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Nepotism, archaeology and trade secrets

This edition provides a vehicle for editorial self-aggrandisement, unearths forgotten old truths about supported housing, and spells out the tricks of an important trade.

Nepotism

It so happens that two pieces of work by Carr-Gomm, the organisation for which I work, arrived on my editor’s desk at the same time: the article on employment, ‘Does work work for vulnerable people?’ by Lucy Asquith and Bernadette Scott, and the shared housing article, ‘Shared living in supported housing’, by Lynn Vickery and Veronica Mole.

I publish them without apology, because they were both written with the explicit aim of involving and informing the wider sector. Both pieces of work are the sum of collaboration between a wide variety of agencies, and deepen our understanding of a significant aspect of our work, affecting the lives of people using support and housing services.

As you will see, we concluded that the vast majority of vulnerable people want to work but face multiple barriers. We issued a challenge to ourselves and the rest of the sector to take practical action by employing more vulnerable people ourselves. There is now a lot of assistance out there for employers, including (for mental health), the website www.mindfulemployer.net. Interestingly, this group pre-empted the Government’s recent proposal for ‘well notes’ by recommending that new tools be developed to discourage GPs from signing people off sick as a first option.

The other article (part-funded by the Housing Corporation) on shared living in supported housing also overlaps the other two categories. It counts as ‘archaeology’ because it helps re-discover the importance and use of shared housing by being very specific about the groups it is supporting, and listening to the people who use services. We re-learn that, although design and location are important, management of the service is crucial. The research challenges providers:

• to provide residents with more say over who moves in
• to ensure that their staff are skilled, particularly in working with groups and enabling peer support
• to offer more structured training and educational opportunities.

This research falls into the ‘trade secrets’ category, too, first because it gives us a model for a whole organisation approach to evaluating shared supported housing. This is something that can ensure that, strategically and operationally, organisations are clear and focused about their use of this kind of provision and its benefits to the residents. Second, I recommend that providers and commissioners download the Summary report on Carr-Gomm’s website at www.carrgomm.org.uk and look at the very useful information on designing or reviewing shared, supported housing in the tables starting on page 19, which set out what works and what doesn’t work for:
Editorial

- mental health service users
- people with learning disabilities
- women fleeing domestic violence
- young people
- homeless people (including people with alcohol problems)
- mothers and babies
- ex-offenders.

Third, we discover that generally, and contrary to perceived wisdom, many Supporting People teams see a continued positive role for shared living in supported housing and, pragmatically, its value as an option in an otherwise scarce landscape.

Archaeology

This is about re-discovering what we once knew, or should have known, about our work. The research on shared living in supported housing echoes the preceding article on extra care housing, 'Never a dull moment?'. This very useful article by Simon Evans and Sarah Vallelly uncovers forgotten truths about housing for older people, by the reasonable method of asking them what is important to them. There is also a refreshing emphasis on identifying what makes for the service user's well-being, rather than what makes for good service provision. Here's the archaeology; it's friendship, community engagement, good design, caring family, staff culture and accessible facilities.

Staff and management attitude and skills are crucial, and keyworking is particularly effective, but there are concerns that this crucial staff interaction is in danger of being undermined by the task-orientated nature of some care contracts. One of the most important external facilities identified was a shop: useful to purchase life's necessities, and a social meeting place that supports emotional well-being.

The archaeology continues in Roger Clough's article, 'Unmet needs for low-level services'. Although it focuses on services for older people, there are many lessons which read across to other needs groups. In particular, the focus is on the outcome for clients rather than processes. Assessments of needs for services are perceived as concentrating too much on the task of daily living rather than on what the person wants to do with their life. The study also picks up and identifies the extent to which anxiety about being able to carry out daily household tasks, both within and outside the home, cries out, often in vain, for a holistic service response. That anxiety, coupled with isolation and lack of information, has significant adverse effects on the well-being and mental health of older people.

The list of practical support that would be most valued goes beyond the activities generally funded by Supporting People and domiciliary care funding, but the principle applies; human contact plus practical help allays anxieties and enables well-being and community engagement. We bump up, yet again, against the silo preventing the solutions that lie outside a single model of service delivery. We all hope that the personalisation agenda, as well as local area agreements, will finally reduce this non-joined-up way of working, and allow multi-agency solutions which include the service user in the management of services.

Interestingly, the report proposes that there is a model that, when run well, can offer a more flexible framework in which the service user can get involved: day provision in centres, clubs or lunch groups. They can provide the social interaction, staff interventions and variety of facilities in more accessible forms than currently offered by residential or domiciliary services.

Trade secrets

Finally, Nigel Walker's article, 'The Strategic Commissioner's box of tricks', makes fascinating reading, helping us understand the context in which commissioners operate and the direction they are following to achieve 'world class commissioning'. The New Joint Strategic Needs Assessment will be the basis, but the Voice of the Customer and market development among a wider range of providers will provide opportunities for smarter procurement and interoperability – but only if the right leadership skills are developed, with a vision that goes beyond organisational and geographic boundaries.

It seems that there is now a concerted effort to get there, and this article provides us with an opening to get on board!

As ever, please comment and respond.

Gary Lashko
Editor
Clean Break drugs and housing project

Alice Evans
Homeless Link

Abstract
This article summarises the findings of Homeless Link’s research, Clean Break. Through action research in three London boroughs, Homeless Link with Tribal Consulting took a systems approach to identifying the barriers to active engagement of homeless drug users in structured treatment in accessing appropriate housing and housing-related support. The work showed that, despite the barriers facing people on their treatment journey, existing resources, if integrated, could overcome many of them.

