

*An evaluation of the Supporting People
Health Pilots*

Care Services Improvement Partnership **CSIP**

supportingpeople

supporting independence

An evaluation of the Supporting People Health Pilots

Ailsa Cameron, School for Policy Studies, University of Bristol

Geraldine Macdonald, School of Sociology, Social Policy and
Social Work, Queen's University Belfast

William Turner, School for Policy Studies, University of Bristol

Liz Lloyd, School for Policy Studies, University of Bristol

Department for Communities and Local Government: London

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On 5th May 2006 the responsibilities of the Office of the Deputy Prime Minister (ODPM) transferred to the Department for Communities and Local Government (DCLG)

Department for Communities and Local Government
Eland House
Bressenden Place
London SW1E 5DU
Telephone: 020 7944 4400
Website: www.communities.gov.uk

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EXECUTIVE SUMMARY

BACKGROUND

The *Supporting People Health Pilots* were designed to explore the extent to which the *Supporting People* framework for policy, planning and commissioning can be used to benefit the physical and mental health of the community.

In May 2003 the then Office of the Deputy Prime Minister (ODPM), now Department for Communities and Local Government (DCLG), invited commissioning bodies and/or service providers in health and social care to bid to become a *Supporting People Health Pilot*. The available funding was designed to support the development of their partnerships in new ways that would contribute to health objectives.

The six Health Pilots selected represented a wide range of people who use services, both commissioning and providing elements, and a range of agencies from the statutory, independent and voluntary sectors.

Bid from:	Project Title	Focus
Doncaster West PCT	'On Track'	Young people with dual diagnosis
Northampton PCT	'SWAN NEST'	Women wanting to exit the sex trade
London Borough of Waltham Forest	'Place to Live'	Supported living for people with learning disabilities
City of Salford Housing	'Sure footed in Salford'	Integrated falls services
London Boroughs of Southwark and Lambeth	'Housing Support Outreach and Referral for hard-to-reach individuals living with HIV'	Hard to reach individuals living with HIV
North Lincolnshire County Council	'SPIDERS'	Older people

The ODPM, now DCLG, commissioned a research team from the School for Policy Studies at the University of Bristol to undertake an evaluation of the pilots. The evaluation looked at both process and outcomes, focussing particularly on what works in joint working.

OVERARCHING THEMES

Evidence from the health pilots suggests that *Supporting People* services can be deployed to benefit people's physical and mental health. The evidence also indicates that agencies and professionals can work effectively together across organisational boundaries, but that the difficulties of doing so should not be under-estimated. Their experiences raise a number of over arching themes that are relevant to joint working in other policy contexts.

ENSURING EFFECTIVE LINKS BETWEEN STRATEGIC AND OPERATIONAL LEVEL JOINT WORKING

Work within the pilots underlines the need for partnerships to be based on joint working at both strategic and operational levels. Commissioning new services that depend on joint working are unlikely to be effective if those working at an operational level do not understand why they need to work together. Similarly, without the support of those working at a strategic level, joint working at an operational level is unlikely to be successful. As well as understanding why they are working together, staff at both levels need to be committed to the aims and objectives of the partnership, and develop strong linkages between these two levels.

The pilots also underline the importance of strong links between individuals working at the *same* level, whether strategic or operational and the importance of effective communication. At the operational level effective partnership working depends on efficient systems that keep partners abreast of progress and that allow them to cross refer people who use services – or pass on information about them – in a timely manner. At the strategic level partners need to be able to discuss and resolve difficulties efficiently and effectively and ensure that the initiative is keyed into strategic planning processes.

COMPLEXITY AND THE NEED FOR CLEAR GOVERNANCE AND MANAGEMENT RESPONSIBILITY

One of the key themes to emerge from the evaluation is the need for joint working to be based on clear arrangements in respect of governance and management responsibility. Transparent arrangements, agreed by all partners, ensure that staff understand to whom they are accountable and enable the work to be managed effectively. Someone needs to be ultimately accountable for the project. Evidence from the pilots indicates that confusion or diffusion of roles and responsibilities underpinned some of the problems that arose.

Where is the management of joint initiatives and accountability for them best located? The experiences of the pilots indicates that whilst it may appear rational to make joint services accountable to committees that are themselves ‘joint’ this too can diffuse responsibility. An alternative might be to ensure that joint initiatives are accountable to one organisation acting on behalf of all of the partners.

MANAGEMENT OF PROJECT WORKERS

As with governance, the pilots highlight particular lessons about the management of project workers, particularly in new services set up to work across organisational boundaries. Managerial arrangements in collaborative services can be complex but the evidence suggests it is important to keep line management simple and to locate it within the organisation in which project workers are employed.

The need to provide specialist supervision to project workers – as opposed to managerial supervision – was also identified as important. Particularly at those pilots which worked intensively with individuals in order to link them into a variety of general and specialist health services. Through the provision of specialist supervision pilots were able to ensure that the practice of individual workers was safe as well as providing them with time to ‘off load’ and reflect on the difficult nature of the work they were doing.

THE NEED TO INVOLVE PEOPLE WHO USE SERVICES AND THE WIDER PUBLIC

All of the pilots regarded the involvement of people who use services as an essential means of ensuring that their work was relevant and, in turn, legitimate. A range of strategies were used. Two pilots used existing forums through which to involve current and potential service users in discussions about the development of the pilot. Others decided it was inappropriate to involve service users in the initial development and on-going management of their work. Instead they held regular meetings with service users to discuss their experiences and any suggestions they might have for improving services. In contrast, one pilot decided that user representatives would play a more prominent role in the development of the service. The original bid included plans for an evaluation to be undertaken by a local service users group. A representative of this group took part in initial discussions about the service and became a member of the steering group. This approach improved the credibility of the service amongst service users and may indirectly, have contributed to the high levels of engagement with the service.

THE CONTRIBUTION OF THE VOLUNTARY SECTOR

The pilots demonstrate the important contribution that the voluntary sector can make in supporting vulnerable people to live independently in the community. First the involvement of the voluntary sector brought additional credibility to the work of several pilots. Secondly, as well as harnessing the expertise that exists within the voluntary sector, pilots were able to draw on their networks to support people to maintain their independence. Finally, the development of new services in the voluntary sector provided powerful models of how services could be provided outside of the confines of the statutory sector. The absence of specific organisational or professional allegiances appeared to enable pilot workers based in the voluntary sector to work more flexibly and intensively with service users.

DATA SHARING AND IT INFORMATION MANAGEMENT

The experience of the pilots illustrates the importance of establishing processes for sharing information at a strategic and operational level. It also highlights the difficulties in doing so. At a strategic level agencies, particularly statutory agencies, need to be able to share data across organisational boundaries in order to evaluate the

effectiveness of joint working and develop future plans and commissioning strategies. Without evidence of the impact of joint working on key targets or performance indicators it is unlikely that agencies will continue to prioritise, or indeed fund, such activities in a context of financial restraint.

Those pilots that developed new services demonstrated the importance of establishing effective ways of sharing data at an operational level. This is particularly important when services are supporting people with complex needs and often chaotic lifestyles. In these circumstances services need to be co-ordinated in a timely manner and based on up-to-date information. Most of the pilots decided to build on local practice, for example adapting existing 'release of information forms' which service users were asked to sign as proof that they had agreed to the pilot contacting other agencies as a means to seek or share relevant information.

WORKING WITH HOUSING

Whilst those most closely involved with the pilots understood and appreciated their aims and objectives, it is clear that staff working in allied services did not always appreciate the housing and support needs of those groups the pilots were supporting. This was particularly the case within housing services where 4 of the 6 pilots identified the need for staff working in homelessness units or hostels to have training about the housing and support needs of vulnerable people. Training in each case resulted in improved working between these agencies and also improved the support these agencies provided to specific individuals.

The pilots also identified specific issues to do with the management of social housing. In several instances, Registered Social Landlords (RSLs) and local authority housing departments needed to accept that it might take longer for some new tenants to move into supported housing. Whilst it is difficult to predict what will happen in individual cases the experience of the pilots indicates that if supported living is to be a realistic option then RSLs and local authorities will need to be sensitive to the needs of different groups and adjust their approach to voids accordingly.

THE ORGANISATIONAL CONTEXT

Effective joint working rests not only on a high degree of commitment and trust between partners, but on a range of other characteristics such as whether or not the service is defined by: the involvement of specific professions; a history of cross agency working and, a history of voluntary sector involvement.

Those pilots that were working in service areas where there is little or no tradition of statutory sector provision, or where services have developed more recently, appeared to have less difficulty working across organisational or professional boundaries. Similarly, a long history of organisational integration as well as the involvement of the voluntary sector appeared to improve the chances of successful joint working.

THE CHALLENGES OF EVALUATION

Current policy emphasises the importance of outcomes for people using services and the pilots were charged with specifying the outcomes each was seeking to deliver, and how these would be measured. Their experience illustrated the challenges inherent in framing work in terms of measurable outcomes. To do so, pilots had first to translate broad aims into discrete, measurable goals and then find ways of assessing their influence – as distinct from other factors – on those goals.

In most cases pilots came to the conclusion that it was unlikely that they could generate evidence that outcomes were directly and solely attributable to their work. What they could do was gather information about the likely contribution of the pilot, and the most sensible sources of such evidence were those whom the project had served, and those who had worked on or with the pilot. The process of establishing outcomes, even proxy outcomes, was useful in terms of building the evidence about whether or not there was a case for mainstreaming the project. Regular monitoring also prompted revisions and improvements in services in a timely fashion.

THE CHALLENGES OF WORKING WITH PCTS

The *Supporting People Health Pilots* were established as a means to encourage greater involvement of PCTs in *Supporting People* partnerships as well as demonstrating the potential benefits to health and social care from *Supporting People* collaboration. In so doing the pilots illustrate some of the difficulties associated with working across organisational boundaries and offer strategies to overcome these.

One of the main difficulties encountered was the lack of appreciation of what the *Supporting People* policy framework entailed and a lack of understanding about the impact *Supporting People* services could potentially have on health targets. Whilst the majority of PCT representatives appeared to understand the significance of the particular initiative they were involved with they often did not understand how the pilot related to the local *Supporting People* framework and commissioning processes, nor indeed what these processes entailed. Of course, these are the problems the Health Pilots were established to address, but they may also reflect more general difficulties associated with moving towards a preventive, community based health agenda within a sector dominated by hospital based services.

Another challenge was the fast changing health policy agenda that often appeared to marginalise initiatives such as the pilots. For example the implementation of *Agenda for Change* within the NHS was cited as a reason why the work of the pilots was not prioritised. Interviewees also identified a range of perennial problems associated with joint working such as the lack of congruent planning and financial cycles across health and local authorities which made the notion of joint commissioning difficult to put into practice. Financial concerns – particularly with respect to PCT funding – and the reorganisation of PCTs also undermined their sustained involvement. Over the course of the evaluation key personnel left and were not replaced either because of

recruitment freezes or because local PCTs were in the process of amalgamating. The loss of key PCT contacts was palpable, undermining the continuity that successful partnerships are based on.

These difficulties were mirrored at an operational level. Several pilots reported that operational staff within PCTs (as well as in Hospital Trusts) often did not appreciate the relationship between housing support services and wellbeing. As a result busy staff would prioritise work related to their own organisational objectives. Additionally several pilots noted the high turnover of healthcare staff as a factor undermining efforts to develop closer working relationships.

Despite these difficulties the pilots continued to find ways to develop better joint working relationships. Several provided training to PCT and hospital staff as a way of raising awareness of the link between housing and health or the specific health needs of groups of people. At a strategic level, several pilots relied on key PCT personnel who operated in the role of 'champion' to bridge the organisational divide.

CONCLUSIONS

The *Supporting People Health Pilots* demonstrate how services can be developed to enable vulnerable people to live independently in the community. They illustrate how agencies and professionals can work across organisational boundaries, ensuring greater access to a wider range of health care services and improved health outcomes for particularly marginalized groups.

The experiences of the Health Pilots raise a number of factors that are relevant to joint working in other policy contexts. First, successful partnerships need to be based on joint working at both strategic and operational levels with strong linkages between the two. However, to be effective joint working also requires that governance and management responsibility are transparent and agreed by all partners. Without clear arrangements it is difficult to manage effectively and ensure the partnership is accountable.

Finally the Health Pilots demonstrate the contribution of establishing clear outcomes as a means of demonstrating the impact of joint working on key organisational targets and performance indicators. Without such evidence it is unlikely that agencies will continue to prioritise or indeed commission such activities. However the experiences of the pilots also demonstrate the inherent problems of this approach, not least the difficulty of establishing processes through which to share information at a strategic and operational level. *The Supporting People Health Pilots* demonstrate that with clear leadership, agreed goals and dedicated partnerships these difficulties can be overcome.

CHAPTER 1

Supporting People Health Pilots: the policy context

1.1 THE SUPPORTING PEOPLE PROGRAMME: PROVIDING HOUSING-RELATED SUPPORT

The Supporting People programme was introduced in response to a need for services that would support independent living in the community for those groups that require low-intensity support as well as for those that are socially excluded, at risk or hard to reach through existing service provision. It reflects wider policy aims associated with taking preventive action, tackling social exclusion, creating sustainable communities, co-ordinating services around the needs of individuals and promoting choice. Its broad aim is to provide housing-related support to help people maintain or improve their ability to live independently. Within policy, there is clear recognition of the importance of suitable housing for good health, wellbeing and social inclusion (ODPM 2005a). Housing-related support is focused on helping people to stay in their own homes or to move towards having their own homes, to increase independence and the capacity for self-care.

In 1998 the then Department of the Environment, Transport and the Regions identified the key aims of the Supporting People Programme, which can be summarised as:

- Prevention – picking up problems before they become a crisis.
- Promoting independence – enabling people to make their own decisions.
- Alleviating crisis – helping people through periods of crisis.
- Resettlement – enabling people to settle in the community in new homes.
- Inclusion – supporting people whose needs are complex and who fall outside conventionally defined client groups.
- Flexibility – moulding services around individuals and the way they live.

These aims have remained central to the programme since its implementation in 2003 and have been pursued through a range of services, organised and provided through strategic local partnerships between statutory and independent sectors. A recent consultation document from the ODPM (2005b) identifies the three groupings of service users, which are not mutually exclusive but which can be seen to share needs in common:

- People who receive care with support through health and social services
- People living independently with support
- People experiencing or at risk of social exclusion

1.2 SUPPORT FOR PEOPLE RECEIVING HEALTH AND SOCIAL CARE SERVICES

This grouping has not been generally associated with Supporting People services. However, providing services within a service user's own home has been a long standing policy aim, not only to prevent unnecessary admission to institutional care but also to ensure that services can be focused on the unique needs of the individual. Housing-related support, provided in conjunction with health and social care services, is therefore an important strategy in maintaining and maximising people's independence in the context of long-term health problems.

A lack of co-ordination between services has been a continuing problem for people within this grouping. In 2005 the Social Exclusion Unit published its findings from a review of services for disadvantaged groups and identified that whilst there is now widespread recognition of the importance of effective coordination between services, progress remains patchy and there is still progress to be made to improve people's experiences of obtaining support (SEU 2005).

In 1998 the New Labour government published a discussion document *Partnership in Action: New Opportunities for Joint Working between Health and Social Services* (DH 1998). Responses to this gave a strong message that a wider network of organisations should be involved in developing health and social care services. This message has been picked up and is reflected in a number of subsequent policy documents, including the current White Paper – *Our Health, Our Care, Our Say: A New Direction for Community Services* (Department of Health 2006) and the Supporting People programme, which is envisaged as a key strategy for promoting better integration (ODPM 2005b). It is also very strongly based in partnerships between statutory and independent sectors and therefore complements the aims of the Department of Health (DH) White Paper *Our Health, Our Care, Our Say* (DH 2006).

The 2004 review of the work of the Social Exclusion Unit, *Breaking the Cycle* (SEU 2004) identified another important issue for joint working. They point out that, particularly where very vulnerable groups are concerned, it may be preferable to have a single agency deal with complex and multiple problems so that service users are enabled to stick with a support service, rather than drift and lose touch. This is an important observation, which considers the interface of client and service provider *from the point of view of the client* and is a

reminder that partnership is a means to an end, not simply a matter of greater efficiency in service planning and delivery. The development of networks of support and services needs to include opportunities for service users to participate in planning and development. Service user perspectives are vital to ensure that a range of needs are considered, beyond those that are addressed by health and social care providers. For example, people with learning difficulties could end up in an isolated form of institutionalisation if they are in touch only with service providers. A broader set of social networks is required that help sustain health and wellbeing.

1.3 THE PREVENTION AGENDA: ENABLING PEOPLE TO LIVE INDEPENDENTLY WITH LOW LEVEL SUPPORT

An important observation in the ODPM's, now DCLG, review of housing provision (ODPM 2005a) is that community care services have tended to focus attention on those whose needs are greatest. This has left a gap in the provision of low-intensity, preventive support, which the Supporting People Programme aims to fill. Low-intensity support can make a critical difference in enabling someone to remain in their own home and can prevent the development of further problems that would entail interventions by statutory services. For older people, low-intensity support can mean being able to remain in their own homes, rather than having to move to sheltered accommodation.

Flexibility in service delivery is an essential aspect of the prevention agenda, since without flexibility choice for service users is impossible. Flexible service delivery entails focusing attention on individual needs and individual solutions. Promoting flexibility and person-centred approaches in service provision is a key point in wider strategies to reform public services and is a strong theme in Supporting People, which has been welcomed by local authorities as a way of building services around individual need, rather than pursuing 'one size fits all' approaches. The concept of 'floating support', which can help keep people comfortably in their own homes, is an important aspect of the Supporting People programme for this grouping. It helps to overcome the difficulties associated with support being attached to specific housing types, rather than with the person.

1.4 SOCIAL INCLUSION: SUPPORTING PEOPLE EXPERIENCING OR AT RISK OF SOCIAL EXCLUSION

The links between poor health and social exclusion are well recognised. For example, people with mental health problems identify the stigma of mental illness as a major factor in social exclusion (Social Exclusion Unit 2005). A similar scenario can relatively easily be imagined for other groups, such as rough sleepers and sex workers. For such groups, a vicious cycle of illness and social exclusion can easily be generated and to prevent this effective interventions are required.

Despite the wide range of services that has developed within the British welfare system, some groups do not receive the support they need because they do not know about available sources of support or find services to be inconvenient, inflexible and unresponsive. The Supporting People programme is intended to provide an essential bridge for particular groups, enabling them to take the necessary steps towards employment and independence. When the complex needs of the groups that have participated in the Supporting People Health Pilots are considered, the risks to health and wellbeing that are associated with living in excluded, deprived communities becomes clear. The White Papers *Better Information, Better Choices, Better Health* (DH 2004) and *Choosing Health: Making Healthier Choices Easier* (DH 2005) stress the importance of enabling people to understand better their own health needs, to access appropriate services and negotiate their way around services.

Some service users find that voluntary sector organisations offer a more informal approach that is more accessible. Initial contact with voluntary services helps to build individual confidence and capacity to engage with statutory organisations that are able to provide essential services through professional input. Combating social exclusion is therefore inextricably linked with effective and integrated partnerships of service provision, although, arguably, with this service user grouping, integration poses the greatest problems because of the highly complex problems that some people face.

1.5 GOVERNANCE

The structures through which governance of services is carried out have been required to change as a consequence of the modernisation agenda. Traditional organisational hierarchies have had to give way to accommodate the broader range of agencies involved in service provision, as discussed above. Achieving greater flexibility in service provision necessitates changes in strategic and operational management and lines of accountability and a more 'whole systems' way of thinking about service delivery (Hudson 2004). However, such changes pose challenges. For example:

- Different organisations may not share priorities in common or be subject to similar financial imperatives.
- The wider policy context may impede progress on particular projects agreed between partners.
- The unequal relationship between statutory commissioning authorities and voluntary provider organisations may have an adverse effect on the ability to form partnerships.
- At a practical level, there may be difficulties in reconciling procedures on data protection and patient confidentiality with new data-sharing protocols between partner agencies.

These are significant challenges facing service organisations requiring more innovative and entrepreneurial approaches to resource management and service delivery. The Supporting People Health Pilots provide a significant opportunity to assess not only the suitability of services for the different service user groups represented but also the effectiveness of the structures and systems established in terms of their capacity to deliver services that are well integrated.

1.6 SUPPORTING PEOPLE HEALTH PILOTS

In this context, the *Supporting People* Health Pilots were set up for a number of reasons:

- The difficulties engaging some PCTs in Supporting People partnerships.
- To demonstrate the policy links and potential benefits to Health and Social Care from Supporting People collaboration.
- To demonstrate benefits of joint working with Supporting People including setting clear outcomes that can be measured.
- To evaluate what helps and hinders joint working and disseminate findings.

The University of Bristol was commissioned to evaluate the pilots and to report on their experiences of joint working. In particular the research team were asked to:

- Examine the potential of Supporting People services to contribute to health outcomes, and
- Learn more about how organisations work across boundaries in order to make joint working more effective.

The report begins with a brief discussion of the selection of the pilots and the approach taken to the evaluation. The development of each pilot is considered in separate chapters that include a table providing detail of their aims, objectives and outcomes. Finally a discussion of the over-arching themes is provided.

CHAPTER 2

Evaluation of the *Supported People* Health Pilots

2.1 SELECTION OF THE PILOTS

In 2003 the then Office of the Deputy Prime Minister (ODPM), now Department for Communities and Local Government (DCLG), announced its intentions to establish the Supporting People Health pilot programme. The aim of the programme was to support commissioning bodies or services providers to develop their partnerships with health and social care services in new ways that would contribute to health objectives. The pilots were designed to demonstrate how the *Supporting People* framework for policy, planning and commissioning could be used to benefit the physical and mental health of the community.

122 bids were submitted, each of which was assessed against 4 categories:

- the nature of the initiative proposed (its aims, client group, geographic spread);
- key features of the pilot (PCT involvement, eligible for Supporting People funding, a high priority for the locality),
- characteristics associated with effective joint working (a history of joint working, strategic commitment, clearly specified outcomes,) and
- specific organisational features (governance and monitoring arrangements, service user involvement).

A short list of five projects was identified, together with two potential substitutes for each project. In the event, six were chosen by those responsible for final selection in the ODPM, now DCLG, and Department of Health (DH), reflecting the wide range of high quality bids.

2.2 THE PILOTS

The six Health Pilots selected represented a wide range of people who use services, both commissioning and providing elements, and a range of agencies from the statutory, independent and voluntary sectors:

Bid from:	Project Title	Focus
Doncaster West PCT	'On Track'	Young people with dual diagnosis
Northampton PCT	'SWAN NEST'	Women wanting to exit the sex trade
London Borough of Waltham Forest	'Place to Live'	Supported living for people with learning disabilities
City of Salford Housing	'Sure footed in Salford'	Integrated falls services
London Boroughs of Southwark and Lambeth	'Housing Support Outreach and Referral for hard-to-reach individuals living with HIV'	Hard to reach individuals living with HIV
North Lincolnshire County Council	'SPIDERS'	Older people

Four of the Health Pilots ('On Track', 'SWAN NEST', 'Sure Footed in Salford' and 'Housing Support Outreach and Referral for hard-to-reach individuals living with HIV') were funded for 2 years and the remaining pilots ('Place to Live' and 'SPIDERS') were funded for 1 year.

