
Deceased	7	3%	0	0
In respite	1	0.5%	0	0
Referred back to Adults (re residential Care)	3	1%	0	0
Still open	8	3%	9	7%
Total	**255**	**100%**	**127**	**100%**

The table above shows the different outcomes at the end of the year. A large number have an outcome around “advice given”. This is primarily due to a case being closed if no other interaction at this stage is due. Many of these may return to the service in the future.

25% of cases have resulted in a move to a new home. However part of this service is also about ensuring that people are well paced for moving in the future should they wish to do so and therefore the work around giving options advice and Extra Care referrals is also important to ensure this accommodation is used appropriately going

forward. A total of 64 people moved home to improve their circumstances or their health.

Approximately the same amount of people have moved home in this 6 month period and a greater number have been made an offer where an outcome was awaited at the end of this period. Any further moves will be included in a full year 2 evaluation.

Destinations for Movers:

Property type/tenure	Number (Y1)	% of movers	Numbers (April – Sept)	% of cases
Extra Care Housing	11	17%	4	12%
Sheltered/Retirement Housing	28	44%	12	36%
Age restricted general needs	12	19%	10	30%
Adapted general needs	1	1.5%	0	0
Bungalow – HA/ALMO	4	6%	0	0
Bungalow - purchased	1	1.5%	0	0
Private rented	3	5%	1	3%
Supported	1	1.5%	0	0
Residential Care	3	5%	3	9%
Temporary Accommodation	0	0	1	6%
Moved in with family	0	0	2	3%
Total	64	100%	33	100%

Previous tenure of movers:

Previous Tenure	Number (Y1)	% of movers	Number (April – Sept)	% of cases
Social Tenant	35	55%	16	48%
Home Owner	12	19%	5	15%
Private rented	7	11%	7	21%
Lodger	2	3%	2	6%
Hospital	4	6%	0	0
B&B/Homeless	2	1%	2	6%
Supported Housing	1	1%	0	0
Shared owner	1	1%	0	0
Hospital	0	0	1	3%
Total	64	100%	33	100%

Of the 64 people that have moved, 35 were current social tenants (RP and council). This service has brought in 29 new social tenants from other unsuitable housing to meet their current health needs. This will hopefully also mean that they may now have a lesser need for other health services and a case study attached to this report gives an example of this.

As Sheltered/Retirement Housing can be more difficult to let, this new source of tenants is also helpful to the ALMO/HAs as otherwise there may be also greater rent loss on some of these properties.

This 6 month period has brought in a slightly higher percentage of new tenants to the social sector from other tenures bringing that extra security to people with an ongoing health or care issue. A number of offers are outstanding so it is expected that the service will move at least as many people as it did in Y1.

A move into the social sector is normally a 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 and the social landlord maintains it. This has been the case in the majority of moves carried out. The average age of a "mover" is 70.

Age:

The average age of clients in all cases was 70 in this time period with a range of 50 – 95. The breakdown has been as follows:

Age	Number (Y1)	% of cases	Number (Apr – Sept)	% of cases
50's	51	21%	28	23%
60's	59	25%	26	22%
70's	58	24%	28	23%
80's	62	26%	37	31%
90's	8	3.5%	1	1%
Total	238	100%	120	100%

It is encouraging to see people in their 50's and 60's seeking advice about their housing options.

The average age of client for this period was 71 with that being driven by more people in their 80's using the service.

Isolation:

It is estimated that approximately half of cases to date have had some element of isolation for the older person. All of these are single people where they may have

lost a partner, have limited contact with others and/or have a health condition that makes leaving their home difficult.

From the cases that have moved house, it was believed that 37 from the 64 (58%) were feeling some level of isolation.

For this period it was believed that 13 from the 33 (40%) were feeling some level of isolation.

Cases also dealt with in Year 1

20 of the 127 cases that the advisor worked with in this 6 month period had been previous cases from Year 1 that had closed. This is around 15%. It is not unusual for a person to get some initial advice and then return to use the service when they have had more time to think about their housing options.

