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1. Executive Summary

“We work with people in the gutter and that step up from the gutter to the pavement is the hardest 4 inches that anyone is going to make in their life”

(Provider)

1.1. On 2 December, 2009 Jocelyn Davies AM, the Deputy Minister for Housing and Regeneration in the Welsh Assembly Government announced that she had commissioned this review of the Supporting People Programme in Wales. The review would provide her with advice on current policies, arrangements, systems and resources, including the making of recommendations that would strengthen the Programme and maximize the contribution it makes to the health and well-being of people for whom the Supporting People Programme is intended. The report on the review would also identify short, medium and long term priorities. Terms of Reference were agreed and these formed the essential framework for the conduct of the review and securing of the review’s desired objectives.

1.2. A number of issues had emerged since the Programme’s inception in 2003 which required thorough investigation and resolution. These related to the process for allocating funds to the Programme across Wales which many considered was an inequitable distribution; the fitness of the division of funding into two separate streams administered respectively by Local Authorities and the Welsh Assembly Government; the cost-effectiveness of the Programme and achievement of value for money; the lack of clarity surrounding the roles and responsibilities of the Welsh Assembly Government, Local Authorities, service providers and other key players. Equally, matters relevant to the Programme’s governance, accountability arrangements, procurement and commissioning process and, indeed, the accessibility of services to the people that needed them were perceived as in need of greater understanding.

1.3. More than 260 people were interviewed, some on more than one occasion, primarily drawn widely from key stakeholders (including the Welsh Assembly and Local Government), service providers, people who need the services, analogous services provided in England, Scotland, Northern Ireland and the international arena and from groups and organisations (including public health and health services) that could provide informed comment on the Supporting People Programme in Wales. Moreover, some 278 documents were examined in evidence in the course of the review. Two literature reviews were also completed during the period of the review: Supporting People programmes across the UK and Housing related support interventions. The documents reviewed also included those solicited from, or volunteered by, a number of organisations in Wales involved in providing housing-related services, support for homeless people and the coordination of such services.
1.4. The review was also informed by an Advisory Group made up of representatives from Welsh Assembly Government, Cymorth Cymru, Welsh Local Government Association (WLGA), Community Housing Cymru (CHC), and Supporting People Leads. To assist in reviewing the evidence and advising on emerging conclusions and recommendations independent or impartial experts were consulted.

1.5. The review has gained a very considerable and in-depth understanding of the Supporting People Programme in Wales and in other countries. In Wales the Programme is providing commendable and sorely needed assistance, support and relief for the most vulnerable and disadvantaged people who have either lost or are at risk of losing their homes. It is estimated that around 50,000 disadvantaged people are helped in this way in Wales every year over recent years. Although there are conventional health and social services to which these citizens may have access, the complexity of their needs and individual circumstances place them at risk of losing their homes or, indeed, have rendered them homeless. Without the support provided by the Programme their additional adverse personal or situational circumstances would not only have compromised their obtaining secure accommodation but would most likely have moved them further down a trajectory to more severe disadvantage and social exclusion. Moreover the review recognises the considerable work of the third sector and their advocacy over decades to direct Government funding to deliver sustainable services.

1.6. The existing structure and distribution of grants disbursed from the Programme’s fund is a historical legacy which is recognised almost universally as in need of adjustment. Allocation by way of the Supporting People Grant (SPG) and the Supporting People Revenue Grant (SPRG) may well have been based on sound reasons for initially structuring the funding streams in this way. However understanding of the ways in which the Programme is currently delivered, the burden imposed upon the Welsh Assembly Government in administering the SPRG and the vagaries inherent in the disbursement by two separate funding streams argue strongly against the retention of this complex mechanism for allocating the Programme’s funds. The introduction of a single, unified, Supporting People Programme Grant (SPPG) is essential for the Programme to emerge unshackled from the obstacles inherent in the current system to achieve its maximum potential. Allocation of the SPPG to Local Authorities outside the Revenue Support Grant (RSG) and ring-fenced, emerged as the preferred option.

1.7. Administration of the allocated portions of the proposed single Supporting People Programme Grant (SPPG) was an issue which taxed the deliberations of the review team. Widely divergent views were expressed by some representatives of Local Authorities, Accredited Support Providers and subcontracted providers but these were in the minority. The general opinion favoured a more collaborative and consensual approach. The single most important concern was the potential demise of the Supporting People Revenue Grant (SPRG) and a unified stream of funding to Local Authorities. Frequently, assertions made among those who opposed this was that it risked
diversion of some of that funding by Local Authorities to support people for whom they held statutory obligations. It was most evident to the review team that there had to be robust and visible mechanisms in place to appease concerns. This was considered essential to ensure that the grant, even if ring-fenced, was used solely to fund support to meet the needs of disadvantaged and vulnerable people strictly within the context of the Supporting People Programme.

1.8. To address these concerns and to exploit the substantial benefits which would be brought by an administration which would rest on a collaborative and multisectorial arrangement, the review advances such a proposition. Arrangements are described for establishing a duly constituted committee to include representatives of the Local Authority, housing related services, probation service, providers of supporting people services, public health, Local Health Board, service users, and independent members. This collaborative committee at the level of the Local Authority would undertake the administration, commissioning, procurement, quality assurance, local regulation and oversight of supporting people services. The committee would have an abiding emphasis on co-design and co-production and the securing of tangible outcomes and their evaluation. It is also advanced that this collaborative arrangement could well form a subcommittee of the relevant Local Service Board.

1.9. Excellent examples of cross-boundary working in the context of the Supporting People Programme already exist and merit strong support by the Welsh Assembly Government. These existing arrangements bring benefits to short, medium and long-term planning and a strong platform for the more efficient and effective use of available resources. This strongly argues in favour of the proposed local collaborative committees as an interim step towards the setting up of single geographically determined collaborative committees across Local Authority boundaries. These would subsume the roles and functions of the constituent Local Authority collaborative committees lodged in Local Service Boards.

1.10. The basis upon which Supporting People funds are currently assigned to each Local Authority also needs urgent adjustment. This is yet another historical legacy which frustrates the more equitable distribution of funds at the local population level. It has been long accepted that the nature of this distribution does not represent actual needs. The review has identified the considerable amount of work which had been commissioned by the Welsh Assembly Government to develop a formula-based mechanism informed by a statistical analysis of needs and costs. A range of options for the development of such a formula has stalled. A preferred option was arbitrarily selected but difficulty was experienced in securing the data necessary to populate this formula which involved an intensive multi-level modelling approach. The current allocation still rests on legacy funding which is far from being equitable and appropriate.

1.11. Experts in the Public Health Wales Observatory were consulted. On the basis of that advice and discrete analysis by the review team of the
mapping of funding in relation to gross measures of deprivation across Wales, led to the evolution of an empirical distribution formula. In essence the formula reflects a small number of appropriately weighted items which are robust, transparent, readily available from existing data sources and includes appropriate adjustments for measures of deprivation or its component parts. After careful consideration the following five variables, appropriately weighted, were selected for inclusion in the distribution formula:

- Welsh Index of Multiple Deprivation;
- Social Fragmentation Index;
- Number of people in receipt of at least the middle rate of the care component of Disability Living Allowance;
- Age structure of the population: the proportion of older people living alone; and
- Local measures of homeless people.

1.12. The proposed distribution formula is recommended for adoption in the short term to disburse the Supporting People Programme Grant to Local Authorities. This formula may be amended over a period of three to five years for the phasing in of a formula which more accurately defines the resources required to deliver the support required by constituent populations. It is strongly felt by the review team that this would also drive forward the pressing need for the gathering of pertinent data which more accurately reveals the nature and extent of citizens’ needs requiring support under the Programme.

1.13. However introduction of the proposed formula should be phase-in and tapered. It became evident early on in the review that Local Authorities receiving larger sums under the current distribution had evolved some highly effective support services. These services would be adversely affected were levels of funding to fall as a consequence of implementing the proposed new formula. Similarly, Local Authorities receiving funds at the lower end of the distribution spectrum currently lack capacity and arrangements to make immediate and effective use of additional funding. It is, therefore, imperative that changes in the levels of grant allocation should not be precipitate. A period of close monitoring should be undertaken of both intended and unintended consequences of the redistribution of allocated funds. Another mechanism which could mitigate the effects of abrupt changes in funding would be greater cross-border working.

1.14. The review reveals mounting evidence that the Supporting People Programme in Wales requires strengthening of its governance arrangements, lacks transparency, at times confuses commissioning and procurement, and is prey to the uncertainty of roles and responsibilities of the Welsh Assembly Government, Local Authorities and principal providers of support services. Strategic direction is wanting and visible leadership needs to be reinforced. The review team considered ways in which these deficiencies might be remedied. To that end a National Advisory Board is advocated. This would be chaired by the Deputy Minister for Housing and Regeneration and provide
her with advice and information to assist her in discharging her functions and accountabilities in regard to the Supporting People Programme. The National Advisory Board’s objectives, constitution, functions and relationships are offered in this report for consideration by the Deputy Minister.

1.15. The present structures and arrangements for the administration, commissioning, regulation and monitoring of support services were the butt of many concerns which surfaced in the review. This pertains at the national, local and community levels. To temper these concerns a more collaborative, consensual and multi-sectorial modus operandi at the level of the Local Authority is called for. The proposed collaborative committees working in conjunction with, and overseen by, the National Advisory Board would further facilitate the resolution of these concerns.

1.16. Collaborative mechanisms proposed in this report are also key to more effective and targeted commissioning. The collaborative committees must ensure that all key players are part of the decision-making process. The review also identified a greater role for public health in commissioning decisions. Health and healthcare intelligence from a population perspective would be brought by expert advice from public health to commissioning decisions. This would also facilitate the introduction of a required element of academic rigour and the more robust evaluation of outcomes.

1.17. Outcome agreements with Local Authorities have been introduced by the Welsh Assembly Government as part of the ‘New Understanding Agreement’. There is welcome evidence that an outcome-based system, based on support plans, has been adopted by a growing number of support organisations. Furthermore, the review commends the sterling work accomplished by the ‘Outcome Development and Pilot Group’. That Group has articulated a number of defined outcomes that serve to measure key strategic aims advanced by the group. The review concludes that this essential approach is promoted and actively supported by leadership and direction from the Welsh Assembly Government and Local Authorities. Of cardinal importance is the setting-up of a National Framework for data collection along lines which are described in this report.

1.18. The accreditation process is well liked and useful. Currently it is only used for those applying for SPRG funding directly from the Welsh Assembly Government. However there is an opportunity to expand this process to all providers. There needs to be a balance among Local Authorities of the monitoring, regulation and inspection of service providers. All providers funded by the proposed SPPG should be included in this process. A light-touch approach to outcomes monitoring would be benefitted by the development of national guidelines based on the current experience gained from SPRG inspections.

1.19. Although the tariff has been seen as a useful guide for funding services the final amount that the end provider receives is usually less than the tariff rate. Furthermore the imposition of tariffs are a barrier to outcomes based
commissioning. They are a process based approach to funding. Current financial arrangements are not seen as transparent; the use of the tariff system contributes to this. Tariffs neither support open commissioning nor cost effectiveness. The evidence gathered in this review does not support the continuation of the tariff system.

1.20. The review elicited some strong opposition to automatic eligibility for Supporting People funds by those who resided in Type II Housing (‘Sheltered Accommodation’). This is related to tenancy not need. It is recognised that there are a growing number of older people with support-needs who do not live in ‘Sheltered Accommodation’. There was very considerable support for basing eligibility on need rather than age or tenure.

1.21. Discovering discrete and robust evidence for the cost-effectiveness of the Supporting People Programme in Wales posed a considerable challenge to the review team. This necessitated the garnering of relevant evidence from a variety of pertinent alternative sources including an analysis of available literature of analogous schemes in the international arena. A recent cost-benefit review completed by Carmarthenshire County Council is of signal importance. That exercise estimated that the value of costs avoided by the programme is over twice the costs of the programme itself. These findings reinforce the benefits identified in an earlier report which took into account the cost-effectiveness of the programme across Wales (Matrix, 2006). The review supports the contention that the Supporting People Programme in Wales is cost-effective and in several respects delivers value for money in the context of a broad public sector perspective.

1.22. Until a robust outcome framework is in place with more rigorous evaluation of supporting people services and outcomes set against alternative mechanisms of support, precise and sturdy data on cost-effectiveness will not be gained. The review has demonstrated that the Programme’s benefits in terms of avoided costs are dispersed across a range of public sector organisations. This renders the Programme vulnerable to under-investment. The returns from the Programme are, thus, not readily identified; no single part of the public sector fully appreciates its value. This skewed perception of the financial benefits which the Programme brings is a major obstacle to recognising fully its salutary and profitable nature and features.

1.23. Due regard must be given to the extent of financial resources required to meet the magnitude and complexity of the Supporting People Programme in Wales. At all times during the conduct of this review, the risks potentially posed to the programme by the current economic climate were uppermost in people’s thoughts. The review confirms that the evidence for the programme’s effectiveness is strong and there is a plausible demonstration of its cost-effectiveness and value for money spent. These findings should weigh heavily in its remaining a priority for adequate funding by the Welsh Assembly Government.
1.24. Informed by the findings and conclusions of this review, recommendations have been formulated. These are by way of advice to assist the Deputy Minister for Housing and Regeneration in discharging her functions and meeting her accountabilities in regard to the Supporting People Programme in Wales. They are offered for her consideration to achieve her objectives of strengthening the Programme and maximising the contribution it makes to the health and well-being of the people for whom the Supporting People Programme is intended.

1.25. The recommendations are wide-ranging and are primarily directed at:
- Revising the process for allocation of funds to the Programme and the manner in which they are distributed throughout Wales;
- Proposals for the introduction of new collaborative, multi-sectorial structures for administration, commissioning and oversight of the delivery of support services;
- Improvements in governance, planning, funding and provision of these services and their regulation;
- Engendering a greater focus on securing tangible outcomes and their robust evaluation; and
- Setting in place mechanisms which would establish precise estimates of the cost-effectiveness of the Programme and its component services and the value for money offered.

1.26. In regard to allocation of the single, unified Supporting People Programme Grant the preferred option is recommended, that its disbursement is made via Local Authorities, ring-fenced and outside the Revenue Support Grant (RSG). Arrangements analogous to ‘Indicator Based Assessments’ should be explored to establish a robust mechanism.

1.27. Recommendations also reflect the pressing need for a collaborative approach across Local Authorities, housing-related services, providers of support services, public health, health services, probation service and other relevant stakeholders with an abiding emphasis on co-design and co-production. Also, emphasis is not lost on assuring that the Supporting People Programme is constantly subjected to review to ensure that it is accessible to all people who need its services, that funds are used solely to meet the needs of those disadvantaged and vulnerable people and that the Programme meets these needs.

1.28. Recommendations also stress that due regard should be given to the literature reviews undertaken as part of this exercise which form appendices to this report. These provide valuable information for guidance on the planning, utilization and evaluation of the provision of support to vulnerable people, homeless or at risk of homelessness.

1.29. A principal recommendation is that the Deputy Minister for Housing and Regeneration considers the establishment of a Supporting People National Advisory Board, chaired by her, to provide her with independent advice and information. This would provide tangible and visible assurance that processes and practices are fair, transparent and equitable; that
procurement and commissioning policies are clearly defined and have proper
guidance, regulation and accountability arrangements in place. It would also
represent a step-change to ensure clarity around the roles and responsibilities
of the Welsh Assembly Government, Local Authorities, service providers
and key players in the Supporting People Programme. The Board would also
provide a forum to advise the Deputy Minister on matters where legislation
might be pertinent. Arrangements are proposed for establishing a National
Advisory Board along these lines.
2. Introduction

2.1. The Review of Supporting People
The Supporting People programme was launched on 1 April 2003 and seeks to enable vulnerable people to gain and retain independence by remaining in their own homes. Through an integrated policy and funding framework, the programme aims to deliver high quality and strategically planned housing-related support services which are cost effective and reliable and complement existing care services.

Since the launch of the programme in 2003 a number of issues has been identified over the way in which the scheme is funded and administered. It soon became apparent that the way in which Supporting People funds are distributed across Wales is inequitable. Work was also carried out in 2006 to assess whether all funding streams should be administered by Local Authorities in Wales. No changes to the arrangements resulted from this work and as a consequence questions surrounding funding streams remain to this day. Further work was commissioned in 2008 to address the issue, this work was never concluded.

In September 2006, the Welsh Assembly Government published ‘Costs and Benefits of Supporting People’. The document quantified the benefits, primarily those to the public purse, of the Supporting People programme in Wales and reported that the Supporting People programme makes a significant contribution to the public purse with an estimated saving of £1.68 for every £1 spent on housing related support services (Welsh Assembly Government, 2006).

On 2 December, 2009 Jocelyn Davies AM, the Deputy Minister for Housing and Regeneration in the Welsh Assembly Government announced that she had asked Professor Mansel Aylward CB to review the Supporting People Programme in Wales. The review would provide her with advice on current policies, arrangements, systems and resources, including the making of recommendations that would strengthen the Programme and maximize the contribution it makes to the health and well-being of people for whom the Supporting People Programme is intended. The report on the review would also identify short, medium and long term priorities. Terms of Reference were agreed and these formed the essential framework for the conduct of the review and securing of the review’s desired objectives.

The Deputy Minister stated that the review should be independent, transparent and comprehensive and should take on board evidence from stakeholders including service users across Wales.

2.2. Terms of Reference
Following discussions with the Deputy Minister for Housing and Regeneration, the following terms of reference for the review were agreed:

To review the current policies, systems and resources that deliver the Supporting People programme and provide advice and recommendations which will help
maximise the long term contribution that the programme makes to the health and well being of people and the communities in which they live. This includes:

1. Whether the current process for allocating funds, via Supporting People Grant (SPG) and Supporting People Revenue Grant (SPRG), needs to be revised or if any other funding streams should be considered;

2. Obtaining an understanding of what the Supporting People programme currently provides, how it operates and how it's administered;

3. To meet with service users and providers and key stakeholders (including Welsh Local Government Association (WLGA) and Welsh Assembly Government) in order to help inform this understanding;

4. To compare and contrast the performance of the Supporting People programme in Wales with other UK countries;

5. To ensure that processes and practices are fair, transparent and equitable and that planning, procurement and commissioning policies are clearly defined and have proper governance and accountability arrangements in place;

6. To ensure that the roles and responsibilities of the service providers, Welsh Assembly Government, Local Authorities and other stakeholders are clearly defined and understood;

7. To ensure the Supporting People programme is accessible to all that need it and that the programme meets these needs;

8. To ensure the scheme achieves value for money; and

9. To prepare a final report making recommendations as appropriate to strengthen arrangements. The report will also identify short, medium and long term priorities.

2.3. **Background – The Supporting People Programme**

Supporting People is a programme which supports vulnerable people to gain and retain independence by remaining in their own homes or securing appropriate accommodation. Projects funded through this programme are housing related but have wide benefits improving health and well being, reducing crime and anti social behaviour and returning people back to work and training. The Programmes provided should complement but not reproduce other services.

The Supporting People Programme should enable vulnerable people to maintain their housing situation, manage their finances, co-exist successfully in their community, acquire independent living skills, stay safe, liaise with other agencies, and access training, education, and employment.
The Ethos

Supporting People provides a holistic, citizen centred approach to help people become independent and move out of disadvantage. Many of the people accessing the services have multiple needs which are being met by health or social services. However, many individuals have additional needs that would not be met by other services. The services provided should be designed to help people develop the skills and confidence necessary to live independently without support, or to maintain independent living with ongoing support.

Supporting People is about individualized care targeted at improving the life of that person whilst developing essential personal, social and financial skills for keeping the home they are in. Regular visits from district nurses and social workers may help in many ways but Supporting People helps with the payment of the bills, managing money and engaging with the other services. This leads to the development of confidence and resilience in client groups.

<table>
<thead>
<tr>
<th>What if Supporting people were not there? What current and former service users have said:</th>
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<tbody>
<tr>
<td>What if you had not been on this programme? Where do you think you would be now?</td>
</tr>
<tr>
<td>‘in a ditch’</td>
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<tr>
<td>‘in prison’</td>
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<tr>
<td>‘in a nursing home’</td>
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<tr>
<td>‘in hospital’</td>
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<tr>
<td>‘dropped out of school, but now I want to go to university’</td>
</tr>
<tr>
<td>‘on the streets, still using’</td>
</tr>
<tr>
<td>‘dead’</td>
</tr>
</tbody>
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Breaking out of the cycle

Supporting People works with individuals and families to help them break out of what may be becoming their ‘usual cycle’. Although focused on keeping people in a home the support ranges from financial planning to cooking sessions and other skills, which lead to increased independence and well being.

The Programme also helps families who are homeless. Those that may previously have been put up in bedsits are now housed in secure accommodation and provided with training and skills opportunities. The clients are provided support in developing financial, parenting and IT which can prevent homelessness from becoming a problem.

Some schemes help young people with complex needs. They will often not only have housing related needs but they may have been bullied, abused, self harming, and not in employment, education or training (NEETs). The schemes can help young people to become engaged again with services and return to education. The expectation is
that within a year they are productive members of the community preventing the well-documented slide into criminal activities, drug and alcohol use and risk of suicide.

What is a support worker?

‘Friend, family, like having a new mum, support, professional, like a friend, but knowledgeable, knows how to act, helps me to go to appointments, shows me how to budget, speak to people, fill out forms.’ (Service User)

The Supporting People Programme: An Overview

The Supporting People Programme is a UK-wide programme, launched in April 2003. The Programme brought together several funding streams including the Transitional Housing Benefit Grant (THB), the Supported Housing Revenue Grant and the Probational Accommodation Grant. The allocation of funding was based upon the numbers of people reported by each Local Authority who were being supported by these grants. Thus the funding was distributed throughout all parts of the UK on that basis.

Supporting People Grant and Supporting People Revenue Grant

In Wales, the funding of Supporting People services is delivered through two funding streams; the Supporting People Grant (SPG) and the Supporting People Revenue Grant (SPRG). This has added complexity to the system as the SPG is administered by local government and the SPRG by the Welsh Assembly Government. Although both are included in the ‘Supporting People Operational Plans’ produced by most Local Authorities all re-configuration and administration of the SPRG has to be agreed locally and be approved by the Minister. In addition, although there may be local reporting and inspections there is also a national reporting and inspection process. Because of the difference in administration and funding mechanisms of the two parts of the programme in some geographical areas there is not coherence between the SPG and SPRG projects.

SPG is administered by local government and is used to fund chargeable support services. It includes the funding of projects for older people and community care projects. People with learning difficulties may be eligible for community care and therefore receive SPG funding, others may not qualify for community care but would be eligible for SPRG funding. Other clients may live in a SPG funded project but receive SPRG funding for another aspect of their needs. Thus an individual may actually be receiving funding from both streams.

SPRG is administered by the Welsh Assembly Government and is used directly to fund Accredited Support Providers (ASPs) which may then commission other third sector organisations to provide the programmes. There are 95 Accredited Support Providers (ASPs), of which 21 are Local Authorities who work with other ASPs or other providers. There are approximately 562 projects administered by 73 ASPs (out of a total 78 registered ASPs).
The Welsh Assembly Government guidance to Local Authorities (Welsh Assembly Government, 2003) states that SPRG is for housing-related support to vulnerable people who are within the following categories (known as the ‘E’ groups):

- People fleeing domestic violence;
- People with learning difficulties;
- People with mental health problems;
- People suffering from alcohol dependency;
- People suffering from drug dependency;
- Refugees;
- People with physical disabilities who require support;
- Young single homeless who require support and young people leaving care;
- Ex-offenders;
- People who are homeless or potentially homeless and in need of support;
- People with chronic illness including AIDS, AIDS-related conditions or who are HIV positive; and
- Vulnerable single parents who require support.

Many of the people who are receiving SPRG funding are ‘non statutory’ groups. This means that the Local Authority has no statutory duty to provide services to them. However, the exact ‘statutory’ nature of people may vary.

**Third Sector Providers**

The review recognised at the outset the commendable work of the third sector, in relation to Housing Related Support. This included not only the current work but their advocacy over decades to direct government funding to deliver sustainable services.

The third sector has the ability to be ‘ahead of the game’. Having front line exposure allows them to be aware of the needs of the most vulnerable and gives them the flexibility to respond to new needs. For example, some existing third sector providers respond to the needs of trafficked people i.e those people who are forced or coerced against their will and transferred to another place and exploited. They have recently been identified as a growing group of vulnerable people. The process of advocacy for such groups to receive mainstream funding is long and arduous. The advocacy of the third sector and the flexibility to respond to need and raise funds from a variety of sources help to protect the most vulnerable in society.

A socially aware, democratic society should listen to the people working at the front line and their advocates and should assign (or ‘mainstream’) funding to provide protection for recognised vulnerable groups. This helps to both bring in regular funds and gives recognition to the projects. By gaining mainstream funding for projects, additional funding can be identified which would not otherwise be allocated without the ‘mainstream funding’ and can free up third sector providers to continue to work and develop projects for the next evolving vulnerable group.
The Legislative Context

The Supporting People Programme does not have primary legislation governing how its money is spent. ASPs and Local Authorities follow the above guidance from the Welsh Assembly Government in discharging their responsibilities on the use to which the money is put.

Section 180 of the Housing Act 1996 empowers Ministers in Wales to make payments to voluntary organisations who work with the homelessness and for matters relating to homelessness. Section 181 of that Act permits the assistance to be subject to conditions; Section 182 permits the Ministers to issue guidance.

In paying SPRG, the Ministers are relying on the powers granted in the Housing Act, 1996 and the Local Government Act, 2003 together with their general powers given in the Government of Wales Act, 2006.

People involved in Supporting People often refer to the ‘statutory groups’ and the ‘statutory duties’ that the Local Authority has, and the relevance this has to the groups of people who are not covered by legislation.

There a number of pieces of legislation that are relevant to Supporting People projects, which include:

- Under the 1996 Housing Act the Local Authority owes a statuary duty to provide housing to people who are in 'priority need' and 'unintentionally homeless' but there is not a statutary duty to provide support; and

- The Community Care Act, 1990 and the Chronically Sick and Disabled Persons Act, 1970 cover the statutary duty of Local Authorities to assess and if a need is identified to provide community care and support. These groups include people with learning disabilities, elderly persons and people with hearing or visual disabilities.

There are people at whom the SPRG is targeted that fall outside of Primary Legislation. However, Grant conditions and Secondary Legislation identify categories of vulnerable people (E groups) which should be provided Housing Related Support by means of the SPRG.

On 21 July 2010 the Welsh Assembly Government received royal approval for a ‘Legislative Competence Order (LCO) in relation to housing and local government’ (Welsh Assembly Government, July 2010) The competence within the LCO would permit the regulation of social landlords, disposals by social landlords, social housing tenancies, homelessness, housing allocations, housing-related support (under matter 11.6 (see box)), the provision of Gypsy and Traveller sites, empty homes and Council Tax for second homes.
Wider Context

A number of documents was considered during the review which helped inform the wider agenda; these include Essex Review (Essex, 2008), the Human Rights Act, *Fulfilled lives, Supportive Communities* Commissioning Framework and Guidance (Welsh Assembly Government, 2007), and the Beecham Review (Beecham, 2006). The review also received submissions relating to the personalisation agenda (direct payments and self directed support) which is developing in England and how this compares to the Citizen Centred approach in Wales. Wherever possible the review took into account the direction of travel presented in these documents.

The sector is also moving forward in this context. Recent work includes views from the sector on delivering quality in Housing Related Support (Stirling, 2009) which details good practice and experience in improving quality in Wales and across the UK.

Matter 11.6

Provision of advice and non-financial assistance to individuals in respect of their obtaining and living in housing.

This matter includes, in particular advice and non-financial assistance in respect of skills that are relevant to the ability to live independently, or more independently, in housing.

The Beecham report argues that citizens should, “receive high quality, personalized, joined up services, planned across organisational boundaries”. This is exactly what housing related support aims to achieve’

(Millward, Kent and Boswell, 2006)
3. Review Methods: process, evidence-gathering and interviews

The underlying principles in structuring and executing the review were to undertake an evidence-based and transparent process. The terms of reference were discussed and shared with stakeholders at the outset. Contributions were actively encouraged. The evidence collected was considered for consistency and consensus and, wherever possible, triangulation of evidence from independent sources was sought before being accepted.

The review used a mixed methodology to gather evidence. During the evaluation process evidence was taken from the literature, key stakeholders and from experts in the field. Throughout the review broad and inclusive methods were used to engage with, and obtain evidence from, as wide a range of interested parties, stakeholders and other relevant sources. Search strategies were also adopted to retrieve pertinent documents.

The literature was consulted in a number of ways. Two formal literature reviews were completed, in addition key stakeholders were asked to identify key documents and widespread consultation led to the submission of grey literature. Greatest weight was given to evidence that met ‘Strong’ and ‘Moderate’ in the evidence rating system employed (Appendix 1).

3.1. Literature

There were a variety of methods used to identify and consult relevant literature. These included:

1. Formal literature review to compare and contrast the nature, procedures and performance of the Supporting People Programme in Wales with similar schemes in other UK countries. (Appendix 3);
2. Formal literature review on ‘Housing related support interventions: a rapid review of the evidence’ to best practice and inform evidence based commissioning. (Appendix 4);
3. Identification of other literature from key stakeholders – grey and unpublished; and
4. Submitted written evidence from a range of stakeholders.

The review identified and examined sources of information including; national and local government publications and papers, peer reviewed publications, service provider umbrella publications, annual reports and a range of other published and unpublished sources. There was also a range of submissions from providers and local

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1 Conference materials, unpublished documents, internal policy and guidance papers that are not easily accessed through commercial publishers. The Grey Literature Network Service defines grey literature as "information produced on all levels of government, academics, business and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body."
authorities which had been collated especially for the review on the work which was being done locally.

There were several groups that provided written information and submissions to the review including Cymorth Cymru, WLGA, and the Housing Related Support Strategy existing working groups. These working groups included representatives of Local Authorities, providers, Welsh Assembly Government, Health and Probation services. They were tasked with reflecting on the principles of partnership and best value for limited resources as set out in ‘Making the Connections’, ‘Delivering beyond Boundaries’ and the ‘Essex Review’ in order to make recommendations to inform a national strategy for the Supporting People Programme. They were also asked by the Welsh Assembly Government to give particular attention to the legislative framework, substance misuse, service user involvement, opportunities for joint working, measuring success, ensuring quality of access and resources implications. The outcomes and recommendations of these working groups were a valuable contribution to the review.

3.2. Interviews

Qualitative social research methods were used in the interviews. A series of fact finding interviews were carried out between February and August 2010. A ‘snowball technique’, a type of purposive sampling, was used to identify informants. There was also an opportunity for people to self refer for interview. Initial key informants included representatives of umbrella organisations, local government and the Welsh Assembly Government. These key informants also provided contact details for further stakeholders to approach in the review. This was continued until saturation of ideas had been reached and no further new evidence was being identified through interviews. Both in-depth interviews (one to one and one to two) and focus groups were used. Two larger sessions were held which were broken down into working groups to explore specific areas. Open ended questions in a semi-structured interview style was used. Interviews were carried out by three members of the review team both together and separately. A consultation strategy was developed at the beginning so that throughout the review the informants could be reviewed to see if all constituent parts of the programme were being represented. These included representatives of service users, Local Authorities, both front line and executive level, Welsh Assembly Government, accredited and non-accredited Support Providers, Cymorth Cymru, providers from a range of sectors, front line workers, public health and partners.

Table 1 gives details of the face to face interviews conducted by the review team.

Appendix 2 lists the organisations and representatives with whom face to face and telephone interviews were conducted.
Table 1 – Interviews

<table>
<thead>
<tr>
<th>Provenance of Groups Interviewed</th>
<th>Number of interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers – Third Sector organisations (Including both SPRG and SPG, Housing Associations, ASPs and non ASPs)</td>
<td>82</td>
</tr>
<tr>
<td>Local Authority – Supporting People leads, officers other than supporting people leads, executives and elected members.</td>
<td>78</td>
</tr>
<tr>
<td>Service Users</td>
<td>42</td>
</tr>
<tr>
<td>Health Services (Public Health and Local Health Boards)</td>
<td>10</td>
</tr>
<tr>
<td>Organisations outside Wales</td>
<td>9</td>
</tr>
<tr>
<td>Policy Makers</td>
<td>4</td>
</tr>
<tr>
<td>Probation Services</td>
<td>2</td>
</tr>
<tr>
<td>Other – Independent Consultants, Academics and Data Experts</td>
<td>4</td>
</tr>
<tr>
<td>Welsh Assembly Government employees and officials</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
</tr>
<tr>
<td>Written Submissions</td>
<td>65</td>
</tr>
<tr>
<td>Total documents</td>
<td>274</td>
</tr>
<tr>
<td>Other submissions – DVDs, YouTube links etc</td>
<td>4</td>
</tr>
</tbody>
</table>

3.3. **Advisory Group and Independent Expert Panel**

An advisory group of key stakeholders was consulted on a monthly basis through the review period, as a key source of information and sounding-board. At a later stage in the review a panel of independent people with particular expertise were brought together to discuss and reflect on recommendations.

**Advisory Group**

A group of stakeholders representing relevant sectors met to advise the review team. However, it was made clear from the outset that the group only had an advisory role. The Advisory Group was given an opportunity to comment on an Interim Report submitted to the Deputy Minister in June 2010 and to confirm, or otherwise, whether the review was progressing in the right direction. The Advisory group consisted of:
Chris O’Meara, Special Advisor to Deputy Minister for Housing and Regeneration;
Joy Kent, Chief Executive, Cymorth Cymru;
Kath Palmer, Department of Housing, Welsh Assembly Government;
Sue Finch, Welsh Local Government Association;
Jane Peglar, Community Housing Cymru; and
Nigel Stannard, Supporting People Lead, Newport.

Independent Group

During a later stage of the review a group of people with a range of relevant knowledge and pertinent expertise were consulted to provide a balanced perspective on the evidence and to guard against bias in the gathering, analysis and formulation of the emerging conclusions and recommendations.
4. Observations and Findings

4.1. Overview

The Supporting People Programme is delivering a considerable amount of essential preventive and effective work to around 50,000 people in Wales in any one year. This includes:

- Working with homeless individuals, who have complex needs to help them transit from a complex life on the street to a settled home;
- Helping young parents build sustainable stable lives with quality parenting skills; and
- Ensuring elderly people maintain their independence in an active way.

Many of the individual projects in Wales carry out their own outcomes analysis. However, there is currently no formal routine evaluation of the programme in Wales.

In a sample submitted of 481 service users who had participated in the Programme in Wales (2009/10):

- 76% felt prepared to live independently without support;
- 77% felt able to manage finances independently whereas initially they had needed support; and
- 85% felt able to maintain their health and wellbeing whereas at the beginning they had needed support.

To illustrate how analogous Supporting People Programmes improve the lives of disadvantaged and vulnerable in England, St Andrews University published the following data in their 2008/09 report on those receiving supporting people services (St. Andrews, 2009):

- 25,033 (77%) better managed their physical health; and
- 34,239 (67.8%) people maintained their accommodation and avoided eviction.

Both of these sets of figures are based on individuals recognising at the outset of the support programme their need for support in these domains.
For illustrative purposes some of the qualitative evidence for the benefits of the programme in Wales is captured in a selection of representative remarks made by people interviewed in this review:

‘I was drinking 6 pints a night because I had terrible debt, I had no fridge...I never thought anyone would help me... I lost my job....Now I’m not drinking, I buy food, I’ve got a fridge, they took me to the bank and to lawyers and helped me to learn how to manage my money. They didn’t give me money. They’ve been great.’ (Service user)

‘Rough sleepers have fallen from about 30 per night, which it had been for a long time, to about 10 per night over 4 years.’ (Provider)

‘I used to call the Samaritans and...(the psychiatric hospital) all the time, now I never call. Not a change in my medication. I just don’t get down and depressed and panicky now I’m not worrying about money.’ (Service user)

Although the Supporting People Programme in Wales is delivering these essential services, there are several areas of contention, inconsistency and imperfection. Many concerns relate to financial aspects of the programme including redistribution, transparency, cost effectiveness and the tariff. The structure of the Programme, regulation and evaluation and whether those in greatest need would continue to be protected, especially during an economic downturn, also emerged as requiring urgent attention and resolution.

The findings and observations have thus been structured to reflect the concerns and firmly held opinions that surround the programme as well as responding to the Terms of Reference. A structured approach to documenting these matters was used, adopting the following topics and themes:

- Context;
- Comparison to the rest of the UK;
- Costs effectiveness, Effectiveness and Outcomes;
- Structure Process and Roles;
- Equality and Access, including distribution of funds; and
- Regulation, Checks and Balances.

Issues which ran across the topics and themes, such as commissioning and outcomes monitoring, tariffs, and cross-boundary working, etc, were address, as appropriate, in the exploration of each of these themes.

**The challenge of the current economic climate**

The current economic climate and the pressure on public spending prompted both verbal and written submissions to the review team expressing concerns that a culture could emerge whereby those who may be wrongly labelled the ‘undeserving poor’ may lose out to the ‘deserving poor’ or ‘statutory groups’.
It was clear to the review team that those working in every sector of the Supporting People Programme are highly committed to the objectives of the Supporting People Programme. They are committed to and indeed passionate about, protecting the most vulnerable in our society and the people at whom this money is targeted. It was evident that there was a strong desire for working collaboratively and in co-production in order to develop and deliver the most efficient, effective programmes to the greatest number of people to address more soundly the unmet needs that exists in Wales.

