The Living Safely & Well at Home campaign is supported by Nationwide as part of the ‘Your Home’ strand of its 2012-17 citizenship strategy ‘Living on your side’. The campaign was launched in January 2014, and this report covers the final full year of both the campaign and the citizenship strategy.

In addition to reporting on the campaign’s achievements during 2016-17, it features some of the highlights of the whole campaign.

The report also explains how the experience of running the campaign, and the impact it has made, have helped shape EAC’s thinking and forward planning.
Campaign overview

The Campaign aims to help older people to live comfortably and safely at home, avoid unplanned hospitalisation and moves into care, and return home successfully after any spell in hospital. It was launched in January 2014 and has been funded in 3 phases: Jan – Sep 2014, Oct 2014 – Sep 2015, Oct 2015 – Sep 2016 and (the current phase) Oct 2016 – Sep 2017.

Specifically, the funding supports EAC’s national FirstStop Advice Line to deliver information and advice to help older people achieve the campaign’s aims. It also covered the cost of a Living Safely & Well at Home (LSAWAH) information pack and widespread distribution of this. And it has supported many local outreach events, run by EAC’s local FirstStop partner organisations to introduce older people to the campaign as well as to provide on the spot information and guidance about housing issues and options.

The balance between these main campaign activities has changed over time. In the early months, the campaign was kick-started by the distribution of large numbers of Information Packs. As the first year progressed, the local events programme swung into gear, and in total over 50 events were staged in 2014-15 and 2015-16.

These led rapidly to an increase in the number of enquiries handled by EAC’s national Advice Line, with the (then) target of 1,000 customers per quarter exceeded by Q3 2014-15. Thereafter, customer volumes continued to increase, indicating the continuing success of the campaign but also alerting us to the danger of overshooting agreed targets without having additional staff in place.

In mid 2015 it was therefore agreed that we would start scaling back service promotion and outreach work, invest additional resources instead into national Advice Line staffing, and (for 2016-17) increase the customer volume target to 5,000 per annum. In practice this revised target was considerably exceeded, with a total of 5,598 new LSAWH customers served during 2016-17.
The LASAWAH campaign pack

In addition to a number of existing leaflets and booklets, the pack contained two new publications:

- one illustrating the range of options open to older people to make their home more suitable for later life, and also outlining options for moving to somewhere more suitable; and
- the other a more detailed guide to improving the home to make it safer and healthier.

The Local outreach events

Over 50 events were staged throughout England in 2014-15 and 2015-16. These took many and varied forms including:

- A ‘market place’ event in a community centre;
- County fairs;
- A Winter Health and Well-being Day;
- Providing information and advice in local hospitals;
- A Campaign To End Loneliness event;
- Dedicated Living Safely & Well At Home events.
Some were single day events, often repeated in several locations, whilst some ran over several days. Some were dedicated LSAWAH events, some part of a larger event. Events were publicised by a variety of means including mailshots, website features, local newspaper articles and local radio programmes. Partners involved included many Age UKs, several Home Improvement Agencies, local authorities and countless other voluntary sector agencies and groups.

All the events and local campaigns were supported by small grants, averaging around £1,500 and paid out of Nationwide’s overall donation to EAC. Care & Repair England managed the small grants programme on EAC’s behalf.

**Customer volumes**

Over the course of the campaign, the number of older people and family members contacting EAC for advice and guidance increased rapidly, and by mid 2015 we faced a risk that its success would overwhelm our already expanded FirstStop Advice service, lead to restrictions on time allocated to each customer and damage to our reputation for responding to over 95% of calls within a minute. Against an initial target of 4,000 new customers a year, the campaign was generating over 5,000, with numbers increasing quarter on quarter.
We responded by a combination of:

- calling a temporary halt (since extended) to funding outreach events by our local FirstStop partners;
- diverting campaign resources instead into recruiting a new part time Advisor to boost service delivery capacity;
- resolving to expedite development of the online version of our ‘HOOP’ tool to further increase service delivery capacity (more about HOOP below).

A total of 5,598 customers received a personal service from EAC’s national Advice Line during 2016-17.

**Changing customer profile**

Over the course of the campaign, the balance of concerns and issues that older people brought to the EAC FirstStop Advice Line shifted significantly, reflecting the campaign’s focus. Increasing numbers were looking for comprehensive advice on the housing options open to them, wanted specific guidance on how to ‘stay put’ successfully, or looked for help to arrange care at home.