6. COSTS AND SAVINGS TO THE PUBLIC PURSE

Savings to public budgets may be realised is different ways. For example, some of the vulnerable older people using the casework services had a history of 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 and the speeding up of discharge also has potentially significant savings to health budgets. Some of the older people using this service had a history of 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 significantly reduce the risk of a hospital admission.

Preventing premature moves to residential care has the potential to generate savings for local authority social care budgets. This service has been able to undertake a number of referrals to Extra Care Housing and to enable others to move to retirement housing schemes. It is hoped that this work will enable people to live in their own home for longer and not have a need for residential care in the near future.

There are a number of challenges in analysing the costs and benefits of services such as the HOOP. One is the relatively short time frame of the service to date. It can be hard to identify savings as ‘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 to do here.

However, a further 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 advisor.

The following data is taken from the First Stop research that was conducted in 2014. It shows costs of being helped to stay put or move and it also shows estimated costs if an intervention has not taken place – although as said earlier, it is difficult to prove a cause and effect.

At this stage we have tried to put a public purse saving onto this work using the information from the First Stop evaluation that was published in Nov 2014. These are very conservative estimates. However some of the information in the case studies attached at Appendix 1 give some evidence of benefits to individuals from using the service. We have only looked at savings around those people that have moved. There will also be potential savings based around those that have received advice and information, however for the purposes of this report we have concentrated on those that have moved home.

We have only tried to quantity savings for some things within this report. We don't know if people are now visiting their GP less often once they have moved to more suitable accommodation for instance which would generate other savings.

At Appendix 1 we have included 5 short case studies from the cases that have been referred to date to give an idea of the type of work involved.

POTENTIAL SAVINGS

A) Delay going into Residential Care

The service has assisted 39 people to move into Extra Care or Sheltered/Retirement Housing. If this move has enabled all of these people to delay a move to residential care for 12 months then the saving would be **£1,078,155** a year to the public purse. This is calculated by deducting the cost of Sheltered/Retirement housing from the cost of residential care (see below).

Y2 update – The service has assisted 16 people to move into Extra Care or Sheltered/Retirement Housing. If this move has enabled all of these people to delay a move to residential care for 12 months then the saving would be £442,320 a year to the public purse. This is calculated by deducting the cost of Sheltered/Retirement housing from the cost of residential care (see below).

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, 201318, 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.

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/Retirement housing over one year is **£7923** (Curtis, PSSRU, 20107, Pg 56), this includes the capital and revenue costs but not household expenditure on personal living expenses.

B) Wellbeing

We have recorded that 37 people (58%) of those that moved were affected by isolation. If we calculate the saving that the move for these people has made then we would calculate a saving around social isolation of **£28,860** a year and for anxiety/depression of **£68,640**. (The 2nd figure here uses the 65% model from the example below).

Y2 update: We have recorded that 13 people (40%) of those that moved were affected by isolation. If we calculate the saving that the move for these people has made then we would calculate a saving around social isolation of £10,140 a year and for anxiety/depression of £35,392. (The 2nd figure here uses the 65% model from the example below).

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, 200919).

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, 200820, 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.**

C) Hospital Discharge

The service has helped 4 people move from hospital to their own home and therefore using these figures we would be looking at a saving of **£4,224.**

Y2 update: The service has helped 4 people move from hospital to their own home and therefore using these figures we would be looking at a saving of £1056.

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, 201216). 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 days17. 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 £1056.00.

D) Moving into a General needs tenancy in social housing.

The service has helped 17 people move into better suited general needs accommodation in the social sector. Using the calculations below this is an estimated to **cost the public purse £68,816 a year**. However if half of those people that have moved now need less health or social care intervention then it is also possible that an overall saving can be made due to improvements in their circumstances or overall general health or feelings of isolation.

Y2 update - The service has helped 10 people move into better suited general needs accommodation in the social sector. Using the calculations below this is an estimated to cost the public purse £40,480 a year. However if half of those people that have moved now need less health or social care intervention then it is also possible that an overall saving can be made due to improvements in their circumstances or overall general health or feelings of isolation.

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 Dataset8 (2012) and assumes receipt of housing benefit, based on the interview findings.