**Advocacy and spreading the good word of what Supporting People does**

The review team spoke to politicians from five different political parties. All were supportive of the programme and believed that it would be essential to protect and preserve this initiative in a time of recession. They recognised there may be some colleagues that may not feel the same way as they did. They felt confident, however, that their colleagues would understand the nature of this programme and, in general, support it.

Most people consulted (Local Authority, policy makers, partners and providers) felt that there had been considerable developments and a degree of progress in the last seven years which had gained widespread support and greater understanding of the Programme. Some strong feelings were expressed that, especially in Wales, there is an inherent awareness of social justice and that the Programme would be widely supported once people understand what it does. Nevertheless, some providers did not feel that there was enough support for the Programme and it was necessary to take away decision-making around this programme from local politicians, as it was perceived that funding would be skewed away from the most vulnerable and disadvantaged people.

There was a common view across all the sectors that for too long the light of this programme has been hidden under a bushel and that it was time to raise the profile considerably.

4.2. **Comparison of the other Countries in the United Kingdom**

Comparisons with other United Kingdom Programmes were made. A rapid review of literature identifying key documents and papers from peer reviewed and grey literature was undertaken by Public Health Wales. This was supplemented by interviews with key stakeholders in England, Northern Ireland and Scotland, providers and other people who had experience of working on similar programmes in both England and Wales.

A summary of the key findings can be found in Table 2 and the full report at Appendix 3.

Following devolution of the programme to the four nations, each defined the programme slightly differently. Notably, the aim of the Supporting People Programme for each of the four nations given in Table 2 illustrates these differences.
Distribution of funds

In 2004 it was recognised across the UK that the distribution of the money among the geographical areas was flawed: it was largely provision-based on the delivery of existing services and did not adequately reflect needs. In some Local Authorities, to ‘maximise the pot’, as many local people as possible who were eligible were registered for the programme. Each country has subsequently looked at ways of rectifying this.

The central commissioning model of Northern Ireland was based primarily on a distribution that aimed to reflect the needs of vulnerable and disadvantaged population.

In Scotland a simple and transparent formula was developed. However the validity of the formula in adequately reflecting needs has been challenged. There is also a belief that the redistribution could have been better managed. There was no attempt at tapering or graduated introduction of the funds.

The Scottish formula was based on:

- 30% on the proportion of older people;
- 30% local rates of homelessness;
- 20% number of people claiming disability living allowance; and
- 20% deprivation.

Whilst being empirical, transparent, and simple to apply, the evidence base for the magnitude of the components in the formula is wanting. In England and the distribution formula used is perceived to be very complex and not transparent. It used both current expenditure and needs based measures in the construction of the distribution mechanism.

There was ‘ring-fencing’ in all four nations initially. In Scotland the ring-fence was removed in 2008. In England, a House of Commons select committee review removed the ring-fence in 2009 and the fund became part of the local government settlement. In Northern Ireland funding remains ‘ring-fenced’. It is distributed through a centralised Unified Statutory Authority, the ‘Northern Ireland Housing Executive’ which is responsible for monitoring and policy. There is a national commissioning group on which representatives of Health, Probation and Housing sit. There are advantages to this simplified system but the Local Authority has no role in strategy or commissioning. The Northern Ireland stakeholders felt that this system was unique in meeting the specific situation in Northern Ireland and could not be easily replicated elsewhere; the Housing Executive had existed prior to housing related support and there was widespread acceptance of housing matters remaining separate from Local Authorities.

In England there has been considerable debate as to whether the removal of the ring-fence has been beneficial. There have been examples of the programme being severely curtailed and funding reduced. In some cases the Local Authority had used money previously used for Supporting People projects to fulfil other priorities.
The Supporting People Programme in Wales: Final Report

However, some Local Authorities have increased Supporting People projects which have flourished following the removal of the ring-fence.

Regulation is located in different arrangements in England, Scotland and Northern Ireland. In England regulation is through the Department for Communities and Local Government (CLG), in Scotland through the Care Commission (independent) and in Northern Ireland through the Housing Executive.

Table 2 Comparison of the Supporting People Programmes in the United Kingdom (full report at Appendix 3)

<table>
<thead>
<tr>
<th>AIM OF SUPPORTING PEOPLE PROGRAMME</th>
<th>England</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To help end social exclusion by preventing crisis and more costly service intervention and enabling vulnerable people to live independently both in their own home and within their community through the provision of vital housing-related support services.</td>
<td>To assist vulnerable people over the age of 16 to move into, or remain in, their own homes.</td>
<td>To commission housing support services that will improve the quality of life and independence of vulnerable people.</td>
<td>‘Supporting People’ is intended to provide high quality and strategically planned housing-related support services which are cost-effective and reliable. (Also key aims of SPG and SPRG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FUNDING</th>
<th>England</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>Wales</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>KEY CLIENT GROUPS 1, 2, 4</th>
<th>England</th>
<th>Scotland</th>
<th>Northern Ireland</th>
<th>Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with physical or sensory disability.</td>
<td>People with physical difficulties/illness.</td>
<td>Older People.</td>
<td>People with mental health problems.</td>
<td></td>
</tr>
<tr>
<td>People at risk of domestic violence.</td>
<td>People with mental health needs.</td>
<td>Young vulnerable people and care leavers people experiencing domestic violence.</td>
<td>People suffering from alcohol dependency.</td>
<td></td>
</tr>
<tr>
<td>Older people.</td>
<td>People experiencing domestic violence.</td>
<td>People in the criminal justice system.</td>
<td>People with physical and sensory difficulties.</td>
<td></td>
</tr>
<tr>
<td>Young people at risk.</td>
<td>People with dementia.</td>
<td>People with physical and sensory disabilities.</td>
<td>People accessing addiction services Refugees/Asylum Seekers.</td>
<td></td>
</tr>
<tr>
<td>People with HIV and AIDS.</td>
<td>Vulnerable due to young age.</td>
<td>People with learning disabilities.</td>
<td>People with learning disabilities who require support.</td>
<td></td>
</tr>
<tr>
<td>People with learning difficulties.</td>
<td>People with sensory difficulties.</td>
<td>Young single homeless who require support and young people leaving care.</td>
<td>Young single homeless who require support.</td>
<td></td>
</tr>
<tr>
<td>Homeless families with support needs.</td>
<td></td>
<td>People who are homeless or potentially homeless and in need of support.</td>
<td>People who are homeless or potentially homeless and in need of support.</td>
<td></td>
</tr>
</tbody>
</table>

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Outcomes

There is an Outcomes and Quality Assessment Framework in England, Scotland and Northern Ireland. Each are different. The framework in England includes the St Andrews basket of measures in England. This is a unified database developed and held at St Andrews University in Scotland. Local providers enter the data onto a web-based system which can be searched by provider, local area or nationally. The outcome measures were developed to be in line with ‘Every Child Matters’ programme (HM Treasury, 2003).

Administration

In both England and Scotland, the programmes are the responsibility of the government (CLG and Scottish Parliament). Local Authorities in Scotland and the Commissioning Body in England contract with the providers. Administering authorities are responsible for implementing the programme by providing the services themselves or working with partners to provide services. These can be third sector or private sector organisations. Some English providers expressed a belief that commissioning and definition of Supporting People projects could be too narrowly defined and this hinders them from delivering citizen-focused services. For example, in one area projects were not allowed to provide childcare for those receiving their support because it was considered to be beyond the remit of the direct support. This was felt to be a strength in Wales as the young parent was much more likely to engage with the support worker if the child was close at hand, but being safely looked after.

Wales

The Welsh Supporting People Programme is held in high regard across the UK and Europe for its flexibility of provision. However, it is also considered to have complex administration arrangements. Another characteristic identified was the lack of outcomes measurement. Despite being perceived as a strong programme it was difficult to evidence this. The planning and commissioning process in Wales was considered neither robust nor transparent as in England.
4.3. Cost Effectiveness

In September 2006 the Welsh Assembly Government published ‘Costs and benefits of the Supporting People Programme’ (Matrix, 2006). The report quantified the benefits, primarily those to the public purse, of the Supporting People Programme in Wales. The report concluded that the Supporting People Programme makes a significant contribution to the public purse with an estimated saving of £1.68 for every £1 spent on housing related services. However as it only considered one financial year and did not consider all the costs and benefits, there were some limitations to this study.

In order to address the requirements of the terms of reference, which states that the Review should ensure the Supporting People Programme achieves value for money, the assumptions and methodologies from the Matrix report were re-examined to assess whether these were complete and still appropriate. Other assumptions and methodologies were considered to see whether these would more accurately reflect current circumstances and whether this would ultimately change the conclusion reached in the Matrix report on value for money. The review also considered similar cost benefit studies in England and elsewhere.

Following detailed examination of the approaches employed and findings from the Matrix report and other studies, the Review concluded that the underlying assumptions used by Matrix in formulating their estimates were generally appropriate. This was also confirmed in discussions with key stakeholders who highlighted the positive preventive impact of the Supporting People Programme on utilisation of other public services.

However, the lack of an outcomes framework, with only anecdotal evidence available as to what would have been the situation without the existence of Supporting People funds and schemes, meant that there is no hard evidence relating to the effectiveness of the Supporting People Programme over the short-term or longer time-periods. It was noted that the Matrix report, as well as several of the other studies examined, were limited by the lack of financial data from the Supporting People Programme. Most of the financial data used were estimates which had been validated by interviews with stakeholders, consultants and Supporting People leads. The accuracy of this information is therefore questionable and as a consequence may lead to bias in the results achieved.

There was nevertheless a great deal of consistency in all the reports and studies on cost effectiveness which the Review examined. Whilst the estimates varied between studies, all concluded that the Supporting People Programme represented value for money. It was also acknowledged in some studies that there was a range of valuable but uncosted benefits which the Supporting People Programme provides. These could include:

- Improved health and quality of life for individuals;
- Increased participation in the community;
- Reduced burden for carers;
- Greater access to appropriate services;
- Improved educational outcomes for children;
• Reduced fear of crime; and
• Reduced anti-social behaviour.

Another important aspect of the assessment of value for money is that Supporting People funds often provide the basis for organisations to access additional funding streams, which have important benefits to the organisations and more importantly to their client groups, receiving the additional service provided. The extent to which Supporting People attracts additional funds is variable but it was evident that some organisations were able to access over 50% of their funds from these additional funding streams.

Other Studies

In September 2010, Matrix provided a similar cost benefit report on Supporting People to Carmarthenshire County Council. Whilst the authors of the report acknowledged that further research to investigate the impact of the Supporting People Programme was needed, the report concluded that Carmarthenshire’s programme helps the County’s public sector avoid costs that would otherwise have been incurred and provides non-monetary benefits to service users and the community through increased independence and higher levels of well-being.

The report highlighted the fact that the non-monetary benefits of the programme may be as, or more important than the monetary savings. For example, cutting Supporting People services could potentially lead to monetary public sector savings in Carmarthenshire, but would likely lead to worse social outcomes, such as; more people sleeping rough, increased offending, a loss of independence for some people who would move into residential settings, and an increased risk of vulnerable people leading more chaotic lives.

The report stated that the best estimate of the value of the costs avoided is over twice the cost of the programme. That is, for every £1 spent on Supporting People services, the public sector saves over £2, resulting in a net saving of more than £1. This figure is greater than the benefits identified in the 2006 Matrix report for the whole of Wales.

The report also went on to say that because the benefits (i.e. avoided costs) are dispersed across different organisations in the public sector, Supporting People is vulnerable to under-investment. This is because the return from Supporting People is not easily identified and no single part of the public sector fully realises its value.

In England, research commissioned by the Department of Communities and Local Government (CLG) in 2008 and 2009 looked at the financial benefits provided through Supporting People investment and how this linked with health, social care and housing. CLG identified the extent to which Supporting People saves money elsewhere through preventing or deferring the use of more costly alternatives such as health interventions, committing or becoming a victim of crime or becoming homeless.

The CLG research found that for every £1 of Supporting People money spent there is a net gain of £1.78 elsewhere in the public sector.
The CLG research clearly showed that the extent of financial benefit of the Supporting People programme is largely dependent on the assumption relating to alternative service provision. For example, the proportion of older people that receive cost-intensive residential care if Supporting People services were removed highly influences the extent to which the programme would be cost-effective.

The research nevertheless estimated that the £1.6bn spent annually on housing related support services generated in year savings of £3.41bn to the public purse by avoiding more expensive acute services. This includes avoiding £315.2m health costs, £413.6m costs of crime and criminal justice and £95m of the costs of homelessness.

In 2004, Brent Council established a project where supporting people funds were used to improve delays in hospital discharges. Brent Council found that for older people the lack of support to sustain independent living after discharge from hospital was leading to either; readmissions to hospital, longer stays in hospital than was necessary or premature entry to residential care.

For a relatively small investment (£40,600 in 2007-08), this support service proved to be an efficient and effective service. For example it:

- Freed up expensive hospital beds by facilitating the timely discharge of older people from hospital and reduced readmissions i.e. the revolving door is partially closed. Based on Audit Commission work from 2005 this is calculated to save up to £35k p.a. in reduced DTOC reimbursements;
- Diverted people away from (or delays their progression to) residential and nursing care. The Review estimates this saves Brent Council around £388k each year;
- Helped to reduce voids in general needs or specialist housing resources, although the data necessary to estimate the level of savings from this was not readily available; and
- Achieved sustainable benefits e.g. our sampling work found that 80% of people who it supports remain in a community based placement for at least 2½ or more years after their support ceases or until they die.

There is no comparable support service in Wales.

Cost effectiveness in the United States

The social structures in the United States are of course different from that of the UK and any comparison between supporting people in Wales and similar schemes in the United States can only be a generalisation. Nevertheless, there is evidence that investment in housing related support in the United States also has costs benefits (Appendix 4).

A study published in 2002 assessed the impact of public investment in supportive housing for people with mental illness. Data was available on 4,679 people housed in New York City between 1989 and 1997. The results of the study showed that people placed in supportive housing had marked reductions in shelter use, hospitalisation, length of stay per hospitalisation and time in custody. Before placement homeless
people with mental illness cost about $40,451 per person per year in services. Placement was associated with a reduction in service use of $16,281 per housing unit per year. Annual unit costs were estimated at $17,277, for a net cost of $995 per unit per year over the first two years (1999 costs). This meant that 95% of the costs of the supportive housing were compensated for by reductions in use of other services that could be attributed to the housing placement.

Despite the shortcomings, the evidence suggests that the Supporting People Programme can be regarded as being relatively cost-effective in that the avoidance of relatively high-cost events and episodes in some groups more than offset the relatively minor benefits that emerge from the use of Supporting People resources within other groups, where the Supporting People Programme represents a relatively insignificant proportion of the overall service portfolio.

Summary

The absence of an outcomes framework and rigorous evaluation of Supporting People schemes compared with alternatives makes it virtually impossible to establish precise estimates of cost-effectiveness. However, on the basis of stakeholder views, the evidence that is available all imply cost benefits to some degree. It would be reasonable to conclude that Supporting People does offer value for money, when a broad public sector perspective is employed.

4.4. Effectiveness of the Programme

A rapid review of the evidence considering the effectiveness of interventions designed to support vulnerable people in obtaining and maintaining appropriate accommodation was carried out (Public Health Wales, 2010). This can be found at Appendix 4. The search methodology covers a broad range of vulnerable groups and was not limited by country or study type but focused on interventional, analytical studies with a housing related outcome.

Many of the published studies originate from the United States and therefore the generalisability may be limited. In addition, the methodologies and nature of interventions vary, and the programmes studied are diverse. There are differences in philosophy, the way in which people were recruited and the types of housing and support provided. The outcomes studied also are diverse; various different definitions of homelessness and stable housing have been used. Follow up periods are often short. All of these make comparing different approaches and applying the evidence to the Welsh setting difficult.

Despite these issues the evidence does provide some general guidance on the types of interventions and approaches that may be beneficial.

In the United States there are some programmes classified as ‘permanent supportive housing’, which are programmes to meet the needs of homeless people with disabilities (including mental health issues). Programmes differ in detail but involve community based housing teams, which provide support to maintain independent living. Programmes can be scattered sites or cluster based. The residential support
teams are usually mobile, not facility based and do not have offices in the buildings where their clients are located.

A meta-analysis of housing models for people with mental illness found that all models achieved greater housing stability than non model housing and that permanent supported housing achieved the greatest effect (effect size =.63, P<0.05) (Leff et al, 2009). Non model housing included people living on the street, using shelters or living in housing described as ‘treatment as usual’.

‘Assertive Community Treatment (ACT)’ (Appendix 4) form an integral element of comprehensive interventions; these have been evaluated independently (Nelson, 2007). A review of 16 controlled evaluations of housing and support interventions for people with mental illness who had been homeless found that programmes providing permanent housing and support, ACT and intensive case management all led to significant reductions in homelessness and other outcomes.

Support often involves an ACT approach providing treatment, medication management, money management and independent living skills. There is evidence (Appendix 1) that these types of models are effective for people with mental health and/or substance misuse problems, including veterans as well as people with other disabilities (Leff 2009, Siegel 2006, Lee 2009, Wong 2006).

In a Cochrane review of ACT for people with severe mental disorders (Marshall and Lockwood, 1998) ACT was found to be superior to hospital based rehabilitation in achieving independent living (Level 1 evidence, Appendix 1). There were no other significant or robust differences in clinical or social outcome.

The evidence suggests that ‘Housing First’ approaches, where people are housed directly from the street without the need to engage with treatment and be clean and/or sober, in combination with assertive community treatment can be effective in maintaining people with mental illness and/or drug and alcohol problems in stable housing for substantial periods of time (Gulcar 2003, Tsemberis 2000). Some evidence suggests that those housed directly from the streets might be less likely to maintain their housing status than those recruited from shelters, hostels or other sources (Pearson, 2009). There is also evidence that some of the housing costs of this type of approach may be offset by reductions in use of other health and criminal justice services (Larimer, 2009). In these studies it is not possible to separate the effect of the housing first approach from that of ACT.

**Benefits to Health**

A study undertaken in San Francisco looked at the impact of permanent supportive housing on the use of acute care by homeless people with mental illness, substance misuse problems and other disabilities (Martinez, 2006). Eighty percent had a diagnosis of mental illness and a substance misuse disorder; 81% remained in permanent supportive housing for at least one year. In comparison with service use in the year before, placement in supportive housing significantly reduced the percentage of residents with an emergency department visit (53% to 37%), the mean number of visits per person (1.94 to 0.86) and the total number of emergency department visits (56% decrease from 457 to 202). Permanent supportive housing placement
significantly reduced the likelihood of being hospitalised (19% to 11%) and the mean number of admissions per person (0.34 to 0.19 admissions per resident).

In Wales although there are no research studies or routine data published there are ad hoc examples of benefit.

One project in Swansea which deals with people with drug and alcohol misuse problems in addition to housing problems attempts to follow up all clients and has data for five years. Sixty-four % of past clients are known to be living independently, one in four of past clients are now in active employment and two thirds remain ‘dry’ four years after leaving the support scheme.

Summary

Evidence from the United States and United Kingdom suggest providing vulnerable people and families with housing related support can lead to significant reductions in homelessness and lead to wider benefits. Housing related support in the community relating to money management and independent living skills can enhance other community support and is more effective than hospital treatment for encouraging independent living. However, there is currently insufficient evidence on the exact nature of the intervention. (Level 1 and 2 evidence, Appendix 1)

4.5. Outcomes

Outcomes measures are utilized to assess the extent to which an intervention has impacted on an individual or a community. Outcomes can be measured without a tool but it is useful to have a method of measuring in a consistent and standard way in order to draw together information across communities. The routine collection of outcomes can provide valuable information about the effectiveness of individual projects and programmes.

Currently in Wales commissioning and monitoring of projects is in greatest part process driven. It is serviced based monitoring and not focused on the individual client based experience. There is however, across the sectors, an acknowledgement that in order to evidence the good work that is happening an emphasis is needed for setting, collecting and collating tangible outcomes routinely and consistently.

In table 3 elements of service-focused and client-focused approaches are compared.
Table 3: Service focused vs client focused approaches

<table>
<thead>
<tr>
<th>Service-focused</th>
<th>Client focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>focus on service deliverer</td>
<td>focus on client</td>
</tr>
<tr>
<td>focus on how you deliver service</td>
<td>focus on how client changes</td>
</tr>
<tr>
<td>focus on quality of services</td>
<td>focus on effectiveness of services</td>
</tr>
<tr>
<td>emphasis on improving quality</td>
<td>emphasis on improving effectiveness</td>
</tr>
<tr>
<td>measure amount of what you do</td>
<td>measure benefit of what you do</td>
</tr>
<tr>
<td>evidence of activities (weak case with funders)</td>
<td>evidence of results (strong case with funders)</td>
</tr>
<tr>
<td>the task is never finished (demotivating for staff)</td>
<td>clients achieve goals (motivating for staff and clients)</td>
</tr>
<tr>
<td>service specified in terms of what is offered</td>
<td>service specified in terms of client need and intended outcome</td>
</tr>
</tbody>
</table>

The Experience from England

The St Andrews database holds data which can be utilized by providers, locally or nationally and is based along the lines of ‘Every Child Matters’. There are five high level outcomes that the supporting people programmes should enable clients to:

- Have economic wellbeing;
- Enjoy and achieve;
- Be healthy;
- Stay Safe; and
- Make a positive contribution.

Fourteen outcomes were developed within the five areas. Each of these required reporting on whether the client needed help in this area, whether it was achieved and if not why not?

Alongside this, providers and some commissioners used distance travelled outcomes monitoring (MacKeith 2007 and 2010). The most commonly used tool is a variation on the ‘Outcomes Star’, which is described later.

The outcomes framework was developed for a number of reasons. Firstly, it aimed to reduce the burden of administration, particularly for cross-authority providers, in capturing local information that would be meaningful at both a service and client level. Secondly, it was designed to provide a consistent measurement of outcomes for benchmarking against regional and national trends. Thirdly, the methodology was designed to capture the range of achievements that reflect the benefits, improvements and changes that occur for individual clients as a result of receiving Supporting People funded services. Discussions with St Andrews have highlighted five key areas to a national database. Primarily it is important that baseline data can be collected. This can be a timely, readily available tool for planning and commissioning. This has been piloted in Swansea. Many currently collect the information for their own use eg demographic data, classifications of need and geographic origin. It is not currently collected on an area basis to inform needs and planning. From this data, real time changes in drug use, financial issues or teenage pregnancy, for example, have been picked up. (Evidence from Pilot in Swansea, Personal Communication).
St Andrews also advise that any national system should be web-based. They have tried several systems but the advantage of a web-based system is that the data can be entered anywhere, even from a smart phone. There is no cost to the provider beyond staff training and time which is simplified and providers report that there are significant cost savings as data entry will be the same for all local areas. St Andrews also advise that wherever possible systems should build on and utilize what is available – individual support programmes and commonly used outcomes measures rather than invent new ones. This enables data entry to be as quick and efficient as possible. Both the SPriNT database (which is used in Wales) and St Andrews reflects the Individual Support Programmes.

Finally, St Andrews advise that it is absolutely essential to invest in front line desk/telephone support services as there will be queries. SPriNT report that they have support services that are also able to deliver in Welsh. They are also able to deliver, and have done, training in Welsh.

**Outcomes Development and Pilot in Wales**

Recognising that focusing on outcomes can lead to a more person-centred approach a group comprising both commissioners and providers met in October 2008. It was established that some providers had been focusing on outcomes in the past and had invested in databases to support this work.

In July 2009 the Welsh Assembly Government agreed to develop Outcome Agreements with Local Authorities, as part of developing the New Understanding between the Welsh Assembly Government and Local Government. The Outcomes Group of Supporting People commissioners and ASPs have attempted to develop a methodology at a provider and local level, which also addresses needs at national level.

In Wales the Local Authorities recognised that they needed to embark on the journey of a cultural shift. Since April 2009 this cultural shift has been happening and this joint group has been developing agreed outcomes measures. The outcomes results have been used for discussions, planning and commissioning. The group has reported to providers, Local Authorities and the Welsh Assembly Government.

Seventeen Local Authorities from across Wales took part in the pilot with a varying proportion of providers, which ran from November 2009 to May 2010. The overarching group, through consultation with partners, identified four key strategic aims that Supporting People services are helping deliver:

- Promoting Personal and Community Safety;
- Promoting Independence and Control;
- Promoting Economic Progress and Financial Control; and
- Promoting Health and Wellbeing.

The group then identified and consulted on eleven outcomes that could be measured to identify the extent to which services are contributing to meeting these objectives.
The eleven outcomes are:

- Feeling Safe;
- Contributing to the safety and wellbeing of themselves and of others;
- Managing accommodation;
- Managing relationships;
- Feeling part of the community;
- Managing money;
- Engaging in education/learning;
- Engaging in employment/voluntary work;
- Physically healthy;
- Mentally healthy; and
- Leading a healthy and active lifestyle.

Providers were asked to work with individuals and to report whether the above outcomes had been ‘met’, ‘partly met’ or ‘not met’; either on exit from a service or at a six monthly review.

After the pilot the vast majority of those interviewed (services users, providers and commissioners) were positive in relation to the development. They liked the simplicity and were positive about the remit of the outcomes collected and how they did not focus on what could be interpreted as simply ‘housing’ objectives.

However, there were still those who need convincing that it will be of value, that it will not lead to more unnecessary paperwork and that by not recording tasks the wider remit of activity engaged in with individuals will be lost. Some Local Authorities have adapted the agreed outcomes and have added in more questions. This has frustrated providers because, by doing so, they have removed the advantage of having one, efficient, outcomes framework experienced for working across Local Authority boundaries.

There is also a feeling that some of these replicate each other and that the list could be reduced even as low as six.
‘There is undoubtedly an appetite within the sector to develop a methodology to evidence what services are achieving - 77% of Welsh Local Authorities have been involved in the pilot.’ Supporting People Information Network (SPIN)

‘We could be at the beginning of quite a significant cultural change. If this development is to be effective; no longer will providers be expected to submit rotas, on-call arrangements, staff qualifications, ask service users to complete 157 question exit questionnaires, etc, instead they will look to provide evidence of what it is their service has actually achieved.’ (Outcomes Pilot Group)

‘Since we have introduced outcomes monitoring we have been able to save staff time and travel cost. Instead of driving around collecting process data which has limited use.’ (Local Authority)

There are already examples of support organisations changing their support plans to reflect the outcomes identified and there are others who are keen to do so, but only once they have received more direction from the Welsh Assembly Government and the Local Authorities they work with.

**Recommendations from Outcomes pilot group (Welsh Assembly Government):**

- The 11 outcomes piloted are adopted as part of a national framework;
- The collection of outcomes, on a consistent basis across all Local Authorities and providers of housing related support; begins in April 2011 through the direct support and prescription of the Welsh Assembly Government;
- That a national database is developed to allow access at service provider, Local Authority and national level;
- From now until April 2011 the Outcomes Delivery Group continues to work in partnership with all in the sector to evolve and improve the model and the group develops/refines any guidance in line with the feedback received;
- Cymorth Cymru and the Local Authority Supporting People Network work in partnership to offer training and awareness raising in relation to the framework in all areas of Wales in the run up to April 2011 and the adoption of the model.
- The existing SPRG Service aims are replaced by a set of ‘minimum standards’ and the outcomes framework;
- Payment of grant should not be conditional on the achievement of outcomes, but is part of the process to inform commissioning decisions;
- Commissioners work in partnership with providers to develop a deep, joint understanding of the outcomes they expect each service to deliver and are mindful of these in analysing returns and the reviewing process;
- The overarching outcomes group work in partnership with the sector to develop a consistent approach to allow reviewing and commissioning to operate in relation to outcomes expected; and
- That the collection of outcomes will not be enough to evidence the value of services. High quality and independent social researchers need to be commissioned to undertake more detailed research identifying the ‘social return on investment’ of services receiving Supporting People funding.
Database

‘The SPriNT database software has been well received by support workers and we have found that using it has saved us time and therefore improved our service to clients. Our records are now better organised and reports are easier to produce for commissioners. We are happy with the software and feel it was a positive and worthwhile move forward in our work.’

Kirstie Pavey, Statistics and Website Co-ordinator, Welsh Women’s Aid.

The Welsh Assembly Government funded a not for profit organisation to develop a database to collect outcomes. The Supporting People Information Technology Network is a web-based system which can be accessed from any computer including hand held devices. It is now providing the software and support to a third of support workers across Wales. It is used by six Local Authorities and a range of Housing Associations and providers throughout Wales. Support workers can collect service user data for easy and quick direct input into a database. The database can then provide timely data to the provider organisation and in some areas this can also be accessed by the Local Authority. The Local Authority can then have timely information to inform planning without the need to travel to each project. Another recent development being used in some areas is an electronic pen which means as the support worker records the outcomes with the service user and the information is entered directly to the database, without the need to input twice or spend long periods of time returning to base to input data. The data in some areas is being held in a wider area database, as it is routinely in England, so larger area evaluations can be done by the Local Authority. Although this is not currently done at a national level in Wales database providers concurred this would be a feasible task. The purchase of the software is currently approximately £15000. Local Authorities who have invested in the software and switched to outcomes based monitoring report considerable cost savings, especially in staff time and travel expenses.

There are several methods utilising distance travelled: the most common of these is the Outcomes Star. This was originally developed by St Mungos in London but is now widely used in the Supported Housing Sector. It is useful for the client to visualize the progress. Providers predominantly with services for the elderly reported that some elderly find it ‘condescending’ or not as useful. Others suggested that this depended on how it was discussed. There is flexibility in the Star and several version of it exist (Figure 1). Scotland has trialled the Outcomes Star and there is a suggestion that they may opt to take this on nationally.
The data that is derived from a distance travelled method is much more useful for analysis and understanding of service groups, project implementation and relevance to strategies. The concept of ‘achieved’ or ‘not achieved’ goal, although useful, does not capture the journey which the individuals receiving support are experiencing. A person may not have achieved their goal of becoming totally independent or confident but have taken several important steps towards that goal which would be captured in a distance travelled data capture.

There has not been any unanimity so the pilot did not opt for a distance travelled method. Firm views have been expressed advocating that all geographic regions should have similar reporting mechanisms, thus increasing efficiency.

4.6. Equality and Access: Distribution of Resources

In this context equality as a concept suggests an equal number of, or an equal distribution of, resources. Equity, on the other hand, has an association with need, or a moral justice. Distributing the money and services purely per capita may result in equality but this would not be seen to have achieved equity. The concept of equity is an ethical principle; it also is consonant with and closely related to human rights principles. There are many ways in which the services provided may not be delivered to those who most need them.

‘To develop clear, consistent equitable and transparent methodology for the funding of housing related support across Wales.’
4.7. **Distribution**

**Figure 2: Supporting People Expenditure by Local Authority 2007/8**

The original distribution of Supporting People funds was recognised to be inequitable as Local Authorities and ASPs were instructed by the Minister for Social Justice and Regeneration at a specially convened conference in 2002 to ‘maximise the pot’. Some Local Authorities did this and their population has since benefited but some areas did not. People living in those areas that did not ‘maximise the pot’ do not therefore have the same opportunity to access services and support. The Welsh Assembly Government has attempted in recent years to distribute any new money on a per capita basis but this has been a very small amount compared to the total amount allocated.

The Public Health Wales Observatory compared the spend on Supporting People per head of population (per capita) and by deprivation. The measure they used was the percentage of Lower Super Output Areas (LSOA), which are in the lowest quintile of deprivation across each Local Authority area.

From Figure 3 it can be seen that not only is there no equality of spend per capita but the spend is not related to deprivation. If the spend were related to deprivation there would be larger spends in Merthyr Tydfil per capita than in Conwy. Age is another factor where the spend could be related, but even with a more elderly population, there will still be increased needs where there is more deprivation.
The distribution has been recognised as inequitable since 2004. In 2008 the Welsh Assembly Government commissioned LE Wales (a private London based consultancy) to examine the feasibility of introducing a formula-based mechanism, based on an assessment of need and current expenditure for the distribution of Supporting People funds to Local Authorities. The report, published in June 2008, concluded that the development of a formula-based mechanism was feasible and advocated that the approach should be based on a statistical analysis of needs and costs (LE Wales, 2008).

A subsequent report by LE Wales, published in April 2009 considered the range of options for developing an appropriate distribution formula. This was considered by the redistribution sub group, the Supporting People redistribution sub group and the Advisory Group in June 2009. No agreement was reached by the groups. However a decision was made to select an option that involved multi level modelling across the Local Authorities. This required additional data from the Local Authorities. It was understood that most of this data could be accessed relatively easily.

Unfortunately, in large part due to the tension between ‘accuracy’ and ‘simplicity’ a formula for distribution had stalled. The review considered a range of elements that could be in the formula.
However, from stakeholder interviews it was apparent as a consequence of this stalled process and the discussion that it has stimulated, there is now almost unanimity across all the sectors that the formula should be:

- Transparent, simple;
- Utilizing readily available data; and
- Introduced as soon as possible.

**4.8. Other aspects of Equality of Access Vulnerable People**

Supporting People funding is directed at a list of vulnerable people as described in the grant conditions (Table 2). A consultation in 2009 reviewed who should be funded and the current list was developed. However, some of those interviewed advocated that other groups be included, such as trafficked humans, asylum seekers prior to being granted asylum, gypsy and other similar travellers. Some providers do not make a distinction against these groups because they see these people in need and will provide support as required.

Currently the Supporting People Operational Plans carry out a service mapping and Needs Mapping Exercise, which identifies the needs of current service users. There was strong evidence that in the majority of areas there was little unmet needs analysis nor, in most areas, an attempt to match the service provision to these needs. In England there are good examples of housing needs and homelessness being brought into the high level Joint Strategic Needs Assessment, which is joint across the sectors. This recognises the impact that housing and homelessness has on health and also the impact health and well-being data has on Supporting People needs (Table 2).

Some Local Authorities do have structures where they have a planning group which consists of people who are familiar with the Health, Social Care and Wellbeing Strategy and other relevant strategies and needs assessments but this is not universal. Also, although a group may exist probation and health are rarely involved and able to advocate for certain groups or where the outcomes may be more pertinent to them. Hence in some areas there has been no reconfiguring of services to meet the unmet need.

There are attempts to bring empowerment to users of the support services. For example, Tai Pawb prioritise work with reference to the Equality Act, 2010 and Human Rights Act, 1998, to ensure that people who are disadvantaged in society are empowered to access services and make choices in relation to their individual health and wellbeing. They have started to work closely with Cymorth Cymru and several providers to improve the situation on the ground. They reported to the review team that there is growing awareness of these issues across the sector.

**Age**

The review revealed ongoing discussion amongst Supporting People providers and Housing Associations in relation to age. In addition, the Welsh Assembly
Government working groups also made recommendations about the provision of housing related support with relation to age and tenure (Table 4).

Currently people over the age of 55 (50 in some areas) automatically get Supporting People services if they are residing in a type two housing (Sheltered Housing). This is related to their tenancy and not to their need. This is recognised as inequitable because:

- Older people in owner occupied housing with a high need are not receiving support; and
- Younger people who are recognised as having a high need for a tenancy or other accommodation cannot receive support as resources are not available.

In some parts of England and Wales floating support services are commissioned over a small geographical area. This support is often based on the support services previously supplied to the sheltered housing but is available to people in any tenure in the surrounding area. This model was popular with service users, housing associations, other providers and Local Authorities.

There is strong consensus for an open debate and Welsh Assembly Government leadership on this issue to link support with need rather than age and a building. It was also suggested that the initiatives of ‘befriending’ carried out by the Big Lottery and others could be utilized to work closely with the services. What many people need is ‘a light bulb changing’ or ‘something from the top shelf’ and having a ‘friend’ to help them may indeed contribute towards them remaining independent or remaining in their own homes but need not necessarily require a paid support worker.
### Table 4: Summary of Recommendations from Welsh Assembly Government working group to improve housing, support and care services and options for older people

<table>
<thead>
<tr>
<th>Objective</th>
<th>Outcomes</th>
<th>Measured by</th>
<th>Actions</th>
<th>Org.</th>
<th>Resource implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that all older people have access to a range of person-centred services that maximise their independence</td>
<td>Maximise the contribution of sheltered housing to the needs of individuals</td>
<td>Production of new well targeted and drafted guidance</td>
<td>To re-examine commissioning guidance for sheltered housing to make it more person centred and less age and building based</td>
<td>WAG to lead and LAs/ Providers to support</td>
<td>No financial implications</td>
</tr>
<tr>
<td></td>
<td>People are given as much information and support to make decisions about their future housing and support needs as they age</td>
<td>Report from project disseminated widely and used to improve information and support provided</td>
<td>Undertake a project to examine and map how people access information on housing and support options and are supported to make choices to enable them to live independently within the community for as long as possible</td>
<td>WAG to commission</td>
<td>Estimate: 15K</td>
</tr>
<tr>
<td></td>
<td>the needs of older people with complex needs are met</td>
<td>Completion of good quality research</td>
<td>Carry out research into whether there is a need for 24 hour floating support for people with complex needs</td>
<td>WAG to commission</td>
<td>15k</td>
</tr>
<tr>
<td></td>
<td>Innovative practice in delivering practical services under the name of housing related support is developed</td>
<td>Range of such services developed and available</td>
<td>To encourage a more creative use of SP funding to deliver services such as handyman, gardening, DIY etc. to help older people remain in their own home for longer or move if they choose to.</td>
<td>WAG Provider and LAs</td>
<td>Depends on mechanism agreed to achieve aim</td>
</tr>
</tbody>
</table>
Rurality

There is awareness that a full range of services are not available in more rural areas, because numbers are too few and money is insufficient. For example, only bigger hostels in cities are able to provide separate Halal kitchens.

