Imogen Blood &
Associates

“Ultimately other services finish at 5pm”

Research into the supported housing sector’s impact on homelessness prevention, health and wellbeing

Full final report

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Contents

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Foreword

The supported housing sector often quietly delivers high quality services that offer value for money and achieve life-changing outcomes for the people who we support. However, this calm and quiet approach has meant that we are seldom recognised for the contribution we make. This low profile has resulted in a chronic lack of focus from government and investment. With the current cost of living crisis affecting residents across the country, the role of supported housing is more important than ever. It provides affordable and good quality homes for residents to live and safe spaces that have positive outcomes for their health and wellbeing.

That's why we are delighted that this research clearly evidences the significant positive impact that these services are delivering on a daily basis while highlighting the complexity of the support needs of the people that we as providers are working with. It also demonstrates that without our accommodation and support the number of people who are homeless would significantly increase. In turn this increase would put further pressure on other statutory services, putting even greater demands on the public purse.

In England there continues to be a shortage of affordable homes and supported housing provides vital accommodation for some of the most vulnerable people in society. The research underlines the critical role supported housing plays in reducing homelessness and shines a light on the considerable role it plays in relieving pressures on the social care, health, criminal justice and housing sectors. The report demonstrates the importance of effective partnership working with NHS and social care, and the contribution which supported housing is making to the strategic aims and statutory duties of these services.

When this research was commissioned, we decided it should focus on supported housing to enable us to evidence its specific impact. At the same time, however, despite being outside the scope of this report we do want to recognise the vital role played by older peoples housing related support services, floating support services and housing first initiatives.

We are confident that the report will help provide the awareness and understanding of the role the supported housing sector plays to politicians and other key stakeholders. We are also hopeful this insight will make the case for securing integrated strategies and much needed longer-term funding. Ultimately it aims to eradicate homelessness and provide vital high quality supported housing for the long term.

John Glenton, Executive Director of Care and Support, The Riverside Housing Group and chair of the National Housing Federation's Homelessness National Group

Donna Kelly, Group Director Support and Neighbourhoods, Jigsaw Homes Group and chair of the National Housing Federation's Health and Housing Group

Executive Summary

Imogen Blood & Associates, with the Centre for Housing Policy at the University of York, was commissioned by the National Housing Federation (NHF) and its members to carry out research on the impact of supported housing on homelessness, health and wellbeing.

This included:

- A snapshot survey of 2,119 individuals living in supported housing projects for working age adults on 1 August 2022. The survey was completed by the support worker who knows the resident the best (their 'keyworker') not by the individual. The survey was distributed by 11 diverse housing associations which are commissioned by statutory agencies to provide support. Housing First and older people's services were not in scope.
- Qualitative interviews with 30 professionals from housing associations, the NHS, and key national bodies, including NHF, NHS England, HACT and Homeless Link.

Key findings

The study found evidence of the positive impact of the sector on outcomes in relation to individuals' quality of life, reducing homelessness, and improving health and wellbeing.

Resident need

The complexity of need of those living in supported housing is striking.

- 9 out of 10 supported housing residents have at least one health condition or disability (including substance misuse, mental ill-health, learning disability/autistic spectrum disorder and physical conditions)
- Half of residents are experiencing more than one of the above conditions

The supported housing sector manages high levels of risk, within a context of reduced availability of statutory services.

- 54% of residents moved in because they needed a 'safe and secure environment'
- 60% of residents are vulnerable to exploitation/ abuse from others, 18% significantly
- 29% of the sample were felt to pose a risk of harm to others, 5% significantly

People do not fit into neat categories. For example, the whole sector is assisting people with support needs arising from mental health and domestic abuse.

- 56% of the whole sample have a diagnosed mental health condition, yet less than a quarter of them are living in a specialist mental health scheme.
- Over half of women living in supported housing across all sectors and client groups are known to be recent survivors of domestic abuse.

We developed distinct theories of change for short- and long-term services; but found many similarities between how these models are operating in practice, and those they support.

The distinction between the 'commissioned' and 'non-commissioned' parts of the sector is also increasingly blurred, as providers try to develop their own move-on pathways and continue to deliver schemes in which local authority support *used* to be commissioned.

Reducing homelessness

Short-term/ transitional supported housing is playing a key role in preventing higher risk forms of homelessness, such as rough sleeping.

Annually, an estimated 50K people a year are being resettled in tenancies from an estimated 80K units of transitional supported housing. This includes generic homelessness, young people's services and a range of specialist recovery services for substance misuse, mental health step-down, survivors of domestic abuse, etc.

We estimate that around half of these people (25K) will have had significant previous histories of homelessness/ housing instability/ time spent in institutions.

However, the sector's ability to move people to independent tenancies is limited by a lack of affordable housing and barriers such as former tenant arrears and landlords' concerns about the potential for anti-social behaviour. This means some people stay longer than necessary from a support perspective.

- 56% in transitional supported housing were felt ready to move on at snapshot date
- For just over half (53%) of those ready to move on, this was not possible because 'finding a suitable move-on option is proving difficult'.

There is also a group of people who require longer term support than some services have been designed and commissioned for. Around 15% of 'short-term' supported housing residents have stayed for more than three years. This indicates both the complexity of need and the lack of resources to meet this need.

We received follow-up data for one fifth of our sample living in transitional supported housing. Three months after the snapshot:

- Around 1 in 10 had left for negative reasons, such as abandonment or eviction
- 13% had been resettled into a tenancy.

Improving health and wellbeing

- 1 in 4 residents (across all scheme types) have a *physical* disability and/or limiting long-term health condition
- An estimated 72K people with a history of mental ill-health are living in supported housing at any one time.

Our findings demonstrate that supported housing helps its residents to access primary care and specialist treatment/ diagnosis where needed. There are approximately 140K people living in working-age supported housing provided by Private Registered Providers (PRPs) in

England at any given time. Out of that population, we estimate that, since they moved in to that supported housing place, the service has assisted:

- 70K people to register with a local GP so they can access primary care services
- 62K people to attend health appointments more consistently
- 36K people to access diagnosis and/ or treatment for mental health conditions
- 32K people to access diagnosis and/ or treatment for physical health conditions

Partnerships

Effective partnership working and integration with NHS and social care is critical given the extent of healthcare needs of so many residents. Where this is working well, outcomes for individuals tend to be better.

However, supported housing services could be even more effective if they had good quality coordination and joint working with properly resourced mental health teams.

> Across all schemes, less than half (43%) of those felt to need the assistance of mental health services had received that assistance in an unproblematic way.

The sector has specialist services for people with particular support needs, such as those arising from mental ill-health or experiences of domestic abuse. We found some evidence of these services enjoying better partnerships with external services linked to their specialism.

Value for money / relieving pressure on services

Supported housing operates within an increasingly challenging and financially insecure context. As local authorities continue to reduce their funding of housing-related support, some providers of supported housing are leaving the market due to high risks.

Based on data received from participating providers, we estimate an average total cost (i.e. including housing and support) of £21K per supported housing place per year.

Were it not for the supported housing sector, we estimate there would be:

- An increase in core homelessness of around 41K people, with a further 30K people at significant risk of future homelessness; the cost to the public purse of long-term homelessness has been estimated at over £40K per person per year
- Need for 14K additional inpatient psychiatric places (each about £170K per year)
- Increased demand, from the transitional/short-term sector alone, for 2.5K places in specialist residential care, many for people with multiple needs including substance misuse, and mental ill-health (each costing in the region of £45-£50K per year).
- A need for a further 2K prison places (each costing an average of £32.7K per annum), due to licences or court orders being revoked.

If funding mechanisms for supported housing collapse or are withdrawn, the impact on rough sleeping, demand for residential care, psychiatric in-patient and prison places would be wholly unmanageable, especially as these services are already over-stretched.

Conclusions

Our findings evidence the substantial impact which the sector is having on reducing homelessness, and improving health and wellbeing for people experiencing multiple disadvantage. Without supported housing, there would be significantly higher levels of homelessness and far fewer people would be receiving the support they need to sustain their accommodation.

However, it is also clear that the return on investment of public monies in this sector could be increased:

- With more move-on housing and accompanying floating support for those who need it, the sector could resettle even more people, further reducing pressure on local authority homelessness functions
- With better access to NHS Secondary Mental Health support, supported housing could reduce demand on NHS inpatient services and support people in the community. With greater integration and co-design with NHS mental health services, supported housing could support earlier discharge from inpatient care, enhanced crisis support and reduced use of costly out of area specialist placements
- With more consistent partnerships with primary healthcare, supported housing could support even more 'hard-to-reach' individuals to access timely and preventative healthcare, reducing avoidable emergencies and admissions
- With better coordination with criminal justice services, supported housing could have an even greater impact in reducing re-offending.

The new Integrated Care Systems (ICSs) provide an opportunity for better strategic integration of supported housing in wider systems at a place-based level. Our study has identified examples where this is starting to happen as a result of:

- Housing association partnerships being represented on Integrated Care Partnerships
- Dedicated housing leads within ICSs, including secondments from the sector
- 'Provider to provider innovation', where NHS provider trusts or collaboratives have taken on responsibility for a whole clinical pathway and are forging partnerships with supported housing providers to develop clinically integrated schemes
- Supported housing providers successfully bidding to lead partnerships delivering integrated care
- Providers developing in-house clinical teams or subcontracting trusts to provide reflective practice and staff development for support staff
- Place-based strategic work to carry out supported housing needs assessments, or co-produce consistent housing and support models.

Whilst these examples are promising, interviewees highlighted the need for a clearer national framework to ensure this innovation is replicated, albeit one which allows sufficient flexibility for place-based partnerships to respond to local priorities. Central leadership is required to ensure consistent definitions, models and outcomes measurement, and to prompt and challenge ICBs to ensure supported housing is integrated in their plans. Partnerships can only flourish where there is sufficient security of funding to develop, plan and deliver high quality supported housing.

1. Introduction

Imogen Blood & Associates, working in partnership with the University of York, was commissioned by the National Housing Federation (NHF) to carry out research:

To quantify, at a national level, the impact of supported housing on:

- Reducing homelessness, including rough sleeping and repeat homelessness
- Health and wellbeing outcomes
- Financial savings to statutory agencies, including Local Authorities, the NHS and Public Health.

To understand the benefits of effective partnership working between housing, health and social care and the role which such collaboration can have on reducing homelessness, health and wellbeing outcomes, and financial savings.

To consider the implications, opportunities and risks for effective partnership working in relation to supported housing within the context of the adult social care white paper and the formalisation of integrated care system structures.

1.1. What is 'supported housing'?

Supported housing is accommodation provided alongside support and supervision to help people live as independently as possible in the community, e.g. a shared house for people with learning disabilities, a hostel for people who have experienced homelessness or a mental health step-down unit.

For the purposes of this study, the following supported housing services were in scope:

- Working-age client groups (i.e., schemes which are specifically designed for older people, such as retirement housing/ extra care are out of scope).

- Both shorter-term/transitional models (e.g., for people at risk of homelessness and/or those fleeing domestic abuse) and longer-term arrangements (including, for example, supported housing for adults with learning disabilities, physical and/or mental health conditions).

- Schemes run by providers who are contracted to deliver housing-related support by local authorities, or other statutory commissioners.

- Floating support and Housing First models were out of the scope of the brief (see **Foreword)**; however, dispersed provision in which there is an integrated package of housing management and support was included in the study.

1.2. Supported housing – challenges and opportunities

In an earlier report for The Riverside Group (see p.10 onwards), we describe the history of successive governments' attempts to curb spending on housing-related support services. This has happened within a context of:

- Wider cuts across the public sector especially for local authorities, resulting in social care resources being shifted towards the highest need individuals
- Ongoing organisational change in health and also in criminal justice
- A procurement-driven, contractual relationship between local authorities and the supported housing sector
- A shift towards localism and devolution.

Since the end of the *Supporting People* programme, the sector has been disadvantaged by a lack of current data in relation to the impact, outcomes and cost-effectiveness of supported housing (SH). Even gathering accurate data about the scale, scope and cost of supported housing has been extremely challenging. As local authority spending on support provision has contracted over the past decade - certainly within the homelessness sector – there has been an increase in 'non-commissioned' provision. This has prompted concerns about the lack of oversight over quality, value for money and safety in the supported housing sector. As government considers how to tackle these concerns, there is a clear need for better data about the profile and needs of people living in supported housing provided by reputable housing associations and its impact on their health and wellbeing, and on the public purse.

1.3. The current context for supported housing providers

Our qualitative interviews asked providers about their current operating context. Key themes are presented below.

Funding for support

The value of support contracts has not increased in line with inflation in many areas, despite rising costs. We heard many examples in which support has been de-commissioned, or partially decommissioned (e.g., where only *some* of the beds in a scheme are now funded to receive support). Providers were left having to choose - either to resettle residents and find an alternative use for the buildings, or re-configure their models whilst managing increased levels of risk, e.g. by replacing overnight support workers with security staff funded through rents with tenants claiming Housing Benefit to cover costs.

Local authority commissioning

Providers' relationships with local authority commissioners varies considerably: one interviewee told us how they had been able to negotiate a 10-year commissioning deal on one scheme (described in section 6.4.1), but others described 'adversarial' relationships and 'punitive' contract terms. Diminishing budgets mean that some housing support contracts were felt to be financially non-viable or even unsafe, and reduced commissioner capacity meant that providers felt model design and expected outcomes were sometimes 'vague'.

Kent County Council has decided that it can no longer fund non-statutory support services for people affected by homelessness.

Recruitment and retention

Providers in different parts of the country are reporting similar challenges with staff recruitment and retention post-Brexit, post-pandemic and given increases to cost of living and inflation. Reduced contract values make it hard to pay staff much above minimum wage despite asking them to manage increasing levels of risk and complexity. However, one provider explained that where contracts were commissioned by the NHS, the picture was much better:

> *"Things are better funded on health contracts, so we can pay our staff better on these contracts and the NHS gets so much more for their money because their Band 3 admin is what we pay our support workers (even on better-than-average pay!)".*

Rising costs

Providers reported increased costs across most budget categories – energy, fuel, building materials and labour at a time of increased Housing Benefit scrutiny. Some reported significant investment in assets to address building safety and compliance issues, such as de-cladding and urgent repairs and renewals. The NHF members we interviewed agreed in principle with increased regulation for housing support, provided it is not unnecessarily bureaucratic and resource-intensive. However, the unknown cost implications of this (for example where Ofsted regulation is being introduced for those supporting 16 and 17 year olds) is adding further uncertainty where margins are already tight.

Development

In 2017, PSSRU projected a need for supported housing for working age adults to increase from 190,000 in 2015 to around 220,000 in 2030, to keep pace with demographic pressures alone. Yet our qualitative interviews confirmed the findings of an NHF survey that concerns about uncertain revenue, combined with insufficient capital grant and access to land and planning permission, are getting in the way of new developments.

New opportunities

Despite these challenges, some providers report new opportunities to develop and deliver supported housing in partnership with the NHS and criminal justice system. We report on some of the ways in which housing associations are adapting and innovating in Chapter 6.

1.4. Methods

A the start of the project, the research team developed two Theories of Change – one for short-term/ transitional supported housing and one for long-term supported housing models and tested these with our steering group of supported housing providers. These are appended.

The study included both quantitative and qualitative data collection, alongside a brief review of relevant existing literature. We carried out:

- A snapshot survey of individuals living in supported housing on 1 August 2022, completed by the support worker who knows them the best ('keyworker'). We conducted this in partnership with a diverse sample of 11 housing associations, including national/ regional and generic/ specialist providers of supported housing.

  The survey asked keyworkers for their understanding of why the individual had moved in, their demographics and needs, the outcomes they had been assisted with, partnership working and what the alternatives/ move-on plan (if relevant) was for them.

  2,119 responses were analysed for this report, using data analysis software (SPSS) to conduct multivariate analysis, and Excel for simpler cross-tabulations.

- 30 professionals were interviewed individually or in groups to explore the context for and learning from partnership working with NHS, local authorities and criminal justice. These included senior managers from housing associations, NHS Directors and Policy Leads with a responsibility for housing, and representatives from key national bodies, including NHF, NHS England, HACT, Homeless Link.

Our methodology and its limitations and the contributors to this report are described in more detail in the Appendix to this report. A key limitation is that it was not possible within available resources to include the views of people living in supported housing; we have tried to mitigate this by including quotes from case studies which are already in the public domain and reviewing other studies which have focused on lived experience.

Provider and scheme characteristics

The total sample size, after a number of cleansing operations[1], was 2,119 returns. The best estimate of the total size of the working-age supported housing population as provided by Private Registered Providers (PRPs) is 140,323.[2] The survey sample therefore represents 1.5% of the total PRP supported housing population.

The sample of 11 providers participating in the survey was selected to ensure a representative mix in relation to regional spread and size. Some of the participating providers are classed as 'specialist', because their sole or primary business is to provide supported housing to a particular client group; others are classed as 'generic', because they provide a range of supported housing models, in addition to their role as a general needs landlord.

[1] This includes removing what appeared to be duplicates and returns that were only partially completed. It also included removal of a number of returns that were for services that were in fact clearly for people living in older persons services.
[2] Based on the Statistical data Return (SDR) 2022.

Table 1: Sample of Providers

Type of Provider	Number of providers participating	Number of survey returns received from this type of provider	% of survey returns received from this type of provider
National Generic	2	1044	49%
Regional Generic	7	912	43%
Specialist	2	163	8%

To put this into context, the Statistical Data Return suggests 36% of supported housing stock is owned or managed by RPs that only operate in one of the government regions. This compares reasonably well with the 43% of survey returns from 'regional generic' providers.

Supported housing takes a number of forms, plays a number of roles, and sits within a number of different service networks. We used a two-fold classification of "Scheme Type" and "Principal Target Group" to categorise this array of service types.

Scheme Type is divided into two broad categories:

- 'Short-term/ transitional', which aims to support a move into settled housing once housing-readiness has been demonstrated and/or a move to longer term supported housing once needs have been assessed and a suitable place found
- 'Long term', which provides long term home in the community.

Principal Target Group is based on traditional client-group labels. The following table breaks down the survey returns against these two categories and compares the proportions against the estimated breakdowns in the 2016 Supported Accommodation Review (SAR).

Table 2: Survey returns by client group

Target Group	Long term Number	Short term Number	Total Number	% of Total (ignoring unknown)	Proportions estimated in SAR, 2016*
Learning disability	143	3	146	7%	24%
Mental health	35	269	304	15%	19%
Generic homelessness	113	931	1,044	52%	22%
Domestic abuse	0	52	52	3%	3%
Substance abuse	0	120	120	6%	3%
Offenders	0	23	23	1%	3%
Young people	8	326	334	17%	12%
Unknown	10	86	96		
Total	***309***	***1,810***	***2,119***	***100%***	

*The SAR included two further categories not present in our list: physical disabilities (6%) and 'other' (including refugees/ asylum seekers) (8%)

Learning disability service users are under-represented in the survey returns, and generic homelessness service users are over-represented. Nevertheless, the number of returns in each target group is sufficient to draw conclusions. We have used the above SAR proportions to weight averages where scaling up to generate national estimates (please see a fuller description of this in the **methodology appendix**)

We were able to match 1,511 of the 2,119 individual responses with basic scheme information. This data shows the following breakdown in terms of staff cover models:

Table 3: Breakdown of staff cover models

Staff cover model	**% of returns (n=1,511)**
24 Hour Cover	54%
On Site Cover	27%
Visiting Staff	18%

It was our intention to include only services where the support is commissioned by a local authority or other statutory agency. However, it became clear from conversations with participating providers that the boundary between 'commissioned' and 'non-commissioned' services is somewhat blurred. Some social landlords continue to operate schemes, despite the withdrawal of local authority funded support from some or all of the bed spaces. Some commissioned providers have also developed their own move-on accommodation, funded by income from rents and service charges, sometimes leaning into other commissioned contracts (e.g. with Public Health) to make these stack up financially.

Of the 1,467 individual returns which we were able to match to data about the scheme funding arrangement, 1,107 (75%) were commissioned and 360 (25%) were not.

2. Profile of supported housing residents

Our survey generated demographic data for 2119 people living in a range of short- and long-term supported housing. Tables providing detailed data on the demographics of those living in supported housing schemes broken down by primary target client group are appended to this report, with headlines presented here.