![Customers by main presenting issues, by month](image)

**Evaluation – customer views**

Since May 2014 we have invited all our customers to respond to a simple survey which asks 5 questions:

1. When you contacted us, who were you looking for advice for?
2. Had you heard about FirstStop before you contact us?
3. Did we provide you with all the information you required?
4. Would you use the FirstStop Advice service again?
5. Would you recommend the service to your family or friends?

This continuous tracking has provided encouraging findings, both about the service that EAC itself delivers and about the support we can draw on within the FirstStop Advice network. Of 830 service users who have responded to date:

- Users were equally divided between those looking for advice for themselves and those looking on behalf of someone else – in the latter case, primarily parents.
- 23% had heard of EAC or FirstStop before contacting us – an indication that campaign events and promotion had paid dividends.
- 77% said that the information and guidance we provided answered their query, and a further 16% said that we had provided details of another organisation that helped them.
- 97% of service users would use the service again.
- 97% would recommend it to others.

Scaling up online service delivery

During their campaigns and events, many local partners chose to distribute copies of EAC’s HOOP (Housing Options for Older People) questionnaire. Often straplined How well does your home suit you? or Should I stay or should I move?, this established tool has proved an effective way of encouraging older people to think about their current living arrangements, and after completing the questionnaire, to return it to the agency from which they received it and ask for any information or advice they need.

EAC had long ago created an online version of HOOP capable of offering initial suggestions for dealing with problems and issues that users identified. But it remained a national tool, providing broad guidance only. The overwhelming success of the LSAWAH campaign persuaded us to try to create a fully localised HOOP Online tool, and explore how far this could satisfy some of the demand for information, advice and guidance the campaign had unleashed.

Successive stages of a HOOP Online development programme, including expanding the directories of local information and services that underpin it, have gradually paid dividends.
Critically, the tool has proved itself capable of delivering information and guidance on a self-serve basis to substantial numbers of users.

During 2016-17 it attracted an average of over 500 users a month, 45% of whom said that it had helped them to review their housing situation, with a further 40% saying it had ‘partly’ achieved that aim. Over the year as a whole, of 6,075 HOOP users, just 574 took up the invitation to contact EAC FirstStop Advice for further information or guidance.

Although only the latter 574 users are included in the figures we report to Nationwide, the evidence is that the new HOOP Online tool enabled us to deliver a valuable service to a further 5,000+ people thanks to investment prompted by the success of the LSAWAH campaign.

If we were to add customers supported via the HOOP tool to those receiving an EAC Advice Line service, the total for 2016-17 would be 10,599.
Reflections on campaign delivery partnerships

Most of the 20+ local agencies EAC worked with on the LSAWAH campaign were already known to us, a majority benefiting from service innovation funding that we had been charged by DCLG to distribute. And for many, the campaign theme chimed with the ways in which they wanted to develop their services to address local health and social care priorities as well as older people’s own concerns.

Joint engagement in the campaign highlighted the practical benefits of the FirstStop Advice partnership model. Their outreach activities successfully reached many thousands of people with a simple, practical offer of help to age successfully at home, and they were grateful for the additional small grants that helped them stage these. They also valued EAC’s role in providing tools to support their advice services (including the localised HOOP ‘app’) as well as its specialist national telephone advice capacity. And of course they valued opportunities to engage with and involve the staff of Nationwide Branches where this was possible.

Our partnership with Care & Repair England (C&RE) during the first two years of the campaign was also very beneficial. As well as managing the Nationwide small grants programme, it was able to build links between the campaign and its own newly launched Silverlinks programme, which recruits, trains and supports older volunteers as ‘peer mentors’, able and willing to share their experiences with and support others. Several of our local campaign partners have subsequently adopted the Silverlinks approach to expanding the capacity of their I&A services. Preston Care & Repair is one example of the campaign’s success at bringing agencies together and cross-fertilising initiatives and innovation to provide housing options advice both more effectively and more cost effectively.

Meeting between Preston Care & Repair, EAC and Care & Repair England, October 2015, to discuss DCLG FirstStop grant funding, a LSAWAH event and possible Silverlinks initiative.
Planning for the future

From March 2015, learning from the campaign fed into a strategic review, involving EAC staff and trustees, as well as a number of external partners and stakeholders, aimed at formulating a vision for EAC FirstStop Advice 2020.