Gender

Gender submissions received by the review were around domestic abuse. There is clearly a wider debate around these services which is already underway. It was expressed to the review that Supporting People services relating to people fleeing domestic abuse should be administered on a national basis by an umbrella body. Another view was that an umbrella body may prioritise women fleeing abuse and that local assessment of needs and sensitive development of services was more appropriate. There was also evidence of tensions in some areas where local strategies conflicted with the provider. However the review did not consider domestic abuse to have a special case compared to any other service user group. Every one of the groups eligible for Supporting People funds represents vulnerable people needing protection and advocacy. There were good examples where co-production and joint planning had resulted in a reconfigured service that was more cost effective and thus enabled a better provision to more people.

Race

The review also received submissions from organisations who deal primarily with ethnic minorities. They did not have issues with the funding of the programme on the whole and the main concern was one of equal access to services in rural areas compared to urban areas.
5. Structure, Roles and Responsibilities

When the Supporting People Programme was introduced in the United Kingdom, Wales chose to split the grant funding into two revenue streams. This revenue division remains unique to Wales. The evidence in this review strongly indicates that this separation was due to lobbying from individuals and organisations who felt that the most vulnerable would not be protected if there were only one funding stream distributed by Local Authorities. There remain strong feelings amongst a small number of providers that this would still be the case if the funding streams were combined and assigned to Local Authorities. However, strong advocacy from providers and the overarching third sector group Cymorth Cymru have reinforced the strong marriage of the importance of supporting all the groups within both SPG and SPRG funding streams.

Responses from providers, third sector, Local Authority and service users suggest that the differentiation is a false one. Many point out that as long as the most vulnerable are protected there is no need for a separation of the funding. Moreover, there is evidence that despite there being separate revenue streams the funding is used interchangeably (Appendix 5).

| ‘Confusing’ | (Frequent remark from wide range of sources internal and external to Wales) |
| ‘Two Masters’ | (SPRG providers) |
| ‘Get rid of ASP role – logical to begin with but not now.’ | (Independent, involved in setting up programmes) |
| ‘If SPRG transfers to the Local Authority and Welsh Assembly Government improves the regulation about how it is administered e.g. ring fenced with the requirement to submit overall grant expenditure accounts each year there should be no reason for a third body to be appointed.’ | (Local Authority) |
| ‘If the review determines that the Local Authority are best placed to manage the two funding streams of Supporting People then immediately third sector providers will be victim to the political vagaries of the Local Authority. These are the Local Authority who originally determined women’s aid was not needed and homeless young people were not a priority, in the future vulnerable and ‘unpopular’ groups will exist on the whim of public popularity and votes.’ | (Provider) |

There was general agreement in interviews and written submissions and strong evidence that the current structure is confusing (Figure 4), not fit for purpose and therefore unlikely to be cost effective. However, this is the area for which there is least empirical evidence and most opinion. In interviews with over-arching bodies and a few individuals there appeared to be two very entrenched views, however in the stakeholder interviews it became apparent that the values of all groups were very similar and that the overall structure mattered less than what was achieved on the ground and delivered to citizens.
The current situation is complex and confused. The responsibilities are mixed and sometimes missing.

Figure 4 Welsh Supporting People Programme – Structure:
(A game of snakes and ladders without the ladders.)
As shown in Figure 5, Supporting People programmes are delivered by a range of providers; housing associations, local authorities, small and large third sector providers, some Accredited Service Providers, some non-accredited and private sector organisations. Private sector organisations cannot be ASPs but are contracted by ASPs and Local Authorities to deliver the support.

Figure 5: Distribution of Supported Housing Service Users by Setting

![](distribution.png)

5.1. **Current Roles and Responsibilities**

**Welsh Assembly Government**

‘Two Masters’

SPRG Service Providers are often answerable to both the Welsh Assembly Government and the Local Authority. They are responsible to the Welsh Assembly Government for the programme they are providing and to the Local Authority to show how it fits strategically with their plan. These ‘two masters’ have different reporting mechanisms, which results in inefficiencies with reporting and has led to conflict. Most providers would prefer to report to a single authority for each geographic region.

What respondents said the role of the Welsh Assembly Government should **not** be:

‘**NOT micro-manage.**’ (Multiple respondents; Providers, Local Authority, Welsh Assembly Government)

‘**Should not have to go to minister for a change in service which the providers and Local Authority agree on.**’ (Providers and Local Authority)

‘**...too small, too much work to do.**’ (Local Authority)

‘**The role of monitoring the Supporting People Revenue Grant is beyond the resource allocated to it.**’ (Provider)
The Welsh Assembly Government officials are perceived to be focusing excessively on ‘micro management and process’, perhaps at the expense of their ability to execute effectively roles in the policy development, strategic and regulatory fields.

Some are concerned that the current structure is providing inadequate returns. Several examples were quoted of delays running into several months for decisions to be reached. Welsh Assembly Government confirmation has to be obtained for each change in a project even if the provider and Local Authority had already agreed on the necessity for that change. This can take many months which leads to a negative impact on the service users.

Worrying evidence of the current structure not being fit for purpose is that a member of the review team was tasked to review all of the ASP annual returns with the primary aim of carrying out an analysis to inform the cost effectiveness workstream. However this process could not identify returns for over £8 million. Without further investigation it was not possible to discover if these had not been returned by third sector ASPs or Local Authorities, whether small projects were not being reported on, or whether these reports had been misfiled in the Welsh Assembly Government. Clearly the Welsh Assembly Government has considerable burdens in the present structure.

In summary, the Welsh Assembly Government has responsibility for both strategic and operational aspects including:

- National strategy;
- Operational guidance;
- Advocacy and informing policy makers;
- Regulation of ASPs including assessing annual reviews; and
- Reviewing Supporting People Operational Plans.

5.2. Regional roles and Responsibilities

Regional working is a promising innovative way of working and is an example of how the Programme could be developed. The model was described in the 2003 Supporting People document in elaborate and exceptional detail (Welsh Assembly Government, 2003). Some form of regional working or cross border working exists in most areas across Wales, as illustrated by the model developed in Gwent which has been in place for some years. This was supported initially by a grant from the Welsh Assembly Government which provided the salary for a person to support this collaboration. The Gwent model is confined to operational activities; strategy does not form part of the model. They carry out regional planning and commissioning, share practices and protocols and have carried out a cost benefit analysis of this way of working. There is also a regional support officer in North Wales. Most areas have examples of some cross-border working. This varies from formal joint commissioning, to sharing policies and procedures, and other collaborative work. The joint Cymorth Cymru response advocated this as the model to take forward. Many respondents, however, were concerned that proper supporting structures as yet were not in place. A comparison of the potential benefits and disadvantages of adopting a regional (cross-boundary) working relationship is described in Table 6.
Table 6: comparison of the relative Strengths and Weaknesses of Regional (cross-boundary) Working

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stronger team across the area</td>
<td>• Reluctance by some Local Authorities to work regionally</td>
</tr>
<tr>
<td>• Local Service meeting local needs</td>
<td>• No clear ‘region’ applicable in some areas</td>
</tr>
<tr>
<td>• Domestic Abuse and Substance Misuse – clients often travel from one area to another – this makes it easier to supply services across the region</td>
<td>• Autonomy among some client groups on certain issues might be compromised</td>
</tr>
<tr>
<td>• Economies of scale re commissioning some services and producing some guidelines - Cost effective</td>
<td>• A potential for bureaucracy to be increased</td>
</tr>
<tr>
<td>• Efficiencies for providers - one reporting process across the region</td>
<td>• Differing political agendas of Local Authorities</td>
</tr>
</tbody>
</table>

‘How do you improve capacity and efficiency? Work together.’ (Local Authority in Gwent)

‘The Gwent model is unique due to the geographical areas and the historical links between the Local Authorities. The model itself may not be appropriate for other Local Authorities but I feel that we should encourage more cross boundary working when commissioning and delivering services.’ (Local Authority)

‘There are potential benefits in terms of expenditure but also benefits for vulnerable people in terms of services being developed that a single authority could never resource.’ (Local Authority)

‘Regional/cross boundary working should not however be seen as the answer for everything. There has to be a balance between regional and local in some instances of service delivery, to ensure commissioning reflects local as well as regional priorities.’ (Supporting People Manager)

‘Cross boundary working in Supporting People via the Gwent model has realised numerous benefits. As well as allowing the commissioning/delivery of Supporting People services that would not have been viable on a locality only basis, the Gwent model has allowed numerous added value – e.g. savings in staff resources (estimated at 600 days p.a. = 2.5 FTE senior staff totalling £100k) also additional Floating Support services at no extra cost (29 units of Floating Support @ £175k).’ (Local Authority)
5.3. **Local**

| "Money should be at the heart of the community – Local Authority are at the heart of the community." | (Local Authority) |
| "Funded nationally – delivered locally." | (Local Authority) |
| "The Local Authority are the right people to have it – but it should be ring fenced." | (Provider) |

Summary of Current Local Authority roles and responsibilities:

- Supporting People Operational Plans – Local Needs Mapping Exercise, Operational plan, local strategic planning;
- Commissioning for SPG;
- Negotiation of SPRG; and
- Inspection of SPG projects and since 2006, Inspections of SPRG (in addition to Welsh Assembly Government).

There was a general consensus that the Local Authority was the strategic enabler and was in the right position to assess need, reconfigure services and commission with partners. There were a small number of providers who did not feel that Local Authorities were the correct organisation to assess need and to commission. A larger number of providers felt that the Local Authorities should have the roles above but did not feel that Local Authorities should have the money. A common comment was ‘if they have the money…they would not be able to ensure it went to the right place…they have perverse incentives’.

They would then usually follow this up by quoting an example in England or one of three Local Authorities in Wales. Many of the providers who expressed a concern with Local Authority being allocated the money had experience of working in one of the three Local Authorities where considerable concern has been raised. They believed that no checks or balances could be put in place to ensure that the money was spent appropriately by Local Authorities. However, the majority of providers agreed that checks and balances could be put in place to remedy the situation. The majority of respondent across all sectors thought that Local Authorities were not only the strategic enablers but also the right organisation to have the money with certain provisos in place.

There was widespread concern among Supporting People teams and providers that, in a time of recession, the money would not be spent on the groups for which it is intended. Either it would be spent on other priorities entirely or on the statutory groups. Informants felt the majority of Local Authorities understood this and would prioritise the money in line with national guidance. However there were still Local Authorities where there was insufficient knowledge or understanding and which would not prioritise the needs of some of these vulnerable people.

Local Authority teams vary greatly in size, they may be confined to the housing department or be part of the Social Services department. This variation in location seems to impact on the type of services they are able to commission, the ability to develop Supporting People
Operation Plans and how thoroughly they can monitor the providers in their areas. It also contributes to the nature of relationships with the providers. Most areas have good relationships between Local Authorities and third sector providers. It has for some time been the aim of the Welsh Assembly Government to hand over the entirety of the grants to Local Authorities. To this end in 2006 there was a ‘Preparedness’ report compiled for each Local Authority. This showed, according to the Welsh Assembly Government that most (16) Local Authorities were prepared for their administration of SPRG in 2006. However, some Local Authorities that were not ‘prepared’ have identified more resources or worked with the Welsh Assembly Government, WLGA or regional networks to become ready. Nevertheless there are still a small number of Local Authorities about which repeated concerns have been raised about their readiness and eagerness to effectively communicate or prepare for any significant changes. Any transfer of funds must therefore be linked to effective regulatory and assurance mechanisms. A light touch approach will be suitable for the majority but a more robust approach will be required for those Local Authorities who do not follow the grant guidance.

Some local Authorities:

‘Lack of Scrutiny.’ (Provider)

‘Poor Communication.’ (Providers)

‘Not a level playing field between internal and external providers’ (Local Authority)

Role of Local Authority from Essex review –
‘As strategic housing enablers and community leaders….having good homes…not least because of its link to the wellbeing agenda’

WLGA

The role of the WLGA was considered to be that of supporting the Local Authority. Although they represent the members’ views they also have a role in advocacy for the programme and improving quality. One such activity is organising peer reviews.

Peer reviews are an example of the good practice in the WLGA. However at the moment these are voluntary and there is evidence that, as in many areas, the volunteers that take part in these peer reviews are not the Local Authorities about which concerns have been expressed.

Supporting People Information Network (SPIN)

SPIN provides support and advice and has an ethos of quality improvement. They have shown leadership in bringing Local Authorities, Providers and Welsh Assembly Government together to progress the Outcomes agenda. There is evidence of their commitment to working with providers to develop the best services for people and to spread good practice to other Local Authorities.

Supporting People Teams in Wales

‘It is an excellent network’

‘Helps a lot’
Cymorth Cymru

Cymorth Cymru brings together the disparate views of providers and coordinates advocacy, quality improvement and sharing good practice. It demonstrates the ability to work well across sectors and should continue to do so. There were providers however that expressed a concern that the ‘line’ that Cymorth Cymru sometimes took and the lobbying that it carried out was more representative of a small number of people rather than the majority. Many Local Authority providers expressed an interest in getting more involved in Cymorth Cymru but felt it was solely for the third sector. Submissions from Local Authority expressed willingness and even an enthusiasm to develop their partnership with Cymorth Cymru.

‘We have a lot to learn from them’. (Local Authority)

Welsh Women’s Aid

Welsh Women’s Aid and other umbrella bodies play an important role in advocacy, coordination and understanding their sector to provide policy advice. They were keen that they should retain direct funding from Welsh Assembly Government in order to protect services and jobs for women. However the review saw evidence of good practice surrounding the issues relating to domestic abuse at several Local Authorities and it now has a relatively high profile and wide strategic support. Some of the concerns about domestic abuse services that had occurred in some areas were not unique to domestic abuse and reflected issues of communication and processes locally. There was a concern expressed that removing the direct flow of money from the Welsh Assembly Government to this Umbrella body could result in the organisation becoming non-viable. The Supporting People Revenue Grant is, therefore, funding this organisation and in turn its other roles. Although these roles are important they may not be considered as the primary aim of the Supporting People Revenue Grant.
6. Checks and Balances

‘Service Providers report (that a problem) is the differing ways in which Local Authorities review and monitor. This could be solved by the Welsh Assembly Government issuing new guidance or a minimum standard of monitoring. The Welsh Assembly Government have not provided guidance since pre 2003 so there can be no surprise in the fact that the Local Authorities have gone off and developed review methodologies which differ from each other. Local Authorities should monitor and review in the same way, using the same process and forms.’ (Local Authority)

‘There is one provider of SPRG that hasn’t been audited or inspected for 15 years.’ (Provider)

‘Why have separate registration for domiciliary care and Supporting People?’ (Provider)

‘No current organisation – Audit Office, CSIW, understand Supporting People enough to monitor it.’ (Local Authority)

SPG funds are managed by Local Authorities who act as the strategic commissioner, contracting Supporting People Services as appropriate. SPG is used to fund services for older people or services provided in conjunction with a community care funded service. SPRG funds are managed directly by the Welsh Assembly Government and are used to fund services not eligible for SPG funding.

It should be noted that SPG funds are not subject to the regulation and inspection processes applied to the SPRG programme. Some providers and Local Authority Supporting People teams commented that internal (to the Local Authority) providers did not always have the same rigour involved with contracting as the external contractors.

SPRG funds are available directly from the Welsh Assembly Government. In order to access SPRG funds, providers must apply directly to the Welsh Assembly Government and meet their preset eligibility criteria. Applications must:

- Be from an Accredited Support Provider;
- Relate to an activity or service listed in the grants terms and conditions;
- Be in keeping with the Local Authorities Supporting People Operational Plan; and
- Comply with the other grant terms and conditions.

Due to the nature of SPRG schemes, the majority of projects are intended to be temporary which would allow for a turnover of new applications. In practice, however, all SPRG funds have been allocated to projects and very little funding is recycled onto new schemes or projects from another provider. Where a scheme or project does come to a natural end or is no longer strategically relevant, the Accredited Service Provider (ASP) tends to seek Welsh
Assembly Government approval to ‘remodel’ the service. All such requests need Ministerial approval.

The accreditation scheme to become an Accredited Service Provider aims to ensure that recipients of SPRG funds have the appropriate governance, skills and experience to provide supported housing services to vulnerable people. It ensures that the support provider is financially viable and is able to sustain and manage the risks of a SPRG service and is also able to demonstrate accountability for the spending of public money. Most ASPs (Local Authority, Housing Association or other) then commission other providers to provider services and the ASP is then responsible for monitoring them, but there is no accreditation process for these providers.

The accredited system appeared to be welcomed by most organisations. Local Authorities felt reassured when dealing with an ASP and felt that this saved them a considerable work because the background and credibility checks of a provider had already been completed by the Welsh Assembly Government.

Peer review was also considered to be a useful way of ensuring checks and balances across the sector. Results of a peer review and progress made could be fed back into the evidence collection process. This review received suggestions that the WLGA could have a role in the peer review of Local Authorities.

6.1. Grant Terms and Conditions

The SPRG grant terms and conditions, which were revised in May 2010, set out in detail the processes which ASPs should follow in the management of the funds together with their role and responsibilities. The grant conditions include, for example, instructions and guidance on such matters as, service provision, monitoring, evaluation, financing, contracting and annual returns. Failure to comply with the grant terms and conditions may result in the funding being terminated and claw back of any funds already provided.

Included in the grant conditions is a requirement for ASPs to provide the Welsh Assembly Government with an annual return for each project in receipt of SPRG. Annual returns are to be submitted to the Welsh Assembly Government by 30 September each year and should include financial and staffing information relating to the project as well as information on monitoring and evaluation.

The review found little evidence that the Welsh Assembly Government used and acted upon the information received via the annual reports. At the time of reviewing the files, annual returns covering projects in excess of £8million were unavailable.

Inspections

In order to monitor and evaluate the SPRG schemes and projects there is also an inspection process which ensures that projects are operating within the terms and conditions specified and are meeting the service specifications.

The Welsh Assembly Government do not undertake the inspections themselves, these are awarded under contract to independent organisations. To pay for this, the Welsh Assembly Government top-slice the SPRG budget by £125k per annum. It was the intention that all
ASP's would be inspected on a 3 year cycle with the option that poor performance would result in more frequent inspections. However, this has not proved to be the case. To date several ASP's have yet to be inspected. The Welsh Assembly Government has therefore prioritised those ASP's and projects for early inspection. Prioritisation has been based on either a perceived risk or where they have received or picked up concerns about a provider or project. Inspection reports are not published and only those immediately affected by the report are consulted.

There were mixed views from providers about this inspection process. Some felt that inspections were initially inconsistent, although all feel that this has improved, did not cover all projects (the Welsh Assembly Government only select some SPRG projects within each ASP) and did not necessarily pick up all the issues. Others felt that the inspection process was clear and better managed than other inspections their organisations were subject too.

It was clear to the review team that some recent inspection reports have indeed identified issues with some providers which are of concern. These include Local Authorities and third sector. Some of the serious issues that have arisen would not otherwise have been picked were it not for the current inspection process.

Most providers however felt that the inspection process was yet another burden on an already over regulated sector. Most providers, for example, already have inspections from other external bodies such as Care and Social Services Inspectorate Wales, as well as having their own internal and external audit requirements. Additionally, Housing Associations are already subject to other WAG controls and regulations and registered charities will need to comply with the strict controls and procedures set out by the Charities Commission.

It should be noted too that Local Authorities can also be ASPs. All but one are ASPs. When acting as an ASP, Local Authorities are equally subject to the same regulation and inspection as other ASPs.

Local Authorities will often sub-contract the service to other providers and in these circumstances will introduce their own regulatory regime. The precise level of control exercised varies from one Local Authority to another but Local Authorities believe that because of their overview of the sector they are well placed to assess whether a service provided is satisfactory or not and whether it is over or under priced.
7. Processes – transparent, fit for purpose

‘SPOP- not fit for purpose – not always produced, not always read. Some are very weak.’ (Local Authority)

‘A move away from the Needs Mapping Exercise forms. We now have a wealth of knowledge from a variety of different sources in relation to unmet housing and housing support needs. The forms only highlight the unmet need from the agencies completing them. The information from the forms is not fully reliable i.e. one provider may return forms on a regular basis but it does not mean that there is a substantial need for services for that particular client group, it just means that the provider is good at returning the NME forms.’ (Provider)

‘Local Authorities need to change their attitude to commissioning and Procurement so it is not a cost drive.’ (Housing Association Provider)

‘We deliver services in England and Wales. In England the process is transparent and fair and even if we don’t get the contract we feel reassured the service users are getting the best and most appropriate service. But in Wales it is a black box and there is no mature two way conversation.’ (Housing Association Provider)

‘In England they have separated out accreditation and commissioning so I don’t have to spend all my time filling out forms saying that my staff have health and safety training. Savings could be made by adopting that.’ (Provider)

‘Lack of Robust Processes There is not a level playing field in my Local Authority – internal contractors don’t have to achieve the same levels as external ones.’ (Local Authority)

‘We need to behave differently, smarter, more business-like, let’s sit down and work out what costs are. Agree outcomes – full satisfying lives - and ask providers how are going to achieve that.’ (Local Authority)

‘Commissioning for outcomes allows innovation and quality improvement.’ (Provider)

There was general feeling that the Supporting People Operation Plans in their current form were not ‘fit for purpose’. There seemed to be variety of theories why this was so. The guidance for how they should be produced was clear and explicit but this was not always possible. In some Local Authorities they did not tie in with higher level strategies (Community Safety, Health, Social Care and Wellbeing).

Occasionally the Plans were influenced by the department in which the Supporting People team were located (housing, social services). In some smaller teams the task of producing the report was arduous and could sometimes be isolated and not linked with other plans and strategies.
The SPRG guidance and SPG guidance is clear that planning should be multidisciplinary and in some Local Authorities this is how the Supporting People Operation Plans were produced. However, there is a broad range of planning procedures, from thorough multi-sectorial through to one person developing the plan alone. One Local Authority does not currently produce a Supporting People Plan.

There is a general feeling that Local Authorities are asked to produce too many strategies and plans and that the Supporting People overarching plan should be part of the overarching Needs Assessments and strategy. However in some Local Authorities it does not yet have the profile to be fully recognised and integrated into these, hence co-production was frequently mentioned and the necessity for advocacy to occur at Local Government level as effectively as it has recently at national level.

\[ ‘We shouldn’t have to produce a detailed plan every year – so little changes... there should be a larger 3 year strategic document – showing where links into other documents and an short annual review.’ (Local Authority) \]

A short annual review demonstrating an awareness of how the Supporting People Programme is delivering on the higher strategic aims and consideration of how demographics or needs may have changed was suggested by several informants.

However in some areas the plan is produced by a multi-sectorial team including providers and service users but this does not always directly link into the commissioning. A very small number of Local Authorities involved providers (as elected from a provider forum) in commissioning.

\[ ‘More needs to be done in terms of integrating Probation and community safety teams into the planning process.’ (Local Authority) \]

\[ ‘Health isn’t involved in our area.’ (Local Authority) \]

### 7.1. Commissioning

‘Commissioning means securing the services that most appropriately address the needs and wishes of the individual service user, making use of market intelligence and research, and planning accordingly.’ (Institute of Commissioning Professionals)

Concern was shared with the review about the current commissioning processes. Currently commissioning is not based on robust multi-sectorial planning nor are other sectors involved in commissioning. The current process was felt to be too frequently based on procurement, with limited information and historical spend rather than a robust transparent commissioning process.
The review noted that the Welsh Assembly Government had issued Statutory Guidance under Section 7 of the Local Authority Act 1970 entitled ‘Promoting Partnerships in Care – Commissioning across Health and Social Services’ (2005). This stated:

- Commissioning whether from in-house or independent sector services is about meeting the needs of people using services and is about outcomes rather than processes; and
- Strategic planning and commissioning should be addressed openly and jointly and with the possibility of in-house, independent or a combination of service providers considered.

The report of Task and Finish groups on Supported Housing (2005) recognised that there were significant advantages to a more cohesive relationship between the commissioning, monitoring, evaluation and inspection processes of SPG and SPRG, moving monitoring of SPG closer to that of SPRG. They recommended that commissioning should involve Service Providers and service users in developing appropriate services provision.

### Local Authority Guidance 2005

1.3 It is recommended to all commissioners and providers of SPG funded services that all parties work in partnership to ensure that appropriate policies procedures and practices are implemented and monitored.

There was consensus across the sectors that the commissioning processes in Wales currently were neither robust nor transparent and in many areas did not follow Welsh guidance. It was recognised that although there were areas of good practice, poorer practice was too widespread.

Key elements of a robust transparent commissioning process included gathering together the correct information from needs assessments (not just service mapping) and then joint planning with partners including service users. A joint strategic needs assessment would take in to
account housing needs of vulnerable people with recognition of the importance housing has towards well being. It was expressed that these processes should be very closely aligned to the commissioning process. See figure 6.

**Figure 6: Model for commissioning**

Appendix 5 provides case studies from a stream of work sponsored by the Department of Health for the development of Joint Strategic Needs Assessments for housing and support for vulnerable people.

Cymorth Cymru in partnership with Association for Real Change Wales, Community Housing Cymru, Learning Disability Wales, Unison and WCVA are working on a ‘Partnership for Excellence’ project (P4E) which aims to promote, ‘A Made in Wales approach to the commissioning and provision of services to vulnerable people which is collaborative, ethical and achieves value by making the best use of the Welsh pound’ (Stirling, 2009).

However there are providers who feel there is an inherent inequality between third sector and commissioners. They express a view that they cannot be equal partners as each partner has to respect what the other brings to the table ‘and this is money’. However in multi-sectorial planning and commissioning, the ‘commissioners’ are drawn from the third sector, health and probation and although limited by money should be driven by needs and outcomes.
7.2. **Accreditation and Commissioning**

The current process is heavily procurement-led which has resulted in a number of calls to separate accreditation from commissioning. It was felt that the tendering process was burdened with filling out forms about health and safety, training etc and only a minimal emphasis on what services could be provided and how. Providers were keen to spend less time filling out forms but recognised the need for accreditation. This would mean that anybody who was accredited in Wales could apply for a contract anywhere in Wales with Supporting People.

The suggestions were that accreditation could be taken over by the Welsh Assembly Government or by the Local Authorities but that each provider only has to register once every three years in Wales or that one Local Authority or another organisation is tasked with administrating this accreditation process.

> ‘Would have to fast track all of the small providers – families essentially. Then in the medium to long term decide how these are going to be classified.’ (Welsh Assembly Government)

**Example from Kent**

Kent Supporting People Strategy 2010-2015

**Commissioning Priorities**

The priorities for new service development are based on analysis of need, consultation with partner agencies and a methodology prioritising risk. Overall, the priority areas for service delivery and resource allocation are identified as client groups who are at high risk of harm to themselves or to the community if services are not provided, for whom there are relatively few services either in the county as a whole or in particular areas, and who have few advocates in the form of organisations with statutory responsibilities.

**An Example from Gloucestershire**

A service provider can only be awarded a Steady State (long term) Contract if all the criteria for Accreditation are met. Service providers who are unable to meet the criteria will be given an action plan to achieve the criteria over a set period of time.

The five criteria that must be met to achieve Accreditation are:

1. Financial Viability;
2. Insurance;
3. Effectiveness of Employment Policies;
4. Robustness of Management Procedures; and
5. Complaints;

A service provider can only be awarded a Steady State (long term) Contract if all the criteria for Accreditation are met. Service providers who are unable to meet the criteria will be given an action plan to achieve the criteria over a set period of time.
8. Tariffs and Cost savings

8.1. Tariff

The review examined in detail the funding mechanisms for the SPRG which is based on a tariff system. All SPRG eligible projects will qualify for the flat rate tariff which is based on the type of project and the number of bed spaces to be provided. Some projects will also qualify for an ‘intensity’ payment, which reflects the need for a higher than normal staff to tenant ratio or a particular staff expertise and skill. The tariff is set by the Welsh Assembly Government and has received regular uplifts but has not significantly changed since it was introduced. The tariff does not apply to SPG.

There were clearly differing views on the value and appropriateness of the tariff system. Those in favour pointed out that tariffs helped protect quality of service, staff tenant ratios and staff salaries whilst those against felt that tariffs restricted ASPs from obtaining value for money from other providers. There were also fears that having no tariff in a time of recession could mean the amount paid to the service provider could decrease at a time when demand for the service actually increased.

It was evident from the review that it has become common practice among ASPs to subcontract to another provider at below tariff rates. This is because the ASPs has either procured the service from a provider at a lower rate or has ‘top-sliced’ the grant to cover expenses such as training, regulation and other costs. In either case, the final amount that the end provider receives is usually “below tariff”.

It is often not clear to the provider why the ASP has top-sliced the grant in this way and how the amount was arrived at. Different ASPs may take different percentages and amounts for different projects. This variation in practice has led to criticism and suspicion by many that the ASP would or could use the surplus grant to fund non SPRG projects. Although the review found no evidence of this, it was clear that this potential exists.

ASP, including Local Authorities, assert that ‘top-slicing’ the grant enables them to be more flexible and to fund other projects within their strategy. They use the money for other projects which would otherwise have a funding shortfall, or be unable to function without the additional resource. The money may also be used for projects for which no budget line exists. Other ASPs assert that any excess that arises from the tariff for the costs directly related to the agreed project allows them to innovate and develop new services. It should be noted however that any redistribution of funds in this way would not have the approval of the Welsh Assembly Government.

Although the tariff system has been seen as a useful guide for funding services, it has nevertheless become a barrier to outcomes based commissioning. The review noted that there was much more focus on measuring how much time support workers spent with clients and how many bed spaces there are, rather than assessing needs and outcomes. Many respondents supported this view and felt that their drive to cut costs was being hindered by the process driven tariff system.

Since the tariff system is only applicable to SPRG, the creation of a single SPPG provides the ideal opportunity to review or discontinue this funding mechanism.
8.2. Cost Savings and Cost Efficiencies

Included in the written and verbal evidence received by the review were numerous thoughts and ideas on how cost savings could be made. Although costs savings as such was not included in the original terms of reference, the review felt that this should be considered in the overall context of achieving value for money and was particularly appropriate given the current economic climate.

Identifying cost savings and efficiencies was also discussed in detail with service providers and stakeholders at the Supporting People Inclusive Forum. There was a general consensus from those present that there was potential for considerable costs savings by better collaborative working and by service providers working together, perhaps in a consortia, on such matters as floating support services. Discussions also identified that there were opportunities for better working practices, which could lead to savings on administration costs such as travel related costs.

The written and verbal evidence considered by the review supported these views, particularly in the areas of collaborative and cross border working. Reducing duplication of effort was a common theme through much of the evidence considered on this matter and the implementation of a national framework was the biggest single factor that providers felt would lead to efficiencies. Providers also emphasised that efficiencies should not always be measured in costs terms; increasing the numbers of people being reached was at least as equally as important.

In summary, suggestions on ways of making savings and efficiencies considered by the review included:

- Increased regional /cross border working;
- Single accreditation process of providers;
- Single national outcomes monitoring;
- Simplifying and streamlining the reports from providers to Local Authorities;
- Robust commissioning;
- Needs driven planning, remodelling and commissioning; and
- Commissioning which reflected true costs, not those based on tariffs.

“If tariff continues…people with complex needs….providers may be put off.’ (Providers)

People Innovate in spite of tariff – not because of it.’ (Provider)

‘Gives a guide.’ (Local Authority)

‘Most projects that go through LA don’t get anything like the tariff – but don’t understand why different LA top slice so differently.’ (Provider)

Although the Tariff system has been extremely helpful ...it is not the only way services can be delivered. .. (we) often have to make creative efficiencies. And savings in order to work. We are not adverse to continuing this way making the SP pot in Wales go further.’ (Provider)
8.3. **Good practice**

In conducting this review, many examples of good practice across the sectors were identified. These included:

- Getting strong, senior advocates of Supporting People; for example appointing a Supporting People Champion within the cabinet/executive of a Local Authority;
- Involving the Supporting People Champion in developments and events;
- Peer reviewing;
- Collaborative working;
- Working across boundaries and sectors;
- Identifying and working with key stakeholders (e.g. Finance Directors);
- Ensuring Supporting people is properly represented at key strategic planning groups; and
- Generally winning hearts and minds by promoting understanding of the Supporting People programme.
9. Allocation and Distribution of Funds

The current structure and process of distribution of the Supporting People Grant to Local Authorities is also a historical legacy which is universally recognised in Wales as in need of adjustment. The distribution is very largely provision based; this must move to a distribution based on needs which is more equitable at a local population level.

Any change, however, should take careful account of consequent transition effects. Local Authorities receiving larger sums under the current distribution may well have established services and projects delivering effective support to vulnerable and disadvantaged people whereas those Local Authorities receiving lesser sums may lack capacity and resources to make immediate and effective use of additional funding. Should a change in the levels of funding be instituted too quickly this could have a significant net negative impact. Very considerable attention should thus be given to the nature and time period for the introduction of an alternative formula for distribution of the proposed unified, single Supporting People Programme Grant (SPPG).

Nevertheless an attempt should be made in the short term to address the inequities in the current grant distribution moving over a period of three to five years for the phasing in of a more robust and evidence-based distribution formula. This formula would more accurately define the levels of resources required to address more soundly the support needed by, and provided to target groups in the constituent populations.

Although, as a short term partial solution to adjust inequity of distribution would be achieved on the basis of a per capita allocation to Local Authorities, there are risks that those with the lowest constituent populations might be compromised without further adjustment to the allocated grant.

Preferably, the vast bulk of the funding formula weighting should reflect a small number of items which are robust. These should be largely ‘generic drivers’ such as population estimates (included age structure) with appropriate adjustments for measures of deprivation or its constituent parts. Adding multiple complexities and level of data which are not robust reduces both transparency and validity where data sources are uncertain in what they represent.

In line with the approach taken in Scotland the formula for distribution in Wales should be simple and transparent but more aligned to reflecting indices of deprivation. The Welsh Index of Multiple Deprivation (WIMD) provides a prima facie demonstration of generic geographically based deprivation across Lower Super Output Areas in Wales. This is a useful surrogate that is very likely to reflect demand and need for support services in the context of the Supporting People Programme.

The Social Fragmentation Index (Congdon, 1996) is a geographically based measure derived from census data which, among other components, includes the proportion of single person households (age < 65 years), persons not married or cohabiting, private renting and residential mobility in the previous year.
A distribution of funding formula weighting which can be introduced in the relatively short term with later refinement should reflect both the WIMD and the Congdon Index.

Receipt of at least the middle rate of the care component rate of Disability Living Allowance quantifies the numbers of disabled people who require attention and support from another person in respect of their bodily or mental functions. It reflects both the degree of disablement and the magnitude of care and support required from another person. It is another reasonable proxy reflecting demand and need for support services by disadvantaged and vulnerable people for whom the Supporting People Programme is intended.

Age structure of the population should also appear in the funding formula weighting. Empirically, this could be taken as the proportion of older people in the constituted population or limited to the proportion of older people living alone.

The review reveals a paucity of available data which reflects the needs of people requiring support under the programme. Most information relates to services which are currently provided. A well judged approach is therefore needed to formulate an acceptably weighted funding formula for distribution. The distribution should primarily rely on a needs-basis and should focus on component variables which address existing inequities. There is an urgent need to formulate a basis for distribution which seeks to revise the existing inequitable allocations to Local Authorities and focus on component variables which more closely approximate to a needs-based distribution.
10. Conclusions

10.1. The Supporting People Programme in Wales is highly regarded throughout the United Kingdom. There is compelling evidence that the Programme in Wales is providing commendable and sorely needed assistance, support and relief for the most vulnerable and disadvantage people who have either lost or are at risk of losing their homes. Though precise figures are not available, it is very likely that around 50,000 disadvantaged citizens across a wide age spectrum are helped in this way each year in Wales.

10.2. Although the people for whom the Supporting People Programme is designed may well have access to conventional health and social services, the complexity of their needs and individual circumstances place them at high risk of losing their homes or failing to secure appropriate accommodation. The review confirms that the Supporting People Programme in Wales looks beyond the bricks and mortar and the roof overhead. It manifestly seeks to provide the necessary further support, interventions, counselling and skills to the people for whom it is designed to enable them to move along a trajectory away from disadvantage, vulnerability and social exclusion.

10.3. The existing structure and distribution of the Programme’s fund is a historical legacy which is recognised almost universally as in need of adjustment. Allocation by way of the Supporting People Grant (SPG) and the Supporting People Revenue Grant (SPRG) needs urgent revision. A cogent analysis of factors favouring retention of existing funding streams or the adoption of an alternative method, strongly supports the latter in bringing together the SPG and SPRG to constitute a single, unified Supporting People Programme Grant (SPPG). For the Programme to emerge unshackled from the vagaries and obstacles inherent in the current system to achieve its maximum potential, the introduction of a single funding stream is an essential prerequisite.

10.4. The basis upon which Supporting People funds are assigned to each Local Authority in Wales also needs urgent adjustment. When the Supporting People Programme was introduced by the UK Government in 2003 it brought together several funding streams including the Transitional Housing Benefit Grant, the Supporting Housing Revenue Grant and the Probation Accommodation Grant Scheme. However the allocation of funding rested on data provided by each Local Authority very largely focussed on the numbers of people who were being supported by these grants. It was understood at the time that the nature of this distribution did not represent actual needs. The present review strongly endorses that view. The distribution is very largely provision based; thus must move to a distribution based on needs which is more equitable at the local population level.

