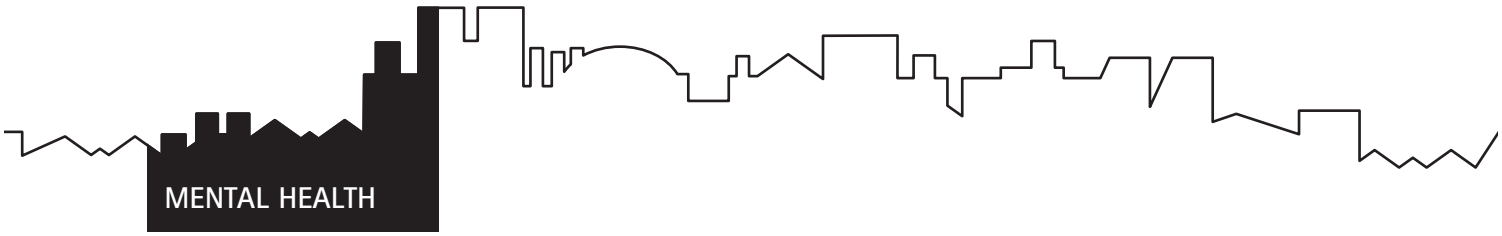

Innovation, local engagement and leadership; the future of supported housing in mental health

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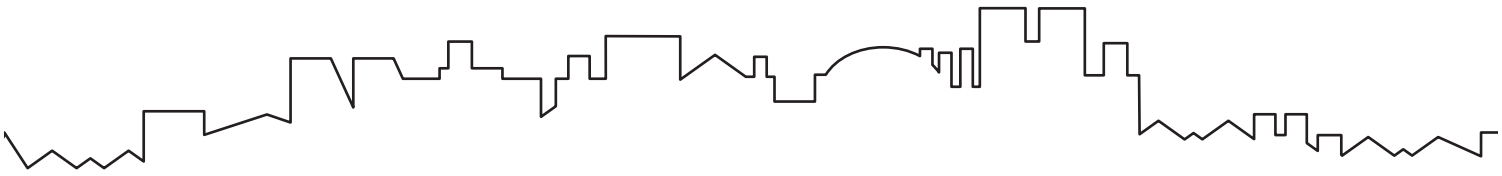
Abstract

The new local government performance framework, in combination with the move towards greater personalisation in services, creates a radically new funding environment for housing with care and support. From the Public Service Agreement (PSA) on achieving settled accommodation for individuals at risk of exclusion, through to the impact of individual budgets, the principles and mechanisms of the new joint commissioning culture create more opportunities for providers to articulate the needs of the client group served, and to assert the case for more joined-up and responsive services.

This may require different skills and new styles of leadership at local level, and providers who have become adept at being competitors may need to re-discover the skills of partnership. Meanwhile, new social inclusion policy frameworks are emerging for supported accommodation, which can support moves away from institutional care for those with mental health problems.



A new framework

In an earlier article for this journal (2006), Sarah Davis of the Chartered Institute for Housing suggested that the new framework of local strategic partnerships (LSPs) and local area agreements (LAAs) would be providing opportunities for greater collaboration between local authorities, in their strategic housing role, and in local leadership in health and social care. Writing in late 2006, Davis observed that:

> *although the details of the framework are still being developed [much would clearly depend on] how central government follows through its commitments to... enabling revitalised and reinvigorated local engagement and leadership.*

With the Comprehensive Spending Review in October 2007,[1] more of the detail of this new framework has now been confirmed, and both the extent and the range of devolved responsibility to local authorities – and, crucially, their partners at locality level – proves remarkably wide. Although the choice of priorities for targets in each area and much of the working detail of local partnerships must be negotiated with the local Government Office, a high degree of flexibility is now left to local stakeholders to determine how they will choose to work together and meet local needs within the pattern of resources and opportunities in each area.

