Leeds CITY COUNCIL

Home Independence and Warmth Service Review

A Health Needs Assessment and Consultation Report

Contents

1. Purpose and Background

Improving health through the home is a fundamental strategy throughout the life course. There are risks to both physical and mental health associated with living in a cold, damp or hazardous home. Or one that doesn't provide a sense of safety. The right home protects people's health and wellbeing by enabling people to live independently and safely, as well as preventing physical and mental ill health. The home can present particular risks to the health and wellbeing of key groups of vulnerable people, e.g. children and their families, people with long-term conditions, people recovering from ill health, older people and people on low incomes**.**

This analysis will inform the design of a delivery model for a new Home Independence and Warmth service which is to be procured during 2018. This will succeed a number of contracts which are currently held with Care & Repair Leeds and Groundwork Leeds.

Care & Repair Leeds (C&R) was established as a Home Independence Agency in 1987 and since then has had various contractual arrangements with Leeds City Council to support older and disabled people to live in safe, warm, secure, healthy, well-maintained and adapted homes.

By 2014, C&R was delivering services for several council directorates:

Environment & Housing	Adult Social Care	Public Health
Home Repairs Service	Hospital Discharge (later transferred to Public Health)	Falls Prevention Service
Home Improvement Agency (HIA) and Disabled Aids & Adaptations	Asian Outreach Service (later transferred to Public Health)	Public Health Winter Warmth Campaign
Housing Choices Service	Leeds Directory	
Warm Homes Service		

At this time, a cross-council review was carried out to ensure that the council was making the most effective use of commissioned resources and that services continued to meet client needs. During this review it was decided that:

- The Leeds Directory, Warm Homes services and Winter Warmth Campaign would continue as they were because their funding and contractual arrangements deemed it necessary.
- The Housing Choices service would continue as part of a wider review of housing related support services.
- The funding for Home Repairs, Disabled Aids and Adaptations, Falls Prevention, Hospital Discharge and Asian Outreach Worker would be combined to form a single Home Adaptation & Repairs contract. This would streamline services and provide a more holistic offer to clients. The new contract was run as a pilot, to allow for the development and testing of a new outcome focussed model and provide a sound evidence base on which to subsequently go out to competitive tender.
- The pilot has now been running since 1 April 2015 and is due to end on 31 March 2018. The findings from this review of the strategic context, best practice, current delivery and health data will inform how the service should now develop.

In 2017, an options appraisal was carried out to again determine the scope of the future provision. The result was that warmth-related services - Warm Homes, Warmth for Wellbeing and Green Doctor - should also be included, given the similarity of aims, client groups and potential for making efficiencies.

The warmth-related services, as referred to above, have been run, facilitated and / or grant-funded by the Sustainable Energy and Climate Change Team for over 10 years. Public Health started commissioning services that aimed to improve cold housing and reduce excess winter deaths about 5 years ago; as did Clinical Commissioning Groups, for their practice populations, initially on a non-recurrent basis. Following a procurement exercise in 2015, the Warmth for Wellbeing contract was awarded to Groundwork Leeds in partnership with C&R. The Green Doctor and Warm Homes Service grants, administered by the Sustainable Energy and Climate Change Team, have been managed in conjunction with the Warmth for Wellbeing contract.

2. Strategic Context

2.1 National Policy

2.1.1 Cross-Cutting Themes

Source	Relevance
Public Health Outcomes Framework	There are a number of indicators to which these services directly and indirectly contribute: • 1.17 Fuel poverty. • 2.24 Injuries due to falls in people aged 65 and over. • 4.13 Health-related quality of life for older people. • 4.14 Hip fractures in people aged 65 and over. • 4.15 Excess winter deaths.
Memorandum of Understanding (MOU) to support joint action on improving health through the home	20 national signatories have agreed: • A shared commitment to joint action across government, health, social care and housing sectors, in England; • Principles for joint-working to deliver better health and wellbeing outcomes and to reduce health inequalities; • The context and framework for cross-sector partnerships, nationally and locally, to design and deliver: 1) healthy homes, communities and neighbourhoods; 2) integrated and effective services that meet individuals', their carer's / carers' and their family's needs; • A shared action plan to deliver these aims.

2.1.2 Hazards in the Home – Falls Prevention

Source	Relevance
NICE Guidance: Falls in older people: assessing risk and prevention	Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention / modifications by a suitably trained healthcare professional. Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team.
Public Health England: Falls: applying All Our Health	Falls and fractures in older people are a costly and often preventable health issue. Reducing falls and fractures is important to maintaining health, wellbeing and independence. Healthcare professionals should: • Know the needs of individuals, communities and population and the services available. • Think about the resources available in health and wellbeing systems. • Understand specific activities which can prevent, protect and promote.
Public Health England / Nationals Falls Prevention Coordination Group: Falls and Fracture Consensus Statement	Advice for commissioning services to help prevent falls.

2.1.3 Affordable warmth - excess winter deaths, cold and damp homes, fuel poverty and energy efficiency

Source	Relevance
NICE Guidance: Excess winter deaths and illness and the health risks associated with cold homes	Recommendation 2: Ensure there is a single-point-of-contact health and housing referral service for people living in cold homes Recommendation 3: Provide tailored solutions via the single-point-of-contact health and housing referral service for people living in cold homes. Recommendation 6: Non-health and social care workers who visit people at home should assess their heating needs Recommendation 7: Discharge vulnerable people from health or social care settings to a warm home. Recommendation 10: Train heating engineers, meter installers and those providing building insulation to help vulnerable people at home.
Cutting the cost of keeping warm: a fuel poverty strategy for England	• The vision is to cut bills and increase comfort and well-being in the coldest low income homes. • The fuel poverty target is to ensure that as many fuel poor homes as is reasonably practicable achieve a minimum energy efficiency rating of Band C, by 2030.
Cold Weather Plan for England	• Although there are several factors contributing to winter illness and death, in many cases simple preventative action could avoid many of the deaths, illnesses and injuries associated with the cold. • Some groups, such as older people, very young children, and people with serious medical conditions are particularly vulnerable to the effects of cold weather.

2.2 Local Strategies and Initiatives

A number of initiatives in Leeds focus on promoting independence and healthy homes. The current services already contribute to many of these aims and will continue to do so with the future model. In particular:

Strategy	Priorities	Indicators
Vision for Leeds 2011-30	• Best city for communities. • Best city for health and wellbeing.	• People are safe and feel safe. • People are active and involved in their communities. • People live longer and healthier lives. • People are supported by high quality services to live full, active and independent lives.

Best Council Plan 2017-18	• Strong Economy and a compassionate city - tackling poverty and reducing inequalities. • Better lives - giving people with care and support needs the right care and support at the right time. • Health and wellbeing - improving physical and mental health. • Low carbon - tackling fuel poverty. • Breakthrough projects - Making Leeds the best city to grow old in.	• More adults and older people helped to live at home. • Fewer people return to hospital following discharge. • Fewer households in fuel poverty. • Improved energy and thermal efficiency performance of houses.
Health and Wellbeing Strategy 2016-21	• People will live full, active independent lives. • Housing and the environment enable all people of Leeds to be healthy, social and active. • An Age Friendly City where people age well.	• People affording to heat their home. • Unnecessary time patients spend in hospital. • Preventable hospital admissions. • Repeat emergency visits to hospital.
Housing Strategy 2016-21	• Improving health through housing. • Meeting housing needs of older residents.	• Contribute to the Yorkshire and Humber target of signing up 20,000 customers to White Rose Energy by 2018. • People whose hospital discharge is delayed due to housing.
Affordable Warmth Strategy 2017-30	• Increasing energy efficiency. • Reducing fuel poverty. • Improving health and wellbeing through increasing affordable warmth.	
Making Leeds the Best Place to Grow Old Breakthrough Project	• The ambition is for Leeds to be a welcoming city, accessible to all and somewhere older people feel, and are, safe. • The council wants to ensure that older people are empowered, independent and able to do the things they want to do, whatever their age. Housing is one of the eight domains to focus action.	
Cutting carbon and improving air quality Breakthrough Project	• Carbon reduction as a contribution to countering climate change. Greater energy security which provides the city with a competitive advantage. • Energy consumption savings to consumers, providing advantages to businesses and residents. • Creation of jobs and apprenticeships. • Greater visibility of energy usage and costs across the city, particularly via smart agenda.	

3. Best Practice Review

This analysis includes investigation of similar provision in other areas. The main differences between areas are around charging and eligibility. For instance, some areas offer minor adaptations under £1,000 for free whilst others charge. Some areas have age eligibility restrictions (e.g. over 60s) whilst others offer services to anyone over 18 if they meet means-tested eligibility.

However, some areas have started to develop different and innovative practices. Ealing and Knowsley, for example, are two areas considered as good practice providers by the Home Adaptations consortium: https://homeadaptationsconsortium.wordpress.com/good-practice/.[1]

3.1 **Knowsley (Merseyside)** has developed a 'one stop shop' (the Pioneer Centre for Independent Living), which brings all its services for older disabled people together under one roof. The Pioneer Centre is a two-floor building and contains a reception area, showroom with room settings, assessment suites, meeting rooms and open plan office space for the combined service. This allows potential clients to view and buy what they require without necessarily having to have an assessment. The one-stop-centre was the legacy of two adjoining warehouse units that were purchased by NHS estates at a central location in the borough. One of these warehouses became the Pioneer Centre, the other an equipment store and repair and recycling facility. The Care and Repair handyperson service carries out about 5,000 jobs per annum and the paperwork is kept down to a one-page assessment form.

Knowsley pooled their funding from DFG (£1.3 million in 2015/16), the ICES budget and wheelchair services. In addition, they have used winter pressures money to fast-track adaptations for people who are going in and out of hospital. In 2015-16, they also topped up the DFG budget with £300,000 of health capital funding. This allowed them to clear a backlog that built up as a result of budget cuts in previous years. This budget is significantly higher than what is available in Leeds and so this approach would be too expensive to replicate here.

3.2 **Ealing's** Home Adaptations for Disabled People includes work carried out through DFG but also operates a handyperson scheme that has a budget of approximately £400,000 that covers around 2,500 jobs per annum. Social care call centre calls and emails relating to adaptations are directed straight to the service. There is no waiting list and no form filling. Contractors are currently paid £25.00 per hour and they are scored on every job they do. Contractors who do not perform consistently well are removed from the list.

[1] The Home Adaptations Consortium is made up of a broad spectrum of national organisations working together with a single aim: To champion quality provision of home adaptations for disabled people. It was initiated in 2008 by Care & Repair England to provide a forum to share and promote good policy and practice. The Consortium aims to identify and highlight the potential impact of wider policy changes, e.g. in social care and health reform on the provision of home adaptations and Disabled Facilities Grant (DFG).

3.3 **Mansfield District Council - ASSIST**. In relation to the evidence of the need for an integrated health and housing service offer for older people, the council responded by transforming, reorganising and restructuring elements of its own housing service to create ASSIST - the Advocacy, Sustainment, Supporting Independence and Safeguarding Team. This scheme commenced operations as a pilot in October 2014 to provide holistic 'whole system' interventions that support the early discharge of patients from hospital. The service is designed to deliver and facilitate:

- Expediting hospital discharge.
- Preventing hospital readmissions.
- Sourcing alternatives to residential care.
- Utilising housing stock to meet local need including direct matching.
- Fast-tracking repairs to properties.
- Providing key safe installation and minor adaptations and handyperson service.
- Installing lifeline and telecare.
- Prioritising the letting of existing adapted accommodation.
- Using temporary accommodation to facilitate discharge.
- Supporting the hospital's emergency department 'front door' by engaging with people who have a social need and freeing up hospital staff to deal with emergencies.

3.4 **Nottinghamshire's** 'Warm Homes on Prescription' (WHOP) scheme looks to improve health through the home. The WHOP scheme has been very successful in Mansfield with further funding secured through the Better Care Fund to provide new heating systems, insulation and advice to vulnerable home owners in fuel poverty. The council has ensured that the STP has the following key objectives within the housing 'theme':

- Expanding the Mansfield hospital discharge model across Nottinghamshire.
- Expanding the WHOP scheme across Nottinghamshire.

3.5 **Derby City Council** have developed a Healthy Housing Hub which they have funded through the Better Care Fund. The house home independence team works to improve the livers of vulnerable people by reducing the risk of poor health and accidents within the home. The service aims to:

- Improve health - whether that is physical, mental or general well-being.
- Reduce longer term demand on health and social care services.

The service works with those people whose housing conditions may harm their health but especially targets:

- Older people.
- Those living with a disability.
- Those living with a long-term health condition.
- Pregnant women or a families with young children.

The service offers:

- Personalised advice.
- Home adaptations.

- Handyman services.

3.6 **Best Practice for Affordable Warmth services is outlined in the NICE guidance:** *"Excess winter deaths and illness and the health risks associated with cold homes" (2015).* The current Warmth for Wellbeing Service was commissioned to closely reflect relevant recommendations in the NICE guidance. The service, jointly contract managed with Warm Homes Service and Green Doctor, also features as a good practice case study on the NICE website, as we evidenced that it implements the NICE Quality Standard: *"People who are at risk of health problems associated with a cold home receive tailored support with help from a local single-point-of-contact health and housing referral service".*

Overall, research suggests that there are common principles and practice through these examples which underpin the best practice; services being holistic, person and property centric, services which are strategically and in some cases physically connected / located. All help to improve the outcomes and whole system delivery for people with age / health / poverty related issues that impact on their ability to remain safe, warm and independent in their home, or to get them to that position as quickly as possible from hospital. Whilst it may not be possible to replicate all elements, it is clear that any future provision should reflect the principles that underpin these best practice examples.

4. Evidence Review - What Works

4.1 Suitable Homes – Adaptions

Home adaptations, which can range from simple grab rails and ramps to accessible shower rooms and stair lifts, can make homes safer, promote independent living for people who require them and improve the quality of life for those who need them. There are a range of benefits to installing adaptations:

- Enabling people to manage activities of daily living.
- Support people to remain mobile and active.
- Reduce the incidence of falls.
- Reducing the cost of health and care.

The Centre for Ageing Better has commissioned a team from the University of the West of England, Bristol (UWE Bristol) and the Building Research Establishment (BRE) to conduct a review of the evidence into how home adaptations can contribute to a good later life.

The full review is due to be published November 2017; however, early headline findings indicate:

- There is strong evidence that minor adaptations result in very good outcomes at low cost.
- There is some evidence on impact of major adaptations but not on cost effectiveness.

- The greatest outcomes are achieved when individuals are closely involved in the decision making process (goal oriented on what a person wants to achieve in the home).
- Enabling people to live safely and well at home and reduce risk, requires a combination of adaptations and repairs to the home, e.g. lighting, carpet tread, etc.
- If adaptations are to be effective, they need to be installed within a reasonable timeframe.

Disabled Facilities Grants (DFG) are means tested and are available for essential adaptations to give disabled people better freedom of movement into and around their homes. Foundations, the national body for home improvement agency and handyperson service issued a freedom of information survey to all local authorities with responsibilities for Social Care in August 2015. One of the aims of the survey was to discover what impact a DFG funded adaptation may have on the age that people are admitted into residential care and how long they stay there. The survey asked Local Authorities to return the average age of people who had been placed in residential or nursing care according to whether or not they had previously received a DFG. For people who have had to move into residential care, those who had previously received a DFG on average moved just before their 80th birthday and stayed there for two years. Those people who had not applied for a DFG moved when they were 76 and stayed in residential care for another six years[2]. The team recommended that further research was required to validate these results; however, the indications are that adaptations should be fully considered as part of a preventative strategy alongside extra care housing, re-ablement or telecare services.

4.2 Reducing Hazards

Falls prevention is a key outcome for this review. A review of interventions for preventing falls in older people living in the community was carried out. As part of this, they evaluated 13 trials and concluded that home safety interventions reduce the rate of falls and risk of falling. The results showed that, overall, home safety assessment and modification interventions were effective in reducing the risk of falls.

However there was no sign in a reduction in risk of fracture. Home safety interventions were more effective in reducing the rate of falls in participants at a higher risk of falling. In addition, home safety interventions implemented by an Occupational Therapist resulted in a statistically significant difference in rate of falls and risk of falling.

NICE guidance, CG161, *Falls Assessment and Prevention of Falls in Older People* recommends all older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. A successful multifactorial intervention programmes should contain the following specific components:

[2] Linking Disabled Facilities Grants (DFG) to Social Care Data. A freedom of Information Survey (2015) Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. *Interventions for preventing falls in older people living in the community.* Cochrane Database of Systematic Reviews 2012, Issue 9

- Strength and balance training.
- Home hazard assessment and intervention.
- Vision assessment and referral.
- Medication review with modification / withdrawal.

In addition, older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention / modifications by a suitably trained healthcare professional. Normally, this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer and appropriate members of the health care team. The guidance stresses that home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation.