10.5. A considerable amount of work has been commissioned by Welsh Assembly Government to develop a formula-based mechanism informed by a thorough statistical analysis of needs and costs. A range of options for the development of such a formula was produced. However that work has stalled due to lack of agreement on the preferred option to be taken forward and difficulty in securing the additional data to populate a proposed intensive multi-level modelling approach. The current allocation thus rests still on legacy funding and is far from being equitable and appropriate. The review reveals a desperate need for the more equitable distribution of funds at the local population level.
10.6. In the short term serious consideration should be given to the introduction of a distribution formula in which the weighting reflects a small number of items which are robust, transparent and include appropriate adjustment for measures of deprivation or its component parts. Moreover the sources of data should be readily available and retrievable. As a short-term partial solution an adjustment of the inequity of distribution would be achieved on the basis of a per capita allocation of the proposed Supporting People Programme Grant (SPPG). There are risks however that the adoption of such a mechanism would compromise funding of Local Authorities with the lowest constituent populations without further adjustment of the allocated grant.

10.7. The vast bulk of the funding formula weighting should, therefore, include ‘generic drivers’ such as population estimates with valid measures reflecting deprivation or its components. On that basis an empirical formula has been devised and is recommended for adoption in the short term. This formula should be amended over a period of three to five years for the phasing-in of a distribution formula which more accurately defines the resources required to target groups in constituent local populations. This would also drive forward a desirable emphasis on the identification and gathering of data which more accurately and properly reveals the nature and extent of needs of citizens requiring support under the programme.

10.8. Local Authorities receiving larger sums under the current distribution have evolved highly effective and targeted services and projects. These would be adversely affected were levels of funding to fall as a consequence of introduction of the recommended formula or any other which seeks to adjust the current mechanism. Similarly, the review has recognised that Local Authorities receiving lesser funds would currently lack capacity and arrangements to make immediate and effective use of additional funding. It is, therefore, imperative that changes in the level of grant allocation should be phased in and tapered.

10.9. There is mounting evidence that the Supporting People Programme in Wales lacks robust governance and accountability, is not sufficiently transparent, confuses commissioning with procurement and is prey to the confusion of roles and responsibilities. Although laudable work is progressing to move from a process-driven, out-put based system to one primarily focused on the achievement of tangible outcomes, progress has been slow and hesitant. Leadership is wanting and strategic direction is ill-defined. A Supporting People National Advisory Board chaired by the Deputy Minister for Housing and Regeneration and providing her with independent advice and information in discharging her function and meeting her accountabilities, properly constituted, would remedy the greater part of these deficiencies. Proposals for setting up a National Advisory Board, its objectives, constitution, functions and relationships are described in Appendix 6 to this report. A principal recommendation in this report is the early establishment of this National Advisory Board along the lines of these proposals.

10.10. Many of the concerns which surfaced in the review revealed considerable discontent with present structure and arrangements for the administration, commissioning, regulation and monitoring of support services and projects. This pertains at the national, local and community levels. A more collaborative, consensual and multi-sectorial approach, in the first instance at Local Authority level, would offer a tangible solution to many of these concerns.
10.11. To temper these concerns and in consideration of the obstacles to more effective administration of the funds which have been identified in the review, the introduction of collaborative, multi-sectorial committees within each Local Authority’s boundaries is advocated. These collaborative committees would ensure a stronger platform for co-design and co-production of services, facilitate more efficient use of available resources and secure a greater emphasis on an outcome-based approach.

10.12. Collaboration is key to commissioning. The review has emphasized the pressing need for collaborative working if successful commissioning is to be achieved. The local collaborative committees which are proposed must be designed to ensure that all the key players are part of the decision-making process. This, at present, is sorely lacking. There is also an evident greater role for public health in commissioning decisions. This requires strengthening. It is essential that health and healthcare intelligence brought by public health expertise from a population perspective is fully exploited. This would also help to introduce an element of academic rigour to the decision-making process and the more robust evaluation of outcomes. The potential which would be offered by a consortia approach to administration, commissioning and procurement would also underpin an enhanced collaboration between health and social care services. Fractured pathways between health and social care services are frequently encountered as obstacles to achieving seamless and comprehensive support services.

10.13. Consideration of various options for the allocation of funds from the proposed Supporting People Programme Grant (SPPG) to meet the support needs of the local populations at community level substantially favours allocation to Local Authorities outside the Revenue Support Grant (RSG). This allocation should be ring-fenced and used solely to fund support services, projects and programmes to meet the needs of disadvantaged and vulnerable people within the context of the Supporting People Programme for whom that programme is intended to support. Arrangements analogous to ‘Indicator Based Assessments’ should be explored to establish a robust mechanism which rests on the criteria for such an allocation expressed above.

10.14. Administration of the allocated portion of the SPPG should be undertaken by the proposed collaborative, multi-sectorial committee; the structure, form and make-up of which is advanced in a recommendation in this report. The collaborative arrangement could well form a sub-committee of the relevant Local Service Board. Its administrative remit should include planning, commissioning, procuring and monitoring the delivery of Supporting People services. A culture could thereby be engendered to ensure that leadership and engagement are encouraged; that the voice of the citizen is heard; that co-production and co-design is an abiding feature and that short, medium and long-term planning is firmly established and unified. Moreover, consideration should be given by the Welsh Assembly Government to lodging with some of the new local collaborative committees, responsibilities for administering and commissioning service provided at the All Wales National level.

10.15. The review has also captured from the wide-range and diversity of those interviewed and others responding to requests for information and opinion that progress should be made to regional or cross-border collaborative working. The review supports that view. The proposed collaborative arrangements at Local Authority level could well prove to be an interim measure in progressing towards developing further arrangements to set up across-boundaries, single geographically determined collaborative committees which
would subsume the administrative functions of the constituent collaborative committees in Local Service Boards. To this end the Welsh Assembly Government should strongly support the cross boundary working that already exists and encourage an extension of cross boundary collaboration and working throughout Wales.

10.16. Currently commissioning and monitoring of service delivery projects are very largely process-driven. This approach is evidently not focused on factors and findings which reflect and measure benefits, or otherwise, brought to the individual person for whom support is provided. It is essential that the nature, quality and delivery of support services are assessed by reference to the impact that interventions bring to the individual person and the community. Though this outcome-based approach is by no means universally adopted, there is clearly an acknowledgement among the great majority of respondents and those interviewed that the setting and assessment of tangible outcomes is an essential objective. Outcome agreements with Local Authorities have been established by the Welsh Assembly Government as part of the ‘New Understanding Agreement’. The review commends the sterling work of the ‘Outcomes Development and Pilot Group’ which has articulated a number of outcomes that serve to measure key strategic aims formulated by the group. There is welcome evidence that a number of support organisations have adopted an outcome based approach to formulating support plans. Now there is a need for greater leadership and direction from the Welsh Assembly Government and certain Local Authorities in promoting and actively supporting this essential approach. The ‘Outcomes Development and Pilot Group’ have produced a series of recommendations (August 2010, Welsh Assembly Government, Local Authority and Providers Joint Working Group, August 2010, personal communication), which this review endorses and urges the Welsh Assembly Government to consider urgently.

10.17. Informed by the work of the ‘Outcome Development and Pilot Group’, and the Supporting People Information Network, and based on the findings of this review, several recommendations are made for the continuation and enhancement of these initiatives over the short, medium and long term. Of cardinal importance is the setting up by the Welsh Assembly Government of a National Framework for data collection the principal elements of which are described in this report.

10.18. The review focused extensively on regulation and monitoring. The review found that the Welsh Assembly Government is perceived to be focusing excessively on ‘micro’ management and process rather than executing policy development, strategic and regulatory roles. It was also evident that the Welsh Assembly Government was not monitoring or ensuring that all the required annual returns from ASPs were complete and accounted for. During the review, annual returns totalling over £8 million relating to SPRG funding were not on file. The report makes recommendations on Local Authorities, in conjunction with Local Collaborative Committees, regulating and inspecting providers and this should replace the inspection process currently operated by the Welsh Assembly Government. The system for accreditation of service providers was however welcomed by most organisations and the report makes recommendations on how this should continue and be strengthened.

10.19. There were clearly differing views on the value and appropriateness of the tariff system. Those in favour pointed out that tariffs helped protect quality of service, staff tenant ratios and staff salaries whilst those against felt that tariffs restricted ASPs from
obtaining value for money from other providers. It was evident from the review that it has become common practice among ASPs to sub-contract to another provider at below tariff rates. This had led to suspicion by many that the ASP would or could use the surplus grant to fund non SPRG projects. Although the review found no evidence of this, it was clear that this potential exists. Although the tariff has been seen as a useful guide for funding services, given that the final amount the end provider receives is usually less than the tariff rate and that tariffs are a barrier to outcomes based commissioning, the evidence gathered in this review does not support the continuation of the tariff system. Since the tariff system is only applicable to SPRG, the creation of a single SPPG provides the opportunity to discontinue this funding mechanism.

10.20. Two literature reviews were completed during the review period: Supporting People programmes across the UK and Housing related support interventions. These provide a valuable source of guidance and information in relation to planning and commissioning services for the homeless and those at risk of homelessness, and evaluation of a wide range of interventions. Evidence from the United States and United Kingdom suggest providing vulnerable people and families with housing related support can lead to significant reductions in homelessness and lead to wider benefits. Housing related support in the community relating to money management and independent living skills can enhance other community support and is more effective than hospital treatment for encouraging independent living. However, there is currently insufficient evidence on the exact nature of the intervention.

10.21. It was clear that the automatic eligibility for Supporting People funds by those over 55 years of age (50 in some cases) who reside in Type II housing (sheltered accommodation), is the cause of much concern. As a consequence eligibility for Supporting People funds is based on age and tenancy and not on need. This results in others who may have a high need not receiving the appropriate support. There is a strong consensus for an open debate and Welsh Assembly Government leadership on this issue and the report makes recommendations to this effect. There were also suggestions that the ‘befriending’ initiative supported by the Big Lottery Fund and others could be utilised to work closely with these services.

10.22. The review was challenged in discovering robust evidence for the cost-effectiveness of the Supporting People Programme in Wales. A particular emphasis has thus been placed upon the gathering of relevant evidence and information from a variety of sources, including a thorough analysis of published literature of analogous schemes in the international arena. Despite the shortcomings, the evidence and allied information permits a conclusion that the Supporting People Programme in Wales can be justifiably regarded as being relatively cost effective and in several respects delivering value for money.

10.23. However, the absence of an outcome framework and rigorous evaluation of the Supporting People services in Wales compared with alternative mechanisms of support have made it most challenging to establish precise estimates of cost-effectiveness. Nevertheless, utilizing the available evidence it is reasonable to conclude that the Supporting People Programme within the context of a broad public sector perspective does offer value for money.

10.24. The above conclusion is reinforced by recent Carmarthenshire County Council estimates that the value of the costs avoided is over twice the cost of the services
provided by the Programme. This figure is greater than the benefits identified in the Matrix report (2006) which took into account the whole of Wales. Because the benefits (avoided costs) are dispersed across different organisations in the public sector, the Programme is vulnerable to under-investment. The return from the Programme is not easily identified and no single part of the public sector fully realises its value. This situation needs to be remedied.
11. **Recommendations**

11.1. The current funding streams require urgent revision. The Supporting People Grant (SPG) and the Supporting People Revenue Grant (SPRG) should be brought together to constitute a single, unified Supporting People Programme Grant (SPPG).

11.2. It is recommended that the SPPG is allocated to Local Authorities outside the Revenue Support Grant (RSG), ring-fenced and used solely to fund support-services, projects and programmes to meet the needs of disadvantaged and vulnerable people within the context of the Supporting People Programme for whom that programme is intended to support. Arrangements analogous to "Indicator Based Assessments" should be explored to establish robust mechanisms for this allocation of the SPPG.

11.3. Administration of the allocated portion of the SPPG to each Local Authority should be undertaken by a collaborative, multisectoral committee duly constituted to include representatives of the Local Authority, housing related services, probation service, providers of supporting people services, public health, Local Health Board and independent members. The overriding purpose of the committee shall be a collaborative approach to the administration, commissioning, procurement, quality assurance, local regulation and oversight of services, projects and programmes with an abiding emphasis on co-design and co-production and the securing of tangible outcomes, their assessment and evaluation.

11.4. It is recommended that this collaborative arrangement could well form a subcommittee of the relevant Local Service Board.

11.5. It is recommended that the collaborative arrangement would be best placed for developing short, medium and long-term service planning that is more effective and unified. A culture could thereby be engendered to ensure that leadership and engagement are encouraged, that the voice of the citizen is heard and that allocated funds are used solely to meet the needs of those people for whom the Supporting People Programme is intended to support.

11.6. It is strongly recommended that Local Collaborative Committees lodged in Local Service Boards are an interim measure towards the aim of developing further arrangements to set up across Local Authority boundaries single geographically determined collaborative committees. These would subsume the administration roles of the constituent Local Authority collaborative committees located in Local Service Boards.

11.7. It is recommended that the Welsh Assembly Government supports the cross boundary working that already exists in Wales and encourages the development of further cross boundary working throughout Wales.

11.8. The current formula for distribution of the Supporting People Grant to Local Authorities is in need of urgent adjustment. The existing distribution is very largely provision-based and should move to a distribution based on needs which is more equitable at a local population level.
11.9. As a first step it is recommended that serious consideration be given to the introduction of a distribution formula in which the weighting reflects a small number of items which are robust, transparent and include appropriate adjustments for measures of deprivation or its component parts. The sources of data for the proposed formula should be readily retrievable.

11.10. It is recommended that careful consideration should be given to the following geographically based measures and their weighted contribution to the allocation (per cent), to constitute a new formula for distribution in the short term:

- Welsh Index of Multiple Deprivation [20%]
- Social Fragmentation Index [20%]
- Number of people in receipt of at least the middle rate of the care component of Disability Living Allowance [10%]
- Age structure of the population (the proportion of older people living alone) [20%]
- Local measures of homeless people [30%]

11.11. It is strongly recommended that the introduction of a new formula for distribution whether or not based on that proposed in the recommendation (10) above, should take careful account of transition effects which could have significant net negative impacts consequent to abrupt changes in the levels of funding to individual local authorities. A phased and tapered approach is strongly advocated.

11.12. The introduction of a distribution formula to address inequities in current grant distribution in the short term should move over a period of three to five years for the phasing-in of a more robust and evidence-based distribution formula which more accurately defines the levels of resources required to address more soundly the support needed by, and provided to constituent local populations.

11.13. It is recommended that a needs-based formula that is proposed for the disbursement of funds in the Supporting People Programme may also have wider currency and be utilised for other expenditure allocation decisions from within the Welsh Assembly Government and indeed Local Authorities where weighting for degrees of deprivation at the local population level are pertinent.

11.14. It is recommended that the Deputy Minister for Housing and Regeneration considers the establishment of a Supporting People National Advisory Board (SPNAB) which would be chaired by the Deputy Minister to provide her with advice and information. The SPNAB would be responsible for providing independent advice to assist the Deputy Minister in discharging her functions and meeting her accountabilities for the execution and performance of the Supporting People Programme in Wales. Consideration should be given by the Deputy Minister to the proposals set out in Appendix 6 to this report on the objectives, constitution, functions, arrangements and relationships for the suggested National Advisory Board. The SPNAB could also serve to advise the Deputy Minister when she might consider using powers enshrined in the Legislative Competence Order (LCO) to address matters which may well arise in strengthening administrative and other elements of the Supporting People Programme.
11.15. It is recommended that the task and finish group which is undertaking the work on outcomes should continue to be led by Supporting People Information Network (SPIN). The work of the group would benefit from statistical / data and health intelligence advice from organisations such as the Public Health Wales Observatory and appropriate database providers.

11.16. Work towards the realisation of a comprehensive database to inform the selection and evaluation of appropriate tangible outcomes across a wide range of existing and future interventions should be taken forward with a degree of urgency. In the short term it is recommended that a national implementation group is convened to deliver in a short timeframe (preferably April 2011) the gathering of pertinent data to serve as a baseline and to derive a small set of well-defined outcome measures applicable to interventions that are currently assessed by process output. Over a period of 2-3 years this work should continue to refine and enlarge the database and document evaluated outcomes with the aim of introducing a national web-based resource to facilitate more robust planning, commissioning, outcome assessment and cost-effectiveness.

11.17. It is recommended that the best available evidence is used in planning and that the literature review Supporting People programmes across the UK at Appendix 3 be widely disseminated as a reference document to inform the planning process.

11.18. It is recommended that in the current economic climate priority is given to funding the Supporting People Programme for which the evidence of its effectiveness is strong, and value for money has been demonstrated. Further work is necessary to establish more exact measures of cost-effectiveness for which an outcomes-based framework is an essential pre-requisite.

11.19. It is recommended that the eligibility criteria for older people receiving Supporting People funds should be based on need rather than age or tenure.

11.20. It is recommended that the tariff system should no longer be used.

11.21. It is recommended that the Supporting People Programme should be brought into the new Housing Association regulatory framework.

11.22. There should be a national accreditation process for all providers with fast track entry for current accredited providers. Furthermore there should be consistent performance monitoring throughout the Programme but this should be light-touch with an emphasis on outcomes. Inspections should be multi-disciplinary and undertaken at three year intervals unless triggered earlier.

11.23. It is recommended that national guidance should be given to Local Authorities regarding inspections. Preferably, the national guidance should be informed by, and developed with, those people who are currently tasked with the undertaking of inspections of Accredited Support Providers.

11.24. It is recommended that the Welsh Assembly Government takes advantage of the current work and enthusiasm for an outcomes-based framework to introduce A National Framework for data collection, the elements of which are discussed in this report.
11.25. A greater role for public health in commissioning decisions is recommended. Health and healthcare intelligence from a population perspective would be brought by expert advice from public health to commissioning decisions. This would also facilitate the introduction of a required element of academic rigour and the more robust evaluation of outcomes.
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Operational Plans for many of the Local Authorities.

Appendix 1 Revised grading system for recommendations in evidence based guidelines

Levels of evidence

1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias

1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews or RCTs, or RCTs with a high risk of bias

2++ High quality systematic reviews of case-control or cohort studies or

High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2- Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal

3 Non-analytic studies, eg case reports, case series

4 Expert opinion

Grades of recommendations

A At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population or

A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+ directly applicable to the target population and demonstrating overall consistency of results

B A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results or

Extrapolated evidence from studies rated as 1++ or 1+

C A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results or

Extrapolated evidence from studies rated as 2+

D Evidence level 3 or 4 or

Extrapolated evidence from studies rated as 2+
## Appendix 2 List Of Organisations Contributing to the Review

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Appendix 3 Supporting People Programmes across the United Kingdom

Author: Lorna Bennett, Specialty Registrar in Public Health, Public Health Wales Observatory
Date: 01 July 2010

BACKGROUND

The Supporting People programme was launched on 1 April 2003 across the UK bringing together several housing-related funding streams under one umbrella programme (Communities and Local Government, 2010).

Supporting People seeks to enable vulnerable people to gain and retain independence by remaining in their own homes. The programme aims to deliver high quality and strategically planned housing related support services which are cost-effective, reliable and which complement existing care services (Communities and Local Government, 2007).

While the programme is UK wide, there are differences in the way it is implemented across the four UK home nations. In Wales, the Welsh Assembly Government adopts a commissioning approach based on collaboration and partnership. Funding is divided between central government and local government. The Supporting People Grant (SPG) is administered by Welsh local authorities and used to fund chargeable support services. These services relate primarily to long term support provision, and generally cater for older people, people with learning disabilities and people with mental health problems. The Supporting People Revenue Grant (SPRG) is administered by the Welsh Assembly Government directly to Accredited Support Providers and used to fund non-chargeable support services, incorporating shorter term support provision (Welsh Assembly Government, 2003).

In 2006, the Welsh Assembly Government published Costs and benefits of the Supporting People programme which quantified the benefits, in financial terms, of the Supporting People programme in Wales. The report concluded that the Supporting People programme makes a significant contribution to the public purse with an estimated saving of £1.68 for every £1 spent on housing related support services (Welsh Assembly Government, 2006).

An Independent Review of Supporting People in Wales is currently underway. To inform the Review, this document aims to provide a comparison of the different models of implementation of Supporting People programmes across the UK and to consider their effectiveness.

The objectives are:

1) To compare and contrast Supporting People programmes in England, Scotland and Northern Ireland to inform the Supporting People Independent Review in Wales.
2) To undertake a rapid review of the effectiveness of different models of Supporting People programmes in terms of outcomes for service users (e.g. independent living) and the ability of service providers to meet the housing support needs of vulnerable adults.
LITERATURE SEARCH

Information about the Supporting People programmes across the UK was gathered via various informal and formal methods. Initially, a short and informal meeting was held with key informants from each country. The individuals involved were:

Vic Rayner Chief Executive, Sitra2 (England)
Yvette Burgess Director, Housing Support Enabling Unit1 (Scotland)
Ricky Rowledge Director, Council for the Homeless1 (Northern Ireland)
Kerry Bailey Review Manger, Supporting People in Wales Independent Review Group
Keith Cox Supporting People in Wales Independent Review Group
Lorna Bennett Specialty Registrar Public Health

This discussion was followed by an examination of key government and service provider organisation websites and Supporting People strategy and guidance documents. This provided background information about the three Supporting People programmes.

Following the informal gathering of information, a more thorough literature search was performed by the Library Knowledge Management Service (LKMS). This process identified papers which further described the Supporting People programmes in the three countries and published evidence or grey literature describing the impact of Supporting People programmes on outcomes for service users and the ability of service providers to meet the housing support needs of vulnerable adults. Search terms were kept broad to maximise retrieval of references. Due to the type of literature for the subject area, the search necessitated a pragmatic approach in order to achieve production of this review document within the short timescales for delivery.

For critical appraisal, the tables recommended for use in the National Institute for Health and Clinical Excellence (NICE) Guideline Development Methods manual were adapted to the type of studies identified for Supporting People programmes (NICE, 2009). The quality of evidence was graded using the NICE hierarchy of evidence (see Appendix II: NICE, 2009). The data relevant to the research questions was entered into an evidence table (Appendix III). Due to time and practical limitations a single reviewer performed the final selection, critical appraisal and data extraction.

A summary of the search strategy is as follows:

**Search terms:** Supporting People, Housing, Evaluation, Review.
**Limitations:** English language only, 2003 onwards, UK only.
**Exclusions:** Cost-effectiveness/economic evaluations.
Individual / project evaluations.
Strategy / guidance documents.

Data sources:
RESULTS

The informal information gathering process has demonstrated some of the key similarities and differences in Supporting People between England, Scotland and Northern Ireland. A summary table of the information contained in the following section is provided in Appendix I.

Supporting People across the UK

England

Overview

From 2003, the Supporting People programme in England has brought support services previously funded from a number of different sources together into a local authority administered funding and regulatory system. It provides housing related support to over a million vulnerable people and is delivered locally by 150 Administering Authorities (Communities and Local Government, 2010).

The Supporting People funded sector includes a diverse range of service providers from statutory bodies to third sector organisations to private companies and individuals. They range in size and provide a wide range of services with funding from different statutory agencies or charitable sources, such as residential or domiciliary care, day services, housing management, drug treatment, training or education as well as support. Some work across local authority and regional boundaries while others may provide one Supporting People funded service in one area only. In April 2003 all existing providers of housing related support services entered into a contract with their Administering Authority to continue to receive the funding which had been transferred from its previous source into Supporting People (Audit Commission, 2005).

The Department for Communities and Local Government (CLG) has the main responsibility for the Supporting People Programme in England. It allocates a SP grant to Administering Authorities and monitors performance. Administering Authorities are responsible for implementing the Programme within their local area. The Administering Authorities contract with providers and partner organisations for the provision of Supporting People services. A commissioning body (a partnership of housing, social services health and probation) sits above an Administering Authority and plays a key role in advising and approving a Supporting People strategy (Communities and Local Government, 2007).

The Audit Commission carries out inspections of all authorities responsible for delivering the Supporting People grant and associated programmes (Audit Commission, 2009). Inspections are carried out with the Commission for Social Care Inspection and the HM Inspectorate for Probation. If there are serious concerns over performance, re-inspections take place. Service users are a major focus of the inspection process.
In England, the quality of Supporting People services is assessed using a new Quality Assessment Framework (QAF), which is a self-assessment tool for service providers. A refreshed version of the QAF was introduced in England from April 2009. SITRA leads on the updating of the QAF and QAF guidance.

**Funding**

Since its introduction in 2003, the total Supporting People grant budget has been reduced from £1.8 billion to £1.6 billion for 2009/10. The allocation of grant to individual authorities has been capped at no less or more than a 5% increase or decrease on that of their previous year.

In October 2003, the Government commissioned an independent review of Supporting People as a result of the significant and late growth in costs by £400 million between December 2002 and April 2003 (Sullivan, 2004). A programme of work was developed to take forward the recommendations which focused on improving how Administering Authorities, service providers and commissioning bodies manage and deliver value for money.

Initially the Supporting People grant given to local authorities was ring-fenced (i.e. it could only be spent on Supporting People services) but this has gradually changed. Firstly local authorities designated as excellent by the Audit Commission had fewer constraints on their spending and could spend their Supporting People grant on any welfare service. In 2007, the national Supporting People strategy highlighted that authorities should be ready for their Supporting People programme grant to be delivered through the non-ring-fenced Area Based Grant (ABG) (Communities and Local Government, 2007). For the year 2009/10, the Supporting People grant was paid to authorities as a specific named grant, but with the same financial flexibility as the ABG. For the year 2010/11, the Government is to include it in the ABG. The decision to remove the ring-fence on Supporting People funding has so far received a mixed response. Some argue the new funding regime could create opportunities to respond to local needs in more flexible ways, by joining up expenditure across health, adult social care and housing related support (SITRA and National Housing Federation, 2009). However, there are also some perceived negative impacts. For example, the Isle of Wight council has recently halved its Supporting People funding from £5.5 million to £2.8 million. Dunning (2010) affirms this type of reduction in funding would have been impossible before April 2009 when the Supporting People was ring-fenced. Dunning also speculates that other councils are likely to follow suit, to the detriment of service users.

**Reviews of SP in England**

In October 2005, the Audit Commission published a national study which reviewed the programme and made a number of recommendations (Audit Commission, 2005). The study concluded that services had improved but there needed to be a ‘long-term commitment and a financial framework to underpin minimum standards’. Furthermore, delivery on the ground ‘was not consistently good’.

A report published more recently by the Audit Commission and an inquiry by the CLG Committee both highlight the achievements of the Supporting People programme (Audit Commission, 2009; Communities and Local Government Committee, 2009). For example, the

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3 For further detail about the Quality Assessment Framework and National Outcomes Framework refer to Appendices 4 and 5
programme has had an impact on service user’s quality of life and has resulted in value for money (Audit Commission, 2009). However, concerns are expressed over the potential for non-ring fenced funding to be diverted away from preventative services to statutory and acute services.

The overall conclusion of the CLG Committee inquiry is that Supporting People in England has achieved a great deal. In particular, it has delivered large cost savings and therefore any threats to the Programme’s continued success should be averted. The Committee maintains that the ring-fence on Supporting People funding should not be reinstated, instead services should be protected. The inquiry compliments the quality of partnership working and acknowledges the successful development of management tools which help to deliver the Supporting People Programme, in particular the Quality Assessment and Outcomes Frameworks which provide an evidence base for which interventions best meet service user needs. However, the inquiry raises concerns over the competitive tendering regime for Supporting People services especially for small voluntary organisations and highlights concern for accommodation based services for older people.

In responding to the recommendations made by the CLG committee, the Government emphasises the role of local government in decision making and control over budgets and thus confirms its stance on non-ring fenced funding for Supporting People Programmes (Secretary of State, 2010). The Government response also stresses the important invest-to-save nature of the Supporting People Programme.

Scotland

Overview
From 2003-2008, funding for housing support services in Scotland was provided through the Supporting People Programme. On 1 April 2008, this funding was rolled up into the main local government settlement and therefore no longer exists as a named grant (Scottish Government, 2010).

The Supporting People Programme in Scotland replaced the previous system of support which was funded by various sources including Transitional Housing Benefit and Communities Scotland Special Needs Allowance Package (SNAP). The aim of the SP programme was to provide good quality services, focused on the needs of users, to enable vulnerable people to live independently in the community, in all types of accommodation and tenure (Berry, 2007). The Scottish Government had responsibility for the programme in Scotland and the Housing Support Enabling Unit was established in 2004 to assist and support independent service providers with implementation. Providers of Supporting People were subject to quality monitoring, through registration by the Scottish Commission for the Regulation of Care, and contract compliance procedures.

Funding
The Scottish Government allocated Supporting People funding to local authorities through Grant Aided Expenditure. The budget for SP in 2007-08 was £401million. Local authorities together with partners from the health service, service providers and service user groups, assessed need in their local areas and commissioned appropriate services to meet those needs. Services were funded on a contract basis and the strategic planning for SP was linked to the Local Housing Strategy and other local plans for community care, health improvement, social inclusion etc. (Joint Improvement Team, 2005).
In 2004, the Scottish Government carried out a review of funding due to concerns over the rising cost of the Programme (PricewaterhouseCoopers, 2004). Following the review, the distribution formula was changed along with an overall drop in funding. At this time, the Scottish Government emphasised the need to seek efficiencies in delivering the Programme (Berry, 2007). Research undertaken on the impact of SP funding cuts reported a funding gap – the difference between funding and costs for providing services (Housing Support Enabling Unit, 2007).

In 2007, the Scottish Government signed a Concordat with the Council of Scottish Local Authorities (COSLA) under which the ring fence was removed. From 1 April 2008, local authorities were no longer required to spend a specific amount on housing support. Instead, the Supporting People programme baseline funding was rolled up into the local government settlement. The removal of the ring fence from the Supporting People programme was said to achieve more flexible support packages and to reduce administrative and accounting functions to ensure maximum resources go to front line services (Scottish Government, 2010). Funding for housing support services still exists but is absorbed within the main local government settlement and no indicative amounts are given for housing support or any other non ring fenced service.

**Reviews of Supporting People in Scotland**

Similar to the English government, the Scottish government has been working towards the development of a tool to evaluate housing support services previously funded through the Supporting People grant. The Outcomes Framework aims to capture the distance travelled by an individual service user with a focus on outcomes on individual’s lives rather than inputs or outputs. A pilot of the Outcomes Framework in seven local authorities, to assess whether the model could be introduced consistently at local authority level, has produced some promising results (Craigforth, 2008). With some key improvements (e.g. in terms of consistency and accuracy of data) the authors conclude that the Outcomes Framework has the potential to measure outcomes at individual service user level. Such information would appear to assist in the development of an evidence base in relation to the impact of housing support services.

Focusing more on the service provider level, the Housing Support Enabling Unit has carried out a survey in relation to the removal of the ring fence and consequent funding levels and service volume of housing support (Housing Support Enabling Unit, 2009). The survey was undertaken due to concerns expressed by service providers about the removal of the ring fence and the knock-on negative effect on housing support. The findings highlight some key issues from the perspective of service providers. The Housing Support Enabling Unit concludes from its process evaluation of Supporting People that i) housing support services continue to face funding difficulties; ii) the sustainability of services providing only housing support is uncertain; iii) services providing less intensive, preventative types of support are more likely to face funding shortfalls and iv) taking steps to reduce costs in order to operate within restricted funding has not been sufficient to bring expenditure within budget (Housing Support Enabling Unit, 2009).
Northern Ireland

Overview

The implementation of Supporting People in Northern Ireland aimed to update housing support services and the way in which they were commissioned, funded and delivered (Northern Ireland Housing Executive, 2005). The Administering Authority for the Supporting People Programme is the Northern Ireland Housing Executive (NIHE); a non-departmental public body and Northern Ireland’s overall housing authority.

In the context of Supporting People, the NIHE has responsibility to:

- Implement the programme
- Strategically plan service development based on need
- Commission services in partnership with the four Health and Social Services Boards and Probation Board for Northern Ireland (PBNI)
- Develop and implement a five year strategy for the programme.

A key feature of the administration of the programme is the Commissioning Body. This includes representation from NIHR, the four Health and Social Service Boards and an observer from the Department of Health, Social Services and Public Safety (DHSSPS). Under the Commissioning Body there are four Area SP Partnership (ASPP) groups, within which local statutory agency representatives can identify needs and priorities for their locality.

The Committee Representing Independent Supporting People Providers (CRISPP) is a representative body for supported housing providers in Northern Ireland. This Committee is chaired by National Federation for Housing Associations and the Council for the Homeless Northern Ireland (CHNI).

Similar to England, the Northern Ireland SP programme utilises a Quality Assurance Framework (QAF) to assist with the continual improvement of quality of housing-related support services. From 2009-10, providers will be required to submit the QAF annually. This will be phased in through each NIHE SP stakeholder area over the year. The NIHE has been working to amend the QAF in line with recent changes to the legislative and policy framework. This has resulted in a new draft QAF (QAF2) and supplementary guidance being produced (Northern Ireland Housing Executive, 2009).

Funding Issues

In Northern Ireland, the investment in Supporting People over the first five years (2003-2008) was £250 million (Northern Ireland Housing Executive, 2005). In 2008-09 the budget was £61 million and this will remain for the following two years. No inflation allowance has been provided. According to the NIHFA in 2008, this means fewer resources are available for individual services and can serve to penalise efficient services for the inefficiencies of a small minority. Supporting People in Northern Ireland has since encouraged providers to become increasingly flexible, allowing them to reinvest savings back into support services (NIFHA, 2008). Unlike the rest of the UK, Supporting People grant funding in Northern Ireland remains ring-fenced.
Reviews of Supporting People in Northern Ireland

Reviews of Supporting People in Northern Ireland identified by the literature search focus on financial expenditure, rather than on outcomes for service users or effectiveness of the administration model.

A project carried out by NIFHA in 2008 aimed to assess the anticipated impacts of reductions in purchasing power of the Supporting People budget in 2009-11. A survey of providers was conducted to gather relevant data. The findings of this survey indicate that base lining budgets has serious financial implications for service providers; the majority stating that they would be operating in deficit funding and many considering whether they would need to withdraw from their Supporting People contract. The report also highlights that a number of service providers of Supporting People are voluntary and community organisations. This sector contributes a large amount to the costs of Supporting People through fundraising; therefore, there would be significant reduction in added value if these organisations were lost.

Evidence of effectiveness or impact

A total of 57 references were identified in the rapid review of the literature which aimed to identify evidence of effectiveness or impact of Supporting People programmes. Many of these were descriptive rather than evaluative and therefore 24 of the 57 hits are included in the evidence table in Appendix III. The sources identified predominantly consist of grey literature in the form of government department reports, background papers and local reviews rather than peer-reviewed research articles. The level of evidence is either level 3 (non-analytic studies) or level 4 (expert opinion, formal consensus). Therefore, there is a lack of high-level evidence (e.g. controlled studies or systematic reviews) which address the effectiveness of Supporting People programmes in terms of outcomes for service users or which compare the effectiveness of the different administration models currently implemented in the UK in terms of the ability of service providers to meet the housing support needs of vulnerable adults. A summary of the references and a brief critical appraisal for each is presented in Appendix III. It should be noted that the vast majority of the literature identified refers to Supporting People in England.

The overall impression from the literature identified is that Supporting People programmes in all three countries brought together a complex web of housing related support programmes from 2003. Both of the national Audit Commission documents based on inspection data highlight that services improved in England since the initiation of the Supporting People programme and state the programme brought improvement to the balance of provision of housing related support compared to identified need (Audit Commission 2005; 2009).

There are some key themes which summarise the evidence table provided in Appendix III. Firstly, when referring to the impact that Supporting People has made on individual service users, most of the literature highlights positive outcomes for service users in terms of quality of life, skills and confidence, independence and the ability to make lifestyle decisions (Audit Commission, 2009; Scragg, 2008; Cameron et al, 2009). Although based on non-analytical studies (e.g. case reports), as opposed to more robust types of study such as randomised controlled trials or before and after intervention studies, the overall consensus is the positive impact of Supporting People on vulnerable adults, particularly for some specific groups such as people with mental health problems and those with HIV (Goldie, 2004; Johnson, 2006;
Cameron et al, 2009). However, only a minority of research studies gathered information directly from service users themselves about the services they received and their satisfaction with them (e.g. Cameron et al, 2009).

Although Supporting People is generally considered as having positive outcomes for service users, services sometimes do not adequately meet the needs of different types of clients groups such as people from ethnic minority communities (e.g. Commission for Social Care Inspection, 2006; Communities and Local Government Committee, 2009). Furthermore impact is both inconsistent across councils and varied according to different types of vulnerable groups (Commission for Social Care Inspection, 2006).

In relation to capturing information about the impact of Supporting People on service users, tools such as the Outcomes Framework are described as useful in terms of measuring distance travelled by individual service users (Craigforth, 2008). Such tools could provide more robust evidence in the future in terms of the impact and effectiveness of Supporting People for service users, for example in relation to utilisation of residential services and ability to live independently. Based on information from a range of witnesses as part of its national inquiry of Supporting People in England, the CLG Committee report makes explicit reference to management tools such as the Quality Assessment and Outcomes Frameworks and how these are helping to build the evidence base for Supporting People Programmes (Communities and Local Government Committee, 2009).

A further theme consistently referred to in the evidence table is the issue of how funding for housing related support is transferred to local authorities and whether this should, or should not, be ring-fenced. Once more, there is no high-level evidence (i.e. level 1 or 2) which demonstrates either positive or negative outcomes associated with different types of funding mechanisms (for example consistency of services, ability of services to meet user needs), however, this issue has undoubtedly created much discussion and debate amongst experts, commissioners and service providers. On the one hand, expert bodies such as the CLG Committee affirm that the ring-fence should not be reinstated so that services can remain flexible (Communities and Local Government, 2009). On the other hand, other reviews and consensus documents such as the Audit Commission (2009) and Sitra and National Housing Federation (2009) maintain the ring-fence should remain so that funding is assured and remains in the longer term. The Audit Commission’s report states ‘there needs to be a long-term commitment and a financial framework to underpin minimum standards’.