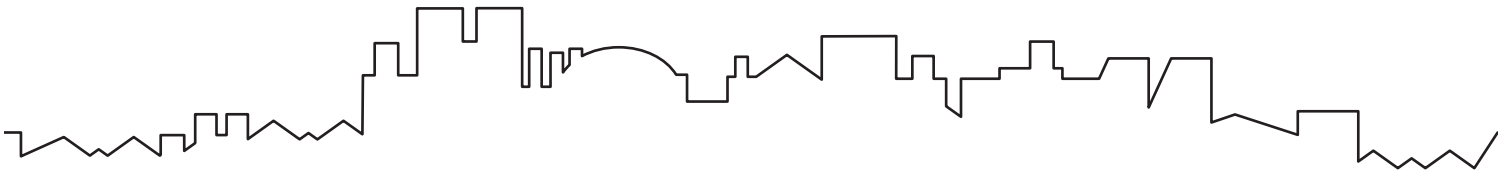
This change in the overall framework removes the micro-management from delivery, and is accompanied by significant shifts in the culture of local commissioning. There is a move away from commissioning for inputs – staff time and activities – and towards commissioning for outcomes – what really changes for the people who use the service. This is made possible by a sweeping reduction in the number of performance targets set by central government. Where once there were some 2,000 or more nationally set targets for each local service to deliver against, the total number of indicators has now been reduced to a mere 198.

Those indicators that remain are couched in very much broader language that frequently cuts across the previously separate jurisdictions of different departments, different services – and different budgets. This new recognition of the interdependence of cross-cutting agendas and budgets provides the basis for new flexibility for providers to work across previously embedded service boundaries, to meet the needs of individuals more holistically and more flexibly. While the local authority is now clearly identified as the key broker of 'place shaping' (Lyons, 2007) through local priorities and strategic partnerships, a number of subsequent policy statements from the Department of Health (DoH, 2007; DoH & CLG, 2007) emphasise that this new policy framework applies also to delivery of health care services, and is to be closely tied to the development of commissioning plans at locality level.

Throughout, there is a stress on joint work at all levels: in joint strategic needs assessment, in more integrated, area-based commissioning and in partnership in the actual delivery of services. The activities of all authorities and their partners will in future be measured, not on a sector by sector basis, but on an area or locality basis, and the new performance framework is complemented by a corresponding change in the regulatory framework, Comprehensive Area Assessment (Audit Commission, 2007) replacing Comprehensive Performance Assessment, which had focused solely on the activities of the local authority itself.

This should allow development of more joined-up services for those who work with people with complex needs and more chaotic lives (SETF, 2007), who have tended to fall through the net of earlier approaches. For those working in mental health, with people whose needs have always straddled the divides between health and social care and between care and support, this new, more flexible framework offers the option to provide services more holistically and more responsively, according to need, rather than within the artificial constraints of one funding stream or another.

[1]Details of the new National Indicator set, and the Public Service Agreement for socially excluded adults, were released with the Comprehensive Spending Review announcements in Oct 2007.



The PSAs

Some providers have suggested that allowing local authorities to determine their own priorities will simply lead to cuts in funding for services for less 'popular' client groups, such as people with mental health or learning difficulties, care leavers or ex-offenders. There are no votes, it has been said, in running a homeless persons' hostel or an outreach service for street drinkers, or other similarly marginal groups.

But this concern has in fact been addressed in the new framework. Underlying the local assessments of priority needs and the local opportunities and gaps in services, there remain the 198 indicators on which the performance of local authorities and their partnerships will be monitored, and of those 198, eight are specifically geared to ensuring that the needs of those most at risk of exclusion are not simply eclipsed.

The announcement of a new public service agreement, committing all the relevant government departments to working together to ensure improvement in outcomes on these eight indicators, confirms the increasingly high priority given by central government to accommodation and employment for adults at risk of social exclusion. Mental health is specified as one of four identified priority client groups (the others are care leavers, ex-offenders and people with learning difficulties), and settled accommodation as one of two key measures of improved inclusion within the PSA cluster, the others being achieving employment or training leading to employment.

On these eight new indicators, close monitoring by a delivery board, on which all the key departments are represented, will ensure consistent and focused attention on the success of activity at local level to support the most vulnerable and the most at risk in achieving and managing more independent living.