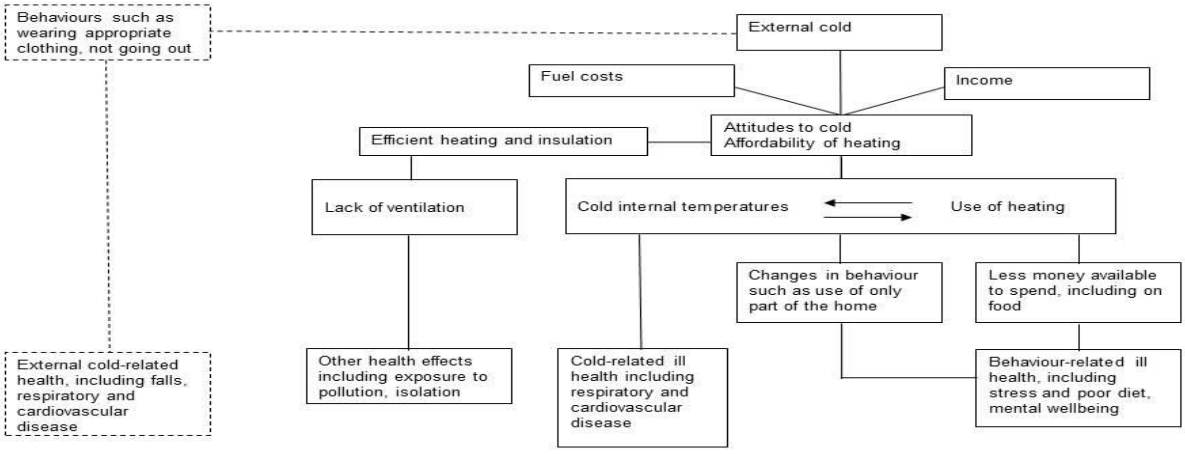
4.3 Improving Affordable Warmth and Reducing Excess Seasonal Deaths and Illness

Fuel poverty and cold homes negatively impact physical and mental health and wellbeing in adults and children. Every year, in England and Wales, there are 20,000 to 40,000 Excess Winter Deaths, between 10% and 25% attributable to these factors.

There are a diverse range of benefits and positive health impacts identified from warmth interventions and energy efficiency improvements, including: general health, respiratory symptoms and asthma; improved mental health and wellbeing; improved nutrition; better social relations, through reducing cold-related illness and associated stress by making it easier for residents to heat their homes. However, evidence on the effectiveness of different interventions for reducing cold home related ill health is less well developed.

The following diagram outlines the factors and relationships between cold temperatures and excess winter deaths and illness[3].

[3] NICE 2015



4.3.1 NICE Guidance

As discussed above, the NICE guidance on Excess Winter Deaths and Illness and the related NICE Quality Standard should guide the commissioning of any affordable warmth service offer for vulnerable households, as it is based on a review of best available evidence. Recommendation 3 "*Provide tailored solutions via the single-point-of-contact health and housing referral service for people living in cold homes"* is of particular importance as it outlines what the service offer should consist of:

- Housing insulation and heating improvement programmes and grants. Programmes should be led, or endorsed, by the local authority and include those available from energy suppliers.
- Advice on managing energy effectively in the home and securing the most appropriate fuel tariff and billing system (including collective purchasing schemes, if available). Note: the most appropriate fuel tariff may not be the cheapest if, for example, someone does not have a bank account or needs to budget on a weekly basis.
- Help to ensure all due benefits are being claimed, as people receiving certain benefits may be entitled to additional help with home improvements - and may get help to manage their fuel bills and any debt.
- Registration on priority services registers (for energy supply and distribution companies) to ensure vulnerable households get tailored support from these companies.
- Advice on how to avoid the health risks of living in a cold home. This includes information about what these health risks are (see Public Health England's Cold Weather Plan for further information).
- Access to, and coordination of, services that address common barriers to tackling cold homes. For example, access to home improvement agencies that can fix a leaking roof or to voluntary groups that can help clear a loft ready for insulation.
- Short-term emergency support in times of crisis (for instance, room heaters if the central heating breaks down or access to short-term credit).

4.3.2 Contextual factors

There is strong evidence collated by Sheffield Hallam University[4] on contextual factors (income, age, social connections, housing tenure and health) and their interaction with beliefs and values of older people regarding keeping warm at home. They also identified barriers that older people experience that prevent them accessing help in keeping warm, such as awareness, technology, disjointed systems and visibility (of fuel, money, information).

4.3.3 Warm Well Families

On the other side of the age spectrum, and no less important (as reflected in the Fuel Poverty Strategy for England 2015, which estimates that 45% of households in fuel poverty have school-age children), the "Warm Well Families" research was conducted by Sheffield Hallam University in 2014. This research explored factors influencing the abilities of households with children with asthma to keep warm at home in winter and access help. It proposed that:

- Much existing information on how to manage and alleviate fuel poverty existed but was not sufficiently accessible or usable. Vulnerable households stressed the notion of 'visible messages' where the benefits of taking a specific form of action could be clearly seen.
- There was much concern about 'damp' properties and mould. Accessible and assessable messages, re: prevention of build-up of condensation and mould should be developed.

4.3.4 National evaluation of Foundations Independent Living Trust (FILT) Warm Homes Service Funding[5]

The evaluation of the Warm Homes fund, which C&R received a proportion of, drew the following conclusions:

- Services are delivered to a large number of vulnerable people.
- This is a missed population often with complex vulnerability and unmet need.
- The fund enabled collaborative and community based response (integrated care).
- This was quick, flexible and responsive in assessing and installing interventions.
- There was an improvement in housing conditions: 'comfortable' temperatures, less damp and easier to heat.

The health impacts were:

- Interventions alleviated stress and had a positive impact on people's quality of life and wellbeing, their feelings of safety and security and their control of the home environment.
- Under the WAH programme, the greatest general health and wellbeing improvements were experienced by those who received heating installation or replacement and for those whom the highest cost work (£1,000 or more) was undertaken.

[4] "Keeping Warm in Later Life". 2011

[5] Sheffield Hallam University 2013

- Those who reported the worst health-related quality of life received higher cost heating measures under the WAH Programme and benefited most from the improvement.
- It is cost effective (e.g. match funding or top-up to other grants)
- As key players in local partnership arrangements, HIAs are essential organisations in making policy happen in practice as per the Cold Weather Plan and NICE Guidelines on excess winter deaths.
- Warm homes interventions can be a key contributor to achieving outcomes within current policy frameworks (NHS, Social Care frameworks, and the BCF).

5. Population and Health Data

This section explores the current population and health data relating to the key 'at risk' groups which form part of the home independence and affordable warmth services. The health needs assessment aims to support commissioning decisions and improve service delivery through the identification of health needs.

5.1 The Leeds Population

Leeds is the UK's third largest city; the most recent population data (ONS) reported 761,500 residents (Mid-Year Estimate of Population, 2013). This is expected to rise to around 840,000 by 2021. The most recent Census (2011) indicates that the Leeds population has grown 5% since 2001.

Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population. In this last decade, this has risen from 11% and the number of residents born outside of the UK has doubled to over 86,000. This presents a range of complex issues due to the speed of change, national identity, language proficiency and transient populations (Leeds Joint Strategic Needs Assessment, 2015).

In the coming years, Leeds is also expecting to see an increase in the numbers of children of primary school age as well as the numbers of those aged over 75 and over 85.

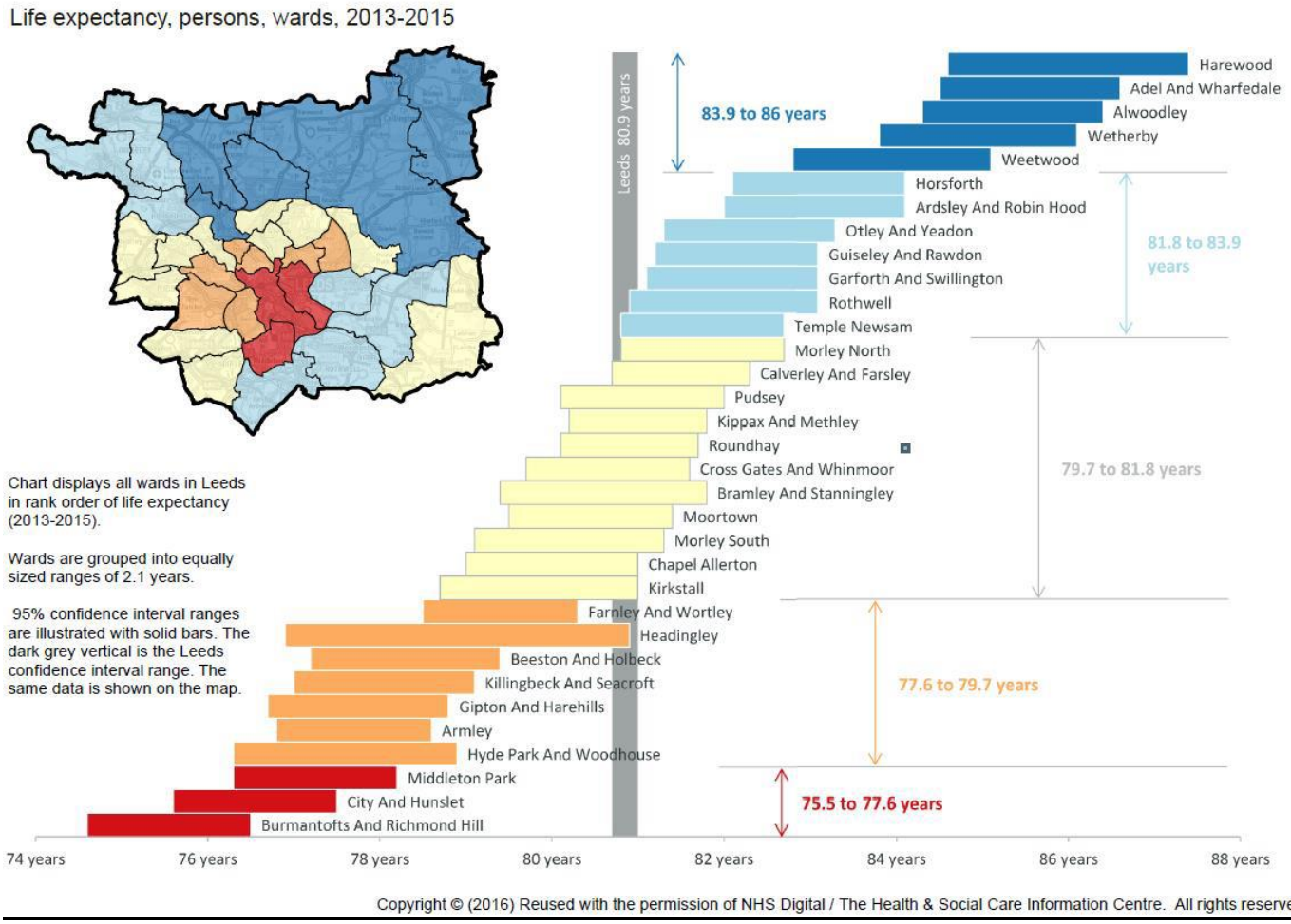
5.2 Life expectancy and mortality

Life expectancy is influenced by a variety of factors including deprivation, wider determinants, lifestyle, genetics and access to healthcare. Average life expectancy from birth for males in Leeds is 78.3, whilst the average life expectancy for females in Leeds is 82.1 (PHE 2017). The healthy life expectancy at 65 is 11.8 years for men and 13.9 years for women. These life expectancy figures are similar to those for neighbouring local authority areas.

Life expectancy is lower than the England average for men and women. There are gaps in life expectancy of up to 11 years for men and 8.4 years for women when we compare life expectancy in the most and least deprived areas of the city (ONS, 2015).

Figure 1 demonstrates the link between life expectancy and where you live in the city; an average life expectancy of 75.5 years to 77.7 years for people living in the most deprived wards of the city such as Middleton Park. Compared to the average life expectancy ranges of 83.9 to 86 for more affluent wards such as Harewood and Weetwood.

Figure 1: Life expectancy by ward in Leeds (2013-2015) Source: ONS deaths extract, GP registered populations



5.3 The Ageing Population

According to the 2011 census, there were 232,120 people in Leeds aged 50-plus: 124,169 female and 107,951 male. 149,776 of these are aged 60-plus: 82,477 female and 67,299 male. 30,914 are aged 80-plus: 19,602 female and 11,312 male.

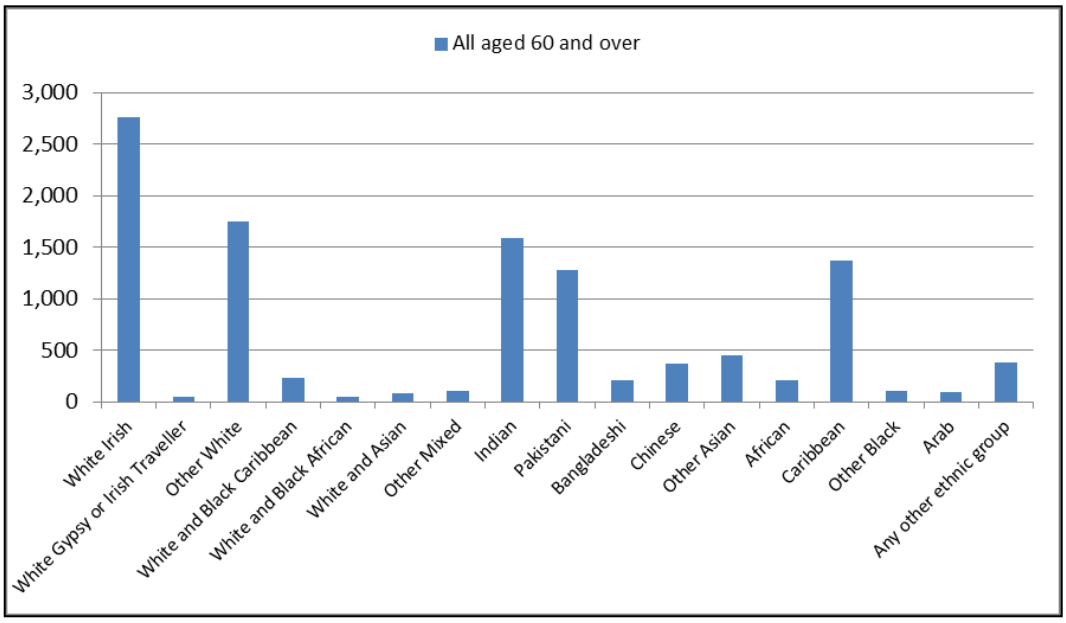
This means 1 in 5 of the Leeds population is aged 60 years and above (20%). This is higher than other core cities such as Nottingham (9%) and Manchester (12%). By 2021, it is expected that those aged 50-plus will rise to 256,585 and those aged 80-plus is expected to rise to 39,091. As more people in the city live longer, there presents challenges in terms of the complex needs they are living with. In Leeds, the number of frail elderly requiring health and social care support is increasing while the financial situation sees budgets decreasing or stopping.

5.3.1 Older Black and Minority Ethnic Groups (BAME)

Over the next two decades, the older population is likely to become increasingly diverse as the cohorts of people who have migrated to the UK since the 1960s enter retirement. This increasing diversity will have implications for providing services to older people, in relation to cultural needs.

In Leeds, ethnicity varies by age with a relatively larger proportion of White people in the older age groups. There are 11,101 people aged 60-plus who are from BAME Communities: 7% of the population. Figure 2 shows the distribution of the population aged 60-plus by standard ethnic classification.

Figure 2: BME population (standard ethnic groups)



5.3.2 Where are older people living within Leeds?

Figure 3 shows where within the city older people are living. Figure 1 highlights which wards have a higher proportion of people aged 60-plus. From this, we can see that as people age they tend to migrate from the city centre to live in the more rural, less-deprived wards on the edge of the city. Although seen as more affluent areas, older people living here face a number of challenges including:

- Poor transport links which can lead to social isolation and loneliness.
- Difficulty accessing services - health, shops, post offices, etc.
- Poorly maintained homes - fuel inefficient.
- They may be asset rich but cash poor therefore experience financial exclusion.
- Fuel poverty.