Such diversity presents a series of challenges in evaluation terms. The approach adopted was therefore one which sought to identify common themes and issues as the basis of an overall evaluation of the initiative per se, but which also took a tailored approach to the evaluation of each individual project.

2.3 THE APPROACH TO EVALUATION

The research team's brief was not only to evaluate the pilots, but to provide advice and consultation. In other words, it lay within the tradition of action research.

Those tendering for Health Pilot status were required to specify 'which health target(s) or areas of health policy is the project aimed at helping to achieve?' and to detail the specific aims of the project. Thus, each project was required to locate its proposal within the national context as well as the local one.

In the weeks after the pilots were selected, the research team worked collaboratively with each pilot to ensure that the outcomes they specified in their original submissions were i) appropriate, ii) measurable (i.e. there were relevant data which could be reliably collected), and iii) which would provide a baseline against which we could assess their progress on key aspects of the nature of the problems they are seeking to tackle.

In order to facilitate this work, we developed 'outcome' pro-formas for each project, based on the information they provided in their tenders. We then arranged an introductory meeting in which we discussed the appropriateness of these i.e. were they deliverable, realistic and measurable. The proforma was subsequently revised and formed the basis for a second meeting, designated the

'set-up' meetings. These meetings comprised project staff, Bristol University representation, a representative from ODPM, now DCLG, and from any other relevant stakeholder group or agency e.g. the Change Agent Team in the Care Services Improvement Partnership at the Department of Health. At these set up meetings, the outcomes were again carefully scrutinised, and further changes made.

The final outcome template for each project formed the basis of data collection on outcomes and was incorporated to the quarterly Project Evaluation Report. Each pilot was asked to set quarterly performance targets for each of their objectives and were asked to report activity against that target in the subsequent quarter. Where possible, baseline data were identified.

The evaluation therefore took the form of a post-test design, focusing on the aims and objectives which each pilot identified in their submission to become a Health Pilot. These provided data pertinent to answering questions about each project's effectiveness, and also to assess each project's contribution or likely contribution towards meeting national targets or addressing national concerns.

2.4 DATA SOURCES

The evaluation methodology rested on two assumptions. First, that the views of all key stakeholders, including those using services, were important. Secondly, that as far as possible relevant data should be collected on as contemporaneous a basis as possible.

As a result, we developed three sources of data collection:

- (i) semi-structured interviews with service users and professional/s from each of the stakeholder groups represented in each project, and covering both commissioning, providing and management;
- (ii) completed Project Evaluation Reports, including reports on progress in relation to identified outcomes (see above);
- (iii) reflective diaries.

Semi-structured interviews

Each pilot was visited on three occasions during which we conducted between six to eight interviews across all key professional stakeholder group, at each of the relevant levels i.e. commissioning (where appropriate), managing and providing, and across each agency. Interviews with professionals explored specific details of individual pilots as well as core themes such as: strategies for joint working, communication and governance arrangements.

The acid test of changes in service delivery is changes in the perceptions and experiences of service users. Minimally, they should experience no deterioration in service provision. The aim of the Health Pilots was that they should experience a range of improvements. Improvements might be in the responsiveness of agencies (e.g. how promptly are referrals dealt with), the 'straightforwardness' with which complex needs are met (a key aim of most projects was that services would be streamlined and more 'holistic' in nature), in outcomes, or all three.

We sought to conduct interviews with people who used services at key points e.g. referral and assessment, during receipt of services and, if appropriate, at termination of service. This approach was successful at 2 of the 5 pilots that were providing a service. In the remaining 3 we had to rely on asking people to reflect on their previous experience of services in light of the service they were experiencing within the pilot.

Project evaluation reports

Quarterly Project Evaluation Reports were submitted from each pilot. These reports had a standard format and served to collect some of the data concerning process and implementation, including issues relating to joint working at the strategic and operational levels.

Reflective diaries

Project workers were asked to complete reflective diaries, in order to capture experiential data that can otherwise be difficult to access. Their purpose was to identify issues that could be incorporated in the more structured elements of the evaluation. They formed the basis of some of our developmental work with the pilots.

2.5 DATA ANALYSIS

The research design enabled the team to explore the development of the Health Pilots from a range of perspectives and data sources (Denzin & Lincoln 1998). The data were analysed thematically to identify trends that are not only generalisable across the pilot sites but also specific to individual sites (Øvretveit 1998).

2.6 ETHICAL SCRUTINY

The research proposal was scrutinised and approved by members of the Ethics Committee at the School for Policy Studies at the University of Bristol. In accordance with the Social Research Associations Ethical Guidelines (2002) all potential participants received detailed information about the project, were given an opportunity to ask questions about the project and were asked to sign a consent form agreeing to take part in the research. All interview data were anonymised and stored on password controlled computer files.

CHAPTER 3

Doncaster

The '*On Track Young Persons Dual Diagnosis*' (On Track) pilot was designed to provide co-ordinated and effective support to young people with mental health and substance misuse needs (dual diagnosis) living independently in the community. Before the pilot there were no dedicated services for people with dual diagnosis in Doncaster.

The aims of the *On Track* pilot were to:

- provide an early intervention floating support service to young people with mental health and substance misuse needs.
- promote a seamless service to the service user, which alleviates bed blocking, delayed discharges and addresses readmission rate to acute psychiatric wards and medical assessment unit.
- co-ordinate with all housing providers to ensure that adequate housing is available at the point of discharge.
- assist service users to either set up or maintain their tenancy based on a floating support model.
- integrate the pilot into mainstream services in the long term.

Description

Project workers provided intensive 'floating support' to enable service users to set up and maintain housing tenancies. After an initial assessment each young person accepted into the service was assigned a project worker who provided tailored support. Project workers met once or twice a week with their clients, providing practical help with housing, life skills, benefits, advocacy and promoting joint working with, and access to, other services, including Social Services, health care services, (psychiatric and CPN services), drug/alcohol agencies and housing services and longer-term floating support. They also provided emotional support.

With two project workers, the pilot intended to support 60 young people over the 2 years and anticipated that this support would last between 8 – 12 weeks. At the end of this period of intensive support the pilot would refer the young person on to longer term support services.

3.1 JOINT WORKING EARLY STAGES

The partnership

This was a joint initiative between:

- Doncaster and South Humber Healthcare NHS Trust,
- Doncaster Community Mental Health Services,
- Doncaster Substance Misuse Service,
- the local Supporting People Team,
- ‘*On Track*’ (a collaboration between Action Housing Association, South Yorkshire Housing Association and Rethink, ‘The National Schizophrenia Fellowship’) and
- *Involve* – Doncaster Mind’s mental health service user involvement project.

Since 2003 local mental health agencies had developed informal links with the original ‘*On Track*’ service¹, sharing policies and practice and referring clients between services. The pilot was therefore able to capitalise on these networks. Although the Community Mental Health Team (CMHT) took the formal lead role, holding the contract with the ODPM, now DCLG, the pilot was always referred to as a collective effort.

Origins of the pilot

The idea for the On Track pilot came from professionals working in local health and voluntary services who identified a gap in existing services for young people with dual diagnosis. Without a dedicated service these young people were falling through the net, being passed from youth to adult services and between drug and mental health services. Partners considered stable housing and intensive support essential in order to engage young people with dual diagnosis in relevant services. They had a clear understanding that rarely could they achieve their own organisational objectives and targets by working in isolation. The pilot was therefore designed to establish a housing related support service that would help young people to engage with appropriate health services. The aim, as one partner described it, was to provide practical help to

‘get a house and then look at their mental health. It is fundamental. If housing needs aren’t addressed it is unlikely they will address mental health needs. You need to understand that for people with mental health problems everything is connected. To address mental health you have to address housing. It doesn’t fit into neat boxes.’

¹ The original ‘*On-Track*’ service provides floating tenancy support to people with mental health needs. Hereafter On Track refers to the current pilot.

The pilot was seen as a positive response to problems identified by professionals working directly with young people, rather than a service initiated at a strategic level. As a result, the pilot enjoyed the backing of a wide range of agencies with a strong commitment towards it, who were willing to invest time, energy and resources to establishing and supporting the new service. As one health partner commented

'We are working together, we are committed to it, we have common goals, common aims and common wins, its not simply about achieving outcomes it is about overcoming cultural barriers.'

Governance

The pilot developed in an inclusive manner that was evident in its governance arrangements, which were considered clear and effective.

A steering group was quickly established which included the project workers and representatives from all partner agencies. A representative from the housing department joined the group later on as a means to strengthen housing's involvement. The steering group met regularly throughout the 2 years. In the early stages meetings focused largely on operational issues and were held monthly. As issues were resolved meetings occurred less frequently. In the second year of the pilot's life the steering group began attending to strategic issues related to future funding.

The non-hierarchical nature of this pilot meant that project workers could call steering group meetings if there were particular problems, such as difficulties in sharing client information that needed to be resolved quickly. All participants agreed that these meetings were the crucial decision-making forum and were consequently well-attended.

Membership of the steering group included the commissioners for Mental Health and Supporting People services. Their role was two fold: to advise on key strategic discussions that might affect the service and to ensure that commissioning groups were fully aware of the progress of the pilot. The mental health commissioner attended several meetings and although not a regular attendee, the operational manager of the pilot (who was the CMHT representative) kept her up-to-date with progress. In contrast, the Supporting People lead officer attended meetings in the early stages and then apparently withdrew from the partnership. Partner agencies regarded this lack of engagement as a serious weakness that undermined the pilot's integration with wider Supporting People commissioning structures.

Getting started

The success of the On Track pilot (see below) reflects the careful and thoughtful manner in which it was set up. As one partner commented:

'we had time to discuss these processes and discuss them with agencies and develop them, it is building on others' good practice'.

The pilot developed clearly stated eligibility criteria, referral and assessment policies and processes. The eligibility criteria were,

- that the young person was aged 16–25,
- homeless or at risk of homelessness,
- with mental health needs and substance misuse problems.

Before the service began the project workers visited potential referral agencies to raise awareness of the new service, describe the process for referring clients and answer any questions colleagues might have. They also oversaw the design of posters and flyers giving information about the service, eligibility criteria and contact details. These were displayed in agencies where young people with mental health and drug and alcohol problems would see them.

The team decided to launch the service at a public event which was attended by senior managers from the health service and local authority, professionals working in statutory and non-statutory agencies, service users and the local MP. All partners identified the launch as a pivotal moment in securing the commitment of most senior officers as well as helping to raise awareness of the service in Doncaster.

Publicity alone however, is unlikely to be sufficient to launch a new service. Most new initiatives benefit from a champion. The locality manager for the CMHT effectively assumed this role, acting as the bridge between the pilot and strategic groups such as the Supporting People lead officer and the mental health commissioner. He also had links with a range of community health and social care services, and used these networks to ensure familiarity and use of the new service.

An additional feature of the Doncaster pilot was the willingness of other steering group members to promote the pilot within their own professional and agency networks. The manager of the drugs agency, for example, presented the pilot's work at a regional conference and project workers regularly attended professional forums within Doncaster to raise awareness of the pilot. The willingness of all partners to take on this 'dissemination' role appears to have helped secure the acceptance of the pilot amongst a wide range of local professionals.

Management arrangements

The practicalities of employing and managing workers to carry out time-limited projects are often complicated. In this pilot the project workers were formally

employed by Doncaster and South Humber Health Care NHS Trust, who held the funding contract with the ODPM, now DCLG, and seconded to work for South Yorkshire Housing Association and Action Housing Association. Accordingly, their day-to-day management support was provided by the individual housing associations whilst personnel issues were dealt with by the Trust.

Although there were advantages to this arrangement, particularly securing the involvement of partner agencies, occasionally they caused confusion and delays. For example, with two housing associations involved in operational management, simple tasks – like accessing petty cash – had to be negotiated with both associations. Such problems were resolved on an ad hoc basis and several interviewees commented that if the pilot was mainstreamed it would be wise to revise these processes. These management arrangements also applied to training, leave and issues related to tenancy support work.

One of the project workers had previously worked as a tenancy support worker for older people. Both had worked in mental health services, one for a local authority and the other within the NHS. This knowledge and experience helped to establish the credibility of the new service. The project workers also spent ten days with the Drug Team as part of a general induction to working with young people with mental health and drug problems.

Given the complexity of the cases with which they were dealing, it became evident that the project workers might benefit from access to professional supervision. The steering group agreed that one of the project workers would receive supervision from a colleague in the Better Deal service (a drug service partner) and that the other would continue to receive supervision from her day to day manager within the Housing Association.

Over the course of the pilot the project workers were also able to access specialist training from partner agencies, attending sessions on: substance misuse, harm minimisation and disposal policies.

3.2 JOINT WORKING MAIN PHASE

The partnership

The pilot was characterised by a strong ethos of partnership working at both strategic and operational levels and a concern to meet the needs of young people with dual diagnosis. Most of the original partners remained actively involved, providing expert support, information, specialist training and/or supervision to project workers throughout the 2 years. At the operational level partners talked about the ways in which effective links with a wide range of agencies enabled the project workers to key young people into those services most able to realise their aspirations for independence.

Over time, however, relationships with the local Supporting People team weakened. Representatives of the team did not regularly attend steering group meetings and one partner described the team's relationship with the pilot as rather 'tenuous'. Deterioration in this critical relationship raised concerns about the long-term future of the service.

Working with housing colleagues

One of the successes of On Track was the development of closer working relationships with Doncaster Metropolitan Borough Council Housing Department. Having identified a series of housing problems the pilot contacted a senior officer within the housing department. This officer spent time with the pilot discussing how the Housing Department could better support young people with dual diagnosis. Project workers were invited to meet staff in the homelessness unit and area offices to discuss the needs of the client group. Members of the partnership also organised for drugs awareness training to be provided to frontline housing staff. On the basis of these improved relationships a housing protocol was developed, which matched accommodation to the support packages required for each young person. As a result of this work one partner described how

'the housing department is now more aware of the needs of people with drug and alcohol problems and they are housing them in places where they are less likely to relapse.'

The improved relationships between the partner agencies and the Housing Department were described as 'a major achievement' by the majority of partners.

Working with health colleagues

The On Track pilot was based within the housing sector and developed from an existing Supporting People funded service. However the lead officer for the pilot worked in the CMHT and several of the original partners were based in community mental health and drugs services. These relationships were constructive and supportive. Project workers were therefore able to access specialist training and supervision and referral of clients between services was unproblematic. Information exchange across organisational boundaries was relatively straightforward because although the project workers were based within the housing sector they were technically employees of the Trust and therefore able to access NHS databases and files (see below).

Although designed to work closely with in-patient services, the pilot initially found it difficult to establish good working relationships with hospital based staff. This was partly due to the high rate of turnover in ward staff, but also stemmed from a longstanding lack of agreement about the use of 'dual

diagnosis' as a medical term between hospital-based and community-based services. Over the course of the pilot the project workers visited the ward to discuss the service and establish cross referral processes. They were eventually invited to attend case meetings with individual patients, leading to the successful discharge of several patients from the hospital into new tenancies.

Relationships between statutory and voluntary services

The pilot was seen as a positive example of how the statutory and voluntary sectors could work together. As one of the local authority respondents observed, the pilot proved *'you can work between the voluntary and statutory sector without compromising values or issues like confidentiality.'* For one health professional, the pilot had demonstrated how, *'the traditional ways of providing services from the statutory sector aren't always the best and that other providers can do it more successfully.'*

Locating the On Track pilot within the voluntary sector was regarded as central to increasing young people's willingness to engage with the service. Several interviewees commented that young people appeared to be at ease with the service because the project workers *'didn't behave as nurses'* and focused on practical issues that the young people wanted to address.

Communication and information sharing

Good communication was a strong feature of this pilot. All interviewees said they were kept fully informed about progress and key issues. The steering group was the main channel of formal communication. Minutes of meetings were circulated to all members whether or not they attended. Between meetings partners communicated regularly through emails and telephone calls and, if problems arose, would meet informally – sometimes at short notice – to resolve them.

Effective joint working relies on the willingness of professionals to share information with colleagues working in other agencies. This is particularly important when people have complex and pressing needs such as those experienced by young people with a dual diagnosis. The project workers developed a 'consent to exchange information' form for young people to sign. The form ensured that they understood and agreed to project workers sharing pertinent information with professionals in other agencies.

Difficulties in sharing information arose with colleagues in the probation service. On one occasion significant information was not passed to project workers that, – had it been available to them – would have altered their assessment of the risks associated with working with a particular client. Liaison with managers of the probation service to agree what information ought to be shared and to establish a process through which to do so ensured this did not happen again.

The involvement of people who use services

Participants saw the involvement of people using services as a major strength of the On Track pilot. INVOLVE (Doncaster Mind's mental health service user involvement project) was included in discussions about the pilot and were commissioned to conduct a service user evaluation. They also had representation on the steering group. The INVOLVE representative described how *'from day 1 INVOLVE were part of it, not an add-on to do a service user evaluation, we had shared ownership.'*

Findings from the service user evaluation were regularly reported at the steering group and informed the subsequent development of the pilot. For example, when the evaluation indicated that service users were unsure what would happen at the end of the period of intensive support it was agreed that project workers would inform people at the outset that they would be referred to a long-term support service at the end of the pilot's involvement.

Monitoring the service

The pilot monitored a range of issues (see Table 1). Monitoring the nature of referrals resulted in visits to agencies to remind them of the eligibility criteria. This resulted in the identification of considerable need for the service amongst the over 25s, particularly young men, who were currently ineligible for the service.

The pilot also developed a 3 month tracking process through which they could monitor how young people had progressed once they had been referred to a long-term support service, for example whether or not they had sustained their tenancies and continued to attend specialist drug and mental health services. The tracking process was only partially successful as it relied on information from those agencies providing long-term support, many of whom who were unable to provide it.

3.3 JOINT WORKING MAINSTREAMING

Securing the future of the service was considered from the outset. Partners recognised the need to secure 'buy-in' from key partners in the NHS (Mental Health) and local authority (Supporting People). Initial problems in engaging the lead officer of the Supporting People team meant that the project had difficulty persuading commissioners of its merits. This posed a threat to future funding, given competing demands on the Supporting People budget. However after a series of meetings, and reassurance from the ODPM, now DCLG, about the strategic significance of the pilot, the lead officer finally agreed to recommend that the Supporting People Commissioning Body fund the pilot in its existing format for a further year.

During the final year the Mental Health Local Implementation Team and the Drug Action Team called for the development of a Dual Diagnosis strategy for Doncaster. A strategy group was set up in 2005 which included many of the pilots partners. On Track was central to these discussions and was incorporated into the design of local Dual Diagnosis services. The local Mental Health commissioning group endorsed the strategy.

3.4 PROJECT ACHIEVEMENTS

Table 1 summarises the outcomes achieved by the On Track pilot. These included improvements in outcomes for people using the service, as well as a range of processes for effective joint working. Although it was funded for 2 years, the table relates to the activities completed up until submission of the final evaluation report, a period of 22 months.

Over the course of the 2 years the service received referrals from 13 statutory and non-statutory agencies in Doncaster. These agencies included: Better Deal Young Persons Drug Service, Young Adult Mental Health Service (YAMHS) and the Early Interventions in Psychosis Service (EIP). The pilot also began working with agencies from within the field of criminal justice including: the probation service, prison services, the Youth Offending Team and Doncaster Intervention Program (DIP).

It is often difficult to anticipate the demand for any new service and the impact this will have on the workload of staff. In order to manage workload the pilot chose to set a total caseload limit of 15 young people per year, whom each worker would support for between 8–12 weeks. However the pilot underestimated the complexity of the cases and the length of time some service users would need support. These pressures were accentuated because there was little or no capacity to cover caseloads when the project workers were on leave. Consequently fewer service users were supported than anticipated although they were supported for a longer period of time.

The pilot also monitored the nature of referrals and the outcome of the intervention. Since the inception of the service they have received 66 referrals 31 of which they accepted as meeting the criteria for the service. 85% (23) of the service users are male. The range of mental health problems reported by service users included: psychosis, depression, anxiety, schizophrenia, personality disorders and self harming. Use of amphetamines, cannabis or alcohol was reported by approximately 1/3 of all service users, 9 service users reported using heroin.

Service users have been supported for between 4 and 30+ weeks with the majority receiving between 5 and 20 weeks intensive support. Project workers supported service users in numerous ways, including securing a tenancy; accessing benefits and sign posting to other agencies for example 12 young

people were referred to training and employment services. Project workers have also acted as advocates for service users; supported them to make contact and engage with specialist mental health and drug services on a consistent basis; advised on harm minimisation and personal health and safety issues and have provided practical support as means of enabling them to live independently in the community.

Innovations in practice

The pilot adopted a consensual style of joint working between partner agencies that was evident at both strategic and operational levels. Policies and procedures were developed in partnership and built on local good practice. These were circulated to all potential referral agencies prior to the service being launched. A care pathway for people with dual diagnosis was established which incorporated the service and meant that all staff working within the CMHT knew how and under what circumstances they should refer people to the service.

The working relationship between the partnership agencies and the housing department strengthened as a result of the pilot. A process was clearly articulated through which people with dual diagnosis could make a housing application and a nominated officer was identified to deal with these applications. As a result partners commented that young people were being offered housing in suitable locations away from areas known to have drug problems.

The project workers developed a flexible and intensive style of working with service users. They focused on what individuals thought they needed to address in order to live independently and would often accompany young people when attending health care services for the first time. This style of working worked well and helped young people engage, and maintain engagement, with services.

Evaluation interviews with young people using ‘*On Track*’

Nine interviews were conducted with On Track clients during the project: one during the first evaluation visit, four during both the second and final visits. Three young people participated in two interviews (second and third visit rounds).

Five men (age range 18 to 25 years) and one woman (24 years old) were interviewed. Consistent with the project’s eligibility criteria all described the diagnosis of a mental disorder (e.g. depression, schizophrenia) and substance misuse (alcohol and/or class A and B drugs).

During the second and third round of interviews, all interviewees reported significant reduction in their substance misuse. The three users interviewed at both stages reported that they had completely stopped using class A drugs. They

attributed this to having secure and stable housing and the support and encouragement of their project worker. Two reported that they were still smoking cannabis which helped them alleviate the effects of the psychotropic medication they were taking.

Most said that while the type and frequency of the services that they were currently accessing (psychiatric and/or drug support) had not changed significantly, it was well-coordinated. For two respondents, the fact that they regularly attended their psychiatric appointments as a result of being reminded by their workers had made a big difference.

At the third visit, all interviewees reported significant improvements both in their physical and mental health, which they attributed either to the project workers' input (*'my worker has been a life saver; my health is getting better slowly'*), or to their having access to specialist medical and/or psychiatric services, or both. They said that the support from project workers had made a positive difference to their lives. One reported that the presence and input of his project worker has helped him to address his cannabis use and that he was taking steps to reduce it further.

The level of satisfaction among users was very high. All respondents acknowledged that their quality of life had improved as a result of receiving support from the pilot; one user noted *'Life has changed a lot, my worker has helped me to keep on track and stay off drugs'*.