Not all areas will adopt indicators from the PSA16 cluster for their local priority issues, their stretch targets. But it is sufficient that a few do, to set the pace for others. In the end, it is the new shared outcomes framework, with the option of partnerships to deliver more holistic outcomes, which is the key to creating flexibility in service delivery. This framework, and the new flexibilities in partnership, will apply even where other issues have been prioritised first.

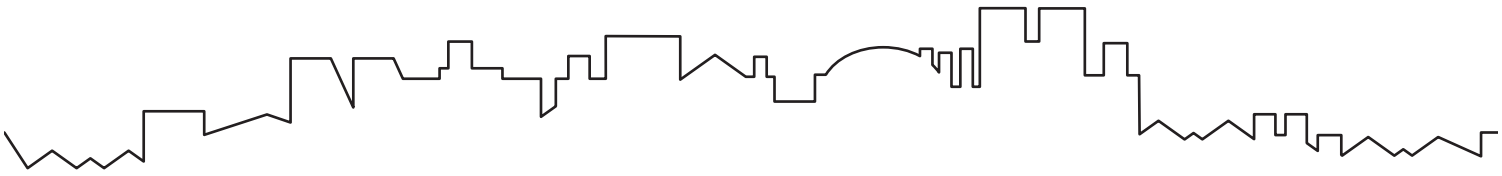
The tools for the job

Achieving stability in housing for people with mental health problems, and for vulnerable adults more broadly, is not simply about early intervention when problems arise. The key to achieving stable accommodation lies in prevention. Tenancy sustainment is not just a name for the activity of housing-related support staff. It is, and should be, a concern for all agencies working with vulnerable people – for housing, for community care staff and for all who work with those at greatest risk of social exclusion.

All agencies and programmes will need to be working towards a sustainable communities strategy that includes the most vulnerable as members of the community, and not as a threat to it (NIMHE, 2006). This includes local management as well as national regulation of general needs housing (MIMHE, 2006). It also includes the activities of public health and specialist secondary care, the operation of housing benefits services, and even economic and social regeneration planning.

Following the publication in 2004 of the Social Exclusion Unit report on Mental Health and Social Exclusion (SEU, 2004), the National Social Inclusion Programme (NSIP) has principal responsibility for co-ordinating the implementation of the report's action agenda, in a range of government departments. This includes working with and through a national Mental Health and Housing Reference Group (HRG) to develop better co-ordinated policy and practice between the housing and healthcare sectors. (The work of the HRG was described in an earlier article for this journal, Johnson, 2005a.)

Over the past three years NSIP and its partners have produced and assisted in the production of a wide range of papers on early intervention and inter-agency work when people with mental health problems who become homeless, and on efforts to communicate more effectively between agencies, to prevent tenancy breakdown in the first place.



The tools for delivery of the improved outcomes that PSA 16 promotes include guidance on:

- inter-agency problems solving and information sharing
- assessment
- early intervention and co-working between mental health and homelessness services
- integrated commissioning
- integrated regulation and audit, to ensure that local services are monitored on the manner of delivery and not solely on the headline figures that numerical indicators can capture.

On or via the NSIP website, readers can access documents such as the following.

- *Effective Rent Arrears Management*, a mental health-specific briefing (NSIP, 2006)
- *Choice-based lettings*, a mental health-specific briefing (NSIP, 2006)
- *At Home?* – mental health issues arising in social housing, a report on the views and experiences of general needs housing staff (NIMHE, 2005)
- *Access to Housing; Information-sharing protocol, confidentiality policy guidanc*e, (Housing Corporation, 2007)
- *Getting Through: Access to mental health services for people who are homeless or living in temporary or insecure accommodation* (NSIP/DoH/CLG, 2006)
- *Reaching Out: An Action Plan on Social Exclusion* (SETF, 2007)
- *Mental Health and Homelessness Policy Briefing* (DoH/CLG, 2008)
- *Our Health, Our Care, Our Say*, White Paper (DoH, 2006)
- *Health and Well-being; The crucial role of the new Local Government Performance Framework*, Joint briefing from DoH/CLG (2007)
- *Connecting Housing to the Healthcare Agenda*, Briefing with practice examples (CSIP Housing LIN, 2007)
- *Comprehensive Area Assessment*, Consultation document (Audit Commission, 2007)
- *Peer Review in the Third Sector – A guide to improving your services.* (Performance Hub, 2008)

The NSIP website, www.socialinclusion.org.uk, hosts a wide range of policy framework documents relevant to mental health, social inclusion and housing, as well as links to other related sites, and there are now discussion boards where interested parties can share information and views on innovative developments.