The overarching conclusions reached by early 2016 were that EAC should:

- Adopt Living Safely and Well at Home as a unifying strapline for all EAC services;
- Sharpen our focus on home and well-being, including strengthening our advice offer in key housing areas (staying put and moving to specialist later life housing);
- Continue to champion and deliver independent, impartial, good quality information and advice to support choice;
- Continue to lead innovation and cost-efficiency within the I&A sector by creating and sharing information resources and tools;
- Promote the maturing HOOP tool as a self-serve source of good quality, local information and gateway to both national and local advice services;
- Maintain the campaigning approach of LASAWAH as a means of encouraging collaboration between providers of housing options services to older people to increase delivery capacity whilst maintaining standards in these difficult times.

John Galvin, EAC
14th April 2017

Appendices (Campaign highlights)

1. National service case examples
3. Examples of subsequent outreach events
4. Outcomes from local outreach activity
5. Local services case examples
1. National service case examples

1.1 Help to firm up on a plan

Mr B contacted us whilst his mother remained in hospital following an operation from which she would take time to recover. He was simply looking for an opportunity to talk through what he needed to do to help ensure his mother’s successful return home.

In the course of a lengthy conversation our Advisor explained how the decision to discharge Mr B’s mother would be reached, suggested questions he should ask about any short term care/support the hospital might arrange, and explained how to go about employing carers and the criteria for financial help with this.

He also advised on the range of equipment (hoists, beds, recliners, etc) that might make Mum’s life easier when she returned home, the common small scale adaptations that could make her home safer, and the role the local Home Improvement Agency could play in surveying her home before making specific recommendations and, if required, carrying out any agreed works.

Mr B left confident that he could take control of the situation he faced, but also that he was welcome to come back to us at any point for a further discussion.

1.2 Bringing Mum closer for support

Ms W wanted to help her mother and father to move from their home in South Wales to be near her in Cambridgeshire. Ms W’s father has been unwell for some time, his mother felt exhausted looking after him, and Ms W wanted to help her shoulder the responsibility.

As her parents would only have about £110k after the sale of their house, we advised on shared ownership and market rent tenure options, provided details of affordable retirement housing developments within 20 miles, and talked Ms W through what she wanted to understand about the implications for her parents of moving from freehold home ownership to a leasehold property.

Over the course of the next two months as mother’s house sale and purchase progressed, we had regular contact with Ms W and her brother, helping them plan for supplementary paid for care/support for father once their parents had made their move.

1.3 Finding and affording a nursing home

Our contact with Ms M spanned the 10 weeks between when her mother was admitted to hospital following a third stroke to when she was released. Both Ms M and our advisor accepted that mother probably would be best cared for in a nursing home because the hospital prognosis showed her unlikely to recover the strength to look after herself.

We worked with Ms M to help her choose between two local care homes she had identified, and advised her in detail on how her mother’s care would need to be paid for. The latter was complicated by both the level of the fees in the selected homes and the question of whether mother was entitled to NHS ‘continuing care’ funding. We advised Ms M of the free, specialist continuing care advice service provided by FirstStop partner Beacon.

We remain in contact with Ms M.
1.4 Inter-agency co-operation achieves quick results

We were contacted by Ms C from Macmillan Cancer Support, who was working to help Mr/s B, a couple who owned their home in Kirkby-in-Ashfield, Nottinghamshire. Mr had terminal cancer and recently McM volunteers went round to their home to repaint one of their rooms. Whilst there they were concerned about the state of the property as there was a considerable amount of damp in the kitchen. Ms C was looking for some local support to help Mr/s B discuss their housing options.

We involved our FirstStop partner agency Age UK Nottinghamshire which:

- Arranged a home visit to offer practical support;
- Assisted with housing applications and advocacy;
- Involved an Occupational Therapist, Environmental Health and DWP in relation to pension income;
- Replaced a broken fridge with a new one via a scheme with Eon.

The advocacy paid off when 4 months after initial contact, Mr/s B were offered a 2 bedroomed detached bungalow - their priority had been increased to Band 1 (highest) after liaising with Environmental Health about their dire living conditions. The gentleman was very poorly and the condition of the house was directly impacting on this. Mr/s B are now planning to have their property auctioned to raise money to keep them comfortable for the future.


Details of 11 events staged during the first 6 months of Phase 3 of the Living Safely & Well Campaign are shown below. In all these events have provided 314 older people with face-to-face advice as well as information packs, as well as providing information to 489 professionals who work with older people.