Figure 3: Location of Leeds Residents Aged 60 and Above, 2015

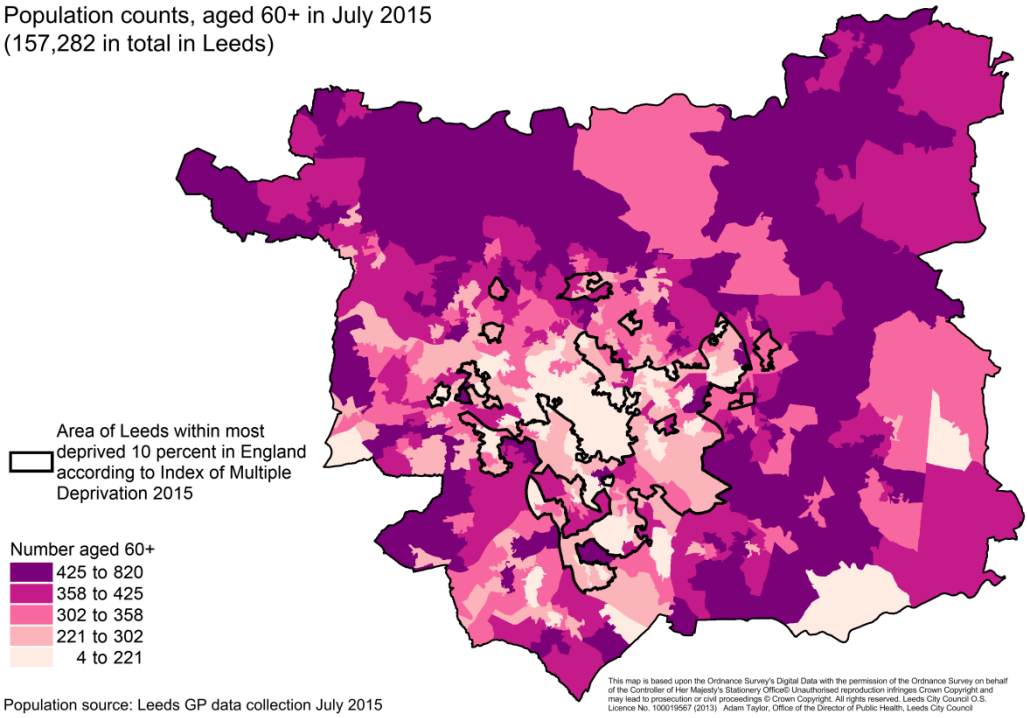
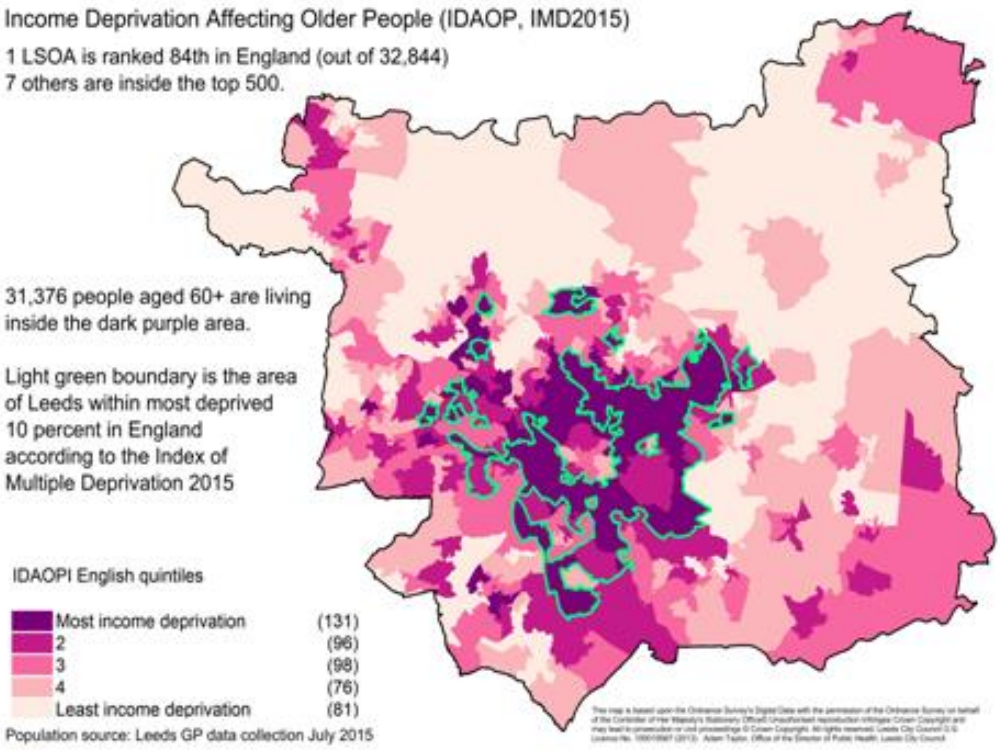


Figure 4 uses pension credit as an indicator of older people's deprivation. From this we can see that income deprived older people live in the inner areas of the city. The wards with a higher proportion of older people receiving pension credit correspond largely with the most deprived wards within the city.

Figure 4: Income Deprivation Affecting Older People, 2015



Older people living within these areas will experience the following challenges:

- Inequalities from a lifetime: low income, poor work conditions and poor access to services.
- Older people tend to be living within social or private housing which can be of poor quality and inadequate for their needs.
- They experience social isolation, fear of crime and ageism.
- Fuel poverty.

The impact of this includes: excess winter deaths, reduced disability-free life years, high fractures and people not dying in a place of choice.

5.3.3 Long-term conditions affecting older people

Long-term conditions are more prevalent in older people (58% of people over 60 compared to 14% under 40). Whether an individual has a long-term condition or not can influence how much they rely on health and social care support.

Projections for the future of long-term conditions are not straightforward. The Department of Health (based on self-reported health) estimates that the overall number of people with at least one long-term condition may remain relatively stable until 2018. However, analysis of individual conditions suggests that the numbers are growing, and the number of people with multiple long-term conditions appears to be rising.[6]

According to the 2011 Census, 38% of the total population aged 50-plus in Leeds have their day-to-day activities limited by a long-term health problem or disability.

[6] Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

For those aged 85-plus, 84% are limited in this way. 12% of those aged 50-plus in Leeds in 2011 described their general health as “bad” or “very bad”. The figure for those aged 85-plus was 24%.

Projecting Older People Population Information (POPPI) estimates that, in 2017, 31,921 people in Leeds aged 65-plus are predicted to have a limiting long-term illness whose day-to-day activities are limited slightly, rising to 43,120 by 2035. Similar figures can be seen for those aged 65-plus with a limiting long-term illness whose day-to-day activities are limited a lot (30,296 rising to 42,745 in 2035).

Table 1: People aged 65 and over living in Leeds with a limiting long-term illness, by age, projected to 2035

No. whose day-to-day activities are limited a little					
	2017	**2020**	**2025**	**2030**	**2035**
Ages 65-74	15,068	15,342	15,411	17,217	18,383
Ages 75-84	12,527	13,127	15,430	16,503	16,945
Ages 85 and over	4,326	4,622	5,320	6,100	7,793
Total	**31,921**	**33,090**	**36,161**	**39,819**	**43,120**
No. whose day-to-day activities are limited a lot					
Ages 65-74	11,558	11,768	11,821	13,207	14,101
Ages 75-84	11,384	11,929	14,022	14,997	15,399
Ages 85 and over	7,353	7,856	9,043	10,368	13,245
Total	**30,296**	**31,553**	**34,887**	**38,572**	**42,745**

For pensioner couple households, 29% (6,552) contain one person with a long-term health problem or disability and 34% (7,631) where both people have a long-term health problem or disability (Census, 2001).

5.4 Reducing Hazards – Falls Prevention

5.4.1 The English Housing Survey

This a national survey of people’s housing circumstances and the condition and energy efficiency of housing in England. The 2014-15 survey found that 9% of all households in England had one or more people with a long-term limiting disability that required adaptations to their home. Those aged under-55 and private renters were most likely to feel that their accommodation was unsuitable for their needs.

The most common adaptations that households needed were inside their home and relatively simple to install.

The four most common adaptations that households needed were inside their home:

- Grab hand rails inside the dwelling (40%).
- Bath or shower seat or other bathing aids (30%).
- Specialist toilet seat (25%).
- Shower to replace a bath (19%).

The next most commonly reported adaptations required to the outside of the home were:

- External grab rails (19%).
- Ramp outside the block or house (18%).

The survey also found that between 2011-12 and 2014-15, there was an increase in the proportion of households requiring a bath or shower seat or other bathing aids (from 26% to 30%) and in the proportion requiring a specialist toilet seat (from 19% to 25%).

All households that did not have the required adaptations were asked why the modifications to their home had not been made. The most commonly selected answer were:

- That they had not had enough time to carry out the modifications (24%).
- They could not afford to pay for them (21%).
- They were not worth doing (13%).

Around a third of households in the private rented sector (32%) and around a quarter in the social rented sector (22% of housing association tenants and 23% local authority tenants) containing a person who had a long-term limiting disability stated their accommodation was unsuitable. This was a higher proportion than for households that owned their accommodation (15%).

This finding may illustrate that owner-occupiers have more control over altering their home and installing their required adaptations. Households that rent privately may encounter reluctance from the landlord to undertake housing adaptations, e.g. a lack of landlord incentive or confusion over responsibility to install or maintain the adaptation.

5.4.2 Falls prevention for older people

Falls and fall-related injuries are a common and serious problem for older people. Falls in older people cause distress, pain, injury, loss of confidence and independence and mortality. Without the correct support, the impact that falls can have on an older persons quality of life can cause many to leave their own homes and move into a care home.

Data taken from the Public Health Outcomes Framework shows that, in 2015/16, there were 2,837 recorded injuries due to falls among those aged 65-plus in Leeds. This translates to a directly standardised rate of 2,391 per 100,000 population. Table 2 shows the age standardised rate of emergency admission due to falls in persons aged 65-plus, 65-79 and 80-plus per 100,000 in 2015/16.

Table 2: Emergency hospital admissions due to falls in people aged 65+

	All	Male	Female
65 years and above	2,391	1,894	2,724
65 years – 79 years	1,096	894	1,269
80 years and above	6,148	4,795	6,942

During this period, there were 781 hip fractures in those aged 65-plus, which was a directly standardised rate of 659 per 100,000 population. Table 3 shows the age standardised rate of emergency admission from fractured neck of femur aged 65-plus, 65-79 and 80-plus per 100,000 in 2015/16.

Table 3: Hip fractures in people aged 65+

	All	Male	Female
65 years and above	659	501	771
65 years – 79 years	282	195	356
80 years and above	1,750	1,389	1,977

In Leeds, the average length of stay in hospital following a hip fracture is 23 days.[7] Length of stay in Leeds is longer than the regional and national average - within the Yorkshire and Humber region, the average length of stay is 18.7 days, compared to the national average of 21 days. Leeds is one of the worst performing areas in the region.

50.5% of those suffering a hip fracture return to their original place of residence within 30 days (some of these could be care homes). Leeds shows a similar picture to the regional (52.1%) and national average (50.5%).

Table 4 shows the percentage of admissions of people who returned to hospital as an emergency within 30 days of the last time they left hospital after a stay. This indicator aims to measure the success of the NHS in helping people to recover effectively from illnesses or injuries. If a person does not recover well, it is more likely that they will require hospital treatment again within the 30 days following their previous admission.

Table 4: Emergency readmissions within 30 days of discharge from hospital (2011/12)

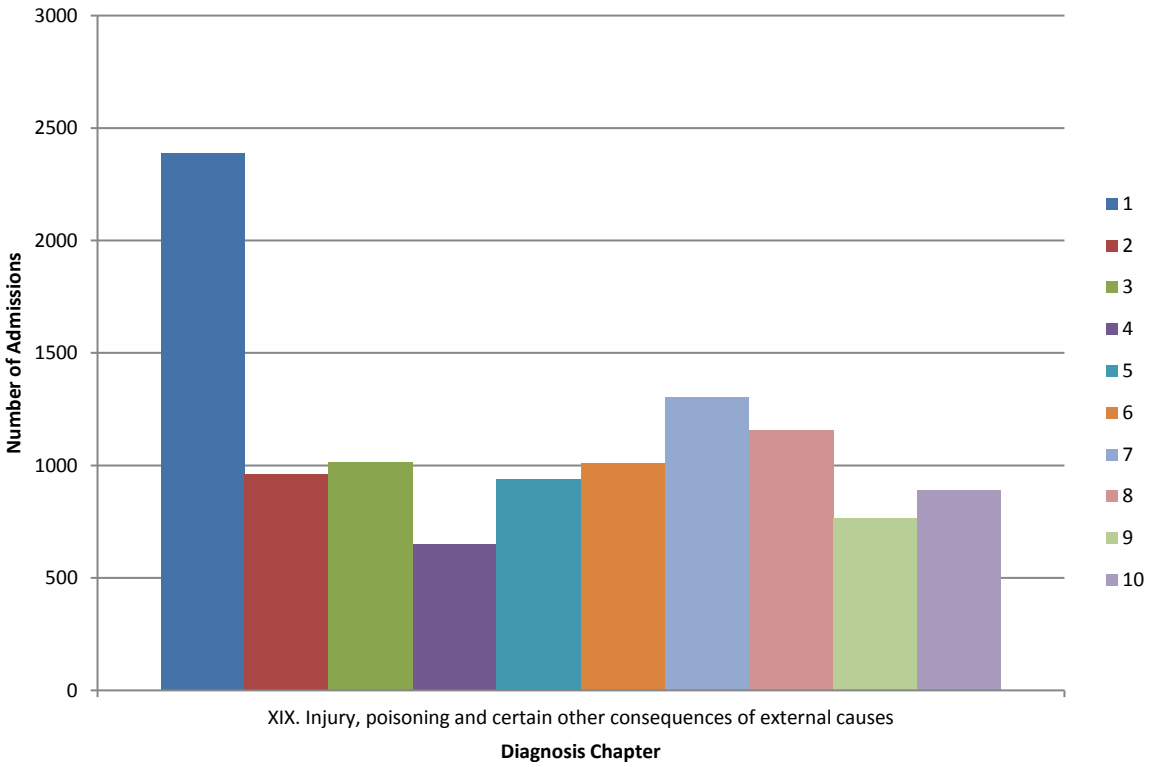
	All	Male	Female
All age	13.4	14.1	12.8

[7] 2016 – National Hip Fracture Database

5.4.3 Falls and Deprivation

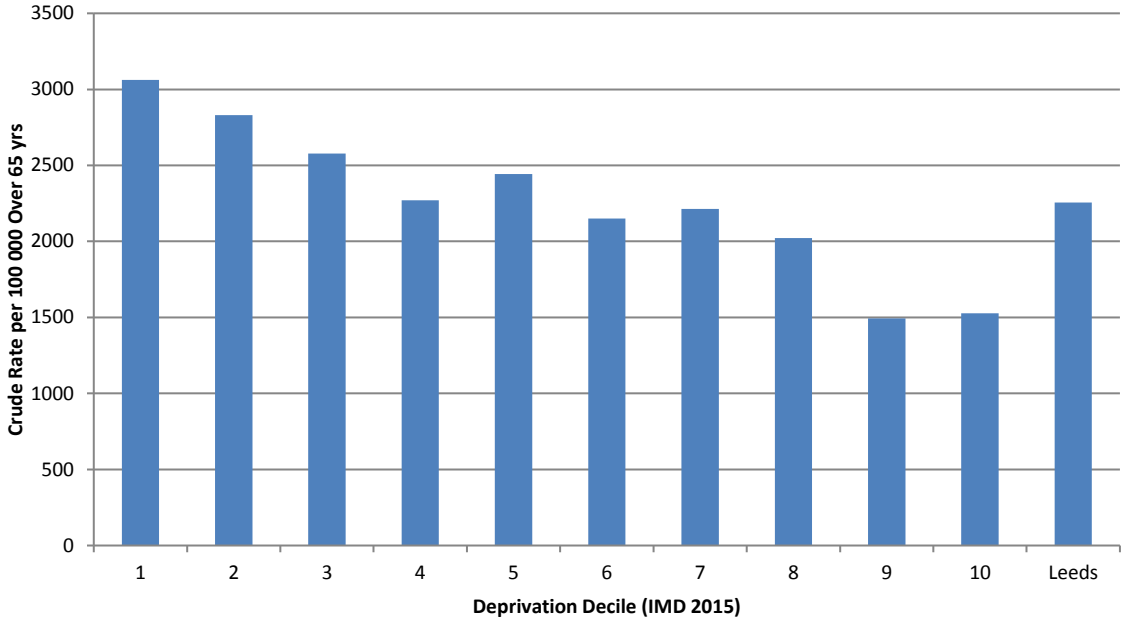
Hospital Episodes Statistics (HES) in patient data has been analysed over a 4 year period (2012/13 to 2015/16) to provide local data about falls with a variety of diagnosis. This data allows us to explore the number of admissions for falls in patients aged 65-plus, presented by the Index of Multiple Deprivation (IMD) 2015 deprivation deciles 1-10, where 1 is the 10% most deprived lower super output areas (LSOAs) in England. The breakdown shows 1 in 5 (21.6%) lived in the 10% most deprived LSOAs.

Figure 5: Number of Admissions aged 65 and above by deprivation decile (2012/13 – 2015/16)



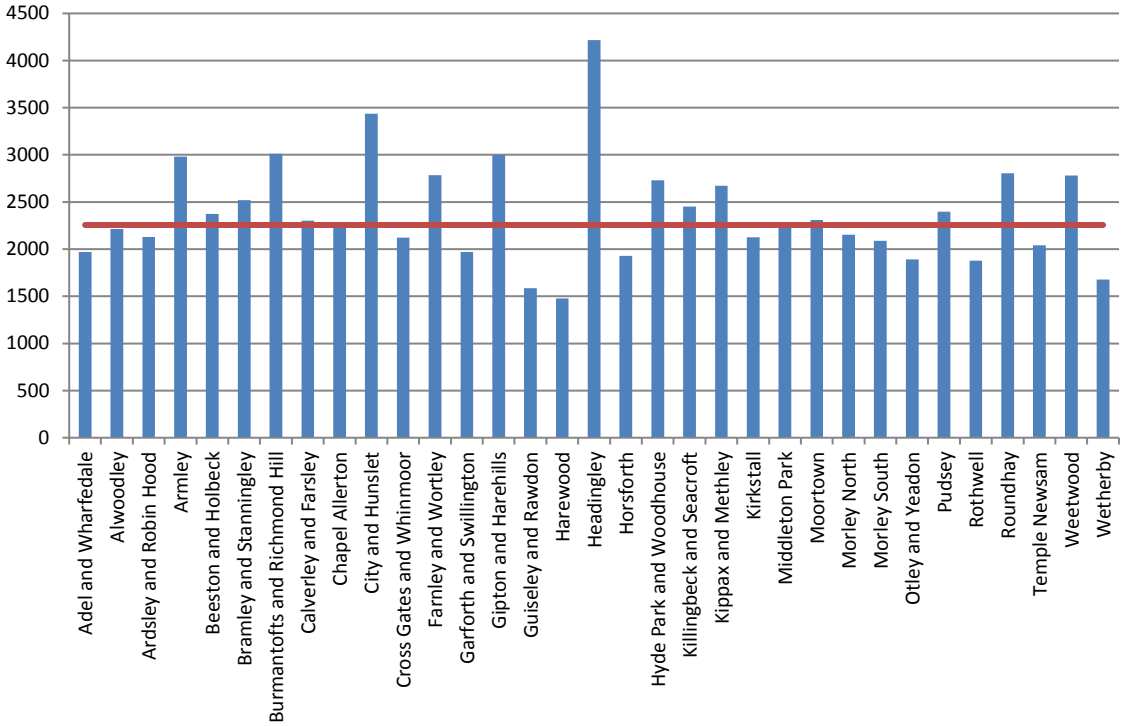
When the rates are standardised, there is a linear trend to the rate of admission and deprivation decile. Those in decile 1 (the 10% most deprived LSOAs) has approximately double the rate of admission when compared to decile 9 and 10.