Keywords
Clean Break; housing; drugs; systems approach

Introduction
The connection between drug misuse and homelessness is strong; the two problems can cause and reinforce each other. Tackling one without addressing the other at the same time can lead to failure. Despite this, agencies and commissioners who are trying to support homeless drug users often work in isolation from each other.

Clean Break was developed in response to the frustrations of Homeless Link members, who all too often see the efforts of homeless people going into treatment going to waste when no suitable accommodation is available. Clean Break focused on how housing and treatment services can work together more effectively to support treatment outcomes and reduce the risk of homelessness among drug users engaging in treatment.

Action research was undertaken by Tribal Consulting in the London Boroughs of Islington, Newham and Havering. It included analysis of the need for and supply of housing and support for homeless drug users, as well as access routes and criteria for existing services. Interviews were undertaken with agencies and service users. A steering group that included the National Treatment Agency, the Home Office, London Probation and the Housing Corporation oversaw the study at national level.

The research was made possible by funding from the London Housing Foundation, the Housing Corporation, London...
Clean Break drugs and housing project

Borough of Newham’s Substance Misuse Partnership and Islington’s Safer Inclusion Partnership.

The context

There are well-established links between drug use and homelessness, which suggest that drugs and other harmful substance misuse are contributing factors to homelessness.

Most studies of the levels of substance misuse among homeless people focus on homeless people living in hostel accommodation. Estimates of the prevalence of harmful substance misuse among this group of homeless people vary, but can be as high as 80% (letter to DATs from Director of NTA, December 2002).

Estimates from local stakeholders during the Clean Break study suggest that the proportion of single vulnerable people accepted as statutory homeless who are engaged in harmful drug use can be as high as 35–50%.

Research into the relationship between homelessness and substance misuse carried out in 2002 (Fountain & Howes, 2001) found that nearly half the sample had been continuously homeless. These respondents were asked to give reasons why, and the two cited most commonly were drugs and financial problems. As for the rest of the sample, drug use was by far the most common reason for homelessness, just over two in five (42%) viewing it as a reason why they still experienced homelessness.

Other research (ODPM, 2002) has found that among rough sleepers the most common reasons given for tenancy breakdown were drink- or drug-related. Long-term drug users in particular reported a series of tenancies lost (30, in one case quoted in the research) because of their lifestyle and offending history.

‘Where I am is a bad, bad place... everybody is scoring. I can hear what people are getting up to in here. People knocking on my door, asking for foil and Rizlas, it is so tempting. I could do something for myself but not here.’

The link between housing and treatment outcomes

Until recently the National Drugs Strategy has focused largely not only on getting drug users into treatment as quickly as possible but also maintaining them in treatment for at least 12 weeks. Research suggests that this is the time required to have any lasting benefit (Gossop et al, 2005).

In 2004 the Audit Commission pointed to over-emphasis on treating drug addiction, and lack of emphasis on providing the support needed to bring order to the often chaotic lives of drug users. It concluded that housing, social care and other services must provide users with support to maintain progress made during treatment and ultimately help them become employed, housed and more self-sufficient.

Public expenditure in England on drug treatment services in 2007/8 will be £600m (including central government funding of £398m). The Government is clear about the benefits of this; for every £1 spent on treatment, at least £9.50 is saved in crime and health costs (Godfrey et al, 2004).

Stable housing is widely regarded as key to successful treatment outcomes (NTA, 2006). Yet problematic drug users are seven times as likely to be homeless as the general population (Kemp et al, 2006), and 40% per cent state that lack of stable housing is the main barrier to achieving their treatment goals (Stephenson, 2005).

The Clean Break study found that, when treatment and housing services work together to support each other, there can be many benefits for service users, commissioners and the wider community, including:

• improved access to a wider range of private sector and social housing
• better engagement and retention in treatment services
• lower rates of tenancy breakdown and repeat homelessness
• reduced offending and anti-social behaviour.

The need for different types of housing and support

In England, most drug treatment is undertaken in the community. There is a need for stable housing throughout the treatment period, as well as in the post-treatment period. Examples of treatment services include substitute prescribing, group work, structured day programmes, residential detox and rehabilitation. Although homeless drug users may be
more likely to access residential treatment services than their adequately housed peers (Gossop et al., 2001), the findings from Clean Break showed that the majority of service users of no fixed abode are undertaking treatment in the community. Analysis of NDTMS data returns in one of the Clean Break case study boroughs showed that just under a third of NFA clients accessing treatment were in residential rehabilitation.

‘[Commissioners should] provide an environment that is safe for people who don’t want to use drugs. It’s a battle within yourself, never mind having to put up with other people’s habits.’

Housing, historically, has been perceived as an ‘aftercare’ service that will be required after the service user has left treatment. However, given that only a third of those who are homeless are likely to be in residential treatment, it is now regarded as a ‘wrap-around’ service which should form an integral part of the care plan for all drug users engaged in treatment.

Journeys to abstinence or stabilisation of drug use are rarely linear; there can be several setbacks along the way (Gossop et al., 2001). Housing and support services need to be flexible enough to respond to changes in the individual’s levels and patterns of drug use, as well as their other needs.