Case study 1

Lee, 18, diagnosed with amphetamine-induced paranoia was referred to the pilot by the carer of a relative. Lee lived with his Nan. When first interviewed he had been supported by the pilot for three months. He talked about how his support worker had been instrumental in addressing his amphetamine addiction by encouraging him regularly to attend his local drug service. He noted that *'(the pilot) has made a big improvement in my life; I can see a purpose in my life'*.

When interviewed six months later the support from the pilot had come to an end. Lee was still attending local drug addiction services and said *'I haven't gone back to my old way of thinking; the whole experience has been quite useful'*. He said that the project had given him confidence and a feeling of well-being which he hadn't had when he was injecting amphetamines and smoking cannabis. He reflected that before he was referred to the pilot he was paranoid and would not leave his home and now: *'I have got a life now, before I just existed, I was on a self-destruct path'*.

He concluded that the pilot *'has given me a chance to do something with myself'*. He was reviewing his employment options and said he wanted to get a job.

Case study 2

Bryan, 25 years old, suffers from paranoid schizophrenia. He was referred to the pilot by his community psychiatric nurse when he was approaching the end of his stay in a probation hostel. When he was first interviewed he had been receiving help from the pilot for four months and had been helped to find a one bedroom flat. He described how his project worker provided intensive support (every other day by phone or home visit) in relation to his crack cocaine and heroin addiction as well as his mental health. He was also receiving additional medical/mental health services from his GP, psychiatrist, CPN, and drug addiction worker. He said that the pilot *'has done a great job,'* helping him to stay away from drugs, crime and address his mental health problems.

Six months later Bryan was still living in his flat. Although the support from the pilot had come to an end he was still regularly attending mental health services as well as the local drug addiction service. He reflected on the pilot's work saying that *'yes, I am pleased with what they did for me; they've helped me to stay off drugs, they gave me a new meaning to my life, have helped me to get a flat, and provided support with my mental health issues'.*

Table 1: 'On Track'

Aims	Objectives	Outcomes
<p>To provide an early intervention floating support service to young people with mental health and substance misuse needs.</p>	<p>To map the existing Dual Diagnosis client group</p> <p>Ensure service users maintained contact and engagement with the pilot service.</p> <p>Increase the numbers of clients with co morbidity accessing substance misuse service and mental health services.</p>	<p>A total of 31 young people aged between 16 and 25 met the criteria for the service. A further 76 were identified who met the clinical criteria but were over the age of 26.</p> <p>Service users maintained high levels of engagement. 20 completed the programme, 3 ended early because of custodial sentences, 2 did not engage effectively and 3 ended their involvement early with no reason given. The remaining 3 remain engaged with the service.</p>
<p>To promote a seamless service to the service user, which alleviates bed blocking, delayed discharges and addresses readmission rate to acute psychiatric wards and medical assessment unit.</p>	<p>Develop a single multi agency referral pathway and shared care arrangements between agencies.</p> <p>Identify the numbers of admissions to hospital for Dual Diagnosis clients and reduce the number of delayed discharges.</p>	<p>31 young people were supported, of whom 6 were referred to the Community Mental Health Team (CMHT), 8 to Drugs Services and 3 Alcohol services. Tracking of service users 3 months post discharge proved difficult to complete because of the range of agencies involved, consequently the pilot did not consider the incomplete data a reliable measure of the impact of the service.</p> <p>A care pathway has been developed for dual diagnosis service users within mental health and substance misuse services. Shared care arrangements have not been formalised because it was thought these would reduce flexibility and hinder accessibility.</p>
<p>Facilitate improvements in general mental health, drug associated behaviours and social functioning.</p>	<p>Ensure all appropriate agencies/teams were aware of and utilising the service.</p> <p>Increase the treatment interventions delivered to service users.</p>	<p>Of the 31 young people supported by the pilot only 3 were admitted to hospital during the period the pilot supported them and 3 young people were referred from hospital based services. Of the 31, 10 had previously been admitted to the psychiatric ward, 8 in the 12 months prior to receiving support from the pilot. Only 1 of these 8 was readmitted whilst receiving support from the pilot.</p> <p>The tracking proved difficult but of the 14 young people tracked 3 months post-discharge all 14 reported that their mental health had not deteriorated and that in 8 cases it had improved; 1 reported their drug use had deteriorated, 8 reported that their social well-being had improved.</p> <p>Project workers visited agencies prior to the launch to raise awareness, they have continued to visit new agencies and have presented their work at various events.</p>
<p>Increase the numbers of service users completing treatment and remaining engaged with appropriate services.</p>	<p>Develop a joint protocol for access to housing services, across the relevant agencies.</p>	<p>8 young people were referred to drugs services, 7 to mental health services (CMHT teams, Early Intervention for Psychosis and crisis resolution), 2 to counselling services, 6 to training/employment (YMCA, Action for Employment, Connexions), 5 to recreational groups.</p> <p>9 young people said their engagement with services had improved whilst 4 said it was the same as before.</p>
<p>To co-ordinate with all housing providers to ensure that adequate housing is available at the point of discharge.</p>	<p>To assist service users to either set up or maintain their tenancy based on a floating support model.</p>	<p>The council is currently reviewing allocation prior to introducing Choice Based Lettings in 2007. All referrals from the pilot are reviewed by a specific contact in the Housing Registration Team.</p>
<p>For the scheme to be further developed and integrated into mainstream services post pilot.</p>	<p>For the scheme to be further developed and integrated into mainstream services post pilot.</p>	<p>At the point of referral: 8 young people were of no fixed abode (NFA), 14 living with their parents, 4 in private tenancies, 2 in a Doncaster Metropolitan Borough Council (DMBC) tenancy, 1 in a Supporting People project and 1 in Prison. At the point of discharge (28 discharges): 12 were living with parents, 5 in private tenancies, 8 had a DMBC tenancy, 3 were in prison/hospital.</p> <p>The pilot service has been integrated to the new Doncaster Dual Diagnosis Strategy adopted by the Mental Health Commissioning Group. The service has been awarded funding by the Supporting People team for 2006/7.</p>

CHAPTER 4

Northampton

The Northampton SWAN NEST² pilot was developed to address some of the accommodation and health needs of sex workers in Northampton. Almost 80% of the sex workers were known to be homeless³ and over 90% drug dependent. This combination of drug use and homelessness was thought to hamper their access to health care and their ability to gain paid employment outside the sex industry.

The aims of the SWAN NEST pilot were to:

- increase the availability and take up of supported housing for sex workers.
- provide for, and use of, safe and supervised environments for contact.
- provide a crisis bed for sex workers.
- increase access to primary care services.
- increase access to drug treatment and support services.
- increase access to treatment for Sexually Transmitted Infections (STIs) and HIV.
- increase access to training and employment .
- increase awareness of health and social care needs of sex workers and the impact on individuals and society.
- reduce antisocial behaviour by sex workers in the managed area.

Description

The supported housing scheme, called the NEST (Now Exiting the Sex Trade), comprised 1 bed for longer-term housing support and a crisis bed scheme to be used as a means of preventing vulnerable women entering the sex industry. Both were to be provided by a local housing association and managed by the Council for Addiction in Northampton (CAN) Homeless Action Team.

The pilot employed a tenancy support worker to manage the supported accommodation and provide on-going support to prevent entry to and support

² Sex Workers Around Northampton Now Exiting the Sex Trade

³ Women living in insecure accommodation, night hostels or unofficially rough sleeping (sex workers were not officially classified as rough sleepers)

exit from the industry. The support was designed to enable women to access appropriate primary health care services, including detox programmes for substance misuse. The tenancy support worker also ensured that women had the opportunity to enter education and training programmes and take advantage of volunteering opportunities as a means of securing long term employment. It was anticipated that the tenancy support worker would also offer a reduced level of support to women who, having left the NEST, had moved on to 'settled' accommodation.

The NEST used flexible tenancies which enabled women to be accommodated for between 3 days to 2 years. In practice the crisis bed was designed to be used for 3 days at a time, although this could be extended if necessary.

4.1 JOINT WORKING EARLY STAGES

The partnership

The SWAN NEST pilot was developed against a backdrop of extensive joint working and built on the success of the SWAN programme, a multi agency initiative involving:

- Northampton Primary Care Trust,
- Northampton Borough Council,
- Northamptonshire Police,
- Maple Access Partnership LLP General Practice,
- Council for Addiction in Northampton (CAN), and
- Drug and Alcohol services.

The SWAN programme was originally developed to address community safety issues in Northampton and reduce health disadvantages experienced by sex workers. The SWAN programme itself comprised: a co-ordinator and a health worker (both funded by the PCT), a drugs worker and a probation worker (both funded from Building Safer Communities). Together they provided a range of support services to sex workers in Northampton. The pilot sought to build on this existing programme to create a supported housing scheme that would be managed by the tenancy support worker, who would also provide housing tenancy and related support to assist women wanting to exit the sex industry.

Although the existing SWAN programme formed the basis of the pilot most partners recognised the significance of CAN's involvement. Their experience as a specialist housing and support provider was widely regarded as being key to the

pilot. Their willingness to manage the NEST made the pilot feasible. As one PCT representative remarked *'neither of us could have provided the NEST without working together'*.

ORIGINS OF THE PILOT

The Assistant Director of Public Health for the PCT and the co-ordinator of the SWAN programme wrote the original bid. Members of the partnership viewed the absence of suitable housing opportunities as an important missing link in their ability to provide sex workers with an exit from the industry. The pilot was based on this shared recognition and its aims were designed to complement those of partner agencies. As a representative of the PCT commented:

'you have to think how it will help partners achieve their aims and objectives, you have to work that out and convince them and then make sure it delivers for them.'

The pilot, for example helped Maple Access Partnership achieve its objective of providing easily accessible GP services to 'chaotic' drug users, including sex workers. It also helped CAN achieve one of its aims which was to target homeless women (living in insecure accommodation or rough sleeping) who had no access to drug and alcohol services.

During the evaluation several partners commented that they had not been involved in early discussions about the pilot and, whilst committed to the central aims of the pilot, had reservations about the practicalities of providing housing support to the two different target groups within the same house. They suggested that the needs of a long-term tenant were likely to differ radically from those of the crisis bed tenant and would require very different types of support. Whilst recognising the importance of providing crisis accommodation they thought the NEST should have focused on providing supported housing exclusively to long-term tenants. This reservation however, did not dampen their enthusiasm for and engagement with the pilot.

The local Supporting People team were also members of the partnership, albeit informally. They saw the development of the NEST as a means of addressing homelessness amongst a marginalized group, promoting their independence, and potentially as a means of tackling drug-associated crime.

Governance

The governance arrangements for the pilot were straightforward. Initial plans to establish a specific steering group to guide the pilot were discarded because of the overlap in membership with the existing SWAN Partnership Steering group. Progress was therefore reported to this existing group which met bi-monthly and comprised of senior representatives from the main partner agencies.

Additionally because the PCT held the contract for the pilot with the ODPM, now DCLG, the Assistant Director for Public Health reported progress to the PCT board.

The Partnership Steering Group was widely regarded as being an effective forum at which to discuss strategic and operational concerns. For example, the group considered a review of the crisis bed and supported the changes proposed (see later). Meetings were well attended and minutes were always circulated. Membership of the group was seen as an essential mechanism to ensure that partner agencies remained engaged with the pilot as well as the overall SWAN programme.

Getting started

Difficulties in finding suitable accommodation resulted in a substantial delay before the NEST was opened. The pilot used this delay as an opportunity for the tenancy support worker to spend time with CAN getting some experience of general tenancy support work. During this time she was able to find temporary accommodation for several women who were already known to the SWAN programme.

One of the benefits of establishing the pilot within an existing programme was that many of the policies and procedures required by the new service already existed. For example, the pilot used SWAN's risk assessment form and worked under SWAN's joint working policy. The pilot did have to develop eligibility criteria for women to be accepted as tenants. Women had to: want to exit the sex industry, be homeless (unofficially rough sleeping or in temporary accommodation) or in inappropriate housing, acknowledge that they had substance misuse problems, be willing fully to engage with the pilot, and to have been assessed as suitable for the NEST.

Although the SWAN Programme publicised being awarded Supporting People health pilot status they deliberately chose not to have a formal launch of the supported housing scheme. There were two reasons for this. First, given the sensitivity of establishing supported housing for sex workers it was felt that any publicity could potentially threaten the initiative. Second, the pilot was acutely aware that they had to manage the expectations of homeless women who were keen to move into temporary accommodation. Any delay to the opening of the accommodation could have caused frustration that potentially could have undermined the credibility of the SWAN programme amongst sex workers.

This pilot was not formally launched, but the tenancy support worker spent considerable time visiting potential referral agencies, ensuring they understood the aims of the NEST and the criteria for women to be accepted as tenants. This resulted in several women being identified as potentially suitable tenants who were able to move into the NEST as soon as it was opened.

Management arrangements

To ensure the integration of the NEST with wider SWAN services the tenancy support worker was based within the SWAN partnership and shared an office with the other workers. Management arrangements were, however, more complicated.

Although the PCT held the contract for the pilot the tenancy support worker was employed by CAN and received line management and professional supervision from the CAN area manager with responsibility for the NEST.

The SWAN co-ordinator, however, had responsibility for monitoring the development of the NEST and overseeing the day-to-day work. Not surprisingly this approach caused some confusion and necessitated regular discussions between the CAN area manager and SWAN co-ordinator to ensure that they provided consistent advice and support.

The decision to ask partner organisations to employ the tenancy support worker was a strategy that the PCT had adopted for several of the SWAN workers. The PCT saw it as an important way of securing the commitment of an individual agency to the partnership. However the decision effectively spread managerial responsibility across the SWAN programme and the SWAN NEST partnership and diffused the PCT's responsibility. A PCT representative acknowledged that this strategy had complicated the management arrangements.

When the SWAN co-ordinator left it was decided that CAN would assume managerial responsibility for the tenancy support worker. This decision brought clarity to the situation and was welcomed by all of the partners.

Monthly supervision sessions from her line manager provided the tenancy support worker not only with oversight of her work with individual clients, for example reviewing resettlement plans, but also addressed her training and support needs, and her emotional welfare. These monthly supervision sessions usually lasted at least 1 hour and were regarded as invaluable.

Although the tenancy support worker had no experience of tenancy support work she had previously worked as a counsellor for a young people's support service, a job that provided her with many of the skills necessary to work in this role. As part of her induction she received specific training in relation to housing law and housing benefits from CAN. Additional specialist counselling sessions were provided by the PCT to all of the project workers at the SWAN programme. One of the courses taken by the tenancy support worker was on conflict resolution.

The pilot had not considered how cover would be provided if, for example, the tenancy support worker was off sick or the tenants required support at the weekend. In the event CAN offered to provide this support from their existing out of hours service.

4.2 JOINT WORKING MAIN PHASE

The partnership

All interviewees commented that the pilot was based on strong and effective joint working relationships at both the strategic and operational levels. The involvement of senior representatives from partner agencies (particularly the police force) was considered to be crucial in effective problem solving. The opportunity to capitalise on these existing strategic relationships was significant, leading one interviewee to comment that joint working had been made easier because they had had a *'positive experience of joint working in the past, we trust each other, you will deliver because you have in the past'*.

Joint working at the operational level was also considered to be very effective. Partners commented that the role of the NEST tenancy support worker complemented those of the existing SWAN team. As a result clients were referred seamlessly between the different parts of the SWAN programme depending on their needs.

Despite this, most interviewees suggested that the nature of the relationship was fragile because it was based on personalities who had worked together over a long period of time. Changes in personnel could therefore impact on the partnership. Consequently no one took the partnership for granted and recognised the importance of demonstrating their on-going commitment to the programme.

During the course of the pilot, a new Chief Constable was appointed to Northamptonshire Police Force. This change was cautiously anticipated because it could potentially have affected the nature of the partnership. Similarly restructuring of the local PCT and Borough Council caused some anxiety whilst the pilot planned its long-term future. At an operational level, the temporary closure of the housing department had a direct impact on the pilot, making it difficult for the tenancy support worker to resolve specific questions relating to individual NEST tenants.

Revising aims and objectives

It was originally intended that a local housing association would provide the NEST accommodation and that CAN, as a specialist housing agency, would support the tenants. Early on in the project the housing association concluded they did not have a suitable property. Fortuitously, CAN had recently increased their own housing stock and were able to offer the use of one of their own properties.

After approximately 6 months it became apparent that the combination of the long-term bed and the crisis bed was not working effectively. The pilot had demonstrated a need for crisis housing, but the tenancy support worker felt that

the frequent changes in tenants undermined the stability required by long-term tenants. Additionally, managing the crisis accommodation was resource intensive. Not only did the women require intensive support but, because they were only eligible to stay in the NEST for 3 nights, they absorbed a significant amount of workers' time settling them in and then arranging their move to longer term temporary accommodation.

Having reviewed the progress of the NEST the Programme Steering Group agreed that the NEST should be used to provide longer-term supported housing to two women. Coincidentally this review occurred at the same time as the SWAN co-ordinator left the PCT and was therefore used as an opportunity to address wider managerial concerns. From this point CAN (the specialist housing support agency) assumed the day to day management of the NEST and the tenancy support worker.

Communication and information sharing

Communication between partners was seen as one of the strengths of the SWAN pilot. Given the nature of the pilot's work partners commented on the importance of having a range of formal and informal communication channels. At a strategic level not only did senior representatives of partner agencies meet at the steering group but they were also in regular telephone and email contact. In particular the co-ordinator of the SWAN programme and the area manager of CAN reported having frequent telephone 'catch up' sessions.

At an operational level the SWAN programme held weekly case review meetings. These were attended by all SWAN project workers and were open to partner agencies. In practice, however, only the police liaison officer attended on a regular basis. These meetings were used to discuss individual cases, ensure that relevant information was shared appropriately and consider how agencies could work together most effectively.

The pilot used a 'release of information form' which each woman entering the NEST was asked to sign, agreeing to the pilot contacting specific agencies as a means to seek or share appropriate information. Although the majority of partner agencies were satisfied with this arrangement some were occasionally thought rather 'precious' about sharing information. For example staff working in one agency regularly asked to speak with individual women to confirm that they had signed the 'release of information form' of which they had a copy.

Involvement of people using SWAN NEST

Although service user representatives were not involved in the overall management of the SWAN NEST the pilot ensured that they were involved in its on-going development. Weekly meetings were held with the NEST tenants to review progress and discuss any problems or ideas about how the supported

housing could develop. The SWAN programme also held drop in sessions at which potential tenants could learn more about the NEST or discuss other accommodation options with the tenancy support worker.

4.3 JOINT WORKING MAINSTREAMING

Although not a requirement of the programme, each pilot was encouraged to establish links with the local Supporting People team. This did not happen at the outset of this pilot, but in the second year the area manager of CAN assumed this role and ensured that the local Supporting People team was informed of progress. Although an ad hoc arrangement a representative of the Supporting People team commented that they were sufficiently informed to *'enable decision makers to make decisions.'*

The relationship with relevant health commissioners was straightforward. Northampton PCT was the lead commissioning agency for sexual health services in the county and the Assistant Director of Public Health for the PCT was the commissioner for sexual health services. As a member of the partnership steering group she was well informed about the pilot and actively pursued opportunities to mainstream the service.

Several interviewees commented that the final stage of the pilot, during which the SWAN programme tried to secure the future of the NEST, was not well managed. This was partly because the PCT had been unable to recruit a suitable replacement for the SWAN co-ordinator to lead this process. It may also have reflected an initial lack of clarity about the role of partner agencies and whether or not there was any expectation that they would assume responsibility for the NEST when pilot funding ended. Despite these difficulties funding was secured from Supporting People to continue the NEST.

Reflections

An important feature of the success of the pilot was the shared sense of realism with which the partners approached their work. As one partner commented

'we never deluded ourselves that this was an easy group to work with. People don't understand how difficult a job it is just to get women to a position of wanting to exit (the sex industry) it is a very long haul, getting other organisations to understand the complexity and the time that it will take.'

As a consequence the pilot appeared to be able to withstand set backs, for example the delay in finding appropriate accommodation for the NEST and, more specifically, when individual tenants left the NEST before they could be rehoused in long term fresh start housing.

4.4 PROJECT ACHIEVEMENTS

Table 2 summarises the outcomes achieved by the SWAN NEST pilot. These included improvements in outcomes for women using the service, as well as a range of processes for effective joint working. Although it was funded for 2 years, the table relates to the activities completed up until submission of the final evaluation report, a period of 22 months.

The SWAN NEST provided accommodation to 14 women, 2 of whom were accommodated on 2 separate occasions. 6 women have since gone on to live in long term housing and 3 have exited the sex industry.

Over the two years the SWAN programme was able to widen the range of health care services they worked with. Although the Maple Access Partnership continued to be the main provider of primary care services the programme began referring sex workers to three other GP practices and to a dental practice. The programme also established a fast track referral service to specialist sexual health clinics and developed much closer ties with the mental health assertive outreach team. These developments were seen as a major advance, ensuring greater access to a wider range of health care services for a particularly marginalized group.

The number of new agencies that began to refer women to the programme also demonstrated its relevance to local services. For example the pilot developed links with a prison resettlement team. The pilot also reported improvements in their working relationship with the local night hostel. Initially the hostel had been reluctant to work with the pilot but, having successfully supported one sex worker, hostel staff approached the pilot to work in partnership to support other tenants. The pilot also provided generalist training to hostel staff about the accommodation and support needs of sex workers. Feedback from the training had been positive and had contributed to the improved relationship. In common with other pilots the original bid did not anticipate the level of demand for the new service or the extent of support that individual women would require.

Innovations in practice

At an operational level the pilot developed a variety of strategies to ensure workers in different agencies communicated effectively about clients and shared relevant information. As well as weekly case review meetings, the partnership developed a 'release of information form' that allowed agencies to share or seek information in a timely fashion. These strategies helped ensure that services could be co-ordinated across organisational boundaries as a means to better support vulnerable women.

Unanticipated outcomes

Over the course of the 2 years the pilot received many enquiries about their work. During the second year CAN was commissioned by a Drug Action Team to set up and provide a similar supported housing service for sex workers in Luton. The tenancy support worker was actively involved in the development of this new service.

Evaluation interviews with women using SWAN NEST

Interviews were conducted with 4 service users: one during the first evaluation visit, two during the second, and one during the final visit. Three of the women were SWAN NEST tenants and the other had been found alternative temporary accommodation in a hostel by the tenancy support worker.

All interviewees said the pilot helped them to access health services that they were not previously in contact with. Two were receiving counselling, one had begun attending a drug detox programme, and two women had been referred to the Genito-Urinary Medicine clinic (GUM), although only one had attended. One of the women reported that she no longer worked in the sex industry. Another said she had reduced her involvement. The other women did not answer this question.

All reported being satisfied with the support provided by the pilot and believed that their health had improved as a consequence. All were living in temporary accommodation. Not only had the pilot helped them to engage with health services, they sometimes accompanied them to appointments. As one woman commented, *'I have got somewhere to live, I've got no worries, I was in hospital because of lung failure from sleeping rough, I was self harming and I was suicidal. Now I am happy in my new house'*.