2.1. Protected characteristics

Age

With the exception of specialist younger people's services, those in the 40-64 age group consistently form the majority of residents (41% of our sample in total). Only a small minority were outside of working age: 3% were aged under 18 and 3% above 65.

Gender identity

With the exception of domestic abuse services (which in our sample were occupied exclusively by women), the proportion of men is greater than that of women in all primary client groups. Those identifying as male made up 68% of our total sample, falling to 56% in younger people's specialist services.

Ethnicity

We asked a simplified question about whether or not individuals identified as being from a black or minority ethnic background. 18% of the total sample did, though that increased to 36% in mental health specialist supported housing, to 23% in domestic abuse services, and to 21% in young people's provision.

Mental health

56% of the whole sample were reported by their keyworker to have a *diagnosed* mental illness. The reported rates of diagnosis were high in all the different types of supported housing, regardless of the principal target user group, including 74% of people in offender services and 53% of people in generic homelessness services. Only 25% of the people with a diagnosed mental illness in the sample survey were actually living in a specialist mental health supported housing service.

Workers were also asked whether they felt the person needed assistance from external mental health services, allowing for people whose mental ill-health had not yet been formally diagnosed to be included. 63% of the sample were felt to fit in this category.

National estimate: 72K people with a diagnosed mental illness are living in supported housing at any given time.

Physical health or disability

12% of the total sample had a physical disability or sensory impairment, increasing to 15% in generic homelessness settings.

18% have a long-term physical health condition, increasing to 22% in generic homelessness settings.

42% of the sample was felt by their keyworker to need assistance from other NHS professionals (i.e. outside of mental health, substance misuse or learning disability specialists).

National estimate: Approximately 60K[3] supported housing residents need assistance from other NHS professionals.

2.2. Support needs

Adult social care involvement

22% of the total sample have a social care package, though the majority of these are in specialist learning disability schemes (where 91% of residents have a social care package) and mental health schemes (where 33% do).

19% of residents of young people's services and 9% of generic homeless service users also have a social care package in place.

We combined the numbers in our sample who already have a care package in place with those whose support workers felt they probably needed a care package but were not receiving one. This produced the following estimates of those in need of adult social care.

Table 4: Estimates of those in need of adult social care by target group

Target Group	% needing adult social care
People with learning disabilities	91%
People with history of mental health problems	33%
Generic - homelessness project	14%
People with experience of domestic abuse	15%
People with history of problematic substance use	11%
People with offending history	4%
Young people	19%
Unknown/no data	66%
Total	***40%***

[3] NB: we have rounded this estimate up from 51K using the methodology stated here to take account of the under-representation of schemes for people with physical disabilities in our sample.

National estimate: 48,000 supported housing users at any one time are in need of adult social care, of which 31,000 are in learning disability services.

Offending history

900 people or 45% of the survey sample had some offending history, according to their keyworker. These were split fairly evenly between our three categories:

- 12% had been convicted of less serious or petty offences in the past but on a one-off or occasional basis
- 15% had been convicted of a series of less serious or petty offences only
- 16% had been convicted of at least one serious offence involving violence, sexual assault, drug dealing, grooming or trafficking.

Rates of offending varied considerably across different client group sectors, with relatively low rates of conviction in learning disability (7% in total), domestic abuse (18%) and young people's (23%) services, rising to 71% in specialist substance misuse services. See appendix for full breakdown.

Based on their keyworker identifying the need for partnership working with Probation/ Youth Offending Teams, we estimate that 30% of those with an offending history (and 13% of our total sample) are current clients of Probation/ Youth Offending.

National estimate: 32,000 supported housing users at any one time have an offending history, of which 15,000 have a history of serious offending.[4]

Domestic abuse

500 people, or 26% of our total sample were known to have some recent experience of domestic abuse[5]. 194 of these people have a domestic abuse experience which was described as "regular and recent/current", which amounts to 10% of the survey sample.

The incidence of domestic abuse doubles where we look only at the women in our sample. (51% had some recent experience; 21% had experienced 'regular and recent/current' abuse).

It is clear from the findings that it is not just specialist domestic abuse services that are supporting survivors (See table in appendix). 61% of women in generic homelessness provision (much of which is likely to be mixed) are recent survivors of domestic abuse; this includes 31% (73 women) who were described as experiencing regular recent/ current abuse. It is striking that 78% of this group of 73 women have either a diagnosed mental health condition, substance misuse problem or both, since these are frequent barriers to accessing specialist refuge provision.

[4] Serious offences are defined as those involving violence, sexual assault, drug dealing, sexual grooming or trafficking

[5] Domestic abuse was defined in the survey as "one or more of: physical, sexual, psychological, economic, or emotional abuse; violent, threatening, controlling or coercive behaviour; between people who have a connection to each other

We did not produce a national estimate, given the impact of gender on the figures.

Substance abuse

40% of the total sample (811 people) have a history of problematic substance use, rising to 50% of those living in generic homelessness provision.

National estimate: 35,000 people with a history of problematic substance use living in supported housing nationally at any given time.

Long term homelessness

303 individuals – or 15% of the total sample were described as having a "history of lengthy or cyclical homelessness". We focus in on transitional or short term supported housing and its role in reducing homelessness in section 4.

National estimate: 12,000 people with lengthy or cyclical histories of homelessness are being accommodated in supported housing at any time.

Experience of local authority care

16% of the total sample has experience of local authority care. Unsurprisingly, the rate is highest in specialist young people's services, where 24% had been a looked after child prior to the point of moving in, and a further 13% had formerly been a looked-after child.

National estimate: 20,000 supported housing users have experience of local authority care

The following table summarises our estimates of the total numbers of people with particular characteristics living in supported housing nationally.

Table 5: Estimates of numbers of people living in supported housing nationally

User characteristics	**National estimate**
People with a history of mental ill-health	72,000
People with physical disability, sensory impairment or other long-term health condition	60,000
People in receipt of an adult social care package	48,000
People with an offending history	32,000
People who have experienced significant domestic abuse	N/A
People with a history of problematic substance use	35,000
People with history of lengthy or cyclical homelessness	12,000
People who were formerly a looked-after child	20,000

2.3. Risk and complexity

Meeting these needs for assistance is all the more challenging because of the complexity of people's circumstances and histories. This includes levels of vulnerability, presenting risks, as well as the co-existence of different health challenges – all of which will present significant challenges delivering a safe and effective service in supported housing.

Workers felt that 60% of the sample are 'vulnerable to exploitation or abuse from others', with 18% felt to be highly vulnerable.
29% of the sample were felt to pose a risk of harm to others, 5% significantly.

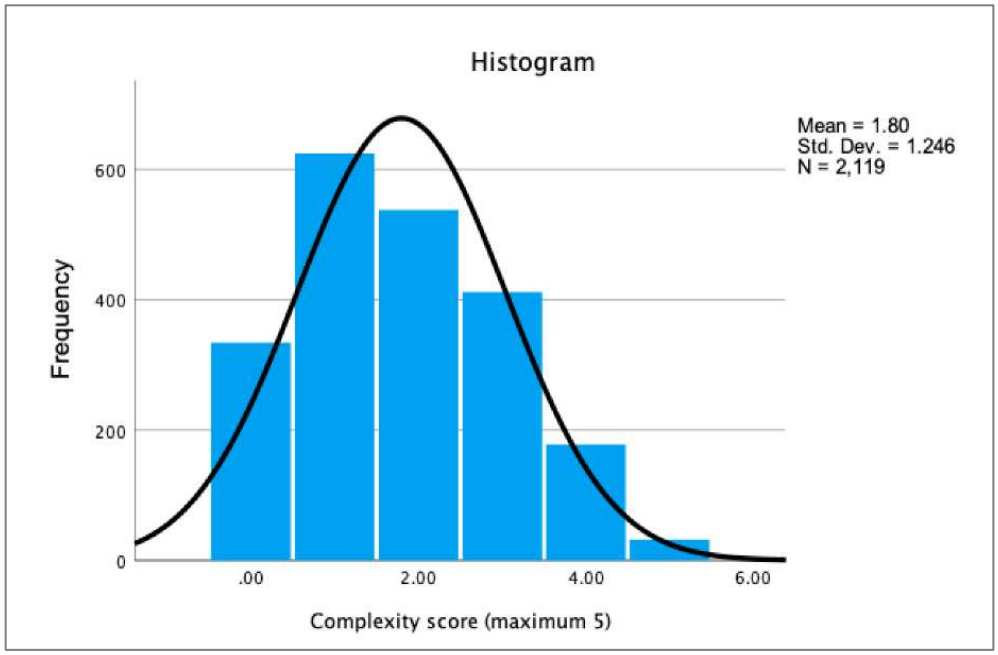
National estimate: 25,000 users of supported housing significantly vulnerable to exploitation or abuse; 4,500 might be considered to present a significant risk of harm to others

Each individual was allocated a 'multiple disadvantage score' (out of a maximum of 5) taking account of the following variables:

- Diagnosed mental illness
- History of problematic substance use
- Experience of domestic abuse
- History of offending
- Recurrent or sustained history of homelessness

The following chart shows the distribution of multiple disadvantage scores across the sample.

Chart 1: Distribution of multiple disadvantage scores



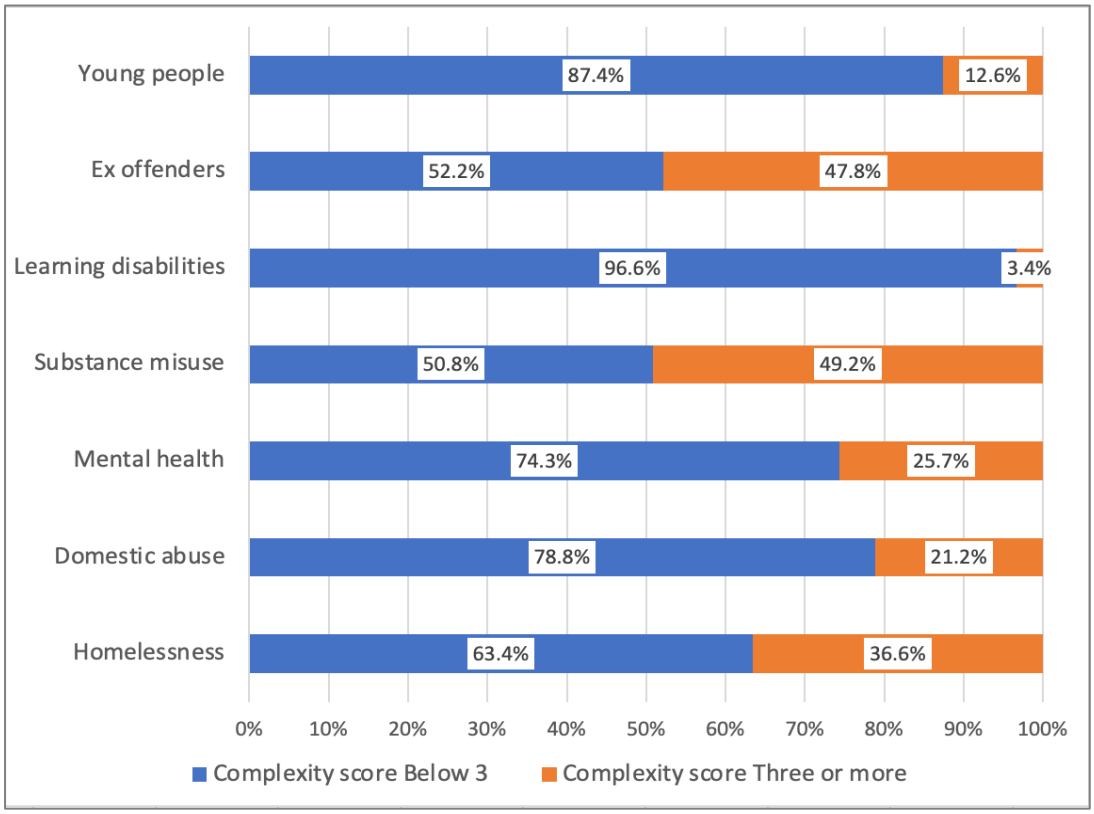
- 16% of the sample had a score of zero; and the average score was 1.8 (mean) and 2.0 (median).

- 622 people (29% of the sample) had a higher score (of 3 and above).
- There was no association between gender identity and a higher score.
- Those aged 40 and over were more likely to have a multiple disadvantage score of 3 and above (36%), than those under 40 (25%).
- People with higher scores were no more likely to be living in a supported housing scheme offering 24/7 cover.
- 32% of those in short term transitional supported housing, compared to 17% of those in long term supported housing have a score of 3 and above.
- 37% of those living in supported housing for those experiencing homelessness had a score of 3 and over, compared to 22% in schemes for other client groups.
- There was an association between homelessness and multiple disadvantage (as defined here); 75% of those with long term or current homelessness had a multiple disadvantage score of 3 or more, compared to 22% of others in the sample.
- Those with higher multiple disadvantage scores were less likely to be felt to be ready to move on from transitional housing (47%), compared to those with lower scores (63%)

This confirms the presence in fixed site supported housing of a potentially high cost, high risk cohort of people experiencing homelessness on a sustained or recurrent basis, who are also experiencing multiple disadvantage.

The following chart shows the proportion of residents with higher multiple disadvantage scores in supported housing aimed at different client groups.

Chart 2: Multiple disadvantage score by supported housing target user group in which person resides



These variations may, of course, reflect allocation policies and entry criteria.

3. What role is supported housing playing?

The rationale behind supported housing is that for a number of reasons people in housing need may benefit from an integrated package of housing and support rather than access to "mainstream" housing, with the potential for support being provided on a separate basis.

For those whose health and care needs are such that supported housing is acting as an alternative to institutional care, the argument is that a supported housing package has the potential to provide a 'half-way' house, with the opportunity to live in an 'ordinary' property/ neighbourhood and with less potential for becoming institutionalised.

This alternative "ordinary housing" scenario could be said to be the norm in terms of housing options for people in housing need, but supported housing offers a more intensive housing management package and potentially elements of building design that can offer greater safety or security. At the same time, the rationale for supported housing is that the service user has multiple needs for assistance that can most effectively be met as part of a combined housing and support package. We found evidence to support this in the survey findings: 84% of service users had at least five identified needs for assistance, where some progress had been made during their stay in supported housing.

The average (mean) number of needs identified was 9.6, and the median was 10. This indicates that supported housing needs to provide a complex and varied service for its service users.

We have identified a number of categories of reason why such a supported housing offer might be appropriate – either as a transitional stage in preparation for a move to "ordinary housing" or as part of a longer-term home. These are as follows[6]:

- The person needed time, space and positive action to overcome the barriers to independent housing
- The person needed assistance to develop independence skills
- The person needed assistance to overcome social isolation
- The person needed to live in a safe and secure environment
- The person needed a stepping-stone down from an institutional environment
- The person made a positive choice to move into supported housing
- The person had no real choice but to move into supported housing

In this chapter we examine the survey findings on the extent to which this theory is reflected in what is happening on the ground.

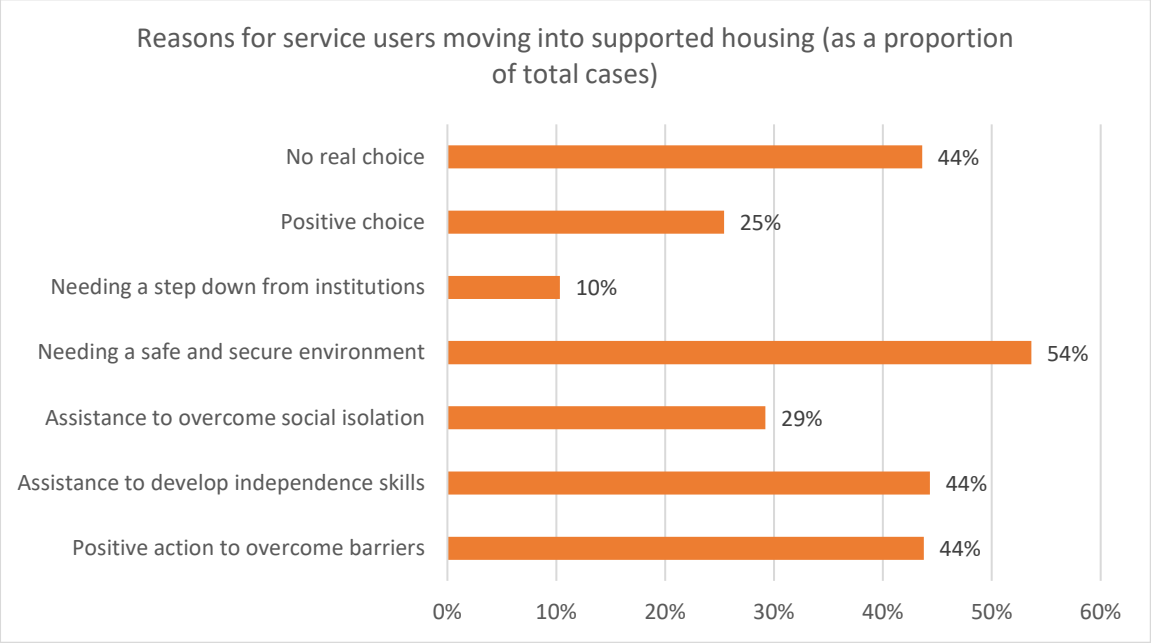
[6] In the survey, key workers were asked to select as many reasons as they felt applied from a much longer list; these bullet points are categories developed during analysis.

3.1. Why do people need to live in supported housing?

We asked staff to select as many as they felt applied from a list of reasons why the service user needed to move into supported housing.

The most frequently selected reason was the need for a safe and secure environment. This could be in order to protect the individual from harassment, abuse or exploitation by others or to provide a supervised environment where health and wellbeing could be monitored.

Chart 3: Reasons for services users moving into supported housing



Three-quarters of people had multiple reasons why they were in supported housing – highlighting the complexity of the job being done by support workers.

There was a total of 301 cases where the reasons for moving into supported housing were limited to either having no real choice or needing some form of positive action to overcome barriers to housing (including the need to understand housing options or the need to convince landlords that they presented an acceptable risk). This represents 15% of the revised survey sample who effectively do not necessarily need the combined accommodation and support package offered by supported housing, but could have their needs more effectively met by other (less potentially expensive) interventions.

Those in long term services were more likely to have needed 'assistance to develop independent living skills' (27%) than those in transitional, short-term services (15%); otherwise the reasons given for the two models were similar.

Individuals' pathways into supported housing vary enormously, even within schemes catering for the same client group. However, there were some noticeable patterns:

- 71% of those in specialist domestic abuse services have a history of settled housing (including living with family), presumably these are women who have lost their previous housing due to domestic abuse.
- 44% of those in specialist substance misuse schemes and 42% of those in young people's schemes were also living with family prior to moving into supported housing
- 17% of mental health service users have come from institutional care of some kind
- 52% of those in specialist substance misuse services have moved directly from a residential detox facility
- For Learning Disability services, the route into supported housing was 41% from settled housing, 36% from family and 12% from institutional care.
- 24% of the total sample had moved from another supported housing scheme; just 9% had moved directly from a mainstream tenancy or owner occupation.

4. Impact of supported housing on the prevention of homelessness

One of our research questions was to explore the impact of supported housing on reducing homelessness and repeat homelessness and to try and quantify this at a national level.

To explore this question, we used data from our survey, including only the responses from those supported housing schemes described as short-term or transitional.

As part of a wider homelessness system, supported housing can potentially contribute to the following different types of prevention (as categorised by Mackie, 2022):

- **Crisis prevention**: as a response to relationship, family or tenancy breakdown, to prevent higher risk forms of homelessness such as rough sleeping, before alternative accommodation can be secured.
- **Emergency response**: housing those who are already homeless, including but not limited to rough sleepers
- **Repeat prevention**: supporting people into sustainable tenancies or suitable longer-term accommodation to meet their needs.

4.1. Crisis prevention/ Emergency response

First, we consider the role which transitional supported housing is playing in terms of emergency response/ crisis prevention. Although people living in temporary forms of supported housing have been defined as experiencing 'core homelessness', it is clear that the sector is reducing and/or preventing other higher risk and sometimes hidden forms of homelessness, such as rough sleeping.