Housing and treatment agencies which participated in the research identified the need for a range of accommodation, from general needs housing with floating support for those who are clean/stabilised, through to 24-hour supported accommodation for chaotic drug users. Very short stay accommodation is often needed to bridge gaps in service availability, enable a period of assessment or enable respite for someone whose needs have changed.

Commissioning and planning of local services are currently hampered by poor data systems and inadequate knowledge of the relative impact of different housing models on drug use. This lack of evidence can be a major barrier to negotiation of additional resources and access to services.

It is difficult to be clear about the impact that different types of housing have on treatment outcomes, because there has been very little research conducted.

However, service users emphasised the importance of:

• being away from active drug users when seeking to end or reduce their drug use
• using good-quality housing as a reward or incentive for positive treatment outcomes
• getting support with drugs and housing at the same time
• having access to ongoing support post-treatment.

‘The trouble with living here is that everybody is at different stages, so there is conflict when people are using and you’re trying to stop.’

Current and former drug users in the case study boroughs were accessing a variety of housing types, including supported accommodation specifically for drug users commissioned with the involvement of the DAT, and ‘generic’ supported housing for single homeless people. These two types of service were very different in both ethos and aims. The former is strongly linked to treatment aims and the latter focuses on housing/homelessness aims.

Examples of services encountered during Clean Break (see Box 1, opposite, for an example) showed that access to and continued occupation of housing are commonly used as both an incentive and a sanction. There appears to be fairly widespread support among professional stakeholders for these models, and indeed from some service users.

Recent draft guidance issued by NICE (2007) suggested that incentives can be used successfully to encourage reductions in drug use. This is supported by research evidence, but the guidance reported that there is no similar evidence to support use of sanctions. There is some evidence from the case study boroughs that supported housing schemes that make continued occupation of housing contingent upon adherence to treatment goals experience high rates of eviction and abandonment.

Newham’s successful experience suggests that neither a supported accommodation model nor threat of accommodation loss is always required to achieve good outcomes.

Clean Break found that the lack of appropriate housing for drug users is leading to:
Clean Break drugs and housing project

- those trying to reduce or abstain from drugs being forced to live alongside those still actively using
- inappropriate referrals to existing supported housing
- chaotic drug users having to sleep rough or move out of borough
- people becoming ‘lost’ in the system.

Pathways and access to housing

There can be many barriers to accessing to housing for drug users at all stages of their treatment journey, but strong partnerships can overcome them and ensure the best possible use of available resources. In all three case study boroughs, good planning for discharge from prison or rehabilitation appeared to be taking place, but was sometimes thwarted by lack of housing options. Knowledge about the drugs sector by the homelessness sector and vice versa varied among staff. Solutions developed in the case study boroughs included:

- development of a systems approach that links housing and treatment agencies together in a mutually supportive way
- more joint working between housing and treatment agencies to enable a more holistic response to the complex needs of homeless drug users
- clearer pathways to and between housing and treatment services which are understood by all relevant agencies
- greater flexibility and capacity among housing providers to respond effectively when needs and levels of harmful drug use change
- development of a stronger evidence base on which to build local support for investment in and access to services for drug users
- a multi-agency approach to commissioning and delivery that pools resources and creates added value.

While new investment is often needed to address service gaps and weaknesses, there are also many examples of how to make existing resources work more effectively.

‘Do not send us on expensive treatment programmes only to house us in hostels where people are using all around us. You are setting us up to fail.’

The Clean Break toolkit (www.toolkits.homeless.org.uk) includes tools and examples of good practice to enable other authorities to replicate these solutions in their local areas.

Conclusions and recommendations

The Clean Break study concluded that there was much that could be done to improve housing and treatment pathways for homeless drug users. The research report includes a number of recommendations for implementation at national, regional and local levels to achieve this. These are summarised below.

- It is important that research is undertaken to evaluate the impact of different housing models on treatment outcomes, in order fully to understand what best affects a person’s ability to complete their treatment journey successfully.
- Joint guidance should be given to local authorities, encouraging them to conduct assessments of the accommodation needs of

Box 1 SERVICES IN NEWHAM

Substance misuse housing advice workers in the London Borough of Newham refer non-statutory homeless clients to a range of housing options in the borough. They include bed and breakfast accommodation, private sector tenancies, private sector leased properties and supported accommodation. Floating support is provided for those in non-supported accommodation.

Access to all these forms of housing is contingent upon the individual’s engaging with treatment services to address their harmful drug use. Applicants can be placed in bed and breakfast accommodation for a week or so to enable them to demonstrate this willingness to engage in treatment. The workers liaise closely with treatment agencies to check that they do, and placements in bed and breakfast will be terminated if the service user is unwilling to comply. Bed and breakfast placements may continue for up to three months while suitable move-on is identified in supported or private rented housing.

Once a tenancy in supported or private rented housing has been allocated, it is not terminated if engagement with treatment services ceases.
drug users. These needs assessments should be underpinned by robust housing needs data.

- Given the unpopularity of drug users in some areas and the difficulty in establishing services for them, it is important that clear expectations of partnership working should be incorporated into regulatory frameworks for housing, support and treatment services.

- Strategic reviews should be undertaken locally to establish a ‘system’ of services with clear pathways between them, strong partnerships between housing and treatment services, and plans to remodel services where required.

- Housing providers, commissioners and other agencies should work together in a mutually supportive way to deliver the flexible range of services needed by drug users.