<table>
<thead>
<tr>
<th>Date</th>
<th>Region/ LA</th>
<th>Group</th>
<th>No.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.09.15</td>
<td>London/SE</td>
<td>SEEFA policy panel</td>
<td>25</td>
<td>Seminar on housing and long term care</td>
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<tr>
<td>13.10.15</td>
<td>Wigan</td>
<td>Launch of OP Involve Group</td>
<td>25</td>
<td></td>
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<tr>
<td>21.10.15</td>
<td>North West</td>
<td>Future North West conference</td>
<td>48</td>
<td>Presentation of survey of LA website I&amp;A with reference to FirstStop as the national provider</td>
</tr>
<tr>
<td>21.10.15</td>
<td>Bristol</td>
<td>Open workshop</td>
<td>9</td>
<td>Silverlinks Housing Options workshop</td>
</tr>
<tr>
<td>13.11.15</td>
<td>Warwickshire</td>
<td>Warwickshire Age UK, Health &amp; Housing Seminar</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>17.11.15</td>
<td>North West</td>
<td>Future North West Forum members</td>
<td>10</td>
<td>Repeat of Conference presentation on Care Act &amp; I&amp;A</td>
</tr>
<tr>
<td>23.11.15</td>
<td>Rochdale</td>
<td>Rochdale Carers Forum</td>
<td>24</td>
<td>Very interested in FirstStop for information. All took flyers for friends and neighbours.</td>
</tr>
<tr>
<td>07.12.15</td>
<td>London (Redbridge)</td>
<td>Redbridge pensioners forum</td>
<td>80</td>
<td>Silverlinks presentation</td>
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<tr>
<td>28.01.16</td>
<td>London (Barnet)</td>
<td>Broad Oak Older People’s Forum</td>
<td>35</td>
<td>Talk on Silverlinks awareness of housing and care options and referral to FS locally and nationally</td>
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<tr>
<td>15.03.16</td>
<td>Rochdale</td>
<td>St Chad’s Mothers Union</td>
<td>8</td>
<td>General awareness</td>
</tr>
<tr>
<td>31.03.16</td>
<td>West Midlands</td>
<td>West Midlands Pensioners Regional Council</td>
<td>25</td>
<td>Silverlinks talk</td>
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3. Examples of subsequent outreach events

**Elders Council of Newcastle**

“In discussions with older people, it often seems that people think the GP Practice is the key place where people go and where they might expect to receive information about a range of issues which go well beyond their health issues. The reality is that we know that GPs and the practice team have very little time to engage with their patients on issues which relate to broader issues of quality of life. The Elders Council set out to engage with two GP practices to see whether, by working with them, we could help to get information to older people about a range of issues, including housing, finance, activities. We agreed to do this through participating in the flu jab days, as a way of engaging with people we might otherwise never meet.

Given the limitations of space and time, the events achieved our aim of raising awareness of a range of issues with a new group of people. It also enabled us to establish a relationship with one Patient Participation Group and to offer support to them in addressing their key issue of loneliness and isolation in the community.”

**Age UK Nottingham & Nottinghamshire**

A series of awareness raising sessions were delivered our Local Day service supporting older people, people with dementia and their carers. An awareness raising display remained at the centre throughout the duration of the project.

Our Community Outreach Advisor hosted an Information Point at a local GP practices and promoted ‘Live Safely and Well at Home’ messages to patients, their friends and relatives and health professionals within the practice. This was particularly successful at the following GP practices:

- Brierley Park Medical practice, Sutton in Ashfield
- Harwood Close Medical Practice, Sutton in Ashfield
- Woodlands Medical practice, Sutton in Ashfield

Members of our housing services delivered packs during home visits, and information was also given to members of our Kindred Spirits Service and through other Age UK Notts services.
4. Outcomes from local outreach activity

4.1 Individual outcomes

Under the funded outreach activity programme local areas were required to report back on the specific one to one advice action taken that contribute to enabling older people to live safely and well at home. A wide range of outcomes were recorded. At the event organised by Spire Homes 20 people were referred on to the Falls Prevention Team and 25 for advice regarding assistive technology. In Northumberland 20 people were referred on for specific advice and support regarding health and social care including falls prevention clinics, pulmonary rehabilitation and exercise classes. In the events organised by Worcestershire Care & Repair and Spire Homes a number of attendees were referred for follow up visits by home improvement agency staff including issues such as adaptations for safe bathing and support for affordable heating. A number of local events involved the Fire Service. At Age UK Hythe & Lyminge’s event this resulted in 18 follow up appointments; in Northumberland 29 follow up visits were arranged for smoke alarms and home safety checks.