Case study 1

Judy, was referred to the NEST by her probation worker whilst in prison. Before going to prison Judy had been living in a council flat which had previously been used as a crack house and was located in the red light area. Although she had asked to be re-housed this hadn't happened and out of desperation she left the flat and began living rough until she was arrested for shop lifting.

Judy has manic depression and described how the pilot had *'helped me get back into the medical system, I am now seeing a psychiatrist and a CPN and I start a detox programme soon. They have supported me to do that. They have got me a dentist and an optician's appointment and the long term accommodation'* (the NEST).

Judy said that the tenancy support worker *'was not stuck up or bossy, they don't treat you like an imbecile, they don't do everything for you which is good, they sorted out my appointments and I've been to see the psychiatrist.'*

She went on to say that *'I hope to be living in normal accommodation and working authentically again and not using any drugs.'*

Table 2: 'SWAN NEST'

Aims	Objectives	Outcomes
<p>Increased availability of, and take up of, supported housing for sex workers.</p>	<p>Develop supported housing opportunities available to sex workers.</p>	<p>The 'NEST' supported housing scheme opened in January 2005. Initially the NEST comprised 1 bed for longer term housing support and a crisis bed. Following a review it was decided to designate both beds to longer term housing support.</p>
<p>Temporary and long term supported housing opportunities accessed by sex workers.</p>	<p>Temporary and long term supported housing opportunities accessed by sex workers.</p>	<p>The pilot has worked with local agencies including CAN and the night hostel to ensure that other housing opportunities are available to sex workers. The pilot is also working with the local authority to develop tenancy support to sex workers living in local authority housing.</p>
<p>Exiting sex workers obtaining fresh start housing support – long term.</p>	<p>Exiting sex workers obtaining fresh start housing support – long term.</p>	<p>14 women have been housed in the NEST (2 women have been housed twice). Of these 14, 6 women have moved on to long term housing and 3 have exited sex work (having not worked for 6 months). The remaining 8 women were evicted for breaching their tenancy agreement – 4 had accommodation to go to.</p>
<p>Measure unmet need – numbers that the service is unable to meet their need.</p>	<p>Measure unmet need – numbers that the service is unable to meet their need.</p>	<p>A further 15 women were assessed to become NEST tenants. Of these: 10 women met the eligibility criteria but were unable to be housed because the NEST was full, 1 woman was deemed too high risk to accommodate, the health needs of 1 woman were thought to be too severe and 3 women were not thought to be sufficiently motivated to exit the sex industry.</p>
<p>Record the number of Sex Workers referred to Northampton Council Housing Advice Service (or other housing advice) and outcome.</p>	<p>Record the number of Sex Workers referred to Northampton Council Housing Advice Service (or other housing advice) and outcome.</p>	<p>10 women were referred to local housing advice services.</p>
<p>Record the number of sex workers receiving support from SWAN and NEST support team to temporary/long-term access housing. Number of sex workers receiving support from SWAN and NEST support team to temporary/long-term access housing.</p>	<p>Record the number of sex workers receiving support from SWAN and NEST support team to temporary/long-term access housing. Number of sex workers receiving support from SWAN and NEST support team to temporary/long-term access housing.</p>	<p>35 women received tenancy support from the pilot. 14 women were accommodated in the NEST.</p>
<p>Provision for, and use of, safe and supervised environments for contact.</p>	<p>Record the number of children/family members using premises for supervised contact and support.</p>	<p>3 women used the SWAN premises for supervised contact with children/family. The pilot discouraged supervised contact sessions at the NEST.</p>
<p>Provision of a crisis bed for sex workers.</p>	<p>Record the number of sex workers using crisis bed, and referrals to housing support agencies. Level of unmet need.</p>	<p>Following a review of the NEST it was decided to designate both beds to longer term housing support. 16 women needing crisis accommodation were referred to the night hostel, 2 of whom were accommodated.</p>

continued

Table 2: 'SWAN NEST' (cont'd)

Aims	Objectives	Outcomes
Increased access to primary care services.	Increase the number of sex workers registered with GP practice.	8 of the 14 NEST tenants were already registered with a GP service, the remaining 6 were supported by the pilot to register.
Increased access to drug treatment and support services.	Record the number of sex workers gaining support from drug support worker.	12 NEST tenants have received support from the drugs worker the remaining 2 were treated elsewhere because they were on a Drug Treatment and Testing Orders.
Increased access to treatment for STI's and HIV/AIDS	Record the numbers obtaining access to drug treatment and detox.	16 women have been fast tracked into drug treatment by the SWAN drugs worker. The outcome of this work is difficult to gauge.
Increased access to training and employment for sex workers.	Record the numbers who stop drug use.	The pilot notes the difficulty of recording this information accurately.
Increased access to treatment for STI's and HIV/AIDS	Record the number of sex workers accessing sexual health services.	All women have direct access to sexual health services and are now encouraged to self refer due to poor attendance at prearranged appointments.
Increased access to training and employment for sex workers.	Record the number of sex workers accessing training (formal and informal).	No women accessed training sessions although the pilot continues to encourage women to access training as part of their tenancy agreement.
Increased awareness of health and social care needs of sex workers and the impact on individuals and society.	Record the number of sex workers undertaking formal volunteering opportunities.	No women accessed volunteering opportunities although the pilot continues to encourage women to do so, particularly at the SWAN programme.
Reduction in antisocial behaviour by sex workers in the managed area.	Record the numbers accessing community punishment at SWAN.	No women have accessed community punishment at SWAN.
Increased awareness of health and social care needs of sex workers and the impact on individuals and society.	Record the numbers of training sessions/ awareness sessions for professional groups.	10 training sessions have been held as a means to raise awareness amongst other professional groups about the needs of sex workers. These included sessions with staff working in housing services, social services, sexual health services and the Jesus Army.
Reduction in antisocial behaviour by sex workers in the managed area.	Record the number of ASBO's for sex workers.	None of the women accommodated in the NEST have received an ASBO.
Reduction in antisocial behaviour by sex workers in the managed area.	Reduction in complaints by residents.	No official complaints have been made by residents living close to the NEST. The support worker is in regular contact with neighbours who have informally contacted the programme, for example to report when the noise from the NEST was too loud.

CHAPTER 5

Waltham Forest

The *Place to Live, Health and Supporting People* pilot (Place to Live) was established as a means to promote a greater understanding and awareness of supported housing amongst people with learning disabilities and their carers, as well as amongst health and social care practitioners. It aimed to give people with learning disabilities greater choice and control over where they lived whilst ensuring that they had better access to health care services. In particular the pilot sought to explore why the number of people living with older carers or in residential care was increasing and establish whether or not they wished to move to supported living.

The aims of the pilot were to:

- increase understanding of the positive attributes of supported housing and the impact it can have on health status amongst users and carers and health and social care practitioners.
- carry out assessments and reviews of 30 adults living in residential care or with older carer, with referrals to supported housing if appropriate.

Description

A project worker was employed to provide a focus for this work. His role was to raise awareness of supported housing and the impact that it can have on health, within the integrated team in which he was based.

He worked intensively with 12 individuals living in residential care or with older carers to explore their housing choices and assess their housing support and health needs. He made sure that appropriate services and support were in place. This could include referral to supported housing. The project worker also ensured that each person had an up-to-date Individual Health Action Plan (IHAP) that was reviewed and changed, if necessary, if they moved into new accommodation. The project worker also supported members of the wider team to work with a further 18 individuals living in residential care or with an older carer to achieve the same outcomes.

5.1 JOINT WORKING EARLY STAGES

The partnership

In 2003 the London Boroughs of Waltham Forest and Redbridge, and Waltham Forest and Redbridge Primary Care Trusts formed a partnership for the provision

of services for people with learning disabilities. The Learning Disability Partnership, as it is known, provides an integrated health and social care service and it is within this organisation that the Place to Live pilot was based. Unlike other pilots in this programme, the main partners were employed by different organisations but worked within the same organisation. Consequently the focus of this pilot was on promoting intra-agency working between social workers (employed by the local authorities) and learning disability trained community nurses (employed by the PCT) within an already integrated team.

Origins of the pilot

The idea for the pilot originated from discussions within the '*Place to Live* Accommodation Group', a strategic policy forum that reviews all accommodation plans relating to people with learning disabilities. It includes representatives from service users, carers organisations and statutory and voluntary agencies. The group had identified an increase in the number of people living either with older carers or in residential care. The over arching aim of the pilot therefore was to provide this group of people with learning disabilities with greater choice and control over where they lived, at the same time ensuring that they had better access to health care services designed around their individual needs. This reflected the widest objectives of the Learning Disability Partnership and, by implication, the spirit of the Valuing People White Paper (DH 2001a). The aims also complemented those of the local Supporting People housing strategy concerned with finding alternatives to residential care.

Despite the resonance of the pilot's objectives to the work of the integrated team it soon became apparent that the pilot was not viewed as a 'joint' venture. The original proposal had been written by social care professionals with little or no involvement from nursing staff. Consequently the pilot was seen as a social care project. As one social worker reflected '*things should have been done differently during the planning stage; we needed to take more people on board, it was important for everyone to own the project.*' The subsequent involvement of community nurses appeared tokenistic.

Governance

The overall governance structures for the pilot were relatively straightforward. The pilot reported to the *Place to Live* Group. This was initially chaired by the Supporting People Lead Officer for Waltham Forest, which ensured that the pilot was linked into wider Supporting People structures and housing debates. Progress reports were also made to the Learning Disability Partnership Board attended by the health commissioner, and to the Accommodation Panel, and to the Learning Disability Partnership forum. The latter was attended by service users, carers and professionals.

Initial plans were to establish a steering group, but it was subsequently decided to use the existing *Place to Live* Group as the forum in which to discuss the

strategic and operational focus of the work. These meetings always included a progress report from the pilot project worker. This provided up to date information on the number of assessments completed and the number of people who had moved into supported housing. However meetings were not as regular as intended. As one partner commented *'it meets sporadically; the idea is to meet every three months. If it doesn't happen we try to feedback to the members of the steering group.'* On reflection several interviewees thought that the pilot should have established a separate steering group that specifically included community nurses, and that this group should have met more frequently and been more directive.

Getting started

The success of any new initiative is partly dependent on clear policies and procedures being in place to guide the work. In the early phases of the pilot the project worker and wider team developed some of the systems by which they would promote independent living. For example, the booklet explaining the purpose of supported living was written and made available in accessible formats. In addition, the IHAP assessment tool was produced. However, other systems were not established, including the process by which social workers would refer clients to the community nurses for an IHAP.

The pilot launched its work at a *Place to Live* event several months after the pilot began. Over 100 people, including services users, carers and professionals, attended the event at which the project worker explained the aims and objectives of the pilot. The event was thought to have been very important in raising awareness about supported housing. Additionally because people with learning disabilities had spoken about their aspirations to live independently it was considered to have been instrumental in the process of beginning to identify the housing needs of people with learning disabilities.

However successful, a public launch does not always ensure that those whose work might be affected by any new initiative understand or accept its aims and objectives. This matters, particularly when, as in this case, they are expected to make appropriate referrals to a project. Whilst those most closely involved in the work said the pilot had been introduced to members of the wider integrated team, other interviewees commented that the purpose of the pilot and the role of the project worker, had not been explained clearly enough.

As a consequence, social workers were said to be unclear of the purpose of the IHAPs, and community nurses were said to be unaware of the relationship between housing and health. In order to resolve this impasse a nursing colleague attended social work meetings to discuss the IHAPs and explain how the assessments would be carried out. The project worker also provided training to nursing colleagues about supported housing and its contribution to well-being. Subsequently the number of people referred to community nurses for IHAPs increased.

Management arrangements

Effective managerial processes are key to the success of any new initiative. Whilst the pilot enjoyed strategic backing there was a lack of continuity in staff at a senior managerial level. In the early stages the service manager within the integrated team was managerially responsible for the pilot. After he left responsibility moved to the manager of the integrated team who left this role shortly after. These successive changes in staff with managerial responsibility for the pilot, and the integrated team in which it was based, meant there were fewer than anticipated operational meetings. This led to a loss of direction and momentum.

Senior managerial responsibility for the pilot was later delegated to one of the newly appointed service managers. This appointment gave the pilot the managerial stability and focus it needed. It also strengthened the links between the strategic and operational level work.

The changes in senior management could have had a direct impact on the work of the project worker. However at an early stage the day-to-day management of the pilot was delegated to the deputy manager of the integrated team who remained in post throughout the duration of the pilot. The deputy manager met with the project worker approximately once a month to discuss progress, and also informally on a daily basis. They were therefore able to discuss problems. The deputy manager also met with the project worker for monthly professional supervision sessions.

5.2 JOINT WORKING MAIN PHASE

The partnership

The pilot was characterised by strong and effective joint working at strategic level. This was particularly evident in the role of the lead officer for Supporting People who acted as a conduit between the pilot and the Housing Department, ensuring that lessons from the pilot informed housing services.

However, the central aims and objectives of the pilot relied on joint working between social work and learning disability nursing staff based within the integrated team and at this level relationships were less effective. It soon became clear that whilst the original bid had emphasised that the partnership was relatively new, it had not anticipated the time it would take for the integrated team to function as such. Indeed throughout the first two cycles of evaluation visits interviewees reflected on this point. One commented that *'the project got a little bit lost at the beginning because the learning disability partnership was very new, so it lost its way.'*

One factor inhibiting the development of the integrated team was the physical separation of social work and nursing staff who were based in different

buildings. Plans to move to a single building did not happen during the lifetime of the pilot. This physical separation accentuated what several interviewees thought to be a reluctance to enter the spirit of integration. Training provided by the project worker did help to build a shared understanding of the pilot and this resulted in an increase in cross referrals within the team. By the final evaluation visit several interviewees commented that the pilot itself had helped to develop a common sense of purpose:

'there has been an improvement between the work of individuals in the team; it is an evolving thing, the project has helped this.'

These improvements were not confined to social work and community nursing staff. The project worker was able to foster the involvement of other health colleagues, including occupational and speech and language therapists in the IHAP assessments. The assessments were consistent with good practice set out by Valuing People, information was shared with a range of health and social care professionals including GPs, dentists and dieticians.

Professional differences

Joint working between different professional groups can be difficult without a common philosophy or language. This appeared to be the case within the integrated team. For example, one interviewee described the impact that different ideas between social workers and community nurses about what constituted a 'health need' and what constituted a 'social need'. This resulted in a lack of appreciation of the importance of housing to health and well-being. The level of co-ordination required between social workers and community nurses also appears to have been seen as rather threatening. As one interviewee commented *'in integrated teams people can get precious about their roles.'*

Service user involvement

One of the strengths of the Waltham Forest pilot was the importance given to ensuring that people with learning disabilities were kept fully informed of the work. At the launch of its work at the *Place to Live* event a group of learning disabled people gave a drama presentation which demonstrated their wish to express their own views. This had particular resonance for the aims of the pilot. Thereafter the pilot made regular reports to the '*Place to Live*' Group, which included people with learning disabilities. This involvement of people who use services in discussions about the pilot was thought to have kept the work well grounded.

Relationship with wider housing concerns

The active involvement of the Supporting People lead officer ensured the work of the pilot was integrated to other aspects of the local Supporting People

team's work. For example, the pilot highlighted concerns that people with learning disabilities had about the quality of support provided by some housing and support agencies. As a result the Lead Officer involved members of the integrated team in service review meetings with Supporting People providers.

As chair of the '*Place to Live* Accommodation Group', the Supporting People lead officer was able to act as a link between the pilot and the housing department, ensuring that some of the wider lessons of the pilot were acted upon. For example, initial concerns about the lack of supported housing available to people with learning disabilities caused many to doubt whether the objectives of the pilot could be achieved. However as a result of improvements in communication between the integrated team and the housing department more houses were made available to allocate to people with learning difficulties. This was regarded as a major breakthrough.

The pilot identified the importance of establishing an accurate two way flow of information regarding the demand for, and the supply of, appropriate properties. On the one hand, it was important to have sufficient units available and on the other to have a commensurate number of people recommended for re-housing into those units. One partner observed that it had taken some time for social workers to recognise the potential for some people using services to live independently in supported housing.

During the course of the pilot the project worker identified a lack of awareness amongst professionals of the housing rights and housing support needs of people with learning disabilities. This was particularly acute within the homelessness unit and caused immense frustration amongst people with learning disabilities. To address the problem the manager of the integrated team met with staff working in the unit and developed a protocol which identified how the housing needs of people with learning disabilities should be addressed. Members of the integrated team also provided training to staff working in the homelessness unit as a way of raising their awareness about the housing and support needs of people with learning disabilities.

Communication and information sharing

As indicated above, the project worker and his line manager enjoyed regular formal and informal contact. However communication between them and members of the wider team was generally regarded as inadequate. One interviewee noted that he had had to make an effort to keep up to date. Another said that a two way flow of information between the strategic and operational elements of the pilot has not been established.

Communication with members of the community nursing team was particularly poor. In part this reflected the difficulties associated with being based in separate buildings with little opportunity for informal discussion and led one

health colleague to remark '*I've learnt through this that there is a need for a fully integrated structure.*' The consequences of this separation were compounded by an unstable email system that regularly failed. As a result, sharing information between staff working within the integrated team was more problematic than might have originally been anticipated.

These communication difficulties appeared to amplify the sense that community nurses were either 'not fully engaged' or were 'not part of the core team'.

Monitoring the service

A database was set up to monitor the work of the pilot including number of referrals to have an Independent Health Action Plan assessment. Activity data were regularly reported to the *Place to Live* Group.

Contextual problems

In common with other pilots the busy policy context was identified as a factor that slowed down some aspects of this project. For example, the implementation of the Single Assessment Process had, for a short while, taken primacy over the pilot. The pilot also highlighted the need for flexible timescales when supporting people with learning disabilities to move into supported housing. For example, service users sometimes require intensive support in the lead up to a move. It is therefore necessary for a 2-way flow of information to operate so that the housing department or Registered Social Landlord is aware of the particular needs of the person with learning disabilities and the possibility of a void, whilst the service user needs to be kept informed about any building delays or necessary adaptations to the house.

5.3 JOINT WORKING MAINSTREAMING

Having completed the pilot the integrated team recognised that the approach might be suitable to a range of people with learning disabilities. It was decided to extend this model of work specifically to young people with learning disabilities who were in the process of leaving care. This was an important learning point, demonstrating the need to think in practical terms about the limits of what can be achieved within available resources and the most effective ways of achieving these aims.

5.4 PROJECT ACHIEVEMENTS

Table 3 summarises the outcomes achieved by the pilot over the course of 1 year. These included improvements in outcomes for people with learning disabilities, as well as a range of processes for effective joint working.

The pilot monitored basic demographic details of the 26 people they assessed, together with outcomes of the intervention. Assessments were evenly split between people living with an older carer and those in residential care. Although 18 of the 26 assessments were for men, only 4 of the 9 people who moved into supported housing were men. As a result of the assessments person centred planning was arranged for 13 people and 4 people received Direct Payments. Additionally 3 people are now accessing supported employment and 3 adult education.

Innovations in practice

The work of the pilot improved how individual people with learning disabilities are supported to make decisions about their accommodation. The provision of up-to-date information about supported housing options and the type of care each provided, together with the development of a housing options booklet enabled individuals to make better informed decisions about accommodation. Additionally the provision of training to members of the integrated team improved understanding about the relationship between health and housing and therefore the role of supported housing. As a result of these developments more applications were made to the Accommodation Panel for people wishing to move to supported housing. Finally the provision of training was identified as having helped to breakdown barriers between the different professional groups within the integrated team.

Evaluation interviews with people using Place to Live

Thirteen interviews with people using the service were conducted: four men (age range 31 to 37 years) and three women (age range 37 to 46 years). Five of these took place during the first evaluation visit, four during the second, and four during the third. Three people (two women, one man) participated in the first two evaluation visit interviews. Two women were interviewed during all three visit rounds.

Consistent with the project's eligibility criteria all had a learning disability and lived with elderly carers or in residential care. All had a medical/psychiatric condition (e.g., epilepsy, depression or a heart problem). At the time of the first visit, two interviewees were living temporarily in a respite care home waiting to be re-housed. One of these had previously been in foster care. The other had lived for most of her life with her now elderly parents. The remaining three people had been living long-term in a residential care home.

By the second visit, one of the two people living in the respite care home had been rehoused in purpose-built shared accommodation run by a Housing Association. She was satisfied with her living arrangements saying '*I feel more settled here*'. Of the three service users previously living in the residential care home, one had moved to a shared housed run by the council. He was happy

with living arrangements but expressed some criticism, especially towards his housemates saying '*I can't have a descent conversation here*'. Both interviewees expressed some concern about either the amount of home support/help received, or the home help arrangements.

Of the people waiting to be re-housed, one said that he was looking forward to the completion of building work on his flat but also said '*I don't know what sort of support I will be getting*', while another had been admitted to a psychiatric unit. The third person continued to reside in the care home.

At the time of the final visit, one of the women commented that she was feeling much better since she had been re-housed. The two people who had been re-housed at the time of the second interview round, continued to be satisfied with their living arrangements.

Case study 1

Clare, 46, was referred by her elderly father with whom she used to live. When first interviewed she was staying in a respite home waiting to be allocated a new flat. She described how the pilot worker had been to see her on a number of times to discuss her housing options and that she was looking forward to living independently, as she used to argue with her parents when she was living at home.

At the time of her second interview she had been sharing a flat for five months. She said that she felt '*more settled here*' and '*not so agitated*' as she used to. The pilot worker had talked to her about the type of support she wanted to receive as a means to live independently and she was now receiving visits from support workers three days a week.

Overall she was satisfied with the arrangements. Clare was also in regular contact with her GP, a psychiatrist and the family planning clinic. She was also attending Maths and English classes with the aim of finding part-time employment. At the final interview Clare was still living in her flat and engaging with services.