Other factors said to be important in terms of the ability of services to appropriately meet need include long-term investment, regulation, quality assessment, accountability and joint working (including local government, health and probation).

A final theme relates to the need for active service user involvement so that services are appropriately tailored and fit for purpose (Audit Commission, 2009). The CLG Committee raises concerns that mechanisms to ensure service users involvement in decision making may be lost as local authorities focus too heavily on costs rather than quality (Communities and Local Government Committee, 2009). This is key issue in terms of the ability of services to effectively meet the needs of service users and a consistent thread that runs through the literature identified.
CONCLUSIONS

There are some key differences and similarities in Supporting People programmes in England, Scotland and Northern Ireland. These are summarised in Appendix I. Notably, both England and Scotland have ceased to provide ring-fenced funding for Supporting People services. There is no comprehensive, good quality research which evaluates the strengths and limitations of each method of funding allocation; however, service providers and umbrella bodies both declare their preference for ring-fenced funding in order to sustain long-term investment and progress.

This literature search has generally highlighted a lack of robust, peer-reviewed research evidence which explores the impact in terms of outcomes for service users as well as the effectiveness of different types of programme administration/funding in terms of the ability of service providers to meet the housing-related needs of vulnerable adults. Instead, there is a large body of grey literature in the form of government reports, background information and independent reviews.

The evidence which has been identified predominantly highlights the positive impacts of Supporting People for service users in terms of outcomes such as independent living and quality of life. However, such outcomes have not been measured using robust research methods and there is a lack of evidence from service users themselves. Most of the evidence is instead based on expert opinion or case studies. None of the literature reports any adverse outcomes for service users. Although, it is often stated that services do not adequately address the needs of different groups (e.g. ethnic minority groups).

To conclude, there are areas in relation to this literature where further work may be beneficial including:

- Appraising more systematically the identified materials in order to develop recommendations for the administration, management and funding of Supporting People in Wales.

- A literature review which addresses outcomes for individual clients and different types of client groups (e.g. people with mental health needs; older people) as a result of Supporting People provision. This might be informed by contact with local providers to identify local programme evaluations.

- Further analysis of evidence submitted by various stakeholders to the CLG Committee. This is an up-to-date and comprehensive source of information.
REFERENCES


Cameron A. (2009). Working across boundaries to improve health outcomes: a case study of a housing support and outreach service for homeless people living with HIV. Health and Social Care in the Community 17: 388-95


Appendix I  
A comparison of Supporting People programmes in England, Scotland and Northern Ireland

<table>
<thead>
<tr>
<th>ENGLAND</th>
<th>SCOTLAND</th>
<th>NORTHERN IRELAND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LAUNCH DATE</strong></td>
<td>1 April 2003</td>
<td>1 April 2003</td>
</tr>
<tr>
<td><strong>AIM OF PROGRAMME</strong></td>
<td>To help end social exclusion by preventing crisis and more costly service intervention and enabling vulnerable people to live independently both in their own home and within their community through the provision of vital housing-related support services.</td>
<td>To assist vulnerable people over the age of 16 to move into, or remain in, their own homes.</td>
</tr>
<tr>
<td><strong>ADMINISTRATION</strong></td>
<td>The Department for Communities and Local Government (CLG) has overall responsibility for the SP programme. Administering Authorities (AAs) (n=150) are responsible for implementing SP in their local areas. AAs contract with providers and partner organisations. A Commissioning Body sits above an AA.</td>
<td>The Scottish Government has responsibility for the direction of the SP programme in Scotland. SP funding was allocated by the Scottish Government to local authorities through grant aided expenditure. Local authorities delivered housing support in their areas as defined by the Scottish Statutory Instrument 2002/444. The local authority then commissioned appropriate services to meet needs, funding them on a needs basis. From 1 April 2008, the SP funding made part of the overall local government settlement.</td>
</tr>
<tr>
<td><strong>MAIN TYPE OF SERVICE PROVIDER</strong></td>
<td>Third sector</td>
<td>Local authorities</td>
</tr>
<tr>
<td><strong>UMBRELLA ORGANISATIONS FOR SERVICE PROVIDERS</strong></td>
<td>Sitra is a membership organisation for practitioners working in the field of housing.</td>
<td>The Housing Support Enabling Unit (HSEU) assists and supports independent service providers with the implementation housing support.</td>
</tr>
<tr>
<td><strong>KEY CLIENT GROUPS</strong></td>
<td>● Older people  ● Homeless (and families)  ● People with physical disabilities  ● People with learning difficulties  ● Ex-offenders and people at risk of offending and imprisonment  ● People at risk of domestic violence  ● People with alcohol and drug problems  ● Teenage parents  ● Young people at risk  ● People with HIV and AIDS  ● Travellers</td>
<td>● Older people  ● Homeless  ● People with physical disabilities  ● People with learning difficulties  ● People with mental health needs  ● People with alcohol and drug problems  ● People experiencing domestic violence  ● People with dementia  ● Vulnerable due to young age  ● People with sensory difficulties</td>
</tr>
</tbody>
</table>
The CLG monitors the performance of AAs. Performance in delivering housing-related support is measured through Comprehensive Area Assessments and through two National Performance Indicators. These measure the number of vulnerable people achieving independence and the number of people supported to maintain independent living. All services are monitored for quality on a regular basis with the use of the Quality Assessment Framework (QAF) – a self-assessment tool. The QAF refresh was published in April 2009 by Sitra.

Housing support services are regulated by the Care Commission. Housing support services (except those provided by Registered Social Landlords) are inspected annually by the Care Commission. The Outcomes Framework aims to capture the distance travelled by individual service users. Outcomes in relation to accommodation; health; safety and security, and social and economic well-being are assessed.

The Quality Assurance Framework (QAF) is used. A new draft QAF (QAF2) with supplementary guidance has been produced. Outcomes monitoring is being carried out on a pilot basis. Publication of evaluation due in April 2010.


## Appendix II
**Evidence levels and Quality Grading**
*(modified from NICE Guidelines manual 2009)*

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2++</td>
<td>High-quality systematic reviews of case control or cohort studies. High-quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2+</td>
<td>Well-conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2-</td>
<td>Case-control or cohort studies with a high risk of confounding bias, or chance and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies (for example, case reports, case series)</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion, formal consensus</td>
</tr>
</tbody>
</table>

### Quality grading

++  = good quality  
+    = fair  
+/-  = fair to poor  
-    = poor
### Appendix III

#### Evidence table

<table>
<thead>
<tr>
<th>Study</th>
<th>Population / setting</th>
<th>Intervention / aim</th>
<th>Results</th>
<th>Comments (italics = reviewers comments)</th>
<th>Design</th>
<th>Evidence level / Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Audit Commission. (2005). Supporting People: London. AC. Available at: <a href="http://www.auditcommission.gov.uk/nationalstudies/locagov/Pages/supportingpeople.aspx">http://www.auditcommission.gov.uk/nationalstudies/locagov/Pages/supportingpeople.aspx</a> [Accessed 24th Mar 2010]</td>
<td>All Supporting People programmes England.</td>
<td>To review the current state of the SP programme, stakeholder concerns and the future of housing-related support. To identify whether change is needed at a national, regional or local level to support future improvement.</td>
<td>Services have improved. There needs to be a long-term commitment and a financial framework to underpin minimum standards. Delivery on the ground is not consistently good.</td>
<td>National review. Based on existing published data and on the Audit Commission’s inspections of administering authorities, together with other Commission inspections of providers – housing associations, council housing departments and management organisations. Stakeholder interviews and focus groups.</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>Audit Commission. (2009). Supporting People evaluation. London: AC. Available at: <a href="http://www.auditcommission.gov.uk/SiteCollectionDocuments/Downloads/spprogramme200509acfinalreportclg.pdf">http://www.auditcommission.gov.uk/SiteCollectionDocuments/Downloads/spprogramme200509acfinalreportclg.pdf</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People programmes England.</td>
<td>To review overall impact and successes of the SP programme following the previous AC report and recommendations in 2005.</td>
<td>The programme has brought improvements to the balance of provision of housing related support compared to identified local need; service quality has had a positive impact on user’s quality of life; good value for money, improvements in service quality achieved within fixed or reducing budgets; tailored support through active service user involvement; and outcomes for service users. Weaknesses include: poor implementation of SP in a minority of authorities; benefits of housing related support not yet well understood across all relevant sectors; some vulnerable groups’ housing related support needs not always fully identified and met. Without statutory status and protected ring fenced grants, SP services may be at serious risk as funding becomes constrained.</td>
<td>National review. Based on assessment of inspection reports, policy and research documents. Also primary research incorporating 60 interviews / focus groups and online questionnaires with various stakeholders.</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Cameron A. et al. (2007). The challenges of joint working: lessons from the Supporting People health pilot evaluation. <em>International Journal of Integrated Care</em> 7: 1-9. Available at <a href="http://www.iijc.org/index.php/iijc/article/view/219/437">http://www.iijc.org/index.php/iijc/article/view/219/437</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People health pilots England</td>
<td>To evaluate the SP health pilots programme and to highlight challenges of working across organisational boundaries.</td>
<td>Integrating services to support people with complex needs works best when the service is determined by the characteristics of those who use the service rather than pre-existing organisational structures.</td>
<td>SP health pilots were announced in 2003. This paper is an evaluation of the 6 health pilots with a specific focus on the issue of joint working.</td>
<td>Qualitative research. Two main sources of data collection were quarterly project evaluation reports and progress reports against aims and objectives. Semi-structured</td>
</tr>
<tr>
<td>Study</td>
<td>Population / setting</td>
<td>Intervention / aim</td>
<td>Results</td>
<td>Comments</td>
<td>Design</td>
<td>Evidence level / Quality</td>
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<tr>
<td>4.</td>
<td>Cameron A. (2009). Working across boundaries to improve health outcomes: a case study of a housing support and outreach service for homeless people living with HIV. Health and Social Care in the Community 17: 388-95</td>
<td>Supporting People (health pilots) England (London)</td>
<td>Reports the findings of an evaluation of the ‘Housing Support, Outreach and Referral’ service developed to support people living with HIV who were homeless or at risk of homelessness.</td>
<td>The local joint working context, the involvement of the voluntary sector and the role of the support workers were important factors that accounted for positive outcomes of service users (e.g. maintenance of tenancy agreements; registration with a GP or HIV clinic).</td>
<td>Looks and the association between housing and health. Outcomes achieved were modest, particularly in terms of the numbers of people the pilot supported. Useful in considering the role of housing support in improving people’s health, and the challenges of working across housing, health and social care boundaries.</td>
<td>Qualitative research. Two main sources of data collection were quarterly project evaluation reports and progress reports against aims and objectives. Semi-structured interviews across all key stakeholders groups and agencies.</td>
</tr>
<tr>
<td>5.</td>
<td>Commission for Social Care Inspection. (2006). Supporting People. Promoting independence. Lessons from inspections. London: CSCI. Available at: <a href="https://www.ofsted.gov.uk/.../Supporting%20people%20-%20promoting%20independence%20(PDF%20format).pdf">https://www.ofsted.gov.uk/.../Supporting%20people%20-%20promoting%20independence%20(PDF%20format).pdf</a> [Accessed 24th Mar 2010]</td>
<td>All Supporting People programmes England</td>
<td>To provide information about the impact of SP programmes on the lives of social care service users.</td>
<td>Impact has been inconsistent across councils Impact on different vulnerable groups has varied Funding reductions has made it difficult for many councils to plan ahead Concern about the quality of some low cost services Take up of services by black and minority ethnic groups has been good Services don’t appropriately address need</td>
<td>Practical information on learning and improvement for local councils</td>
<td>Based on inspections of Supporting People programmes and case material</td>
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<td>6.</td>
<td>Communities and Local Government Committee 13th Report. (2009). The Supporting People programme. London: TSO. Available at: <a href="http://www.publications.parliament.uk/pa/cm200809/cmselect/cmcomloc/649/64902.htm">http://www.publications.parliament.uk/pa/cm200809/cmselect/cmcomloc/649/64902.htm</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People programmes England</td>
<td>To investigate: i) the extent to which the Government has delivered on its commitments it made in Independence and Opportunity: our strategy for Supporting People published in 2007. ii) the implications of the removal of the ring fence.</td>
<td>Progress of the SP programme has been good overall, but there are some areas which require further progress/ clarification as to how objectives will be achieved. Two major issues: 1) the burden of the competitive tendering regime for SP services; 2) the lack of clarity as to the future of accommodation-based services for older people. Concerned that mechanisms to ensure service users' involvement in decision-making may be lost and that Third Sector organisations could be overlooked as local authorities focus too heavily on the cost of providing services, as opposed to considerations of quality. Concern that the needs of some groups not being met. Housing-related support should be specifically referenced in new guidance for joint strategic needs assessments for social care and health</td>
<td>Not intended as a research study but a very useful and comprehensive compendium of information from a range of stakeholders.</td>
<td>Results based on four oral evidence sessions, and written evidence from over 100 witnesses.</td>
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<td>Study</td>
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<td>7.</td>
<td>Craigforth. (2008). Evaluation of Supporting People (housing support) outcomes framework. Edinburgh: Scottish Government. Available at: <a href="http://www.scotland.gov.uk/Resource/D2ce/231399/0063114.pdf">http://www.scotland.gov.uk/Resource/D2ce/231399/0063114.pdf</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People in Scotland – 7 local authority areas who volunteered to be involved in a pilot of the Outcomes Framework model</td>
<td>An evaluation of the Outcomes Framework model (which uses a distance travelled concept) and whether it could be introduced to capture useful information to inform reporting at a national level.</td>
<td>The Outcome Framework is useful for measuring distance travelled by service users, even with the changed circumstances surrounding funding for housing support services. Provides useful evaluation information about a tool which can be used at an individual level to measure distance travelled of service users and therefore measure the impact of the SP programmes.</td>
<td>Evaluation of the Outcomes Framework is based on i) a survey of providers involved in the pilot and ii) observations and interviews with service provider staff and service users.</td>
<td>3</td>
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<td>8.</td>
<td>Communities and Local Government. (2008). Changing Supporting People funding in England: results from a pilot exercise: summary. London: The Department for Communities and Local Government. Available at: <a href="http://www.communities.gov.uk/documents/housing/pdf/supportingpeoplefunding.pdf">http://www.communities.gov.uk/documents/housing/pdf/supportingpeoplefunding.pdf</a> [Accessed 24th Mar 2010]</td>
<td>A pilot exercise in removing the ring fence from SP funding was conducted in 15 English local authority areas during 2008/9.</td>
<td>To explore current and anticipated impacts of the removal of the ring fence on the future provision of housing related support to vulnerable groups.</td>
<td>Removal of the ring fence had mixed views – some saw it as a positive change, others were concerned about funding loss and that the SP programme would be lost or dissolved. However, the research was carried out early in the process and dramatic changes were not anticipated. Some respondents had the view that not enough time had elapsed for the impacts of ring fence removal to be fully assessed.</td>
<td>Research conducted by the University of York for the Department for Communities and Local Government. A qualitative study based on telephone interviews with service providers and SP lead officers, chairs of SP commissioning bodies and representatives of Local Strategic Partnerships.</td>
<td>3</td>
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<tr>
<td>9.</td>
<td>Communities and Local Government. (2008). Research into the effectiveness of floating support services for the Supporting People programme: final report. London: The Department for Communities and Local Government. Available at: <a href="http://www.communities.gov.uk/documents/housing/pdf/floatingsupportresearch.pdf">http://www.communities.gov.uk/documents/housing/pdf/floatingsupportresearch.pdf</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People England</td>
<td>To explore the effectiveness of floating support services, and the balance needed between floating support and accommodation based services in order to improve service delivery and choice and control for service users.</td>
<td>The review found a number of benefits in providing floating support services. These are mainly focused on the delivery of flexible, person centred services to enable people to establish and maintain independence in ordinary housing.</td>
<td>Research undertaken by Civis for Communities and Local Government. Literature review as well as various qualitative methods including: Meetings with 8 key stakeholders. A questionnaire to SP inspectors. Telephone interviews with administering authorities and providers.</td>
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<td>10. DTZ Consulting and Research, (2007). <em>Supporting People outcomes framework final report</em>. Edinburgh: Scottish Executive. Available at: <a href="http://www.scotland.gov.uk/Resource/Doc/1035/0048538.doc">http://www.scotland.gov.uk/Resource/Doc/1035/0048538.doc</a> [Accessed 24th Mar 2010]</td>
<td>Supporting People Scotland</td>
<td>To inform the development of an Outcomes Framework model.</td>
<td>The recommended model is based on the distance travelled model and has been modified to allow the measurement of change over time and to allow for reporting at the national level.</td>
<td><em>This is not a research study. It presents a recommended model for measuring distance travelled by clients. The model was piloted and evaluated in 2008.</em></td>
<td>Document analyses Client record data</td>
<td>4</td>
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<td>11. Eliot J and Hamilton N. (2009). Supporting People and the future of housing-related support. <em>Housing Care and Support</em> 12: 30-5</td>
<td>England</td>
<td>A joint briefing by the National Housing Federation and Sitra in response to the CLG Committee inquiry.</td>
<td>Housing related support is important and should be valued Vital services are at risk The achievements of SP need to be preserved (including the development and use of the QAF) Contract prices have been squeezed Commissioners need to focus on full value for money Providers need to be able to get their case heard locally A broad spectrum of services are required to meet the full range of needs Need to safeguard investment for specialist housing Clearer local strategies for older people’s housing Recommends that SP should be retained as a ‘named grant’.</td>
<td><em>This is not a research study. Rather it pulls together the key points from both organisation’s evidence to the parliamentary inquiry into SP.</em></td>
<td>Best practice review of relevant policy and literature in the area of outcomes measurement, and a focussed programme of consultations with Scottish local authorities that are developing and implementing outcomes models for SP, and discussion with others across the UK.</td>
<td>4</td>
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<tr>
<td>12. Fyson R, Tarleton B and Ward L.</td>
<td>Supporting People</td>
<td>To examine how local SP impact of SP on housing and support for people with</td>
<td></td>
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<td>Detailed qualitative</td>
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<td>(2007). Support for living? The impact of the Supporting People programme on housing and support for adults with learning disabilities. York: Joseph Rowntree Foundation. Available at: <a href="http://www.jrf.org.uk/sites/files/jrf/2092_housing-support-learning%20difficulties.pdf">http://www.jrf.org.uk/sites/files/jrf/2092_housing-support-learning%20difficulties.pdf</a> (Accessed 24th Mar 2010)</td>
<td>England</td>
<td>teams were interpreting national guidelines in relation to the provision of housing-related support and to explore the impact that this was having on housing and support for people with learning disabilities.</td>
<td>learning disabilities has been mixed. An increasing number of supported living services have been developed and people have been complimentary about their homes and the support they received. Lots of choice and control given to clients. However, decisions largely made by service providers. Schemes based on shared tenancies with accommodation-based support were sometimes little different from the registered care homes they had replaced. Research highlighted failure of most service providers to adequately support social integration of people with learning disabilities within their local communities.</td>
<td>Same study as above but reported in different journal.</td>
<td>research with 4 Administering Authorities</td>
<td>3</td>
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<tr>
<td>13. Fyson R, Tarleton B and Ward L. (2007). Supported living through Supporting People: the experiences of people with learning disabilities. Housing Care and Support 10: 35-40</td>
<td>Supporting People England</td>
<td>To examine how local SP teams were interpreting SP teams were interpreting national guidelines in relation to the provision of housing-related support and to explore the impact that this was having on housing and support for people with learning disabilities.</td>
<td>Impact of SP on housing and support for people with learning disabilities has been mixed. An increasing number of supported living services have been developed and people have been complimentary about their homes and the support they received. Lots of choice and control given to clients. However, decisions largely made by service providers. Schemes based on shared tenancies with accommodation-based support were sometimes little different from the registered care homes they had replaced. Research highlighted failure of most service providers to adequately support social integration of people with learning disabilities within their local communities.</td>
<td>Same study as above but reported in different journal.</td>
<td>Detailed qualitative research with 4 Administering Authorities</td>
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<td>14. Goldie N. (2004) The Supporting People programme and mental health. London: Sainsbury Centre for Mental Health. Available at: <a href="http://www.scmh.org.uk/pdfs/briefing+26.pdf">http://www.scmh.org.uk/pdfs/briefing+26.pdf</a> (Accessed 24th Mar 2010)</td>
<td>Supporting People for people with mental health needs</td>
<td>Looks at critical implications of the SP programme for people with mental health needs.</td>
<td>States that SP has benefitted thousands of people with mental health needs. It has encouraged the development of new forms of support that promote independence and helps people to live their lives as they choose. However, the briefing paper raises concerns with regard to the impact on such groups if SP budgets are reduced in the future.</td>
<td>Not a research study</td>
<td>A briefing report which draws on official documents, reports, Information and views gathered by the SCMH from various commissioning and provider agencies. Interviews were conducted with staff in four commissioning agencies, five provider agencies and other relevant stakeholders.</td>
<td>4</td>
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<tr>
<td>16. Housing Support Enabling Unit. (2009). HSEU research into housing support</td>
<td>Supporting People Scotland</td>
<td>To investigate provision and funding of housing</td>
<td>Findings show that housing support services continue to face funding difficulties. The sustainability of services 251 out of 1080 services responded to the survey.</td>
<td>Postal survey carried out in</td>
<td></td>
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### Study

#### Funding levels and service volume in Scotland in 2008/09.


- **Population / setting:**
- **Intervention / aim:** Support services following the new funding arrangement introduced in 2008 (i.e. removal of ring-fenced funding).
- **Results:** Providing only housing support (rather than being combined with other services) is particularly uncertain. Services providing less intensive, often preventative support are more likely to be facing funding shortfalls. This particularly affects older people. Taking steps to reduce costs in order to operate within restricted funding has not been sufficient to bring expenditure within budget and brings into question the sustainability of services.
- **Comments:** This represents a response rate of approx. 23%. The profile of respondents for the 2 surveys was similar.
- **Design:** May 2008 with housing support managers in Scotland registered with the Care Commission. Survey repeated in July 2009.
- **Evidence level / Quality:** Case studies undertaken to illuminate findings of the survey.


- **Population / setting:** Supporting People in England
- **Intervention / aim:** Commentary on 2007 SP Strategy.
- **Results:** Explores the impact that SP could have on MH care and the role of low-key preventative services.
- **Comments:** Commentary
- **Design:**
- **Evidence level / Quality:** 4


*Housing Care and Support* 12: 25-9.

- **Population / setting:** 13 pilot sites for individual budget pilot exercise
- **Intervention / aim:** To report findings of individual budget pilot sites.
- **Results:** The take-up of Supporting People for individual budgets during the pilot period was relatively limited. Many positive stories of how individual budgets have made a difference to people's lives, enabling person-centred support and informed choices about integrated packages of care and support. Examples of creative joint working. Individual budgets should not be considered as the only option for personalising housing-related support services and increasing choice. Commissioned SP services can be responsive and person-centred as well as providing consistent coverage. More work is needed to understand better how IBs can work together with commissioned services to deliver a seamless service.
- **Comments:** No specific research methods reported. Mainly consensus opinion.
- **Design:** Unclear
- **Evidence level / Quality:** 3/4


- **Population / setting:** Supporting People Northern Ireland
- **Intervention / aim:** To assess impacts of reductions in SP budgets in 2009-11.
- **Results:** Findings highlight serious financial implications for service providers; the majority stating that they would be operating in deficit funding and many considering whether they would need to withdraw from their SP contract. A number of service providers of SP are voluntary and community organisations. This sector contributes a large amount to the costs of SP through fundraising; therefore, there would be significant reduction in added value if these organisations were lost.
- **Comments:** Response rate to survey was 37% (n=38/104 service providers).
- **Design:** Survey
- **Evidence level / Quality:** 3


- **Population / setting:** Supporting People Scotland
- **Intervention / aim:** Supporting People client statistics.
- **Results:** In 2006-07, 175,934 individuals were assisted. Clients were mainly older people, homeless or rough sleepers.
- **Comments:** Provides client profile and support received, but does not provide quantitative statistics.
- **Design:**
- **Evidence level / Quality:** 3

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**Note:** Italics indicate reviewers' comments.
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<td>[online]. Available at: <a href="http://www.scotland.gov.uk/Resource/Doc/172318/0048171.pdf">http://www.scotland.gov.uk/Resource/Doc/172318/0048171.pdf</a> [Accessed 24th Mar 2010]</td>
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<td>people with a physical disability, illness or sensory impairment. Older people are the majority group. 57% of clients are female. Only 13% of clients are aged 25 or under. Overall, 4% of the adult population received support in 2006-07. The largest providers of support services were local authority social work departments (32% of clients), local authority housing (26%), and registered social landlords (25%). Voluntary organisations provided support to 18% of clients. 34% of clients received 1-4 hours per week of floating support, 10% received 1-4 hours per week of accommodation linked support and 7% received continuous accommodation linked support. For the majority of clients (51%) the support received is permanent. Over half of all clients received support in mainstream housing (54%), with a further 23% in sheltered housing.</td>
<td>not assess impact on clients. Information is gathered from Local Authorities and is not always complete.</td>
<td>Case Study</td>
<td>3/4</td>
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<tr>
<td>21. Scragg T. (2008). Reflections on Supporting People: a case study of Outreach3Way, Housing Care and Support 11: 16-9</td>
<td>Supporting People England</td>
<td>The experience of a service for people with learning difficulties and the developments that have taken place since the introduction of the SP programme.</td>
<td>The main benefit of SP has been the ability to provide a wide range of living options and flexible support to service users, tailored to their needs. Service users have developed skills and confidence to participate in local communities and to make major lifestyle decisions. Working with private landlords has been more challenging than working with housing associations.</td>
<td></td>
<td>Government response</td>
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- Housing related support is important and should be valued  
- Vital services are at risk through the removal of the SP ring fence  
- The achievements of SP need to be preserved (e.g. the development and use of the Quality Assessment Framework to assess and demonstrate the quality of services).  
- Commissioners need to focus on full value for money (i.e. a full competitive tendering process is not always the most effective way of securing value for money services).  
- A broad spectrum of services are needed to meet the full range of needs  
- Clearer local strategies for older people’s housing | A briefing document created in response to the Select Committee inquiry but with some useful comment about the removal of the ring-fenced funding | Content developed in consultation with members of both organisations through surveys, written responses and events | 4                        |
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• Respondents welcomed opportunity offered by commissioning regime to secure funding and staff time for specialist support (e.g. mental health, substance abuse) alongside generic housing support funded by Supporting People. Lack of specialist support (including crisis intervention) has inhibited service development for those with high needs who are not a priority for community care.  
• Respondents felt that people can be put off by formalities which draw them into ‘the system’ and define them in ways they consider stigmatising. Respondents suggested that funding of designated ‘access’ support should be explored as a way to encourage people to engage with services.  
• Service planners showed scepticism about Supporting People’s capacity to extend into the private housing sector. They had mixed views on whether to adopt a promotional approach or to go for incremental growth through individual referrals of people living in private accommodation.  
• The aim of improving services for those with multiple needs or those who are resistant to, or remote from, services means that commissioners and service providers will work in a climate of higher management and financial risk. Locally based players were committed to this aim, but were concerned that local Supporting People budgets will not meet the inevitable extra costs. | Review document based on document analysis, e-mail contact with 35 SP teams, discussion, with senior practitioners and interviews | 3 |
Appendix IV
Quality Assessment Framework (England)


The Quality Assessment Framework (QAF) was introduced in England in 2003. It is a set of nationally defined standards which are designed to provide a standard against which Supporting People teams are able to assess the quality of support services. They are designed for providers to monitor and improve their own provision and the providers’ own assessment is then checked by the Supporting People team. The framework currently has 5 core service objectives including:

1. Assessment and Support Planning
2. Security, Health and Safety
3. Safeguarding and Protection from Abuse
4. Fair Access, Diversity and Inclusion
5. Client involvement and empowerment

There are also supplementary standards the Supporting People team can ask providers to complete that are designed to highlight an area of concern regarding a particular provider or a priority area for the local authority. The QAF has been recently refreshed and the new version was launched on the 1st April 2009.

The QAF is no longer mandatory, but the majority of Administering Authorities continue to use the QAF. There is also evidence that other areas across authorities, such as Adult Social Care, are also adopting the QAF as the standard tool to measure the quality of services being delivered.

A refreshed QAF-lite will be available shortly. This can be used for community alarm services, sole traders and services delivered by small providers that employ no more than one full-time equivalent member of support staff, and/or have a contract value of less than £5,000 per year.
Appendix V
National Outcomes Framework (England)


The Department for Communities and Local Government (CLG) has developed a national outcomes framework for the SP programme in England. The outcomes framework uses 5 high level outcomes based on the Every Child Matters: Change for Children programme:

- Economic wellbeing,
- Enjoy and achieve
- Be healthy
- Stay safe
- Make a positive contribution.

A set of specific indicators sit under each of the five high level outcomes. An SP Client Record Form is completed by service providers when a new service user enters a service (except for sheltered services which are exempt from completing this form). Information from these forms is analysed and managed by the Centre for Housing Research at St Andrews, on behalf of CLG. There is a different form for short and long-term services.

The completion of the outcomes framework by providers is not mandatory but is strongly recommended by the CLG.

From 31st May 2007, providers have needed to complete the short-term form for all clients exiting their service and to submit them quarterly. The long-term form needs to be completed annually on a sample of clients.

Data is made available to local authorities on a web-based system, after the end of each quarter. Key reports are provided for each local authority. Local authorities have access to the outcomes data at individual service and provider level. They can access their raw data if they want to carry out further analysis.

Providers can access their data via the local authority Supporting People team commissioning their service.

If authorities want additional outcomes information, they are encouraged to use only those listed in a national ‘basket of indicators’ developed and circulated by the CLG. These have been developed to encourage consistency and reduce administrative burden.
Appendix 4 Housing related support interventions: a rapid review of the evidence

Author: Sian Price, Public Health Specialist, Vulnerable Groups Team, Public Health Wales
Date: 20th September 2010

Summary

- This rapid evidence review considers the evidence base for interventions to help vulnerable people obtain and maintain appropriate housing and is restricted to analytic studies. It has been undertaken to support the review of the Supporting People Programme in Wales.

- The evidence base presented in this document is derived largely from studies conducted at single sites in the USA typically involving single people, often male, often African-American and usually with mental illnesses and/or substance misuse problems. Some of this differs from the situation in Wales limiting its generalisability to the Supporting People programme.

- The evidence does, however, provide some general guidance on the type of interventions that may be of benefit. Overall the evidence suggests that providing vulnerable people with support can lead to significant reductions in homelessness.

- The definition of support is broad and includes access to subsidised housing and psychosocial support. Psychosocial support includes helping people engage with services and the development of money management and other independent living skills.

- Those who are the most difficult to engage and who have the most severe problems may be more difficult to maintain in stable housing. Nevertheless, there is evidence that they can be successfully housed.

- Some of the costs of providing supported housing may be offset by reductions in the use of emergency medical care and criminal justice services.

- An analysis of descriptive studies may provide further detail of interventions and evidence on how these can be effectively implemented.

Background

Supporting people
Supporting People is a UK wide programme launched in 2003. The services provided through the programme are designed to help vulnerable people with complex needs develop the skills and confidence necessary to live independently without support or
to maintain independent living with ongoing support. Support is provided to single people and families enabling them to develop essential personal, social and financial skills.

In Wales vulnerable people eligible for the programme will come from the following groups¹:

- People fleeing domestic violence
- People with learning difficulties
- People with mental health problems
- People with drug or alcohol dependency
- Refugees
- People with physical disabilities
- Young single homeless and care leavers
- Ex-offenders
- People who are homeless or potentially homeless
- People with chronic illness including AIDS, AIDS related conditions or who are HIV positive
- Vulnerable single adults who require support

**Review of Supporting People in Wales**

A review of the Supporting People programme in Wales was commissioned by Jocelyn Davies AM. The review considered the policies, systems and resources used in delivering the Supporting People programme and will make recommendations to maximise the long term contribution the programme makes to health and wellbeing. The review has used mixed methods to gather evidence. These have included interviews with, and written submissions from, a range of stakeholders. A literature review has been undertaken with the primary aim of comparing and contrasting the nature, procedures and performance of the Supporting People programme in Wales with similar schemes in other UK countries. Public Health Wales is undertaking three further pieces of work to support the review. These are:

- A review of the international literature on the effectiveness and cost effectiveness of interventions/programmes/services that aim to support vulnerable groups in obtaining and maintaining housing.
- A review of the UK evidence base on the effectiveness and cost effectiveness of Supporting People
- A review of evidence (if any exists) on the effectiveness and cost effectiveness of Supporting People programmes within Wales.

This document is the first of these pieces of work.

**Purpose and methodology**

This rapid evidence review builds on work already undertaken as part of the Supporting People review and considers evidence for the effectiveness of interventions designed to support vulnerable people in obtaining and maintaining appropriate accommodation. The search methodology on which it is based covers a
The Supporting People Programme in Wales: Final Report

broad range of vulnerable groups and was not limited by country or study type. The search strategy is included at appendix I. This yielded a large and diverse literature. Because of this, this review focuses on analytical studies with a housing related outcome. Evidence on cost effectiveness has been included where it is available.

Descriptive studies have been excluded but a review of these would provide information on how interventions can be most effectively implemented and a second paper is planned covering these.

More detailed reviews focusing on other outcomes (for example quality of life, use of health care, client satisfaction) or evaluation methods might be useful.

The evidence base

Methodological issues
Most studies have been conducted in the USA, many at single sites, this means that findings may not generalise to a UK setting. At population level there are considerable differences in political, social and economic ideologies and this is reflected in policy as well as housing supply and regulation. In addition there are likely to be differences in services and there may be some differences in client characteristics.

At an individual level, however, these differences may be less important. Response to a specific intervention may be significantly determined by factors operating at individual level.

The evidence base is diverse and is presented here mainly by client group, where relevant subdivided by type of intervention. The majority of studies are on people with mental illness and/or substance misuse problems. It is not clear what proportion of the population of interest within Wales has these problems but it is likely to be significant. The evidence base for other populations is sparse.

Many of the studies raise methodological issues and concerns. These are noted in an evidence table included in appendix II.

Adults with mental illness and/or substance misuse problems

Housing first approaches
Housing first approaches offer homeless people with mental illness and often substance misuse problems immediate access to independent housing and supportive services. This is without any requirement for them firstly to engage with psychiatric and/or substance misuse treatment or to be clean and/or sober. This approach seems to have originated in the United States of America (USA).

Definitions of independent housing vary but are usually self contained apartments. These may be in specialist housing provision or owned by private independent landlords. Housing is intended to be permanent; that is clients would not be expected to move on after a certain period of time but would be free to do so if they wished.
In an intervention study, undertaken in New York City, comparing two approaches to housing chronically homeless people with mental health problems a housing first programme was compared with a continuum of care programme\(^2\). The continuum of care programme began with outreach and drop in centre programmes, progressing through a series of communal living arrangements with varying levels of on site support. Clients eventually moved on to independent living. Enrolment in the programme was contingent on abstinence from alcohol and drugs and compliance with mental health treatment.

In the housing first programme support services were provided by a multidisciplinary assertive community treatment (ACT) team. Teams were on call 24 hours, 7 days a week and provided services in the clients’ homes. Unlike traditional ACT clients could chose the frequency and type of services they received. Teams practiced a harm reduction approach for clients with substance misuse and mental health problems. The ACT teams offered housing support, money management, vocational rehabilitation and mental health and substance misuse treatment. There were two requirements of clients. They had to contribute 30% of their income towards their rent and had to meet with a staff member at least twice a month. Participants on the housing first programme were housed earlier and spent more time in stable housing than those in the continuum of care programme. Participants were followed up for two years. In this example it is not possible to separate the effect of the housing first approach from ACT.

A larger study was undertaken in New York City by Pathways to Housing a non profit agency providing housing for street homeless people with severe mental illness and concurrent substance abuse problems. This compared a housing first approach (242 participants) with a linear treatment model (1,600 participants)\(^3\). Participants were recruited through referrals from outreach teams, drop in centres or shelters. The interventions are very similar to those in the study above. Some of the participants may be the same, but this is difficult to deduce from the published paper.

After 5 years 88% of those housed using the housing first approach remained in these homes compared with 47% using the linear treatment model. The analysis, which controlled for differences between the groups that may have contributed to outcome, showed that programme type was the second most important predictor of tenure, but again does not differentiate between the effects of housing first and ACT. Age was the most important predictor, being older increased tenure.

A more recent study of three housing first programmes in New York City, Seattle and San Diego followed 80 clients for 1 year\(^4\). 84% of those enrolled remained engaged with the programme after 12 months. Those who entered the programme from the streets rather than a shelter, psychiatric hospital, prison or some other location were more likely to have left in the first 12 months. 69% of those recruited from the streets had left at this stage.

An evaluation of a housing first intervention for chronically homeless individuals with severe alcohol dependence explored the impact of this on their use of services\(^5\). Services included jail bookings, days incarcerated, shelter use, hospital treatment including emergency care and drug and alcohol detoxification. This was a small study using an interventional design. 95 clients on the housing first programme were
compared with 39 waiting list controls. Follow up was for one year. Analysis showed a 53% reduction in total costs for those housed through the programme. Total cost offsets for housing first participants averaged $2449 per person per month after accounting for housing costs (2004 costs)

**Assertive community treatment and case management**

Although ACT and other types of case management often form an integral element of comprehensive interventions, these have been evaluated independently\(^6\). A review of 16 controlled evaluations of housing and support interventions for people with mental illness who had been homeless found that programmes providing permanent housing and support, ACT and intensive case management all led to significant reductions in homelessness and other outcomes.