The survey asked keyworkers to categorise the individual's recent housing history, and where they had been staying immediately before moving into the supported housing scheme. The responses to these two separate questions are shown in the following tables.

Table 6: Recent housing history of transitional supported housing residents

Description of recent housing history	Number	Proportion of Total*
Lengthy or cyclical experience of homelessness	288	16%
In and out of a series of addresses	490	28%
In prison/ in and out of prison for a number of years	120	7%
Spent all/ a large part of recent life in institutional care	126	7%
TOTAL WITH UNSTABLE HOUSING HISTORY	**1,024**	**58%**
Mostly lived at home supported by their family	418	24%
Mostly lived in settled housing until the need for supported housing	316	18%
TOTAL WITH RELATIVELY STABLE HOUSING HISTORY	**734**	**42%**
Not Known	52	
TOTAL (without not knowns)	**1,758**	

*We use the total excluding not knowns here

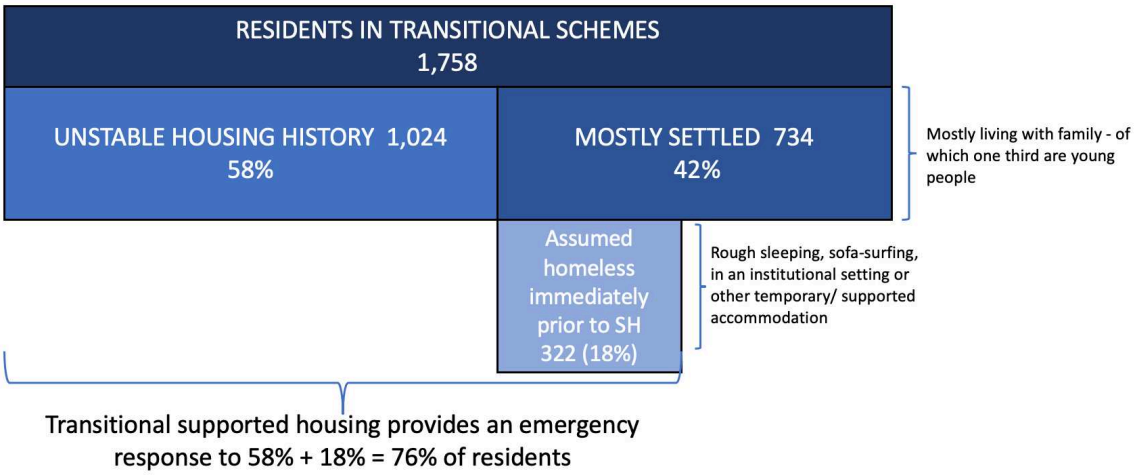
Table 7: Accommodation of transitional supported housing residents immediately before move-in

Accommodation	Number	% of total
Assumed to be homeless		
Bed & breakfast accommodation (funded by local authority)	67	4%
General hospital or some other form of medical facility	19	1%
Other supported housing	164	9%
Prison /secure hospital or children's home	92	5%
Psychiatric ward /unit /hospital or mental-health facility	105	6%
Refuge or domestic abuse service	9	0%
Registered care or nursing home	5	0%
Residential detox /rehab	67	4%
Sleeping on the streets	154	9%
Sofa-surfing with friends or family	137	8%
Some other form of temporary accommodation	61	3%
Supported housing /night shelter /hostel for people who have experienced homelessness	259	14%
Not known	79	4%
(blank)	19	1%
Assumed not to be homeless		
At home with parents or other family members	334	18%
Householder in owner-occupied property	6	0%
Sheltered housing	23	1%
Tenant in privately rented property	85	5%
Tenant in socially rented property	78	4%
With foster parents or in local authority care	47	3%
Unknown status		
Not known	79	4%
(blank)	19	1%
Total	***1,810***	***100%***

Again, the emergency response/ crisis prevention impact of supported housing is evident in the table above. For example:

- Risks to health and wellbeing should be significantly reduced for people who were previously rough sleeping or sofa-surfing
- Those whose family living/foster care arrangements or previous tenancies had broken down could otherwise have ended up at risk of rough sleeping, hidden homelessness or in emergency accommodation
- Supported housing typically provides better value for money than bed & breakfast, offering support, catering facilities and greater levels of security
- Those leaving hospital or prison have benefitted from a facilitated discharge and the risk of literal homelessness at these key transitions has been prevented.

We looked at the intersection of the responses to these two questions (about housing history and accommodation immediately prior to moving in to supported housing). This highlights the complexity of people's journeys: for example, 322 of those with settled housing *histories* had come directly to the scheme from a state of core homelessness (i.e. they were either rough sleeping, sofa-surfing, or had come from an institutional setting or temporary accommodation placement). This is summarised in the visual below:



Transitional supported housing might therefore be described as providing an emergency response to 76% of residents, i.e. the 58% with histories of housing instability plus the 18% who had recently become homeless. The remaining 24% might arguably be described as having received a 'crisis prevention', having avoided street homelessness at the point of family or tenancy breakdown

4.2. Repeat prevention: supporting move-on

There are two key functions to which supported housing is potentially contributing within Mackie's prevention model: enabling people to exit homelessness by helping them to secure tenancies, and facilitating change to maximise the chances of that tenancy being sustained and further homelessness prevented.

4.2.1. Assistance to secure tenancies

In most parts of England, there is a shortage of affordable housing and those with a history of homelessness face a number of barriers to accessing that which is available[7].

Keyworkers responding to our survey felt that approximately two-thirds of those who needed assistance to 'understand their housing options', had been supported to make significant progress in this by the time of the snapshot date.

[7] See for example Centrepoint's report on barriers facing homeless young people or Housing Rights research paper on barriers to accessing the Private Rented Sector or Crisis's report on Moving On.

Effective partnership working with local authority housing options teams was reported to be in place for just 27% of transitional supported housing residents; there was involvement from housing options but it was 'proving difficult' for a further 17%.

Staff judgement is that 51% of those who had been resident in the scheme for 6 months or less are ready to move into settled housing. This increases such that 66% of those who have been in the scheme for 12 months or less are ready to move on. After 2 years of residence, the proportion of people ready to move on declines.

15% of those in transitional supported housing had been there for 3 years or more. This would appear to confirm previous research findings that some people with higher levels of health needs and/or higher levels of complexity may stay longer in supported housing that is supposedly 'short term'. There is a lack of longer term housing, support and care options for people with disabilities or long term health conditions who also have issues related to substance misuse and/or offending. The presence of this group of longer-stayers may also evidence challenges and resource issues around joint working, since putting the right package of care, treatment and support together for people with complex needs is often challenging, as well as accessing suitable and affordable housing.

Complexity of need and access to external services were both related to whether or not those using transitional supported housing[8] were reported by staff to be ready to move on.

- 63% of people with a multiple disadvantage score of less than three, compared to 47% of those with a score of three or more were reported as ready to move into independent housing.
- People who were ready to move on were reported as having a slightly higher rate of successful contact with external services (2.3 services on average) than those who were described as not yet ready to move on (2.1 services on average), but the effect was quite small and must be seen in the context of a complex picture of variable access to external services, which we discuss in section 6.

Overall 55% of the sample were ready to move on into settled housing on the snapshot date.

For just over half (53%) of all those deemed ready to move on (regardless of length of stay and levels of multiple disadvantage), this was not happening because 'finding a suitable move-on option is proving difficult'.

Barriers include affordability and issues such as perceived risks from behaviour and former tenant arrears. A lack of financial resources to access accommodation was mentioned for 196 individuals ready to move but unable to do so because of lack of move-on options; previous debts for 106 of them. In 179 of these cases, the support worker reported that the person's current behaviour is such that a landlord would be unlikely to take the risk of letting to them.

[8] Base: 1,664 people in this form of supported housing.

Keyworkers were also asked whether they thought the individual was likely to leave the supported housing scheme in the next three months, either due to positive move-on, or because of a breakdown in the placement, due to disengagement with support, behaviour or a deterioration in physical or mental health[9].

Overall, staff projected that 22% of service users would move into settled housing[10] in the next three months.

This compares to the 55% that staff thought were ready to move on at the snapshot date. It also compares to the 13% of the 339 individuals for whom we received follow-up data three months after the snapshot who had actually moved to settled housing.

We used the difference between the **projected** and **actual** move-on figures to generate national estimates for the numbers of people being resettled from transitional supported housing[11].

If our sample was representative[12] of the estimated total of 80,000 units of transitional supported housing nationally (of which around 32K are in the homelessness sector), and assuming that this quarterly move-on pattern is sustained in each quarter, this would mean that over a year the numbers moving into settled housing would be as high as 52,000 people. Of these, we estimate that around 24,500[13] might be expected to have a long term history of homelessness, housing instability or institutionalisation.

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[9] The question was phrased: **"***Are you likely to ask them or arrange for them to leave the accommodation in the next 3 months, and if so, what do you expect the main reason to be?***"**

[10] In the survey, we defined 'settled housing' as '*a social or private tenancy, moving back through choice to a family home or some other long-term housing arrangement, with or without floating or resettlement support in the immediate future. It does not include a move to other supported housing unless this is long-term*'.

[11] 45 of the follow-up sample of 339 users had moved into settled housing during the intervening three months – this represented 13% of the total user group. This equivalent percentage based on the projections in the survey had been 19% for this specific provider.
This gives a basis to calculate and apply an optimism bias, by relating these 2 figures. A calculation of 13/19 provides the basis for an Optimism Bias of 0.684. If we apply this to the overall proportion projected to move on in the following quarter this would produce a more realistic estimate of 15% of service users moving on into settled housing over a quarter.

[12] We applied a weighted average to balance the over-representation of generic homelessness services in our sample. Since the SAR (2016) does not estimate the breakdown of transitional only supported housing into principal target groups, we used the following assumptions, based on survey findings: none of the Learning Disability provision; all of domestic abuse, substance use, young people's and offenders' provision; 88% of mental health supported housing and 89% of generic homelessness provision is short term/ transitional.

[13] 199 (20%) of the 1,024 people with histories of homelessness, housing instability or institutionalisation were predicted at snap-shot to be resettled in settled housing in the next 3 months. Applying the 'optimism bias' – see footnote 11, suggests that for this cohort a reasonable move-on rate would be 13.5% per quarter i.e. 54% over a year.

Given the numbers judged ready to move but unable to, we can assume this figure would be much higher if there were not such profound difficulties finding move-on accommodation. This means some people stay longer in supported housing than they need to.

4.2.2. Improving the likelihood of tenancy sustainment

The snap-shot survey conducted for this study cannot provide evidence of tenancy sustainment for those supported by transitional supported housing to access settled tenancies. There is a need here for further longitudinal research. However, the survey did ask keyworkers to assess the extent to which supported housing had been able to assist people in achieving a range of health and wellbeing outcomes.

A systematic review of international evidence identified a number of factors which seemed to be associated with tenancy sustainment following homelessness, including:

- Quality/ affordability of housing and security of tenure
- Good access to and relationships with support workers as needed
- Access to and coordination of relevant health, care and support services
- Support to maximise income through welfare rights and/or employment
- Improving wellbeing and stabilising substance use and/or mental health
- Strengthening positive support networks, including within the local community
- Neighbourhood factors, such as community safety and access to transport
- Realising choice and independence

In the next section, we present and discuss our findings in relation to the impact of supported housing on improving health and wellbeing outcomes. These include several points related to the above list, including linking residents into health, care and support services and enabling them to build their personal and economic resilience. Whether or not these outcomes are sustained post move-on will of course depend on a complex interaction between a number of individual, organisational and structural factors.

5. Impact of supported housing on health and wellbeing

We were asked to explore the impact which supported housing has on health and wellbeing outcomes, and quantify these at a national level.

89% of our sample had at least one of the following, 49% had two or more:

- Physical disability and/or sensory impairment
- Diagnosed mental illness
- Diagnosed learning disability
- Other long-term health condition
- History of problematic substance use
- Diagnosed Autism / autistic spectrum disorder

Our study takes a wide view of health and wellbeing, including in this social inclusion, meaningful activities, psychological wellbeing and self-determination. The role of housing, employment, social connection and other social determinants of health is well established, and most recently acknowledged in NHS England's Core20PLUS5 strategy.

Where our focus in the last section was on transitional supported housing, we also include here longer term models of supported housing which are intended to maximise quality of life for people with ongoing health and care needs.

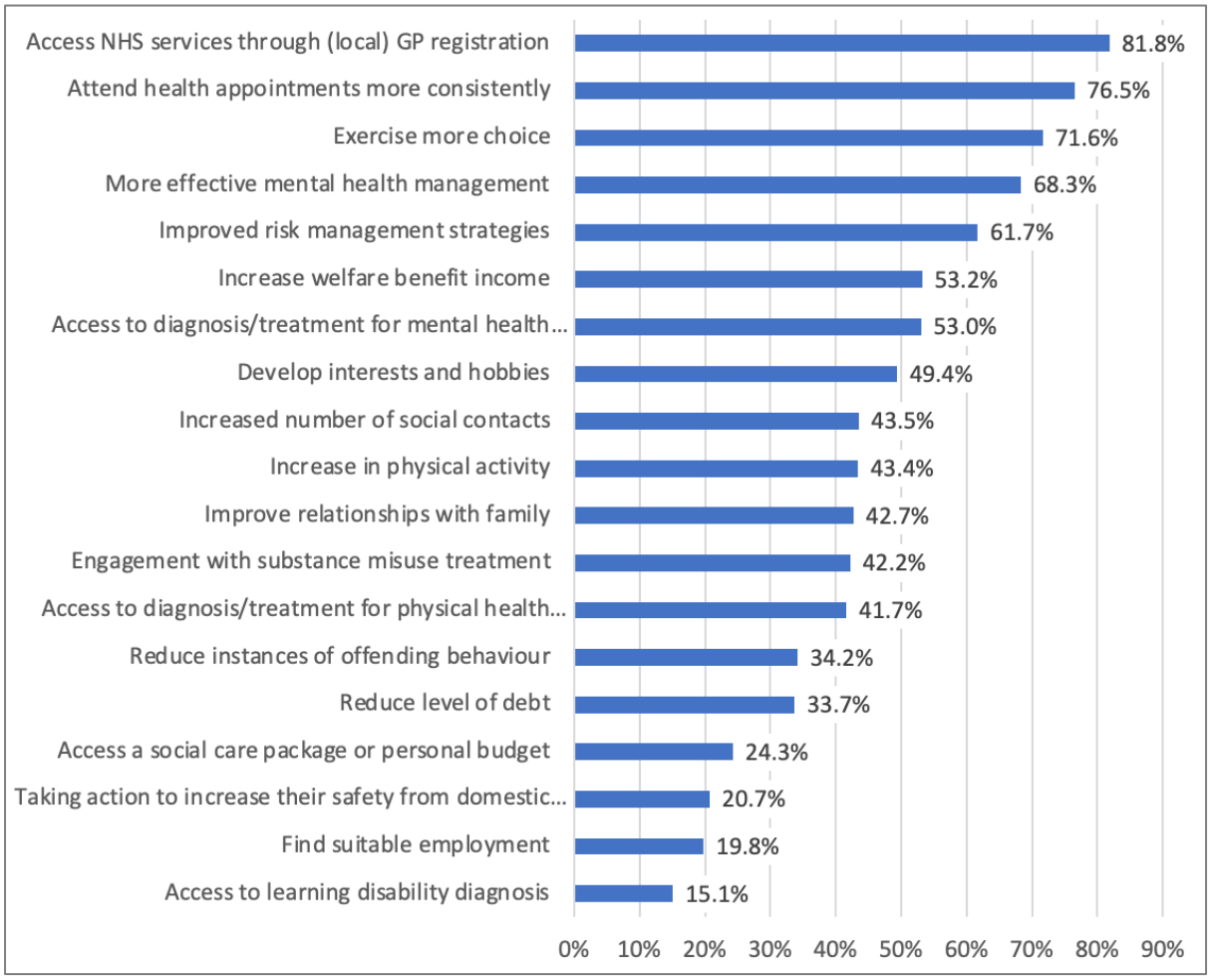
5.1. Survey findings: outcomes

Our survey did not ask detailed questions about the state of individuals' health and whether or not keyworkers felt this had improved, since the factors driving this – and even how it might be defined – are incredibly complex, especially where there is such a range of often-overlapping conditions. Neither did it attempt detailed comparisons of people's health service usage before and since moving into the current scheme, since we recognised that keyworkers may not have accurate information on this, especially where the person has been living in the scheme for a long time.

Instead, the survey asked keyworkers, "*In your opinion, how would you say the supported housing service has been able to assist them?"* and listed the following outcomes, giving the option for workers to respond "yes – a bit", "yes – significantly" or "not applicable'.

The following chart shows the proportion of the total sample reported to have made some progress by their keyworker (i.e. either 'yes- a bit' or 'yes – significantly') in relation to each outcome, in descending order of prevalence.

Chart 4: Proportion of individuals making at least some progress against health & wellbeing outcomes



It is striking that the most frequently reported outcomes from this list relate directly to improving access to NHS services (i.e. assistance to register with a GP and to attend health appointments more consistently, which are reported for the vast majority of supported housing residents, across all client groups). Registration with a GP is a necessary first step in being able to access timely and preventative care.

We were also asked to quantify outcomes nationally. The table below shows our estimates for the numbers of residents in supported housing in England who, at any time, may have achieved significant outcomes as a result of the support received. To generate these estimates, we have been more conservative and included only individuals for whom *significant* progress was identified. We have, as before, applied weighted averages to reflect the make-up of the sector and rounded the results to the nearest thousand.

Table 8: Estimated number of supported housing residents who have at any one time, been assisted significantly to achieve health & wellbeing outcomes

Outcome	National estimate
Improvements in health, safety and care:	
Access NHS services through (local) GP registration	70K
Attend health appointments more consistently	62K
Access to diagnosis/treatment for physical health condition	32K
Access to diagnosis/treatment for mental health condition	36K
Access to learning disability diagnosis	13K
Increase in physical activity	27K
Engagement with substance misuse treatment	19K
More effective mental health management	46K
Taking action to increase their safety from domestic abuse	14K
Access a social care package or personal budget	21K
Improvements in economic position:	
Find suitable employment	9K
Reduce level of debt	15K
Increase welfare benefit income	36K
Improvements in wellbeing:	
Increased number of social contacts	25K
Reduce instances of offending behaviour	16K
Improve relationships with family	20K
Develop interests and hobbies	31K
Improved risk management strategies	38K
Exercise more choice	52K

A set of outcomes scores for each individual was constructed under each of the three broad headings from the table above (i.e., improvements in health, safety and care; in economic position, and in wellbeing), For this, we combined the positive responses ('yes – a bit' and 'yes – significantly').

Typical scores across these three sets of outcome measures varied:

- Improvements in wellbeing, typical values were a mean of slightly over three (3.03) and a median of three out of a possible six
- Improvements in health, safety and social care were rather higher, with a mean of 4.67 and a median of 5 out of a possible ten
- Improvements in economic position: the mean (an average of 1.06) and median scores were both one out of a possible three

Overall then, supported housing appears to be having the greatest impact on individuals' health, safety and social care scores.

People who had been in supported housing for longer stays were more likely to report a higher health, safety and social care score: those living in supported housing for one year or

more reported an above-median score on this measure in 60.7% of cases, compared to 49.7% people who had been resident for up to three months.
As highlighted in the previous chapter, previous research has suggested that long-term residence is associated with the presence of multiple and complex support needs, i.e. if someone is resident for a long-time, it may be because their needs are more complex.