‘It’s been a really useful event. I’ve spoken to lots of people who were all really helpful. It was well worth coming to.’ Attendee at event organised by Spire Homes

4.2 Raising awareness amongst professionals of the importance of home safety checks and the big impact of small changes in the home environment

Although the local events were targeted at older people in many cases arranging the events provided an opportunity to raise awareness amongst other professionals about issues involved in enabling older people to live safely and well at home. Typically, almost 140 brochures were provided to staff working in other services. For example, feedback from Age UK Northumberland noted that hospital staff and ward managers were particularly interested in the Live Safely and Well at Home materials and the Age UK guides for their waiting rooms and day rooms.

‘We found that one-to-one conversations were by far the most successful way of sharing information’. Professional attending local event organised by Age UK Hythe & Lyminge

4.3 Development of links with local health providers

A number of local events were specifically aimed at developing links with local health providers. Age UK Northumberland arranged a ‘road show’ which was taken to six local hospitals whilst Worcester Care and Repair focused their events on six GP practises and health centres.

A number of local partners commented on the value of the events in developing links with local health providers. Worcester Care & Repair commented that the events enabled them to create awareness in health care settings where they have not previously worked, and in a number of localities they have been asked to run further sessions. In addition events were supported by members of the local Patient Participation Groups, providing a further route to extend awareness of sources of information and advice to enable people to live safely and well at home.
“There was a shift in emphasis in the project as there was a high demand for support from GP practices…. If [further grants are available] in the future we will ideally allocate the majority of the resources to GP practices, ensuring maximum access to patients and professionals’. **Age UK Notting & Nottinghamshire**

A similar picture emerged from the events which took place in Northumberland. Age UK Northumberland noted that referral pathways have improved, particularly with community hospitals.

Following the success of the events funded through Nationwide they intend to provide regular advice sessions on living safely and well at home in a local GP practise and in two local hospitals, demonstrating a lasting impact of the local event grant.

Links were also strengthened with the Northumberland Handyperson service which will enable older people in need of minor repairs to be promptly referred on for assistance.

### 4.4 Development of community connections to support older people to live safely and well at home

Project reports all noted very positive feedback. Local events have enabled more effective links to develop between different agencies and have also resulted in greater awareness of how services may work better together.

> ‘We found the day very useful and enjoyed speaking to your attendees (even the one that was promised a good looking warden). Hopefully the information and equipment we were able to share will help keep them safe and happy.’ **Paul James, Kent Community Warden Service, local event organised by Age UK Hythe & Lyminge**

In some localities agencies intend to build on this to arrange further events in the future. For example, AgeUK Northumberland UK and the Fire Service have discussed working together around other issues around hoarding and fire safety.

Age UK Notts commented that the project has helped foster good relationships to further the wider health and social care integration agenda and commented that statutory, health and other professionals are now better informed about the range of third sector support available to patients.

> ‘The proactive nature of the project ensured older people were informed and enabled to live safe and well in their own homes. With this information and support older people were less likely to be admitted to hospital, less likely to fall and less likely to experience cold related health problems’ **Age UK Notts and Nottinghamshire**
4.5 Significantly raised profile of sources of information, advice and help with living safely and well at home

Whilst in some localities local partners focused their activities on developing and improving links with local health agencies, in other areas the focus was on building networks and raising awareness amongst both statutory and voluntary sector agencies. In Staffordshire a Living Safely and Well at Home fair was arranged involving a number of different agencies including Stafford Borough Council, Beat the Cold, Medequip (a company running community equipment stores providing a range of aids for people with disabilities) and Stafford and Rural Homes Telecare.

‘The event was very worthwhile for us, and we would like to be considered for similar events across the region’. Medequip, Stafford event

In Rutland Spire Homes organised a Winter Health and Wellbeing Day. A wide range of agencies were welcomed to the event by the Director of Housing Services at Spire Homes outlining the aims of the day noting that the funding was provided via Nationwide through the EAC First Stop. About 45% of attendees travelled in from surrounding rural areas extending the reach of the Live Safely and Well at Home message.

‘That was fantastic - we are so glad we popped in. We’ve spoken to lots of people and taken details of a couple of services we’ll be phoning soon.’ Attendee at the event arranged by Spire Homes

4.6 Leveraging additional support

The success of small local events can on occasions enable further local events to be delivered. For example, in Kent the experience of running the Live Safely & Well at Home event encouraged Age UK Hythe & Lyminge to successfully apply to deliver an outreach day in similar style at a rural village hall which took place in Bossingham, Kent, on 17th March 2015.
## 5. Local services case examples