Table 3: 'Place to Live'

Aims	Objectives	Outcomes
<p>To increase understanding of the positive attributes of supported housing and the impact it can have on health status amongst users and carers and health and social care practitioners.</p>	<p>Provide information about housing options in a range of accessible formats.</p> <p>Provide training to health and social care professionals about supported housing.</p> <p>Hold a seminar for services users and professionals.</p> <p>Revise the assessment tool.</p>	<p>A booklet was developed, describing housing options for people with learning disabilities and their carers. It was intended that this would help them make decisions about future housing. It is intended to review and update this regularly and to make it available in future in a range of different formats.</p>
<p>To carry out assessments and reviews of 30 adults living in residential care or with older carer, with referrals to supported housing if appropriate.</p>	<p>12 of these assessments were to be carried out by the project worker. The remaining 18 by members of the integrated team.</p> <p>Provide Care Co-ordination to a minimum of 6 people moving into supported housing for the first time.</p> <p>Provide Direct Payments to a minimum of 3 users moving into supported housing.</p> <p>Ensure that appropriate changes are made to Individual Health Action Plans associated with moving into supported housing.</p> <p>Improve assessment and care management systems as a means to collect and collate data on housing, support and health needs.</p> <p>Provide training in best practice in assessment and care management, which incorporates housing and support needs, delivery of individual Health Action Plans, using a person centred planning approach</p> <p>Map the current provision of housing provision and the level of support provided as a means to inform: the Individual Health Action Plans and the development of the five year Supporting People Strategy.</p>	<p>Supported Housing training sessions were provided to social workers and community nurses.</p> <p>Seminars were held for people with learning disabilities and their carers.</p> <p>The assessment tool was revised and incorporated to the single assessment tool. The team plan to discuss the tool with the homelessness section of the housing department.</p> <p>26 assessments and reviews of adults living in residential care or with older carers were completed out of a target of 30. Of these 9 moved to supported housing.</p> <p>All service users were provided with Care Co-ordination ensuring quality service to meet their care needs, through regular assessments and reviews.</p> <p>4 people have begun receiving Direct Payments.</p> <p>A health action plan was completed for each individual assessed.</p>
<p>Improve assessment and care management systems as a means to collect and collate data on housing, support and health needs.</p> <p>Provide training in best practice in assessment and care management, which incorporates housing and support needs, delivery of individual Health Action Plans, using a person centred planning approach</p> <p>Map the current provision of housing provision and the level of support provided as a means to inform: the Individual Health Action Plans and the development of the five year Supporting People Strategy.</p>	<p>Improve assessment and care management systems as a means to collect and collate data on housing, support and health needs.</p> <p>Provide training in best practice in assessment and care management, which incorporates housing and support needs, delivery of individual Health Action Plans, using a person centred planning approach</p> <p>Map the current provision of housing provision and the level of support provided as a means to inform: the Individual Health Action Plans and the development of the five year Supporting People Strategy.</p>	<p>Training sessions were provided by the head of the community nursing team about how to access health services and implement the health action plans.</p> <p>Training was provided on improving assessment procedures and Person Centred Planning (PCP) is in place for 13 people.</p> <p>A map of current providers and the types of support provided was produced.</p>

CHAPTER 6

Salford

The *Sure Footed in Salford* pilot was developed specifically to support the implementation of Standard 6 of the National Service Framework for Older People (DH 2001b). This requires local authorities and the NHS to work in partnership to reduce the incidence and impact of falls. In so doing, localities are encouraged to develop an integrated falls service that incorporates Primary Care Groups and Trusts, social services and housing support services. The pilot therefore aimed to support this initiative by demonstrating how the Supporting People Programme is able to contribute to wider health objectives.

The aims of the *Sure footed in Salford* project were to:

- create an information sharing protocol across the Salford partner agencies that will enable data sharing and an integrated and holistic approach to ‘falls management.’
- develop a joined-up approach to falls management and integration of falls services within Salford.
- expand the role of staff of a Supporting People service provider to identify causes of and factors contributing to falls.
- prevent accidents and reduce the number of hospital admissions as the result of falls, by trialling the use of falls detectors and bed sensors.

Description

The pilot chose not to have a dedicated project worker. Instead one member of the partnership led each element of the work. The improvements to the management and integration of the falls services, including the expansion of the role of the Care on Call wardens, was co-ordinated by one member of staff. At a strategic level the work was driven by the Salford Falls Strategy and Implementation Steering Group.

6.1 JOINT WORKING EARLY STAGES

The partnership

The pilot developed against a backdrop of extensive joint commissioning and partnership working between the PCT and Local Authority. This tradition of co-operation was particularly well developed in relation to services for older people and forums existed through which partners could jointly plan service

development. At the strategic level partners worked together in the Older People's Partnership Board. This included the Directors of each of the major partners:

- Housing and Planning,
- Community and Social Services,
- Salford PCT,
- Age Concern and
- Service User representatives.

Operational matters were addressed through the Joint Commissioning Group and an Older Peoples Development Board. Membership comprised senior operational staff from the statutory agencies, a wide range of independent and voluntary sector organisations and representatives of older people. An Older People's Think Tank also met quarterly and was used as an opportunity for 'blue skies' thinking. Below these forums sat a number of sub-groups which dealt with specific service issues. The Salford Falls Strategy and Implementation Steering group oversaw all work related to the NSF falls standard and it was to this group that the pilot reported.

At an operational level the relationship between the pilot, which was based within the Housing Department, and the Supporting People funded Care on Call service was already well developed. This relationship was fundamental to the improvements the pilot wanted to make to the co-ordination of falls services.

The origins of the pilot

The Sure Footed in Salford bid was prepared by the Assistant Director for Community Housing Services with the support of a Systems and Information Officer based within the Housing Department. The pilot was regarded as an opportunity to reinforce the existing partnership by delivering tangible outcomes that were relevant to all partners.

At a strategic level all partners agreed that the aim of developing an overarching information-sharing protocol and an integrated IT system was the bedrock on which an integrated falls service could be built and critical to the future of joint planning between both organisations. One interviewee spoke of wanting to change the attitude of both the Local Authority and the PCT from that of '*data guardians*' to '*data sharers*', enabling partners to plan and develop falls services in a co-ordinated manner.

At the operational level, the project aimed to develop a joined-up approach to falls management and falls services and to improving local understanding of falls

prevention. The provision of specialist training to Care on Call wardens, for example, was seen as part of the process to improve access to falls services across organisational boundaries.

Governance

The governance arrangements for the pilot were initially regarded as relatively straight forward. The pilot reported to the Salford *Falls Strategy and Implementation Steering Group*. The steering group met monthly and reported both to the Older People's Development Board and the Supporting People Core Strategy Development group. It included representatives from Salford Housing Services and Community and Social Services Directorate, the PCT, the Salford Royal Hospitals Trust, Salford Community Leisure and Age Concern. The group acted as the clearing house for all falls work related to the implementation of the NSF for Older People and ensured that the different initiatives linked together.

However as work progressed the difficulty of separating the pilot from other aspects of the 'falls' agenda became apparent. To address this difficulty the steering group decided that the Sure Footed in Salford title should be adopted as the banner for all work taking place under the auspices of the Falls Strategy Development and Implementation Steering group. Whilst this decision signalled the integration of the pilot into mainstream work it did little to help the overall governance of the pilot. Indeed the complexity of the pilot, its relationship with other falls work and the number of partner agencies involved, made the governance arrangements more complicated than originally conceived. As one participant commented *'I don't necessarily understand the process of who agrees to what. It is like working through a soggy structure of committees which aren't clear, particularly who does what.'*

Getting started

The pilot was launched at a 'Falls Awareness Day' held 2 months after it began. The event was organised by the Falls Steering Group and was attended by representatives of all the major agencies and older people. It aimed to raise awareness about a range of different falls initiatives in Salford. In particular members of the Falls Steering Group wanted to introduce and discuss the Falls Service Directory (developed as one of the objectives of the pilot) with older people themselves who welcomed the efforts to co-ordinate services across boundaries. The event also helped to foster the integration of health care services with the pilot. For example, as a result of the launch health professionals contributed information about relevant services to the Falls Service Directory.

Management arrangements

The pilot had no dedicated worker consequently elements of work were led by different individuals. For example, the information technology work was initially the responsibility of the Systems and Information Officer based within the

Housing Department. The falls awareness training was led by the Falls Strategy Development and Implementation Manager who was employed by the PCT.

This pragmatic approach made management of the pilot difficult at times. At an operational level the responsibility for co-ordinating activities rested with a member of staff who balanced a number of different projects at one time. At least three changes in key staff exacerbated the inherent challenges in co-ordinating activities. For example, the technical work underpinning the development of the integrated information system stalled after the departure of the Systems and Information Officer.

Overall strategic co-ordination for the pilot was provided by the Steering Group. Although membership of this group was relatively stable several partners thought the sheer complexity of the pilot made strategic management difficult, particularly when key operational staff left. Additionally, developments in the wider policy context meant that partner agencies had to contend with changes outside of the pilot's control, leading one partner to comment *'there have been difficulties working across partnerships, so many things are hanging in different areas, it seems like you are trying to map on to shifting sands.'*

6.2 JOINT WORKING MAIN PHASE

The partnership

The pilot was the result of effective joint working at a strategic level. The idea for the pilot had arisen within a network of professionals who had previously worked together on a number of joint initiatives. They were frequently described as *'a core group of enthusiasts'*, committed to developing services for older people. However, as the evaluation progressed several interviewees suggested that the core partnership might have been strengthened had health professionals, with knowledge and experience of managing NHS data sets and IT system, been involved from the outset.

At an operational level the relationship between the different organisations participating in the pilot were strong. For example the manager of the Supporting People funded service, Care on Call, was a member of the Steering Group. Similarly the newly appointed Falls Strategy Development and Implementation Manager became a key member of the steering group ensuring that the operational work of the pilot was integrated with developments in the PCT.

These relationships were fundamental to the success of the pilot's work. For example the training sessions for Care on Call staff were organised by the Falls Strategy Development and Implementation Manager and provided by colleagues from the PCT and the Royal Hospital Trust. The sessions focused on improving their understanding of falls prevention and ensuring they were able to make fast

track referrals to the appropriate services. The training included sessions from an occupational therapist, a podiatrist and a clinical psychologist on subjects such as risk assessment in the home, fear of falling, and how to use the Falls Risk Assessment Tool. The pilot developed a protocol to ensure that all Care on Call staff recorded falls and were able to refer customers who had fallen to appropriate services. The same operational links were used as the basis of a small-scale trial of the use of falls detectors and bed sensors amongst a group of Care on Call customers who were known to fall frequently. All partners noted the success of this work, with one health colleague remarking it had *'raised consciousness to the potential of Care on Call services in the future,'* whilst another partner commented *'it is getting people to see how (Care on Call) wardens are well equipped to be trained and developed beyond their traditional role.'*

Finally to support the operational integration of falls services the pilot contributed to the development of a search facility within the Local Authority's Older Peoples service information directory, 'Ask Sid'. The directory included details of all falls services, contact information and referral routes. The directory was launched in August 2005 with the intention that nominated partners will regularly update entries. Feedback from those using the directory suggests that further work is required to ensure that the search facility is made more sensitive to 'falls services'.

Working with health colleagues

One of the most common difficulties associated with working across local authority and health boundaries has been securing the participation of senior medical staff. One of the strengths of the Salford pilot was the active involvement of a local Consultant Physician who had responsibility for the development of falls services within the Salford PCT. Her involvement ensured that the views of the PCT were represented in discussions about an integrated falls service. It also helped support the development of community-based services such as the falls clinic and raised awareness about the importance of housing to health. Another key health person was the Falls Strategy Development and Implementation Manager who was appointed by the PCT. This post was crucial in linking the pilot with the wider falls work within the PCT. The involvement of these different perspectives led one partner to comment that *'local initiatives on falls are much better informed and more measured.'*

However, several partners commented that the size of the PCT's agenda meant that health commissioners were too far removed from what was happening in many service areas. Several participants also suggested that the aims of the pilot might have been more realistic had NHS colleagues, with experience of NHS IT systems, been involved in developing the original proposal.

Communication and information sharing

Information sharing was central to this pilot. The Falls Steering Group became the main channel of formal communication between partner agencies. Minutes of meetings and relevant papers were circulated to all partners. If there were matters that needed to be addressed quickly partners did so by email and phone. Interviews revealed contradictory views on the effectiveness of this level of communication. Several interviewees felt out of touch with the pilot. One interviewee said she only felt fully informed about progress directly after a steering group meeting. Another argued that she didn't need to be kept fully informed of every detail and didn't have time to read all of the papers. These conflicting views probably reflect the difficulties associated with managing a complex pilot in which various elements of work involve different sets of people with only a small group of people requiring a detailed knowledge of all elements.

At the micro level the pilot was undermined by difficulties obtaining older people's NHS numbers. These difficulties reflected concerns about data protection. This information was fundamental to tracking people through the falls information system. As a result the pilot was forced to look for other ways to achieve its aims (see next section).

Developing the information sharing protocol

One of the main aims of *Sure Footed in Salford* was to develop the infrastructure needed to share information across organisational boundaries both at the strategic and operational levels. All partners were committed to this aim but by the mid point of the evaluation they began to recognise that establishing an integrated IT system was highly ambitious. Not only were there wider political discussions that impacted on the protocol but also there were very practical problems, for example incompatible IT systems. One partner observed that the aims of the original bid were unrealistic and '*naïve about computer networks.*' Indeed the aim was based on an understanding that a new piece of software would be introduced which would interrogate the different databases used by partners. However the software was not introduced.

The pilot decided to integrate the information sharing protocol with the implementation of the Single Assessment Process (SAP). The intention was to get the protocol for the Sure Footed project incorporated within the upper tier of an information-sharing agreement that would underpin the SAP. The detail of what information and how it would be shared would be discussed once agreement had been secured. However, these discussions were dominated by the health and social care agenda with little room for the involvement of housing related services. Although by March 2005 a draft SAP information sharing agreement had been circulated to partners for comment, it did not include sufficient falls services information to work effectively. Finally, the pilot resorted to drafting a 'falls information sharing protocol' which has been circulated to partners for agreement.

The pilot's experience demonstrates the need for realism when attempting to integrate data collection and analysis at both strategic and operational levels. As several partners commented, statutory agencies must share the basic aim of wanting to integrate information systems. Without an integrated IT system, such aims are unlikely to be achieved.

The involvement of people who use service

Salford City Council has an excellent history of ensuring that older people are involved in strategic discussions about the development of local services. For the purposes of this pilot, older people were represented on the Older Peoples Development Board to which the steering group reported. Older people also attended the Falls Awareness day that was used to launch the pilot and were involved in the equipment trials. Their involvement ensured that the work of the pilot addressed the concerns raised by older people.

Monitoring

The improvements made to the recording and tracking of falls information at an operational level were monitored by tracking the experiences of 100 Care on Call customers who fell during a 3 month period and used their alarm. Whilst these activity data are limited, they provide a framework through which partners can map how different services relate to each other and over time will enable them to plan service developments and improve the relationship between existing services.

Contextual issues

Although the pilot was established against a backdrop of extensive joint working it faced many contextual difficulties associated with joint working. For example, although joint commissioning structures existed, organisations worked to different regulatory and funding frameworks. This slowed down the process of joint working. Similarly, interviewees noted that statutory partners were at very different stages of development. For example, the PCT was only just beginning to refocus its work towards the provision of community based services and were still facing some professional resistance to such developments. Finally in common with other pilots interviewees thought that the busy policy context continued to impede some aspects of joint planning. As one interviewee said there are *'dilemmas between time frames and the mandatory nature of government incentives. Some performance indicators and priorities are contradictory.'*

6.3 JOINT WORKING MAINSTREAMING

Supporting People and PCT commissioners were kept informed of the pilot's progress through the Older People's Partnership Board. The Assistant Director

for Community Housing Services (who wrote the original bid and was a member of the Falls Steering Group) was a member of the board, thereby ensuring that the lessons learnt by the pilot were integrated in relevant discussions.

The pilot's work undoubtedly acted as a catalyst for strategic aims related to falls prevention. For example, the pilot identified the need to explore the contribution of new technology to promoting older people's independence. The pilot also provided a model of joint working which was influencing the broader approach to service integration.

Reflections

The *Sure Footed in Salford* pilot achieved many of its aims and objectives, particularly those designed to improve joint working at an operational level. However its efforts to improve co-ordination at a strategic level were less successful. Towards the end of the evaluation partners thought that the initial bid had been over ambitious and had underestimated the difficulties of co-ordinating activities across organisational boundaries. The pilot had provided an opportunity to strengthen the strategic partnership between housing, social care and health (the PCT and Hospital Trust) and despite the challenges faced all agencies remained committed to integrated working.

6.4 PROJECT ACHIEVEMENTS

Table 4 summarises the outcomes achieved by the pilot. These included improvements in outcomes for older people, as well as a range of processes to augment effective joint working, most notably the demonstration of the contribution Care on Call staff can play in falls prevention.

In order to monitor the improvements made to the recording and tracking of falls information at an operational level the pilot monitored the experiences of 100 Care on Call customers who fell during a 3 month period and used their alarm. Having been visited by a warden 27 older people attended a local A&E; the remainder were able to stay at home. Of the 27 who attended A&E 18 were admitted to hospital, the vast majority of whom were admitted to a Care of the Elderly ward. 11 older people were later referred to intermediate care services. In the 5 months since their falls 15 patients have re-presented at A&E on 48 occasions resulting in 29 subsequent admissions.

Innovations in practice

The *Sure Footed in Salford* pilot was based on an extensive history of joint working at both the strategic and operational levels which provided a firm basis on which to build. Over the course of the pilot these relationships continued to mature and will provide a platform for future partnership working.

At an operational level the pilot capitalised on the involvement of key PCT personnel to make the links between the PCT and Local Authority. The involvement of the Falls Strategy Development and Implementation Manager was instrumental to the success of the training sessions provided by PCT and Hospital Trust staff to Care on Call staff (the Supporting People funded service). At a strategic level the involvement of a local Consultant Physician with responsibility for the development of falls services within the PCT meant that the pilot was aware of developments within NHS falls services.

Unanticipated outcomes

Partners identified a number of unanticipated benefits arising from the pilot. The success of the falls awareness training event for Care on Call wardens had led the PCT and Royal Hospitals Trust to jointly fund the development of training packs and a DVD to disseminate the training more widely. The training was also thought to have illustrated the key role that Care on Call wardens could play in preventative services. The training was later rolled out to include Age Concern After-Care volunteers (who provide short term social and practical support to older people on their return home from hospital) and Area Sheltered Housing Wardens.

The pilot was also thought to have had a very positive influence on the trend towards developing health services within the community, the community falls clinic acting as a model for how services could be developed. Finally, the experiences of the pilot were also thought to have informed the development of the Older People's Housing Strategy and, specifically, the development of Telecare services and the implementation of the Assistive Technologies Grant.

Evaluation interviews with people involved with *Sure Footed in Salford*

Thirteen interviews took place during the evaluation, of which seven interviews were conducted during the first evaluation visit, three during the second, and three during the third. Three users participated in all evaluation visit interviews.

Four men (age range 74 to 95 years) and three women (age range 68 to 82 years) were interviewed. One respondent lived in his home with his family; three lived alone in council properties and three in warden controlled flats. They had all been referred to the Care-on-Call service either because there was no warden at their flats during the weekends or at night or because they had recently fallen or were at risk of falling. For those living in their own homes the service provided regular weekly visits. All had fixed fall alarms installed in their homes and older people who participated in all three interviews had been provided with portable fall alarms.

Interviewees were generally satisfied with the Care-on-Call wardens. The level of use of the service appeared to be a function of two factors: a) whether the user

was accessing additional practical and emotional support from members of his/her immediate family (one user described that her first port of call would be her family in case anything happened to her), and b) the appropriateness of the fall prevention devices provided. One user commented that the portable alarm that had been provided to him hadn't been used but the knowledge that it was in place provided reassurance and peace of mind. His wife, present during the third interview visit, said that the portable fall alarm provided extra assurance that, if he happened to fall, Care-on-Call would provide assistance, especially if she was out of the house.

Case study 1

Bill, aged 82, had severe sight and hearing loss and had been living in a one-bed warden controlled flat since his wife's death. Although suffering from regular blackouts that contributed to an increased frequency of falling he was keen to maintain his own independence. He had been provided with a 'panic button' that linked him to the Care-on-Call service during weekends when the warden was not working. Bill later moved from Salford.

Case study 2

Dorothy, 74, was interviewed on three occasions in her home. Over the course of these visits she described that she had been suffering from panic attacks and as a result had become increasingly house bound.

As Dorothy became more frail a number of adaptations and falls prevention devices were provided to enable her to stay at home. For example a bathing hoist had been fitted and a fixed alarm installed. She had also been provided with a portable alarm. Care-on-Call visited her weekly to check how she was doing and she also had regular visits from a district nurse and a psychologist.

During the interviews Dorothy commented that the position of the fixed alarm was unsuitable, she could not reach the cord if she fell whilst in her bedroom or bathroom because it was installed in a corner of her sitting room which was hard to reach due to the furniture layout. In addition, she thought the portable alarm wasn't a particularly attractive piece of equipment to wear around her neck and was awkward to wear at night. Despite these reservations she appreciated the usefulness of the portable alarm. At the last interview Dorothy reported that her panic attacks had been increasing in frequency and that she had used her alarm on several occasions.

Table 4: 'Sure Footed in Salford'

Aims	Objectives	Outcomes
<p>An information sharing protocol to be created across the Salford partner agencies that will enable data sharing and an integrated and holistic approach to 'falls management.'</p>	<p>Development of an information sharing protocol which has been agreed and signed by all relevant partner agencies.</p>	<p>The overarching information sharing protocol was not developed. However the pilot has drafted a falls information sharing protocol which is awaiting agreement with key partners.</p>
<p>A joined up approach to falls management and integration of falls services within Salford</p>	<p>Design, populate and test a Falls Service Directory.</p>	<p>The falls information has been integrated with the older peoples information directory 'AskSid' launched in 2005.</p>
	<p>Develop, approve and implement a Falls Strategy.</p>	<p>The Sure Footed in Salford – Salford's Strategy for Falls was updated in 2005.</p>
	<p>Establish an equipment project group.</p>	<p>The group was established and oversaw the small scale falls detector trial.</p>
	<p>Establish a Screening/Training working party.</p>	<p>The group was established and oversaw the training programme of the Care on Call wardens.</p>
<p>An expansion of the role of a Supporting People service provider's staff to identify causes and contributory factors, which may result in falls.</p>	<p>Train all Care on Call staff to assess and refer customers who have fallen or who are at risk of falling.</p>	<p>30 Care on Call wardens received training. The training was later rolled out to include Age Concern After care staff, Area Sheltered Housing Wardens and members of the integrated care teams.</p>
<p>Preventing accidents and reducing the number of admissions as the result of falls.</p>	<p>Trial the use of fall detectors and bed sensors.</p>	<p>26 people who had fallen in the previous 3 months were invited to take part in the trial of whom 12 clients accepted. Only 6 completed the trial none of whom have fallen during or since the trial. 5 returned the equipment having failed to get used to it and 1 older person entered residential care.</p>

CHAPTER 7

London Boroughs of Lambeth and Southwark

The London Boroughs of Lambeth and Southwark have the highest HIV prevalence rates in the country. Figures suggest that diagnosed HIV infections amongst residents of Lambeth, Southwark and Lewisham Primary Care Trusts account for almost one in five of all diagnosed HIV infections in London (South East London Sector 2003). This pilot was designed to set up a proactive and assertive outreach service to people living with HIV who are homeless or at risk of homelessness⁴ and have communication difficulties that necessitate the need for advocacy support.

The aims of the pilot were to:

- develop an outreach service with clear eligibility criteria and referral mechanisms.
- increase contact with hard to reach users as defined by the eligibility criteria.
- increase tenancy achievement and sustainment within the client group.
- increase registration with and use of primary care services.
- improve general health amongst the target group.
- increase knowledge and satisfaction with housing and support services.

Description

The London Boroughs of Lambeth and Southwark commissioned the Terrence Higgins Trust/Lighthouse to set up and provide the outreach service. Two workers were employed to work intensively with individual clients to set up a housing tenancy and provide on-going support to ensure that the tenancy was maintained. The outreach workers also made sure that clients were registered and engaged with the full range of local primary, secondary and specialist health care services and that they understood how these services should be accessed.