Figure 6: Rate of Admission per 100,000 aged 65 and above by deprivation decile (2012/13 – 2015/16)



When the data is broken down to ward level (see Figure 7), the more deprived wards show high admission rates. However, the high rates for wards which are less deprived (e.g. Headingley) are due to the effect of care homes and the high admission rates from these.

Figure 7: Admission rate per 100,000 aged 65 and above by ward (2012/13 – 2015/16)



5.4.4 Falls and older people – projections for Leeds to 2035

In 2017, 32,358 people in Leeds aged 65-plus are predicted to have a fall, rising to 44,957 by 2025. This data demonstrates a need for additional capacity within services to support those who are at risk of or who have had a fall within the city.

Table 5: People aged 65 and over living in Leeds predicted to have a fall, by age and gender, projected to 2035

	2017	2020	2025	2030	2035
Ages 65-69	7,251	6,895	7,548	8,550	8,632
Ages 70-74	7,254	7,966	7,294	8,040	9,121
Ages 75-79	5,202	5,462	6,950	6,420	7,161
Ages 80-84	5,728	5,957	6,242	8,068	7,573
Ages 85 and over	6,923	7,353	8,514	9,761	12,470
Total	**32,358**	**33,633**	**36,548**	**40,839**	**44,957**

An upward trend is also predicted for the number of hospital admissions due to a fall. In 2017, 2,519 people in Leeds aged 65-plus are predicted to have a fall resulting in an admission, rising to 3,615 by 2025.

Table 6: People aged 65 and over predicted to be admitted to hospital as a result of falls, by age, projected to 2035

	2017	2020	2025	2030	2035
Ages 65-69	184	174	190	215	218
Ages 70-74	282	309	283	312	354
Ages 75 and over	2,053	2,164	2,528	2,760	3,043
Total	**2,519**	**2,647**	**3,002**	**3,287**	**3,615**

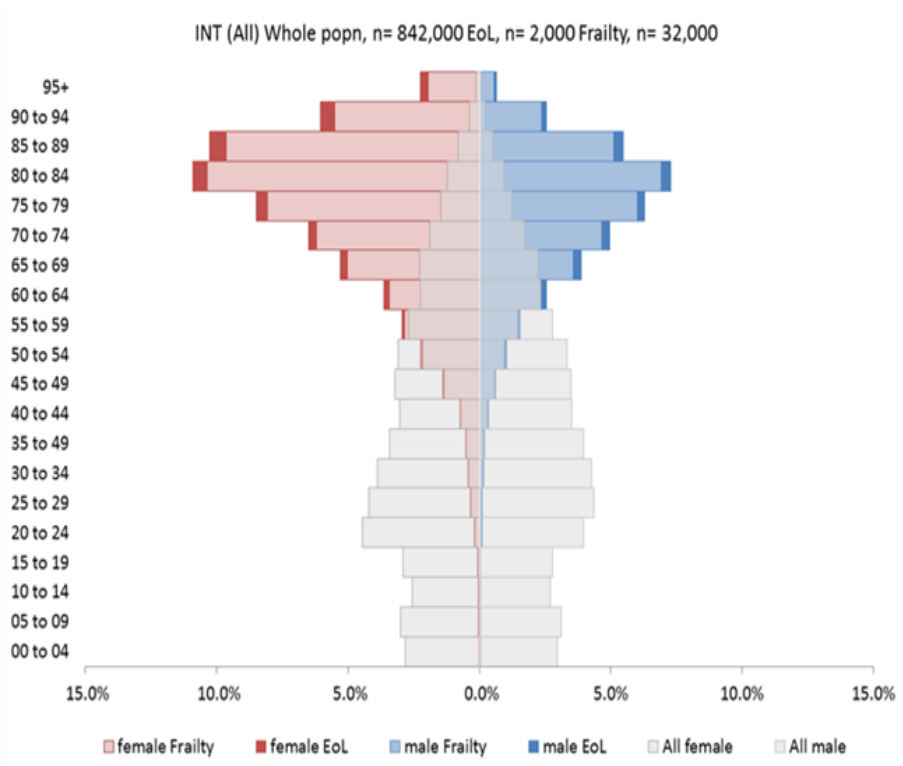
5.5 Living with Frailty

5.5.1 Age and gender distribution

Figure 8 shows the distribution of people with frailty. The bars to left of the central line (in red) show the distribution of females by age band as a percentage of the total cohort (n=34,000 including 2,000 people on palliative care registers: the darker bands). The bars to the right of line (in blue) are the proportion of males. The grey bars show the same distribution for all Leeds GP registered people.

From this chart it can be seen the majority of people (over 90%, n=29,000) are 60-plus. Though there are also younger people with a significant level of frailty (n=5,000). It should be noted almost two thirds of this cohort (62%, n=21,000) are female.

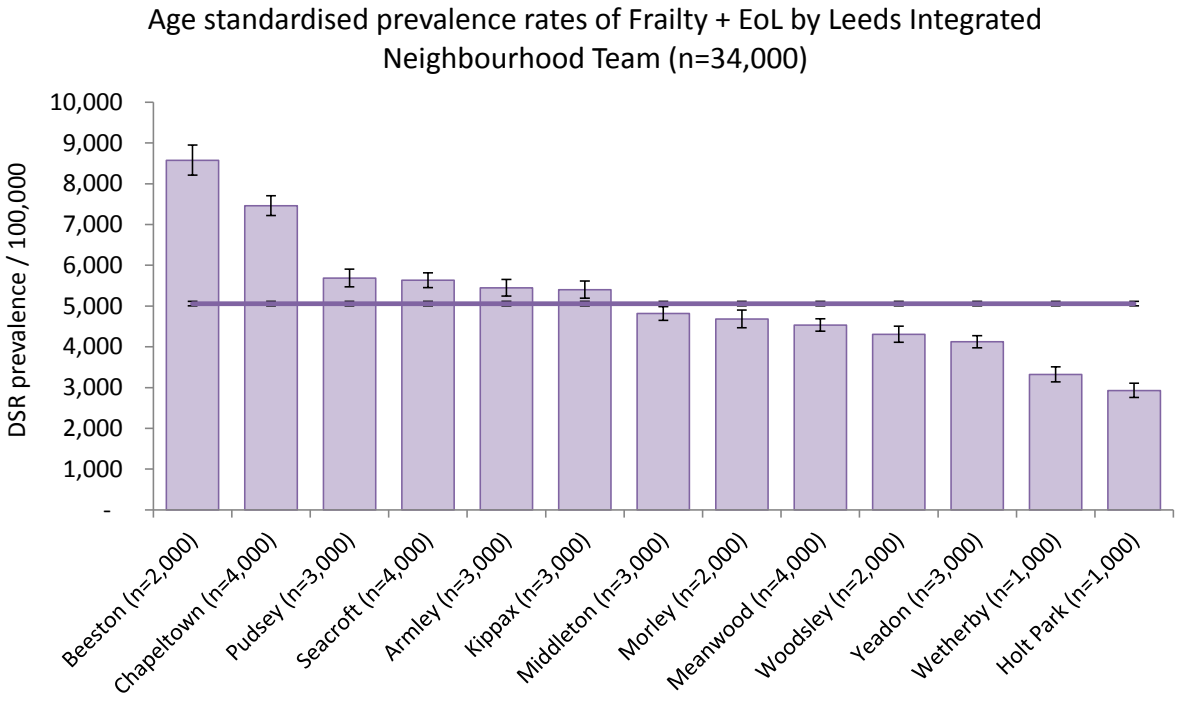
Figure 8: Age and gender distribution of people living with frailty



5.5.2 Geographic distribution of Frailty – age standardised prevalence

Figure 9 shows the age standardised prevalence rates of those on an end of life care (EoL) register or frail by Integrated Neighbourhood Team (INT). Standardising for age (i.e. calculating the prevalence of Frailty if all INT had the same age distribution) shows that areas with higher levels of deprivation have higher levels of Frailty.

Figure 9: Age standardised prevalence rates of those on an EoL register or frail by INT



5.6 Housing

According to the 2011 census, there are 84,621 people aged 65-plus who live in households where all the residents are aged 65-plus (pensioner-only households), of which:

- 38,326 (45%) live alone, 44,698 (53%) live as a couple and 1,597 (2%) live in some other type of household.
- 31% of lone pensioners are male and 69% are female.
- Pensioner-only households account for 12% of all households in the city.

5.6.1 Characteristics of older households

Nationally, the English Housing Survey 2014-15 found that the vast majority of older households (aged 55-plus) were owner-occupiers (76%). Data from POPPI provides a breakdown of tenure by age bracket for older people living in Leeds:

Table 7: Proportion of population aged 65 and over by age and tenure, i.e., owned, rented from council, other social rented, private rented or living rent free, year 2011

	Ages 65-74	Ages 75-84	Ages 85 and over
Owned	70.84	68.16	59.74
Rented from council	18.20	19.03	21.09
Other social rented	5.31	6.59	9.98
Private rented or living rent free	5.65	6.22	9.18

Over 65s living as couples are more likely to live in owned property (83%), whereas a higher proportion of single older people (1 in 3 or 34%) live in social rented accommodation[8].

The English Housing study found that older households were more likely to live in detached homes and bungalows compared with younger households. The proportion of older households living in flats has fallen while the proportion living in detached homes has increased.

The high level of owner-occupation and the ability to release the equity in the home have implications for the housing and care choices older people can afford to make. These choices are likely to be influenced by a desire to pass on to the next generation some of the wealth built up in homes.

5.6.2 Downsizing

Older people tend to move home less frequently than the rest of the population.[9] Older people are choosing to remain within the family home and not to downsize. This means that we need to think about how homes are used differently. The homes in which people are ageing in need to be adapted to ensure they are suitable for their changing needs. Retrofitting is needed to ensure they are appropriate for safety, health and climate change.

5.6.3 Design and living conditions

However, 96% of older households live in homes not designed specifically for older age. In addition, older people are more likely to live in non-decent homes (Public Health England, 2016). A decent home is defined as one that meets the current statutory minimum standard for housing:

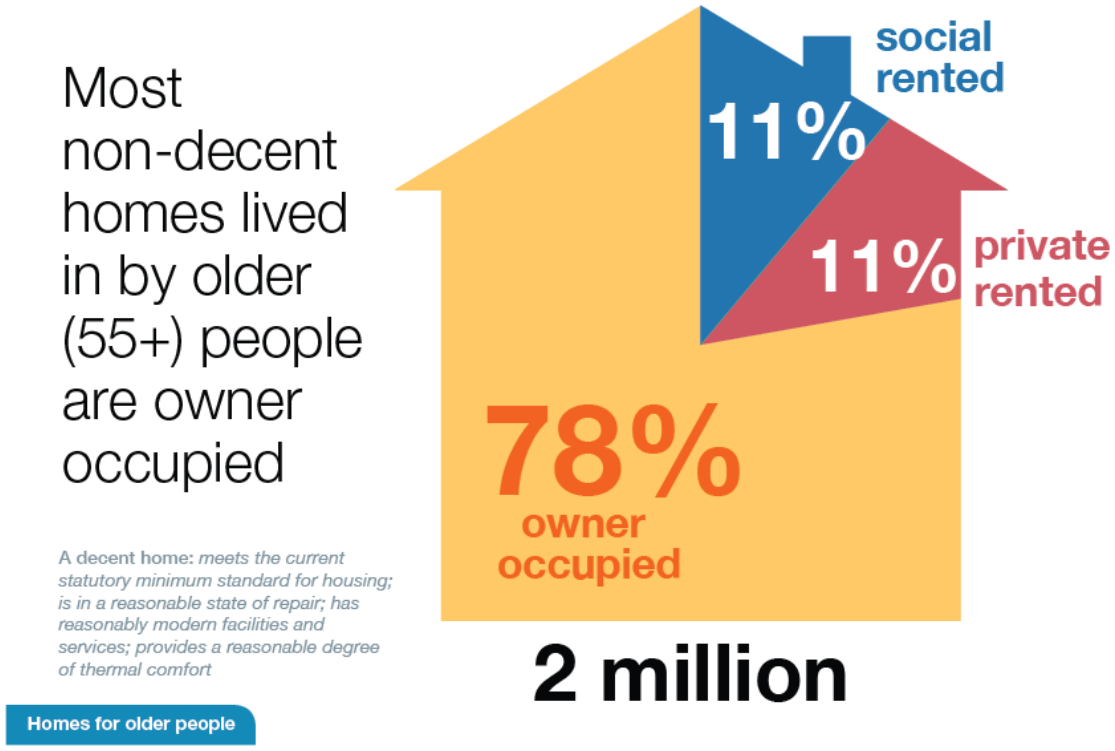
- Is in a reasonable state of repair?
- Has reasonably modern facilities and services?
- Provides a reasonable degree of thermal comfort?

[8] 2011 Census

[9] *Housing Choices in Old Age*. Counsel & Care and the Dept. of Applied Social Science, Lancaster University, 2003

The fabric of our housing affects our wellbeing, risk of disease and demands on health and care services. We need warm, safe and secure homes to help us to lead healthy, independent lives and to recover from illness.

Figure 10: the proportion of older people by tenure living in non-decent homes (Public Health England, based on the 2014 to 2015 English Housing Survey (EHS) dataset



5.7 Affordable Warmth, Adverse Weather and Cold-Related Illness

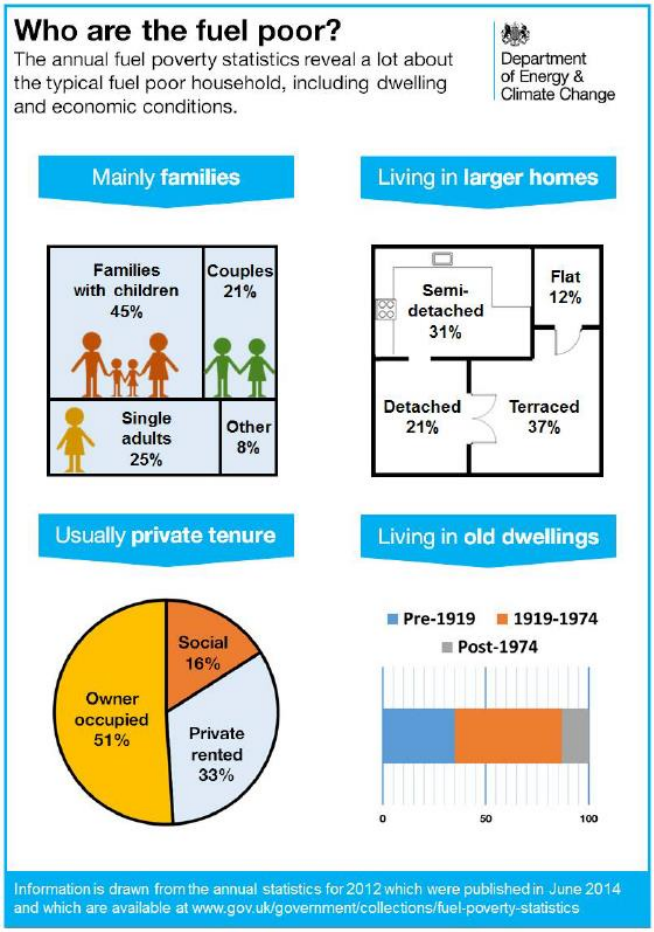
The NICE guidance on excess winter deaths and illness and the health risk associated with cold homes (2015) states that the following groups are vulnerable to cold living conditions:

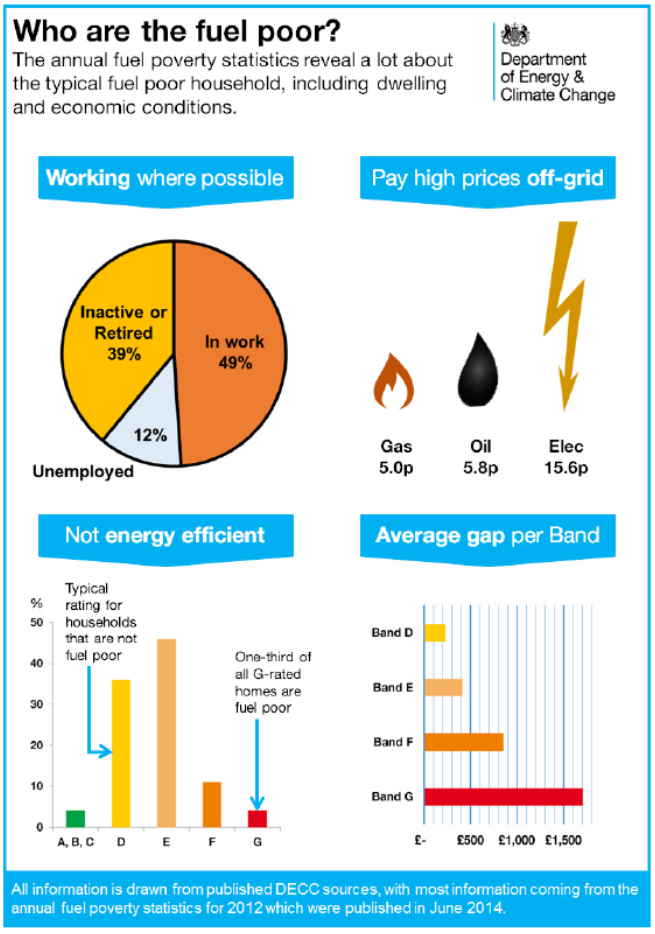
- People with cardio-vascular conditions.
- People with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma).
- People with mental health conditions.
- People with disabilities.
- Older people (65-plus).
- Households with young children (from new-born to school age).
- Pregnant women.
- People on a low income.