- Local pathways to treatment and accommodation should be well understood by all staff working with drug users, and accessible to those in need.

The findings suggest that, even where there is no funding for additional services, there are advantages to be gained from more effective pathways between, and use of, existing services.

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References
Does work work for vulnerable people?

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Abstract
This paper summarises the roundtable discussions convened by the charity Carr-Gomm in October 2007. Participants included providers of services to vulnerable people, policy makers and academics, creating a useful mixture of theoretical and practical knowledge. The Social Exclusion Task Force report in 2006 gives a clear indication of the picture of unemployment for vulnerable people. In addition, developments in funding for key government departments, coupled with population projections, suggests that there is a strong external impetus for vulnerable people to be employed. Discussions covered a range of topics including Who benefits when vulnerable people work?, What constitutes good work? and Barriers to supporting vulnerable people into work.

Overall, the group concluded that the most urgent priority is for third sector employers themselves to create flexible work opportunities which can be taken up by vulnerable people. This experience should then be used to disseminate learning and to make the case for change with other employers.

Keywords
Vulnerable people; unemployment; work

Introduction
In late October 2007, Carr-Gomm convened a roundtable discussion to review attitudes and barriers to vulnerable people in employment. The goal was to have informed discussion which would be followed by practical action. Participants included providers of services to vulnerable people, policy makers and academics, creating a useful mixture of theoretical and practical knowledge.

Policy context
The discussion proved very timely, as there are a number of
indicators of increasing external pressure for vulnerable people to be employed (Box 1).

Key issues and challenges

Who benefits?

for those able to work, employment is the best route out of poverty... the health and wellbeing of people of working age is therefore of fundamental importance to our future. (DWP, 2004)

The group began by analysing the benefits of working. There was swift agreement that employment benefits vulnerable people and their families. However, it was noted that these benefits are more likely to be experienced in quality of life, health and well-being before the financial benefits are realised. It was agreed that there are secondary benefits to the Government, tax payer and possibly employers, but it was accepted that the financial and political case for the employment of vulnerable people has not been articulated effectively. For example, employment of vulnerable people may have more impact on areas of criminal justice and health than on the UK job market. This is an area which needs further investigation.

What is good employment?

McJob – a low-pay, low-prestige, low-dignity, low-benefit, no-future job in the service sector. Frequently considered a satisfying career choice by people who have never held one. (Westwood, 2002)

Information from the Work Foundation cautions that a number of social problems (including sickness and dependence on welfare benefits) have their roots in ‘bad jobs’, indicating that it is important for vulnerable people to have a ‘good job’. However, it is really not clear what a ‘good job’ would look like for a vulnerable person.

During the discussion, there was general agreement that employment should be viewed as a continuum, ranging from structured activity at one end to earning a living wage at the other. Linda Butcher presented the useful framework shown in Figure 1, opposite.

Reviewing the framework gave rise to a number of important points.

- There is less provision at the early stages when it’s most needed.
- There is a tendency at Stage 4 (Support) for each agency (health, social services, etc) to carry out their own assessment, with the result that the individual is repeatedly asked the same questions. This could be addressed by the individual’s support provider acting as a broker between the individual and the agencies.
- Not everyone will go through every stage, and some stages can be undertaken concurrently.
- Stage 7 (sustainable employment) may not be the ultimate goal for everyone. Alternatively, this stage could be renamed as ‘sustainable occupation’ (not necessarily paid employment).
- It was agreed that the attitude and culture at Rolls-Royce may need to be replicated elsewhere.
Does work work for vulnerable people?

Figure 1  A CONTINUUM OF EMPLOYMENT

Stage 1 – ENGAGEMENT

Stage 2 – NEEDS ASSESSMENT

Stage 3 – INDIVIDUAL ACTION PLAN

Stage 4 – SUPPORT
Holistic, flexible, tailored, ongoing

Stage 5 – LABOUR MARKET PREPARATION
Work placement, volunteering, in-house employment, supported scheme placements in social enterprises

Stage 6 – IN WORK SUPPORT
Supported employment, mediation services with employers and social enterprises in work, financial advice, progression routes, employers' support and advice

Stage 7 – SUSTAINABLE EMPLOYMENT

Source: Fothergill (2007)
At Rolls-Royce, the phrase ‘can attend work for a cup of tea’ has become an accepted informal ‘certification’. It means that a person who has been off sick is now ready to have some engagement. (Mindout for Mental Health, 2003)

So what’s stopping us?

The group accepted that one of the key reasons why there are fewer ‘starter’ jobs available for vulnerable people is that employers are increasingly turning to immigrant labour. The group agreed that the additional costs associated with supporting people into work must be acknowledged, and there must be greater clarity over who should pick up this cost.

The group noted that third sector organisations are sometimes reluctant to encourage clients into employment, partly for historic reasons associated with charitable status, and partly because they may fear that work might have an adverse impact on their clients. There was general agreement that this attitude is unhelpful.

Another key barrier seems to be inexperience on the part of employers in managing vulnerable employees. Their concerns about sickness, absence, fluctuating work patterns and the reaction of other employees can be easily addressed by effective training, but this is not happening at present.

It was also agreed that the need for flexible working must be reflected in the benefits system, since, in spite of much rhetoric, the benefits trap remains a key barrier for most vulnerable people’s progress into work.

Summary of findings

The group established and prioritised a clear set of findings as follows.