E) The benefits of accommodation that meet health needs

From the 64 people that the service has helped to move we could assume the following:

10% may suffer a fall in their old home – COST = **£14,000k**

10% may have an avoidable hospital admission – COST = **£11,300**

30% may have needed more ongoing Adult or Health Service involvement via a social worker (60% of those that moved were referred to the service by a health or social care professional). If we calculate that 20 people are now having 1 hour less a week of social work involvement this would save **£57,200** a year.

10% of people will now not need to move from a low to median care package – COST Saving = **£66,456.**

Y2 update: From the 33 people that the service has helped to move we could assume the following:

10% may suffer a fall in their old home – COST = £6,600k

10% may have an avoidable hospital admission – COST = £5,738.00

30% may have needed more ongoing Adult or Health Service involvement via a social worker (84% of those that moved were referred to the service by a health or social care professional). If we calculate that for these 20 people they are now having 1 hour less a week of social work involvement this would save £28,600 a year.

10% of people will now not need to move from a low to median care package – COST Saving = £36,550.

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, 201113). 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 person 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, 200314). 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**.

Tian et al found that the total cost of in-patient 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, 201215). 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 need for social care - Social care staff involvement
Without housing related 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 **£55** (Curtis, PSSRU, Pg 198). ***figure here was much higher in an earlier version and £226 is the figure quoted in the reference report. We feel this is much too high so have reverted to a figure from a later report.*

Increased need for social care - Social care support at home
Without housing related 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 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 housing related 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.

SAVINGS TOTAL

It is clearer to show these savings in the following table:

Saving from:	**Year 1**	**April – Sept 2016**	**Total**
Less Residential care	£539,077	£221,160	£760,237
Social isolation	£28,860	£10,140	£39,000
Anxiety and depression	£68,640	£35,392	£104,032
Hospital discharge	£4,224	£1,056	£5,280
Less falls	£14,000	£6,600	£20,600
Avoidable hospital admissions	£11,300	£5,738	£17,038
Social/health worker involvement	£57,200	£28,600	£85,800
Care packages	£66,456	£35,500	£101,956
Total	**£789,757**	**£344,186**	**£1,133,943**
Outgoings:			
General needs tenancies	£68,816	£40,480	£109,296
Cost of advisor	£40,000	£20,000	£60,000
Total Savings	**£680,941**	**£283,706**	**£964,647**

The average cost per case (which was also outlined at the beginning of this report) is as follows:

Level	Number	Cost per case	Budget (pro rata)
1	761	£4.20	£3,200
2	68	£70.58	£4,800
3	187	£171.12	£30,000

All the cases that have moved are level 3 cases and the cost of these 64 cases on a per case basis was just £10,951.68 bringing solid value for money. **For every £1 spent, £62.00 is saved.**

This report does not look at the potential savings that the advice given to a further 191 people may also bring in the future. This group of people, many who are planning for their housing needs in years to come, will also bring savings as they make informed choices in the years ahead.

Year 2 update: The average cost per case (which was also outlined at the beginning of this report) is as follows:

Level	***Number***	***Cost per case***	***Budget (pro rata)***
1	***237***	***£4.20***	***£1,000***
2	***22***	***£90.90***	***£2,000***
3	***105***	***£161.90***	***£17,000***

All the cases that have moved are level 3 cases and the cost of these 33 cases on a per case basis was just £5,342.70 bringing solid value for money. **For every £1 spent, £53.00 is saved.**

*References above:

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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

All the above references are taken from a report from the Cambridge Centre for Housing and Planning Research - **FirstStop local partners: costs and potential savings to public budgets of client casework 2014** - **November 2014**

http://www.housingcare.org/downloads/kbase/3363.pdf

A new report has also been released on the 8th June 2016 by the APPG on Housing and Care for older people: Housing our ageing population: positive ideas

http://www.insidehousing.co.uk/journals/2016/06/07/o/x/p/HAPPI3.pdf

In this one of the recommendations from the enquiry Chair, Lord best is for Government to increase its support for housing and information services – like the First Stop Advice service – so older people can better exercise their housing choices and make informed decisions about the options available to them in retirement.

APPENDIX 1

This section has 5 case studies bringing to life just a small number of the people that have used and benefited from the service in the past year.