### Spire Homes, Northamptonshire

<table>
<thead>
<tr>
<th>About the person</th>
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<tbody>
<tr>
<td>Mrs D, 73 years old and recently widowed. Lives alone in a 3 bed semi-detached property that she had shared with her husband since the 1960’s. Generally fit and well with no current physical health needs.</td>
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<table>
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<tr>
<th>About the issue</th>
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<tbody>
<tr>
<td>Mrs D was concerned about how she would manage in the property alone. Her husband had managed not only the maintenance of the property but also the couple’s financial affairs. She had contacted both the Local Authority and County Council along with local voluntary organisations but did not meet the criteria for support as she had no obvious needs.</td>
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<tr>
<th>Action taken</th>
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<tr>
<td>Our caseworker visited Mrs D in her home to discuss her concerns and provide advice. Mrs D discussed her general anxiety about having to manage the property alone and worries about not knowing where to turn to for help if needed; however she did not identify any specific needs at the time. The caseworker completed the service’s Healthy Home Assessment with Mrs D, by focusing on specific issues within the home it was easier to identify current needs.</td>
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- The property was currently manageable, but Mrs D was concerned about how to access support if something went wrong. Details of local Handyperson and gardening services were provided.  
- There was concern about how affordable the property would be for Mrs D alone, she had been reluctant to turn her heating on due to cost. We looked at and referred for energy efficiency measures and discussed changing providers to ensure that she was on the most appropriate tariff. With advice, and support of family, this was something that Mrs D felt she could take ownership of and gave her an increased confidence in her ability to manage independently.  
- We also arranged a referral for a benefit check to ensure that Mrs D was receiving all income she was entitled to.  
- Although Mrs D did not identify any physical difficulties or problems in the home she mentioned through the assessment process a couple of near-miss falls. A Community Occupational Therapy referral was made for minor aids such as grab rails.  
- Mrs D was concerned about her old boiler. As the boiler was still working there were no current grants available to get this replaced, however funds were identified that could help should Mrs D have future problems with her heating system. This gave peace of mind to the client.  
- There was also a discussion about future options both for staying put and moving should Mrs D think further about it in the future. |

<table>
<thead>
<tr>
<th>Outcome</th>
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<tr>
<td>Mrs D did not meet the criteria for support at this time as there was no identified need. The advice, support and referrals for work received from our service will however reduce her risk and prevent the need for statutory services and more costly interventions in the future. Mrs D now feels more confident about managing alone in the future and anxiety has reduced, thus increasing her personal well-being.</td>
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<tr>
<th>Any comments/quotes from others involved</th>
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<tbody>
<tr>
<td>Mrs D thanked the service for the advice provided and advised that having a third party to discuss her concerns provided a great comfort.</td>
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### Age UK Warwickshire

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<thead>
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<th>About the person</th>
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<tbody>
<tr>
<td>Client 74 years of age had lived alone in a small, housing association sheltered flat for many years. It</td>
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became increasingly difficult to manage at home due to mobility problems (use of frame) and the lack of space at the property. A recent hospitalisation with respiratory issues exacerbated the problems. Client was concerned about the upheaval of moving home with no family support.

### About the issue

Having spent 5 weeks in hospital and a further 4 weeks in the rehabilitation unit, client was concerned about his ability to manage at home on discharge despite the package of care available to him. He had been seeking alternative accommodation for some time through the council’s Housing scheme but had not met with success.

### Action taken

The HCO advisor contacted the manager of a local Extra Care Housing Scheme to discuss the case. Further to this discussion the client was invited for an assessment and his situation discussed by the Housing Association panel. Within a short period of time the client was offered an apartment and invited to view. During the visit it became clear that the distance of the apartment in question to the main reception and hub of the building would be too great for client to comfortably walk. In turn he was offered the show flat and all fixtures and fittings gifted to him. Client was given practical and emotional support for the move by HCO advisor.

### Outcome

Client now lives in a one bed-roomed purpose built apartment in an extra care establishment. This provides:

- a more secure environment
- increased opportunity for social interaction
- a safer and more spacious living space with less risk of falling
- increased support
- pleasant environment with gardens and patio areas
- problems previously encountered with unreliability of community carers were resolved.
- client is delighted with service provide by In house carer service
- client takes his meals each day in the restaurant

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### Age UK Northumberland

#### About the person

84 year old male homeowner who lives alone and has long term health problems.