In terms of housing stability the best outcome was found for combined housing and support (effect size =.67), followed by ACT alone (effect size .47). The weakest outcome was for intensive case management alone (effect size =.28).

A study conducted in Florida compared a comprehensive housing programme in which clients had guaranteed access to housing, housing support services and case management with case management only\(^7\). 83 clients were assigned to the comprehensive programme and 69 to case management only. Both groups had a severe mental illness but differed significantly in psychiatric symptoms and days of substance use at baseline. Those in the case management only group were more impaired. Follow up was for 1 year but only 65% of clients were available at six months and 58% at twelve. The loss to follow up in the case management only group was significant, only 36% remained at twelve months. Clients with high levels of psychiatric symptom severity and substance misuse achieved better housing outcomes with the comprehensive programme than with case management alone. Housing outcomes included proportion of time in stable housing, proportion of time literally homeless and proportion of time functionally homeless. Those with low symptom severity and levels of substance misuse did just as well with case management alone. These findings suggest merit in matching type of service to the clients’ level of need.

An experimental comparison of three types of case management for homeless people with mental illness was conducted in St Louis, Missouri\(^8\). Clients were recruited from either inpatient units or a psychiatric emergency room. The three interventions were brokered case management, in which clients’ needs were assessed, services were purchased from multiple providers and the client was monitored; ACT only in which comprehensive services were provided for an unlimited period; and ACT augmented by support from community workers who assisted with activities of daily living and were also available for leisure activities. 165 clients were recruited, 135 of whom could be followed up at eighteen months. Clients who received ACT only achieved more days in stable housing than those in the other two conditions. Clients who received ACT and augmented ACT had higher rates of contact with the intervention programme, higher levels of resource utilisation (for example use of entitlements), reduced severity of thought disorder and reported higher levels of satisfaction. There were no significant group treatment effects for income, self-esteem or substance misuse.
In a Cochrane review of ACT for people with severe mental disorders, ACT was found to be superior to hospital based rehabilitation in achieving independent living (odds ratio (for not living independently) 0.19, 95% confidence intervals 0.06 – 0.54). There were no other significant or robust differences in clinical or social outcome.

A five year demonstration project covering 15 US cities examined the effect of the case management relationship on clinical outcomes for people with severe mental illness. The association between case manager relationship at baseline, three and twelve months and clinical outcomes at 12 months was assessed. Clients were categorised as not having a relationship with their case manager or as having a low or high therapeutic alliance. Analysis was conducted on 2,798 clients who had outcome data at 12 months. No significant associations were found between relationship with case manager at baseline and outcomes at 12 months but clients who had formed a therapeutic alliance with their case manager at three months had significantly fewer days of homelessness at 12 months.

**Outreach**

An 18 site five year demonstration programme in the USA followed up homeless mentally ill people first contacted through a street outreach programme. 11,857 clients were contacted at outreach, 5,431 were subsequently enrolled in a case management programme. Of these 4,587 were followed up three months after enrolment. In comparison with those contacted in shelters clients contacted through street outreach were more likely to be male, literally homeless before contact and to have psychotic disorders. They also took longer to engage in treatment and were less likely to enrol in case management.

Those who did enrol identified greater need for both health and social services but interestingly reported being less depressed and having a higher quality of life. At the end of three months the outreach group, when baseline differences were taken into account, had improved significantly on 14 out of 20 housing, quality of life and health outcomes. The other group had improved on 19. Although the street outreach group improved in the desired direction they did not show significant improvement in housing outcomes.

**Shelter based interventions**

A small intervention study undertaken in the USA assessed the effectiveness of a shelter based intervention. 51 homeless people with mental health and substance misuse problems were randomised to receive psychiatric management which emphasised continuity of care and included case management services that encouraged staying in mental health treatment and working towards housing and employment. The control group saw a psychiatrist in the shelter but psychiatrists were volunteers and there was no continuity of care. Case management was not provided but, on their own initiative, participants could make appointments for case management services. Those in the treatment group were significantly more likely to attend 1 or more community mental health centre appointments and to participate in substance abuse treatment. There were no significant differences in housing outcomes although those in the treatment group were more likely to have housing when they left the shelter (44.9% vs 38.3%).
Critical time interventions

Critical time intervention (CTI) aimed to prevent homelessness among men with severe mental illness by providing a bridge between institutional and community care. The intervention had two components. The first aimed to strengthen the individuals long term ties to services, family and friends; the second to provide emotional and practical support during transition. Clients had been discharged from an on-site psychiatry programme in a New York City men’s shelter to return to community housing. Clients in the programme had access to housing ranging from intensively supervised community residences to single room occupancy hotels with on site social services. 48 clients were assigned to the CTI group and 48 to treatment as usual. In months 1 to 3 CTI clients received home visits, were accompanied to appointments, CTI workers met with caregivers and substituted for them where necessary, they provided advice to clients and caregivers and mediated conflicts between them and helped to negotiate ground rules for relationships. In the care as usual group shelter staff assisted patients and caregivers on request and substituted for care givers where necessary. In the CTI group between 4 and 7 months CTI workers observed how the ground rules were working and helped to modify these where necessary. Between 8-9 months CTI workers reaffirmed the ground rules and held parties/meetings to symbolise transfer of care. Services as usual were received by the CTI group from 10 to 18 months and by the treatment as usual group from 4 months. Over the 18 month period the average number of homeless nights was 30 for the CTI group and 91 for the usual services group. Survival curves showed that after the 9 months of active intervention the differences between the two groups did not diminish.

A cost-effectiveness assessment of the same trial showed that for acute care, outpatient services, housing and shelter services, criminal justice services and transfer income the CTI group incurred means costs of $52,374 and the intervention group $51,649 (1991 - 1993 costs). For each willingness to pay value (the additional price society is willing to spend for an additional non homeless night) greater than $152, the CTI group showed a net housing stability benefit when compared with treatment as usual.

Inpatient treatment, rehabilitation and outpatient services

A small study conducted by Camden and Islington Mental Health and Social Care Trust considered whether admission to a designated ward for the homeless mentally ill improved outcome in terms of housing stability and engagement with services 12 months after discharge. There were 29 cases and 21 controls. Cases were more likely to be street homeless on admission. Both groups were equally likely to be discharged to stable accommodation and at 12 months there was no difference in their housing stability. Cases however were more likely to be engaged with services. All cases and controls were clients of a specialist community mental health team for homeless people with mental illness.

A study to assess a psychiatric rehabilitation approach for organising and delivering services to street homeless people with severe mental illness was conducted in New York City. The rehabilitation approach offered outreach and engagement, an invitation to attend a low demand centre that offered services such as food and showers and assistance in obtaining health, mental health and dental services and developing and implementing rehabilitation plans; respite in 10 bed informal church based shelters or in a block of YMCA rooms overseen by programme staff and in community and on-site rehabilitation services to assist individuals in finding and
maintaining community based housing. Client to staff ratio was about 13:1. Staff were rehabilitation specialists who had received training and had ongoing supervision from Boston University. Respite staff oversaw the respite housing and operated the centre on weekends and holidays. Many respite staff had been homeless and were in recovery from substance misuse. Standard treatment included a range of programmes for homeless people and speciality programmes for homeless people with mental illness. 91 people were assigned to the rehabilitation programme and 77 to standard treatment. At 24 month follow up those in the rehabilitation group were more likely to attend a day programme (53% vs 27%), spent less time on the streets (55% vs 28% reduction) and spent more time in community housing (21% vs 9% increase). They also reported greater improvement in life satisfaction and reduced psychiatric symptoms.

A study conducted in Philadelphia, USA explored the relationship between prompt receipt of aftercare services following discharge from acute hospital care for mental illness and episodes of homelessness. The study population of 150 was drawn from all shelter users who had a recorded stay in the Philadelphia emergency shelter system between July 1 1991 and June 30 1992 and had a psychiatric hospitalisation within 180 days of their initial shelter stay. 96 of the sample had only 1 shelter stay prior to the index hospitalisation; the remaining (54) had used the shelter system repeatedly for several stays before their hospitalisation. Follow up was for one year following the index hospitalisation. Only 41% were successfully connected to aftercare services within 30 days of discharge. Those who had had a single shelter stay who were connected with outpatient services within 30 days of discharge from hospital were less likely to become homeless again than those who were not connected. Although those with multiple shelter stays were successfully connected with aftercare services at the same rate as those with single stays they did not experience a decrease in homelessness as a result. The effectiveness of aftercare and outpatient services in preventing or delaying homelessness appeared to be related to homelessness prior to hospitalisation.

Subsidised independent housing

A demonstration project carried out in San Diego, California assessed the impact of using section 8 certificates as a means of providing permanent housing to homeless people with mental illness. Section 8 is a federal programme allowing certificate holders to pay 30% of their income for a private rental unit. The programme does not require individuals to live in special low income housing but encourages holders to seek private housing in the community. 362 clients were assigned to one of two types of supportive case management (comprehensive or traditional) and one of two levels of access to independent housing using section 8 certificates. Clients were followed up for a period of two years. Analysis showed that those with section 8 certificates entered stable housing more rapidly than those without, but access to a section 8 certificate did not increase the probability of achieving stable housing overall.

Permanent supportive housing

The concept of permanent supportive housing seems to have come from the United States Department of Housing and Urban Development and is an element of the Department’s principal programme to meet the needs of homeless people with disabilities. The programme was established to offer homeless people with disabilities, including mental illness, an assurance of permanent housing and
appropriate supportive services. Programmes differ in detail but involve community based housing (usually subsidised via section 8 certificates) and residential support teams. Residential teams provide support to maintain independent living, programmes can be scattered site or cluster based. The residential support teams are usually mobile, not facility based and do not have offices in the buildings where their clients are located. A meta-analysis of housing models for people with mental illness found that all models achieved greater housing stability than non model housing and that permanent supported housing achieved the greatest effect (effect size = .63, P<0.05)\(^19\). Non model housing included people living on the street, using shelters or living in housing described as treatment as usual.

A study conducted in New York City compared the impact of two supported housing programmes against the impact of community residences\(^20\). In the first supported housing programme tenants mainly lived alone in studio or one bed apartments located throughout the city. Sobriety and treatment were not preconditions of housing. An ACT team saw the tenants at least once a week and provided medication, money management and other support and treatment services. The team was available 24 hours a day, 7 days a week. Recreational programmes were offered at a central location. In the second programme tenants lived in studio apartments in a residential hotel. 30% of the apartments in the hotel were for people with a mental illness. Tenants were screened for evidence of six months clean and sober and could be asked to leave if they did not maintain ‘good neighbour status’. On site crisis services were available at all times as was on site case management and additional services and amenities such as a job training programme, gym and computer room. In each programme residents paid 30% of their income in rent. The community residence sites were buildings with single or shared rooms or studio apartments. They were solely for people with mental illness and substance use disorders. Buildings had common dining, meeting and services space. Each tenant was assigned a housing case manager and attendance at a day treatment or rehabilitation programme was strongly encouraged. Sobriety was closely monitored, loss of sobriety led to mandatory treatment or expulsion. Tenants gave their monthly income to the programme, a personal needs allowance was returned to them. 67 participants entered supported housing and 72 community housing. After 18 months tenure in housing did not differ by housing type but tenants in supported housing reported greater housing satisfaction in terms of autonomy and economic viability.

237 people with serious mental illness living in supported independent residences in Philadelphia were followed up for 30 months\(^21\). Residential support teams provided support to tenants to maintain independent living through skills development and by linking them to community based mental health services. 6 to 12 months clean and/or sober was a condition of acceptance onto the programme. 69% of tenants maintained continuous residence during this period. 14% had a positive departure. Positive departure referred to moving to a higher level of independence including living alone or living with a spouse in other subsidised housing, living in unsubsidised market rate rental housing or privately owned housing. A higher income was associated with increased probability of positive departure. 17% experienced a negative departure. A negative departure referred to leaving supported independent living for less independent settings. These included nursing homes, psychiatric hospitals, mental health residential programmes, drug and alcohol treatment facilities as well as jail or
return to shelters or the streets. A self reported past substance abuse problem increased the probability of a negative departure.

Another study conducted in Philadelphia between 2001 and 2005 examined the experience of 943 residents of permanent supportive housing\textsuperscript{22}. All residents had a mental illness. Permanent supportive housing included a variety of approaches but all were subsidised with no stay limit. The study was retrospective and explored difference between those who stayed in the housing and those who left. Those who left were followed up for 18 months after they left. Leavers were designated either positive or negative. Individual use of behavioural health services was found to be a key factor predicting leaving or staying. Leavers as a group were more likely to, have experienced inpatient mental health care, used community residential services and to have used emergency medical services during their tenure in permanent housing. Those who stayed had more contact with community residential services prior to entering permanent housing and more contact with outpatient services during their stay. This suggests difference in the mental health status of the two groups. Relapses in mental health status may have contributed to failure to maintain tenure in permanent housing. One third of those who left were described as positive leavers, these moved to independent and other living arrangements.

A study published in 2002 assessed the impact of public investment in supportive housing for people with mental illness\textsuperscript{23}. Data was available on 4,679 people housed in New York City between 1989 and 1997. The results of the study showed that people placed in supportive housing had marked reductions in shelter use, hospitalisation, length of stay per hospitalisation and time in custody. Before placement homeless people with mental illness cost about $40,451 per person per year in services. Placement was associated with a reduction in service use of $16,281 per housing unit per year. Annual unit costs were estimated at $17,277, for a net cost of $995 per unit per year over the first two years (1999 costs). This meant that 95% of the costs of the supportive housing were compensated for by reductions in use of other services that could be attributed to the housing placement.

A more recent study undertaken in San Francisco looked at the impact of permanent supportive housing on the use of acute care by homeless people with mental illness, substance misuse problems and other disabilities\textsuperscript{24}. The sample consisted of 236 single adults placed in two supportive housing sites between October 1994 and June 1998. Eighty percent had a diagnosis of mental illness and a substance misuse disorder. 81% remained in permanent supportive housing for at least one year. In comparison with service use in the year before, placement in supportive housing significantly reduced the percentage of residents with an emergency department visit (53% to 37%), the mean number of visits per person (1.94 to 0.86) and the total number of emergency department visits (56% decrease from 457 to 202). Permanent supportive housing placement significantly reduced the likelihood of being hospitalised (19% to 11%) and the mean number of admissions per person (0.34 to 0.19 admissions per resident).

**Integrated services**
The ACCESS (access to community care and effective service supports) programme in the USA set out to evaluate the effectiveness of efforts to improve the integration of services on outcomes for homeless people with severe mental illness\textsuperscript{25}. The
programme provided technical support and funding to support systems integration. Programme sites were compared with nine other sites. These comparison sites received funding to support outreach and assertive community treatment to assist 100 clients each year at each site. Service integration was measured by assessing client referrals, information exchanges and funding flows between agencies in the ACCESS network. Clients at all sites demonstrated improvements in all outcome measures however clients at the experimental sites showed no greater improvement on mental health or housing outcomes than those at comparison sites.

**Veterans**
In 1992 the US department of Housing and Urban development (HUD) and the US Department of Veterans Affairs (VA) established the HUD-VASH supported housing programme. In a study assessing the effectiveness of the programme 460 homeless veterans with psychiatric and/or substance disorders were randomised to one of 3 groups. The first received section 8 vouchers and intensive case management (HUD-VASH); the second case management only and the third standard VA care. Follow up was over three years. Those in the HUD-VASH group had 16% more days housed than the case management only group and 25% more than standard care. The case management only group had 7% more days housed than the standard care group. The HUD-VASH group also had 35% and 36% fewer days homeless than each of the control groups. There were no significant differences on any measures of psychiatric or substance misuse status. HUD-VASH was 15% more expensive than standard care. A reanalysis of the data from the HUD-VASH study that accounted for missing observations showed that the intervention was also associated with improved substance misuse outcomes (fewer days intoxicated).

A five year follow up from the same study examined the risks and predictors of returning to homelessness in a sample of 392. The 392 were those from the original sample of 460 who had been housed at some point after the baseline interview. It should be noted that only 150 participants were followed up for the full five years. Participants who were in the Section 8 voucher and case management group had significantly longer periods of continuous housing in comparison with those in the other two groups. Decreased housing tenure was also predicted by drug use and post traumatic stress disorder.

**Women**
A study of 149 homeless mothers with young children who took part in a substance abuse programme conducted in St Louis, USA compared the effectiveness of residential and non residential treatment programmes. Although very high numbers dropped out of both programmes, both groups showed improvements in housing stability over time. Follow up was for 18 months. Lower overall housing stability was predicted by psychiatric and legal problems.

**Health advocacy**
A small intervention study conducted in Liverpool assessed the effectiveness of a health advocate’s work with homeless people in a primary care setting. Homeless people moving into hostels or other temporary accommodation (outreach group) and those registering at an inner-city health centre as temporary residents were allocated to health advocacy or care as usual. 222 people (of 326) returned baseline questionnaires and 117 follow up questionnaires. The role of the advocate was to help
homeless people access health and associated care. Frequently this involved liaison with housing departments. At three month follow up a higher proportion of the outreach advocacy group were either re housed or had achieved a positive housing outcome (70% compared with 50% in the control group and 59% of the health centre advocacy group). This finding was not statistically significant.

**Adolescents**
A Cochrane Review considered the effectiveness of independent living programmes in improving outcomes for young people leaving the care system. Housing was included as an outcome. The reviewers found no controlled trials that met their inclusion criteria. They identified 18 studies that reported generally favourable outcomes for independent living programmes but concluded that no reliable inferences could be drawn from these studies because of their weak methodology.

**Families**
A study in New York City explored processes of family entry to and exit from homelessness shelters. The study used 8 years of administrative data from January 1988 to October 1995. The significance of type of housing placement at shelter discharge as a predictor of re-entry was tested. 27,919 shelter exits were considered. An exit was defined as a departure lasting 30 continuous days. 48% of exits were to subsidised housing; 41% were unknown and 7.5% were to apartments the families found themselves or to the families former residence. Families were observed for two years after they left the shelter. 37% of families who exited to unknown arrangements re-entered, 13.2% of those who went to their own housing and 7.2% who went to subsidised housing. Housing placement type was a significant predictor of shelter readmission.

**Discussion**
This rapid evidence review was undertaken to consider the extent to which there is an evidence base underpinning interventions designed to prevent homelessness by supporting vulnerable people in maintaining and retaining appropriate accommodation.

This literature review does not provide clear and unambiguous evidence of which interventions are likely to be most effective in preventing homelessness in vulnerable people. Furthermore, the extent to which the evidence can be applied to the Supporting People Programme in Wales needs to be considered.

Most studies have been conducted at single sites within the USA. Outcomes will have been influenced by both local and national factors. Most study populations were single people, often male, often African-American and usually with mental illnesses and/or substance misuse problems. Much of this differs from the situation in Wales.

The programmes studied are diverse. There are differences in philosophy, the way in which people were recruited and the types of housing and support provided. The outcomes studied are diverse; various different definitions of homelessness and stable housing have been used. Follow up periods are often short. All of these make comparing different approaches and applying the evidence to the Welsh setting difficult. At an individual level the effectiveness of an intervention will be influenced by individual circumstances. For example severity of substance misuse, psychiatric
symptoms, level of functioning, economic circumstances and the availability of social support. Despite these issues the evidence does provide some general guidance on the types of interventions and approaches that may be beneficial.

The evidence suggests that housing first approaches, where people are housed directly from the street without the need to engage with treatment and be clean and/or sober, in combination with assertive community treatment can be effective in maintaining people with mental illness and/or drug and alcohol problems in stable housing for substantial periods of time. Some evidence suggests that those housed directly from the streets might be less likely to maintain their housing status than those recruited from shelters, hostels or other sources. There is also evidence that some of the housing costs of this type of approach may be offset by reductions in use of other health and criminal justice services. In these studies it is not possible to separate the effect of the housing first approach from that of ACT.

Other evidence supports the effectiveness of ACT alone but some suggests that any housing intervention plus support is superior. Recent studies conducted in the UK have found that ACT delivered by assertive outreach teams was not more effective than community mental health treatment in preventing homelessness. It has been argued that this may be because ACT delivered in UK studies differed significantly from the original model developed in the USA. In the USA model cases are shared and not managed by individuals, case numbers per team member are low (10 – 12) and teams deliver a broad range of interventions. These include independent living skills, money management as well as psychological therapies and medication management. A large multi-site study in the USA found that for people with mental illness their relationship with their case manager was important. Those who formed a therapeutic alliance with their case manager had fewer days homeless at follow up. Therapeutic alliance is a concept widely discussed within psychotherapy, particularly those adopting a psychotherapeutic approach. It is not an easily defined, described or measured concept.

Some evidence from outreach programmes suggests that these approaches can be useful in engaging street homeless people with high levels of psychiatric morbidity. Although housing outcomes may not be as good as for those already engaged with services, this type of approach can lead to improvements in housing, quality of life and health outcomes. Outreach to street homeless combined with a psychiatric rehabilitation programme may also reduce time spent on the streets. A small study conducted in Liverpool suggests that outreach health advocacy (delivered in hostels or temporary accommodation) might be useful in improving housing outcomes. This UK study is one of the few where participants were not confined to those with mental health and substance misuse problems. The health advocates role was to support people in accessing care and services including housing. Critical time interventions designed to strengthen engagement with services and social support and provide an emotional support during transition from institutional care to community housing have been shown to reduce homelessness in men with severe mental illness.

Permanent supported housing programmes usually provide subsidised housing combined with support to maintain independent living. Support often involves an ACT approach providing treatment, medication management, money management and independent living skills. There is evidence that these types of models are
effective for people with mental health and/or substance misuse problems, including veterans as well as people with other disabilities\textsuperscript{19-24, 27}. For homeless families there is very little evidence of effective interventions. A large observational study from New York suggests that the most important predictor of stable housing for families leaving homeless shelters is the availability of subsidised housing.

**Conclusion**

This rapid evidence review supports the review of the Supporting People Programme in Wales. It considers the evidence base for interventions to help vulnerable people obtain and maintain appropriate housing and is restricted to analytic studies. The evidence base presented in this document is derived largely from studies conducted at single sites in the USA involving people with mental illness and/or substance misuse. This limits generalisability to other settings; generalisability to the Supporting People programme in Wales is likely to be further limited. The evidence does provide some general guidance on the type of interventions that may be of benefit. An analysis of descriptive studies may provide further evidence on how interventions can be effectively implemented.

Overall the evidence suggests that providing vulnerable people with support can lead to significant reductions in homelessness. The definition of support is broad and includes access to subsidised housing and psychosocial support. Psychosocial support includes helping people engage with services and develop money management and other independent living skills. Those who are the most difficult to engage and who have the greatest problems may be more difficult to maintain in stable housing, nevertheless there is evidence that they can be successfully housed. Some of the costs of providing supported housing may be offset by reductions in the use of emergency medical care and criminal justice services.
References


5. Larimer ME et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA* 2009; 30: 1349-57


36. Killaspy H. *Assertive outreach services – should we integrate them with CMHTs? Recent experience and evidence from England.* Presentation to Wales Mental Health Managers Network, The Pavilion, Llandrindod Wells, Powys. 7th September 2010
Appendix Evidence tables

The convention used in these tables to indicate the type of evidence is:

**Type I:** well-designed systematic review (including at least one randomised controlled trial)
**Type II:** well-designed randomised controlled trial
**Type III:** well designed interventional studies without randomisation
**Type IV:** well designed observational studies
**Type V:** expert opinion; influential reports and studies


### Housing first approaches

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<th>Reference, location &amp; type</th>
<th>Intervention</th>
<th>Participants</th>
<th>Follow up and outcome</th>
<th>Comments</th>
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<tr>
<td>Gulcur L et al. Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programs. <em>J Community Appl Soc Psychol</em> 2003; 13: 171-86</td>
<td>Housing first programme vs continuum of care</td>
<td>Chronically homeless individuals with mental illness +/- substance misuse 126 control condition 99 housing first 76% male, ages 18-70, 28% white, 40% African-American, 33% Hispanic 68 of participants were recruited from psychiatric hospitals and 157 from the streets</td>
<td>2 years, 90% follow up</td>
<td>Repeated measures ANOVA showed significant effect of programme assignment on proportion of time homeless, the control group spent significantly more time homeless ($F = 19.8, df = 1, 195 p &lt;0.001$). The sample recruited from the streets spent a significantly larger proportion of the time homeless ($F = 63.4, df = 1, 195, p &lt;0.001$) but the experimental condition reduced rates of homelessness more for this sample ($F= 12.2, df= 1, 195 p&lt;0.001$). There were also significant time x programme, time x sample and time x programme x sample effects. Impact on proportion of time hospitalised was also reported.</td>
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<td>*Tsemberis S, Eisenberg RF. Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatr Serv 2000; 51: 487-93. Available at: <a href="http://psychservices.psychiatryonline.org/cgi/reprint/51/4/487">http://psychservices.psychiatryonline.org/cgi/reprint/51/4/487</a> [Accessed 2nd Aug 2010]</td>
<td>Pathways to Housing supported housing programme (housing first approach with support services delivered using modified ACT) vs linear residential treatment approach</td>
<td>Street homeless people with mental illness housed between January 1993 and September 1997. Intervention group 242, control 1,600. Intervention group 67% male, 56% black, 28% white, 13% Hispanic, 58% substance misuse. Control group 73% male, 55% black, 20% white, 19% Hispanic, 49% substance misuse</td>
<td>5 years maximum but no indication of proportion of participants followed up for a full five years. At 5 years 88% pathways and 47% control remained housed. Cox regression survival model used to control for differences in client characteristics that may have contributed to housing tenure. Type of programme was the second most important predictor of tenure (risk ratio .235, P &lt;0.001), age the first (risk ratio p &lt;0.001). Dual diagnosis reduced housing tenure in both programmes.</td>
<td>Samples differed significantly on all characteristics at baseline except age. Participants in experimental condition more likely to have schizophrenia, those in control more likely to have mood disorders. It is not clear what proportion of participants could be followed up or for how long.</td>
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<td>Pearson C, Montgomery AE, Locke G. Housing stability among homeless individuals with serious mental illness participating in housing first programs. <em>J Community Psychol</em> 2009; 37: 404-17</td>
<td>Housing first approach to provide permanent supportive housing. DESC in Seattle; outreach, housing in DESC owned buildings with 24 hr onsite staff trained in property management and supportive services. Pathways to housing in NYC recruitment by referral, subsidised housing and ACT. Initial placement may be in a shelter or temporary housing. ACT teams provide intensive clinical, rehabilitation and support. REACH in San Diego. Programme entry from streets via outreach to safe haven or Single room hotel before moving to permanent housing, case managers coordinate services, available 24/7</td>
<td>80 Single homeless adults with SMI +/- substance misuse recruited between June 2003 and June 2004 25 participants DESC, 26 pathways to housing, 29 REACH DESC: mean age 47.9, 64% white, 84% male, 84% substance misuse, 52% schizophrenia or other psychotic disorder. Pathways: mean age 47, 31% white, 85% male, 77% substance misuse, 85% schizophrenia or other psychotic disorder. REACH: mean age 39.7, 66% male, 55% white, 66% substance misuse, 59% schizophrenia or other psychotic disorder</td>
<td>80% followed up for 12 months 84% of participants remained housed at 12 months, no statistically significant differences in housing stability between the programmes. Participants who entered from the streets most likely to leave (p&lt;0.10), those with highest levels of stability entered from shelters, jail or psychiatric hospital. All women were stayers (p&lt;0.05). There were no significant changes in psychiatric symptoms or substance use.</td>
<td>Significant differences in baseline characteristics</td>
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<td>Reference, location and type</td>
<td>Intervention</td>
<td>Participants</td>
<td>Follow up and outcome</td>
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<td>Larimer ME et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. <em>JAMA</em> 2009; 30: 1349-57</td>
<td>Housing first programme for homeless adults with alcohol problems. Housed on one site, no treatment requirement, allowed to drink in rooms. On site case managers, meals and on site health care also available</td>
<td>Chronically homeless with severe alcohol problems +/- other psychiatric and physical problems enrolled between November 2005 and March 2007. 81 housed, 53 waiting list controls. Treatment group 94% male, mean age 48, 40% white 27% Alaskan/native American, 7% African American. Controls 95% male, mean age 48, 36% white, 31% Alaskan/native American, 15% African American.</td>
<td>Intervention group 12 months, controls 6 months. Use and cost of services including jail bookings, days incarcerated, shelter and sobering centre use, hospital based medical service, alcohol and drug detox and treatment, emergency and other medical services. Significant difference between treatment and control groups in total costs, treatment groups costs 53% less over the first 6 months (rate ratio 0.47, 95% CI 0.25-0.88). Housed participants $3567 less per month during housed period relative to controls. Housing costs $1120 per person per month, mean cost offset of $2449. There was an approximately 2% decrease per month in daily drinking whilst participants were housed (rate ratio 0.98, 95% CI 0.96 – 0.99). Kendall coefficient of concordance showed a significant decrease in days intoxicated ($\chi^2 = 14.6, p = 0.003$).</td>
<td>76 in intervention group completed 12 month follow up (95 included in cost use analysis) and 29 in control group followed up to six months (39 included in cost-use analysis). Power analysis showed 0.80 could be achieved to detect standardised mean difference of 0.30 with 60 housed participants and 40 controls.</td>
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### Assertive community treatment/case management

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<th>Reference, location and type</th>
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<th>Participants</th>
<th>Follow up and outcome</th>
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<tr>
<td>&quot;Nelson G, Aubry T, Lafrance A. A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. Am J Orthopsychiatry 2007;77:350-61&quot;</td>
<td>Controlled outcome evaluations of housing and support interventions for people with mental illness who have been homeless</td>
<td>With mental illness +/- substance misuse 10 controlled studies</td>
<td>6 studies compared permanent housing plus support with standard treatment average effect size 0.67 3 studies compared permanent housing and case management with case management only an effect size ($ES = 0.37$) could only be calculated for 1 study 2 studies compared short term residential treatment with standard treatment. An effect size (-0.43) could be calculated for 1.</td>
<td>Literature review assigned type III because of limitations in the methodology of the review and the included studies Considerable baseline differences between studies in participant characteristics for example % with schizophrenia ranges from 5 to 82 and substance misuse from 0 to 100</td>
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All included studies undertaken in the USA. Boston, San Diego, New York, Dan Francisco, New Orleans, Cleveland, Chicago, Los Angeles, Washington and Florida  
Study type III Literature review
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<th>Reference, location and type</th>
<th>Intervention</th>
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<th>Follow up and outcome</th>
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| Clark C, Rich AR. Outcomes of homeless adults with mental illness in a housing program and in case management only. *Psychiatr Serv* 2003; 54; 78-83. Available at: [http://ps.psychiatryonline.org/cgi/reprint/54/1/78](http://ps.psychiatryonline.org/cgi/reprint/54/1/78) [Accessed 2nd Aug 2010] | Guaranteed access to housing, housing support services and case management (2 programmes) against case management only | Homeless people with severe mental illness  
Housing programme 69 case management only  
Housing programme 52% male, 81% white. Case management 51% male, 74% white | 12 month follow up, 71% had at least 1 follow up interview. 65% were assessed at 6 months and 58% at 12 months  
Chi square analysis found no significant differences in drop out rates as a function of demographic characteristics or as a function of past homelessness.  
Analysis did not show any significant differences in housing outcomes between the two groups.  
Participants with high levels of impairment showed less gain in stable housing and less reduction in functional homelessness in the case management only condition, but those with low and medium impairment did just as well as those in the comprehensive housing programme. | Experimental and control groups differed significantly in baseline housing status, number of times previously homeless, psychiatric symptoms and substance use. Those in the case management only group were more impaired  
The case management only programme had links to services similar to those provided by the other two programmes but did not have the guaranteed housing and housing services aspects  
High level of attrition by 12 months, particularly in case management only group  
The method used for accounting for missing data is open to question |
The Supporting People Programme in Wales: Final Report

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<tr>
<td>St Louis, Missouri</td>
<td>Brokered case management in which clients needs assessed, services purchased for providers, client monitored; ACT only comprehensive services provided for an unlimited period and ACT augmented by support from community workers assisting with activities of daily living</td>
<td>58% male</td>
<td>Both assertive community treatment only and assertive community treatment with community workers groups received more assistance from the programme than clients in the other group</td>
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<td>Study type III</td>
<td>55% African –American</td>
<td>45% white</td>
<td>ANOVA showed a significant treatment group effect for days in stable housing ($F=3.54$, $df = 2,129$, $p&lt;0.032$) Clients in assertive community treatment only averaged more days in stable housing at 18 months than in the other 2 conditions.</td>
<td>No comparison of baseline characteristics</td>
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<td>Numbers in each group not provided</td>
<td>135/165 followed up at 18 months</td>
<td>The numbers in each condition do not appear in the paper, no information on attrition rates in each group, makes it difficult to assess the quality of the study.</td>
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<td>Chinman MJ, Rosenheck R, Lam JA. The case management relationship and outcomes of homeless persons with serious mental illness. <em>Psychiatr Serv</em> 2000; 5: 1142-7. Available at: <a href="http://psychservices.psychiatryonline.org/cgi/reprint/51/9/1142">http://psychservices.psychiatryonline.org/cgi/reprint/51/9/1142</a> [Accessed 2nd Aug 2010]</td>
<td>Study followed first two cohorts entering the access to community care and effective services support (ACCESS) programme in 1994. The programme provided outreach and intensive case management for people homeless with severe mental illnesses</td>
<td>3,481 provided baseline assessments, mean age 38.5, 64% male, 45% African American, 6% Hispanic, 45% major depression, 66% psychotic disorder, 44% alcohol use disorders, 38% drug use disorders</td>
<td>2,798 (80.4%) clients were followed up at 12 months. This group were less likely to be male and more likely to be African American than those lost to follow up. Analysis was undertaken using three one-way multivariate analyses of covariance (MANCOVAs) Clients who reported a high alliance (measured using the Therapeutic Alliance Scale Horvath and Greenberg, 1989) with their case manager at 12 months had significantly fewer days of homelessness at 12 months than those with a low alliance. Those who reported a low alliance at 12 months had fewer days of homelessness than those who reported no alliance ($F = 15.97, df = 2, 2, 404$, $p&lt;0.002$) There was no significant association between the relationship with case manager at baseline and outcomes at 12 months.</td>
<td>See also reference 11</td>
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<td>Lam JA, Rosenheck R. Street outreach for homeless persons with serious mental illness. <em>Med Care</em> 1999; 37: 894-907</td>
<td>ACCESS (access to community care effective services and supports), 5 year demonstration programme examined whether street outreach population were different from the rest of the homeless population in terms of psychiatric impairment, can they be successfully engaged and do they benefit from services. Street outreach from specialised teams to make contact with people with untreated mental illness &amp; facilitate contact with more intensive services, then intensive case management providing services for up to 1 year.</td>
<td>11,857 homeless people with mental illness contacted at outreach (May 1994- May 1997), 5,431 entered case management. Mean age 38.5, 62.7% male, 44.5% African American, 67% had a psychotic disorder and/or bipolar disorder, 43% alcohol misuse, 38% drug misuse</td>
<td>4,587 followed up at 3 months. Clients contacted through street outreach were more psychiatrically impaired, less interested in treatment than those contacted in other settings and were less likely to be enrolled in case management (p&lt;0.001)</td>
<td>See also reference 10</td>
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<td>18 sites USA Bridgeport and New Haven, Connecticut; uptown and loop area, Chicago; Topeka and Wichita, Kansas; St Louis and Kansas City, Missouri; Raleigh and Charlotte, North Carolina; West and centre city, Philadelphia; Fort Worth and Austin, Texas; Richmond and Hampton/News, Virginia and Uptown and Downtown Seattle, Washington.</td>
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<td>After controlling for baseline differences at 3 months both the street and other outreach population showed a significant increase in the number of days housed in the past 60 days compared to baseline (Street sample 8.84% to 25.08% t=11.58, p&lt;0.001; other outreach sample 14.75% to 30.8%, t=36.1, p&lt;0.001). The difference between to two groups was significant (p&lt;0.001)</td>
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### Shelter based interventions

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<tr>
<td>&quot;Bradford DW et al. Can shelter-based interventions improve treatment engagement in homeless individuals with psychiatric and/or substance misuse disorders? A randomized controlled trial, Med Care 2005; 43: 763-8&quot;</td>
<td>Shelter based intervention including intensive outreach by a psychiatric social worker, weekly visit with the same psychiatrist designed to support individuals into treatment. Management included psychotherapy and pharmacotherapy and case management which emphasised staying in mental health treatment and working towards housing, employment or disability application. The control group saw another psychiatrist and saw a different psychiatrist at each visit. They could schedule appointments with shelter staff for case management services but had to do this on their own initiative.</td>
<td>Recruited between March 2002 and December 2003 102 mentally ill homeless people with substance misuse disorder, 51 in each condition. Intervention 64.7% male, mean age 39.09, 35.3% white, 64.7% black, substance disorder 44.7%, psychotic disorder 8.5%  Control 72.6% male, mean age 39.68, 41.2% white, 54.9% black, substance disorder 30%, psychotic disorder</td>
<td>Follow up to shelter exit Those receiving the intervention were more likely to attend 1 or more community mental health centre appointments (64.7% vs 37.3%, p=0.006, risk difference 0.27 (0.09-0.46, NNT 3.64 (2.17-11.38, relative risk 1.74 (1.15-2.62)) and to participate in a substance misuse programme (51.4% vs 12.5%, p=0.083, risk difference 0.32 (0.16-0.48), NNT 3.13 (2.08 -6.25), relative risk 4.20 (1.72-10.26)) but there were no significant differences in attending 3 visits, being employed or having housing at shelter exit</td>
<td>Small study Of 154 consecutive referrals to psychiatry clinic during recruitment period, 120 were assessed of whom 102 were enrolled. Control group had lower levels of substance misuse and psychotic disorder.</td>
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### Critical time interventions