- It is important to differentiate between the differing needs of vulnerable people when discussing employment. One size does not fit all.
- We must focus on the vulnerable people who want to work (and not get too side-tracked by the small minority who are not interested in this opportunity).
- We need more varied pre-employment opportunities.
- Employers need more intermediary support.
- We lead multi-dimensional lives. Work is simply one element. We must recognise the impact of progress and regression in each of the multi-dimensional areas of a vulnerable person’s life.
- Agencies tend to ‘hold people back’ for a number of good and less good reasons.
- The benefits trap remains paramount.
- This is a marginal issue from a political point of view; dealing with the employment of vulnerable people won’t improve GDP.

Summary of priority actions

The following issues were prioritised for further action.

- Implement culture/system change regarding the employment of vulnerable people within our organisations.
- Develop tools for HR staff and managers to use in implementing change.
- Research and develop social enterprise models which offer viable alternatives to open market employment.
- Get engaged in a debate about the cost/benefit analysis of vulnerable people working.
- Develop new tools to discourage GPs from signing people off sick.
- Develop and articulate the political and financial arguments.

Conclusions

Overall, the discussion concluded that the barriers are significant, and that policy in this area is complex and overlapping.

The group concluded that the vast majority of vulnerable people want to work, but that myriad barriers prevent them from getting involved.

There was strong agreement that, in the labour market, ‘equality begins at home’ and that third sector employers can and should take practical action by modelling best practice in the employment of vulnerable people.

Participants

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Does work work for vulnerable people?

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Martin Kinsella, P3, www.p3charity.com
Andrew McCulloch, Mental Health Foundation, www.mentalhealth.org.uk
Judy Weleminsky, Mental Health Providers Forum, www.mhpf.org.uk
Joan Smith, University of North London, www.londonmet.ac.uk

The event was facilitated by Lucy Asquith from Cordis Bright, www.cordisbright.co.uk and recorded by Bernadette Scott of Carr-Gomm.

Resources which informed the discussion
CBI (2005) Making the Case for Diversity – The CBI’s diversity statement. CBI.
Orr L, Bell S & Lam K (2007) Long-Term Impacts of New Deal for Disabled. DWP.
Never a dull moment?
Promoting social well-being in extra care housing

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Abstract
Extra care housing is an increasingly popular form of housing with care for older people, largely because of its potential for maximising independence by providing flexible care and support. However, far less attention has been paid to another important aspect of quality of life, social well-being. This article reports on a research project that explored good practice in promoting social well-being in extra care housing. We identify several key factors in supporting the social lives of residents and present recommendations for good practice.

Keywords
extra care housing; social well-being; older people; care and support

Introduction
Well-being is at the heart of what older people say they want from public services. The first report of the UK inquiry into Mental Health and Well-being in Later Life (Lee, 2006) identified the key aspirations of older people as freedom from discrimination, participation in meaningful activities, good relationships, good physical health and an adequate income. The Joseph Rowntree Foundation Task Group on Money and Care for Older People (JRF, 2004) stressed the importance of looking at older people’s issues from a ‘whole person’ perspective. It identified a range of principles important to older people, including ‘being valued for their lives and experiences’ and ‘having the choices and control to feel independent’. Opportunity Age (DWP, 2005)
is the first ‘joined-up’ national strategy on ageing, and has a cross-cutting agenda to address the inclusion of older people. Crucially, Opportunity Age emphasises active ageing in communities, and choice and independence in services. The Sure Start to Later Life policy (ODPM, 2006) is another key initiative focused on well-being for older people. Opportunities for leisure, learning and volunteering have been shown to enhance well-being, in addition to having a ‘decent’ home.

**Extra care housing**

Extra care is an increasingly popular model of specialist housing with care provision for older people, and developing extra care is a key plank of government policy to promote choice, independence and well-being for older people. In addition to development funding from the Housing Corporation, the Department of Health has invested £147 million between 2004 and 2008 in the Extra Care Housing Fund. An additional round of funding for 2008/09 has recently been announced. There are many different models of extra care in existence, but at its core is provision of housing with the full legal rights associated with being a tenant, or home-owner, in combination with 24-hour on-site care that can be delivered flexibly according to a person’s changing needs. Extra care is primarily about quality of life, not just quality of care, and there is growing recognition that it should cater for people with diverse needs, including those with dementia (Evans et al, 2007). It can be for rent, outright sale or part ownership, and an increasing number of developments are mixed tenure.

This research addresses specifically the challenge of how to maximise the potential of extra care housing in minimising social isolation, and was commissioned in recognition of the fact that there is a gap in the existing knowledge base on how best to promote social well-being in extra care housing.

**The research**

The research was funded by the Joseph Rowntree Foundation and was carried out by the University of the West of England, Bristol and Housing 21. Data was collected through in-depth interviews with tenants and managers from six extra care housing schemes in England. Research governance was provided by the University of the West of England, Bristol in its role as research sponsor. The research was supported by a project advisory group, which included service user representation.

**Factors in social well-being**

Interviews with tenants and scheme managers identified six main factors that play a part in promoting social well-being:

- friendship and social interaction
- engaging with the wider community
- the importance of design
- the role of family carers
- staffing and the culture of care
- providing facilities.

This section provides an overview of the main findings in relation to each of these factors.