#### About the issue

This gentleman had heated his home with a coal fire throughout his life but the boiler had broken and needed replacing. He concluded that cleaning and maintaining the coal fire was too strenuous for him now as he has experienced life-long asthma and is on medication for heart failure. Therefore, he arranged to have a gas boiler fitted and approached the energy supplier who supply his electricity to supply gas. He was told by the Customer Service Advisor that he would need to contact them after the boiler was fitted (which was arranged for the following day). He would then need to wait a further 7 – 14 days for his details to appear on the National Grid. At that point they would contact him to arrange for a worker to come out and connect his gas supply. As his boiler had broken down at the beginning of December, he had borrowed a plug-in electric heater from a neighbour for use in his living room until the boiler was fitted and the gas connected, but he had no heating for the rest of his home and no hot water. He was very concerned that the weather may turn cold and he would be left without heating for a couple of weeks.

#### Action taken

I contacted the energy supplier with the client and we ensured that they had the full details about his health problems. The Customer Service Advisor added his details to their Emergency List and they contacted him each day to update him and check the progress with having his boiler fitted.

#### Outcome
The boiler was successfully fitted the following day and because he was on the supplier’s Emergency List, his gas was connected and up and running within 5 days after that.

Any comments/quotes from others involved

The client said he was very grateful for the help and very relieved that it was all sorted out so quickly.

Age UK Wigan

About the person

Mr LH is 79 and has lived in a privately rented flat with a housing association for several years. He is estranged from his family and only has a tenuous link with his granddaughter who he sees informally at a local market where she runs a stall. He has lived alone in the flat for several years and receives weekly support from a support at home worker. For the last 3 years he has become unsettled with the poor state of repairs as his health has deteriorated. He has friends in a local cafe where he likes to eat breakfast and he likes to have a pint at the local pub. He also likes to attend church.

About the issue

Mr LH’s mental and physical health has deteriorated rapidly in the last 12 months after being diagnosed with vascular dementia, encephalitis and heart problems and high cholesterol. He had started to neglect his personal hygiene. Mr LH looked smart and always wore a shirt and tie, but close scrutiny showed he had faeces on his socks. He was very wary of people he didn’t know and he was starting to carry large amounts of cash around with him and stated he was budgeting and paying bills, but was starting to get into arrears. His support worker was worried that rats had got into his flat. Droppings had been found in the kitchen and bedroom. Previous social care needs assessments on Mr LH revealed he had intermittent capacity so no action was taken.

Action taken

Housing and Care Options adviser liaised with Mr LH’s support worker and completed housing forms to obtain medical and welfare priority and to ensure he was on the housing register for social housing. The H&CO Adviser also attended the Extra Care Allocations panel and advocated for Mr LH at panel. A request for another social care needs assessment was put through and a visit to an extra care scheme was arranged for Mr LH to view a flat.

Outcome

Mr LH was taken ill and was admitted to hospital for 3 days before discharge to respite care. This caused Mr LH a lot of distress and he believed he had given up his flat and was living permanently and unhappily in the care home.

An emergency Best Interest meeting was arranged between Social Worker, Senior Social Practitioner, Mental Health nurse, support agency coordinator and the H&CO advisor. It was agreed Mr LH’s health and wellbeing would be better managed in extra care, where with the right care package he could live more independently for longer and reduce the risk of further hospital admissions and bed blocking situations.

Mr LH has moved into the Extra Care scheme and is settling in well. He has started going out to meet his friends, but as yet is not able to remember the way back to the scheme. so he will be monitored over a two week period to see where his support needs to be changed or adapted.

Age UK West Cumbria

About the person

Mrs W is an 84 year old lady who lives in a privately run care home. She has lived in the home for 8 years. She is self-funding her stay in the home. Mrs W has long standing health problems which affect her balance & mobility.

About the issue
The owner of the care home contacted Age UK and Social Services because she suffered a recent bereavement and no longer wanted to run the care home. The care home was due to close at the end of November. She had seven residents that were all found other suitable accommodation but Mrs W refused to consider anywhere else other than the village that the care home was situated in. The care home owner requested help from Age UK to help find suitable accommodation for Mrs W.

**Action taken**
The Housing Options Adviser, Social Worker & Care Home Owner all had a meeting with Mrs W in her room to discuss housing options. A care needs assessment had been carried out & Mrs W could manage washing & dressing independently but could not manage her medication & meals. Although Mrs W insisted that she would not consider anywhere other than the village she currently lived in, she reluctantly agreed to visit an Abbeyfield property in a neighbouring village to have a look at a vacant bedsit.

**Outcome**
The Housing Options Adviser took Mrs W to view the Abbeyfield bedsit and she was very impressed with the whole of the accommodation. The Housing Options Adviser completed the application form and medical questionnaire. Mrs W moved in to the new bedsit and has a carer to assist with medication. The Housing Options Adviser contacted the pension service to advise of Mrs W's change of circumstances & her Attendance Allowance was restarted.