First Stop Manchester Case Study 1

E is 60 years old and lived in his home which he rented from a social housing landlord for over 10 years. He worked at a local hospital until he gave up his job to become a carer for his elderly mother, who lived in her own home close by. In 2015, E's mother passed away. Overnight he felt he lost his support network-his mother and the health professional care team who cared for her daily. This had a huge detrimental effect.

E became ill mentally and physically. While his physical ailments were treated successfully, his mental health declined. E suffered severe anxiety attacks calling the emergency services at all hours of the day. One day a total of 60 calls made by E were recorded. Outpatient interventions were not successful in reducing E's anxiety or reducing his calls to emergency services, so in July 2015 ER moved into residential care on a respite basis. This move was to reduce the cost to public services incurred by these calls and also to help E overcome his anxiety attacks.

Adult Services at MCC contacted First Stop Manchester in October 2015 to ask for help to rehouse E back into the community. It was clear when you visited E at the residential home he was not suitably housed. Our initial point of contact was E's social worker. We discussed all information available from health professionals and case management meetings. There were divided opinions as whether a move into the community would be successful for E. We met with E and staff from the residential home where he was staying and decided that a trial stay in extra care living scheme should be arranged. At first E was apprehensive, he said himself he didn't know how he would react staying on his own even for a few hours. We arranged short escorted visits to all 3 extra care schemes (care teams on site in event of emergency 24/7) in North Manchester, E started to show enthusiasm for the first time. He was very involved in getting his rehousing application in place.

The trial stay was cancelled once due to E not being well, but when it did go ahead for 3 nights E enjoyed his stay. A minimal care package was put in place, and ER did not press his alarm buzzer for attention at all. Northwards Housing was able to offer E a property soon after the trial stay.

E accepted the offer at first, but declined at point of sign up. He did not have anxiety about his health resulting in contacting the emergency services anymore, but he was now anxious about taking on his own tenancy. To help E overcome this, we liaised with Adults Services for E to move into the respite flat in the scheme for a four week period. At the end of this period we liaised with Allocations Panel for extra care living

in North Manchester for E to be made an offer that would allow him to move straight over from respite flat into his own tenancy.

First Stop Manchester liaised closely with E, his social worker and other agencies throughout the whole rehousing process. We advised Adult Services about benefit and rent issues that accrued when E moved into residential care, we arranged for these issues to be disregarded for the purpose of E's rehousing application.

E is now very happy in his new home, and volunteers occasionally helping out in the scheme café. We helped E buy cleaning materials and a hoover from our First Stop Manchester Fund and E keeps in contact regularly to let us know how is getting his new home together. The scheme managers say that E is well liked and very sociable around the scheme. The care team see E daily to prompt with medication only.

OUTCOME

E no longer lives in residential care. He has made new friends and is active in the scheme. His mental health is improving and there have been no issues with needing extra care by calling carers or the NHS due to him feeling anxious. It is very difficult to explain fully the huge difference this move has made to E and the savings for both health and social care.

First Stop Manchester Case Study 2

K was referred to North Manchester Crisis Team by the Ambulance Service. The service noticed they had responded to 7 calls over a 3 week period from the public concerned about K's welfare. K is an 83 year old lady who lived in bed and breakfast accommodation for over 10 years. K was the only female living there with approximately 15 males.

Due to deteriorating ill health and mobility, K often fell over when she went out. K has suffered from mental ill health for over 40 years, though her physical health has only declined over recent years. She struggles when climbing steps and standing for periods. When the ambulance service responded to calls about K falling, they assessed that K should go to Accident and Emergency on most occasions, but she refused, asking them to take her home instead. They referred to the Crisis Team (MCC) due to their concern both about K's failing health and their concern about her living environment and conditions.

Crisis Team contacted First Stop Manchester to ask for housing and care options and advice for K. We arranged a joint visit to meet with K at her home within a few days. K was eager to move home as she realised that she was vulnerable in her current home. We discussed all possible housing options including extra care living

and sheltered housing. K expressed an interest in moving to sheltered housing closer to where her son lived. She explained she tried to keep in touch with her son who suffers with ill health himself. K initially refused re-enablement care when the Crisis Team met her, but we discussed that re-enablement would be ideal for K to help her move into a new life in a sheltered scheme. K had not cooked a meal or prepared food since she moved into the bed and breakfast over 10 years previously; she had not used a bath or shower or done any housekeeping, laundry or chores. K eventually agreed to daily visits from the re-enablement team to help prepare her for the move and help improve her mobility.