⁴ The pilot aimed to work with rough sleepers, people living in insecure accommodation or temporary accommodation awaiting a settled home and those living in a settled home but having difficulty maintaining their tenancy.

7.1 JOINT WORKING EARLY STAGES

Partnership

The pilot built on a long history of partnership working in South London in the field of HIV services. The Boroughs of Southwark and Lambeth had previously collaborated in the commissioning of HIV services. The South London Partnership brought together all the PCTs in south east London (with the exception of Bromley) with 12 London Boroughs (Bexley, Bromley, Croydon, Greenwich, Kingston, Lambeth, Lewisham, Merton, Richmond, Southwark, Sutton and Wandsworth) jointly to plan and commission HIV services.

The pilot is a partnership between the two Supporting People Administering Authorities and Lambeth PCT (which commissions voluntary sector services on behalf of Southwark and Lewisham PCTs). Together they commissioned the Terrence Higgins Trust/Lighthouse to develop the outreach service.

Whilst Terrence Higgins Trust/Lighthouse had no experience of providing a floating tenancy support service they had an established record of providing a range of services to people living with HIV including advice, counselling and buddy services. Consequently they had a wealth of experience of working with acute health care providers, which the pilot was able to capitalise on.

Origins of the pilot

The pilot was built on a shared understanding about the HIV population within both boroughs. They were aware that homeless people living with HIV were often falling through the net of established services and, as a result, were not engaging with health care services. Consequently there was shared recognition of the need for a dedicated service, which would support homeless people to secure and maintain a tenancy and engage with health-related services as a means of living independently in the community. As one health partner commented, all partners were *'committed to providing a service for the client group that cuts through the inter-agency bureaucracy and rivalry.'*

The aims and objectives for the pilot were developed in such a way that they complemented those of each partner agency. The overarching aims of the Supporting People authorities to reduce homelessness and support vulnerable groups to live independently complemented the PCT's aim of improving access to specialist health services amongst marginalized groups. The pilot also supported the work of the specialist housing officers based within the housing departments of each authority.

The pilot served two further purposes: first, both Supporting People authorities were planning to review their existing support services for people with HIV which were largely accommodation based. The pilot provided an opportunity to 'test out' alternative forms of housing related support. Second, it offered the

prospect of learning more about the process of joint commissioning across two Supporting People authorities. This was of particular importance in light of the burgeoning sub-regional agenda that may require administering authorities to pursue joint commissioning.

Governance

The governance arrangements for the pilot were effective. Progress was reported to the appropriate Supporting People forums in both authorities as well as to the South London HIV Partnership Commissioning group. The pilot was also accountable within Terrence Higgins Trust/Lighthouse to the operations manager for South London.

A steering group was established and became the main forum through which the partners could advise and support the new service. Membership included representatives from both Supporting People teams, the HIV/AIDS commissioner for Lambeth, Lewisham and Southwark PCT, specialist housing support workers, specialist health service workers and the pilot team. Meetings were held quarterly at which progress reports were presented giving activity information, referral data, and user feedback. Although membership of the group was restricted to the key partners, minutes of the meeting were circulated to associated agencies to keep them informed of developments.

The steering group was the link between the strategic and operational levels and was used as a planning group as well as a problem solving forum. For example, difficulties experienced by the pilot with staff at one of the homeless persons' units were resolved through discussion within this group. Several members of the group commented that the relationship between partners did not profess to be one of equals. It was clear that the Supporting People officers were the commissioners and that Terrence Higgins Trust were the contracted providers of the service. Nevertheless all interviewees thought that members of the group provided effective support.

Getting started

The Supporting People officers and PCT HIV/AIDS commissioner developed the eligibility criteria for the pilot before awarding the contract. The criteria for prioritising access to the service were:

- people diagnosed with HIV who are homeless or at risk of homelessness;
- who are experiencing multiple problems (drugs, mental health);
- have no current or very poor access to appropriate health services;
- have communication difficulties that necessitate advocacy/facilitation; and

- have no access to other types of support and are legally entitled to receive relevant statutory services.

Before the support workers were in post the Terrence Higgins Trust developed a service manual containing all of the policies and procedures that would underpin the new service, including referral mechanisms, an initial assessment form and support plan and a client complaints policy and procedure. Where possible existing policies were used, including the confidentiality policy and those covering 'risk assessment' and 'staff safety'. As a result of this ground work the new service was able to accept referrals almost as soon as the support workers were in post. At a later date several policies, including the staff safety policy, were reviewed in the light of the pilot's experience. From the outset the commissioners decided that the service must conform to the Supporting People quality assessment framework and like other providers the pilot was reviewed to ensure that the framework was in place.

The support workers visited potential referral agencies to raise awareness about the service. These included the HIV community nursing service, the HIV mental health service, drug projects, voluntary organisations and homelessness projects.

Two other factors were widely acknowledged to have had a major impact on the speed at which the new service was established. First, the Supporting People lead officer for the London Borough of Southwark acted as a champion or advocate for the new service. His previous work experience in the HIV sector, knowledge of key agencies and enthusiasm for working in partnership were crucial to the pilot's success. Secondly, the decision to commission Terrence Higgins Trust/Lighthouse meant that the new service could build on their existing networks and associated services and benefit from the positive reputation it already enjoyed amongst professionals and – most importantly – service users.

The early days of any new service are often critical to how it is perceived by front line workers, and early success is a key means of building momentum. In the early stages one of the specialist housing officers commented '*in the 2 cases that they have worked with our clients they have achieved results that no one has achieved before.*' As a result of these and other cases, the pilot demonstrated its benefit to partners.

Management arrangements

The managerial arrangements for the pilot were quite straightforward. Overall managerial responsibility for the pilot rested with the Information and Advice Manager for Lighthouse South London. He wrote the service manual and line managed the housing support supervisor who, in turn, managed the day-to-day work of the support worker. The team had regular informal meetings, sometimes on a daily basis depending on the nature of the work they were

covering. Nonetheless partners recognised that the pilot required more managerial input than was originally anticipated.

Professional supervision was provided to both workers to ensure that their professional practice met the expectations of Terrence Higgins Trust/Lighthouse. These monthly sessions usually lasted for over an hour and gave the workers an opportunity to deal with the demanding nature of their work. Both project workers valued these sessions, as one said *'you need a channel to off-load. A couple of our clients have tried to commit suicide so it is good to have supervision.'*

The pilot workers brought complementary work experience to the new service. The housing support manager had previously worked in a Supporting People service whilst the support worker had worked with people with HIV. Over the course of the pilot both attended additional training courses on a wide range of subjects such as a non-clinical approach to HIV, protection from abuse and housing benefit training.

Managing workload

The major challenge facing the pilot was their capacity to cope with the level of demand for the new service. There were 2 aspects to this challenge. The first was whether or not the pilot could physically deal with the high level of referrals being made, particularly for people with very complex needs requiring more intensive support than was originally anticipated. Eventually in the second year the pilot decided temporarily to close its books to new referrals, leading several partners to question whether the pilot needed to reconsider the nature of the support provided in order to cope with the demand for the service if it were mainstreamed.

Some PCT community nurses were frustrated by the strict limit placed on the number of service users the pilot could support. Although the support workers visited them to raise awareness about the service, these visits occurred after the service was launched. By this time the pilot had already received a considerable number of referrals and community teams had clients who met the eligibility criteria who were unable to receive support from the pilot. Despite this frustration they welcomed the service and recognised the value of the work they were doing.

The second aspect of the challenge was how the pilot would provide cover when one or other of the two front line workers went on leave. As one partner asked *'if things go wrong in a small team what message is given if someone isn't there for them at a crucial time?'* Consequently the team decided that they would do joint initial visits so that both workers knew each others' clients and were able to cover should the need arise. Additionally the project manager was involved in front line work and could cover a case if necessary. Again this was

seen as an interim measure and a more sustainable solution would have to be found if the project were mainstreamed.

7.2 JOINT WORKING MAIN PHASE

Revising aims and objectives

Despite the aims and objectives being designed to complement those of partner agencies it soon became apparent that the pilot potentially duplicated a new service set up by the PCT to improve access to health services amongst the African population living in South London. Several interviewees suggested that had health partners been more actively involved in developing the eligibility criteria this overlap would have been avoided. To prevent duplication it was decided that the pilot would concentrate specifically on meeting the needs of people living with HIV who were homeless and hard to reach or those at risk of homelessness.

The partnership

The pilot was based on strong and effective joint working relationships at both strategic and operational levels with excellent communication and support between both. Undoubtedly the pilot benefited from the history of joint working within HIV services. This approach was regarded as an effective way of addressing a complex problem. However most interviewees commented that it was the active involvement of the Supporting People lead officer and the PCT representative which had been crucial to the effectiveness of this approach at the strategic level.

At an operational level partners described how the support workers worked intensively with service users as a means to understand their needs. They would then become the 'crucial link' between their clients and the specific agencies they wished to access. For example the support workers would set up appointments with specialist healthcare services and accompany clients to them. Given the chaotic life style of many of those using the pilot this approach was seen to be appropriate and effective. When describing their approach to joint working, one of the workers emphasised the importance of *'keeping people involved, aware of what we are doing and agreeing responsibilities so that we don't duplicate our work.'*

Working with other agencies

At an operational level the outreach workers attended the South London HIV Providers forum. This forum provided an opportunity to network with other agencies, ensure that referral processes were understood, and develop new contacts. Over the course of the two years the pilot began to work with a range of new agencies. These included statutory services such as specialist health services, a detox unit, social services, Connexions, Brixton prison, CASCAID

(a specialist Mental Health HIV team), and a range of non-statutory and charitable organisations such as Positively Women and Crusaid.

In common with others the pilot found that it was important to understand the different priorities and commitments that other agencies were working towards. For example the pilot found it difficult to engage the interest of local social services departments. They thought that this was because departments were focused on developments within children's services and had little capacity to engage with other agendas.

The support workers also identified a number of difficulties with housing services. Generalist staff in homeless units did not recognise the housing and community care needs of this group, even though 7 of the people the pilot was supporting were rough sleepers and had complex health problems. There was also a lack of appreciation and sensitivity towards service users from allied housing services such as building maintenance. Finally partners noted that it took a long time for service users to be allocated accommodation. This meant that the pilot often had to support clients for a longer period which meant that fewer people could access the service.

Relationships between statutory and voluntary services

Within HIV services there is a well established history and ethos of joint working between the statutory and non-statutory sectors and the decision to commission Terrence Higgins Trust/Lighthouse to provide the service was widely regarded as an important factor in determining the success of the pilot.

The reputation of the Terrence Higgins Trust and their established links within the statutory sector, particularly clinical health services, was deemed an important factor in the service's effectiveness. They were also in contact with a wide range of voluntary organisations to which they could refer people, for example community transport services and the Food Chain⁵. These wider contacts were acknowledged as important factors in enabling service users to live independently.

Despite the tradition of cross sector working within HIV services some tensions between agencies were reported. These were most notable amongst staff working in one of the homeless persons units where there had been initial reluctance to identify a link worker between the pilot and the unit. This reluctance appeared to be based on a perception that voluntary sector organisations were not as 'professional' as statutory services. For example, one of the outreach workers commented that some '*statutory services see us as do-gooders, they don't see us as a professional service or as an equal.*' These professional rivalries also surfaced in relation to a specific client that the

⁵ The Food Chain is a registered charity that delivers specially prepared meals to people living with HIV and AIDS in Greater London.

homeless persons unit had previously tried and failed to re-house. These rivalries were not reported amongst the specialist housing support workers who viewed the pilot as an ally and support to their own work.

Communication and sharing information

Communication was a strong feature of the pilot. Detailed progress reports were presented at the steering group meetings, which were the main forum for communication. If it was necessary to discuss any difficulties between meetings partners communicated by email or phone. As one partner reported

‘communication is key, you have to inform people to make sure they have ownership and feel committed to the pilot. Keeping people on track with aims and objectives.’

The success of this pilot depended on agencies being willing to share sensitive information in a timely fashion. The pilot used a ‘letter of authority/client consent’ form that was already in use by the Terrence Higgins Trust. Each client was asked to sign the form. This allowed the pilot to act on the client’s behalf and gave consent for any relevant information to be passed to them as well as allowing them to pass on any information to general support services. The latter included: welfare benefits, housing, employment and health. This process appears to have worked well with no major difficulties being reported.

People who use services

Although the pilot was committed to involving service users in the development of the service the complex and often chaotic nature of their lives made it unrealistic to involve them in the formal management of the pilot. A user group was established that met every quarter and gave users an opportunity to discuss their experiences of the service and make suggestions about how it could be developed. This group was well attended possibly because it was felt to be accessible. The pilot also used satisfaction surveys as a means of obtaining feedback on the service from a wider group of service users.

Monitoring including service user interviews

Monitoring all aspects of the service was a strong feature of this pilot. From the outset the Supporting People lead officer for the administering authority ensured that the operational procedures, including monitoring requirements complied with existing quality assessment frameworks. Indeed the contract specified basic Supporting People Performance Indicators, which the pilot was required to monitor. On this basis the pilot was able to present detailed activity and outcome reports to the steering group.

7.3 JOINT WORKING MAINSTREAMING

The Supporting People lead officer of the London Borough of Southwark, Lambeth's Supporting People strategy manager and the PCT commissioner for HIV/AIDS were members of the steering group and were therefore involved in the discussions about the future development of the service.

After 16 months the Supporting People officers were of the opinion that the outreach service should continue. Funding has initially been agreed to support the service until March 2007 with an additional contribution towards overheads from the London Borough of Southwark. A review of the existing accommodation-based services is currently taking place and the lead officers anticipate that they will re-tender all HIV housing support services in early 2007 as a cross authority floating support service. The PCT representative also thought that the lessons from the pilot would inform the review of all HIV services funded by the South London Partnership prior to services being re-tendered in 2006/07.

Lessons for commissioners

At an early stage the commissioners of the pilot were able to identify a number of potential lessons for the wider joint commissioning and procurement process. For example the initial joint process of commissioning the service had taken longer than anticipated. This led the lead officers to consider how they might apportion administrative costs and how they would manage performance issues in a consistent manner across authorities. The experience also raised questions about how the detail of the commissioning process should be handled. For example should the two boroughs issue concurrent contracts or a sole contract with a service level agreement between the boroughs?

The pilot also highlighted the potential tension between the importance of sub-regional commissioning within local authorities and the move to local commissioning within health care. For example whilst Supporting People Administering Authorities are beginning to consider how to commission services regionally, health service commissioners are being urged to commission on a 'practice' basis.

The review of the outreach service conducted by one of the Supporting People teams allowed the team to compare the work of the pilot to that of the existing providers. The review revealed that the existing accommodation based support service for people with HIV was successfully meeting the needs of a relatively stable and healthy population but was relatively unsuccessful at engaging with this challenging population. The pilot therefore offered a bench mark against which they could, in the future, commission HIV services. Finally the outreach model was one that they were developing to use with other client groups. For example the London Borough of Southwark was investigating the development of an outreach service for people with dementia, travellers and people with Dual Diagnosis.

7.4 PROJECT ACHIEVEMENTS

Table 5 summarises the outcomes achieved by the pilot. These included improvements in outcomes for people using the service, as well as a range of processes for effective joint working.

The pilot was funded for 2 years however, due to a delay in the commissioning process and the subsequent recruitment of staff, the service was launched 6 months later than anticipated. The outcomes therefore reflect what was achieved after 15 months.

Over the course of 15 months 56 referrals were received of which 27 met the eligibility criteria. 16 of these referrals were for men, 11 for women. Ages ranged from 23 to 51 years. At referral 7 were rough sleepers, 1 was in hospital, 1 in prison, 2 were staying with friends, 2 in hostels, 1 in supported housing and 3 were in temporary accommodation awaiting assessment from the Homeless Persons Unit. 10 were in local authority or housing association accommodation.

15 people received tenancy support of which 12 were helped to access temporary accommodation (of whom 4 have since been supported into a permanent tenancy). All tenancies were maintained. 42 successful charity applications for clothes and household items were made and 6 Disability Living Allowance grants were awarded. 18 people registered with a GP and 13 have registered with an HIV clinic and have commenced antiretroviral therapy. Improvements in CD4 (a receptor for HIV) counts were reported for 5 service users. 4 service users were assisted with HIV adherence support and 7 service users were supported through their hospital discharge.

Innovations in practice

The Terrence Higgins Trust was commissioned to provide the new out-reach service. As a result of delays in the commissioning process the Trust had to use their existing policies and procedures rather than develop them in collaboration with partners. However as part of the monitoring process the pilot reviewed the effectiveness of these policies and adapted them in the light of experience.

The support workers developed a flexible and intensive style of working with service users. They focused on what individuals thought they needed to address in order to live independently and would often accompany them when attending health care services for the first time. This style of working appears to have helped people engage, and maintain engagement, with services.

The pilot also demonstrated the importance of establishing effective monitoring processes to capture evidence of the outcomes of joint working. The detail of the monitoring data was specified in the contract, consequently there was no ambiguity about the measures against which the effectiveness of the service was measured. This information also proved essential to the discussions about how to mainstream the new service.

Evaluation Interviews with people using the HIV outreach service

Thirteen interviews took place with eight men (age range 25 to 43 years) and one woman (36 years old) using this service. Over the course of the evaluation two people were interviewed during the first evaluation visit, five during the second, and six during the final visit.

As the period of individual support ranged between six to nine months it was not possible to follow the same people throughout. Two respondents who participated in the first round also participated in the second. Two others who attended the second round participated in the third.

All were unemployed and/or in receipt of state benefits. At the point of acceptance into the service: 1 interviewee was rough sleeping; 2 were staying temporarily with friends and had no alternative accommodation, 4 were in homeless hostels and 2 were living in their own flats but were finding it difficult to manage their environment. At the time of the interviews all respondents were living either in temporary accommodation waiting to be allocated their flats, or were already in their own one- or two-bedroom council flats. The range of medical services service users were accessing varied and was based on their individual circumstances.

The level of satisfaction amongst all respondents was extremely high. They commented on the suitability of the support they were receiving, arguing that it was not oppressive and prescriptive, but acknowledged their individual needs and circumstances. All said that their relationship with their worker was very good and allowed them to discuss and address issues relating to their personal care. For example one respondent said *'I have taken life more seriously now, she accompanies me to the alcohol centre and checks how I am doing'*. Another said about the health care he was receiving *'I have had support for my epileptic fits, but this support is much better; they support me to live with HIV'*.

Respondents also said that their quality of life had improved as a result of receiving support from the pilot. 5 of the interviewees described how at the time of joining the pilot they had spent a significant amount of their life being homeless, sleeping rough and/or sharing accommodation with others in very confined spaces. Their workers helped them to apply for housing and get housed. All described how their workers were actively helping them deal with housing issues; helping one respondent to deal with necessary house repairs and distressing rent arrears, and supporting others to apply for Social Security grants with which to furnish their flats.

Project workers also helped them access necessary medical services (HIV clinic, dental and GP services) which, at the time of the interview, they were regularly attending. At the time of joining the project one interviewee said that all medical services were in place but his engagement with these services was poor. Having had the opportunity to discuss his concerns with his worker, it was decided that it would be beneficial if he was accompanied to his medical appointments. He

described how subsequently his doctor's attitude towards him had changed, that his doctor spent more time with him and that he found him more informative. He said that *'things have been explained to me; I am not stressed out during my appointments'* and *'their presence (pilot workers) makes me feel more comfortable, three months ago I was rock bottom'*. With the support of his worker, this service user said that he felt strong enough to start thinking about addressing his alcohol misuse problem.

Respondents also commented positively on the fact that although they were still trying to deal with issues relating to their medical condition, especially their HIV status, their health was not deteriorating any further. As one said *'My health would be a lot worse if I hadn't been involved with the project'*. More than half of the interviewees expressed aspirations of further training, education and/or employment once their weak physical condition, due to either advanced stage of HIV infection and/or adverse reaction to the antiretroviral medication they were receiving, improved.

Case study 1

Lloyd, 38, had been homeless and a long-term drug user when he joined the pilot three months prior to his first interview. When interviewed he had been living in his one-bed council flat for a couple of weeks, obtained with help from the pilot. He said that his project worker *'has done everything for me; I don't know where I would be without her'*. She had helped him register with a GP, got him in contact with the Benefits Agency, and most importantly, facilitated access to HIV medical services; at the time he had started antiretroviral medication. *'Three months ago I was rock bottom'* he noted, and added *'I would be a lot worse if I hadn't been involved'*.

At the second round of interviews six months later Lloyd was still living in his flat and was in regular contact with health services including the local drug team and had recently enrolled on a methadone programme. On reflection, he was extremely satisfied with the work of the pilot and his health had significantly improved.

Case study 2

Ryan, 43, suffered from depression and social phobia. He found out about the pilot through a friend and referred himself. When first interviewed he had been receiving support for a period of nine months. He described his worker as instrumental in addressing a range of practical and medical issues. *'When I was first referred, I had not washed for a long time'* he noted. He described how the pilot had supported him to register with a GP, and he had also been referred to a dietician, a dentist, a psychologist, a physiotherapy (for his leg and hip), and has had his eyes tested.

Southwark building services had been contacted by the project workers to make the necessary repairs and adaptations to his flat, and he had also been provided with taxi vouchers as a means to encourage him to get out and about. Ryan was also receiving support from a 'buddy' (through THT), had food delivered to his home by the charity, Food Chain. Most importantly he had made contact with his HIV clinic, having in the past failed to attend appointments. He described how *'someone is keeping me on track with my appointments'* and as a result he had started regularly taking his HIV medication.