**Any comments/quotes from others involved**
Mrs W has settled well in the new accommodation. She has made new friends and is happy there. She said, “I am surprised that I like it so much here. It’s so homely and the meals are fantastic. I am very grateful for the help from Age UK.”

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**West of England Care & Repair**

**About the person**

Mrs E is 65 years old. She has lived in her three bedroom house for 18 years. She has mental health issues. She lives alone and has a brother and sister in law living nearby.

**About the issue**

Mrs E fell down her stairs and went through the glass door at the bottom. This was in June 2015. She was admitted to hospital and then had time in an Intermediate Rehab Centre. Mrs E was medically fit for discharge in September. However it became apparent that her home was in severe disrepair. Including a collapsed ceiling, roof leak, no heating or hot water and a rodent infestation. The repairs were deemed too extensive for any funds available so Mrs E decided to move. Meanwhile she had been placed in a residential care home, despite not having care needs, as there was no where else for her to go. This was being funded by Health and Social Care. By the time this had been passed to the Housing and Care Options Caseworker, her placement had been funded by the public purse for two months.

**Action taken**

After discussing her options, Mrs G decided she no longer wanted the responsibility of being a homeowner, and responsibility for the repairs. She had found this difficult to cope with in her house. We helped her apply for sheltered social housing. This usually takes three months to process. However due to the need for swift action, we were able to get her rehousing application submitted and considered the same day by the health team at rehousing, as we have built a trusting working relationship with the team.

**Outcome**

Now she will be able to move into a suitable home with working facilities. We will be supporting her to sell her property and resettle.

This clearly demonstrates a cost saving to the public purse, as we will ensure she is rehoused as swiftly as possible. The social workers involved did not have enough housing knowledge to enable Mrs E to make an informed choice and facilitate this choice. Hence she was referred to WECR. Furthermore, this frees up a family size property which was being under occupied.
### West of England Care & Repair

#### About the person
Mrs M is 51, with progressive mobility difficulties, with a three bedroomed house. She is divorced with one son, who is away at university.

#### About the issue
The house was difficult to adapt, and quite a distance from local amenities. At 51 she was too young to consider retirement housing. Moreover, she has a son at university, who still needs a home to return to during the holidays. A move to social housing would have been restrictive, as she would have only qualified for a one bedroom property. Due to the mortgage remaining on the house, she would have been unable to buy something suitable.

#### Action taken
We then decided to look at the possibility of shared ownership. Shared ownership is usually restricted to people who have equity below 40K. However, because of Mrs M’s circumstances, the scheme considered and accepted her application.

#### Outcome
Several months later, she has sold her house, and moved into a brand new apartment in the centre of Bath, very close to her mother. Because she was able to purchase a two bed flat (no bedroom restriction), she can also accommodate her son when he needs it. She is close to amenities, and is mortgage and debt free.

This demonstrates clearly how a Housing and Care Options service can help with downsizing and freeing up housing which is underoccupied. Furthermore, in the longer term, this will provide a cost saving to the public purse, as she will no longer need costly adaptations.

### Age UK Nottinghamshire

#### About the person (age/tenure/length of residency/household status etc)
Mr S is 73 and lives alone in a privately rented flat. He has several health problems including cancer and kidney disease which are seriously affecting his ability to remain independent in his present home.

#### About the issue
In addition to the health problems causing concern as most recently he had also suffered 2 falls as a result of the steep winding stairs that are the entrance/exit to his home, he had been given 28 day’s notice to quit his property by his ‘landlord’. There was also an imminent cancer operation planned which required a stay in hospital but he was considering delaying this due to all of the above.

#### Action taken
During the HOA assessment visit when all of the above was highlighted it was evident that immediate action was required to avoid a worsening crisis. All housing options were discussed and it was clear that the correct housing with security and support would enable this Gentleman to continue living independently. An online housing application was completed and submitted during the visit in addition to the HOA networking with the local authority to highlight this situation. Unfortunately a couple of days later Mr S took very ill and was admitted to hospital via A&E which increased the urgency to access appropriate housing as when the HOA liaised with the discharge nurse the ward had concerns about him returning to his present property for both health and safety reasons but he was fit for discharge. The HOA liaised with a health & housing co-ordinator at the LA and a property in a supported living scheme was fast tracked for Mr S in his chosen location, and a full furniture package was also secured.

#### Outcome
Mr S was able to be discharged from hospital to an adapted, fully furnished flat which could only have a positive impact on his future health and wellbeing.