We also compared outcomes across short- and long-term schemes targeting different primary target groups. We present here the most striking findings from this analysis:

- All types of service reported a high proportion of residents whom they had supported to access GP registration. The highest proportions were reported by some of the specialist services, e.g. for substance abuse (86% supported significantly and 11% 'a bit'), mental health (76% significantly and 14% a bit), and domestic abuse (67% significantly and 21% a bit).
- Although generic homelessness services reported positive outcomes assisting people to attend health appointments more consistently (43% significantly, 30% a bit); specialist services for people with histories of substance misuse (71% significantly and 19% a bit) or mental health (69% significantly and 18% a bit) reported the highest levels of success in this area.
- Access to physical health diagnosis/ treatment was less relevant for residents of young people's and domestic abuse schemes; but otherwise was reported frequently across all services.
- Assisting people to access mental health treatment and diagnosis and/or to better manage their mental health was reported as an outcome across all forms of supported housing; for example, 55% of people living in specialist learning disability schemes were supported to access mental health treatment and/or diagnosis to some degree.
- Those services which have a specialist recovery focus, e.g. in relation to mental health, substance misuse, or domestic abuse generally reported higher outcomes in relation to supporting people improve their social contacts, develop hobbies and interests or supporting family relationships. This is important, as loneliness and isolation can be as damaging to health as smoking or obesity, and is linked to increased risk of cardiovascular disease and cognitive decline.
- Generic homelessness services reported a substantial impact on helping people to engage to some degree with substance misuse treatment – this applied to nearly half of people living in such schemes.
- Access to social care packages or personal budgets is unsurprisingly reported more frequently as an outcome in specialist learning disability (for 66% of residents in our sample), young people's (for 31%) or mental health (for 27%) schemes; however, it is striking that 15% of those in generic homelessness services were reported to have been supported to access these, at least to some extent.
- Specialist substance misuse services report a high impact on reducing offending: this was not felt to be relevant to 42% of their residents for whom a survey was

completed, and for all bar 7% of the remainder a positive reduction was reported: 28% 'significantly' and 23% 'a bit'.

- Generic homelessness services also reported a significant impact on reducing re-offending: with 17% reported to have made a significant reduction, and 21% reducing their offending 'a bit'.
- Three-quarters of people with learning disability and of those living in specialist young people's schemes were reported to have increased their ability to exercise choices in their lives.

5.2. Understanding how supported housing assists with health and wellbeing outcomes

A recurring piece of feedback from our qualitative interviews was that colleagues outside of the housing world, particularly in the NHS, often do not understand what workers in supported housing schemes do in order to achieve health and wellbeing outcomes and where the boundaries lie within these roles. The value of diversity in supported housing models is a challenge here, however, our interviews suggest common themes in both transitional and longer-term provision and across target client groups.

Meeting basic needs

Especially where supported housing is providing a crisis response, e.g. to those who have been sleeping rough or have fled domestic violence, meeting basic needs for food, safety and shelter is the priority. The health impacts of this are clear: for example, the current average life expectancy of people sleeping rough is 45 years for men and 43 years for women.

> *"When you are homeless you are cold all the time, Oak Tree House is warm. When I was on the streets I lost over two stone".*
>
> Anonymous, resident at Oak Tree House, Jigsaw Homes – for more detail about Oak Tree House, see the Appendix

Supported housing can support people's health through access to nutritious food and help with cooking. Cooking is a skill that not everyone has a chance to learn, and where housing providers work with community pantries or community allotments, they can help people access nutritious food that would be impossible to reliably find and cook if someone was homeless.

John Glenton, at Riverside Housing Group explains:

> *"Hardly any of our schemes still have a catered meals service – instead we provide kitchens where people can prepare their own meals...but we provide lots of help to access and prepare food……Historically, that sort of service [where meals were provided] came with a lot of conditions – there were strict meal times and if you missed a meal you were sanctioned. We've*

moved away from that sort of institutional regime with its conditionality over the past couple of decades – supported housing is now more about empowerment and treating people as responsible adults."

Personalised support planning

Once someone's basic needs have been met and any crises addressed, supported housing has a key role in helping someone to plan their support. This includes accessing services such as GP registration and benefits, both of which may involve ongoing advocacy and negotiation.

"Every single person will get an individual assessment from our support staff - some people who come to us have never been registered with a GP or never been to a dentist – they might have grown up with parents who have addictions, so sometimes it's about meeting really basic needs."

Donna Kelly, Group Director, Jigsaw Homes Group

Informal emotional support

Many supported housing residents have been through significant trauma and the majority have mental health challenges. Support workers provide informal emotional support, by being a patient, listening and consistent presence in the housing setting.

"The staff….. just listened to my problems – I think that was half the battle, just telling people your problems and someone not being judgemental, just listening and understanding how you really feel…… knowing I could go and talk to someone, with any issue I had".

David who was supported through Framework's Lincolnshire hostel from being homeless to living in his own place[14].

"There's always someone to talk to 24 hours a day 7 days a week. This is important for me with my Mental Health issues."

Anonymous , resident at Oak Tree House, Jigsaw Homes – for more detail about Oak Tree House, see the Appendix

"Through sensible adult conversations, we can talk to people about the choices they make and what that might mean for their future, e.g. if they return to that group of friends – not telling them not to, but just making them aware. Relationships with key workers can make a huge difference – someone who takes interest in you, shows a level of care for you means you can feel like you are worth something – can show people are valued"

Donna Kelly, Jigsaw Homes

[14] Taken from Framework's website.

Ad hoc practical support

Support staff can assist people to navigate their lives – for example, paying bills, responding to official letters, remembering appointments, dealing with emotions, offering prompts around personal or food hygiene, etc.

> *"Having someone who can help you through the minutiae – the crap that happens in your everyday life and which you have to navigate your way through. If you are not feeling able to because you have mental health issues – or whatever – you have got someone who can help you with all of that. And ultimately other services finish at 5pm….really, but supported housing is there to respond to all those other needs."*
>
> Lindsay Ryder, Director of Housing & Wellbeing, Nacro

Wellbeing activities

Health is not merely the absence of illness; it is a positive state where people are happy, connected to their communities and loved ones, and are able to enjoy their life. Many supported housing providers are working to promote this sense of wellbeing through helping people access a range of person-centred activities, from walking groups to cookery lessons. This can be complex to provide; people's interests are varied, not everyone wishes to engage and, as one provider commented, "*we can't be paternalistic*".

> *"I came to Oak tree following a relationship breakdown which led me to be homeless. I was staying on friends' sofas for a while but it wasn't ideal. I settled in fairly quickly, but I did struggle with anxiety, which meant I didn't sleep well at all. Subsequently I abused substances to try and help me sleep. My support worker helped me complete a routine planner and once I started to sleep properly, I started to feel better, I got involved in groups, sessions and activities. I found I really enjoyed cooking and baking, and art helps me focus when I feel overwhelmed. Staff also helped me look at some of my behaviours and looked at more positive ways to react or deal with situations. I now volunteer at Oak Tree and help with facilitating groups, such as cooking sessions and art sessions. I want to help people like Oak Tree helped me."*
>
> Anonymous , resident at Oak Tree House, Jigsaw Homes – for more detail about Oak Tree House, see the Appendix

People with learning disabilities in supported living were more likely to know and like their neighbours compared to people in residential care (200 Lives, p.174); they were more likely to live closer to their families, see more of their friends and be in a relationship (p.175); this sense of social connectedness is protective against conditions ranging from dementia to cardiovascular disease, and provides people with the hope and feeling of being valued and cared for, and of valuing and caring for others, which can help them to take positive action in their lives.

Help to access other agencies

Navigating health and care can be confusing, and for someone with previous bad experiences of the NHS or of social care, it can feel extremely intimidating to start the process of accessing help, especially for someone with stigmatised conditions such as addiction or mental health. Many supported housing services provide advice work, helping people to identify their health and care needs, apply for any benefits they are entitled to, and work out how to access support for their health.

It is also important not to underestimate the difficulties of managing multiple health conditions, especially where these include mental ill-health, learning disability, autism, substance misuse problems. These challenges are particularly acute for those experiencing homelessness. Notifications and reminders for appointments often come by email or text, requiring reliable access to a device and charging facilities. Some people living in supported housing may also struggle with literacy, or with remembering where and when appointments are scheduled and working out how to get to them. Medicines may require refrigeration, safe storage due to resale value, or need to be taken at specific, hard to recall times of day to avoid interactions or side effects.

We have appended two case studies of partnerships set up between supported housing providers and public health or the NHS to deliver health services on-site within hostels. These include:

- a case study of John, who was able access support from a specialist substance misuse worker, funded by Public Health and based at Riverside's Jamaica Street hostel.
- a description of how Look Ahead has worked in partnership with the local authority and local health partners at its central London hostel to provide wound care, nurse care, hospice and GP services on site.

Another service told us they had worked with GPs to offer clinics within the scheme, significantly reducing the number of appointments that people were missing. NHS estimates a cost of £30 per missed GP appointment, and many services will cancel care, deny repeat prescriptions or cancel outpatient services for a patient if they miss more than one appointment, severely delaying care.

People may also normalise a level of pain and discomfort that those in more stable housing would not. Sanctuary Supported Living identified a young man as having suicidal thoughts and persuaded him to go to hospital for his safety and wellbeing; on admission he was diagnosed with a dislocated hip that had been untreated for some time.

> *"At times, a resident's mental health can deteriorate to the point of crisis. In the past year, a resident of mine had become suicidal and was standing on a local bridge with the intent to jump. Following crisis intervention, I worked closely with the resident on a daily basis to build structure, routine and a sense of purpose, which included supporting him to get a pet. This level of responsibility brought new meaning to his life and gave him the confidence to rebuild his relationship with his children."*
>
> Supported housing officer, Tyne Housing

Independence and choice

The goals of supported housing include building independence for individuals, and moving away from an institutional approach to one where people have choice and control over their lives. This is a more dignified approach, and more motivational in terms of people becoming less reliant on services and making the changes they want to make to meet their own life goals.

The 200 Lives report found that, overall, supported living schemes were less institutional in their practice than residential care homes for people with learning disabilities – there was certainly much less 'block treatment' and less rigidity of routines, though rules and social distance between residents and staff featured more strongly in the supported living models included in the study (p.24-25). Participants in that study valued day-to-day autonomy, and although one person who had moved from a long-term hospital into supported living stated. "it's much better, more freer, I mean have been doing more things". Nevertheless, the degree of autonomy and independence varied between models – for example, whether the property was shared or self-contained – and was dependent on culture, relationships and availability of staff.

The 200 Lives report found that those living in supported living tended to have exercised more choice about where and with whom they lived, than those in residential care, though there were limitations and variations here. For example, most people in supported living said they had chosen their current home although fewer people had looked at anywhere else before moving. Almost half of people in supported living chose who they lived with, although relatively few people were involved in choosing new people who moved into their home after them. (p.173)

This is illustrated in Stephen's story, who comments on his move to Golden Lane Supported Living:

> *"The main thing between being in hospital and my new home is the outlook, it's positive. I have choice now – with meals, what I do and when and buy what I want. At the hospital everyone was in bed by 11pm. Now, if I can't sleep and want to chat to someone, I can".*

5.3. Capturing health and wellbeing outcomes in supported housing

Since the end of the Supporting People programme (during which national outcomes data was collected by St Andrew's University), there has been no standardisation of the data which supported housing providers collect to monitor the impact they have on their tenants. Providers we interviewed reported that different commissioners require different data from them. Data collection is further complicated by the way in which housing underpins so many potential impacts; these range from increasing health service use where people have unmet health needs, decreasing their use of emergency health settings, reducing involvement with criminal justice, through to harder to measure benefits like re-establishing links with family members (or indeed reducing contact with people who are harmful to them), or forming a loving relationship. This can make it significantly harder to unpick what data would be most useful in terms of both evidencing benefits, and building a business case for commissioners.

Our interviewees who work at the interface between supported housing and health highlighted the importance of collecting data which aligns with NHS priorities. In their recent health and social care research, St Mungo's involved a clinician who helped them to shape the questions. HACT focus group contributors suggested that alignment with HoNOS (Health of the Nations Outcomes Scores) could be helpful, especially in specialist mental health settings, or where mental health issues are present.

Home Group use a range of measures to capture the impact of their supported housing, most of which is for people with mental health difficulties or learning disabilities. This includes the Warwick-Edinburgh Mental Well Being Scale (WEMWBS), Adult Social Care Outcomes Framework (ASCOF) and HACT's Social Value Bank. Using this data, on average, during 2022, Home Group's supported customers reported a 30% increase in their wellbeing from the start of their service to the point of move on (for short-term services) or review (for long-term services). It is estimated that on average, this increase in wellbeing equates to a social value of over £6K per person per year.

Given data protection concerns over the small sample sizes involved, there are challenges breaking this down by different types of scheme or tracking individuals progress, however, to inform this study Home Group have extracted data for just their supported learning disability customers (across all residential-based services). Between March 2018 and November 2022. 14 customers completed customer surveys at the point of move-in and 79 customers completed surveys at least 2 years into their service or at the point of move-on. On average, these customers reported a 27% increase in their quality of life during their time at Home Group.

5.4. Impact on the health and care system

The NHS was never intended to stand alone; at its birth, it was envisaged that health would be supported by care and housing. We have seen how the supported housing sector supports the NHS by providing a safe place to discharge people following episodes of hospital care, by helping people access the most appropriate care for their needs, thereby reducing acute crises, and by reducing the risks that homelessness and poor housing pose to health.

The specific risks to health posed by homelessness and bad housing are varied and severe. People who are homeless are 50 times more likely to have Hepatitis C than the general population, 34 times more likely to have Tuberculosis, 20 times more likely to die of causes associated with illicit drug use, 9 times more likely to die by suicide, 8 times more likely to have epilepsy and 4 times more likely to have a mental health problem. They are also at significantly higher risk of traumatic head injury and assault.

People sleeping rough are 7 times more likely to go to the accident and emergency department than the general population, and tend to access inpatient care in emergencies rather than in a planned way; this leads to worse outcomes for them, but also to more expensive care than if they had been treated in a more planned way at an earlier stage in their illness.

The relationship between poor housing, homelessness and mental health works in both directions. Poor housing and homelessness cause depression and anxiety, but people may struggle to maintain a traditional tenancy if they are, for example, too depressed to reliably clean or maintain rent payments. Supported housing can support people directly with access to mental healthcare; having a safe, warm place to live may in and of itself reduce anxiety and depression, and people in supported housing can be helped with the practical aspects of maintaining a tenancy.

It is hard for people with significant, complex needs to receive appropriate health care for a number of reasons; their health conditions can be hard to diagnose because it is hard to take detailed histories, people may be confused or appear aggressive - especially if they are frightened because of previous bad experiences, withdrawing from drugs or alcohol, or have the cognitive impairments associated with traumatic head injuries.

They are also too often discriminated against; GP reception teams may be reluctant to register them without paperwork, despite guidance saying it is not needed, because of their perceived risk of problematic behaviour. It is also still common practice to stop treating people who miss appointments for "failure to engage" or wasting resources, or to refuse to refill prescriptions unless they come in for check-ups. Supported housing workers may be able to prompt health services to look for hospital discharge letters, where someone with complex needs may be viewed as aggressive if they make the same request.

Attending check-ups is, in turn, far harder for someone who is confused, anxious, or who simply did not receive an email or letter because they have no permanent home and no way of charging a phone, or keeping it safe if they do. It may also be hard for someone with

complex needs to prioritise their own care if they are using all their energy for survival. Supported housing provides people with a safe place to live, but also with someone who can remind people to check if they have an appointment, and with someone to support them through the process of making appointments and over the psychological hurdles they face if they have felt repeatedly rejected by health or care in the past.

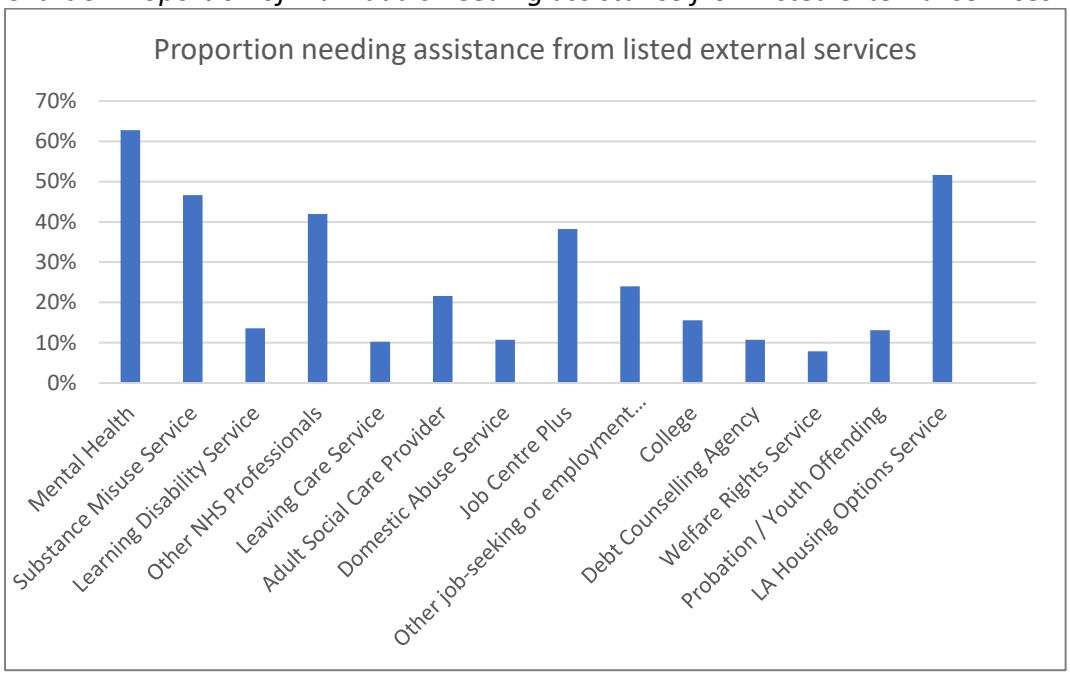
Overall, very few of these impacts will be cash releasing. The case for change is – as well as improving outcomes for individuals - more around freeing resource for more appropriate care, and reducing the risk of delayed discharges and emergency care being needed, which in turn will make the resources available for others.

6. Partnership working

6.1. Survey findings: the involvement of external agencies

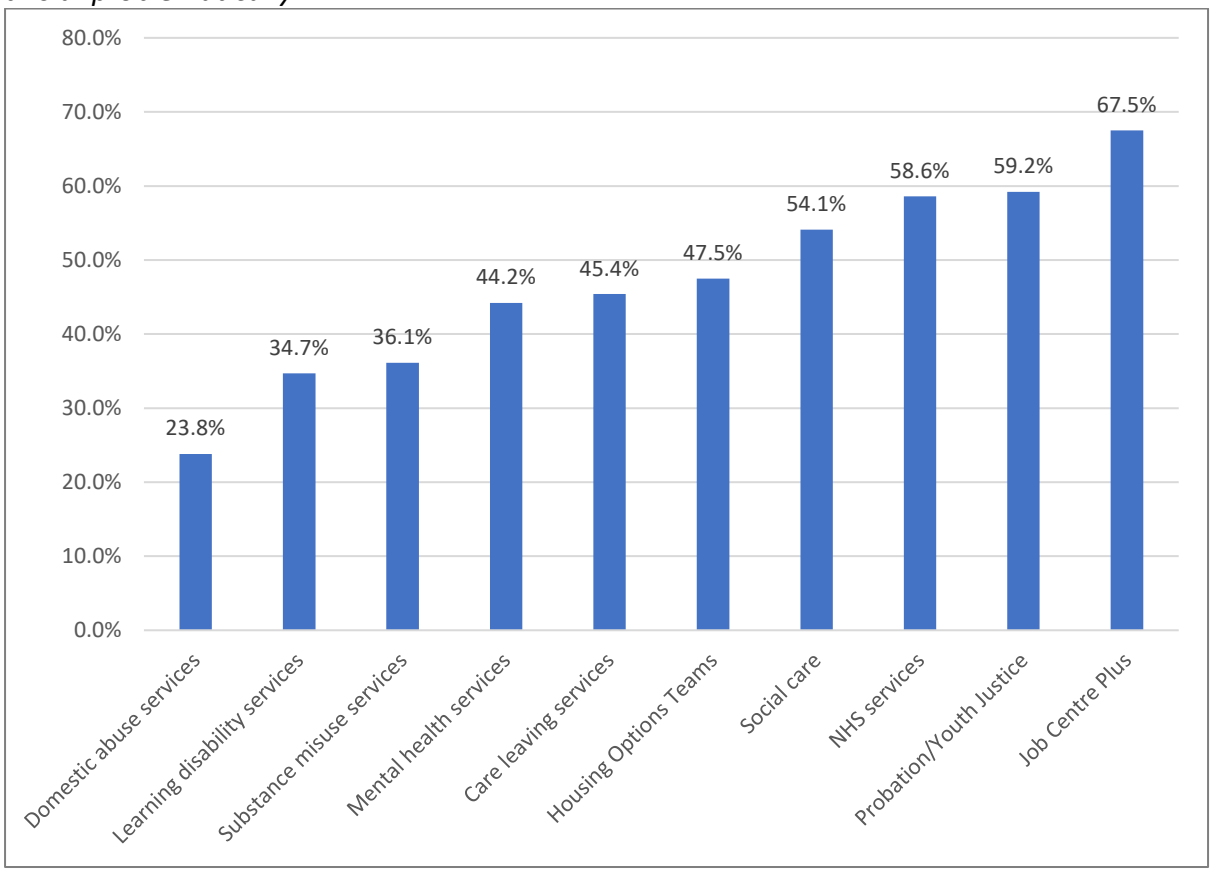
The survey asked keyworkers "Which other agencies are, or should be but are not, actively involved with you in providing assistance?" to the individual. Chart 5 below shows the responses.