5.7.1 Cutting the Cost of Keeping Warm: Fuel Poverty Strategy for England (2015)

The Fuel Poverty Strategy for England has estimated the number and type of households affected by fuel poverty. The picture is very complex, with a range of households affected. The graphics in Figure 11 summarise key household characteristics from 2014. This picture will change over time as energy prices, relative incomes and energy efficiency levels all change.

Figure 11: Characteristics of households affected by fuel poverty





5.7.2 English Housing Survey 2015 on Heating and Energy Efficiency

The English Housing Survey, which was quoted earlier in relation to older people and housing, also reports on factors that influence householders' ability to achieve affordable warmth.

Interestingly, the Housing Survey asked householders about "subjective overheating", i.e. whether residents feel that any part of their home gets uncomfortably hot, and, if so, which parts. However, the survey did not ask about "under-heating" which could affect the health and wellbeing of householders, especially those with a vulnerability as per NICE guidance.

The Survey reported on energy efficiency **'SAP' ratings**, which affect the effectiveness of heating a property (and retaining warmth), or maintaining a cool indoor temperature in summer. Almost half (48%) of dwellings in the social rented

sector had an energy efficiency rating of A-C (with 'A' being the highest rating and 'G' lowest), compared with 26% in the private rented sector and 24% of owner occupied homes.

There are two key methods of increasing the energy efficiency of existing dwellings -
1. Upgrading the heating system:

- The proportion of homes with central heating was 92%. The private rented sector had the lowest proportion of homes with central heating (84%), followed by housing association homes (88%). Owner-occupied and local authority homes had the highest (both 95%).
- 59% of dwellings had a condensing-type boiler installed (mandatory for new and replacement boilers since the mid-2000s). 21% of owner-occupied dwellings and 13% of private rented dwellings had a standard less energy-efficient boiler, compared with 8% of social sector dwellings.

2. Increasing insulation:

- Since 2008, insulation levels increased in all dwellings. This is likely due to initiatives such as the Decent Homes programme, energy efficiency requirements on new build properties and an increased awareness of energy efficiency and ways of increasing it.
- Taking dwellings with predominantly cavity or solid walls separately, 68% of dwellings with cavity walls had insulation installed compared with only 9% of dwellings with predominantly solid walls. Only a third of all dwellings had the required level of loft insulation (200mm+). N.B. only 87% of dwellings had lofts.

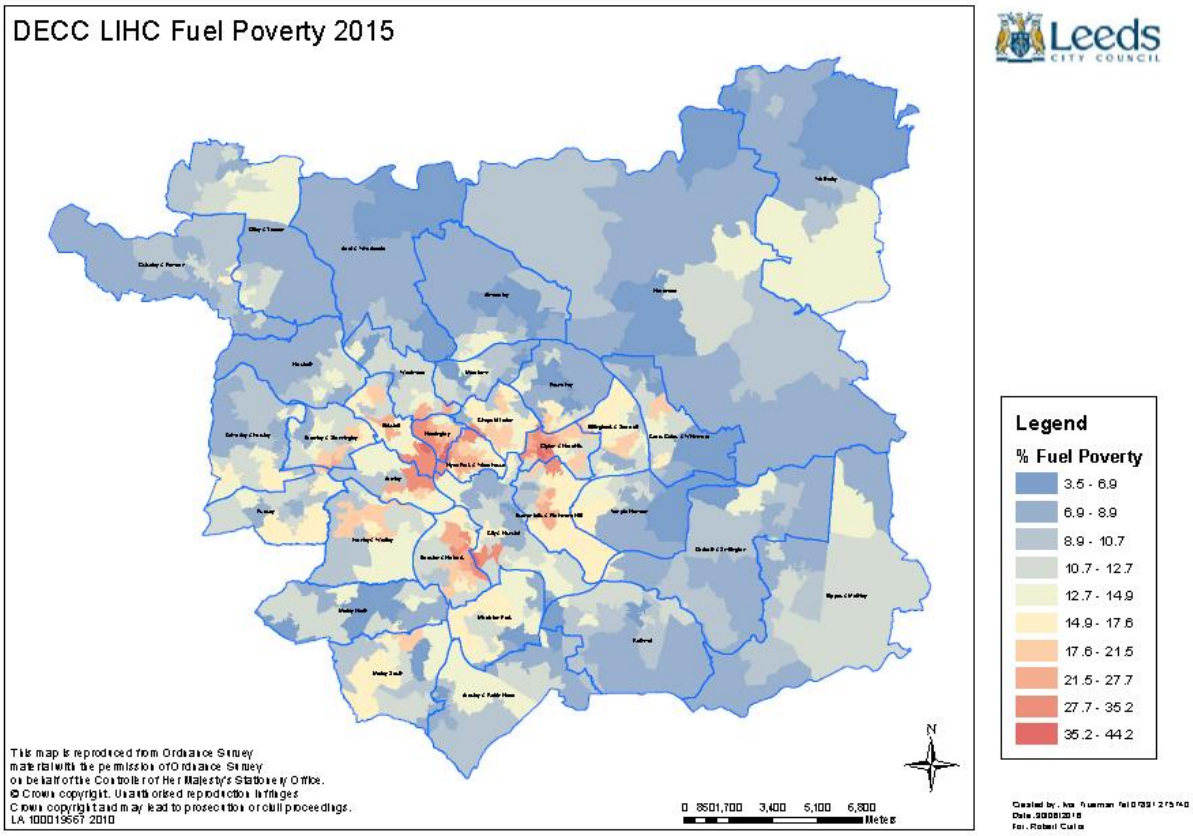
5.73 Fuel Poverty Statistics in Leeds

The 2017, the BRE (Buildings Research Establishment) Client Report into the state of private sector housing in Leeds, commissioned by Leeds City Council, noted that over 46,000 private sector dwellings (17%) have category 1 HHSRS Hazards such as excess cold and fall hazards.

According to the latest figures available from the Department of Business, Energy and Industrial Strategy, 13.5% of Leeds Households were in fuel poverty in 2015 (according to the Low Income / High Cost indicator), an increase from 11.9% in 2014. This was higher than the proportion for England which was estimated to be 11% in 2015.

The map (figure 12) provides a geographical representation of where fuel poverty is the most (dark red), and least (dark blue), prevalent in Lower Super Output Areas (LSOAs) in Leeds. The areas with the highest prevalence are Inner North-West (Headingley; Hyde Park & Woodhouse; Burley), Inner East (in particular Gipton & Harehills; Burmantofts & Richmond Hill) and Inner South (in particular Hunslet; Beeston & Holbeck).

Figure 12: Fuel poverty across Leeds


DECC LIHC Fuel Poverty 2015
Leeds
CITY COUNCIL
Legend
% Fuel Poverty
3.5 - 6.9
6.9 - 8.9
8.9 - 10.7
10.7 - 12.7
12.7 - 14.9
14.9 - 17.6
17.6 - 21.5
21.5 - 27.7
27.7 - 35.2
35.2 - 44.2
N
0 850 1,700 3,400 5,100 6,800
Meters
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6. Current Provision

6.1 Suitable homes and reducing hazards – Home Adaptations & Repairs

The current pilot model brings together the various delivery strands into one contract, with caseworkers working holistically across all types of intervention, removing the need for clients to be transferred between services and caseworkers for different works. This improves the support that the client receives and makes the provision easier for both C&R and LCC to manage.

However, the new arrangements have also highlighted an issue which had not been apparent before. With all referrals now being managed centrally, rather than by different teams, it became apparent that there are sometimes several referrals being made for the same client by multiple health professionals. This has several implications:

- Clients are receiving multiple visits, which is not only inconvenient but is probably also very confusing.
- Multiple visits will be incurring separate labour charges.
- It's difficult and confusing for C&R staff when referrals contradict each other.

This is mostly caused by the fragmentary nature of healthcare services, where different specialists, such as occupational therapists and physiotherapists, community and hospital, have specific roles and focuses but no central way of recording what support a client has already received.

Although managed as a whole, the service has three distinct functions:

- Hospital Discharge - minor adaptations that help people to return home. Referrals are sent by fax from the hospital clinician to C&R outlining the measures required before the patient can be discharged. Usually, this involves rail installations, but can also include measures such as moving bedroom furniture downstairs or moving electrical sockets. The aim is to enable the client to return home as soon as possible after they are fit for discharge, so the timescale for job completion is usually 1-2 days.
- Major Adaptations - large adaptations to enable people with disabilities to stay in their current home. Measures are funded by the Disabled Facilities Grant, with referrals coming through the council's Health and Housing team.
- Minor Adaptations and Repairs - minor adaptations to help prevent falls and repairs that enable older people to remain at home. Referrals can be sent through multiple routes, whether health professionals, other agencies or by the clients themselves.

For the purposes of this analysis, the major adaptations element is not included as it has already been decided that, because it is quite distinct from the rest of the service, it will not be part of the new contract and will be managed separately from 2018.

The data highlighted in the following tables covers the first two years of the pilot arrangements.

6.1.1 Hospital Discharge

Over the years in question, 1,539 Hospital Discharge referrals were made, with the bulk coming from St James's hospital (57%). LGI provided 17% of referrals, with the rest coming from a wide range of hospitals both in and outside of Leeds, including Chapel Allerton, Pinderfields, Harrogate and Dewsbury. The number of referrers will be an important consideration when implementing any changes to referral mechanisms.

The number of referrals has been steadily increasing each quarter, although this is not something that the service can control as it depends on the demand from within the hospital population. There had been a suggestion that there might be peaks of referrals in the autumn as newly qualified (and possibly more risk-averse) staff began work; however, this has not been borne out by the data.

Table 8: Referrals received for Hospital Discharge

Hospital	2015/16	2016/17	Total
LGI	120	146	266 (17%)
St James	296	587	883 (57%)
Other	163	227	390 (25%)
Total	**579**	**960**	**1,539**

During this period, 1,314 people were supported and most jobs were completed within very short timescales. Over half of the jobs were completed within 24 hours and 82% within 72 hours. The timescale is to some extent dictated by the request of the referrer but the current service would appear to be able to meet these requirements in the vast majority of cases. Some jobs may take longer because of access problems or difficulty making contact for example. The quick turnaround ensures that people who are fit to be discharged are not having to stay in hospital for longer than necessary and is a key factor in determining the need for this service.

Table 9: Time taken for Hospital Discharge jobs to be completed

	2015/16*	2016/17	Total
All jobs completed	528	556	1,224
Within 24 hrs	51%	55%	53%
Within 48 hrs	16%	12%	14%
Within 72 hrs	23%	12%	17%

** Note: this is not a full year's data as the measures were changed after Q1*

The fitting of rails is the primary job carried out. Of the measures carried out (see Table 9), 94% were the fitting of rails. The next biggest job was moving or removing furniture (6.7%).

It is clear that the key factor in making the home more secure / secure enough for the client to return home is the fitting of rails to mitigate possible falls.

6.1.2 Minor Adaptations & Repairs

Table 10 shows the volume of referrals for this element of the service, averaging at 667 each quarter. Primarily, referrals come from health professionals or the individuals themselves. Many of the other referrals come from other voluntary organisations but very few come from Adult Social Care, who carry out less urgently-required works themselves.

Table 10: Referrals received for Minor Adaptations & Repairs

Source	2015/16	2016/17	Total
OTs	853	1,190	2,043 (38%)
NHS Trust	559	280	839 (16%)
Self	462	277	739 (14%)
Physiotherapist	300	293	593 (11%)
Friend / Relative	137	158	295 (5%)
Social Care	48	48	96 (2%)
Other	322	415	737 (14%)
Total	**2,681**	**2,661**	**5,342**

During the two-year period, 4,472 jobs were completed: an average of 559 each quarter. Of these, 893 included a visit from a case worker for a more detailed assessment of needs. The remaining jobs were able to be carried out on the basis of the information provided in the referral (and telephone conversations with referrers and / or the client). When bringing the services together, it had been envisaged that a higher proportion of clients would receive the holistic assessment than proved to be the case. In practice, the volume was largely determined by case worker capacity as much as whether the type of referral warranted further investigation. If we want to further the aim of conducting holistic assessments, it will be necessary to increase caseworker capacity within the new model.

Timescales for how quickly jobs were completed was influenced by whether a visit was carried out. Nearly a third of those jobs not requiring a visit were completed within 2 working days and nearly two thirds completed within 10 days. Given the need to arrange convenient meeting times, the majority of jobs took longer than 10 days. Nevertheless, 11% were still accomplished within 2 days. Overall, 60% of Minor Adaptations and Repair jobs took less than 2 working weeks, again highlighting the speed which is key to this service.

Table 11: Time taken for Minor Adaptations & Repairs jobs to be completed

Time taken	With visit	Without visit	Overall
Within 2 days	11%	29%	25%
3-5 days	7%	22%	19%
6-10 days	17%	16%	16%
More than 10 days	66%	34%	40%

The balance of the type of works carried out in this element has changed during the lifetime of the pilot, as the limited budget has been managed to prioritise health concerns over repairs. Historically, the service would have included a broad range of measures to keep homes in good repair and enable people to stay in their own homes, which could include quite minor works, such as fixing taps and shelving. This has changed to focus on health and wellbeing, such as heating repairs (including draught exclusions), improving lighting, fixing trip hazards such as poor floorboards and security measures.

Table 12: Primary repair works undertaken

	2015/16	2016/17	Total
Plumbing (Water)	109	62	171
Security Measures	85	22	107
CO Detector	53	40	93
Electrical	51	35	86
Joinery	56	30	86

In contrast, minor adaptations and the provision of equipment increased in the last year as the budget was prioritised to support those at risk of falling. However, it should be noted that the increase in equipment is exaggerated because of a change to recording systems - the numbers are artificially low in 2015/16 and more accurate in 2016/17.

Table 13: Minor adaptations and equipment provided

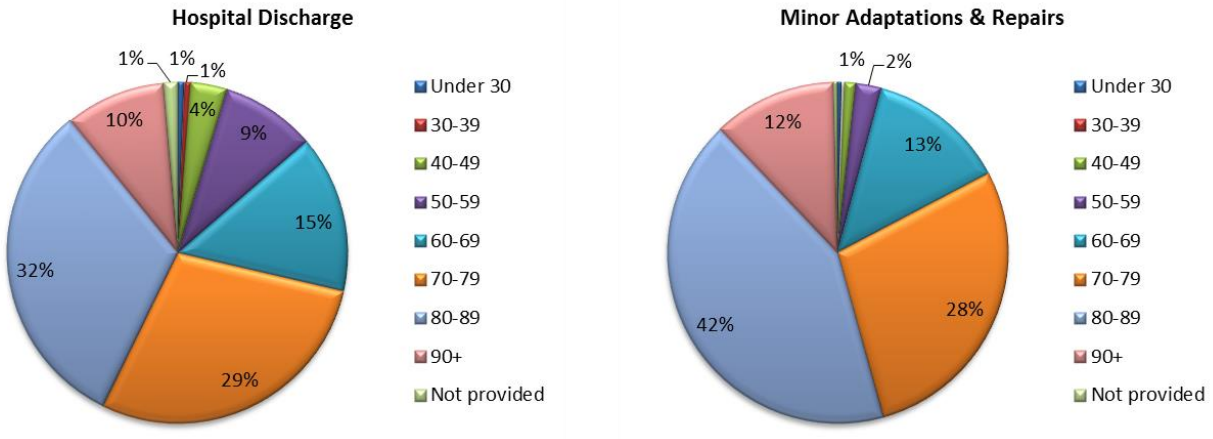
	15/16	16/17	Total
External rail	628	589	1,217
Stair rail	433	706	1,139
Bathroom rail	297	722	1,019
Other internal rails	410	317	727
Free standing toilet frames	15	43	58
Furniture move	12	18	30
Raised toilet seat	2	26	28
Bath board	1	26	27
Bath seats	3	20	23
Bath steps	0	20	20
Fit new threshold strips	7	3	10

Since demand for falls prevention measures continues to grow, it is important to retain this provision, especially given the wider implications of falls (which are discussed later). The repairs element of the provision also enables older people to remain in their own homes for longer; however, the practice of the current service to prioritise repairs aimed at maintaining health and wellbeing should be formalised within the new model, in order to make the biggest impact with the available budget.