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<tr>
<td>Susser E et al. Preventing recurrent homelessness among mentally ill men: A “critical time” intervention after discharge from a shelter. <em>Am J Public Health</em> 1997; 87: 256-62. Available at: <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380803/pdf/ajphp00501-0114.pdf">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380803/pdf/ajphp00501-0114.pdf</a> [Accessed 2nd Aug 2010]</td>
<td>Critical Time Intervention for 9 months vs services as usual. CTI aimed to enhance continuity of care for individuals being discharged from a shelter to community living. All discharged to supportive housing, broad spectrum of provision including intensively supervised community residences and single room occupancy hotels with on site social services</td>
<td>96 men with severe mental illness and comorbidities including substance misuse. 48 control, 48 intervention; all were patients discharged from an on site psychiatry programme in a men’s shelter during 1991 to 1993</td>
<td>18 months, complete data for 94 participants</td>
<td>Mean number of homeless nights was 30 for the CTI group and 91 for services a usual (Difference -61, 95% CI -105, -19, using non-parametric bootstrap, -110, -19, z= 2.8, P=0.003). During the last month of follow up 4 in the CTI and 11 in standard treatment were homeless (χ² = 3.87, df=1, p=0.5, relative risk 0.36, 95% CI 0.12 to 1.06). Extended homelessness (more than 54 nights) occurred in 10 of the CTI group and 19 in standard treatment (χ² = 4.0, df = 1, p=0.045, relative risk 0.53, 95% CI 0.27 to 1.01) Over the study period CTI group incurred mean costs of $52, 374 and standard treatment $51,649 for acute care, outpatient, housing and shelter services, criminal justice and transfer income. For each willingness to pay value four greater than $152, the CTI group demonstrated significantly greater net housing stability benefit, indicating cost effectiveness, compared with usual care</td>
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<tr>
<td>New York City</td>
<td>CTI two components. First to strengthen the individuals ties to services, family and friends. Second to provide practical support during transition. Clinical plan devised for transfer of care from shelter to other formal and informal supports, focused on specific areas of potential discontinuity related to the risk of homelessness for that individual, for example medication management, money management. Each man was assigned to a CTI worker (supervised by a psychiatrist or other mental health worker) CTI needed to have previous experience of working with this population and ‘street smarts’. CTI work included visiting the family home or community residence, attending appointments with client and providing crisis support. The CTI worker spent time with the client in the 2 weeks post discharge and observed the client in their physical and social surroundings, subsequent support was individually tailored.</td>
<td>The usual service group were referred to mental health and rehabilitation programmes.</td>
<td></td>
<td>No detail on method of randomisation so designated type III study. There is potential for the type of housing placement to have influenced number of homeless nights and homelessness at 18 months. There is no discussion of type of placement or possible influence. The authors note that all participants had already completed on site treatment before discharge so the most challenging clients may have been excluded from the study.</td>
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4 The additional price society is willing to spend for an additional non homeless night.
### Inpatient treatment, rehabilitation and outpatient services

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<td>Kilaspy H et al. Treating the homeless mentally ill: does a designated inpatient facility improve outcome? <em>Journal Ment Health</em> 2004; 13: 593-9</td>
<td>Admission to a designated ward for homeless mentally ill to improve 12 months outcome in terms of housing stability and engagement with services.</td>
<td>All participants were clients of a specialist community mental health team for homeless mentally ill people. Cases were admissions to designated ward for homeless mentally ill between January 2001 and January 2002. Controls were admitted elsewhere.</td>
<td>12 months</td>
<td>Small underpowered study. 40 participants required for 80% power at 0.05 level, to show proportion of patients remaining in stable accommodation 12 months after discharge to be around 70% compared with 20% for other wards assuming equal number of cases and controls. Of 50 admissions in the study period only 32 agreed to participate.</td>
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<td>Camden and Islington.</td>
<td>19 cases and 13 controls. Cases more likely to be street homeless at admission ($\chi^2 = 5.5, df=1, p=0.02$) and had moved more frequently in the preceding 12 months ($p=0.04, 95%$ CI 0.13 to 5.0)</td>
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<td>Study type III</td>
<td>Cases and controls were equally likely to have a problem with alcohol or drugs. There were no statistically significant differences between cases and controls in mean ratings of engagement with services or influences on medication compliance.</td>
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<td>Both groups were equally likely to be discharged to stable accommodation ($\chi^2 =1.16, df=1, p=0.29$) and 12 months later there was no difference in their housing stability. (Proportion in stable housing $\chi^2 =0.55, df=1, p=0.46$, mean days in stable housing mean difference = 33.4, 95% CI -67 to 134, $df=47$, $p=0.51$).</td>
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<td>Over the 12 months mean engagement scores improved significantly in both groups but the proportion who showed any improvement from baseline was significantly higher amongst cases ($\chi^2 =4.49, df=1, p=0.04$), however using an ANCOVA model and considering the changes form baseline there was no significant between group difference ($F=1.8, df=1, p=0.19$)</td>
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| Shern DL et al. Serving street-dwelling individuals with psychiatric disabilities: outcomes of a psychiatric rehabilitation clinical trial. Am J Public Health 2000; 90: 1873-8 | Choices an approach for organising and delivering services designed to overcome access barriers and any dissonance between services offered and client defined needs compared with standard treatment. Standard treatment was all usual homelessness and specialty mental health service offered in New York City; including outreach, drop in centres, case management, mental health care, case management programmes, soup kitchens, municipal and private shelters. Speciality housing ranging from structured community residences to independent apartments was available to both experimental and control groups. Choices included:  
- outreach and engagement to develop relationships between Choices staff and homeless people  
- Invitation to attend Choices centre, a low demand environment where resources such as food and showers were available between 7am and 7pm. Participation in structured activities was not required, assistance was available in obtaining health, mental health, dental and social services and in developing and implementing individual rehab plans. The centre also offered the opportunity to socialise  
- Respite housing in 10 bed informal church based shelters or in blocks of YMCS rooms rented by the programme and overseen by programme staff. Choices was similar to intensive case management, staffed by 6 rehabilitation specialists with a client staff ratio of about 13:1 | Street homeless people with severe mental illness.  
Experimental group 91, control 77.  
No breakdown of characteristics by group.  
Typical subject described as non Hispanic 90%, black, 61%, male 76%, single 88%, aged approximately 40 years (mean 39.97, range 21-66) | 2 years, complete data only available for 44% of subjects. Differences in attrition between control and treatment groups, fewer experimental subjects were lost to follow up. Both groups showed decrease in time spent on the streets, the rate of decline was approximately twice as great in the experimental group (t=4.18, p<0.001) Those in the Choices group reported a 23% increase in the proportion of time they spent in shelters (rather than on the streets, (t= -5.73, p<0.001). The experimental group increased their time in community housing at twice the rate of those in standard treatment (t=2.27, p<0.05). At final follow up 38% of the experimental group were living in community settings and 24% of the control group. | Participants were diagnosed as mentally ill on the basis of street screening procedures.  
People assessed as being a risk to themselves or others were excluded.  
There appears to be few differences between the experimental and treatment as usual conditions. Statistically method used to account for missing observations might not be considered best practice by current standards. |
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<tr>
<th>Reference, location and type</th>
<th>Hypotheses</th>
<th>Participants</th>
<th>Follow up and outcome</th>
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<tr>
<td>Averyt JM et al. Impact of continuity of care on recurrence of homelessness following an acute psychiatric episode. Continuum 1997;4: 199-208. Available at: <a href="http://works.bepress.com/cgiviewcontent.cgi?article=1052&amp;context=dennis_culhane">http://works.bepress.com/cgiviewcontent.cgi?article=1052&amp;context=dennis_culhane</a> [Accessed 2nd Aug 2010] Philadelphia, USA Study type III</td>
<td>Homeless mentally ill people who receive an aftercare service within 30 days of discharge from inpatient hospitalisation are less likely to become homeless again in the following year. Timely aftercare services have more significant effect on preventing homelessness among those with single shelter stays than those with multiple shelter stays</td>
<td>Mentally ill, homeless people. 150 participants drawn from all shelter users who had a recorded stay in the emergency shelter system between July 1 1991 and June 30 1992 and had psychiatric hospitalisation within 180 days of their initial shelter stay. 96 had 1 shelter stay prior to hospitalisation, 54 used the shelter system repeatedly before hospitalisation</td>
<td>Follow up 1 year following index hospitalisation There was a significant difference in the mean length of initial shelter stay between single and multiple stayers (single stayers 61.4 days, multiple stayers 16.5 days t test p=0.001) 34% of single stayers and 59% of multiple stayers had a homeless episode in the year following discharge ($\chi^2$ p=0.003) 41% of all participants were successfully connected with outpatient services within 30 days of discharge. Single stayers who connected with outpatient services within 30 days of discharge were less likely to become homeless again than single stayers who were not connected ($\chi^2$ p=0.038). There was no difference in homelessness between multiple stayers who connected with services within 30 days of discharge and those who did not.</td>
<td>Part of the ACCESS programme see references 10 &amp; 11</td>
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### Subsidised independent housing

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<td>18 Hurlburt MS et al.</td>
<td>Effectiveness of section 8 certificates as a means of providing independent housing to the mentally ill homeless</td>
<td>People with severe mental illness either currently homeless or at risk of homelessness</td>
<td>2 years. 181/232 (78%)&lt;br&gt;Tests of differences between models found a significant association between section 8 manipulation and housing outcome (LR(5) = 43.05, p&lt;0.01) but no association between case management condition and housing outcomes (LR(5) = 6.05, p&gt;0.1)&lt;br&gt;Clients with comprehensive case management were no more likely to achieve stable housing than those with only traditional case management.&lt;br&gt;The prediction that section 8 clients would achieve stable housing was not confirmed (LR(1) = 2.92, p&gt;0.1). Access to section 8 certificates did not increase the probability of obtaining some type of stable housing.&lt;br&gt;Clients with access to section 8 certificates were more likely to achieve stable independent living arrangements than clients without access (LR (1) = 35.35, p&lt;0.01).&lt;br&gt;Within the group achieving stable living arrangements, those with access to section 8 were more likely to follow a stable independent housing pattern than those without (?odds ratio 7.56 95% CI 3.49 to 15.33)&lt;br&gt;Those with access to section 8 stabilised in independent housing faster than those without access (LR (1) = 16.7, p&lt;0.01, ? odds ratio 8.4 in the first 6 months, no confidence interval)&lt;br&gt;Clients without access to section 8 were more likely to achieve other types of community housing in the first 6 months (? Odds ratio 3.4, no confidence interval)</td>
<td>Analysis seems to be unnecessarily complex. Decision to analyse by type of housing appears to have been post hoc. Odds ratios seem to have been calculated but this is not actually stated in the text. Section 8 Section 8 is a federal programme allowing certificate holders to pay 30% of their income for a private rental unit, they do not require individuals to live in special low income housing but encourages holders to seek private housing in the community. Those with severe drug and alcohol problems were excluded from the study</td>
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<td>San Diego, California Study type III</td>
<td>Four conditions&lt;br&gt;Comprehensive case management + section 8 certificate&lt;br&gt;Traditional case management + section 8&lt;br&gt;Comprehensive case management – section 8&lt;br&gt;Traditional case management – section 8</td>
<td>232 from streets or shelters, 130 no stable home.</td>
<td>2 years. 181/232 (78%)&lt;br&gt;Tests of differences between models found a significant association between section 8 manipulation and housing outcome (LR(5) = 43.05, p&lt;0.01) but no association between case management condition and housing outcomes (LR(5) = 6.05, p&gt;0.1)&lt;br&gt;Clients with comprehensive case management were no more likely to achieve stable housing than those with only traditional case management.&lt;br&gt;The prediction that section 8 clients would achieve stable housing was not confirmed (LR(1) = 2.92, p&gt;0.1). Access to section 8 certificates did not increase the probability of obtaining some type of stable housing.&lt;br&gt;Clients with access to section 8 certificates were more likely to achieve stable independent living arrangements than clients without access (LR (1) = 35.35, p&lt;0.01).&lt;br&gt;Within the group achieving stable living arrangements, those with access to section 8 were more likely to follow a stable independent housing pattern than those without (?odds ratio 7.56 95% CI 3.49 to 15.33)&lt;br&gt;Those with access to section 8 stabilised in independent housing faster than those without access (LR (1) = 16.7, p&lt;0.01, ? odds ratio 8.4 in the first 6 months, no confidence interval)&lt;br&gt;Clients without access to section 8 were more likely to achieve other types of community housing in the first 6 months (? Odds ratio 3.4, no confidence interval)</td>
<td>Analysis seems to be unnecessarily complex. Decision to analyse by type of housing appears to have been post hoc. Odds ratios seem to have been calculated but this is not actually stated in the text. Section 8 Section 8 is a federal programme allowing certificate holders to pay 30% of their income for a private rental unit, they do not require individuals to live in special low income housing but encourages holders to seek private housing in the community. Those with severe drug and alcohol problems were excluded from the study</td>
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<td>1996; 24: 291-310</td>
<td>Comprehensive case managers had smaller maximum caseloads than traditional (22 vs 40), were available 24/7 and had higher salaries. Comprehensive case management adopted a formal team approach, attempted to establish support groups for clients in housing and tried to find them employment.</td>
<td>66.9% male, 63% white, 19.6% black, 12.4% Hispanic, 33.7% had been homeless for 4 years plus, 55.4% schizophrenia, 28.3% major depression, 16.3% bipolar disorder</td>
<td>2 years. 181/232 (78%)&lt;br&gt;Tests of differences between models found a significant association between section 8 manipulation and housing outcome (LR(5) = 43.05, p&lt;0.01) but no association between case management condition and housing outcomes (LR(5) = 6.05, p&gt;0.1)&lt;br&gt;Clients with comprehensive case management were no more likely to achieve stable housing than those with only traditional case management.&lt;br&gt;The prediction that section 8 clients would achieve stable housing was not confirmed (LR(1) = 2.92, p&gt;0.1). Access to section 8 certificates did not increase the probability of obtaining some type of stable housing.&lt;br&gt;Clients with access to section 8 certificates were more likely to achieve stable independent living arrangements than clients without access (LR (1) = 35.35, p&lt;0.01).&lt;br&gt;Within the group achieving stable living arrangements, those with access to section 8 were more likely to follow a stable independent housing pattern than those without (?odds ratio 7.56 95% CI 3.49 to 15.33)&lt;br&gt;Those with access to section 8 stabilised in independent housing faster than those without access (LR (1) = 16.7, p&lt;0.01, ? odds ratio 8.4 in the first 6 months, no confidence interval)&lt;br&gt;Clients without access to section 8 were more likely to achieve other types of community housing in the first 6 months (? Odds ratio 3.4, no confidence interval)</td>
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## Permanent supported housing

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<th>Intervention</th>
<th>Participants</th>
<th>Follow up and outcome</th>
<th>Comments</th>
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<tr>
<td>Leff HS et al. Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness. <em>Psychiatr Serv</em> 2009; 60:473-82. Available at: <a href="http://ps.psychiatryonline.org/cgi/reprint/60/4/473">http://ps.psychiatryonline.org/cgi/reprint/60/4/473</a> [Accessed 2nd Aug 2010]</td>
<td>Non model interventions – studies describing outcomes for people living on the street, using shelters, or residing in housing described as ‘treatment as usual’, no reference made to any service provided specifically to find housing or provide support. Residential care and treatment models providing room and board, supervision and in some cases treatment. Residential continuum models – housing models viewed as more ‘normalising’ than residential care and treatment. Services are not routinely provided and staff presence is limited. Residents are expected to leave their housing during the day to attend treatment, day activities or work. Residents are expected to move from one housing model to another as their rehabilitation progresses. Permanent supported housing models provide support and treatment but do not expect residents to move on to different accommodation as their needs change. Housing is generally a low demand or least restrictive environment.</td>
<td>Homeless, mentally ill people 30 studies included; 44 interventions, 13,436 total participants. 389 – non model interventions 1,636 residential care and treatment interventions 3,457 residential continuum interventions 7,954 permanent supported housing interventions</td>
<td>6 to 52 months  All three housing models achieved greater stability than non model housing. The effect size was greatest for permanent supported housing (effect size 0.63, p&lt;0.05 when compared with non model housing) but the differences in effect size between the three housing models were not significant. Residential care and treatment was significantly more effective in reducing psychiatric symptoms than non model housing (effect size 0.65, p&lt;0.05). Residential care and treatment and permanent supported housing were more effective than non model housing in reducing hospitalisation (effect sizes 0.34 and 0.72, p&lt;0.05). Permanent supportive housing achieved the greatest effect size for satisfaction (0.73) this was significantly greater than that for non model housing (p&lt;0.001) and residential care and treatment (p&lt;0.05)</td>
<td>Search strategy not comprehensive, restricted to USA, ?years included, limited databases. The decision to conduct a meta-analysis is open to question, there is insufficient information on the included studies to assess this properly. Interventions were grouped as one of four types and within each type interventions may not sufficiently similar. It is not clear if the validity of the included studies was assessed, however the authors conclusions are probably sufficiently cautious given the probable limitations of the meta-analysis.</td>
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<tr>
<td>New York City</td>
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<td>Study type III</td>
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<td>Effectiveness of supportive housing vs community residences</td>
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<td>Supportive housing tenants, mostly lived alone in one bedroom studio apartments located throughout the city. No precondition to be clean/sober. ACT team sees clients at least weekly, provides medication and money management, support and treatment, 24/7 availability. Community residences tenants live in studio apartments in a renovated residential hotel. Tenants pre-screened for 6 months clean/sober. On site services and case management are available.</td>
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<td>157 enrolled but data beyond baseline interview not obtained for 18 Consecutive tenants who gave consent and entered the selected sites between October 14 1998 and April 19 2000. All had a diagnosis of schizophrenia, schizoaffective, bipolar or depressive disorder</td>
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<td>18 months on 91/157 (58%) remained in study Tenure in housing did not differ by housing type. Tenants in supported housing reported greater satisfaction in terms of autonomy and economic viability. Independent of housing type symptoms of depression or anxiety at housing entry increased likelihood poorer outcomes</td>
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<td>Attrition meant fewer than 60% of original sample followed up Significant differences in group characteristics at baseline but no breakdown provided. Allocation to housing type may have been influenced by client characteristics. Decision to analyse by ‘propensity stratum’ appears to be post hoc.</td>
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<td>Lee S, Wong YL, Rothbard AB. Factors associated with departure from supported independent living programs for persons with serious mental illness. <em>Psychiatr Serv</em> 2009; 60: 367-73.</td>
<td>Follow up of people living in independent supported residences to assess extent to which personal and housing characteristics predicted positive and negative departures from housing</td>
<td>237 people with mental illness recruited in 2002 – 2003, resident in current supported housing for 6 months or more and with serious mental illness</td>
<td>30 months</td>
<td>69% maintained continuous residence throughout the study period, 14% had a positive departure and 17% a negative one. Self reported past substance misuse increased the probability of negative departure (Hazard ratio 2.09, p&lt;0.05) a more supportive relationship with programme staff decreased the probability (hazard ratio 0.95, p&lt;0.05).</td>
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Philadelphia |
Study type IV | Mean age 45, 60% African American, 71% schizophrenia |
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<tr>
<td><strong>Wong YI et al. Predicting staying in or leaving permanent supported housing that serves homeless people with serious mental illness.</strong> Pennsylvania: University of Pennsylvania, Center for Mental Health Policy and Services Research; 2006. Available at: <a href="http://www.huduser.org/Publications/pdf/permhsgstudy.pdf">http://www.huduser.org/Publications/pdf/permhsgstudy.pdf</a> [Accessed 2nd Aug 2010]</td>
<td>Retrospective cohort Examined residents experience of permanent supportive housing between 2001 and 2004 Case control Prospective tracking of those who left between February 2003 and December 2004</td>
<td>943 residents with mental illness 100 who left matched with 96 who stayed</td>
<td>18 months after leaving for leavers. Leavers designated either positive or negative. No difference between positive and negative leavers in terms of socio-demographic characteristics, psychiatric diagnosis or level of functioning on all measures taken on entering permanent housing. No difference in service use prior to entering permanent housing. Negative leavers made disproportionate use of homeless services, in patient and emergency psychiatric services during their stay in permanent housing. These differences were reported to be statistically significant. This higher use was also reported subsequent to leaving, this was also reported to be significant. These findings suggest a difference in mental health status between stayers and negative leavers.</td>
<td>No detail of any statistical analysis provided</td>
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<td>Culhane DP et al. Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. <em>Housing Policy Debates</em> 2002; 13: 107-63. Available at: <a href="http://repository.upenn.edu/cgi/viewcontent.cgi?article=1067&amp;context=spp_papers">http://repository.upenn.edu/cgi/viewcontent.cgi?article=1067&amp;context=spp_papers</a> [Accessed 2nd Aug 2010] New York City Study type IV</td>
<td>Case control study assessing cost effectiveness To assess the impact of public investment in supportive housing for people with mental illness</td>
<td>4,679 with mental illness housed between 1989 and 1997</td>
<td>People place in supportive housing has marked reductions in shelter use, hospitalisation, length of stay per hospitalisation and time in custody. Before placement costs were about $40,451 per year in services. Placement was associated with a reduction in service use of $16,281 per housing unit per year. Annual unit costs were estimated at $17,277 for a net cost of $995 per year over the first 2 years (1999 costs). 95% of the costs of supportive housing were compensated for by reductions in use of other services.</td>
<td>Relied on use of administrative databases</td>
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<td>&quot;Martinez TE, Burt MR. Impact of permanent supportive housing on the use of acute care health services by homeless adults. Psychiatr Serv 2006; 57; 992-9. Available at: <a href="http://psychservices.psychiatryonline.org/cgi/reprint/57/7/992">http://psychservices.psychiatryonline.org/cgi/reprint/57/7/992</a> [Accessed 2nd Aug 2010] San Francisco Study type IV</td>
<td>Assess impact of permanent supportive housing on the use of acute care public health services</td>
<td>236 homeless single adults with mental illness, substance use disorder or other disabilities entering housing between October 10 1994 and June 30 1998. Housing allocated via lottery, clients recruited via outreach to streets, shelters and food lines. 73% males, 53% African American, all had been homeless for at least 8 months</td>
<td>Service use 2 years before and after entry to housing 199 followed up to 3 years. 81% remained in housing for at least 1 year. 63% remained for 2 years 48% stayed at least 3 years Housing placement significantly reduced percentage of residents with an emergency department visit (53% to 37%), mean number of visits per person (1.94 to 0.86, ( F=16.96, df=1,198, p&lt;0.001 )) and total number of emergency department visits (56% decrease, form 457 to 202). The likelihood of being hospitalised was significantly reduced (19 to 11%) and the mean number of admissions per person (0.34 to 0.19 per resident, ( F=4.42, df=1,198, p&lt;0.05 )) It was estimated that service reductions reported in the study translated into public cost reductions of $1,300 per person for the first 2 years after moving in</td>
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## Integrated services

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<td>25 Rosenheck RA et al. Service systems integration and outcomes for mentally ill homeless persons in the ACCESS program. <em>Psychiatr Serv</em> 2002; 53: 958-66. Available at: <a href="http://psychservices.psychiatryonline.org/cgi/reprint/53/8/958">http://psychservices.psychiatryonline.org/cgi/reprint/53/8/958</a> [Accessed 2nd Aug 2010]</td>
<td>Evaluation of ACCESS (access to community care and effective services and supports). Part of a 5 year demonstration project which aimed to enhance the integration of service delivery systems for homeless people with serious mental illness. ACCESS programmes provided case management standardised to conform to the ACT model. These studies concerned with 2 questions. Does better integration of service systems improve the treatment outcomes of homeless people with severe mental illness?</td>
<td>25,729 clients recruited between May 1994 and July 1998. Clients at the experimental sites were worse off than those at the comparison sites on 15 measures (including days literally homeless, severity of mental health problems and drug problems) and better off on only 1 (they felt closer to more people).</td>
<td>25 Complete data available for 7,055 clients. Clients at the experimental sites showed no greater improvement on measures of mental health or housing outcomes than clients at comparison sites, however clients of sites that became more integrated regardless of the degree of implementation or whether they were experimental or comparison sites, had progressively better outcomes. Integration was assessed on the basis of the extent to which an organisation sent clients to or received clients from other agencies specifically related to homeless people with mental illness; the extent to which an organisation sent or received information from other agencies for coordination, control, planning or evaluation purposes concerning people who are homeless with severe mental illness and the extent to which the organisation sent or received from other such agencies.</td>
<td>See also references 10 &amp; 11.</td>
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### Veterans

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<td>27. Rosenheck R et al. Cost-effectiveness of supported housing for homeless persons with mental illness. <em>Arch Gen Psychiatry</em> 2003; 60:940-51. Available at: <a href="http://archpsyc.ama-assn.org/cgi/reprint/60/9/940">http://archpsyc.ama-assn.org/cgi/reprint/60/9/940</a> [Accessed 2nd Aug 2010]</td>
<td>US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) supported housing programme</td>
<td>460 homeless veterans with psychiatric and/or substance misuse problems who had been literally homeless for 1 month or longer.</td>
<td>3 years. Follow up rates were significantly higher in the HUD-VASH group (127/182 at 3 years)</td>
<td>High levels of attrition in comparison groups.</td>
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| | | Case management 43/90 at 3 years | Case management only 43/90 at 3 years | Standard care 75/188. |
| | US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) supported housing programme | | HUD-VASH had 16.9% more days housed than case management (*t* = 2.90, *p*<0.004) only and 25% more days than standard care (*t* = 4.88, *p*<0.001). Differences were significant across time for the first 2 years but attenuated in year 3. |
| | 3 conditions | | Case management only had 7% more days housed than standard care (*t* = 1.06, *p* = 0.29). The HUD-VASH group experienced 35.8% fewer days homeless than case management only (*t* = 2.87, *p* = 0.004) and 36.2% fewer than standard care (*t* = 3.56, *p* < 0.001). |
| | HUD-VASH section 8 vouchers and intensive case management | | There were no significant differences on any measures of substance abuse or psychiatric status or on measures of community adjustment. The HUD-VASH group reported greater subjective satisfaction with housing than the other 2 groups. HUD-VASH cost 16% more than standard care. Incremental cost effectiveness ratios suggest that HUD-VASH cost $45 more than standard care for each additional day housed (95% confidence interval $19 to $108). |
| | Case management only | | A subsequent reanalysis of the data using multiple imputation technique to account for missing data suggested that HUD-VASH produced significant benefits in drug and alcohol abuse outcomes. The HUD-VASH group had fewer days of alcohol use than standard care (p=0.0047), fewer days on which they drank to intoxication (p=0.0053) and fewer days of drug use (p=0.028). |
| | Standard VA care | | A five year follow up of 392 participants examined the risk and predictors of returning to homelessness. Cox regression analysis found that participants in HUD-VASH had significantly longer periods of continuous housing than in the other 2 groups. Other predictors of decrease housing tenure were drug use and diagnosis of PTSD. |

| | | Initial contact through outreach. No significant differences at baseline in clinical, socio demographic or community adjustment measures. | HUD-VASH 182 |
| | | Case management only 90 | Case management only 90 Standard VA care 188 |
| | | Standard VA care 188 | |
| | | | Standard care 75/188. |
| | | | There were no significant differences on any measures of substance abuse or psychiatric status or on measures of community adjustment. The HUD-VASH group reported greater subjective satisfaction with housing than the other 2 groups. HUD-VASH cost 16% more than standard care. Incremental cost effectiveness ratios suggest that HUD-VASH cost $45 more than standard care for each additional day housed (95% confidence interval $19 to $108). |
### Women

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<tr>
<td>Smith EM, North CS, Fox LW. Eighteen-month follow-up data on a treatment programme for homeless substance abusing mothers. <em>J Addict Dis</em> 1995; 14: 57–72 St Louis, Missouri Study type III</td>
<td>Non residential vs residential treatment programme. The programme used a 12 step approach in a modified therapeutic community setting. The women were either resident in the centre or attended a day programme. The only difference between the groups was the housing assignment. The children of non resident women attended the centre with their mothers. The programme lasted 1 year. Phase 1 was a 90 day module conducted in a substance free community setting, using both individual and group treatment. Phase II, in which all families lived in the community, provided ongoing professionally facilitated group support.</td>
<td>149 homeless mothers with a substance misuse problem. Women had one or more children aged 12 or younger in their care. Residential (67) mean age 29.4, 98.5% African American, alcohol use disorder 45.5%, cocaine use 84.8%. Non residential (82) mean age 30.1, African American 96.3%, alcohol use disorder 45.1%, cocaine 81.6%</td>
<td>18 month follow up 61 participants actually started the residential treatment programme and 65 the non residential programme. There did not appear to be any significant differences in baseline characteristics between those who started the programme and those who did not or between those who dropped out of the programme and those who completed it. Housing stability score was an adjusted measure for the percentage of time spent in stable housing during the period between each assessment. It quantified permanence and independence of housing. Both treatment groups showed significant improvements in housing stability over time. Predictors of lower overall housing stability scores were more severe psychiatric or legal composite scores after leaving the programme.</td>
<td>High attrition rate - Only 10 participants completed the full programme and 9 others were still in the programme at the end of the study period.</td>
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### Health advocacy

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<td>Graham Jones S, Reilly S, Gaulton E. Tackling the needs of the homeless: a controlled trial of health advocacy. <em>Health Soc Care Community</em> 2004; 12: 221-32</td>
<td>Health advocacy vs usual care. The health advocate worked with temporarily registered patients in a single, large inner-city practice over a period of 3 years. 3 conditions  Care as usual – new temporary residents accessing usual care  Health centre advocacy – receptionists put these people in touch with the advocate (family health worker) before or soon after first consultation with GP.  Outreach advocacy group – outreach visits to hostels and bed and breakfast hotels during intervention months to proactively register new arrivals as temporary patients.  The health advocate role was to help homeless people access health and associated care. This frequently involved liaison with housing departments, hospitals and social security offices on behalf of clients as well as referral to other agencies such as social services, health visitors, drug dependency agencies, education welfare and child protection services.  The health advocate was a registered general and mental health nurse and had extensive community experience.</td>
<td>Homeless people moving into hostels or other temporary accommodation in the Liverpool 8 area  326 people given baseline questionnaires, 222 returned these, 171 were traceable at follow up, of these 117 returned follow up questionnaires.  Of the 117, 72% were women, 74% of whom were aged under 30, white British (91%), single (63%) or separated (23%), living with their children (41%) in women’s refuges (30%) or family hostels (25%). In 44% of cases the cause of homelessness was domestic violence.  The mean age of the outreach advocacy group was significantly lower than that in the health centre advocacy group (<em>F</em>= 3.327, <em>df</em>=2,115, <em>p</em>=0.04, Bonferroni corrected <em>p</em>&lt;0.05)</td>
<td>At 3 month follow up a higher proportion of the outreach advocacy group were either re-housed or had achieved a positive housing outcome compared with both the control and health centre advocacy groups although this difference was not statistically significant.</td>
<td>High rate of attrition.  Care as usual and health centre advocacy groups recruited on the basis that they registered as temporary patients with an inner city – not all of these would necessarily have been homeless presumably this was checked at baseline but does not appear to be discussed in the paper.</td>
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### Families

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<td>Wong YL, Culhane DP, Kuhn R. Predictors of exit and reentry among family shelter users in New York City. Social Services Review 1997; 71: 441-62. Available at: <a href="http://repository.upenn.edu/cgi/viewcontent.cgi?article=1089&amp;context=spp_papers">http://repository.upenn.edu/cgi/viewcontent.cgi?article=1089&amp;context=spp_papers</a> [Accessed 2nd Aug 2010] New York Study type IV</td>
<td>Explored processes of family entry to and exit from homelessness shelters. Tested the significance of housing placement at shelter discharge as a predictor of re-entry. Exit was defined as a departure lasting 30 continuous days.</td>
<td>Used 8 years administrative data from January 1988 to October 1995. 27,919 shelter exits were included. 90.9% were single mother families, mean number of children 1.8, 59.2% black, 73.6% reason for homelessness economic, 9.9% domestic abuse</td>
<td>Minimum 2 years after shelter exit 48% of exits were to subsidised housing. 41% were unknown and 7.5% were to apartments the families found themselves or to the families former residence. 37% of families who exited to unknown arrangements re-entered, 13.2% of those who went to their own housing and 7.2% who went to subsidised housing. Shelter exit to subsidised housing was associated with a significantly lower probability of shelter readmission (risk ratio 0.173, p&lt;0.01)</td>
<td>Relied on administrative data. Complex analysis using multiple variables.</td>
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Appendix 5 Joint Strategic Needs Assessment Development Programme – Vulnerable Adults, Housing and Support Case studies.

East of England

What they did

Throughout 2009/10 partners in the East of England have been working together to help ensure that future Joint Strategic Needs Assessments (JSNAs) and Strategic Housing Market Assessments\(^5\) (SHMAs) provide full and appropriate evidence of housing related support needs which could better influence the commissioning of services.

The Supporting People\(^6\) Eastern Regional Group (SPERG), the then East of England Regional Assembly (EERA) and the Regional Department of Health Team (DH) have now agreed a final report ‘Strategic Needs Assessments: health, housing, care and support. A research paper making the case for housing related support in JSNAs and SHMAs in the East of England.’\(^7\)

While this Case Study describes a regional investigation into JSNAs and housing, the findings and messages regarding different needs assessments and the relationship between them, is equally important at a local level.

Why

They embarked on this because of a growing realisation that the data and intelligence needed, to better understand the impact of growing older population and inward migration, to support the Planning function, should, have been readily available, from the JSNAs in the area.

As there were plans to refresh the 09/10 Action Plan of the Regional Housing Strategy, - including an updated assessment of housing need - the partners realised the compelling efficiency argument for aligning needs assessments across partnerships. Not only was this vital to making better use of resources but there was a firm and shared belief that was an essential pre-requisite for more joined up services

The Aim

Overall then the aim was to identify which ‘needs’ for housing related support services should be included in JSNA’s and SHMAs, to what extent this was already being covered, and what gaps and examples of good practice existed.

The Steering Group which governed the work included the leads for JSNA, Housing and for Supporting People and they drew on relevant guidance to set the context for the review They particularly wanted to follow up on 2 key recommendations in Housing, care, support: a guide to integrating housing November 2008 (CLG, CSIP, Housing LIN, Housing Corporation).\(^8\)

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**Recommendation 1:** The Joint Strategic Needs Assessment and Strategic Housing Market Assessment should be aligned to provide a local assessment of housing-related support needs, with common metrics in order to enable the aggregation of data at a regional level

**Recommendation 3:** The National Indicator Set and Supporting People Outcomes Framework should be used by commissioners to provide a basis for commissioning joined-up services that deliver outcomes relevant to housing, health and social care
The Benefits and Learning

Although they had committed to a ‘common agenda’, the significant knowledge, perspective and cultural differences between the partners soon became clear. Discussions with SHMA, housing strategy and investment leads, revealed that they were used to working with hard evidence and wanted the research to help them nail down ‘need’ in terms of required numbers and locations for specific types of properties, whilst the Supporting People leads wanted to know what the housing related support needs would be to properly house and support, for example, the 250 offenders who return to Suffolk each year.

During discussions it also became apparent that amongst the partners, no one person had an understanding of all 3 areas of ‘health’, ‘housing’ and ‘vulnerable people’. However as they continued to work together, their mutual learning developed, as did an appreciation of each other’s perspective, roles and the linkages between them.

The final report contains recommendations which clarify what each of the 3 partners should do to ensure that JSNAs and SHMAs include appropriate assessments of need for housing related support to inform strategic decision-making processes.

It recommends that the responsibility for producing robust assessments of need rests with Supporting People commissioning bodies, or their equivalents who should ensure that the outputs are available for inclusion in JSNAs and SHMAs; that all JSNAs should include an assessment of future needs for housing-related support of different types for vulnerable client groups, and that when work is undertaken to revise or update the current SHMAs, this should include an assessment of the need for housing for the appropriate client groups in each area and to take account of the JSNA outputs.
What next

A launch event is planned for later this year, to which all key partners and commissioners will be invited, will discuss the recommendations, and agree an outline action plan and the appropriate governance structure to see that the changes are implemented.

The partners, who have invested their time and funding now jointly ‘own’ a report which provides a ‘common language and reference point’ which is understood by the key partners in Housing Strategy, Supported Housing, Social Care, Health and JSNA leads. There is a shared view of the necessity to invest to save across the whole system with a widened understanding of JSNA and the policy aims surrounding it and of the potential for JSNA to be an effective tool for them.

Key Messages
An integrated JSNA should help to describe and read across the different sets of ‘needs assessments’ and demonstrate links to determining the quantity of affordable, adapted and supported housing.
Many Local Strategic Partnerships⁹ and Local Authorities are still working through how best to get the housing and support needs of vulnerable adults, counted, and included in the JSNA, but going through this process is building greater capacity.
Perspectives are different across the worlds of ‘Housing’ (mainstream strategy and capital investment) and Health, with Supported Housing proponents still trying to bridge the gap.