Chart 5: Proportion of individuals needing assistance from listed external services



Mental health services were most frequently (for 63%) felt to be needed, followed by local authority housing options services, substance misuse services and other NHS professionals. Keyworkers were then asked to state whether these required partnerships were in place and working. The results, for a selection of core statutory services, are shown in Chart 6 below.

Chart 6: Percentage of those who need assistance from external services that are receiving this unproblematically



If the individual was **not** receiving assistance from the external services they needed, their worker was asked to give a view on whether this was because they did not want to engage or because of access difficulties. In practice, we recognise grey areas here – some people are unwilling to engage because they have previously found services to be inaccessible, or even re-traumatising[15]; where others are not at a stage where they are ready to change or accept they have an issue.

We append the full table showing the breakdown for each service type listed in the survey – the proportion felt to need the service and, of these, the breakdown between those for whom:

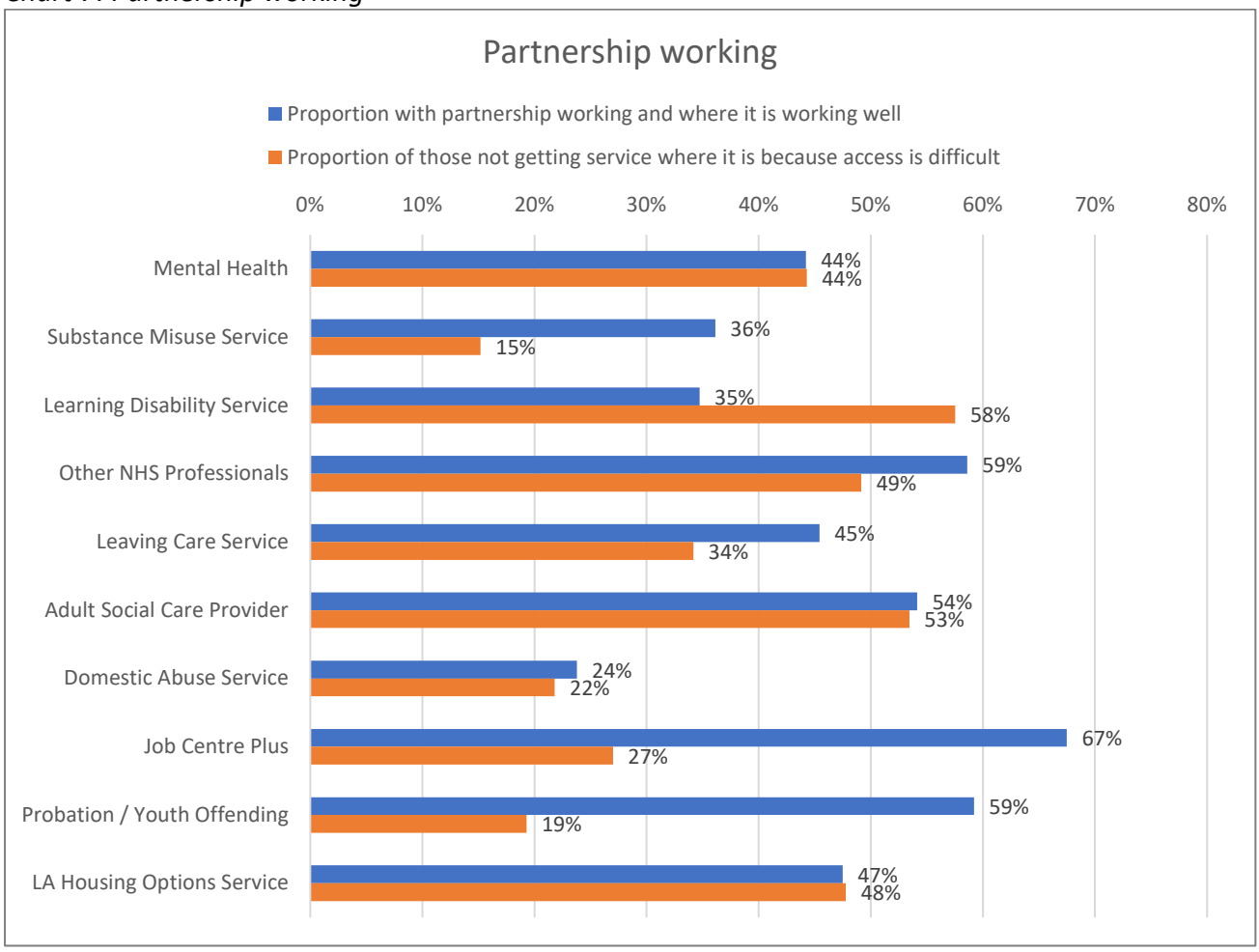
- The agency is actively involved and this is working well
- The agency is involved, but this is proving difficult
- The individual is felt to need the service but does not wish to engage
- The agency is not involved due to problems with access

In Chart 7 below, we show the proportion of those who are not getting the service where this is because access is difficult in orange; we have included in blue the proportion (as in

[15] For example, this is discussed in relation to the reluctance of some survivors of domestic abuse to engage with mental health support in a literature review commissioned by Women's Aid

Chart 6 above), where effective partnership working is in place for comparison. Note, these two figures are not supposed to total 100.

Chart 7: Partnership working



This flags up some interesting variations in partnerships, for example:

- In some services, such as adult social care and mental health services, access difficulties are high, but the proportion of effective partnership working for those who are able to access services is also relatively high.
- In some services, people not wanting to engage appears to be a more frequent barrier than access difficulties – this is true, for example of substance misuse services (where 35% of those felt to need the service do not wish to engage) and domestic abuse services (where this is true of 46% of those felt to need the service).

Whatever the reasons for people not accessing the services they need, this leaves supported housing schemes trying to support a high number of individuals who need but are not receiving specialist forms of support and healthcare. For example, across all supported housing schemes, 57% of those felt to need mental health services and 63% of those felt to need substance misuse services did not have good quality access in place.

Only a small group of individuals (111 people, 5%) were reported as not needing **any** of the 10 core external services listed in Chart 7 above.

The remaining 2,008 people required a total of 6,579 external services between them (i.e. an average of 3.3 each).

In just under half (49%) of these 6,579 instances of needing access to a service, good access to that service was reported to be in place.

Access to external services seemed at its strongest when someone was living in specialist supported housing designed for their needs. For example, 69% of people living in supported housing for people experiencing domestic abuse were described as having good quality contact with external domestic abuse services. The picture was the same in relation to supported housing for people with a history of substance misuse, 81% of whom had good access to external addiction services, alongside the 70% of people in supported housing for people with a mental health problem who were reported as having good access to external mental health services.[16]

We gave each individual a 'coordination score', based on the level of access each had to those core services. We then compared this to their other characteristics, such as their multiple disadvantage score and the outcomes reported by support staff.

There was a broad pattern of people with lower levels of multiple disadvantage (score <3) being more likely to have good access to the external services they needed (78% on average) than those with higher levels of multiple disadvantage (score of 3 or more) (64% on average).[17]

However, there was marked variation across the individuals in the survey over the extent of the assistance they received from external services. Some individuals did not have access to *any* of several external services that they needed, while others had good quality access to several services.

It is clear that the infrastructure of specialist health, mental health and addiction services that would enable supported housing to work more successfully with people with multiple and complex needs is not uniformly present.

[16] All @ <.001

[17] Measured according to a service need being identified and met with good quality access to those services, so, on average, people with a multiple disadvantage score of three or more successfully accessed external services, for which they had an identified need, in 64% of cases.

6.2. Survey findings: impact of partnership working on outcomes

We were asked to explore the impact of effective partnership working on supported housing's ability to assist its residents to achieve health and wellbeing outcomes. We present here the findings from our quantitative analysis of the survey data, then discuss qualitative findings related to this topic in the second half of this chapter.

As highlighted above, the patterns of external service contact were complex and variable, but there was some broad evidence that higher rates of successful contact with external services were associated with more positive outcomes. On average:

- Those reporting above-median scores on wellbeing outcomes were successfully engaging with external services at a higher average rate (2.4 services per person) than those with below-median wellbeing scores (1.92 services per person).
- Those reporting above-median scores on health, safety and social care outcomes were successfully engaging with 2.37 external services per person, compared to 1.86 services per person for those with below-median scores on health outcomes.
- There was a weaker effect in relation to economic outcomes, but those reporting outcomes above the median level were in contact with an average of 2.4 external services compared to an average of 2 per person for those who were not.

We then tested whether this varied for groups of people with different support needs: mental health problems, substance misuse problems, and histories of offending.

Mental health

There were significant positive associations between rates of external mental health service contact and outcomes for the 1019 people who were reported as having a mental health problem. Having good specialist external support in place clearly makes a difference for this group.

However, it was also true that, on average, those who did not have good external mental health input were also achieving good health, safety and social care outcomes, just not quite as good. 79.8% of people with a mental health problem who reported good contact with external mental health services compared to 70.6% of people with a mental health problem who did not report good contact with external mental health services scored above the median score on health, safety and social care outcomes.

This also holds true – in fact the outcomes are even more positive – for those with mental health problems who also have multiple needs than for those with mental health problems and fewer additional support needs.

This suggests that supported housing is:

- Facilitating connections to external services for people with a mental illness, including those who also have multiple and complex needs
- Playing a direct role in achieving positive outcomes around health, safety and social care for people with mental health problems, i.e. 70.6% of those *lacking* contact with external mental health services were still reported as showing some improvements.

Substance misuse

Access to external addiction services did not have a statistically significant impact on the health, safety and social care outcomes of those with substance misuse problems. However, again, those with substance misuse issues and higher levels of multiple disadvantage reported positive outcomes at a higher rate than those with lower levels of multiple disadvantage.

This can again be read as suggesting that residence in supported housing was associated with gains in health and wellbeing for people with multiple and complex needs, despite challenges with access to external services and with securing suitable housing for move-on.

Offending

Ninety per cent of people with a history of offending were reported as showing at least some reduction in offending when contact with Probation/Youth Justice services was good. Even when assistance from Probation/Youth Justice was poor or non-existent, there was still a reported improvement in 78% of cases, suggesting that:

- An independent effect in reducing offending may be achieved by supported housing provision, something that has been suggested by other research.
- External contact with specialist services seems to have improved outcomes still further, reflecting the orthodoxy that a multidimensional pattern of support is the best route to reducing recidivism.
- There was no significant association between complexity of need (a multiple disadvantage score of three or more) and recidivism, suggesting that supported housing and supported housing working with Probation/Youth Justice services was having a broadly beneficial effect on recidivism among people with different levels and complexity of support need.

6.3. The policy and structural context for partnership working

We were asked to consider partnership working within the context of the Integrated Care System structures and the Social Care White Paper. We begin this section by summarising key aspects of this changing landscape which may be relevant to the supported housing sector. This draws both from our qualitative interviews (from which quotes have been taken) and a brief review of existing literature.

6.3.1. Integrated Care Systems

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities in July 2022.

These structures replace Clinical Commissioning Groups and also take over some of the commissioning responsibilities of NHS England; of particular relevance to supported housing

this includes some specialist (e.g. forensic) Learning Disability and Mental Health commissioning.

ICSs consist of a Board (ICB), which is an NHS governance structure, and typically a number of place-based partnerships (ICPs) which report to it. These ICPs are statutory joint committees of the ICB and local authorities in the area and are intended to bring together a broad set of system partners to develop an integrated health and care strategy. It is within these partnerships that housing providers should hopefully be represented.

There is considerable variation within the 42 ICSs in relation to:

- The size and population of the area covered
- The number and type of local authorities covered – two-tier authorities can pose particular challenges from a housing perspective
- The levels of deprivation[18] and the impact of government cuts[19]
- The maturity of the structures and partnerships
- The composition of partnerships and boards

Our interviews identified challenges with the change to the ICS system, for example:

> *"Some IC systems are very NHS dominated – some of the people coming into the new roles have no idea what local government looks like, never mind the housing association sector!"*
>
> *"It's a massive structural challenge – [North East and North Cumbria} is the biggest ICS in the country – it's basically The North…. and the organisational change, just 5 or 6 years after we set up the CCGs – they will just all be changing seats and setting up structures and it will take a couple of years to bed in".*

Integrated Care Systems: Implications and opportunities for supported housing

Although there was some scepticism amongst housing association interviewees about the potential for this most recent NHS reorganisation to impact on the provision of supported housing, others highlighted the opportunities:

1. Priorities to be determined at a local level, which can create an opportunity to build the needs of your target group into strategies if you can 'find a hook' which might be indirect, e.g. around alcohol, New Psychoactive Substances or multiple and complex needs.

[18] https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like

[19] Harris T, Hodge L, Phillips D. *English local government funding: trends and challenges in 2019 and beyond.* Institute for Fiscal Studies; 2019 (https://ifs.org.uk/publications/14563).

Practice Example: Influencing ICP strategic priorities

Sitting on one of the place-based partnerships under the Nottinghamshire Integrated Care Board has enabled Framework Housing Association to influence the creation of a strategic priority and workstream on Severe and Multiple Disadvantage (SMD). Framework is well-placed to co-produce and evaluate different parts of the system to inform planning. Apollos Clifton-Brown (Director of Health and Social Care) explained, "*ICB partnerships don't really have their own resources as such, so we have effectively become a resource for this workstream and I act as its executive sponsor*". As part of that workstream, there is a fortnightly meeting of 42 providers, to plan and review commissioning for people with SMD.

2. There is an acknowledgement of the key role which non-statutory partners should play in integrated care partnerships; however, the specific role of housing providers is often not well-understood, e.g. in relation to leveraging capital, the lead-in times required to supply properties, and housing and asset management functions.

Practice example: Place-based landlord as link to ICS for housing association partnership

Sarah Roxby is a Service Director at Wakefield District Housing. She works one day a week for the West Yorkshire ICS and leads their Housing and Health Programme.

> *"I sit on the Integrated Care Partnerships at a local and regional level, but we had spent a lot of time developing those partnerships. It's been a 10-year journey…."*

That 'journey' has included:

- A secondment at the CCG to build better relationships between housing and health, raise awareness, follow up on ideas and actions, and also generate insight into NHS challenges and priorities
- Taking a paper to the newly-formed ICB system leadership team on housing as a social determinant of health. This led to an invitation to join the Improving Population Health team.
- Networking, 'just being at those meetings', understanding the opportunities.
- The creation of the West Yorkshire Housing Association Partnership, enabling Sarah to act as an intermediary between the ICS and the wider housing sector
- An invitation to join the Mental Health, Learning Disability and Autism Programme Board as a housing representative, and influence the commissioning of a Supported Housing Market Needs Assessment for West Yorkshire.

3. Some NHS provider trusts are directly involved in ICBs and they are increasingly being asked (sometimes working together as 'provider collaboratives') to take on more responsibility for redesigning and commissioning local pathways. This represents a move from transactional procurement to a more collaborative approach, creating new opportunities for 'provider-to-provider' innovation to tackle issues such as delayed discharges or expensive out of area placements.

Andrew van Doorn, Chief Executive of HACT explains:

> *"Where trusts hold the risk of over-spend, they are incentivised to solve the problems……. Housing providers need to view the world through that pathway methodology – start with the problems, because people in NHS often don't understand Housing, they tend to put it in a particular box. What is the route into those pathways, what might housing providers do to reduce blockages?"*

6.3.2. Adult Social Care White Paper

People at the Heart of Care recognises the centrality of housing to the successful delivery of social care, and the need to embed housing within local health and social care systems.

The paper sets out the government's intention to bolster the supply of specialist supported housing and establish a £300 million fund to enable this. The white paper was criticised for a lack of detail on how this would be implemented, and the prospectus was not publicly available at the time of writing.

However, we understand that the Department of Health and Social Care's planned Housing Transformation Fund[20] focuses on much-needed revenue funding, prioritising:

- Place-based partnerships which have evidence-based longer term strategies and can demonstrate political support, and
- New projects and services which bring about and can evidence a clear change in delivery and outcomes.

6.4. Enablers and barriers to effective partnerships

In this section, we present the findings from thematic analysis of the qualitative data from the interviews. These are separated into system-level enablers/ barriers, which focus on strategies, structures and commissioning, and provider-level factors, which consider the relationships and communication between supported housing providers and clinicians in particular. Whilst we include shorter practice examples here to illustrate themes, we also refer to longer case studies of initiatives contained in the appendix.

6.4.1. System-level factors: strategic development of supported housing

Composition and understanding of those leading Integrated Care structures

As highlighted above, where the ICB Place Lead understands social care, housing and the wider social determinants of health, this can have a positive impact on the opportunities for partnership working; if they are purely from clinical backgrounds, this may be more difficult.

[20] Greater Manchester Housing Transformation Fund Briefing – Update July 2022, unpublished.

Strategic planning

We heard that, in many parts of the country, there is a lack of strategic planning in relation to housing and supported housing. Clinicians rely on care providers to find housing on an ad hoc basis, and often with little lead-in time, whilst cash-strapped local authority social care departments focus on responding to the needs of individuals to whom they owe a statutory duty and are keen not to attract any more into their area.

> *"There's not enough dialogue between them and there is no single body that has overview and responsibility…….There needs to be a regionally based comprehensive housing needs assessment from higher to lower interventions – around what's required - numbers, timescales, partners, funding – and it's nowhere near that".*
>
> Housing association

Sussex Health & Care (ICS) has developed a Mental Health and Housing Strategy. This evidences the importance of partnership working between mental health and housing, explains the role which supported housing can play in mental health pathways, and sets out a number of priorities, including further development of Discharge to Assess models, and specialist provision for younger people. An individual case study on the ICS's web page illustrates how step-down from hospital to supported housing facilitated a move-on to an ordinary tenancy, where residential care had previously been deemed necessary by the mental health team:

Joe's Story

"I was referred to D2A following a serious attempt on my life. I have Bi-Polar Affective Disorder and experienced a relapse after losing a close family member. When admitted to hospital I was uncertain about my future and anxious about becoming homeless. My mental health team were talking about a long-term residential care home but instead referred me to D2A as a 'trial' placement in the community.

"I was offered a six-week placement in a supported housing service and there I could access support that made me feel safe and think about my longer-term goals. A social worker assessed my longer term needs and we agreed that it was best for me to move into my own independent accommodation with a small package of care because I had shown in the D2A placement that I don't need to live in residential care.

"I got help to look for different types of accommodation and viewed a flat provided by a private landlord which I accepted. I was helped to purchase essential items and got other things I needed from local charities.

"I'm really optimistic about my future. I have good, stable accommodation and a package of support. I now really want to become a peer support worker to help others who are going through what I did."

Local authority structures and resources

Interviewees from housing associations and from the NHS reported challenges and huge variability in local authorities' appetites and abilities to engage at a strategic level in relation to the commissioning of housing-related support. Key themes included:

- Very different degrees of access to and control over housing, depending on whether or not the local authority has housing responsibilities and what relationships and nominations agreements it has with housing association providers
- Some interviewees felt that local authorities are reluctant to evidence needs through strategic assessments which they know they will struggle to resource
- Different approaches to homeless healthcare, depending on the incidence of visible homelessness and on Rough Sleeper Initiative funding. The most innovative are seconding mental health professionals into their housing support pathways; others have no commissioned support services for those experiencing homelessness.
- Delays in local authority gateways, assessments, decision-making and placement-finding (in relation both to adult social care and homelessness) can then impact negatively on individuals, NHS pathways and supported housing providers' voids.
- Depleted supported housing markets in some areas, due to historic de-commissioning and lack of commissioner capacity
- Clinicians assume that local authorities' statutory responsibilities will cover housing; housing associations may look to the local authority to act as a bridge to the NHS.