6.1.3 Client Demographics

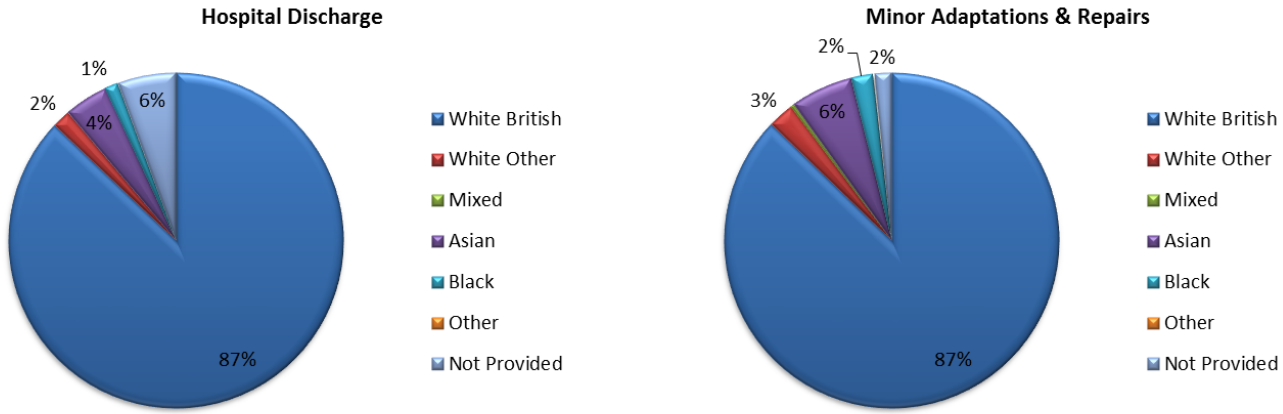
- *Age Group*

The Minor Adaptations & Repairs element is for those aged 60-plus, although exceptions can be made for someone younger in particular need of the service. Hospital Discharge, however, is available to anyone of any age. Although the number of those aged under 60 is small, there is still demonstrable demand from this group.



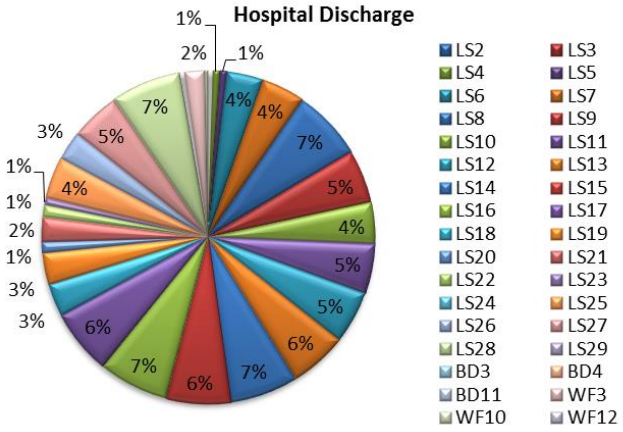
- *Ethnicity*

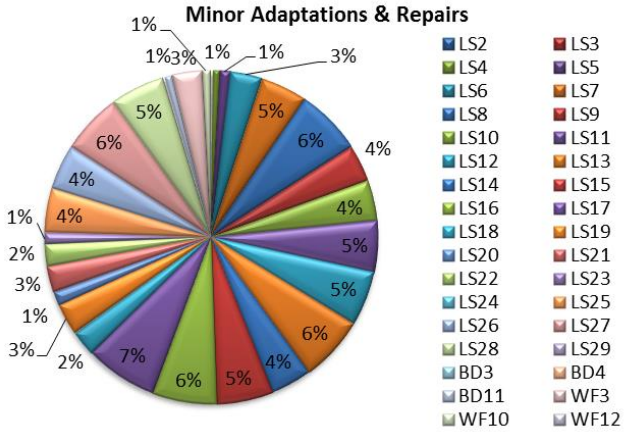
The ethnicity profile of current clients does not match the city's population, suggesting that there may be unmet need within some communities. Across these services, 89% of clients (excluding those whose ethnicity is unknown) are White British, compared with 81% of the Leeds population.



- *Postcode areas*

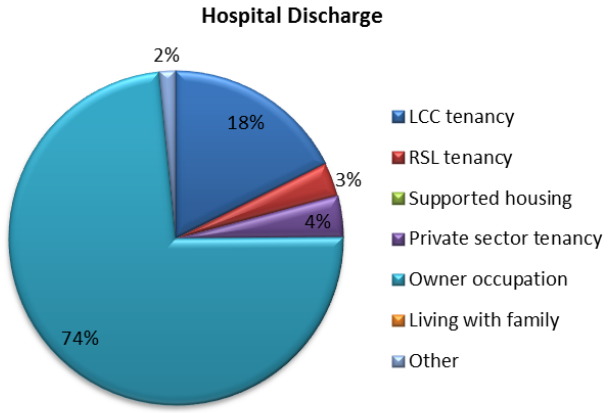
The current provision is open to all residents within the Leeds Metropolitan District and analysis shows that there is demand from people across the whole area. Only one postcode area (LS1) has not had any clients during the two years in question.

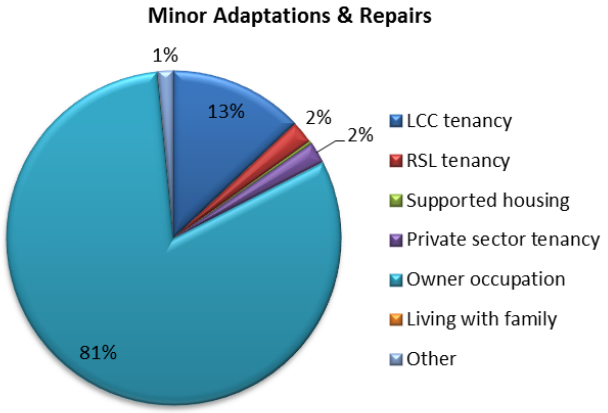




- *Tenure*

Although residents in all tenures can make use of the service, it is primarily aimed at owner-occupiers, which is the largest client group.





6.2 Affordable Warmth – Warm Homes / Warmth for Wellbeing / Green Doctor

These contracts are managed in partnership, since they share the aims of:

- Reducing preventable, excess winter death and illness rates.
- Improving health and wellbeing among vulnerable groups.
- Reducing pressure on health and social care services.
- Reducing 'fuel poverty' and the risk of fuel debt or being disconnected from gas and electricity supplies (including self-disconnection).
- Improving energy efficiency of homes.

They are delivered by:

- Warm Homes Service - Care & Repair.
- Warmth for Wellbeing - Groundwork Leeds and Care & Repair.
- Green Doctor - Groundwork Leeds.

6.2.1 Warmth for Wellbeing

The services offer the following assistance to vulnerable low-income households:

- Advice and help with reducing utility bills and energy use, e.g. Warm Homes Discount and low cost improvements such as draught proofing.
- Assessment of heating/energy efficiency needs; onward referrals for boilers, insulation etc. and other support (e.g. social care, housing providers, foodbanks, benefits / debt advice).
- Provision of emergency heaters, servicing or repairs of heating / hot water systems.

In addition, the service providers also deliver training for frontline workers to increase their confidence and skills so that they can support vulnerable people with related enquiries.

Response times have not been routinely monitored / reported; the provider, clients or referrers have never highlighted this as an issue. Expected quality standards as listed in the Service Specification are as follows:

- % of referrals for emergency assistance to first contact within 2 working days.
- % of emergency assistance, from householder agreement to intervention completed, within 10 working days.
- % of referrals for non-urgent support (e.g. advice) to first contact within 5 working days.
- % of non-urgent support, from householder agreement to intervention completed, within 20 working days.

Since the start of the contract in October 2015, over 2,200 households (over 4,400 people) have been visited and supported *(NB. up to July 2017)* – 55% of those funded by Clinical Commissioning Groups.

During the financial year 2016/17, 1,272 vulnerable households were visited. During these visits, nearly 5,000 interventions were carried out, involving both repairs and the distribution of items that can help people to improve the energy efficiency of their home and stay warm. A large part of this involves small measures and cost to the service, but which can make a significant impact to the individual, such as providing replacement lightbulbs and carbon monoxide detectors.

Table 14: Work carried out by Warmth for Wellbeing

	2016/17
Items provided	2,266
• *Lightbulbs*	*1,551*
• *Dehumidifier*	*336*
• *CO detector*	*271*
• *Blanket/hot water bottle/winter warmth pack*	*79*
• *Energy Monitor*	*29*
Heating system	1,618
Draught proofing	588

Water system	345
Other	40

Householders were also given advice on keeping warm at home, managing condensation, energy saving, assistance with their energy bills and applying for grant funding (table 15).

Table 15: Other assistance provided by Warmth for Wellbeing in 2016/17

	No.	Monetary Impact (pa)
Energy supplier switches	164	£34,662.74
Contacts with energy suppliers about bills, debts, tariffs etc.	174	
Warm Homes Discount applications (closed during Q1)	79	£8,680.00
Applications for the social Water Tariff 'Water Support' or 'Water Sure'	42	
Applications / advice for other grant schemes	20	
Water meter applications	42	
Other	33	

In addition, the Sustainable Energy and Climate Change Team funded visits that were carried out by Groundwork's Green Doctors (350 visits per annum) and Care & Repair's Warm Homes. This is to assist private sector households with an annual income below £21,000 who ***all*** suffer from a cold-related illness (table 16).

Table 16: Visits carried out through Warm Homes service

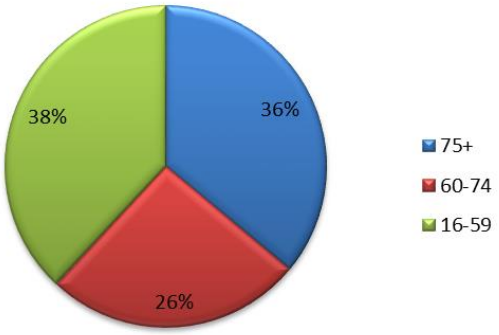
	2016/17
Households assisted	95
Heating / boiler installation	83
Repairs	1
Miscellaneous works	18

6.2.2 Client Demographics

It should be noted that the measures taken will benefit all members of the household; however, this data relates to the resident who was referred and eligible for the Warmth for Wellbeing service and for whom the case worker / home assessor recorded demographic information on the client.

- *Age Group*

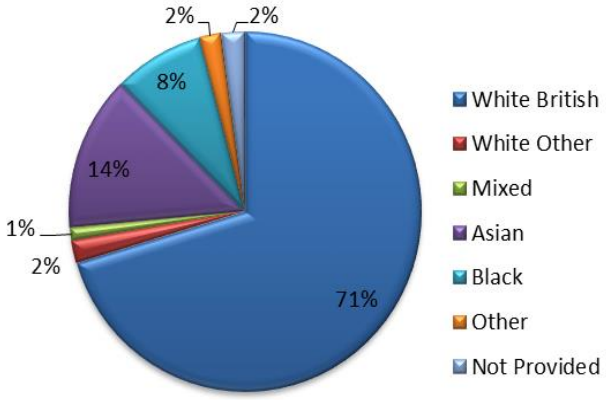
Those in the over 75 age group are proportionality over-represented, in part because there is targeting of that age group in the South & East CCG area. It is worth noting that the split between older people and under 60s evens out after excluding South & East funded visits. This is because the scheme is for all those who are particularly vulnerable to fuel poverty and cold-related ill-health and so caters for all age groups.



A small % of working age clients are parents / carers of *children* who were eligible for the service because of their age, health condition or disability. In that case, the main householder gets recorded as the client as the providers' systems does not enable them to do this in the child's name.

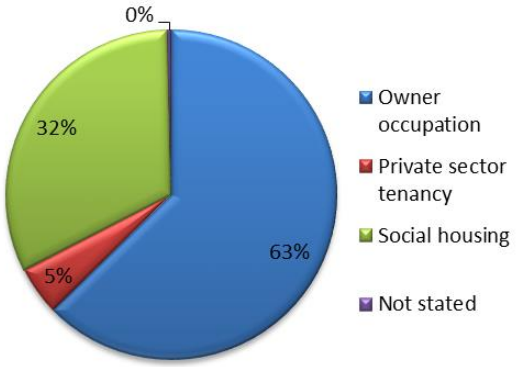
- *Ethnicity*

Across these services, 71% of clients (excluding those whose ethnicity is unknown) are White British, compared with 81% of the Leeds population. Uptake is more diverse than the Home Adaptations & Repairs service as BME communities are over-represented in the areas being targeted by the service, which are the most deprived neighbourhoods and areas with poor quality private sector housing.



- *Tenure*

Beneficiaries are predominantly owner-occupiers. This is partly because they will have control over works done in the home, and partly because of targeting of over 75s in some areas, who are more likely to be owner-occupiers. Given that some of assistance relates to support with energy supplies however, there are likely to be people in private tenancies who would benefit from the service who are not currently. The under-representation of private sector tenants is noted by current service providers and efforts must continue to increase support for clients living in such tenure.

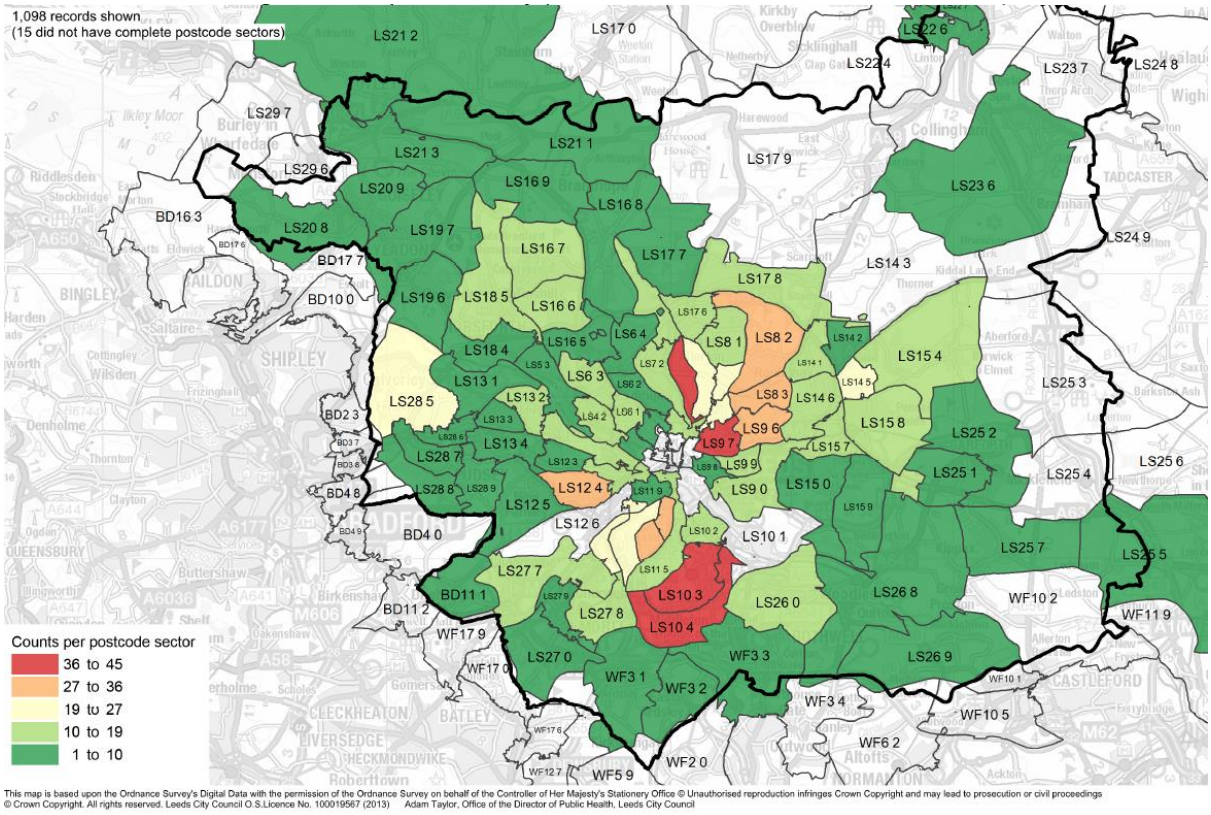


- *Area*

Figure 13 shows where the service was provided in the year to September 2016. The highest concentrations can be found in areas of higher deprivation, except for West / North West Leeds which has not received CCG funding to support additional households in their area. Visits do not appear to correlate with fuel poverty levels; however, inequities in funding across Leeds has been a confounding factor. It should also be noted that additional visits funded by the Sustainable Energy and Climate Change Team would give a more comprehensive picture of activity;

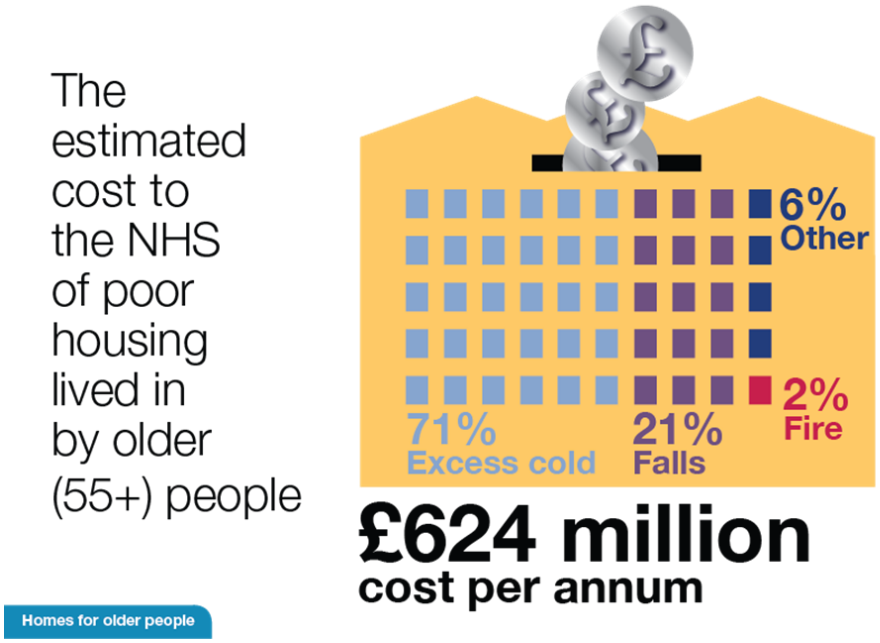
however, this data is not routinely provided. Year 2 (Oct 16 - Sept 17) postcode data will be available by the end of October 2017.