We processed a Manchester Move rehousing application for K straight away and contacted her current landlord, with her permission, to ask for information to help make K's transition into sheltered housing as smooth as possible. The landlord was very helpful and agreed to forfeit any notice period for K when the time came for K to move. We learnt that K was a hoarder, so we asked for the re-enablement programme in place to approach clean-ups/throwing away multiples with care and importance. We kept in contact with K daily then when a flat became available in an area near where K's son lives we discussed this with her at length. The scheme manager at this scheme has a strong background of helping tenants with chaotic lifestyle histories settle in, so we was keen for K to visit the scheme to meet her.

K loved the scheme and the scheme manager when she visited. Crisis team leader and I took K to visit the scheme by taxi. Her mobility had declined further (she is now considering hip operations) and she was using a wheelchair. She asked me to bid for the flat on her behalf and she was successful. As K was in bed and bedroom accommodation she did not have any furniture of her own. I applied for an emergency grant for people leaving supported living and K was awarded a fridge, microwave, bed and bedding. FirstStop Manchester funded curtains, sourced a settee and bedroom furniture that another tenant no longer used. We also liaised with managers of the New Tenancy Team to negotiate with them to decorate and carpet the flat as K had no physical support to make the flat into her home.

The keys to the successful transition for K, to move from a chaotic lifestyle in bed and breakfast accommodation into a home of her own with support in sheltered accommodation, was communication and joint working between the services and K herself. Plans were made Manchester Equipment and Adaptations to assess for/provide aids around the new home to help with K's mobility issues, also for the re-enablement programme to continue for at least 4 weeks on a daily basis once K moved into her new home. At the end of the 4 week period, K was assessed for a care package and is now receiving daily calls once a day to ensure she is taking her medication and help to prepare one meal. K is still deciding whether to go ahead with hip replacement operations. She has an arrangement in place for a cleaner to come once a week, a shopper once a week and for laundry to be done. K says she is getting used to the shower and understands the importance of regular bathing now her mobility is limited. The scheme manager has arranged for a benefit check for K

to make sure she is claiming the correct benefits and assisted K to register with a local GP and health care centre. K joins her neighbours for weekly breakfast mornings and is starting to use the communal lounge slowly. She is happy in her new home, is taking responsibility to report repairs and arrange appointments, and she now sees her son on a regular basis.

OUTCOME

K is now settled in her new home. There have been calls to the ambulance service since she has moved and reablement has helped her to gain a better quality of life. She is participating in activities in the scheme where she lives.

First Stop Manchester Case Study 3

AN (age 94) was referred to FirstStop Manchester service by a social worker (SW) in response to a safeguarding query. AN lived for many years in a social rental flat on the floor below the home of one of her daughters who was her main care giver. Their relationship had broken down because AN had started to contact her daughter both day and night asking for help with personal care, housework and to prepare food and drinks. Her daughter said her relationship with her husband was suffering and she was at breaking point due to her mum's constant demands.

Adult Social Care arranged for an emergency care package to be implemented immediately. AN received four calls daily and was issued with an alarm pendant. AN has severe mobility issues and was very frightened and anxious between calls and without her daughter's attendance. AN's younger daughter who lives in another area did visit daily, but this was only possible on a short term basis.

The first HOOP visit was with AN at her home with her younger daughter. AN expressed how frightened she was in her own home at times without the security of knowing her daughter was just a call away upstairs. AN said she had started to forget things and felt she was getting confused, she said her GP had examined her and felt at this stage it was age related memory loss. Her sight was deteriorating and her hearing is very poor. We spoke about arranging tests for sight and hearing, and I suggested a possible visit by the sensory team to AN's home. Her daughter said they would discuss and then arrange.