Despite these challenges, we heard some positive examples of local authority commissioning practice, especially in relation to supported housing for care leavers. For example, Mosscare St Vincent's has successfully negotiated a 10-year commissioning deal for the support costs at their latest foyer development in Manchester.

Chief Executive, Charlie Norman explains:

> *"The argument for that was that housing associations work on 30 year business plans – we contribute to the local authority discharging its statutory duties sustainably by getting people into long-term homes, so we need the local authority to play its part by making longer term commitments to enable us to do that. The wraparound support is what has the most impact for people and we just can't provide that on 1-, 2- year commissioning cycles".*

Short-term budgets and election cycles can often act as a barrier for the development of high quality, preventative interventions, but where – as in the case of Manchester – a council is prepared to commit to a longer term partnership, there is clear evidence of improved value for money and better outcomes:

> *"Manchester City Council had previously been paying around £3k per week to accommodate some of these young people out of area. Now it is costing*

around £500 per week for a place in a purpose-built foyer with intensive wraparound support and they are back in their city, and they have all the support around them that they really need. People are really flourishing, life chances are coming their way – so it's cheaper and provides much better outcomes."

Other supported housing providers reported positive partnerships with local authorities in relation to care leavers, but reported that it was much harder to convince local authorities to do this for other client groups, where the statutory duties are not such a driver.

Market-shaping by NHS providers

As NHS provider trusts increasingly take over commissioning responsibilities for whole pathways from Integrated Care Boards and in some cases from NHS England, many are recognising the need to shape the supported housing market directly.

For example, HACT has been supporting the South London Mental Health and Community Partnership as it reviews the whole of the Complex Care pathway in London. Collectively, the South London trusts are funding around 1800 individuals in high-cost placements, many out of area. They are now engaging with the supported housing market locally, recognising a need to develop around 600 additional supported housing placements in South London.

We also heard positive examples of providers working in partnership to develop longer-term supported housing for those with high and complex care needs relating to learning disability and/or mental health. In some of these cases, interviewees explained that health and local authority commissioners were 'both on the call' to discuss new developments; others represented 'provider-to-provider innovation', in which health trusts are working directly in partnership with housing associations to build new models.

See for example our appended case study on **Thirteen's partnership with local social care company PIPS, set up by the regional NHS Foundation Trust**.

Devolution

We heard how regional devolution has created opportunities to strengthen strategic partnerships across a number of local authorities, the NHS and the housing association sector. Interviewees attributed this to joint governance structures which bring local leaders and commissioners together, profile-raising by mayors, and opportunities to develop a strategic approach with sufficient economy of scale. Having a dedicated Supported Housing lead within NHS Greater Manchester was also felt to have been pivotal to ensure sufficient visibility, understanding and capacity to drive this area of work. See the practice example on the **strategic development of supported housing for people with complex learning disabilities and autism in Greater Manchester**.

6.4.2. Provider-level factors

Relationships, risk and trust

A recurring theme throughout the interviews was that, despite its structural complexity and hierarchical culture, effective partnerships with the NHS typically grow out of good relationships with individual professionals.

Interviewees reported that few clinicians have a real understanding of 'housing' and 'support' and what might be possible within the community, so they tend to make risk averse decisions and look to more secure, institutional or residential care settings for individuals coming out of hospital.

Getting the language right

Those attending the HACT focus group agreed that the 'whole leadership in the NHS structure is focused on bed management'. Mirroring NHS language and finding the right 'hooks' were felt to be important. This might involve talking about how supported housing can provide 'bedspaces' in the community, improving 'flow' through NHS 'pathways'. It may be compelling to demonstrate how supported housing providers can help the NHS reach 'hidden populations' post-pandemic, including 'frail' residents. The NHS does not always understand the role they can play in supporting the breakdown of tenancies and why this matters so much. Gill Leng from Healthy London Partnership highlighted that housing-related support may fall under the umbrella of 'healthcare public health' (those things which impact the effectiveness of NHS interventions). For example, the new specialist detox centre for people experiencing homelessness at Guy's and St Thomas' NHS Foundation Trust struggled with low referrals initially because of a lack of suitable pre-access assessment and post-detox step-down accommodation.

However, we also heard in the HACT group discussion that some in the NHS are tired of 'sales pitches from private developers of supported housing'; there appears to be an appetite instead for 'more grown up' dialogue between social landlords and the NHS to work together to tackle shared problems and goals. Sitting on relevant partnership boards can help housing providers understand local systems, challenges and priorities.

Understanding what housing can bring

Within this, interviewees highlighted the importance of housing providers bringing their whole offer and not just their supported housing to the table. For example, whg offers a social prescribing service, Your Housing provides keyworker accommodation to NHS trusts, St Basils' provides accommodation and support to young people with experience of homelessness working as apprentices in the NHS.

Interviewees also urged supported housing providers to create opportunities to explain the work they do to NHS professionals and build their trust at an operational level.

For example, one supported housing provider explained that they contract NHS professionals from the local mental health trust to facilitate regular reflective practice

sessions with their support staff. This brings a number of benefits: it improves staff development, wellbeing and effectiveness, and also gives NHS professionals greater insight into the work and skills of supported housing staff. Another housing provider explained,

> *"When health professionals see that you are working with someone and they understand the value of that relationship, then they ring you. So it's about commissioning stuff in a way that there is an expectation that you will form those partnerships".*

Participants at the HACT focus group explained that the supported housing sector can be hampered by a lack of clarity around what different supported housing interventions entail, who they are best targeted at and with which outcomes. This is in stark contrast to the NHS, which is very clear about different models and interventions and their efficacy. The quality case of supported housing is yet to be made effectively.

Specialist supported housing providers such as Home Group and Look Ahead have worked hard to improve the way in which they market their services to the NHS.

Look Ahead has developed and labelled five key supported housing models, and can describe how these fit into NHS pathways and how they might support reduced costs and pressures for the NHS.

Home Group has a small Sales Team dedicated to building links with the NHS and social care – they have found their online networking events to be particularly effective:

> *"An operational colleague [from Home Group] will host a virtual event focused on a particular service or product. The Sales Team generate the interest, and we can see up to 50/60 contacts at the event, and the beauty of virtual events is we can pick up those partnership opportunities straight away!"*
> Rachael Byrne, Executive Director

Funding considerations

Interviewees confirmed that the bureaucracy involved in the NHS England Transforming Care/ Building the Right Support programme for supported housing (to reduce the number of people with a learning disability/ autism in mental health inpatient settings) can act as a barrier to development. Others within the NHS pointed out that the funding to move everyone out of inpatient care in their area alone would require more than the programme's whole national budget.

However, despite challenges with capital, guaranteeing sufficient levels of revenue continues to be the main issue.

Those taking part in the HACT focus group highlighted the over-reliance by the NHS on short-term reactive and non-recurrent spending via winter pressures monies, and the spot-purchasing of expensive private care placements via Section 117 arrangements. This practice fuels the perception that housing, care and support can be 'turned on and off quite

quickly', where good quality housing takes time to deliver and requires good strategic relationships with social landlords. The ballooning of spot purchasing has had a negative impact on clinical integration – risks are simply passed on and tend to be managed by the use of greater restrictions on residents' freedom. By contrast, trust and effective partnership working between clinicians and supported housing providers is most likely to occur in block-funded, carefully planned developments where there is a high degree of trust between different workers, who work together to manage risks.

This process of partnership-building is neither quick nor easy. As one supported housing provider explained:

> *"The clinical side of mental health work is about managing risk and illnesses – by contrast, supported housing staff work to an enabling model, our focus is on forming relationships and supporting recovery. We have found a real disconnect between what each agency believes success to mean for individuals. For us, success is that someone has the skills and confidence to live their lives and navigate the world and we have helped them on that path. Clinicians tend to focus on whether they are stable on their medication and whether the risk has reduced. So it is two incredibly different mindsets trying to forge a path together – both have something to learn from each other, but it takes time to build that trust and understanding."*

7. Value for money to wider services

7.1. Introduction

We were asked to quantify at national level the impact of supported housing delivery on financial savings to statutory agencies, including local authorities, NHS and public health.

A clear message from our stakeholder engagement was that aggregated and simplistic national estimates of 'cost savings' can do more damage than good in convincing statutory agencies like the NHS of the value of supported housing. Most of the so-called 'savings' cannot be realised by statutory organisations who are facing huge demands in the current context. These sorts of calculations have been attempted previously by a number of cross-client group studies, e.g. DCLG/ Cap Gemini (2009), building on Matrix (2004), Cardiff University in 2020 (for Welsh Government). There has been further work on the cost savings arising from mental health supported accommodation, by PSSRU/ Housing and Health (2022) and by Look Ahead/ Europe Economics (2021) and from specialised supported housing for people with learning disabilities by Mencap/ Housing LIN (2018). We refer the reader to these, where appropriate.

Our study makes the following additions to this evidence base and narrative around value for money within the supported housing sector:

- An estimate of the unit cost of supporting housing, in models with different types of staffing arrangements, and a weighted average across all of these models.
- An estimate of the 'counterfactual' impact of supported housing on homelessness and the risk of homelessness, and on demand for in-patient psychiatric care, residential care (and other forms of community-based care) and prison places – in other words, what the impact on these other sectors might be, were it not for the supported housing sector.

Given the under-representation of long-term specialist provision for people with learning disabilities from our sample, it was not possible to accurately estimate the counterfactual impact on demand for residential care as a whole. DCLG/Cap Gemini had found this to be by far the largest cost benefit from longer-term supported housing services to the wider health and social care system, and Mencap/ Housing LIN compared the costs of specialised supported housing for people with learning disabilities with the costs of specialist residential or inpatient care. We do however have sufficient data to estimate the counterfactual impact on registered care usage were it not for *transitional* supported housing specifically. This reflects findings of other studies highlighting high levels of frailty in homeless hostels and the need for greater supply specialist forms of residential care for those with histories of homelessness.

- A narrative, drawing on our survey and qualitative findings, existing literature and previous work conducted by our team, on the cost benefits of the impact which supported housing is having on reducing homelessness, and on the contribution it makes to strategic priorities and to improving operational effectiveness in the NHS.

7.2. Supported housing costs

Housing associations participating in the survey shared data on the total costs (i.e. including both rent and support costs[21]) for 100 separate schemes, broken down by different types of staff cover. This produced the following average weekly costs shown in the table below.

Table 8: Average weekly costs for supported housing

Staff Cover Type	Average weekly cost per place	Average annual cost per place*
24 Hour Cover	£475	£24.7K
On site cover	£344	£17.9K
Visiting staff	£270	£14.0K

**Rounded to nearest £1,000*

Applying weighted averages to reflect the balance of these models within our survey sample, this generates an estimated **average annual total cost for a supported housing place of £21K per year**.

This breaks down into an average of £9,500 housing costs and £11,500 support costs per year (rounded to the nearest £500).

7.3. What would happen were it not for supported housing?

Staff completing the survey were asked, "If a supported housing place was not available, what do you think would happen to the person instead?" and given a number of options from which to choose. These options and the responses are shown in the table below.

Table 9: Projected outcomes if supported housing was withdrawn

Projected Outcome if supported housing was withdrawn	% of total
They would probably need to be placed in a registered care or nursing home	3%
They would probably need to be in a psychiatric care facility	3%
They would probably find other accommodation that gives them the support they require	21%
They would probably find other accommodation but not the support they needed to sustain it	26%
They would probably sleep rough Including very short-term sofa-surfing, squatting, living in a temporary structure etc	38%
They would be at risk of prison, given the conditions of a current license or court order	6%
Not known	2%

[21] Strictly speaking this is therefore an average income figure. It was pointed out by participants that this might be lower than the actual costs of delivering the service where the service is effectively being cross-subsidised by activity elsewhere.

We used these responses to estimate the counterfactual, although we also took into account where people had been living prior to moving into the supported housing service, on the basis that current residents may have made sufficient progress to mean that they would be able to cope without an alternative service, but this would not necessarily have been the case if the supported housing had never been there in the first place. For example, some of those who had previously been in hospital might not have been able to be discharged had a supported housing service not been in place.

We have also applied weighted averages as previously described, to take account of differences between the breakdown of different types of supported housing in our sample and the most recent estimated national breakdowns. The results, alongside examples of comparative unit costs are presented in the following table.

Table 10: Estimating costs of the 'counterfactual' to supported housing
NB: Average annual total cost per person of supported housing is estimated to be £21,200

Counterfactual impact (if no supported housing)	Individuals affected (national estimates)	Notes/ commentary	Unit costs of alternative
Increase in core homelessness	41,000	This includes people rough sleeping, sofa surfing and people living in other temporary housing circumstances[22].	University of York research in 2016, estimated the average cost of long-term homelessness at £34,518 per person per year, including usage of drug/alcohol, mental health, other NHS, criminal justice and homelessness services (see chart below to see how these costs breakdown between agencies). Allowing for inflation at December 2022, this would be **£43,606.**
Increase in those at risk of repeat homelessness	30,000	Based on those thought likely to find accommodation, but not the support needed to sustain it. We have no way of estimating how many would become homeless and over what time frame	For those who remain homeless long term, the **£43,606** annual average cost from the row above might apply; Where people present to local authorities as homeless, unit costs range from £900 to £11.5K[23], depending on the outcome of the priority need/ intentionality decision and whether in London or not.
Increase in psychiatric care usage	14,000	Includes those discharged from psychiatric care into supported housing (6%) and those who were felt to need psychiatric	Factoring in inflation, psychiatric inpatient care would cost £444 (PSSRU NHS figures), rising to £489 in London (Europe Economics/ Look Ahead) per day, or **£162,060/**

[22] We applied weighted averages to gross up responses, "They would probably sleep rough (including short term sofa-surfing, squatting, living in temporary structures etc)".
[23] See p.27 of LSE's The Cost of Homelessness in London – we have used the Bank of England inflation calculator to 'MHCLG not in priority need' for the lower end of this range and to the 'LSE London Acceptance' figures to give this range.

Counterfactual impact (if no supported housing)	Individuals affected (national estimates)	Notes/ commentary	Unit costs of alternative
		care as a counterfactual (3%) and allowing for 2% who fell into both groups. NB. 4K of this group were not in specialist mental health supported housing.	**£178,485 per year** respectively. Availability would also be challenging, given high occupancy rates on psychiatric wards.
Increase in residential care (from short-term supported housing only)	2,500	Includes those who were discharged from residential care into supported housing and those who were felt to need residential care as a counterfactual at snapshot – note however, that many of these people's needs would be better met in a setting with care were this currently accessible to them.	Allowing for inflation, average weekly costs of over 65s residential care would be £830, and £996 for nursing homes (PSSRU) i.e. **£43,160 or £51,792 per year**, respectively. However, it would be challenging to find suitable older people's residential care settings for many of this cohort, given their complexity, lifestyles and often pre-retirement ages. This is likely to lead to more expensive average placement costs.
Increased prison places	2,000	This estimate is based on the assumption that without the supported housing place the individual is at risk of being recalled to prison. We have **not** included those in prison immediately prior to supported housing since their release would not have been delayed were suitable accommodation not available.	Average cost per prisoner per year in 2021 was **£32,716**, according to the MOJ.

It is clear from the above table that the **average cost of supported housing compares favourably with the average costs of the alternatives.**

7.4. Value for money narrative

7.4.1. Homelessness

The main elements of potential cost offsets and savings from supported housing in relation to homelessness can be summarised as follows:

- Prevention of repeat and sustained homelessness associated with populations with multiple and complex needs, where high rates of emergency service use can be associated with significant costs
- Reduction in offending behaviour (where applicable) through the right mix of emotional and practical support and access to the right multi-agency packages of services being facilitated by supported housing, with associated benefits for the criminal justice system
- Reductions in health service use, associated with stable access to ordinary GP registration and access to treatment through that route, rather than repeated and unplanned use of A&E, ambulance and emergency mental health and addiction services
- Reduction in the potential 'lifetime' costs of someone experiencing homelessness on a repeated or sustained basis, both in the sense of stopping those experiences continuing when a pattern has already been established and, particularly, in relation to preventing someone at potential risk of recurrent or sustained homelessness from having those experiences, by providing the right support to rapidly end homelessness, rather than allow it to become a pattern in someone's life that is at a high human cost to themselves and a high cost to the public purse.

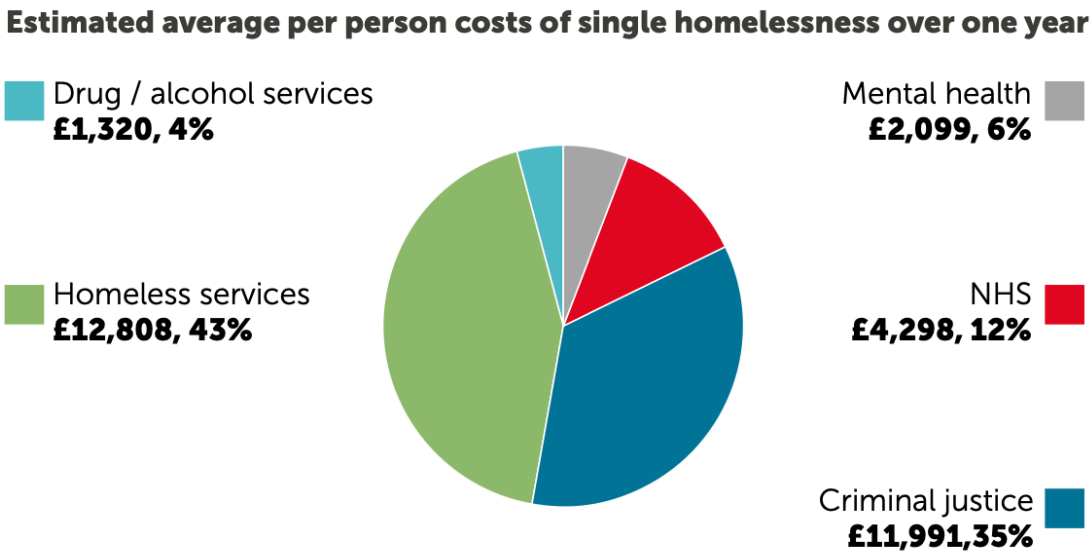
There are some reasons to be careful when looking at the costs and benefits of supported housing in relation to other services. One issue is that prolonged and recurrent use of supported housing services that are designed for short- or medium-term use can be significantly more expensive than resettlement or tenancy sustainment in ordinary housing with support from a housing-led or Housing First service. Housing First has, for example, been successfully used as a means to reduce long and repeated stays by people with multiple and complex needs becoming 'stuck' in fixed site services because the right mix of housing, services and support has been difficult to assemble. As is noted elsewhere in this report, fixed site supported housing for people experiencing homelessness is reliant on strategic integration and effective coordination with social landlords, social care, NHS and mental health and addiction services, and in some cases domestic abuse and criminal justice services, in order to function well, particularly when working with high risk, high cost individuals experiencing homelessness.

Another challenge lies in which costs are realisable. An A&E department may be very grateful if a small group of rough sleepers who were attending 30 or 40 times a year were supported into stable contact with a GP and helped to attend outpatient and other treatment by supported housing workers, but even such 'frequent flyers' only constitute a tiny proportion of resource use. In other words, reducing this group's use of A&E would not allow what is (always) an overstretched A&E department to free up significant time among

medical or administrative staff, because the overall demand is so high relative to their resources, those staff would always be busy all the time anyway. Equally, the Police would be grateful if someone they had repeat contact with while they were living rough was in a position where that ceased to be the case because they had the right housing and support, but the time officers nominally 'saved' would be instantly absorbed by other pressures on Police time.

In some instances, where people experiencing homelessness have not been receiving the support and treatment they need, costs will spike on contact with supported housing as it connects to the services they should have been using.

Pleace & Culhane[24] undertook exploratory work to estimate the costs to the public purse of services used by a sample of 86 single homeless people over a 90 day period. If their service usage were to remain consistent over the course of a whole year, this would amount to £34.5K per person per year. The following chart shows the breakdown of these costs to different public bodies.