**Friendship and social interaction**

Most tenants expressed satisfaction with their social lives in extra care housing, and several compared it positively with the situation in their previous accommodation. For many tenants the friendships that they developed within the scheme were the basis of their social lives, ranging from casual acquaintances to intimate friends. Other tenants were more reserved about their relationships with other tenants, as described in the following comment from a female tenant living with her husband.

> ‘The social life is not too bad. Yes, we have very good neighbours, very good neighbours. We don’t put ourselves forward, we don’t impose ourselves on people, we never have done.’ (female tenant)

The main opportunities for social interaction were activities arranged within the scheme. These were highly valued by residents, as demonstrated by comments such as ‘Never a dull moment!’. A variety of external trips were also organised for tenants, including visits to restaurants, garden centres and concerts, and a firework display, boat trips and regular visits to a swimming pool.

There was considerable variation between schemes in the range of activities on offer. All the schemes studied organised regular social activities, but some were more imaginative than others.
Examples found during the study included music and dance workshops, exercise classes, arts and craft sessions, a men’s group and hydrotherapy. Where activities of this sort existed, they appeared to be greatly valued by tenants, as the following quotation suggests.

'It keeps us on the move, we don’t do anything other than the sitting down, but it is arm exercises and spreading your hands and all this sort of business, keeping your joints on the move mainly which is quite enjoyable.’ (female tenant)

Some tenants found it difficult to take a full part in all the available activities. This highlights the need to take into account a range of ability levels when planning activities, to ensure that they are inclusive. The study found good examples of inclusive activities, as described in the following remark from a tenant who used a walking frame to get around.

'I like music and as I say I like dancing. I get hold of the back of the chair and I dance around it, looking silly but not caring. I don’t care a blow what they think of me, I am dancing with a chair!’ (female tenant)

Several men interviewed felt that the activities on offer didn’t cater for their specific interests and as a result they spent a great deal of time alone in their flats. In one scheme this issue had been recognised, and a men’s group was established. Funds had been raised to purchase a pool table and an electronic dart board, both of which were very popular. Tenants who attended the weekly group talked very enthusiastically about it, and it seemed to generate a strong sense of belonging.

Although social activities present significant opportunities for social interaction and can be important components of social well-being, several tenants told us that they preferred to spend most of their time on their own in their flats, often watching TV or listening to the radio. For example, one tenant enjoyed having the opportunity to join in social activities, but equally important for her was having the choice not to take part.

'The best part of this is you can go downstairs and have a chat with them and be with them, but if you want to shut your door then you do. You shut your door and you don’t want to see nobody, you don’t want anybody chatting to you.’ (female tenant)

As we have seen, social interaction within housing schemes is central to the social lives of many tenants. However, external friendships are also important. Several tenants told us that they continued to have regular contact with external friends. For many this took the form of meeting to go out to shops, restaurants and other local facilities.

Engaging with the wider community
Another factor that can influence the level of external social contact is the development of links between the scheme and local community. For example, one tenant described her love of Sunday visits to the homes of Help the Aged volunteers for tea.

'I am taken to somebody’s house for tea, they take people in my position, an elderly person that doesn’t get out, and the drivers are all voluntary. We go to someone’s house; we have been to [a number of towns]. In the summer they have got beautiful houses, we sit out in the garden and you know strawberries and cream and all that.’ (female tenant)

Tenants gave a real sense that being part of community activities that took place away from the scheme made life more interesting, stimulating, exciting and engaging. For many of them, getting ‘out and about’ was something they would continue to do for as long as they possibly could.

The ability to engage with community activities was linked to a range of factors, including the availability and accessibility of transport, the quality of pavement access for those with mobility aids and the support of care staff. Those residents who were not able to take part in the community because of lack of mobility or ill-health suggested that this affected their general sense of well-being, largely because they felt restricted and missed doing activities they had enjoyed previously. Several tenants talked about using their electric scooters as a way of getting out and about, allowing them access to local pubs and
amenities. They also identified how poorly maintained footpaths and anxiety about crossing local roads could act as barriers to visiting local amenities.

The importance of design
Although a wide range of models fall under the umbrella concept of extra care housing, one increasingly common design feature is the use of indoor ‘streets’ around which schemes are arranged. These streets form a central route through the scheme and are often the site for shops, restaurants and a range of other facilities. The indoor street style of design has a number of advantages. By providing a safe, dry and level environment it maximises accessibility and increases the opportunity for tenants to move around the scheme and meet each other for both formal and informal social activities. There are additional potential benefits in getting the exercise that walking provides and accessing on-site facilities, thereby supporting independence. Accessible design is crucial in long-term care settings, and particularly for tenants with impaired mobility.

Our findings suggest that location can also affect social well-being in a number of ways, including ease of access to the local community and the opportunities it provides for social interaction. For example, schemes in rural areas are less likely than those in urban settings to be within easy reach of shops, banks and other community facilities, particularly for tenants who are physically frail. It can also be more difficult for people living in rural schemes to maintain contact with external friends, unless they live very locally. Equally, people from the local community are less likely to visit a scheme to use facilities such as on-site shops and restaurants if access is poor, which can reduce tenants’ opportunities for social interaction. The nature of the immediate site on which an extra care scheme is built is also important, particularly for physically frail tenants. One scheme in this study was on a steeply sloping piece of ground and was therefore virtually ‘out of bounds’ to tenants, because the sloping paths could be slippery, particularly in wet weather.