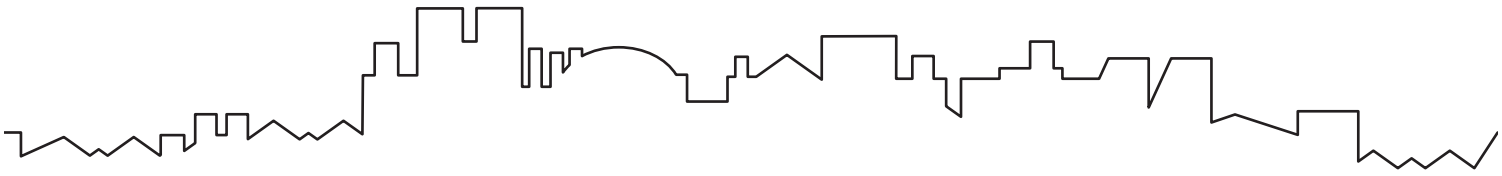
Towards the new commissioning culture

Local integration of funding streams has been made possible by development of the purchaser/provider separation, and the structures of locality-based commissioning (Johnson, 2005b). But these structures are now well established and embedded, and it is time for the relationship between commissioners and providers to reach for a new level of maturity. In the words of Nigel Walker, Senior Commissioning Adviser at the Department of Health, speaking at the 2008 Housing with Care and Support conference:

> *'We need a completely and radically different relationship between commissioners and providers. Increasingly providers are becoming the people who know the business, and commissioners don't. The day-to-day running of the business is done by the providers. Commissioners ought to be the experts in bringing people together and driving innovative process that enable those people who do run the services to be innovative themselves.'*

It is now the task of commissioners to create the funding environment that will allow providers to meet needs flexibly and responsively. For example, the days of saying that providers cannot do A, B or C, because that would be 'social care' and that Supporting People does not fund 'care' are gone. Those old default settings no longer apply, and providers can be more assertive in future in articulating the needs of the population served.

Providers, according to... (CHECK REFERENCE).....should be members in their own right of the LSPs. Joint strategic needs assessments (JSNAS), joint commissioning plans and partnerships should include the provider sector in discussions of priorities and in an opportunity audit of local resources and needs. But this is not just a matter of identifying gaps in provision for new services to fill. If existing services are not as well joined up as they should be, the JSNA represents an opportunity to raise such issues. Providers should therefore welcome the opportunity to engage with



the process, as active, involved contributors to local needs assessment and SWOT analysis.

New markets

It is in this context that we should see two other developments which may have initially caused some concern in the provider sector: removal of the ring-fence from the SP Grant, and the move towards more personalisation of services, direct payments and individual budgets taking centre stage.

The National Service Framework for Mental Health (DoH, 1999) had proposed that all areas of the country should have a range of housing options for people with mental health problems, and cited staffed and supported accommodation, supported living options including individual tenancies and shared living with flexible support, long-stay secure accommodation, family placement and respite, and – interestingly – crisis and refuge places, including service user-run 'sanctuaries'.

With the introduction, also in 1999, of Health Act flexibilities, or HAFs, came the notion of 'health care gain' - that is, that health funding can be spent on any activity or agency that promotes health care gain, and not solely on NHS or other independent health care providers. The SP Initial Strategy consultation document (ODPM, 2005) in November 2005 set out to dispel the myth that support services must always be hermetically sealed from care. It restated the fact that the SP grant from government was not the sole source of support funds, and argued for closer dovetailing of support funding with other sources of funds where needed to create more flexibility.