Figure 13: Postcode sectors of Warmth for Wellbeing clients, October 2015-September 2016



7. Cost Benefit Analysis

The measures put in place through these services have a wider financial benefit, in addition to those felt by the individuals assisted. In particular, there is significant cost to the NHS as a result of poor housing.



Locally, recent research has indicated that through mitigating Category 1 hazards, such as falling, collisions and excess cold, an estimated £20,682,600 could be saved across various sectors each year in Leeds[10].

7.1 Adaptations, Repairs and Falls

On average, an excess day in hospital costs around £306[11]. In 2016-17, 786 people were assisted with hospital discharge interventions. If each of these people went home just one day earlier, this would equate to a saving of £240,516 in hospital costs. In comparison, the approximate annual investment for Hospital Discharge measures is £150,500.

Furthermore, there is evidence that longer hospital stays for older patients can lead to worse health outcomes and an increase in their care needs on discharge, which in turns leads to higher health and social care costs. This includes:

- The loss of mobility while they are not being active - a recent review highlighted a study which showed that, for healthy older adults, 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity;

[10] *Housing Stock Modelling & Health Impact Assessment: Private Sector Housing, Leeds City Region*, Ian Watson, Principal Consultant, Chartered Environmental Health Practitioner

[11] *Department of Health Reference Costs 2015-16*

- Ability to perform everyday activities can reduce while in hospital - one study found that 12% of patients aged 70-plus saw a decline in their ability to undertake key daily activities (bathing, dressing, eating, moving around and toileting) between admission and discharge from hospital. And the extent of decline increased with age;
- An increased likelihood of contracting hospital infections - between 2008 and 2012, the Methicillin‑resistant *Staphylococcus aureus* (MRSA) infection rate for men aged 85-plus was 574 times greater than the rate for those aged under 45 years, with a similar pattern observed for women.[12]

It is estimated that it costs between £25,000 to £30,000 for health and social care services if a person falls and breaks their hip. The Falls Prevention element of the service costs approximately £96,000 per annum. Therefore, if 4 people a year are prevented from falling and breaking a hip, the cost to the public purse has already been recouped.

7.2 Affordable Warmth Interventions

Calculating the financial benefits of addressing excess cold hazards includes conditions ranging from mild pneumonia to heart attacks and fatalities. However, an average saving to the NHS has been estimated at £706 per year and savings to wider society of £1,764 for each job undertaken[13]. This represents a substantial return on investment, given that the average cost of each Warm Homes intervention is £200.

A national evaluation of the FILT Warm Homes Service funding (2013), which C&R also received a proportion of, drew the following conclusions in relation to cost effectiveness:

- Overall, it appears to be cost-effective from a health perspective, with sizeable benefits when compared with the average cost of the intervention: e.g. for every £1 of Warm Homes funding provided by FILT, an additional minimum £2.42 was levered in from other sources.
- Cost effectiveness needs to be weighed against the fact that health and wellbeing benefits of higher cost interventions are greater than those with a lower cost.
- However, the impact of smaller measures should not be underestimated as they resulted in sizeable improvements in wellbeing and comfort.
- Qualitative interviews provide clear narratives of where health benefits were realised and it is possible to see how negative health events would have been avoided.

[12] *Discharging Older Patients from Hospital.* National Audit Office 2016

[13] *A Retrospective Health Impact Assessment of Housing Standards Interventions in Derby*. BRE

8. Consultation

8.1 National

There is extensive evidence on older people's lifestyle and housing preferences at the national level[14,15,16,17,18]. Key issues highlighted in studies include:

- Older people want to retain their independence for as long as possible and their housing choices reflect this.
- Safety and accessibility are stressed as important in older people's living environments. In addition, social connections and friends were seen as crucial elements that make for a good later life.
- The majority of older individuals are reluctant to consider moving and would want support to stay in their homes even if their needs increased, allowing them to 'age in place'.
- There is an recognition that in order for older people to 'age in place' they will have to consider how they adapt their current home to enable them to remain independent for as long as possible. Minor changes to people's homes are generally accepted.
- Retirement / specialist housing should be local to enable older people to preserve their sense of neighbourhood and community.
- Older people have a strong attachment to their familiar neighbourhood and, if they had to move, would prefer to do so within a small geographical area.
- There is scope for 'downsizing'. However, there is a lack of housing options. Although older people generally require less space, they still want sufficient space to hold on to things they value. The majority of older people want to own a home with at least two bedrooms but the majority of specialist stock only has one bedroom and is not available for purchase.
- Moves into supported housing, are, for the most part, made through necessity rather than choice.
- Older people and their families face considerable problems accessing information on housing and care options as they age.

8.2 Leeds-wide: "Me and My Home"

An event was held in Leeds which brought local older people to come together to gain insight into the issue of older people's housing. It enabled older people in Leeds to share their views on their housing and support needs now and in the future. The feedback was:

Older people want to retain independence in later life -

- I don't see why I should have to move.
- I want to be treated as an individual.

[14] Age UK. Housing in Later Life, 2014

[15] Ipsos MORI and Centre for Ageing Better. *Findings from Ipsos Mori and Centre for Ageing Better deliberative workshops*. 2016

[16] Harris K. *Neighbouring and older people: An enfolding community*. (2008)

[17] Homes and Communities Agency. HAPPI Housing our Ageing Population: Panel for Innovation (2009)

[18] Croucher K. *Housing Choices and Aspirations for Older People: Research from the New Horizons Programme.* Communities and Local Government. *(2008)*

- I like to feel part of the community and live in a safe environment.
- I like to live near family and / or friends.
- I need access to the local community, services and shops.
- I need my home to be safe, warm and energy efficient.
- I want support to be available to help me live independently when I need it - for people who come to me to be ongoing and not a one-off.
- I want my cultural needs to respected and valued.

Older people want to access information and advice on housing options -

- I want to be able to plan ahead for my future and not wait until I am housebound.
- I need support services to be local to where I live.
- I need to know where to go to get information.
- I need accurate and up-to-date information which is clearly explained.
- I need information telling me what's available locally.
- I need good financial advice about my home.
- I need advice about benefits, adaptations and carers' support.
- I need to be informed of what my realistic housing options are.
- I want information that is respectful of older peoples' needs.
- I need real help - support rather than purely information.

Older people want the opportunity to move to a home with extra support when needed -

- There needs to be more availability of purpose-built homes with extra support to give me the option of living where I want to be.
- I need to know more about what support is available in sheltered housing and extra care housing.
- I need to understand about any additional costs of moving into sheltered or extra care housing.
- If I move into a home with extra support, I need the staff to understand my needs and help me to adjust to my new home.

Older people want their needs considered and their voice heard -

- When new homes are built for older people, I think that the people who are going to live in them should be consulted about the design, layout and features of the homes.
- If I move into a newly built home, I expect it to be a lifetime home and easily adaptable as my needs change.
- We need a mixed offer – rented / private - in a complex / single.

8.3 Clients of Current Provision

8.3.1 Home Adaptations & Repairs, 2016

A total of 54 clients were chosen at random and contacted by phone. Of the 54 contacted, 25 clients answered the phone and completed a feedback survey. The main purpose of the survey was to quality assure the current service.

Whilst carrying out the surveys, it became evident that the contractors completing the work had also identified other issues in the home which needed resolving, such as fitting grab rails or completing referrals for additional work. An example of this a contractor who carried out a visit to a client for the warmer homes element of the service and identified that the client was having difficulty getting upstairs. A referral was made to Adult Social Care who subsequently installed a stair lift to the property. This demonstrates the importance of having contractors being attune to the range of potential needs of the client.

84% of service users felt that the improvements and advice they received had had a positive effect on their general health and wellbeing. The one person who felt that the improvements did not have a positive effect on their general health and wellbeing said it was because their health condition had deteriorated. Similarly, 93% felt safer and more secure within their home as a result of the work.

8.3.2 Warmth for Wellbeing, 2016/17

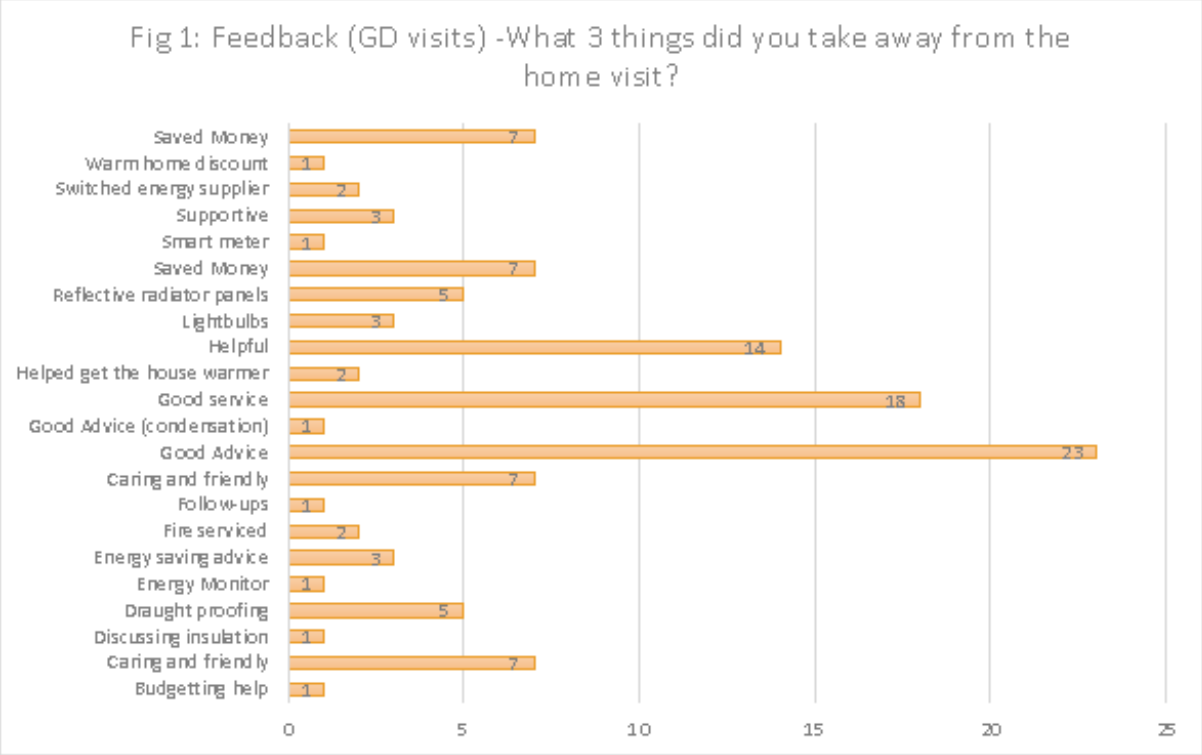
Comments also included:

- I'm always cold, the house is much warmer, thanks.
- Feel safer now it has been done.
- It is a joy to turn on the heating and have it work correctly.
- If it were not for you I would be still be living in a cold house.
- Very happy indeed, great relief.

8.3.3 Green Doctor, biannual

Groundwork carry out telephone surveys with clients who have received a visit by a Green Doctor. These surveys gather a mixture of quantitative (e.g. 5-point scale) and qualitative information (e.g. views on the quality of service received). Recent feedback is summarised below:

QUESTION	AVERAGE
ON A SCALE OF 1 - 5 HOW SATISFIED WERE YOU WITH THE GREEN DOCTOR ADVICE?	4.6
ON A SCALE OF 1 - 5 HOW SATISFIED WERE YOU WITH THE ENERGY EFFICIENCY MEASURES? (E.G. LIGHT BULBS, REFLECTIVE PANELS, DRAUGHT PROOFING)	4.3
OVERALL HOW SATISFIED WERE YOU WITH THE GREEN DR HOME VISIT (SCALE 1 - 5)?	4.6
IS YOUR HOME WARMER AS A RESULT OF THE VISIT?	Yes: 64% No: 34%
FOLLOWING THE GREEN DOCTOR VISIT DO YOU FEEL THAT YOU NOW HAVE MORE CONTROL OVER YOUR HEATING NEEDS?	Yes: 62%, No: 32%



8.3.4 Home Adaptations & Repairs, ongoing

Client feedback forms are sent to all clients once works are completed and the responses are analysed on a quarterly basis.

They support the findings of the telephone surveys and demonstrate that clients are consistently happy with the service and quality of work. The data also shows the

health benefits being realised, with the vast majority reporting that they had not fallen since the works had been carried out and that there had been a positive effect on their general health and wellbeing.

8.4 Staff of Current Provision

8.4.1 Online survey, March 2016

All staff were emailed a link to an online survey, which they could complete anonymously if they wished. The purpose of the survey was to gauge opinions of how the pilot was working.

- 100% of staff felt that clients were getting a better quality service with 90% feeling that they were getting a faster service.
- The pilot service enabled caseworkers to provide a more holistic service.
- Clients received a more efficient and effective service, with only one worker dealing with their issues.
- Staff did raise the issue of having to spend more time with clients to offer a broader range of services.
- Staff suggested that training was needed for health professionals so that they have a better understanding of the eligibility criteria and what services offer.
- Comments were also raised regarding the current referral system and the need to streamline referrals via an on-line system.

8.4.2 Workshop, December 2016

Client Need	
Have client needs changed?	• Clients are getting older. People are living longer and staying in their homes longer. Client needs are becoming more complex, e.g. conditions such as dementia.
Trends / patterns	• ASC only refer to C&R when quick intervention is required. • Trips / falls assessments are being duplicated by various agencies. • Because people are living longer, there seems to be an increase in social isolation. • There is an increase in cold homes and people unable to heat their homes sufficiently.
Un-met client needs and any gaps / issues / barriers	• There are clients under 60 that still have clinical need. The eligibility needs to consider this. It might be preferable to have a needs-led service, irrespective of age. • Clients under 60 appear to have issues with accessing services / being aware of services. Provision has tended to be 60-plus. • The needs of carers are often overlooked. Signposting services for carers needs to be improved. They need to be aware of what is available for people they look after. • There is a lack of incontinence facilities. • There are a lack of befriending services. • Trips and falls assessments: the length of time to get a referral through ASC service is too long; it can take 8 weeks. It is also not clear who does what and why. Why would ASC assess instead of C&R? • Reductions in funding: this limits the amount of rails / adaptations that can be offered – this links to how rails & equipment are sourced / procured through the new service.

	• Clients being supported to stay in their homes longer will ultimately get frailer and have additional needs in the future. This needs to be recognised and resourced if people are to remain out of care / hospital services. • New clients are often unaware of where to go to for help. • Clients often don't know which questions to ask when they seek help from health professionals. • Hoarding clients can have problems returning home. It can lead to clients having to stay in hospital when they no longer have a clinical need. There is currently no city-wide approach to hoarding. • There is some anecdotal evidence of family members being reluctant to admit their parents to residential care (possibly to protect savings) which means them struggling at home and not knowing what other options are available for them. • Older people often struggle to maintain homes but there is not the funding for repairs anymore. • Security for homes is only available in a number of geographical areas.
Ideas – What would you do? Provide the same, something completely different?	• Offer earlier intervention. • Provide a full home safety assessment for everyone. • Simplify the referral process. • Ideally, all services / information should be provided from one location (e.g. one stop shop or independent living centre). • A city-wide restructuring of all related services should take place (to eradicate duplication). • It would be preferable if the initial needs assessment could cover all possible needs (e.g. not just rails but areas such as warmth, social isolation, benefits, mental health, etc.). • The assessment process needs to ask the right questions to ascertain all client needs. • There should (ideally) be a continuity of staff, e.g. one person dealing with the client throughout the process. • Additional time (funding) would allow staff to carry out more effective assessments. • Be proactive not reactive, e.g. blanket visiting to carry out needs assessments. • GPs need to engage more with other services; tap into social prescribing. • C&R (or provider) to do all minor adaptations regardless of tenure.
Other thoughts	• A typical client is someone with a need / condition that is likely to deteriorate. • Funders need to remain empathetic to client needs.