Source: Pleace, N. and Culhane, D. (2016). Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. London: Crisis UK

7.4.2. Psychiatric care

PSSRU estimate that each readmission to inpatient mental health care costs £11,500.

Supported Housing can help people avoid admission or readmission to inpatient mental health services in a range of ways, from providing safe storage and prompts to take

[24] Pleace, N. and Culhane, D. (2016). Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England. London: Crisis UK

psychiatric medicines, help to access outpatient and community services, and emotional support and informal monitoring of symptoms.

Good supported housing could ease the pressure on inpatient beds. Psychiatric hospitals in 2022 were operating at an average bed occupancy rate of 90% (with 85% considered safe), and this results in a higher risk of patients being placed out of their areas. This is a bad outcome for patients, further dislocating them from their familiar communities and any loved ones who may be able to support them; it is also much more expensive for the NHS. An out-of-area placement in 2017 cost £500 compared to in area £361 and £132 in supported housing.

Using 2017 figures, York university estimate a cost of £5,777 for all health care per year per mental health patient adjusted to 2019 costs; of these an average of £2,567 related directly to mental health, shared amongst community, in patient and primary care services. This compares to £1,621 for a member of the general public. Preventing the deterioration of mental health is therefore cost saving in and of itself. It is impossible to say for certain what proportion of people in Supported Housing would have gone on to develop worsening mental health without the service, but given the threats to mental health posed by homelessness, it is likely that there is a cost avoidance case on these grounds. The median costs were far lower than the mean costs, indicating that a small number of people incurred far larger costs and a larger number of people were helped in low-cost services.

Access to primary care may also support lower cost, earlier intervention for issues such as harmful drinking. One study of alcohol misuse found that brief, nurse-delivered interventions in primary care were effective and saved £204 per person in direct costs, and potentially scaled up to £40 million to the NHS and another £40 million to criminal justice if the model became universal[5]. Brief interventions rely on GP registration and a stable enough home environment for people to attend and engage with the service, which are issues that supported housing helps to address.

In addition, dealing with problems before they reach crisis point can reduce the risk of people going to the emergency department; A&E liaison for mental health costs £206 per patient.

8. Conclusions

Our findings evidence the substantial impact which the sector is having on reducing homelessness, and improving health and wellbeing for people experiencing multiple disadvantage. Without supported housing, there would be significantly higher levels of homelessness and far fewer people would be receiving the support they need to sustain their accommodation.

However, it is also clear that the return on investment of public monies in this sector could be increased:

- With more move-on housing and accompanying floating support for those who need it, the sector could resettle even more people, further reducing pressure on local authority homelessness functions
- With better access to NHS Secondary Mental Health support, supported housing could reduce demand on NHS inpatient services and support people in the community. With greater integration and co-design with NHS mental health services, supported housing could support earlier discharge from inpatient care, enhanced crisis support and reduced use of costly out of area specialist placements
- With more consistent partnerships with primary healthcare, supported housing could support even more 'hard-to-reach' individuals to access timely and preventative healthcare, reducing avoidable emergencies and admissions
- With better coordination with criminal justice services, supported housing could have an even greater impact in reducing re-offending.

The new Integrated Care Systems (ICSs) provide an opportunity for better strategic integration of supported housing in wider systems at a place-based level. Our study has identified examples where this is starting to happen as a result of:

- Housing association partnerships being represented on Integrated Care Partnerships
- Dedicated housing leads within ICSs, including secondments from the sector
- 'Provider to provider innovation', where NHS provider trusts or collaboratives have taken on responsibility for a whole clinical pathway and are forging partnerships with supported housing providers to develop clinically integrated schemes
- Supported housing providers successfully bidding to lead partnerships delivering integrated care
- Providers developing in-house clinical teams or subcontracting trusts to provide reflective practice and staff development for support staff
- Place-based strategic work to carry out supported housing needs assessments, or co-produce consistent housing and support models.

Whilst these examples are promising, interviewees highlighted the need for a clearer national framework to ensure this innovation is replicated, albeit one which allows sufficient flexibility for place-based partnerships to respond to local priorities. Central leadership is required to ensure consistent definitions, models and outcomes measurement, and to prompt and challenge ICBs to ensure supported housing is integrated in their plans. Partnerships can only flourish where there is sufficient security of funding to develop, plan and deliver high quality supported housing.

9. Appendices

9.1. Methods

9.1.1. Participants

The following table shows the organisations which funded the research and/or took part in the survey.

Table 11: Participating organisations

Organisation	Funder	Survey participant
BCHA - Bournemouth Churches Housing Association	x	**Yes**
Centrepoint	x	**Yes**
East Midlands Housing Association (emh)	**Yes**	**Yes**
Falcon Housing Association	x	**Yes**
Home Group	**Yes**	**Yes**
Jigsaw Homes	**Yes**	**Yes**
National Housing Federation	**Yes**	x
One Housing Group	**Yes**	**Yes**
Peabody Housing Association	**Yes**	**Yes**
Phoenix Futures	**Yes**	**Yes**
Porchlight	**Yes**	x
Raven Housing Trust	**Yes**	x
Regenda Homes	**Yes**	**Yes**
The Riverside Group	**Yes**	**Yes**
Together Housing	**Yes**	x
Tyne Housing	**Yes**	**Yes**
Wakefield and District Housing	**Yes**	x

Interviews

Full formal interviews:

1. Jim Aspdin – Southdown
2. Sarah Murphy – Southdown
3. Rachael Byrne – Home Group
4. Sarah Roxby – Wakefield and District Housing
5. Warren Heppolette – Greater Manchester Health & Social Care Partnership
6. Drew van Doorn – HACT
7. Apollos Clifton-Brown – Director Health & Social Care at Framework
8. Sue Ramsden - NHF
9. Suzannah Young – NHF
10. Helen Simpson – NHS GMcr
11. Jo Chilton - NHS GMcr
12. Clare Skidmore – LD & Autism Lead at NHS England
13. Gill Leng – Healthy London Partnership/ ex-Public Health England

14. Chris Smith – Thirteen
15. Helen Berresford - Nacro
16. Lindsay Ryder – Nacro
17. Charlie Norman – Mosscare St Vincent's/ chair of Greater Manchester Housing Partnership
18. Rosa Napolitano– Look Ahead
19. Peter Smith – Director of Sector Development at Homeless Link
20. John Glenton – Riverside
21. Donna Kelly – Jigsaw Homes

More information conversations

22. Bekah Ryder – Research Lead, NHF
23. Ian Copeman – consultant working on parallel research into scope, scale and cost of supported housing for the Learning Disability and Autism Network/ Golden Lane
24. Marie Davies – CEO Falcon support provider (homelessness) – managing agent for emh
25. Dave Black – Director of Care and Support Contracted Services, Peabody
26. Vicky Ball – CEO of Phoenix Futures

Group discussion organised by Sarah Parsons and Andrew van Doorn of HACTHACT and facilitated by IBA:

27. John Pritchard – Southern Health NHS Foundation Trust, Associate Director for Housing, ex Home Group
28. Chris Harris – Associate Director for Housing, Sussex Partnership NHS Foundation Trust (SPFT)
29. Patrick O'Dwyer – HACT Associate, HACT
30. Andrew Godfrey – Managing Director for Learning Disabilities and Forensics Services at Hertfordshire Partnership NHS Foundation Trust (HPFT)

9.1.2. Survey responses

Census date for information was 1 August 2022 (though some information did not comply with the census date but was included).
Responses submitted between 1 August and 15 September 2022

Table 12: Number of responses

Complete responses received	2,258
Partial responses added to complete responses after review* (total partial responses 679)	28
Number of responses for analysis	**2,286**
Number of responses removed after initial analysis work+	167
FINAL TOTAL OF RESPONSES ANALYSED FOR REPORT	**2,119**

*Partial responses were reviewed and if it was felt that sufficient questions had been answered for the data to still be meaningful (min up to Q14) and they were not deemed to

be duplicates of responses already completed, they were updated in SmartSurvey to be included in the analysis adding an additional 28 responses.

[+]Following initial analysis work on the survey using data from providers re: types of schemes, a number of responses were eliminated from the final analysis – the majority because the data pertained to housing for older people, which was not to be included.

Table 13: Responses by organisation used in final analysis

Organisation	Responses number	Responses %
Bournemouth Churches	158	7%
Centrepoint	73	3%
East Midlands Housing (emh)	36	2%
Falcon	74	3%
Home Group	474	22%
Jigsaw	82	4%
One Housing	100	5%
Peabody	70	3%
Phoenix	90	4%
Regenda	200	9%
Riverside	570	27%
Tyne Housing	192	9%
Total responses	***2,119***	***100%***

9.1.3. Limitations

We recognise the following methodological limitations and describe here our rationale for selecting methods and any mitigating actions taken.

No lived experience voices; survey completed by individuals' keyworkers

The survey was completed by the residents' key workers, who used their knowledge and experience of the people they were supporting to answer a series of questions about those residents' history and current circumstances. The conclusions are therefore based on the key worker's perceptions and understanding rather than reflecting any input directly from the users of services themselves[25]. This approach was taken largely because it allowed for a larger sample than would have been the case if it had been the users themselves that were completing the survey. It has to be acknowledged however that the picture presented by the survey is inherently subjective. On the other hand, it is the subjective views of the

[25] Some service providers will have taken the view that they should discuss the questions with service users themselves before answering the survey. This was not, however, a requirement of participating in the research.

people who are closest to the direct participants of the services, and who could therefore most reasonably claim to have an informed view.

We considered supplementing the survey with a targeted number of qualitative interviews of people using supported housing services; however, we decided it was not possible, within the resources of this study to do so in a meaningful and balanced way, ensuring that we captured diversity in terms of demographics, client group, supported housing type and experience of supported housing. We have included case studies and referenced other studies which have interviewed people living in supported housing, however, we recognise this is a gap for future research.

Representativeness of the sample

Participation in the survey was largely through direct invitation to specific supported housing providers. This started with members of the study's steering group and the NHF's national homelessness and housing and health groups, but was extended to other providers who had come to hear of the research and expressed an interest. In order to ensure as representative group of providers as possible, we checked that we had a balanced number of national and regional/ generic and specialist providers, as described in Chapter 1.

In our briefing document for support staff completing the survey, we asked workers to complete an individual return for all individuals they keywork if possible. However, recognising that time is limited and to reduce the risk of selection bias, we asked staff to work through individuals in alphabetical order. Since we did not ask for individuals' names, we have no way of assessing how many received or followed this instruction.

Once the individual responses were received, we checked the 'principal target group' of the schemes in which individuals were living to test how representative the sample was in that regard. The best estimates against which to compare our principal target group breakdowns were those made by the Supported Accommodation Review (SAR) in 2016, presented in Chapter 1. It is clear that learning disability service users are under-represented in the survey returns, and generic homelessness service users are over-represented.

9.1.4. Method for generating national estimates

We also used the SAR breakdowns, having adjusted for the lower total number of supported housing units suggested by more recent Statistical Data Return (SDR) figures, to gross-up the results from the survey in order to calculate the implications nationally. We did this by multiplying the total number of units as recorded in the SDR by the proportion of units by principal target group as recorded in the SAR, as demonstrated below.

Table 14: National estimates

Principal Target Group	% of Total from SAR	Number of Estimated Units from SDR
Learning Disabilities	24%	34,085
Mental health	19%	26,117
Generic Homelessness	22%	31,429
Domestic Abuse	3%	3,984
Substance misuse	3%	3,984
Offenders	3%	3,984
Young people	12%	17,264
Physical Disabilities	6%	7,968
Other (including Refugees / Asylum Seekers)	8%	11,509
TOTAL		***140,323***

We then multiplied the number of estimated units for each principal target group by the percentage for that target group with any particular characteristic. So, for example if 50% of service users in services aimed at the principal target group of mental health have a particular result in the survey, then we would estimate that nationally 26117 x 50% would have this characteristic i.e. 13,000 (rounded).

For the purposes of these exercises we did not take account of the "Physical disabilities" or the "Other" categories from the SAR breakdowns, as we have none of these included within the survey, so we could not identify a reasonable percentage to apply when grossing up. This means that all the national projections contained within this report have the potential of being an under-count, as we are calculating the prevalence of user characteristics across 120,846 of the 140,283 SDR units.

In some instances (e.g., when producing national estimates of the numbers of people moving on from supported housing into settled housing each year), it was necessary to have figures for the total number of units of *transitional* supported housing (in order to scale up) and the breakdown of principal target group provision within that (in order to weight our averages). These figures do not exist elsewhere, so we used the following assumptions, drawing on our survey findings:

Table 15: Assumptions used

Service	Assumption
Learning Disability Services	Assume 0% short-term (i.e. all long term)
Mental Health Services	Based on survey results, assume 88% are short-term
Generic Homelessness Services	Based on survey results, assume 89% are short-term
Domestic Abuse Services	Assume 100% short-term
Offender Services	Assume 100% short-term
Substance Misuse Services	Assume 100% short-term
Young People Services	Assume 100% short-term

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Applying these assumptions to the SDR total generate an estimated number of transitional housing units of **80K units (rounded), with the following breakdowns:**

Table 16: Estimated numbers of transitional housing units

Group	**Total units nationally**	**Short-term/ transitional nationally**
People with history of mental health problems	26,117	22,983
Generic - homelessness project	31,429	27,972
People with experience of domestic abuse	3,984	3,984
People with history of problematic substance use	3,984	3,984
People with offending history	3,984	3,984
Young people	17,264	17,264
Total	***86,762***	***80,171***

9.2. Theory of Change: Short term/ transitional supported housing

The primary purpose of this form of supported housing is to address the reasons why an individual cannot or does not want to move into mainstream housing straight away, with the aim of preventing their future homelessness. This is where the greatest cost benefits are likely to occur.

The primary outcome measures are therefore around the numbers of people sustaining accommodation as an alternative to homelessness in the short term AND then moving into settled housing in the medium term.
Supported housing projects carry out a number of activities to support progress/ change in relation to those factors which increase/ decrease the risk of that individual remaining/ becoming homeless again in future. The secondary outcome measures are therefore around progress / change in relation to these factors that increase/decrease the risk of further homelessness. Many of these secondary outcomes will relate to individuals' health and wellbeing.

Activities	**Inputs**	**Assumptions**	**Short-term outcomes**	**Medium-term outcomes**	**Impact**
Provision of accommodation (with housing management/ supervisory functions to ensure health & safety)	PIE building Appropriate staffing levels, skills & style A range of move-on options is available Staff know of them and there are access routes Clear processes to remove barriers to mainstream housing	Risks can be managed, and a sufficiently 'safe space' created A range of move-on options can be accessed within a reasonable timeframe	Those who would otherwise be roofless are accommodated They sustain accommodation until ready to move to settled housing	Appropriate, settled accommodation is identified and accessed.	Settled housing is sustained
MEASURES			Number accommodated (previously/ otherwise homeless) Number leaving in unplanned way	Proportion moving to more settled and/or suitable housing	The individual does not re-present as homeless in future

			following eviction / abandonment.		
Provision of personalised support to: • Stabilise personal issues • Reduce barriers to housing • Develop positive support networks • Enhance confidence to manage independently	Individual agency and choice is promoted Effective referrals and alternative models available Effective multi-agency partnerships Wider services are accessible to people experiencing homelessness and/or complex needs	Individuals engage Sustainable behaviour change is desired and possible People can access any specialist support they need	Support needs are effectively identified Appropriate support is accessed	Barriers to more independent/ settled housing and risk factors for future homelessness are reduced	Capacity to prevent further homelessness is increased
MEASURES	Support staff assessment of whether those agencies that need to be involved are and how well they are working together?		Engages with / makes more preventative use of support services	• Substance use is stabilised • Mental health conditions better managed • Practical skills/ confidence improved • Pro-social networks developed • Housing barriers (e.g., affordability/ exclusions) reduced	

9.3. Theory of Change: Long-term supported housing

The primary purpose of this form of supported housing is to promote health and wellbeing through the maximisation of independence, choice and control in order to prevent the need for more institutional form of care. The prevention of the need for more institutional forms of care is where the greatest value-for-money impacts occur.
The principal outcomes measures for long-term supported housing are therefore around the numbers of people sustaining accommodation and not needing recourse to more institutional health or social care AND maximising their wellbeing.
The secondary outcome measures relate to progress / change in relation to the principal factors that contribute to health & wellbeing, e.g.:

- How well mental health is managed
- How well physical health is managed
- Levels of community engagement
- Levels of economic engagement
- Extent to which family / personal relationships are sustained/improved
- Access to other services

Activities	**Inputs**	**Assumptions**		**Impact**
Provision of **accommodation** (with housing management/ supervisory functions to ensure health & safety, and accessibility)	• Accessible and suitable property/ies, which are well-located in relation to community safety, facilities, transport, access to green space, etc. • Appropriate staffing levels, skills & style • Landlord responds quickly to repairs and invests appropriately in décor, fixtures, furniture, equipment and adaptations, etc.	Individuals' choices are respected in relation to the location and type of property; and whether and with whom they share it. A homely environment can be created.	The property enables maximum independence and privacy.	People feel secure and settled in their homes.

MEASURES (given focus of this study)	Landlord investment?	Assessment by support staff of whether the individual is in the 'right' place	Assessment by support staff of quality/ accessibility of property	Length of stay Staff assessment of feeling settled
Provision of personalised **support** to: • Carry out day-to-day activities with maximum independence & dignity • Express preferences and views • Develop/ maintain positive relationships • Access timely and where possible preventative healthcare • Do things you enjoy • Have opportunities to contribute	• Assessment and referral processes are effective • Alternative models/ properties/ housing and care options are available • Psychologically-informed support • Positive approach to risk management • Effective multi-agency partnerships (health, VCS, ETE, social care, leisure, etc)	A positive balance can be achieved between risks, rights and responsibilities People can access any specialist support they need Wider services and settings are accessible to people with disabilities.	• Strengths, interests, significant relationships are effectively identified • Access to required services and to life outside of services is enabled • Use of restraints, deprivation of liberty is minimised	Health and wellbeing outcomes are maximised; the individual is reaching their potential in relation to: • Emotional • Physical • Social • Economic/ ETE wellbeing.