Table 5: 'London Boroughs of Lambeth and Southwark pilot'

Aims	Objectives	Outcomes
<p>The development of eligibility criteria and referral mechanisms for the service.</p>	<p>Develop referral process and make known to other agencies.</p> <p>Monitor referrals to ensure they remain appropriate.</p>	<p>The criteria were developed prior to the contract being awarded. The pilot developed the referral processes and made these known to 80+ agencies.</p> <p>56 referrals were received: 27 were accepted; 4 were given advice only or referred to another service, 5 didn't attend initial assessment, 3 were ineligible, 3 didn't consent or inappropriate referral information was submitted, 14 were either placed on a waiting list or the service will make contact with them again once they are in a position to accept new referrals.</p>
<p>Increased contact with hard to reach users as defined by the eligibility criteria.</p>	<p>Develop a database on which to track client progress.</p> <p>40 clients supported intensively over the life time of the project – year 1 = 20 clients, year 2 = 20 clients.</p>	<p>The database and monitoring processes were developed and reviewed by the Supporting People team. An outcome report was submitted with each evaluation report.</p> <p>27 service users supported within the first 15 months. 4 cases have closed because needs have been met, 2 service users died.</p>
<p>Increase in appropriate tenancy achievement and sustainment, of the client group.</p>	<p>Record the number of clients for whom tenancy has been arranged. Track this information over 3 monthly intervals.</p>	<p>15 clients received tenancy support. Of these: 12 accepted temporary accommodation of whom 4 are now in permanent homes, 1 client is in temporary accommodation because his home is in major disrepair, 1 client returned home after a short prison sentence, 1 client has moved to Brighton.</p>
<p>Increased registration with and use of primary care services.</p>	<p>Record whether or not tenancy has been sustained at 3 monthly intervals and the reason for tenancy failure.</p>	<p>All tenancies have been maintained. Support with sustainment includes 6 supported to pay off rent arrears and payment plans negotiated to pay off rent arrears for 3 clients.</p>
<p>Improvements in general health.</p>	<p>Record the number of clients registered with appropriate primary care services.</p> <p>Record whether or not clients are maintaining contact, attending appointments at 3 monthly intervals and reason for non-take-up or cessation.</p>	<p>18 clients have been registered with a GP, 13 with HIV treatment centre, 4 with a dentist, 5 re-engaged with HIV clinic. All service users now registered with a GP.</p> <p>18 of current users are maintaining engagement. At the start of the service 58% described their health as poor – none as good. Following support 30% described their health as poor – 50% as good.</p>
		<p>After 6 months of using the service, service users are asked if their general</p>

<p>health has improved since using the service, 80% said yes.</p> <p>Tracking results from service users engaging with HIV clinics has shown a fall in viral load for 5 service users.</p>	<p>Measure ill-health episodes and how they are managed.</p>	<p>Episodes include: 1 client admitted for palliative care, 1 client admitted due to a blood clot, 1 client sectioned, 1 client admitted whilst awaiting psychiatric treatment, 6 admitted to Mildmay for respite/adherence care. 8 service users supported through hospital discharge. 2 service users have died. 5 service users have been referred to respite outside of London.</p>
<p>Increased knowledge and satisfaction with housing and support services.</p>	<p>Carry out before and after questionnaire testing whether knowledge of services and pathways has improved.</p>	<p>At the start of the service 63% said they were not at all knowledgeable about housing and support service and 4% said they had a good understanding. Following a review 10% said they were not knowledgeable and 50% said they had good knowledge. After 6 months 100% of users said their knowledge of housing and support had improved since using the service.</p>
<p>Carry out before and after questionnaire testing whether satisfaction with services improves.</p>	<p>Carry out before and after questionnaire testing whether satisfaction with services improves.</p>	<p>At the start of the service 88% said they were not at all satisfied with housing and support service and 4% said they were very satisfied. Following a review 10% said they were not satisfied and 70% said they were very satisfied. After 6 months 90% of users said that their satisfaction with housing and support had improved since using the service.</p>

CHAPTER 8

North Lincolnshire

The SPIDERS⁶ project was developed to ensure that the Supporting People policy framework was integrated in the planning and commissioning of services in the health sector in North Lincolnshire. Whilst a commitment to joint planning and commissioning already existed at a strategic level amongst a core group of professionals from both the local authority and the PCT, knowledge about the Supporting People framework had yet to be cascaded down to operational staff.

The aims and objectives of the pilot were to:

- raise awareness of the local Supporting People programme and its linkages with the health agenda.
- encourage and extol a longer term approach to investment in support and care.

After 8 months a third aim was added:

- to demonstrate how a Supporting People service can directly support health objectives.

Description

The pilot decided to concentrate its work on demonstrating the contribution that Supporting People could make to services for older people. Initially the pilot had wanted to employ or second a project worker. However, having failed to make this appointment the pilot decided to commission the Community Investment Team (CIT) from within the Local Authority to carry out the 'developmental' aims of the pilot.

The Supporting People lead officer and the manager of the Community Investment Team spent several months meeting with health colleagues to map which meetings and decision making forums they needed to involve in pursuing the aims of the pilot. The Community Investment Team also began working with health colleagues to identify information sources as a means to establish a baseline from which to monitor the impact of Supporting People services. A community organisation was commissioned to produce case studies of the impact Supporting People services could have on hospital admission and discharge rates.

⁶ Supporting People Initiative to Develop and Enable Rehabilitative Support

8.1 JOINT WORKING EARLY STAGES

Origins of the pilot

The idea for the pilot originated from discussions between the Supporting People lead officer and a senior health colleague who represented the North Lincolnshire PCT on the Supporting People Commissioning Body. They had come to the view that the significance of the Supporting People policy was not being realised within the health community. Together they wrote the proposal with the aim of educating health partners at a strategic and operational level about the impact Supporting People could have on the health agenda.

Although the bid was written jointly by representatives of the local authority and the PCT several interviewees suggested that greater efforts should have been made to involve a wider group of health professionals. Because the bid was written from the perspective of Supporting People enthusiasts, they thought it had underestimated barriers within the health system. Consequently the aims and objectives were perceived as ‘unrealistic’. In addition, had the original bid been discussed more widely with health colleagues there might have been a greater degree of ownership from the outset. However, there was recognition amongst partners that the bidding time frame had made extensive consultation difficult.

Despite these reservations all partners acknowledged that the decision to focus the pilot’s work on older people’s services had provided a measure of clarity. However, whilst there was recognition amongst health partners of the need to move towards a preventative agenda and an understanding that the Supporting People agenda might help them do that, several partners suggested that the aims and objectives of the pilot were ‘a bit vague’ and ‘woolly’, perceptions that echoed the problems that the pilot was set up to address. Indeed whilst partners said they were committed to the aims of the pilot they were not sure what their involvement entailed. As one partner said *‘there is a lot of good will, the right people are on board but now what are the team going to do, that is not clear’*.

The experience of the pilot underlines the importance of ensuring that the aims and objectives of any joint initiative are developed to meet the core interests of all partners. If they are unclear or tangential to core business there is always the strong possibility that busy professionals will prioritise other activities. When the pilot’s progress was reviewed at a later date, and a decision taken to adopt the additional aim of developing a specific service, the pilot found it easier to stimulate support amongst health colleagues (see later section).

The partnership history

All interviewees agreed that there was a well-developed history of strategic joint working between the local authority and health services in North Lincolnshire. This was attributed to co-terminous boundaries between the local authority and

PCT. Interviewees also thought that the size of the authority had a positive impact on joint working. Because the local authority and PCT were two of the largest and most stable employers in the county, staff remained in post for a long period. Consequently there were strong professional relationships between senior staff.

However the relationship between the PCT and local authority was thought to be weaker at the operational level. Although there were examples of integrated services including intermediate care, community equipment and discharge and bed management there was no integrated services board for older people.

Several partners expressed a fear that the pilot ran the risk of developing a tick box approach to joint working in which staff regarded discussion about the pilot to be evidence of joint working. They suggested that without the commitment of service level managers to the aims of the pilot, there would be little improvement.

Governance

Governance arrangements for the pilot were deemed clear and had initially worked effectively. The pilot reported to the Housing Sub Group of the Older People's National Service Framework Local Implementation Team (LIT). This arrangement ensured that the pilot's work was integrated with wider initiatives. The Supporting People lead officer also reported progress to the Core Strategy Group and the Commissioning Body.

A small steering group was established to support the pilot. Initially this included the Supporting People lead officer, the PCT commissioning representative and the Community Investment Team. Having decided to focus the pilot's work on services for older people the group was expanded to include the Local Authority's Assistant head of Adult Services and the National Service Framework Modernisation Officer for Older People, a joint appointment between the council and PCT. The group initially met regularly and reported formally, every month, to the Housing Sub Group. However as the work of the pilot appeared to stall these meetings became less frequent and as one partner described '*it all started slipping really early on.*'

Later, following a decision to refocus the pilot and jointly commission a health related service the membership of the steering group was further widened to include the discharge manager from Scunthorpe General Hospital and a manager from Adult Care Services within the local authority. The group met regularly to develop the service specification and tender documents and were involved in the selection of the provider. The willingness of both managers to be involved was regarded as evidence that the new focus had captured the interest of operational managers including health colleagues.

Over the course of the evaluation interviewees noted that the focus of the Housing Sub Group had become unclear and that the group met less frequently. Consequently several interviewees thought that the governance arrangements for the pilot had weakened noticeably, adding to the sense of inertia that surrounded the pilot during the mid phase.

Getting started

The pilot chose not to have a formal launch and instead the Supporting People lead officer attended key meetings to inform people that funding had been awarded. These meetings were used as an opportunity to begin the process of raising awareness about Supporting People.

From the outset, the original Supporting People lead officer and the PCT representative were regarded as the champions for the pilot. They had a shared vision about Supporting People and determination that they would ‘educate’ people about its potential benefits to the health agenda. Although interviewees recognised the value of such champions there was a view that the pilot needed the explicit backing of more senior figures. There was also a sense that no amount of talking about the potential value of Supporting People services was going to capture wider interest from within health services because the work of the pilot felt intangible to PCT colleagues.

Management arrangements

The start of the pilot was delayed because the original plan to employ or second a project worker was unsuccessful. Having commissioned the internal Community Investment Team to undertake the work the lead officer met the team manager to discuss the progress of the work on a fortnightly basis. Whilst this arrangement seemed pragmatic there was a view that these meetings needed to involve some of the core partners to clarify progress, offer support and ensure that the pilot was more *‘tightly managed.’*

8.2 JOINT WORKING MAIN PHASE

Revising the aims and objectives

After 8 months the original Supporting People lead officer and the CIT manager moved jobs within the local authority. Their departure prompted the remaining partners and the new lead officer to review the pilot’s progress. Together they concluded that without any tangible outcomes the pilot was unlikely to generate any further interest in Supporting People amongst health colleagues.

In consultation with the ODPM, now DCLG, the pilot decided that the remaining funds should be used to jointly commission a service that was directly in tune with the PCT’s and local authority’s commissioning priorities. It was decided

that the pilot would jointly commission a Home from Hospital service to demonstrate the impact that a Supporting People service could have on a health priority. The Home from Hospital service not only met the PCT's and local authority's aim of promoting independence, it also contributed to the Acute Trust's aims of supporting safer hospital discharges and reducing delayed transfers and inappropriate hospital readmissions. The decision helped achieve the Supporting People team's aim of managing the market and developing new providers. The decision appears to have marked a watershed in the pilot's fortunes. As one interviewee commented '*this ticks everyone's boxes*' whilst another described the new aim as a '*win win all the way round*'.

The partnership

Whilst the relationship between the core members of the pilot appeared to be strong, the pilot was initially unsuccessful in involving other senior health professionals. Indeed the first phase of the pilot was characterised by a lack of sustained engagement amongst health professionals at both strategic and operational levels. This reflected the lack of clarity about the pilot's aims and objectives. It was also thought to reflect the structural difficulties that the pilot was attempting to overcome.

The decision to refocus the pilot towards service commissioning was met with increased interest and a willingness amongst partners to become more centrally involved. Significantly, involvement was not restricted to strategic PCT colleagues. Having decided to commission a Home from Hospital service the pilot succeeded in involving the Acute Trust's discharge manager who immediately understood the practical relevance the service would have on key performance targets. The involvement of the Acute Trust was regarded as '*a breath of fresh air*' and evidence that the pilot could foster an operational model of joint working.

Communication and information sharing

The varying effectiveness of communication within the pilot reflected the stages of the pilot's development. In the initial stages communication within the core partnership was effective, with core partners meeting regularly to discuss progress. The positive working relationship that developed was regularly identified as a major strength of this pilot.

However during this phase communication amongst the wider partnership was less successful. Although the pilot presented a written report to the Housing Sub Committee there was a sense that this alone was not sufficient. As the momentum behind the pilot waned and steering group meetings became less frequent communication between partners focused on the process of joint working rather than the outcome of the pilot's work. An interviewee commented '*we talk a lot about joint working but we don't have the outcomes*'.

for service users. We need to demonstrate whether or not we are any good at it.'

Not surprisingly the nature of communication between partners changed when the pilot turned its attention to commissioning a service. Not only did steering group meetings become more frequent but the nature of discussions focused on the practicality of service delivery. If partners were unable to attend meetings they were kept informed of developments through a 'virtual' group run through email. During this stage communication appears to have been more effective and all partners commented that they felt fully informed of progress.

One of the initial objectives of the pilot was to develop case studies to illustrate the relationship between Supporting People services and health outcomes. The pilot hoped to use local health data as the basis of these case studies. Initial discussions with health colleagues proved unproductive. Health colleagues were reported to be concerned that the small area data that the pilot wished to use might compromise the anonymity of individual patients. In part this reluctance might reflect a failure either to explain the aims of the pilot or a failure to understand them. However it also demonstrates the fears that many agencies have about sharing data, particularly the implications for data protection. Clearly this has implications for planning joint initiatives. As one partner observed *'you have got to spend time thinking through the implications for other agencies for example the information sharing, we should have checked that the protocols existed already but you don't when you are in a bidding process.'*

Contextual issues

In common with other pilots the demanding nature of the health policy context was identified as a major factor hindering joint working. One interviewee commented that the pilot was in competition with much larger initiatives such as the introduction of the Single Assessment Process and that these all had pressing timescales. Additionally the reorganisation of the PCT threatened to undermine the involvement of health colleagues in the pilot during its final stages. However such was the commitment of PCT colleagues to the work of the pilot that they continued to be fully involved in the development of the Home from Hospital service despite the pressures they faced in their own organisation.

Partners identified a series of capacity issues related to the lack of congruence between short term and long term performance agendas, different priorities, and the political context in which the council worked (which led to a perceived increase in bureaucracy). At the heart of these perceptions was a view amongst health professionals that it was unrealistic to expect health to invest in Supporting People services when they faced a budget deficit. There was also a shared perception, among officers in the local authority and PCT that *'Supporting People is not a core part of the PCT or local authority. Senior managers don't think it will last forever.'*

8.3 JOINT WORKING MAINSTREAMING

Links between this pilot and the relevant commissioning bodies within the local authority were particularly strong. The Supporting People lead officer regularly updated the Assistant Director of Adult Social Care who was a member of the Supporting People Commissioning Body. The lead officer also reported on the pilot's progress to the Core Strategy Group and Commissioning Body. Having commissioned the Home from Hospital service the new lead officer decided that it would be required to monitor its activities from the outset using the quality assessment framework and would be subject to a Supporting People review. This decision ensured that the service collected appropriate information in order (subject to a positive evaluation) that the service could be mainstreamed.

The links between the pilot and the PCT commissioning structures were also regarded as strong. Although the PCT representative on the Commissioning Body was less involved with the pilot as the focus moved to older people's services she was kept informed of all developments. The PCT's involvement with the pilot was assigned to the Modernisation Manager who was more centrally involved in Older Peoples services.

8.4 PROJECT ACHIEVEMENTS

Table 6 summarises the outcomes achieved by the SPIDERS pilot. These included improvements across a range of processes for effective joint working, raising awareness about the Supporting People framework amongst PCT staff and, most importantly, the establishment of a new Supporting People service.

Innovations in practice

Before creating a new joint working relationship it is often helpful to identify the key players and forums that need to be involved. The SPIDERS pilot demonstrated the importance of this process and although the first phase of their work was not entirely successful the 'mapping' process informed the pilots decision to refocus its attention to commissioning a new service and ensured that relevant managers were involved in the process.

The pilot capitalised on the involvement of key PCT personnel, such as the National Service Framework Modernisation Officer for Older People (a joint appointment between the PCT and Local Authority) and a senior PCT officer who represented health on the Supporting People Commissioning Body. These officers acted as conduits between the local authority and PCT at both a strategic and operational levels and were therefore important to building the links and the process of commissioning the Home from Hospital service.

Unanticipated outcomes

Despite the pilot's failure to meet some of its original aims it did succeed in fostering much closer strategic level links between the PCT and local authority, particularly in regard to the Supporting People programme. Having commissioned the Home from Hospital service the pilot began discussing how it could eventually be integrated with wider preventative services such as the Fresh Start Centres to be set up as part of the Department of Health, Partnerships for Older People Projects (PoPPs) initiative.

The decision to refocus the pilot's work towards jointly commissioning a new service was also identified as an unanticipated benefit. Having awarded the contract to the British Red Cross the pilot had done much to invigorate the local voluntary sector patch. Indeed many of the partners anticipated that if the Home from Hospital service succeeded they would be able to encourage the Red Cross to diversify into other service areas within North Lincolnshire.

Table 6: 'SPIDERS'

Aims	Objectives	Outcomes
<p>To raise awareness of the local Supporting People programme and its linkages with the health agenda.</p>	<p>To produce a map of key decision making forums.</p> <p>Establish systematic data collection of information sources to establish a baseline from which to monitor the impact of Supporting People services.</p> <p>Establish Performance Indicators against which activity could be measured.</p> <p>Produce a tool kit of transferable lessons for use in other localities.</p> <p>Establish a health 'Supporting People visionaries forum.</p> <p>Produce a directory of Supporting People services.</p> <p>Develop a training programme to raise awareness amongst health professionals about the potential contribution of Supporting People.</p> <p>Develop a themed Supporting People inclusive forum.</p> <p>Increase Supporting People presence in whole system strategic capacity planning group.</p> <p>Produce case studies as a means to illustrate the impact Supporting People services could have on reducing emergency admissions and readmissions, an increase in the use of home support packages to enable a speedier and more effective transfer and more effective transfers of care from hospital to community.</p> <p>Increase in the proportion of the overall resource commitment from the health sector.</p>	<p>The map was completed.</p> <p>Having decided to refocus the aims of the pilot towards commissioning a new service the systems to collect data were not established because they were no longer relevant.</p> <p>Having refocused the aims of the pilot the general performance indicators were not established. However the new Home from Hospital service will be required to collect data to demonstrate progress against relevant performance indicators.</p> <p>Having refocused the aims of the pilot this work was not completed because it was no longer relevant.</p> <p>Advocates within the PCT were not identified; however the new Home from Hospital scheme will help to raise the profile of the Supporting People programme with PCT colleagues.</p> <p>A directory of services was produced for use by key commissioning partners and elected members of the Council.</p> <p>The training programme was not delivered. However the pilot has begun to improve awareness of Supporting People services amongst GPs and practice staff and will continue to do so.</p> <p>Having refocused the aims of the pilot the forum was not established. Little progress was made.</p> <p>The work was not completed because the pilot was not satisfied with the quality of the case studies carried out by a community group and having refocused the aims of the pilot this work was no longer relevant.</p> <p>This aim was not achieved. However it is hoped that the Home from Hospital service will act as a catalyst and increase PCT interest in commissioning Supporting People services.</p>
<p>Aim added after 8 months.</p> <p>To demonstrate how an Supporting People service can directly support health objectives</p>	<p>Identify a service that will contribute to health targets.</p> <p>Jointly commission the service.</p>	<p>The pilot identified that a Home from Hospital service would meet the priorities of the PCT and Acute Trust.</p> <p>A Home from Hospital service has been jointly commissioned.</p>

CHAPTER 9

Overarching themes

Evidence from the health pilots suggests that *Supporting People* services can be deployed to benefit people's physical and mental health.

The evidence also indicates that agencies and professionals can work effectively together across organisational boundaries, but that the difficulties of doing so should not be under-estimated. Joint working was a primary focus for these pilots, working, as they were, with a variety of groups to achieve health outcomes. Their experiences raise a number of overarching themes that are relevant to joint working in other policy contexts.

9.1 ENSURING EFFECTIVE LINKS BETWEEN STRATEGIC AND OPERATIONAL LEVEL JOINT WORKING

Securing 'buy in' at both levels: Work within the pilots underlines the need for partnerships to be based on joint working at both strategic and operational levels. Commissioning new services that depend on joint working are unlikely to be effective if those working at an operational level do not understand why they need to work together. Similarly without the support of those working at a strategic level, joint working at an operational level is unlikely to be successful. Managers are needed to resolve the difficulties that inevitably arise when working across organisational boundaries, and are key to resourcing the work. Partners at both levels need to appreciate why they are working together and be committed to the aims and objectives of the partnership.

Vertical links 'Buy-in' at strategic and operational levels is, however, necessary but not sufficient for effective joint working. What is required also is strong linkages between the two. The pilots developed different strategies to ensure that such co-ordination took place. For some, steering groups provided the link. At Doncaster, Northampton and Lambeth and Southwark the steering group included representatives from all partner agencies as well as the project team and acted as the forum at which operational problems could be discussed and solutions identified and resourced. These steering groups also became the forum in which strategic issues could be addressed, such as whether or not to revise the original aims and objectives of a project, or planning how services could be 'mainstreamed' in the future.

In some pilots, individuals provided the link between the operational and strategic levels of joint working. In Waltham Forest, the lead Supporting People officer acted as the link between the pilot and the housing department, ensuring that lessons from the pilot were having an impact on key discussions elsewhere

in the authority. Effective communication is central in both approaches to linking work at strategic and operational levels. However, arrangements that depend on individuals are more vulnerable to staff changes than those residing in formally constituted groups.

Horizontal links The pilots underlined the importance of strong links between individuals working at the same level, whether strategic or operational. At the operational level effective partnership working depends on efficient systems that keep partners abreast of progress and that allow them to cross refer people who use services or pass on information about them in a timely manner. At the strategic level partners need to be able to discuss and resolve difficulties and ensure that the initiative is keyed into strategic planning processes.

9.2 COMPLEXITY AND THE NEED FOR CLEAR GOVERNANCE AND MANAGEMENT RESPONSIBILITY

One of the key themes emerging from the evaluation is the need for joint working to be based on clear arrangements in respect of governance and management responsibility. In other words, how best to ensure that the joint working to which partners aspire is delivered, works, and works well? Transparent arrangements, agreed by all partners, ensure that staff understand to whom they are accountable and enable the work to be managed effectively. However it is clear from the pilots that effective governance arrangements for joint working and management responsibility need to address more than transparency. Someone needs to be ultimately accountable for the project, and someone needs to 'hold the ring' for the project's progress on a day-to-day basis. These may or may not be the same person or committee in any one set of circumstances. Evidence from the pilots indicates that confusion or diffusion of roles and responsibilities underpinned some of the problems that arose.

Governance arrangements in Salford initially looked straightforward. Here the pilot reported to the Falls Strategy and Implementation Steering Group that acted as the central committee for all falls work. However, the sheer complexity of the pilot's work highlighted that what were described as governance arrangements were, at best, only reporting arrangements with little or no accountability. The allocation of individual elements of work to different partner agencies, a lack of clarity as to where ultimate responsibility for individual elements lay as between the steering group and individual agencies undertaking the specific pieces of work, and questions about the authority of the steering group all left the real governance of the pilot unaddressed. This difficulty is not unique to the Salford pilot. Indeed it reflects the complexity of much of the whole systems reforms that local authorities and their PCT partners are required to implement.

By contrast, the governance arrangements for the Lambeth and Southwark pilot, although potentially very complex, were from the outset clearly articulated and

effective. Although this pilot involved two Supporting People administering authorities as well as the PCT, ultimate accountability for the pilot was located with the lead commissioning authority for the pilot, namely the London Borough of Southwark. The pilot's progress was also reported to significant committees within the strategic partnership. This meant that partner agencies were kept aware of key issues and could support the pilot appropriately.

The experiences of the pilots raise the question about where the management of joint initiatives and accountability for them is best located. It may appear rational to make them accountable to committees that are themselves 'joint' (such as the Falls Strategy and Implementation Steering groups) but evidence from the health pilots suggests that this can diffuse responsibility. A better alternative might be to ensure that joint initiatives are accountable to one organisation acting on behalf of all of the agency partners. In this way, individual elements of work are mandated to specific organisations with clear lines of internal and cross-agency accountability. Similarly, locating management responsibility with one agency ensures that staff and commissioners are clear about who is responsible for day-to-day delivery, such as allocating resources, bringing difficulties to the attention of the relevant committee, and addressing performance issues.