What you do	
What works	Hospital discharge works well but additional information would be useful (e.g. info that is on the referral but not on the job-sheet signed by client.)
What doesn't work	• Data-sharing is problematic - this needs to be resolved at the front end, i.e. within Health departments. They do not know what one service is doing from another. It leads to duplication of work, visits, assessments and interventions. • Falls service / hospital discharge was historically brought together in the past but has not been tweaked / changed for some time; therefore, it is not completely fit for purpose.

	• There is anecdotal evidence of some OTs referring with a lack of knowledge about rails. • There is anecdotal evidence of some OTs asking clients to do their own measuring for rails. • CCG funding can be arbitrary from one area to another. This doesn't help a consistent city-wide provision. • C&R staff sometimes receive conflicting information from OTs and physios through referrals about what clients need in their homes. • There is often a lack of access to information, re available services: a single point of information would be useful.
Ideas – if you could change anything about what you do, what would it be?	• A central IT hub where all stakeholders can access client information, e.g. SharePoint site. To reduce duplication. • A referral form that includes full assessment needs. • Save time and money by possibly transferring needs-assessments (for certain clients) from OTs to C&R staff. C&R handymen / women noted that they could carry out a lot of jobs just as well without a pre-assessment from an OT. Give C&R staff autonomy to make decisions without paperwork: they have the skills and experience to do so. • OTs cover risk management for hospital discharge but this could work differently in the community. • Give some OTs additional training so they can cover all duties. (There is anecdotal evidence of some mental health OTs not being able to raise toilet seats.) • A future service should possibly be about 'safety measures'. There would need to be a prescriptive list of work that would fall under this category. • Emphasis to shift from reactive to proactive in time. Focus on preventative services rather than those reacting once someone has fallen or is in hospital. • A single, streamlined referral process is required. • There needs to be improved marketing (e.g. improved information available in hospitals and other locations.) of what is available for people.
Other thoughts	• Need to consider the long-term impact of not helping people to stay in their own home. The outcome is likely to be future hospitalisation as they become frailer. • Staff noted that they want to be able to do more: but more efficiently. • Adaptations vs repairs: which should be prioritised? This might depend on the impact on safety. • Equity release for major adaptations (as per Manchester City Council) was mentioned as a source of good practice.

8.5 Stakeholders

8.5.1 Senior Clinician's Forum, April 2016

The attendees were asked to comment on the current service challenges and ideas for improvement on the provision. The findings included:

Ideas

- Referral form linked to SystmOne
- Making patients aware that they are free to paint / varnish some of the fittings
- Email referral good idea
- Can you give us a time inclination for fitting (within 7 days /28days?)
- Feedback for delays
- Referrals by coordinator only
- Faster response time, e.g. moving beds –clarify wait times
- Clarity re age limit- younger disabled patients?

Challenges

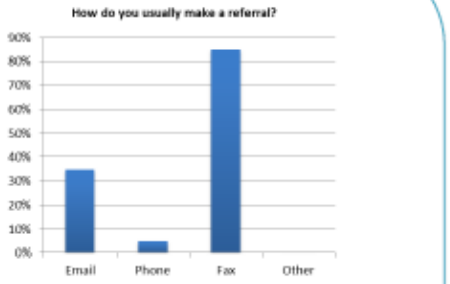
- Some of the equipment is available from LES - why would we use C&R over LES?
- Who marks up for equipment & assesses appropriateness?
- Not available equally in all areas, should be standardised.
- Delays.
- Not trained on marking up.
- Do they have to be on benefits as advised in the past?
- Long delays in staff coming out.
- Clinical staff do not know how to decide where to measure + complications such as 'is the wall suitable?'
- System required to know if anyone has referred.
- Duplicate referrals - should document on SI.
- Some services don't have SI, e.g. social services.

Questions / Observations / Issues

- What's turnaround time - from referral to fitting & falls referral?
- Can anyone refer – professionals?
- Electronic referrals - unsure what all the benefits are.
- Linking the C&R referral to Elsie; adding to favourites.
- Benefits - does this always need to be filled?
  - Are they up to date?
  - Can they not be abbreviated?
- Can C&R give guidance on how to access aids & adaptations for people ages under 60, i.e. DSTOT referral?
- Know if other referrals have been received.
- Computer systems do not communicate with one another.
- Can anybody refer, e.g. non-registered staff?
- Who pays costs, e.g. rails?
- On 'fall prevention' referrals are we now expected to mark for rails?
- Why won't you do bathroom rails in isolation?

8.5.2 Survey of Health Professionals, 2017

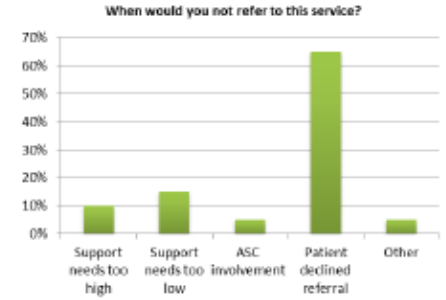
Health practitioners were asked to complete a web-based questionnaire. The key points of feedback were:



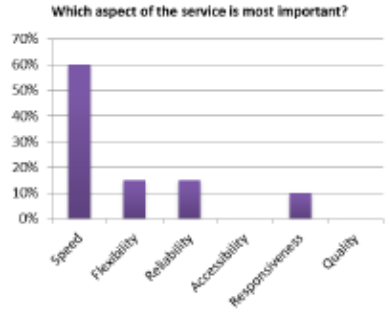
Historically, referrals from hospital staff were made by fax and this is still continuing. Most responses came from hospital staff, which accounts for the higher proportion of referrals being by fax.

However, 20% of respondents said they would like some sort of electronic referral process, and most suggested using online forms.

Some respondents would like more direct contact with the contractors, including joint site visits



The most common reason for not making a referral is that the individual did not want it, rather than because the service was not suitable for their needs.



As we expected, most confirmed that all the suggested aspects were important, but speed was the overwhelming priority.

This was largely to enable patients to be discharged from hospital as soon as possible.

55% of responses said it is not always necessary to conduct a site visit and mark up where rails need to go.

The responses included many positive comments about the quality and reliability of the current service

8.5.3 "Winter Friends" Briefing Sessions, February-April 2017

Public Health and Affordable Warmth teams held "Winter Friends" briefing sessions to give advice about available interventions that help keep (older) people fit and well over winter. They also visited or spoke to 24 community organisations / groups that had received a Winter Wellbeing small grant via Leeds Community Foundation with the aim of raising awareness of the service.

The consultation was received well with positive quotes from stakeholders:

- *"They helped the clients make referrals".*
- *"Home to Hospital" service is positive".*
- *"There is nothing really like it, brilliant".*
- *"Green Doctor in particular is good".*

8.6 Care and Repair Trustees

Staff from Strategy and Commissioning attended the April 2016 meeting of the Board of Trustees to get their feedback on the pilot.

The comments were overwhelmingly positive, with the main benefit being that the service is more holistic for clients. The inconvenience and uncertainty caused by having several visits has been removed, and clients are being supported by just one caseworker. This has put an emphasis on getting the most out of every visit, which is good for the client, as well as being more efficient for the service.

The changes to the financial arrangements have been positive, because it has taken away the piecemeal nature of the funding which was restrictive and resulted in multiple visits for clients. The new arrangement has therefore helped the service be more holistic. However, there was some initial uncertainty about how far the budget would reach, as the number of clients and cost of each job could not be definitely predicted. It did not become a problem though.

The trustees were asked whether there are any clients' needs that are not being met, to which the feedback was that the overall budget for the service limits the amount that can be spent on each client. Some people come to expect continuous service, so they have to be referred to the Leeds Directory. The Trustees felt that there are additional pressures on services because demand has increased and funding has reduced.

8.7 Summary

- Clients are overwhelming positive about the works that are carried out and the impact they have had on their wellbeing.
- The referral process needs to be simplified and modernised, to benefit everyone involved.
- Referrers need more information about what the service can and cannot do.
- The more holistic approach gives a better service to clients, who have a more thorough assessment of need and time with their caseworker if they have one, with works generally being carried out quicker than they used to be.

- There are good relationships between referrers and contractors. However, this is the result of working together over several years and could not be guaranteed if the provider and / or contractors were to change.
- Referrers are reliant on the speed and flexibility of the service. This could be about arranging a site visit when a relative is available as much as being able to complete a job within a day or two.
- Thought should be given to how much marking up in the property is required by referrers and how much can be left to the experience and common sense of the contractors. However, clarity around responsibility and risk will be needed.
- There could be demand for out-of-hours provision.

9. Case Studies

Mrs B

Mrs B is aged 37 and lives with her husband and nine children ageing from 17 years to a baby 2 months old. Mrs B has diabetes and suffers from unexplained seizures. They have a disabled child aged 6 who is wheelchair bound and needs around the clock care. The house had been adapted for him, so he sleeps downstairs and has a dedicated bathroom.

The Warmth for Wellbeing service received a referral from an Occupational Therapist as the boiler was not working and the family did not have adequate heat or hot water, which was having a detrimental effect on the health and well-being of the family.
The Warmth For Wellbeing contractors visited the home and found that the boiler was beyond repair and required replacement. Warmth For Wellbeing secured funding from Foundations Independent Living Trust, Leeds City Council's Fuel Poverty Fund and South & East Clinical Commissioning Group via the Warm for Wellbeing Service. To renew the heating system.

The family now have a warm home and hot water to keep all the family warm this winter.

"Everything is ok now, we have heating and hot water."

Mr A

Client aged 77 with dementia, asthma and rheumatoid arthritis. Referral received from Memory Services at St Marys Hospital as client struggling with bathing. Agreed the following actions:

- Horizontal rail over the bath.
- Referral to domiciliary physio for walking aids.
- Arranged servicing of gas fire and Co detector under Warmth for Wellbeing.
- Sent Support My Life catalogue.
- Referral to Welfare Rights Unit for entitlement to Attendance Allowance.
- Referral to Adult Social Care for a wet room, external metal long rail and transfer trolley.
- Arranged to install a long horizontal rail over the bath.

Mr and Mrs P

Couple aged 84 and 79 who are both deaf. Mr P has asbestosis, poor balance and osteoarthritis. Mrs P has gout, arthritis and poor mobility. Referral received from clinical care co-ordinator at GP surgery for help with bathing as Mrs P was assisting Mr P into the bath and could not continue to do so due to Mr P's size and weight. Agreed the following actions:

- Referral to Adult Social Care for a bathing assessment with a view to a wet room.
- Referral to Fire Service for vibrating smoke alarms.
- Referral to domiciliary physio for walking aids to aid balance.
- Arranged to install 2 grab rails at front door.

Mrs SB

Mrs SB was first referred for an energy visit in May 2016 as her energy bills were much higher than what she could afford. She was in receipt of benefits and was suffering from mental health illness. As the property (tower block flat) was uninsulated, it was very costly to heat, with the cost being approximately £10 per week.

Green Doctor visited and advised on different energy suppliers, tariffs and payment methods to help save money. Draught proofing was fitted to the property and energy efficient light bulbs were issued.

Mrs SB further contacted Green Doctor in August 2016 in a distressed state as the meters had been changed and were not drawing electricity from the night time rate of her Economy7 meter. As a result, she was unable to afford to use the heating or hot water.

As Mrs SB spoke little English, she struggled to communicate with the energy supplier. This resulted in them disregarding her complaint and no action was taken to rectify the matter.

Green Doctor visited Mrs SB again and found that the meter was not switching to her off-peak setting, increasing the cost of heating. The energy supplier had also missed numerous appointments to the property.

Due to the severity of the situation and the affect the situation was having on Mrs SB's mental health, Green Doctors negotiated with the energy supplier on Mrs SB's behalf. After some time, the problems were finally rectified.

Mrs S

Client aged 84 who has very poor mobility, cellulitis, and osteoporosis and is also the main carer for her husband aged 85 with dementia. Referral received from another C&R service for a toilet frame to aid with transfers from the toilet. Agreed the following actions:

- Referral to Adult Social Care for a perching stool and bed stick to help with getting in / out of bed.
- Delivered a toilet frame.
- Sent a Support My Life catalogue.
- Referral to Warmth for Wellbeing to repair boiler as shower not producing hot water.
- Referral to domiciliary physio for a Zimmer frame for downstairs use.
- Arranged to install grab rail at top of stairs and grab rail at front door.

Mrs M

Mrs M was referred to us by a concerned relative due to a broken central heating boiler.

Mrs M had recently been discharged from hospital following an episode of pneumonia and had no heating or hot water except for an electric fan heater. Mrs M, who is widowed and lived alone, was very vulnerable with no children or immediate family support and struggled to maintain an independent lifestyle.

The Warmth for Wellbeing Service arranged an urgent engineer visit which uncovered that the boiler had an extensive leak whilst Mrs M was in hospital and it had caused considerable damage to the boiler and the property.

The wooden floorboards and carpets were saturated and all the internal doors did not close due to the moisture causing them to swell and warp, adding to the loss of heat. The engineer condemned the boiler and recommended a replacement; however, it was Christmas Eve, therefore we provided emergency heating over the holiday period.

The support worker then visited Mrs M after Christmas and carried out a holistic assessment of her needs, identified emergency funding for the boiler. Mrs M also had hoarding issues and was socially isolated; therefore, a referral to the local Neighbourhood Network was made. A benefit check was completed and a referral made to minor adaptations and repairs service as Mrs M was struggling with bathing and toileting.

Mr K

Client aged 80 who has dementia, arthritis and diabetes. His main carer is his wife who has poor mobility and vertigo. Referral received from a befriender from the Black Health Initiative for external rails and general assessment for prevention of falls.

Agreed the following actions:

- Referral to Adult Social Care for perching stool, bedstick, external metal rail at the front door and stair lift for stairs.
- Referral to domiciliary physio for walking aids.
- Delivered 1 toilet frame and 1 raised toilet seat.
- 2nd visit to deliver another toilet frame and raised toilet seat.
- Arranged to repair boiler through Warmth for Wellbeing.
- Referral to Green Doctor for draught proofing and energy switching advice.
- Arranged to install grab rail in the shower and grab rail at the front door.

Conclusions

The new model should be based on a set of central principles:

Principle	Why
Responsive	The new provision must be responsive and efficient at managing referrals from a variety of sources in a streamlined and effective manner. This includes a swift response where necessary to facilitating hospital admission and preventing illness or serious injury to those at highest risk. The current service is able to respond quickly to referrals, which distinguishes it from statutory provision. However, different interventions may take longer than others, such as boiler replacements and other larger warmth-related works.
Proactivity	The service will need to be proactive in terms of reach and links to ensure that the prevention agenda is embedded throughout provision.
High impact	For relatively small investment in each household, substantial benefits in terms of both individual wellbeing and savings to the public purse can be made.
Person-centred	The service will be to support individuals and households to stay independent and resilient; therefore, it is crucial that the client is at the heart of what is delivered and how. This includes giving thought to how to streamline referral processes. Importance of understanding context, attitudes, barriers and how to support behaviour change.
Needs-led	All services must be focussed on the needs of the individual and / or household.
Holistic	Client consultation has demonstrated the value to clients of caseworkers, home assessors and contractors being able to identify additional needs that can be addressed within the same service. A more holistic approach will deliver more sustainable outcomes and efficiencies than a piecemeal one. It also aligns with NICE guidance.
Accessible & inclusive	Consultation feedback has shown that clients often do not know who is providing the current service, so there are likely to be many people who would benefit but are unaware that it is available. Flexibility of access will also be important, where contractors are able to arrange site visits when key-holders / householders are available. Service data highlights the need for a provision which is inclusive for all groups. The risk of falls, or provision of warmth measures cuts across all groups irrespective of protected characteristics and therefore provision, whilst targeted, must also reflect the characteristics of all wider groups in Leeds.
City-wide	There is currently demand from across the city for this service. Whilst the issues being addressed are often related to areas of deprivation, people who are asset rich but cash poor should not be excluded because they happen to live in a more affluent areas. The service needs to be linked with key initiatives and networks across the city.
Targeted	Current service data illustrates that although services must be available and accessible city wide, they must also be targeted to specific groups, for example; those with long-term health conditions; the elderly; the very young; those at risk of falling; those on low incomes; those who may be isolated.
Enabling / maintaining independent living	Client feedback indicates improved feelings of safety and wellbeing within their homes. Minor works such as those carried out by these services ensure people are able to stay in their own homes, rather than moving into residential care.

Improving health at home	This addresses many local strategic priorities.
Recognising wider & wellbeing needs	The client group is likely to have other health and wellbeing needs, e.g. housing-related support, care support, social isolation or mental ill-health. So the service should be able to identify these, offer appropriate information and advice and signpost appropriately.
Enterprising	Service outcomes will cut across a number of strategic and funding areas, be it health, social care, and housing. Provision must be reflective of these cross-partner outcomes and enterprising in the funding and grant opportunities that such a cross-cutting provision offers, as well as always considering the impact of delivery against the 'Leeds Pound'.
Multi-faceted	The range of needs and demands identified mean that the model will need to bring together a number of specialisms and functions, including advice, signposting, assessments and facilitation of works. There are also a significant number of key stakeholders who will refer to and benefit from it.