MEASURES	Support staff assessment of whether those agencies that need to be involved are, and how well they are working together			Staff assessment of: • How well mental health is managed • How well physical health is managed • Levels of community engagement • Levels of economic engagement • Extent to which family / personal relationships are sustained/improved • Access to other services

9.4. Resident profile tables

Age Group

Table 17: Age Group of residents

	Age Group						
Target Group	**16-17**	**18-25**	**26-39**	**40-64**	**65 or older**	**(blank)**	***Total***
Learning disability	0%	13%	23%	58%	6%	0%	***100%***
Mental health	0%	16%	33%	45%	4%	1%	***100%***
Generic homelessness	1%	14%	36%	46%	3%	0%	***100%***
Domestic abuse	2%	15%	50%	33%	0%	0%	***100%***
Substance abuse	0%	6%	31%	60%	3%	0%	***100%***
Offenders	0%	9%	43%	48%	0%	0%	***100%***
Young people	14%	68%	10%	8%	0%	0%	***100%***
Unknown/no data	0%	26%	32%	39%	3%	0%	***100%***
Total	***3%***	***23%***	***31%***	***41%***	***3%***	***0%***	***100%***

Gender identity

Table 18: Gender identity of residents

	Gender Identity					
Target Group	**Female**	**Male**	**Non-binary**	**Other**	**(blank)**	***Total***
Learning disability	36%	63%	1%	0%	0%	***100%***
Mental health	31%	67%	0%	2%	1%	***100%***
Generic homelessness	22%	76%	0%	1%	0%	***100%***
Domestic abuse	100%	0%	0%	0%	0%	***100%***
Substance abuse	23%	77%	0%	0%	0%	***100%***
Offenders	43%	57%	0%	0%	0%	***100%***
Young people	41%	56%	1%	1%	1%	***100%***
Unknown/no data	32%	66%	1%	0%	1%	***100%***
Total	***30%***	***68%***	***1%***	***1%***	***0%***	***100%***

Ethnicity

Table 19: Ethnicity of residents

	Identifies as being from a black or minority ethnic background				
Target Group	**Yes**	**No**	**Don't know**	**(blank)**	***Total***
Learning disability	3%	95%	0%	1%	***100%***
Mental health	36%	62%	2%	0%	***100%***
Generic homelessness	16%	82%	2%	0%	***100%***
Domestic abuse	23%	77%	0%	0%	***100%***
Substance abuse	4%	96%	0%	0%	***100%***
Offenders	4%	96%	0%	0%	***100%***
Young people	21%	77%	2%	0%	***100%***
Unknown/no data	13%	88%	0%	0%	***100%***
Total	***18%***	***80%***	***2%***	***0%***	***100%***

Disabilities/ Health Conditions

Table 20: Disabilities/significant health conditions of residents

	Would you say that they had any of the following disabilities or significant health conditions?					
Target Group	**Physical disability and/or sensory impairment**	**Diagnosed mental illness**	**Diagnosed learning disability**	**Other long-term health condition**	**History of problematic substance use**	**Diagnosed Autism / autistic spectrum disorder**
People with learning disabilities	14%	50%	67%	13%	5%	21%
People with history of mental health problems	9%	91%	12%	15%	28%	7%
Generic - homelessness project	15%	53%	8%	22%	50%	3%
People with experience of domestic abuse	6%	50%	8%	12%	23%	0%
People with history of problematic substance use	13%	47%	5%	26%	91%	1%
People with offending history	13%	74%	4%	22%	61%	9%
Young people	4%	39%	13%	10%	19%	8%
Unknown/no data	13%	68%	10%	21%	36%	2%
Total	***12%***	***56%***	***13%***	***18%***	***40%***	***5%***

Needing Adult Social Care

Table 21: Residents needing adult social care

Target Group	% needing adult social care
People with learning disabilities	91%
People with history of mental health problems	33%
Generic - homelessness project	14%
People with experience of domestic abuse	15%
People with history of problematic substance use	11%
People with offending history	4%
Young people	19%
Unknown/no data	66%
Total	***40%***

History of Offending

Table 22: Residents' history of offending

	Have they had any history of offending?					
Service Target Group	**They do not have any offending history as far as we know**	**Convicted of less serious or petty offences in the past but on a one-off or occasional basis**	**Convicted of a series of less serious or petty offences only**	**Convicted in the past including at least one serious offence***	**(blank)**	***Total***
Learning disability	92%	3%	1%	3%	1%	***100%***
Mental health	67%	10%	7%	13%	2%	***100%***
Generic homelessness	45%	15%	18%	21%	1%	***100%***
Domestic abuse	83%	6%	8%	4%	0%	***100%***
Substance abuse	29%	16%	39%	16%	0%	***100%***
Offenders	30%	9%	26%	35%	0%	***100%***
Young people	75%	8%	8%	7%	1%	***100%***
Unknown/no data	45%	24%	17%	15%	0%	***100%***
Total	***56%***	***12%***	***15%***	***16%***	***1%***	***100%***

***'Serious offence' is one involving violence, sexual assault, drug dealing, sexual grooming or trafficking**

Experience of domestic abuse

Table 23: Residents' experience of domestic abuse

	Do they have any experience of domestic abuse?				
Target Group	**Regularly experienced domestic abuse in the recent past (including currently)**	**Experienced domestic abuse on an occasional or one-off basis in the recent past**	**They have not experienced domestic abuse in the recent past as far as we know**	**(blank)**	***Total***
Learning disability	4%	8%	88%	1%	100%
Mental health	4%	14%	79%	2%	100%
Generic homelessness	11%	15%	73%	2%	100%
Domestic abuse	17%	65%	17%	0%	100%
Substance abuse	12%	14%	71%	3%	100%
Offenders	17%	26%	57%	0%	100%
Young people	10%	23%	61%	6%	100%
Unknown/no data	6%	21%	73%	0%	100%
Total	***9%***	***17%***	***71%***	***2%***	***100%***

Long-term homelessness

Table 24: Residents' long-term homelessness

Target User Group	**They have had a lengthy or cyclical experience of homelessness**
Learning disability	1%
Mental health	11%
Generic homelessness	19%
Domestic abuse	8%
Substance abuse	20%
Offenders	17%
Young people	8%
Unknown/no data	13%
Total	***14%***

Local authority care

Table 25: Residents' experience of local authority care

	Have they been in local authority care?				
Target Group	**Was a looked after-child prior to taking up residence**	**Was formerly a looked-after child**	**Was never a looked-after child as far as we know**	**(blank)**	**Total**
Learning disability	3%	12%	84%	1%	***100%***
Mental health	1%	8%	90%	1%	***100%***
Generic homelessness	2%	10%	86%	2%	***100%***
Domestic abuse	4%	8%	87%	2%	***100%***
Substance abuse	1%	13%	86%	0%	***100%***
Offenders	9%	4%	87%	0%	***100%***
Young people	24%	13%	61%	1%	***100%***
Unknown/no data	4%	8%	85%	2%	***100%***
Total	***6%***	***10%***	***83%***	***1%***	***100%***

9.4.1. Involvement of external agencies

	Mental Health	Substance Misuse Service	Learning Disability Service	Other NHS Professionals	Leaving Care Service	Adult Social Care Provider	Domestic Abuse Service	Job Centre Plus	Other job-seeking or employment skills training service	College	Debt Counselling Agency	Welfare Rights Service	Probation / Youth Offending	LA Housing Options Service
Proportion of total sample needing access to these services	63%	47%	14%	42%	10%	22%	11%	38%	24%	16%	11%	8%	13%	52%
Of this:														
Proportion with partnership working and where it is working well	44%	36%	35%	59%	45%	54%	24%	67%	44%	52%	30%	43%	59%	47%
Proportion with partnership working but where there are difficulties	21%	23%	15%	21%	18%	21%	18%	20%	23%	12%	16%	17%	20%	30%
Proportion in need of partnership working but where access is difficult	15%	6%	29%	10%	12%	14%	13%	3%	8%	6%	11%	11%	4%	11%
Proportion where partnership working is needed but individual does not want to engage	19%	35%	22%	10%	24%	12%	46%	9%	25%	31%	43%	30%	17%	12%
Total	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***	***100%***
Proportion of those not getting service where it is because access is difficult	44%	15%	58%	49%	34%	53%	22%	27%	25%	17%	20%	27%	19%	48%

9.5. Individual case studies

9.5.1. Riverside - Jamaica Street Case Study

Jamaica Street is a 58-bed supported accommodation, located in the heart of Bristol. It is an integral part of the homelessness pathway in the city and delivers support and housing to some of the city's most vulnerable and complex people affected by homelessness.

John (not his real name) came to Jamaica Street in April 2022. He had a history of long-term substance abuse which had led to relationship and family breakdown. When he arrived in Jamaica Street, he was estranged from his children and family, his heroin use was daily and had experienced intermittent periods of rough sleeping.

In May 2022, in partnership with Public Health, Riverside created a Specialist Substance Support worker role based in Jamaica Street. The funding came from the central government lead ADDER project. One key aspect of the role is that it is based within the scheme, enabling it the fluidity to fit in with the customers meaning that the engagement was less rigid and completely person-centred. The Specialist worker has lived experience which affords him a far greater understanding and the ability to build relationships with customers due to having followed a similar path at times in his life. This has been invaluable in creating positive relationships with customers.

When a customer moves into Jamaica Street the Specialist will always engage with them and outline the support they deliver. *John* quickly engaged with the Specialist with the intent to look to step away from his substance use, his ideal aim to have his own accommodation where he could have his children stay.

The Specialist worked closely with *John* and the other agencies based in Jamaica Street to set a realistic, person-centred plan for John. This coincided with the GP led Homeless Health Service, based at Jamaica Street becoming the first practice in England to trial the use of Buvidal as an alternative treatment pathway in recovery outside of the established Methadone and Subutex.

During this time all staff at Jamaica Street provided *John* with support in all aspects while on his recovery journey. They supported him to keep his room of a good standard, made agreements to clear his arrears, worked closely with housing and benefits teams to ensure that all his needs were met. This was done in a collaborative and person-centred way with the team ensuring *John* demonstrated both ownership and commitment.

Over approximately six months *John* was supported by the Specialist and the team at Jamaica Street as he began his recovery treatment path. It was a hard journey for *John*.

Jamaica Street were able to always support him, and that the embryonic multi agency hub developing in Jamaica Street was within the building where John was living, which meant that all his needs were met under one roof.

Jamaica Street empowered and supported *John* to realise his goals. The team were able to not only support him through his recovery but also work closely with him to access housing and ensure that he did not move on into the next chapter of his life unsupported. They ensured that he had the type of accommodation and location best suited to *John*, that his benefits were in place and that the housing provider would still deliver the support that *John* required.

In November 2022 *John* moved into his own flat. And at Christmas his children stayed over.

9.5.2. Jigsaw Homes Group: Oak Tree House

Oak Tree House is a supported housing environment located in Lancaster and funded by Lancashire County Council Public Health. Our aim is to provide quality accommodation and support to people who are experiencing or threatened with homelessness and have complex needs.

Our ethos is *"A Place for change".* We work closely with partnership agencies and referring agents to identify those experiencing homelessness. This happens in many forms and includes outreach work with the local authority.

The service has supported 435 clients since it was opened in 2015. We take a humanistic, asset based approach and focus on the skills individuals have and build upon these. We promote employment for people who have lived experience and have had three people who have been service users join our team.

Our bespoke support planning takes a holistic and asset based approach to each individual. Through supporting clients to register with GPs, dentists, substance misuse services and a host of third sector and statutory services. We support clients to appointments, set-up prescription to meet their needs (deliveries/blister pack, weekly rather than monthly). We advocate on their behalf, champion for them when in need of services and arrange multi-disciplinary meetings.

Our clients have often experienced trauma to some extent, our compassionate and caring staff provide a warm and welcoming atmosphere that encourages a supportive, trusting and open relationship, were clients feel accepted for who they are.

We run a range of educational, therapeutic and social activities. These include art sessions, cooking on a budget, baking, debate and quiz nights, life skills sessions, healthy relationships, as well as social and sporting outings. These are to help develop residents living skills, social skills and promote a peer supportive community. Our bespoke behaviour change programme focuses on six core elements, and uses a range of therapeutic approaches including CBT, to help resident recognise barriers, overcome these through their support networks and local services, whilst recognising and supporting more positive approaches to challenges and set-backs. This program has proven to have a positive impact on the development of individual resilience.

Testimonials from people who have been supported at Oak Tree House:

"I've known my partner for 5 years and we have been together off and on ever since I came out of prison. Before we came to Oak Tree House we were sleeping on the Town Hall steps. Being a couple is stressful but being homeless makes everything ten times harder. When we found that we could be in Oak Tree House as a couple we couldn't believe it, it was a shock. When you are homeless you are cold all the time, Oak tree House is warm. When I was on the streets I lost over two stone. We have a home here, in a home you can be with your partner and eat what you like when you like."

"I am so grateful for all the help, encouragement and guidance whilst I've been living here. Thanks for all the time you spent with me giving me comfort, hope and courage to move on with life no matter how hard it is. Thank you for accepting me as I am and never judging my behaviours and for genuinely trying to understand my difficulties… Without the help I received here, I genuinely believe I wouldn't have managed to stay out in the community and manage my eating and personality disorder."

"I was terrified, it was a new place and I didn't know anyone but everyone was dead friendly, dead polite to me. The staff are a crazy bunch with good hearts they have helped sort everything out for me, there's always someone to talk to 24 hours a day 7 days a week. This is important for me with my Mental Health issues."

9.6. Partnerships: practice examples

9.6.1. Look Ahead: Clinical provision in a homelessness hostel

One of Look Ahead's homelessness hostels is located very close to a hospital in London. The 79-bed men's hostel has a high proportion of male residents aged over 50, many with complex health conditions. Residents kept presenting at the hospital with infected wounds which could have been prevented with earlier wound care and other physical health ailments – this prompted partnership working to develop a more effective pathway.

The initiative received funding from the Department of Levelling Up, Housing and Communities to ringfence 10 beds in the hostel, including two for people who have no recourse to public funds. These beds provide step-up/ step-down from hospital, in order to prevent (re-)admissions and facilitate safe discharge. The initiative also has three years' worth of health funding (originally from the Clinical Commissioning Group, but this now sits under the wider Integrated Care System umbrella).

Initially clinical staff came into the hostel to do wound care on site, then a clinical room with a sluice was built within the hostel. As a further development, Look Ahead now employs a support worker (who has lived experience of homelessness) as a preventative and early intervention health worker. Their sole focus is to try and persuade hostel residents who are reluctant to access health care to do so.

This initiative has built up over time and with a concerted effort and determination from each of the partners. Look Ahead is now hoping to employ a dedicated mental health worker/ Community Psychiatric Nurse within the hostel as a next step in the development.

9.6.2. Framework: A Housing Association delivering health and social care contracts

Framework works across Nottingham and the East Midlands to deliver housing, care and support to those affected by homelessness and multiple disadvantage. They provide a range of specialist supported housing services and have, over the past decade, also developed health and social care provision – through direct delivery and by influencing wider systems change. This has been driven by an understanding of the barriers which the people they support face when trying to access wider services, and the impact of this on their mission. Apollos Clifton-Brown, Director of Health and Social Care at Framework explained, '*Where the system is not working well for those we support, we decided we would deliver*'.

Examples of Framework's health and social care services include:

- Acting as lead provider for the city's drug and alcohol services via the Nottingham Recovery Network – an integrated partnership, commissioned by Public Health, which includes the NHS Healthcare Trust as a sub-contractor. Apollos explained, "*We provide a universal service, but we do so in a way that people with severe multiple disadvantage can access it and be successful: it's about cutting out the closed doors*".
- Delivering the Wellness in Mind service which acts as the central point of advice and support for anyone in Nottingham seeking better mental health

- Delivering these services, alongside a range of partners from a Wellbeing Hub, where people can access support and specialist healthcare without having to wait.

Key enablers have included:

- Learning and relationship-building from the 8-year Fulfilling Lives project, Opportunity Notts, and from Changing Futures both hosted by Framework.
- **In-house health and social care professionals**: Framework funds in-house clinical psychologists, to oversee trauma-informed approaches across supported housing and other services. They employ nurses and social workers, and offer lots of student practice placements - all overseen by a Director who has a nursing background and acts as the Caldicott Guardian and chair of the Clinical Governance group. This has helped build high levels of trust with commissioners and statutory agencies: some of Framework's social workers now have trusted assessor status and can carry out Care Act assessments on behalf of the local authority.
- Offering spaces in hubs or hostels for other health and care providers.

The impact of these partnerships on supported housing projects and residents includes:

- All supported housing staff receive trauma-informed training and ongoing second-tier supervision from clinical psychologists.
- Supported housing residents can access substance misuse and a range of other services from wider systems.
- The well-established information sharing processes with the NHS make it much easier for support workers to chase up missed appointments, prescriptions, etc.

9.6.3. Home Group – New Models of Care

Home Group has a large number of supported housing schemes, alongside regulated care services. They offer short- and long-term housing and support to people with mental health conditions and/or learning disabilities, homelessness and bespoke services they design in conjunction with commissioners.

Rachael Byrne, Executive Director explains,

> *"We have realised that the customers who are referred to many of our services have increasingly complex health and care needs, particularly across Learning Disability or Mental Health. We recognised our service models needed to change, with input from a number of NHS Trusts, we have developed a clinical offer across our supported housing, we have a number of different disciplines for example occupational therapists, psychologists, physiotherapists, positive behaviour support and mental health nurses, Clinicians work with both customers and colleagues. This partnership with heath underpins our New Models of Care initiative, and many of the commissioners recognise the benefit of that changed approach.*

The changes have also improved staff development, job satisfaction and retention. Our processes around risk are now clinically informed, with strong clinical governance in place.

We have a clinician on-call out of hours, so colleagues can access clinical advices and input from them during crises. It's key that we don't replicate or replace where health should step in, but we play our part bringing health, housing and care together."

9.6.4. Thirteen - Fellows Hall

Fellows Hall was formerly a general needs block of flats in East Cleveland owned by housing association Thirteen. The block was refurbished in 2016/17, using £426,217 from the NHS North Region Learning Disability Capital Grant, to provide seven self-contained furnished flats for people with high mental health support needs leaving long-stay hospital placements or residential care. The service was commissioned by the Clinical Commissioning Group (with some care funding from NHS) in partnership with the local authority and is delivered by a local social care company PIPS, which was set up by the regional NHS Foundation Trust. Thirteen provides a bespoke housing management service; PIPS provides the care and support and holds the relationships with commissioners. Thirteen now has a total of six schemes delivered and operational within this partnership.

There are many examples of excellent outcomes for individuals (and significant cost avoidance for health and social care as a result of these). For example, one 50-year old man had a history of over twenty failed placements, mostly in residential care, interspersed with periods of hospitalisation, due to his mental health condition, challenging behaviour, excessive drinking and self-harm. He was in the police force's top ten for making nuisance calls. This negative service history reinforced his low self-esteem and feelings of rejection.

18 months into his tenancy at Fellows Hall, he is proud of his flat, has been on holiday twice and developed friendships in the local area. He seems to particularly benefit from the mix of space afforded by having his own front door, with the option to mix in the communal areas when he chooses to. Support workers have helped him to manage his money, prepare food and pay for his occasional damages to the property. His Care Coordinator of twenty years reports that this is the best she has seen him.

Chris Smith, Deputy Chief Executive at Thirteen explains,

"When we can get these schemes off the ground, they work really well, and some of the individual outcomes are amazing, but it is hard work and it's risky….. we spent ages negotiating not only with commissioners and delivery partners, but also with Planning and Housing Benefit….. And the smaller examples are never scaled up to really affect the problem at the front end… and for me that's our hope for the role of the ICB – how do you galvanise the ability, funding and expertise – it's the leadership isn't it really?"

9.6.5. Greater Manchester's strategic development of supported housing for people with complex needs

Greater Manchester has been able to lay key strategic foundations on which more effective partnerships to develop and deliver supported housing can grow. Prior to the formalisation of the ICS structures in July 2022, these initiatives were based on '*negotiation and cajoling to try to get 30 sovereign organisations to work together*', now NHS Manchester can agree things collectively and has formal statutory committees with each of ten local authorities.

As a starting point, a tripartite agreement was published, formalising the partnership between the GM Integrated Care Partnership, GMCA and the GM Housing Providers and sets out their shared vision for 'Better Homes, Better Neighbourhoods, Better Health'.

> *"The agreement has made a difference – because it does set out everyone's roles, so people are clearer about what you do ….. of course in practice there are about a dozen or so in the NHS who live and breathe it, and the rest of the NHS doesn't know it's there. But it does at least set out it out so you can refer others to it."*
> Housing Association

Having a Supported Housing Strategic Lead at ICB level and carrying out a series of needs assessments, evidence reviews and co-design activities has also been instrumental to the development of a more strategic approach.

> *"Housing providers might be doing 'hit and hope' developments – they may think they are developing schemes which respond to need, but they have no reassurance on that, and are therefore taking more risks than they need to…. It's so much better to have a conversation about what is really needed and develop that in a strategic, planned way".*
> Chief Officer (Strategy & Innovation), NHS Greater Manchester Integrated Care

Supported housing is a strategic priority within the Adult Social Care Transformation Programme, recognising its contribution to tackling priorities around residential care home supply and quality, reducing out of area placements for people with learning disabilities and autism, and reducing delayed discharges. As part of this, the **GM Complex Needs project** has been focusing on developing suitable local supported housing solutions for 67 Greater Manchester citizens with complex needs related to learning disability and/or autism in long-term (often out of area) hospital settings.

Jo Chiltern, Director for the Adult Social Care Transformation Programme explains:

> *"We identified a need to commission differently in Greater Manchester and the starting point was a learning disability and autism project with a focus on supporting people to leave long stay hospitals and return home. All ten GM localities and care providers and housing partners are working together in collaboration to achieve the best outcomes for people by developing the*

best care and support so people get the right care, in the right place at the right time.

The project involved people with learning disabilities, autistic people, their families and carers right from the start, with design workshops, preparing specifications and interviewing and selecting support providers across the whole of GM. So instead of commissioning for a very specialist serve ten times, we did it once.

We've developed a memorandum of understanding across all 10 localities enabling much more choice and control for people in terms of where they want to live. It has taken a significant period of time to get this right with supported housing being a key challenge, but we now have a clear plan in place and are now starting to focus on people with complex needs relating to mental health and/or dementia.".