We discussed different housing and care options available to AN. We spoke briefly about residential and nursing care but AN did not want any further information. SW had completed a living community assessment for AN and the report concluded that sheltered or extra care accommodation would be suitable for AN. We discussed the insecurity and anxiety that AN felt in her current home without constant access to daughter upstairs so I suggested that AN apply for Extra Care housing as this type of accommodation is staffed 24/7 which may help AN's anxiety. Extra Care housing is designed to accommodate tenant's changing health needs so would provide further

security over the next few years. AN and her daughter agreed to apply for Extra housing.

HOOP managed AN's Manchester Move rehousing application to make it valid as AN was registered, but it was not active. I liaised with SW to complete the Extra Care assessment form which was presented with all supporting information about AN's care/housing needs to Chair of the extra care panel within four weeks of our initial meeting. AN asked to be considered for a home in Whitebeck Court which is in the same area as her old home.

AN was assessed at panel as having medium care needs for extra care housing. She was offered one bedroom apartment within two weeks of the panel meeting. AN received 4 x daily care calls from the in-house care team when she moved into her new home. Her mental health improved straight away due to her feeling secure in the knowledge that staff were in the scheme 24/7. AN 's visits then decreased to 1 x daily from the care team as she repaired her relationship with her older daughter, who now calls to her daily to help prepare food, clean and do laundry. AN is able to go to the café in the scheme for lunch and enjoys socialising with other tenants on a regular basis. Her family are thrilled and say that because AN now socialises she is less dependent on them. Her older daughter says she has got her relationship with her mum back on track because they both now agree that due to the distance between their homes, and even though she visits daily, she will not attend unless the visit has been arranged or there is an emergency. AN's case has been closed by social work team.

OUTCOME

The move to Extra Care Housing occurred within 6 week of ANs involvement with the HOOP service. Her health and care needs have reduced as a consequence of housing better suited to her needs. AN is now less isolated and anxious.

First Stop Manchester Case Study 4

EE (age 68) was referred to FirstStop Manchester by a hospital discharge social worker (SW). EE had been in hospital as an in-patient for a few months due to health complications related to excess alcohol. Department of Adults and Social Care had provided temporary respite care for EE as she was ready for discharge from hospital, but she was unable to return to her own home of 10 years because of concerns for her safety from former friends as well as stairs and layout in her home.

HOOP liaised with EE, her daughter (who has power of attorney over EE's affairs) and SW to register EE for rehousing with Manchester Move and to provide information about all the housing and care options available. EE and her daughter agreed that EE would not be able to purchase a new home with the proceeds of a sale from her old home due to house prices in the area it was in, and that she was in

danger if she stayed in that area as her health had deteriorated greatly resulting in numerous hospital stays over the past ten years. Private rental was discussed, the pros (choice) and cons (lack of security) weighed up and it was decided this was not a suitable option for EE at this time. I explained rehousing policy about home owners and that she would be eligible for priority as she could not go home in the near future.

We discussed EE areas of preference and the types of accommodation available. We discussed general needs flats, bungalows, sheltered/Retirement and Extra Care schemes. EE said she would prefer general needs accommodation. Her daughter encouraged her to consider sheltered for the support it offered. I suggested a property on the peripheral of a sheltered scheme that may offer the best of both. When EE said she hoped to replace her late pet dog in her new home, it was agreed that a flat on the peripheral of a sheltered scheme that accepted pets would be ideal.

I made enquiries into which schemes in EE's chosen area would accept dogs in their peripheral properties. When a suitable scheme was identified I asked the scheme manager to contact me as soon as there may be a vacancy. There was a bid placed for a property that met all EE's needs, she was offered that property. I liaised successfully with the housing officer for the new property to remove an additional charge for a furniture package in the property that EE did not need/want. Her daughter was insistent they would not sign for the property until the charge was removed. We discussed assessments for possible adaptations that may help EE in her new home, opportunities in the area for voluntary work and access to short courses at local colleges and community hubs. EE's daughter arranged her mum's move and EE's case was closed by SW when she settled in.

OUTCOME

EE is now settled in her new home. The move occurred within 8 weeks of her involvement with the HOOP service meaning that she can now live independently in her own home, without social work involvement or in expensive respite care.