In conjunction with the pooling of budgets being introduced via local partnerships, this means that services can now be geared to meet the needs of service users, and not just of funding eligibility criteria. This includes the possibility of developing housing-related or housing-based alternatives to health care provision, such as those identified in the NSF. NSIP team are currently gathering a range of examples of particularly constructive practice in this area, and will publish a further paper later in 2008, drawing together common threads from many of these projects and the lessons learnt.

Similarly, with personalised budgets comes the possibility of service packages that cut across the old boundaries of support and care, following the individual on their own individual path to recovery. More traditional services such as domiciliary or home care services are unlikely to be able to gear up to work supportively with those with more complex needs. Rather, it is the floating support services that developed via SP that seem most likely to have the delivery systems, flexibility, training and supervision, and quality assurance in place to expand into this new emerging market.

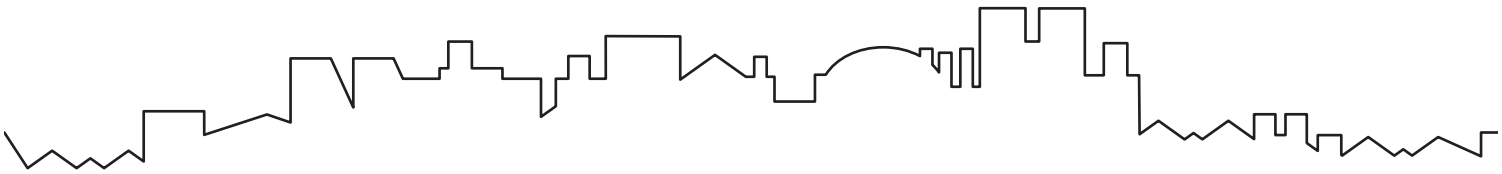
Leadership and partnership

In her article in December '06, Davis observes that leadership at local level will be crucial in taking forward these opportunities with the maximum of creativity and 'local engagement'. However, leadership in this more flexible environments is no longer simply a matter of hierarchical managerial authority within a single agency, operating within fixed parameters (Armstrong, 2004). With partnership models in funding and in delivery, leadership may be much more fluid, and dispersed throughout the matrix of agencies and services (Cooper & Dartington, 2004).

Housing support services are getting used to a world in which the goalposts move constantly. We are now entering a world where the goalposts are re-negotiable at the start of the match, and this will require rather different management skills. It has already been suggested that the relationship between commissioners and providers needs to mature, in order to implement the flexibilities of the new framework to maximum effect. The same may be true of the relationship between providers, who are becoming used to seeing each other as rivals rather than as partners.

This is not unique to housing, however, or to the world of state-funded services. In what some are calling the post-industrial revolution:

> *The new* [approaches and] *technologies bring in their wake not only new services but a more complicated set of marketplace relationships in which the traditional lines between the organisation and its competitors, suppliers and customers are less revealing…* [This is] *a turbulent setting in which the rules of the game change as quickly as the players….* Hirschorn (2007).



If the provider sector as a whole is to be represented effectively in JSNAs, LSPs and LAAs, it may also require some form of matured representation structure between providers. Smaller and more specialist providers, though often closer to their particular client group, may struggle to manage a new series of meetings, however valuable. The future may lie with those agencies that have learned to co-operate, blending capability with credibility, such as the recently successful SP consortium bid for SP floating support services in Nottingham. Here, too, the NSIP team will be keen to assist in identifying examples of co-operation and partnerships in delivery which help promote effective working between mental health and housing support services.

Conclusion

The new local government performance framework, in combination with the move to greater personalisation in services, creates a very new funding environment for housing with care and support. The extent to which this new framework will encourage and pave the way for further expansion and innovation for the supported housing sector in this more devolved approach remains open. To some extent, that is precisely the intention, as the nature of devolution and 'place shaping' is to move the debate over priorities and effective delivery to locality level. But there are certainly opportunities here for the provider sector to play a more constructive role, both in developing local needs analysis and in new forms of delivery.

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