Accessible design needs to extend beyond the immediate scheme and be implemented in the local community as well. One scheme in an urban setting had good local pavements and many tenants used scooters to visit local friends and shops, but going any further was more difficult. There was a railway station 300 yards away, but it could only be accessed by a flight of steps. There were several bus services that served the local area, but the nearest stop was a 10-minute walk away. These factors can be substantial barriers to tenants who are physically frail. This highlights the need for better integration of extra care housing with local services and amenities.

The role of family carers
Family carers played an important role in the lives of many tenants in our study, in the practical, social and emotional support they offered. Practical support included hair cutting, cooking, decorating, home maintenance, shopping and providing transport to attend a range of events, facilities and appointments. There was a real sense that visits by relatives made tenants feel cared about, supported and special. In families that demonstrated care, affection and support, tenants articulated clearly a sense of belonging that underlined their independence and well-being. For many tenants, visits from family members were their main form of social interaction, and those with no close relatives or whose families lived too far away appeared to be at greater risk of social isolation. Some tenants could go out of the scheme only when relatives came to take them out. One tenant told us:

‘My daughter has got my car and she does a tremendous amount for us. If I had to go somewhere she would take me, and the same goes for my wife, you see?’. From the perspective of care managers, family support could be a key element in tenants’ successful integration into the housing scheme. Although structured care was provided through formal care packages, families offered a different type of support that could prevent tenants becoming isolated and help maintain their independence. The key to family involvement was clear communication by the staff to relatives about what was being provided for tenants in
their care, and ongoing encouragement to stay involved.

**Staff and the culture of care**

The findings of this study demonstrate that the culture of care in extra care housing can have an impact on social well-being in several ways. To a large extent, the overall approach in any scheme to tenant welfare and well-being is determined by the policies of provider organisations and the experience and attitude of scheme managers and other staff. For some tenants, care staff are their biggest source of social contact, and this is most likely to be the case for those who have little or no regular contact with family and friends. The system of care working in operation can be important in this respect. For example, some schemes operate a keyworker system in which one or two care staff regularly supported each tenant, while other schemes move staff around and also use agency workers. We found that the keyworker system offers more opportunity for social interaction through development of a stronger relationship between tenants and staff.

The opportunity for staff to interact with tenants on a social basis can also be limited by the task-orientated nature of some care contracts with the local council. One tenant described how this system operates, saying:

‘sometimes they haven’t got time and you have to sign their book, but usually they have at least 5 or 10 minutes talk with you.’

A task-centred approach also affects the ability to support tenants in accessing activities and facilities both within the scheme and beyond it in the local community. This can mean that there is little or no capacity to offer additional support to help a tenant get out, unless a tenant pays extra for this service.

Another feature of care provision in the extra care setting is that, while some care is available 24 hours a day, in the evenings and at night time the staffing is at a lower level. In one scheme a single member of staff was on duty after 5pm and at weekends, which limited the opportunity for tenants with impaired mobility to get around the court and attend social activities.

**Providing facilities on site**

The extra care housing schemes that took part in this study provided a range of on-site facilities including shops, restaurants, communal areas, hairdressers, beauty salons, gardens, day centres and guest rooms. For many tenants such facilities served as important venues for meeting people and were a focus of their social lives. On site shops and restaurants were particularly important in this respect, as indicated by the following comment.

‘No, there isn’t a shop, that is one of the drawbacks really. We all say we wish there was a shop if only to walk around and maybe meet people in the shop and get to know local people.’

One scheme had a restaurant when it opened, but it had proved uneconomical and had to close down. As a result, tenants had ready-cooked meals delivered to the scheme, which they heated up in their own kitchens and ate in their flats. This led to comments about missing the social interaction that communal mealtimes provided, as well as criticism of the quality of the food.

Communal gardens are highly valued by tenants as important social venues, particularly during the summer. In some schemes, poor access to the outdoors can be a barrier, particularly for tenants who use a walking aid. For example, one scheme in our study had a courtyard garden that could only be reached via a flight of steps, which made it inaccessible to several tenants.

All schemes have a communal lounge, and they are often the most popular area for socialising. Some schemes also have smaller ‘pod’ lounges, which are situated near tenants’ flats and take the form of separate rooms or areas adjoining corridors. They were important in creating a feeling of ownership and belonging, as suggested by a female tenant who said:

“Yes, this is our special one... we come in here for our meals, it is really nice.’

On-site facilities can also promote social interaction and well-being by attracting people from the local community into extra care schemes. Restaurants and shops appeared to be particularly successful in this respect, and
schemes with both these facilities gave the impression of being the most integrated with the local community. In some schemes these facilities could be maintained as commercially viable only through the custom of people from the local neighbourhood.

**Conclusion**

The findings of this study suggest that social well-being is an important issue for people living in extra care housing and should be considered in the commissioning, planning, designing and managing of extra care housing. Some tenants are at particular risk of social exclusion, including people who have recently moved in, people who don’t receive regular contact from family or friends, people who have impaired mobility and those with dementia. It is important to identify tenants to whom any of these conditions might apply, and to offer them appropriate support. Accessible design throughout a housing scheme is central to promoting social interaction for all tenants. The opportunity to develop and maintain a social life that is independent of the housing scheme is also crucial. This means facilitating tenants to engage with the wider community by, for example, accessible design and convenient transport.