First Stop Manchester Case Study 5

MT (age 71) and PT (53) are mother and son who were referred to FirstStop Manchester by Mental Health Team (MHT) and Active Case Management (ACM). MT suffers mental and physical ill health using a wheelchair now and PT is her full time care giver. They lived in a social rented house with three bedrooms and a bathroom upstairs, and a WC downstairs for 15 years. For 3 years MT was unable to go up the stairs which resulted in MT and PT living and sleeping in the living room. PT was helping MT to bathe in the kitchen.

When the HOOP service first met MT and PT they were both very anxious about their current living conditions and possible resolutions. It was noted that they had

been on the rehousing register Manchester Move for over two years and been offered suitable properties which they had refused. It was obvious from the first meeting with them that they were both overwhelmed by the prospect of moving. On my first visit I introduced myself and explained about the HOOP service. I reassured them that they were the people who would make the decisions about their future, that FirstStop was there to make sure they knew all their options including moving home or staying put by providing information , advice as well as practical help arranging a move/adaptations if required. I explained that with their permission I would share information with MHT and ACM and Manchester Move about their housing options and requirements. MT and PT gave me their permission.

On my subsequent visit we discussed possible adaptations to make their home more accessible e.g. stair lift but this was quickly ruled out as MT was scared of going upstairs in her home due to mental health problems as well as suffering from very poor mobility. We discussed how MT not being able to go upstairs was having a negative impact on PT's health as well as he was sleeping in living room in a chair as he did not want to leave his mum downstairs alone at night. The upstairs of their home was not being heated or ventilated so we discussed the implications of this. As their home had a big garden around three sides of the house, it was a struggle to upkeep due to PT being busy looking after MT. When we discussed issues about upkeep of home and garden, utility bills, access in and out of their home (step at front and back door), as well as the detrimental effect that sleeping in the living room was having on their health and their relationship, they decided that moving into a home on one level was the most suitable option for them.

As PT was 53 years old, he would be able to move with his mum into age restricted property. They decided to look at 2 bedroom properties on one level where PT met the age restriction. This gave options of ground floor flats, some bungalows and high-rise living in the areas surrounding their current home.

MT and PT did not have computer access, so I spoke to them on a weekly basis to update them with all suitable properties on Manchester Move. I checked that they had all priority that they were entitled to on their application. As they were moving out of a family type property into non-family type properties they were awarded band 1 priority for rehouisng. I placed bids on suitable properties and they were successful in their bid for a 2 bedroom flat in a block of flats for people over fifty. The flat is on one level with lift access, and close to local amenities (café, extra care scheme with access to events, shops, bus stop).

Once the offer was made; I liaised with housing officers for both their current and new homes about their move. It was arranged that MT and PT could leave any unwanted items in their old home without charge. Their new housing officer helped them through the whole process from the sign up to their move into their new home. She met them at the new flat for viewing then arranged the sign up at their convenience. The housing officer helped with reading the meters at both properties

and reported the readings to utility companies so they would not get more anxious. We discussed MT required any further adaptations in their new home , and I helped MT and PT book the moving company and arrange for carpets and blinds to be fitted. Both the housing officer and I were available for the day of move in case of emergencies (however this wasn't needed). This reassurance reduced the stress and anxiety of moving for MT and PT considerably.

MT and PT had been visited weekly, as well as on a crisis ad hoc basis, by MHT and ACM for many years. In the 12 months previous to their move, the crisis ad hoc visits by MHT and ACM had become more frequent. Due to MT's mental and physical diagnosis/prognosis it is unlikely that the visits will stop completely but it is expected that crisis ad hoc visits will continue to decrease considerably. MT and PT are now able to live comfortably and securely in a spacious home with minimal upkeep. They are utilising all the local amenities that are within walking distance of their home, and they are gaining confidence in the knowledge they can access support and integrate with their neighbours and community if they wish to.

OUTCOME

MT and PT have now moved into a property that meets their health and care needs by no longer having to use stairs or only live in part of the home. They are now being visited less often by mental health and active case manager services less and are hopeful that these visits will be able to stop completely as they gain further confidence in their new living environment. They are less isolated, there is less chance of a fall in the home and they live near enough to Whitebeck Court and Victoria Avenue to use local facilities should they wish to do so.