Cambridgeshire

What they did

Cambridgeshire adopted a different approach to JSNAs from the outset. While it clearly set out the common purpose of the JSNA as the means to describing the future health, care and well-being needs of the local populations and the strategic direction of services to meet those needs, it also began to investigate more fully the many different factors which influence people’s health which lie outside the direct influence of health care, including housing and the environment.

Realising the scale of this challenge, Cambridgeshire carried out three phases of JSNA to gather the relevant information. It is important to understand in a little more detail how Cambridgeshire did this as it provides the key to ensuring that the housing and support needs of vulnerable adults are effectively connected to the JSNA.

In Phase 1 a public health and health inequalities dataset was produced, which included the data recommended in national JSNA guidance. Cambridgeshire also produced six JSNAs, which focussed on different vulnerable groups within the population: Children and Young People, Adults of Working Age, Adults with mental health problems, Adults with learning disabilities, Adults with sensory or physical impairment and long term conditions, and Older People.

Phase 2, consisted of a review of existing surveys and consultation with service users, carers and the public, to provide qualitative information on local health needs and Phase 3, produced two further JSNAs which looked at the needs of people who are homeless or at risk of homelessness; and migrant workers¹⁰.

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⁹ Creating Strong, Safe and Prosperous Communities Statutory Guidance
¹⁰ Joint Strategic Needs Assessment for Cambridgeshire, Draft Phase 3
The Cambridgeshire JSNA categorises homeless people into three overlapping groups, including those who are statutory homeless and hidden homeless and those at risk of homelessness. However, the JSNA then focuses primarily on the *single homeless and rough sleepers (SHRS)* group of homeless people for whom there may be no statutory duty or simple solution, as this group has the poorest outcomes in Cambridgeshire.

**Why**

Each Phase built on the previous one and the latest Cambridgeshire JSNA published in January 2010 now provides a rich and maturing resource which includes an overview of Cambridgeshire’s population, the key findings from each of the JSNAs, any overarching themes and ongoing work from all of the previous JSNAs and sets out the work that the combined JSNA will feed into.

Partnership working has been an essential part of the JSNA process and key to understanding the needs of the local homeless population. This JSNA was developed through joint working between the NHS, the County Council, the City and District Councils in Cambridgeshire, and voluntary sector agencies.

There was recognition that the causes of Homelessness are complex and more than a housing issue. Homeless people experience poorer health outcomes compared to the general population, with physical health, drugs, alcohol, mental health and well-being being recognised as priority health issues. Added to this, homeless people generally experience difficulties in accessing health services which further impacts on their health status.

**The Aim**

The compilation of the JSNA document is now seen as part of a wider process which provides evidence to inform decisions on how to improve the health and wellbeing of the Cambridgeshire population and the figure below illustrates this.
The Benefits and Learning

This approach enabled each JSNA to be constructed from a wide range of data, and with the direct involvement and expertise of the appropriate agencies. This has helped to increase understanding of the individual and common challenges associated with homelessness and to create the relationships and partnership structures to respond to them. It also develops a much stronger involvement in JSNA from a greater number of people, who understand its importance to meeting their own goals and responsibilities.

For the first time, in a health context, is a user friendly yet detailed examination of the health impacts of homelessness which is drawn from and completely consistent with the data and analysis in District Authorities Homelessness Strategies and the Supporting People Strategy.

The JSNA examined data from the Cambridge Access Surgery (CAS), a dedicated GP practice largely for single homeless and rough sleepers with about 500 registered patients at any one time. Amongst the 40 patients who are known to have died over the last five years, the average age at death was 44 (please note this is not the Life Expectancy of this group, just the average age of death of those who did die). Many of CAS patients are at the very lowest point in their lives with 50% having an alcohol problem 66% a drug problem, 50% have a mental health problem and many people have two or all three of these problems.

These multiple and overlapping needs are also reflected in the way services for the homeless are commissioned, involving different funding streams and a variety of commissioning and provider organisations. There are concerns that the fragmented commissioning of services is creating gaps and duplication of activity which is not working well for the homeless.

The JSNA acknowledges that this group are often difficult to engage with services and although relatively small in numbers they represent significant costs to the public purse with, frequent hospital admissions and A&E visits, and as intensive users of community and housing support services, as well as police, probation and prison. They are also the largest client group accessing Supporting People funded services

Also noted in the JSNA is that the housing pathway differs for statutory and non-statutory homeless and that for the non-statutory homeless there are a range of entry points which together with the often chaotic lifestyle of this group means that their journey may not follow a clear pathway.

In Cambridgeshire, as elsewhere, data on homelessness is collected by numerous service providers. However, most of these operate stand-alone information systems with no robust way of uniquely identifying service users resulting in likely instances of double-counting. They also note seemingly insurmountable problems in correlating information from different agencies due to the categories used, and the difficulty of identifying individuals across services.

All of this makes it difficult to describe (and plan to respond to) the needs of the homeless population, which is further complicated by their transient nature. With an overwhelming concentration of services in Cambridge City the corollary is, generally speaking, that where there are no services there are no data - hence there is limited information for much of Cambridgeshire.

What next

In response to this analysis, the JSNA makes a number of recommendations to begin to overcome the obstacles to engaging this group, improving joint data on their number and
pathways leading to joint commissioning to ensure services are integrated, needs-led, evidence based, person-centred, and focussed on prevention and early intervention.

These recommendations have been developed into a clear JSNA Homelessness Action Plan, the implementation of which is managed by the Homeless JSNA Implementation Group (HJIG), reporting to Cambridgeshire Homelessness Executive (CHE). The membership of this group - which developed from the City Council’s Homelessness Strategy Executive has been revised to include more commissioners from across all the relevant partners with senior representatives from the PCT, Mental Health, Adult Social Care, Drug & Alcohol, Probation, Police, Voluntary and Community Sector and Community Engagement meet together with Supporting People, and Homelessness leads from each of the Districts.

In overseeing the implementation of this County wide JSNA, CHE monitor a number of implementation groups set up to deliver ‘Service Specific’ recommendations and common strands within the District Authorities Homelessness Strategies which would benefit from a collective approach.

The Homeless JSNA and it’s recommendations have been signed off by the County Health and Wellbeing partnership and the Cambridgeshire Together Board (Cambridgeshire’s ‘Local Strategic Partnership’); they are keen to monitor progress and have asked for regular updates.

Using the evidence of the jointly produced JSNA, the Action Plan and the decision making structures described, the partners in Cambridgeshire have agreed to employ a jointly funded Chronic Exclusion Development Worker to set up joint commissioning processes and a system for convening MAPPA\textsuperscript{11}/ MARAC\textsuperscript{12} style multi agency case conferences. Using the New Directions Team Assessment\textsuperscript{13} tool the most chronically excluded adults will be identified and pooled budgets will allow for integrated packages of care.

Keen to gather more direct information from the identified group about what would make most difference for them, Cambridgeshire is now also piloting the use of the ‘Working

\textsuperscript{11} Multi Agency Public Protection Arrangements places a duty on the police and the National Probation Service to assess and manage risks posed by ex-prisoners in every community in England and Wales.
\textsuperscript{12} Multi Agency Risk Assessment Conference where multiple agencies get together to provide a co-ordinated response for those at the highest risk of domestic abuse.
\textsuperscript{13} The New Directions Team Assessment (Chaos Index), (2008)
Together for Change\textsuperscript{14} approach, which has been hugely successful in engaging other vulnerable people such as those with Learning Difficulties.

The decision to produce a JSNA for people who are Homeless or at Risk of Homelessness has brought significant benefits and is widely welcomed by those whose main aim is to prevent homelessness and manage its consequences.

### Key Messages

A detailed JSNA process, focussing on vulnerable groups, creates a shared understanding of needs and fosters a genuine sharing of expertise and responsibilities, for people with multiple and complex needs.

Undertaking a JSNA for the Homeless and those at Risk of Homelessness reveals the complex health and social challenges facing many people who fall into this group, and provides a clear structure and strong basis for Homelessness leads, commissioners and providers in the public and Voluntary and Community Sector, to tackle this together.

Setting up a multi agency system to respond collectively and quickly to very vulnerable groups as identified in the local JSNA helps all the agencies meet their individual responsibilities, to safeguard individuals and ensure they are properly served and potentially provide large savings to the ‘public purse’

### Devon

#### What they did

The first JSNA produced in Devon in 2007 was seen as the evidence base from which to build, during 2008, a Strategic Framework and Plan entitled ‘The Way Ahead’ which summarises Devon Primary Care Trust and Devon County Council’s vision and plans for health, wellbeing and social care for the five years to 2013\textsuperscript{15}.

This framework, and the integration of Devon’s Supporting People function in a joint social care and health team, provided the backdrop and support for developing a number of client focussed JSNAs, to fully explore, with partners, the housing and support needs of particular vulnerable groups.

Detailed ‘Accommodation and Support JSNAs’ were produced for Older People, Learning Difficulties and for people with Mental Health Needs. Designed to be co-terminus with JSNA boundaries, share a common methodology for assessing need and set what other local authorities might call client focussed housing and support strategies, in the new world and wider context of JSNAs. This enabled those responsible for housing and support services to have a tangible product, which was recognisable and useful to JSNA leads, and upon which the need for further data, analysis and debate could be agreed.

#### The Aim

The Supporting People Team in Devon were keen to see the wealth of data and intelligence about the housing and support needs properly recognised in the Joint Strategic Needs

\textsuperscript{14} Working together for change: using person-centred information for commissioning

\textsuperscript{15} The Way Ahead A Strategic Framework for health and social care Devon (2008)
Assessment (JSNA) as a means to ensure that better outcomes and value was achieved for the County and those who were most vulnerable.

**Why**

While originally wanting to engage colleagues on how to better understand, join up and manage the needs of people who are ‘socially excluded’ there was an early realisation that successful and effective partnerships are based on common ground, mutual interest and shared priorities. Across the Health, Housing and Social Care agencies in Devon, as elsewhere, this common ground was most developed for older people (most people will have built relationships on closure of long stay hospital wards and around the National Service Frameworks) and where there was potential for shared efficiency savings.

**The Benefits and Learning**

This has reaped several rewards. The original JSNA in Devon 2007 included limited reference to housing or support needs, while ‘The Way Ahead’ recognises that *Health and social services alone cannot improve the population’s health. Wider long-term partnership is crucial if we are to address the impact of poverty, deprivation, poor housing, rural isolation and homelessness on Devon’s health inequalities*’ and states clearly that Devon intends to ‘extend our planning relationships beyond health and social care ’ and is committed to the ‘continued development of integrated health, social care and housing’.

The Accommodation and Support JSNA for older people examined in detail the population and service pressures and set these against the health profiles and older people’s aspirations. One finding was that in the County, over half of the 13,000 people in need of a service have no access to face-to-face help. By reviewing options together, across health, social care and housing, a Mobile Response and Early Intervention Service (MRS) has been commissioned.

Seen in this practical context the local use of the Cap Gemini Research into the financial benefits of the Supporting People programme16 (which illustrates housing, health and social care as key stakeholders in preventative services like the MRS ) modelled the whole systems cost benefits which could be achieved.

From the pilot stage of the MRS, and with a £572,000 investment over 53 weeks, there is very strong local evidence that a cost saving to partners of at least £211,000 has already been achieved. On this basis, a 3 year contract worth £1,683,000 has been approve to continue the service until April 2013.

The service design also built on the joint need and shared desire for integrated working. For example, there was unanimous support from Adult Care and Health Services to providing floating support services to older people on an agreed cluster basis which would enable the wider services in each cluster to work together to develop interventions that kept people at home, prevented people requiring social care or health services, and helped to discharge older people from hospital.

The Accommodation and Support JSNA for Older People, the increased relevance of housing support services in the refreshed JSNA and in ‘The Way Ahead’, paved the way for the new integrated service. But it doesn’t end there, as under the local Putting People First17 programme the Early Intervention and Prevention Board in Devon, meets with a membership including officers from Supporting People and Housing to oversee the performance of the MRS and monitor its benefits.

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16 [Supporting People financial benefits model documentation and user guide](#)  
17 [Putting people first: a shared vision and commitment to the transformation of adult social care](#)
In Devon, those championing the importance of housing and housing support services in improving health and wellbeing, not least in the Supporting People team, see JSNAs as a powerful evidence base for the accountability behind any credible commissioning plan and believe that internal and external partners will increasingly demand to scrutinise this piece of evidence in the face of efficiencies needing to be made.

Max Sillars, the Supporting People Manager in Devon believes that partners ‘must be willing to let go some of your language and adopt the language of others in order to make it possible to share common terms, aims and goals’ and that ‘You won’t find out what opportunities JSNAs offer unless you’re willing to let go of what you think you know, and get involved’

What next

The continued integration of services like the MRS and the joint approach to their creation is also expected to improve the understanding and potential for further joining up and efficiencies around back office systems, management and support functions.

**Key Messages**

Revisiting, or undertaking client based housing and support strategies in the wider health context, to suit and supplement the JSNA, will help attract renewed interest and attention in the importance of housing and support services for vulnerable groups.

Get housing and support services for vulnerable groups into the JSNA by starting with groups where there is most common ground, mutual interest and shared priorities.

Prepare to compromise on language, terminology and previous ‘conclusions’ on assessments of need, and accept that these may change when more intelligence, in the JSNA process, is available.

**North West Region**

**What they did**

The Case Study in the North West is a good example of Local Authorities sharing expertise and resources to raise awareness of an established methodology for assessing the supported housing needs of vulnerable adults, conscious of its importance to JSNA’s.

**Why**

What had become clear to partners in the North West was that while the North West Joint Improvement Partnership\(^{18}\), (largely made up from health and social care representatives), were exploring how to widen the scope of JSNA and improve the link to Strategic Commissioning, ‘next door’ the NW Regional Supported Housing Strategy Group (made up of supported housing stakeholders and key bodies including the National Housing Federation, Homes & Communities Agency, Shelter etc;) were considering how they could further develop their Supported Housing Needs Model\(^{19}\) for vulnerable adults, by linking this to the JSNA.

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\(^{18}\) NWJIP Business Plan Summary 2009/10 Supporting improved outcomes in social care, health and wellbeing for people and families in the North West

\(^{19}\) The Need for Support and Supported Housing Services in the North West 2008-2020
This highlighted a common concern that the wealth of data and understanding of the needs of vulnerable adults captured and managed within the housing world are not routinely connected to those responsible for improving health.

While there is a methodology being trialled in the NW for helping to turn the results of the Housing Needs model into commissioning priorities there are still limitations. There will always be more needs than can be met within available resource; the model alone cannot establish the relative importance of needs e.g. for a handyperson service for an older person against the need for supported accommodation while a drug user is undergoing treatment, nor can it determine the exact or best type of service and level of intervention that lies behind the number of ‘units’ required or their optimum cost. This is equally true of the JSNA and in the ever present search for new efficiencies, developing useful needs assessments, as a truly joint venture, is clearly the way forward.

The Aim
The current Action Plan of the NW Strategic Framework for Housing Support now specifies that ‘Developing the NW Housing related Support Needs Model to link to JSNA’ as a key action for 2010/11\(^\text{20}\). In practice, members of the NW JIP, NW JSNA leads and NW commissioners are now better placed to agree how the JSNA, and Housing and Housing Related Support should be brought together in the NW Local Authorities and Partnerships.

The Benefits and Learning
What was clear to Housing and Supporting People professionals in the NW was that their learning from the development of the NW Housing Needs model had lots in common with the ambitions and initial limitations of the JSNA. This included a recognition that most attempts at predicting needs are inevitably highly technical exercises, determining what might constitute the best possible source data in itself often a matter of dispute and that public service needs projections become relatively impenetrable to the mass of concerned professionals or service users.

The NW Supported Housing Needs model was therefore from the outset designed to be driven by local knowledge and concerns and not simply ‘handed down’ from central planners, comprehensible by a wide range of interested parties, (not just specialist staff with a statistical background) and able to both integrate appropriate technical detail and be susceptible to strategic direction.

At a local level however, there have been different experiences of how to get the housing and support needs of vulnerable adults, particularly as identified in Supporting People strategies and quantified using the NW Housing Needs model, recognised within the local JSNA processes. What was agreed though was that none of the NW authorities felt that existing

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\(^{20}\) Regional Strategic Framework for Housing Support 2009-20
housing needs data was being properly recognised or understood at a local level, nor were housing representatives always being effectively engaged.

All Local Strategic Partnerships will have intelligence and assessment of the housing and support needs of Vulnerable Adults. Supporting People Strategies were a requirement of all Upper Tier and Unitary Authorities and these were based on a local assessment of the housing and support needs of all vulnerable adults.

What next
The good news however, is that there are now some effective links across Health, Social Care and Housing in respect of developing the JSNAs in the NW. This will assist stakeholders to lobby for this to be recognised and mirrored, in their own local areas. It also provides an evolving model to help with this.

Equipping the NW Housing Needs model for the future, representatives had already acknowledged that the model remained generally unattached from the statutory JSNA process in local authorities, which weakens its impact on Authorities’ overall priorities and that it does not in itself directly help authorities to set commissioning priorities, especially across the wider extent of local strategic partnerships

The NW Regional Supported Housing Strategy Group are therefore looking instead at developing a clearer definition and set of questions designed to help identify ‘who needs to be asked what’ in order to inform local entries into the model. This will be less about guidance that people can choose to ignore and more about a clear step by step process.

It is believed that this approach will maximise the chances of entering robust data into the model, which helps to fill gaps and fit local requirements, and there is now a formal sign up to do this.

While this is still a work in progress, and not all areas in the country use the NW supported housing needs ‘model’, there are already some positive and common messages for all local authorities and JSNA co-ordinators.

While these are the main messages from the NW case study, the Bolton story below, is just one example of how a NW local authority has used the model to enhance the JSNA and wider commissioning.

The Bolton Story
Bolton Borough Council in the North West, strengthened its leadership and structures to ensure that the new JSNA - to be published in June 2010 - is based on a broader range of intelligence and data than the original Dataset, moving on from the earlier health focus. A JSNA Steering Group, now with wider ranging membership, met to consider the newly assembled JSNA data and the picture it painted.

They discussed the main pressures and priorities which emerged, as well as possible responses to them. Feedback from participants showed that they felt, for the first time, that they had a full understanding of the JSNA process and what it meant for Bolton. As one participant said ‘I now fully appreciate the limited life chances that vulnerable people have living in some of the most deprived neighbourhoods of Bolton and this gives a commissioning challenge in redirecting and changing the way service delivery meets need for example in improving people’s mental well being’

Many of the conclusions about vulnerable adults are drawn from the Supporting People data supplied into the JSNA from the Bolton data using the NW Supported Housing Needs Model. This source will be identified in the Bolton JSNA and attached as an Appendix.
As this approach to JSNA in Bolton developed last year, so too did a review of Commissioning structures and practice. A draft report now suggests that Borough wide Commissioning Strategies should be developed to cover, across all client groups, Specialist Care, Personalised Services, Targeted Prevention, and Market Development - with supported housing services seen as essential to commissioning for successful Prevention. The established Supporting People Commissioning Body is seen as the best basis from which to build an effective governance group to implement this.

The approval for this approach will be taken through to the Bolton Vision Partnership as a means of delivering on the health and wellbeing priorities in the Bolton JSNA.

**Key Messages**
Regional networks can provide an opportunity and platform to connect Housing and Health, on JSNAs, needs modelling and other topics, and provide direction and support to their member authorities.

Supporting People teams can provide all LSP areas and JSNA’s with data and intelligence on all vulnerable adults and their housing and support needs, as well as considerable experience in how to measure need and use this to assess and drive multi agency commissioning.

Data collection, identifying and analysing needs – however robust - does not automatically produce a priority list of vulnerable clients or the best services to commission. JSNA’s should recognise all available data, draw on the best sources and provide rounded intelligence for partners to base decision making.

**London Borough of Havering**

**What they did**

The first JSNA in Havering confirmed the significant demographic challenges facing the Borough which resulted in an additional £5m being identified from the council’s budget planning process, and allocated to Adult Social Care Services to address this. Plans were put in place to create a permanent, joint funded and co-located team to ensure that the JSNA is continually improved and refreshed. This was seen as essential to enable the partners to have a shared understanding of the most relevant local data and information, to act as a strong strategic platform from which they could commission.

In addition to two additional posts to assemble and analyse data within the JSNA, a cross directorate Strategic Commissioning Team was established with roles focussing on Prevention – including the development of Extra Care Housing and Inclusion - to ensure that the needs of people who are homeless, with drug and alcohol, mental health or related issues, are recognised. Co-location of commissioning across health and social care was also achieved in 2009.

This team is led by a new post of Assistant Director for Strategic Commissioning who has wide ranging responsibilities which covers adults, children and corporate commissioning to ensure that representative governance structures work well to support improvements to the health and wellbeing of vulnerable groups. Housing support services are fully included in this, which is unsurprising given that the postholder, began his career in housing and with the Supporting People programme.

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21 Extra Care Housing is designed with the needs of frailer older people in mind and with varying levels of care and support available on site.
Why

The Havering Joint Strategic Needs Assessment, refreshed in 2008/9, brought sharply into focus the scale of the ageing population in the Borough. Havering has the highest proportion of older people in London and the gap is widening. The JSNA also noted that the numbers of carers in Havering is very high and set to grow.

According to Andrew Ireland, Havering’s Director of Social Care and Learning ‘the scale of the demographic challenge means that the Borough faces issues more like those in Tokyo (with an ageing population, who’s children are less healthy and a weakened economy) than those in Tottenham’.

The economic pressures of responding to the needs of a rising population of people aged over 85 was a key concern, as was an identified unmet demand for carers services and for those with physical and sensory impairments.

Taken together, the partners agreed with the Directors conclusion that ‘industrial scale action’ and significant change were needed if the Borough was to rise to and meet this challenge. Recognising this, the partners (LA and PCT) accelerated their plans to use the widest extent of their commissioning and strategic powers to positively influence the health and wellbeing of the population and saw the JSNA as the evidence base for this.

Just as importantly, this team and the developments it has driven, are seen as an integral part of the Transformation of Adult Social Care, managing efficiencies in the current economic climate and completely consistent with and essential to meeting the Putting People First agenda.

For example, as the JSNA highlights a faster growing cohort of older people than any other London Borough, it also reveals that there are more people who buy their care privately than those who receive care and support via the Council (as occurs in many Shire Counties).

With the traditional system of care management targeted at people with substantial or critical needs (as is the case in 75% of Local Authorities) this provides limited support and safeguards to people with low or moderate needs or who fund themselves. Practical plans to improve the health and wellbeing of this group and prevent or delay their need for care and health services, is therefore essential to the Partnership in Havering.

The Aim

This led to a focus on how the provider market could be stimulated to support these people. As Personalisation\(^\text{22}\) becomes the norm, by 2011 Havering will see a rise from the current 556 to around 1800-2000 people who will be Self Directing their own support and care. It is anticipated that at least 600 people will want Personal Assistants, who are currently are not available. There are also concerns that there is no national drive to regulate or stimulate the Personal Assistant market.

The Benefits and Learning

In April this year a cross authority contract, led by Havering, was awarded to Outlook Care for the stimulation and regulation of the Personal Assistant market to see the safe and

\(^{22}\) Personalisation, defined in ‘Putting People First’ is intended to ensure that every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.
sustainable development of services which people will commission themselves. The first ‘accredited’ Personal Assistants will be available to customers in September 2010.

Although current health legislation does not yet align with developments in social care, personal health budgets are being piloted in Havering (and 19 other areas) and this will help people with long term conditions who often fluctuate between health and social care eligibility and who are not currently able to purchase health care in a self directed way.

As a practical example, the infrastructure for Telecare\textsuperscript{23}, which is already established and effective in Havering, is compatible for Telehealth\textsuperscript{24} which will become available to the 900 people who regularly need in-patient hospital services due to long term conditions, and who will be able to be managed at home.

The Health & Well being Board of Havering Strategic Partnership is attended by one of the new jointly appointed JSNA officers and has already commissioned outside of traditional boundaries with the JSNA used to identify and drive Joint investment in new services for a range of user groups including

An information service, a single point of contact, emergency contact card for Carers and ‘Daybreak’ commissioned to provide support to carers and family members of substance misusers transitional accommodation in twelve flats at Royal Jubilee Court with a care package of rehabilitative re-ablement, community nursing support, housing related support and a Telecare assessment and implementation.

A rent deposit scheme commissioned with Supporting People will start in July 2009 through Family Mosaic, a Registered Social Landlord. This will enable clients in treatment to access private sector accommodation with a 12 month package of tenancy support. This is designed to enhance treatment outcomes and gains, often compromised by a lack of independent, less stable or absent accommodation.

**What next**

Additional Housing data will be considered this year for the first time as will the use of Leisure services - since it has been noticed that the take up of free swimming is lower in deprived areas where more marketing is now to be channelled.

**Key Messages**

Co-locating staff in an integrated team, with responsibility for compiling, refreshing and using the JSNA as the basis for services commissioning provides a clear ‘home’ for including the housing and support needs of vulnerable adults.

Ensuring the widest needs of vulnerable adults are reflected in the JSNA will extend the role and understanding of housing and support services to a much wider audience; widen the scope and experience of the commissioning partnership, and make it easier to overcome professional, organisational and funding barriers.

The evidence in JSNA’s can be used to strengthen the case for action and/or to accelerate progress on other key areas for change, such as investment in prevention and personalised services and the stimulation of new markets.

\textsuperscript{23} Telecare is the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living

\textsuperscript{24} Telehealth is the consistent and accurate remote monitoring and management of a patient’s health condition
Bristol

What they did

Having been a pioneer in the early use of the Housing Health and Safety Rating System\(^\text{25}\) (HHSRS) Bristol’s Private Rented Sector team had been recording incidents of hazards since 2003.

The HHSRS is a risk based approach to assessing housing conditions focussing on the potential threats to health and/or safety attributable to any deficiencies. The range of 29 HHSRS housing hazards recognises their differing characteristics; for some the outcome can be fatal; for some the occurrence may be almost instantaneous (such as a fall) while for others any health effect will only occur after a period of exposure (such as excess cold or dampness). The HHSRS therefore uses a formula to generate a numerical Hazard score.

Why

Bristol’s Private Rented Sector team were disappointed not to see much reference to the importance of housing within the JSNA Guidance and Core Data set. With no direct recognition of their role in improving living conditions in targets in the National Indicator set\(^\text{26}\) either, the team were determined to show what a difference their work made and what more they could do.

The Aim

Bristol’s HHSRH statistics and the information in their 2007 house condition survey enabled the Council to predict that 5 per cent of residential properties have a category 1 hazard. Cross referencing this with Primary Care Trust (PCT) health profiles and local authority statistics the housing team aimed to identify significant forms of ill health across the city. The key problems of relevance to housing were found to be:

- A higher than the national average of hip fractures among older persons;
- Children under 15 years old ‘not in good health’;
- Early deaths from heart disease and stroke;
- Fear of crime.

The Benefits and Learning

To ensure this was fully recognised, this health and housing evidence was fed into Bristol’s JSNA which concluded that

“There are close links between poor housing and poor health outcomes. Almost a quarter of Bristol’s private sector homes are ‘non-decent’. Housing requirements are changing due to an ageing population, with more people with disabilities and limiting long-term illness living at home and demand for smaller household units.”

Initiatives to deal with these issues are listed in the JSNA as:

\(^{25}\) Housing Health and Safety Rating System - Guidance for Landlords and Property Related Professional
\(^{26}\) The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators
The Supporting People Programme in Wales: Final Report

- Low cost or free loft and cavity wall insulation for vulnerable persons in all parts of the city and promotion to people with chronic obstructive pulmonary disease referred by the PCT;

- Subsidised loans for homeowners to enable them to improve their properties to meet the Decent Homes Standard;

- More support and advice is being offered to landlords for managing housing for vulnerable people; and

- Home adaptations, making use of the Disabled Facilities Grant, are helping to plug the gap in suitable housing provision for Bristol’s ageing population.

While many Councils have experience of such initiatives and collaborative working across public health and housing, Bristol PRS developed their data and using the JSNA and the evidence collected, set up a programme of Home Action Zones (HAZs) to target the ten most deprived areas of the city where the most significant impact in improving housing conditions and health could be achieved. Two pilots were completed in December 2009 and two new zones will start in early 2010.

Residents of the HAZ’s can access a range of services linked to HHSRS hazards such as energy efficiency improvements, home fire safety checks, and small adaptations and equipment such as bath boards, grab rails, WC pan risers and grabbers/pickers.

To strengthen the message and the relevance to health of housing data, Bristol City Council has made good use of the Chartered Institute of Environmental Health’s (CIEH) Toolkit HHSRS Cost Calculator. For example they found that the total cost of dealing with expected occurrences of excess cold in Bristol would be £2.2m with a resultant annual saving to the NHS of £7.4m: a payback period of around 3 months.

Just as important, the Bristol team wanted to evaluate what difference local residents felt this made to their health and wellbeing. A satisfaction survey found that:

- 36% of respondents who received a low interest loan or grant to make their home decent felt warmer in their home and more comfortable as a result;

- 50% felt that the health of the household had improved;

- 41% felt ‘happier’; and

- Of those households receiving just free home security work 58% feared property crime and burglary less and 6% said their health had improved.

What next

The Council has also been working with Warwick University and five other councils, using a more developed form of the CIEH cost calculator to more accurately demonstrate the cost of improvement against savings to NHS. The newly published report Linking Housing Conditions and Health develops this further.

26 Good Housing Leads to Good Health, A Toolkit for Environmental Health Practitioners
27 Linking Housing Conditions and Health
This work is kept connected to Bristol’s Health & Wellbeing Partnership board through the Joint Director of Public Health (DPH) who is the direct link between this board and the JSNA Steering Group. The DPH is supported by a senior health officer who is a member of the Strategic Housing Partnership, ‘Homes 4 Bristol’, and who is championing a key, housing led project to create balanced communities. Nick Hooper, Strategic Services Manager, Neighbourhood and Housing Services believes that ‘it will be the next iteration of JSNAs which will get to the fine grained stuff and better able to help us hone in on geographical areas’.

Linda Prosser, Interim Service Director - Older People agrees and said ‘The JSNA really highlighted to us the significant impact of below standard housing on the health and wellbeing of some of our most vulnerable population. Since our objective is to ensure that people are safe and their independence maximised, whilst keeping long term care costs to a minimum, we want to capitalise on opportunities to make homes more suitable. Consequently we agreed that one of our top objectives for 2010/11 is to: ‘Ensure Health & Social Care staff take appropriate action to maximise access to ‘Warm Front scheme’ grants for vulnerable people particularly disabled and elderly whose homes fall short on warm front triggers’. We intend to develop this by linking into the cities green agenda and making the most of opportunities to invest in initiatives to reduce CO2 emissions, further lowering energy costs in the homes of vulnerable adults.

**Key Messages**

JSNAs should make use of Local Authority Private Sector Housing Teams data and experience, recognising that they have significant statutory responsibilities and powers which can improve health and wellbeing, extending to targets to improve the quality of the environment.

JSNAs should ensure that the housing and support needs of all vulnerable adults are included, by connecting with housing partners who can represent the whole sector. There are a wide range of housing responsibilities, organisations and professionals, across all sectors, who connect to ‘health’ and impact on vulnerable people, in different ways.

Linking Health and Housing through JSNAs can provide a basis for a joint understanding and agreement on the future use of Cost Benefit Models, such as the enhancements to the CIEH ‘cost calculator’ and the Cap Gemini model to show the financial benefits to the health sector of supported housing services.
References

DH Guidance on Joint Strategic Needs Assessments Department of Health in partnership with Communities and Local Government and Department for Children, Schools and Families (2007)

HM Government Creating Strong, Safe and Prosperous Communities Statutory Guidance Communities and Local Government (2008)


DH The JSNA Core Dataset Association of Public Health Observatories (2008)

CLG Strategic Housing Market Assessments, Practice Guidance Department for Communities and Local Government (2007)

CLG Housing, care, support: a guide to integrating housing related support at a regional level CLG, CSIP, Housing LIN, Housing Corporation (2008)


South West London and ST Georges Mental Health NHS Trust The New Directions Team Assessment (Chaos Index) (2008)


Devon The Way Ahead: A Strategic Framework for health and social care Devon Primary Care Trust and Devon County Council (2008)

Devon Accommodation and Support Joint Strategic Needs Assessment for Mental Health Devon County Council (2008)

Devon Strategic Review of Older Persons Housing and Support Services Devon County Council (2008)

CLG Supporting People financial benefits model documentation and user guide Capgemini UK plc Communities and Local Government (2009)


NWJIP Business Plan Summary 2009/10 Supporting improved outcomes in social care, health and wellbeing for people and families in the North West North West Joint Improvement Partnership (2009)

4NW The Need for Support and Supported Housing Services in the North West 2008-2020 HGO Consultancy (2008)

4NW Regional Strategic Framework for Housing Support 2009-20 Regional Leaders Board (2009)

Audit Commission Housing Inspectorate Key Lines of Enquiry Local Authority Strategic Involvement: Supporting People (2008)


Bristol Joint Strategic Needs Assessment...keeping you informed Understanding Health & Wellbeing in Bristol. Bristol City Council, Bristol Local Involvement Network and NHS Bristol (2009)

CIEH Good Housing Leads To Good Health: A toolkit for environmental health practitioners Chartered Institute of Environmental Health (2008)

Appendix 6 A Supporting People National Advisory Board

The Supporting People National Advisory Board (SPNAB) could be set up under general powers conferred on the Welsh Ministers.

The SPNAB would be responsible for providing independent advice to assist the Deputy Minister for Housing and Regeneration in discharging her functions and meeting her accountabilities for the execution and performance of the Supporting People Programme in Wales.

The SPNAB would increase the transparency and accountability for the operation of the Supporting People Programme in Wales but would not interfere with the Deputy Minister’s accountability to the National Assembly for Wales for the discharge of her functions.

The SPNAB would, moreover, provide tangible and visible assurance that processes and practices are fair, transparent and equitable and that planning, procurement and commissioning policies are clearly defined and have proper governance, regulation and accountability arrangements in place. It would also oversee the proposed new structures for the distribution of the Supporting People Programme Grant and its administration at local, community and national levels.

The SPNAB would also represent a step-change move to ensure that the roles and responsibilities of the Local Authorities, service providers, housing-related services, partners and key players in the Supporting People Programme are clearly defined and understood. The role of the Welsh Assembly Government in the proposed new structures would also be made more transparent. In supporting the Deputy Minister who would chair the SPNAB, the Board would provide advice on the policy and strategic framework for the Supporting People Programme in Wales.

It is proposed that in order to meet the requirements for transparency and accountability, the SPNAB would meet in public and the agenda, papers and minutes of the SPNAB will be a published record. This would be subject to circumstances where it would not be in the public interest to hold meetings in public and the chair would determine any such occasions. SPNAB members must maintain the confidentiality of any matters considered in private session or set out in documents which are not publically available. Disclosure of any such matters would only be made with the express permission of the SPNAB chair.

The SPNAB may invite individuals or groups to address and/or inform its meetings, but there will be no right to public participation in the proceedings of the Board.

Membership

A suggested membership of the SPNAB would be:

- Chair – Deputy Minister for Housing and Regeneration;
• Vice-Chair – for decision by the Deputy Minister; and

• Representatives of those bodies, organisations or groups with understanding or, and an involvement in administration planning, commissioning, procurement or delivery of the Supporting People Programme in Wales (eg: Local Authorities, Local Service Boards, Housing-related services, Probation Services, Providers of Supporting People Services, Public Health, Local Health Boards & Co)

**Officials in attendance**

• Officials in attendance would reflect the needs, purpose and objectives of the SPNAB; the precise composition of which would be determined by the Deputy Minister for Housing. It is suggested that other officials may also be invited to attend by the Chair of the Board to present papers as required by the Deputy Minister.

• Secretariat:

  The SPNAB will be supported by a small Secretariat provided from the Sustainable Futures Directorate General. The Secretariat will provide the first point of contact for Board members and will co-ordinate the activities of the SPNAB.

**Appointed Board members would:**

• Contribute to discussions at meetings;

• Advise the Minister on policy, priorities, practices and strategic direction to achieve an effective, efficient and value-added delivery of outcome-based support services and projects to meet the needs of disadvantaged and vulnerable people encompassed by the remit of the Supporting People Programme in Wales;

• In developing advice and in the presentation of information, draw on the best available evidence and thinking on those matters relevant to the provision of services to meet the needs of the people for whom the Supporting People Programme in Wales is intended; and

• Assist with the forming and shaping of plans, priorities, standards and values through constructive challenge and scrutiny of policies and proposals.

**Relationships:**

Consideration should be given to forming relationships with key representative groups involved in, or relevant to the Supporting People Programme in Wales.
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Collaborative Committee
- Common (shared) services
- Neighbourhood level focus
- Horizon scanning
- Planning funding and securing
- Unified plan to WAG / NAB
- Commissioning and procurement, etc
- Regulation and monitoring, etc

Money

WAG
- Policy development
- Strategic Direction
- Basis for allocation
- Political awareness
- Accountable to tax payer
- Cross departmental approach
- Ministerial Statement of intent
- Emphatic guidance
- National Leadership

National Advisory Board
- NAB quarterly or thrice yearly
- Chair = Deputy Minister for Housing Standards
- Prioritisation
- Assurance
- Governance
- National perspective
- Ex Cathedra
- “Group SP”
- LCO Advice

Secretariat
- Small WAG resource
- Officials in attendance

Ringfenced outside RSG
LOCAL AUTHORITY
- Indicator Based Assessments

SUBCOMMITTEE OF LSB
(Suitably constituted)
Consensual, Collaborative, multisectorial

Commissioning
Audit
Procurement