9.3 MANAGEMENT OF PROJECT WORKERS

As with governance, the pilots highlight particular lessons about the management of project workers, particularly in new services set up to work across organisational boundaries.

Line management issues At Doncaster the pilot was staffed by seconding two workers, specifically employed to work in this pilot, from Doncaster and South Humber Healthcare NHS Trust to work for the two housing associations that formed the basis of the service. Similarly although the PCT held the funding contract in Northampton the tenancy support worker was employed by CAN. At both sites the decision to second or employ project workers within partner agencies was seen as a means to integrate them into the host organisation and to strengthen the ties between partner agencies. However, this rationale masks complexities in managerial arrangements that can impact on project workers and that will need to be addressed if the projects continue.

For example, project workers in Doncaster had to resolve day-to-day operational problems with the two housing associations, but any personnel issues needed to be addressed by the Trust. Even though problems that emerged were resolved quickly it was unclear how more serious issues – for example about work performance – would have been addressed. In Northampton the situation was similarly complex. Although the tenancy worker was employed and managed by CAN, the PCT co-ordinator of the SWAN programme had managerial overview of her work in relation to the development of the NEST. Not surprisingly this

arrangement caused some confusion, not least for the tenancy worker. Partners at both pilot sites concluded these arrangements were potentially untenable and that should the services be mainstreamed they would probably need to be revised.

Supervision and training The need to provide specialist supervision to project workers – as opposed to managerial supervision – was not originally considered by any of the pilots. However the importance of doing so became evident early on, specifically in pilots that were working with people with particularly complex needs and chaotic life styles (Doncaster, Northampton and Lambeth and Southwark).

Workers at these pilots had to work intensively with individuals in order to link them into a variety of general and specialist health services, and other agencies such as housing and probation. Not only did this require them to have a detailed knowledge of a range of services it also required them to have an understanding of how best to support individual clients. Through the provision of specialist supervision pilots were able to ensure that the practice of individual workers was safe as well as providing them with time to ‘off load’ and reflect on the difficult nature of the work they were doing. Additionally many of the pilot workers needed training in a variety of different skills and subjects. For example the SWAN NEST tenancy worker received training in conflict resolution and housing law, whilst those at Doncaster received training on issues such as harm minimisation. The training was seen as an important element of ensuring that pilot workers provided appropriate support to individual service users.

9.4 THE NEED TO INVOLVE PEOPLE WHO USE SERVICES AND THE WIDER PUBLIC

The process of joint working is typically thought of solely in relation to how different agencies or professionals work together. The pilots illustrate the importance of involving people who use, or may use services in their commissioning, development, management and evaluation.

All of the pilots regarded the involvement of people who use services as an essential means of ensuring that their work was grounded in issues of immediate concern to service users which in turn helped build the legitimacy of the venture. However several pilots also argued, very powerfully, that the involvement of services users was fundamental to their general philosophy towards joint working. This philosophy was most notable in Doncaster and perhaps reflects the broader role of service users in mental health services.

Two of the pilots used existing forums through which to involve current and potential service users in discussions about the development of the pilot. In Salford, early discussions about the pilot were held with the Older People’s Partnership Board and the Older People’s Think Tank whilst the idea for the Waltham Forest pilot originated from discussions at the ‘Place to Live Group’

which included representatives from service users and carers organisations. Progress was regularly reported to these groups and additionally both pilots held information sessions to keep people informed of their work.

Given the complexity of the problems facing those people using the services developed in Northampton and the London Boroughs of Southwark and Lambeth neither pilot thought it appropriate to involve them in the initial development and on-going management of their work. Instead the SWAN NEST pilot held regular meetings with tenants to discuss their experience of living in the house and any suggestions they might have for improving the NEST. In Lambeth and Southwark the pilot developed a service users group, which met regularly. This gave people the opportunity to discuss not only the service they received from the pilot, but also any wider concerns they had about access to HIV services.

In contrast, the On-Track pilot in Doncaster decided from the outset that user representatives would play a more prominent role in the development of the service. The original bid included plans for an evaluation to be undertaken by a local service users group. A representative of this group took part in initial discussions about the service and became a member of the steering group. As the service user evaluation progressed the evaluators made regular presentations to the steering group and their findings informed the subsequent development of the service. Not only did this approach improve the credibility of the service amongst service users but it may indirectly, have contributed to the high levels of engagement with the service.

9.5 THE CONTRIBUTION OF THE VOLUNTARY SECTOR

The pilots demonstrate the important contribution that the voluntary sector can make in supporting vulnerable people to live independently in the community. First the involvement of the voluntary sector brought additional credibility to the work of several pilots. For example the decision to commission the British Red Cross to provide the 'Home from Hospital' service in North Lincolnshire was thought to have reduced the perceived risks of failure associated with establishing a new service. The British Red Cross had experience of developing similar services which reassured partners that the organisation would succeed in transferring an existing service model to North Lincolnshire.

Secondly, as well as harnessing the expertise that exists within the voluntary sector, pilots were able to draw on their networks. The decision to commission Terrence Higgins Trust to provide the outreach support service in the London Boroughs of Lambeth and Southwark was a significant factor in the pilot's success. Not only did they have credibility amongst service users but they also had established links with statutory health services as well as an extensive network of voluntary organisations. The outreach service was therefore able to capitalise on these connections and link individuals into a range of additional

services such as the community transport service, furniture projects and food supplies. Undoubtedly these additional contacts helped people to maintain their independence.

Finally, the development of new services in the voluntary sector provided powerful models of how services could be provided outside of the confines of the statutory sector. The decision to place new services in the voluntary sector in Doncaster, Northampton and Lambeth and Southwark appeared to be critical to the success of their work. Many of their partners commented that they thought service users found it easier to engage and remain engaged because the services were based in the voluntary sector. In essence they argued that service users found voluntary sector services more accessible because they were not tied in with statutory functions. The absence of specific organisational or professional allegiances may have enabled pilot workers to work more flexibly and intensively with service users, not least of all because they didn't have fixed notions about what their involvement *should* entail. This may also have placed them in a stronger position to focus on what individuals thought they needed to do in order live independently, rather than providing support based on a preconceived professional or organisational agenda.

9.5 DATA SHARING AND IT INFORMATION MANAGEMENT

The experience of the pilots illustrates the importance of establishing processes through which to share information at a strategic and operational level. It also highlights the difficulties in doing so. At a strategic level agencies, particularly statutory agencies, need to be able to share data across organisational boundaries in order to evaluate the effectiveness of joint working and develop future plans and commissioning strategies. Without evidence of the impact of joint working on key targets or performance indicators it is unlikely that agencies will continue to prioritise, or indeed fund, such activities in the context of financial restraint.

The Sure Footed in Salford pilot aimed to establish an overarching data sharing protocol between statutory agencies to inform the commissioning and development of the falls service. It soon became clear that they were unlikely to achieve this within the time frame because of broader and more pressing policy agendas. They therefore decided to link their work to the development of a data sharing protocol for the Single Assessment Process. However these discussions were dominated by the interests of health and social care services and the protocol that was finally agreed did not include sufficient numbers of housing related services to be of use. Consequently the pilot decided to scale down their aspirations to a specific falls information sharing protocol which is currently with partners awaiting agreement.

In North Lincolnshire the pilot explored the use of health data as a means to develop a baseline from which to monitor the impact of Supporting People

services on health outcomes. However they were unable to do so because health professionals had concerns that sharing data with colleagues in the local authority might compromise the confidentiality of individual patients.

Those pilots that developed new services demonstrated the importance of establishing effective ways of sharing data at an operational level. This is particularly important when services are supporting people with complex needs and often chaotic lifestyles. In these circumstances services need to be co-ordinated in a timely manner and based on up-to-date information.

Most of the pilots decided to build on existing local practice. For example the SWAN NEST partnership used an existing 'release of information form' which each tenant was asked to sign as proof that they had agreed to the pilot contacting other agencies as a means to seek or share relevant information. The pilots in Doncaster and Lambeth and Southwark developed similar systems. Whilst these appeared to work, all of the pilots reported examples of individual professionals and sometimes specific agencies questioning the appropriateness of sharing information. Typically they cited concerns about the pilots' intended use of the data. Sometimes they questioned whether or not service users had actually signed the forms. Whilst these questions reflect real concerns about data protection and confidentiality they reflect a lack of appreciation of the professionalism of project workers and/or a reluctance to 'share' information about 'their' clients with other agencies.

9.7 WORKING WITH HOUSING

Training Whilst those most closely involved with the pilots understood and appreciated their aims and objectives, it is clear that staff working in allied services did not always appreciate the housing and support needs of those groups the pilots were supporting. This was particularly the case within housing services where 4 of the 6 pilots identified the need for staff working in homelessness units or hostels to have training about the housing and support needs of vulnerable people.

The project worker in Waltham Forest found that people with learning disabilities were extremely frustrated about the lack of understanding of their housing rights amongst housing staff. The pilot in Doncaster highlighted a lack of understanding about mental health and drug issues amongst staff working in the homeless unit. This sometimes resulted in young people with Dual Diagnosis being offered unsuitable accommodation. In both instances the pilots provided specific training sessions as a means to address these problems. Training in each case resulted in improved working between these agencies and also improved the support these agencies provided to specific individuals.

Managing expectations The pilots also identified specific issues to do with the management of social housing. In several instances, RSLs and local authority

housing departments needed to accept that it might take longer for some new tenants to move into supported housing. This, however, can have a negative impact on void rates. For example in Waltham Forest several partners suggested that intense pre-tenancy support work might need to take place in the period immediately before an individual with learning disabilities moved into their new home. This could inevitably result in delays to their moving in. Whilst it is difficult to predict what will happen in individual cases the experience of the pilots indicates that if supported living is to be a realistic option then RSLs and local authorities will need to be sensitive to the needs of different groups and adjust their approach to voids accordingly.

9.8 THE ORGANISATIONAL CONTEXT

Evidence from the pilots indicates that effective joint working rests not only on a high degrees of commitment and trust between partners, but on a range of other characteristics such as whether or not the service is defined by: the involvement of specific professions; a history of cross agency working and, a history of voluntary sector involvement.

Those pilots that were working in service areas where there is little or no tradition of statutory sector provision (for example with sex workers) or where services have developed more recently (HIV services), appear to have less difficulty working across organisational or professional boundaries. Indeed these pilots appeared to be based on a profound sense of 'needing' to do something to fill a gap in provision. The HIV sector, for example, has a strong ethos of partnership working across the statutory and voluntary sectors, which appears to lend itself towards a more flexible approach to supporting vulnerable people.

In Doncaster, a long history of organisational integration with mental health services appears to have helped break down professional boundaries. Similarly there is a greater degree of involvement from the voluntary sector. Moreover, recognition of the need to address the needs of people with dual diagnosis is relatively recent.

In contrast although the core partners in those pilots working in the fields of learning disabilities and older people services displayed a high level of commitment to joint working this did not always appear to be as widespread within the agencies concerned. For example, although the Waltham Forest pilot was based in an integrated team they were not co-located, nor were team meetings integrated. The interviews also revealed that social workers and community nurses did not have a shared understanding of the relationship between housing and well being. As a result the pilot struggled initially to develop an ethos of joint working. Similarly although core strategic partners within the North Lincolnshire pilot shared a history of joint working this was not as well developed at an operational level.

9.9 THE CHALLENGES OF EVALUATION

Current policy emphasises the importance of outcomes for service users and pilots were charged with specifying what outcomes each was seeking to deliver, and how these would be measured. The pilots illustrated the challenges inherent in framing work in terms of measurable outcomes.

To do so, pilots needed to do two things. First, they had to translate broad aims into discrete, measurable goals. Secondly, they needed to find ways of assessing the influence of the pilot – as distinct from other factors – on those goals.

Attributing influence In most cases pilots came to the reasonable conclusion that it was unlikely that they could generate evidence that outcomes were directly and solely attributable to their work. What they could do was gather information about the likely contribution of the pilot, and the most sensible sources of such evidence were those whom the pilot had served, and those who had worked on or with the pilot.

Some pilots hoped to use time-series data to demonstrate their impact e.g. the Salford pilot, but problems in data collection undermined this otherwise sensible strategy. At Doncaster the pilot hoped to track young people after they had been referred to long term support. However this proved difficult because it required other agencies to collect additional data that had little relevance to their own organisation.

Setting measurable goals One of the first tasks of the evaluation team was, in fact, to help pilots develop measurable goals. The tables included in each of the preceding chapters capture the process of translating broad aims into more easily measurable objectives. It does not indicate the scaling down of aims and objectives that was also part of this process.

For example the original aim in Doncaster was to reduce suicide. Leaving to one side the issue of causal attribution, it is difficult to demonstrate an impact on relatively low frequency, and often ‘hidden’ events, particularly over a two year period. The pilot therefore developed a number of proxy indicators such as engagement with services and sustainment of tenancy. In Salford, the pilot’s aims originally included reducing the incidence of death caused by accidents, and promoting health and active life for all older people. The difficulties of identifying reliable indicators of these ambitious aims meant they had to be put aside. This was partly because of the challenge of attributing causal links between these outcomes and the project, but also because of the difficulty in demonstrating changes in low-frequency events such as death by accidents.

The process of establishing outcomes, even proxy outcomes, was useful in terms of building the evidence about whether or not there was a case for mainstreaming the project. The regular monitoring through the pilot also prompted revisions and improvements in services in a timely fashion – one of

the benefits of ‘action research’. For example, the project in Lambeth and Southwark was initially thought of in terms of improving hospital discharge rates but the information provided through the collection of the evaluation data indicated that it may have been successful in stopping admissions.

9.10 THE CHALLENGES OF WORKING WITH PCTS

The Supporting People Health Pilots were established as a means to encourage greater involvement of PCTs in Supporting People partnerships as well as to demonstrate the potential benefits to Health and Social Care from Supporting People collaboration. In so doing the experience of the pilots illustrate some of the difficulties associated with working across organisational boundaries and also some techniques to overcome these.

One of the main difficulties encountered in trying to encourage greater involvement of PCT colleagues was the lack of appreciation of what the Supporting People policy framework entailed and a lack of understanding about the impact Supporting People services could potentially have on health targets. Whilst the majority of PCT representatives appeared to understand the significance of the particular Supporting People initiative they were involved with and recognised the impact it could have on the area of PCT services in which they worked, they often did not understand how the pilot related to the local Supporting People framework and commissioning processes nor indeed what these processes entailed. In one case PCT colleagues did not see the relevance of the pilot’s work or wider Supporting People services, to NHS performance targets and regarded it as a temporary policy phenomena which would not last long. In part this reflects one of the problems the Health Pilots were established to address: the absence of ‘examples’ of how Supporting People services can contribute to the achievement of health targets. However it may also reflect general difficulties associated with moving towards a preventative, community based health agenda within a sector dominated by hospital based services.

Another factor that was reported to have had a negative impact on the involvement of PCT representatives related to the fast changing health policy agenda that often appeared to marginalise initiatives such as these. For example the implementation of *Agenda for Change* within the NHS and the *Single Assessment Process* within the NHS and local authorities were both cited as reasons why the work of the pilots was not prioritised. Interviewees also identified a range of perennial problems associated with joint working such as the lack of congruent planning and financial cycles across health and local authorities which made the notion of joint commissioning difficult to put into practice. For example, in Lambeth and Southwark the review of PCT funded HIV/AIDS services is due to take place almost a year after the review of Supporting People services. As a result any discussion about joint commissioning of the outreach service will have to take place after the PCT review.

Financial concerns – particularly with respect to PCT funding and the reorganisation of health care services – also contributed to a lack of sustained involvement at several pilots. In Northampton the PCT co-ordinator of the SWAN programme was not replaced when she left because of a recruitment freeze. Similarly, in Doncaster the Trust mental health commissioner who played an active role in the development of the pilot and who was involved in the Supporting People commissioning body was not replaced because local services were in the process of amalgamating. Because both had developed contacts within partner agencies and would have played a key role in discussions about how to mainstream the services, their loss was palpable.

These difficulties were mirrored at an operational level. Several pilots reported that operational staff within PCTs (as well as in Hospital Trusts) often did not appreciate the relationship between housing support services and wellbeing. As a result busy staff would prioritise work related to their own organisational objectives above the pilots. Additionally several pilots identified the high turnover of healthcare staff and difficulties developing links with shift based staff in hospitals as undermining efforts to develop closer working relationships.

Despite these difficulties the pilots continued to find ways to develop better joint working relationships. Several of the pilots provided training to PCT (and hospital) staff as a way of raising awareness of the link between housing and health or the specific health needs of groups of service users. In North Lincolnshire the pilot deliberately moved away from talking generally about Supporting People services and instead referred to concrete examples of the type of service that could benefit PCT partners, for example enhancing the role of wardens in sheltered housing in order to reduce the incidence of falls.

At a strategic level, several of the pilots used key health personnel as ‘champions’ as a means of bridging the organisational divide. In Doncaster this role was taken on by a representative of the Community Mental Health Trust (CMHT). He appreciated the importance of stable housing as a prerequisite to addressing mental health problems. Not only did he act as the link between the pilot and strategic health forums but he also had links with a range of community health and social care services and used these networks to ensure familiarity and use of the new service. At Salford and North Lincolnshire the pilot relied on people employed specifically as joint appointments between the PCT and Local Authority to act as the bridge between the two organisations.

CHAPTER 10

Conclusions

The Supporting People Health Pilots were established as a means to encourage greater involvement of PCTs in Supporting People partnerships as well as demonstrating the potential benefits to health and social care from Supporting People collaboration. In so doing the pilots demonstrate how services can be developed to enable vulnerable people to live independently in the community. They illustrate how agencies and professionals can work across organisational boundaries, ensuring greater access to a wider range of health care services and improved health outcomes for particularly marginalized groups.

Importantly the experiences of the Health Pilots echo themes identified elsewhere in the policy context. Flexibility in service delivery for example, is a significant part of the prevention agenda and its importance was demonstrated by several of the pilots notably 'On-Track', 'Housing Support Outreach and Referral for hard-to-reach individuals living with HIV' and 'SWAN NEST'. Projects worked intensively with individuals to identify what they wanted to address in order to live independently and supported them to achieve the goals they set for themselves. This person-centred approach helped people engage and maintain engagement with services, which they had often failed to do in the past.

The Health Pilots also highlight the importance of low-intensity support as a means to maintain independence. At Salford the provision of portable alarms enabled older people to remain in their homes, potentially preventing further problems that might have required intervention from statutory services. Additionally the provision of training to community alarm wardens improved the linkages between community and hospital based falls services ensuring older people who fell, or were at risk of falling, were referred to appropriate services in a timely fashion. In Lambeth and Southwark the pilot supported people living with HIV to maintain their tenancies by involving local authority building services to make the necessary repairs and adaptations to their flats. Without such low level intervention they may not have been able to remain in their own homes.

The involvement of the voluntary and non-statutory sectors is another powerful theme underpinning current policy and was a crucial factor in the success of several of the pilots. First, the involvement of the voluntary sector brought additional credibility to new services, particularly if it is a nationally recognised agency, such as the Red Cross, or if it has a good local reputation like the SWAN programme. Secondly, location in the voluntary sector allowed access to networks and expertise that exists outside of the statutory sector. This was the case in Lambeth and Southwark where the out-reach service capitalised on the extensive networks that the Terrence Higgins Trust had which were critical to

the success of the service. Finally the experience of the pilots suggests that some people, particularly those with chaotic and complex lives may find it easier to engage with a service (and remain engaged) chiefly because it is based in the voluntary sector. Indeed some people find voluntary sector services more accessible because they were not based around statutory professions such as social workers and community nurses. Others need the enhanced flexibility and responsiveness that they perceive in the voluntary sector.

The Health Pilots also highlight the importance of involving people who use, or may use, services in their development and in monitoring their delivery. Not only does their involvement improve the credibility of the service amongst people who use services but it can help maximise the relevance and effectiveness of services.

The experiences of the Health Pilots raise a number of factors that are relevant to joint working in other policy contexts. First, successful partnerships need to be based on joint working at both strategic and operational levels with strong linkages between the two. However, to be effective joint working also requires that governance and management responsibility are transparent and agreed by all partners. Without clear arrangements it is difficult to manage effectively and ensure the partnership is accountable.

Finally the Health Pilots demonstrate the importance of establishing outcomes as a means to demonstrate the impact of joint working. Without evidence of the impact of joint working on key targets or performance indicators it is unlikely that agencies will continue to prioritise or indeed commission such activities. However the experiences of the pilots also demonstrate the inherent problems of this, not least the difficulty of establishing processes through which to share information at a strategic and operational level. The Supporting People Health Pilots demonstrate that with clear leadership, agreed goals and dedicated partnerships these difficulties can be overcome.

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APPENDIX 1

Supporting People Health Pilots sketch

Project Title	Focus	Partnership agencies	Nature of pilot
'On Track'	Young people with dual diagnosis	Doncaster and South Humber Healthcare NHS Trust, Doncaster Community Mental Health Services, Doncaster Substance Misuse Service, the local Supporting People Team, 'On Track' (a collaboration between Action Housing Association, South Yorkshire Housing Association and Rethink, 'The National Schizophrenia Fellowship') and <i>Involve</i> – Doncaster Mind's mental health service user involvement project.	Floating support, including help to engage with relevant health and social care services.
'SWAN NEST'	Women wanting to exit the sex trade	Northampton Primary Care Trust, Northampton Borough Council, Northamptonshire Police, Maple Access Partnership LLP General Practice, Council for Addiction in Northampton (CAN), and Drug and Alcohol services.	Provision of supported housing and support, including help to engage with relevant health and social care services.
'Place to Live'	Supported living for people with learning disabilities	Social workers and learning disability nurses who were members of the Learning Disability Partnership (London Boroughs of Waltham Forest and Redbridge, and Waltham Forest and Redbridge Primary Care Trusts partnership).	The promotion of supported housing and its benefits for health status amongst people with learning disabilities, carers and health and social care practitioner. Support to move into independent living if appropriate.
'Sure footed in Salford'	Integrated falls services	Salford City Council Housing and Planning Services, Community, Health and Social Services, Salford PCT, Age Concern and, Service User representatives.	The development of a joined-up approach to falls management and the integration of falls services within Salford.
'Housing Support Outreach and Referral for hard-to-reach individuals living with HIV'	Hard to reach individuals living with HIV	Supporting People Administering Authorities from the London Boroughs of Lambeth and Southwark, Lambeth PCT (which commissioned voluntary sector services on behalf of Southwark and Lewisham PCTs) and, the Terrence Higgins Trust/Lighthouse.	Floating support, including help to engage with relevant health and social care services.
'SPIDERS'	Older people	The Supporting People Administering Authority for North Lincolnshire, North Lincolnshire PCT, North Lincolnshire County Council Social Services.	Raising awareness of the local Supporting People programme and its relevance to the health agenda.