Extra care housing is a relatively new and increasingly popular choice for older people. The evidence for its effectiveness is still thin, and further areas suggested for study include the impact of systems of care provision, how to maximise support for couples, an evaluation of the value of extra care to the wider community it serves, gender, and the role of specific facilities in supporting independence and quality of life. It is important that an evidence base of good practice is developed and disseminated. Involvement of designers, local planners, service providers and other interested parties at an early stage of development is crucial to achieving schemes that are integrated with the local community.

**Acknowledgements**

The full report from this study can be downloaded from the Joseph Rowntree Foundation website at www.jrf.org.uk/bookshop/details.asp?pubID=912, along with a review of the literature on quality of life and well-being in housing with care settings. A directory is also being developed containing suggestions for good practice for social well-being and signposting to further information. This will be available on the website of the Housing Learning and Improvement Network in the spring of 2008, which can be found at: www.icn.csip.org.uk/housing/.

**References**


Shared living in supported housing – client responses and business decisions

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**Abstract**

The shared housing model has been used widely for many years in association with supported housing. It is the subject of debate among providers and commissioners, who may regard it as old-fashioned and not conducive to independent living, but for some clients and organisations it continues to offer a positive option in helping alleviate loneliness and isolation. Current growth in the work of social landlords and their agents includes a wider range of client groups with a variety of aspirations and support needs. Shared housing may offer new opportunities to these groups. With the new emphasis on neighbourhoods and inclusion, does the shared housing model possess attributes that commend it to communities in new ways, or is it a model of the past? The article offers suggestions to enable shared housing to be evaluated as part of housing associations' business plans while keeping a focus on residents' views, as reflected in 25 case study locations.

**Keywords**

shared housing; supported housing; business planning

**Introduction**

This article is based on the case study element of research conducted for Carr-Gomm and supported by the Housing Corporation. The research had a number of aims, including providing evidence of the effectiveness of shared supported housing, and providing guidance for
practitioners and commissioners that would assist them to evaluate their existing shared housing portfolio.

Central to the approach of the research was the focus on residents’ views of their housing environment and evaluating:

- the impact of shared living on positive outcomes such as development of individual skills and sense of independence, strengthening social networks
- the impact of shared living on mixed-needs groups in terms of positive outcomes
- the influence of external factors such as location, availability of other services and other factors such as existing social networks, stigmatisation and peer/informal support
- the diversity implications with regard to gender, sexuality, age and ethnicity
- differences in outcomes for each need subgroup (mental health, learning disability, substance misuse, offending behaviour, for example).

The Partner housing associations (Look Ahead, Stonham, Ekaya, McIntyre Homes, Tuntum and Carr-Gomm) were chosen to give case studies from national and local housing organisations with shared housing models for a range of groups requiring support in the fields of:

- mental health
- learning disability
- domestic violence
- young people
- single homeless
- mother and baby
- ex-offender.

**Working definition**

There is no single definition of supported shared housing, so for the purposes of the study the following statement was adopted.

**Accommodation occupied by individuals who may require support and where there is a degree of shared use of all or any of the following: kitchen, bathroom and toilets, and other facilities such as sitting rooms which are offered in conjunction with private space (e.g. bedroom).**

**‘Kitchen table’ interviews**

The field work element of the research was conducted as ‘kitchen table interviews’. The research team invited the ‘household’ to meet and discuss their experience of and insight into living in a shared house, using the key themes of:

- environment (description of personal and shared space and how it works for them)
- people (perceptions of living with others)
- lifestyle (views on the impact shared living has on lifestyle)
- any other general issues on shared supported housing not covered by the interview that residents wish to convey.

**Summary of key findings**

From the evidence of interviews and meetings with nearly 100 residents, staff, Supporting People teams, and other associated professional and policy influencers, we are able to offer some insight into the impact shared social housing (SSH) has on people and policy. The results are summarised under the following themes, which run through residents’ responses to shared housing in terms of ‘what works – what doesn’t work’: the impacts of living and experiencing shared social housing.

**Themes**

**Theme 1: Buildings matter**

- Residents value good-quality buildings that are clean, tidy, safe and well-managed.
- ‘Dead’ space in a shared living environment is detrimental to successful outcomes for residents. Shared space must always have a function.
- Circulation areas are crucial for some groups. People like to see and hear people moving around a building, even if they wish to remain private and not join any activity.
- A private toilet is by far the most desired facility across all groups. This wish can be expressed in gender and cultural terms, where different habits can cause considerable distress to those who share a toilet.
- Most groups of residents, when asked to prioritise sole use of a kitchen or bathroom, say that a private bathroom is more important.
- Residents like clean, well-equipped and frequently used communal kitchens. There should always be somewhere to sit round a table. Communal kitchens are still valued, even if residents have their own kitchen.
- Location of buildings is particularly important for all groups. Residents wish to be in safe locations with good
Transport links to areas where they can extend their life and networks. Being near cafés, shops and places of entertainment is important.

**Theme 2: The challenge of on-site management**

- Good management can overcome the disadvantages of poor locations, but poor management cannot be overcome by a good location and/or a good building.
- Residents understand the roles that on-site staff play in fostering independence, and are generally aware of the intention that move-on is one of the key outcomes. Most residents fall into three groups in relation to moving on: those who are anxious to establish themselves in independent self-contained housing (for example women fleeing domestic violence and some young people and ex-offenders), those wanting to move on but who anticipate the need for ongoing support, and those who are anxious about moving out under any circumstances. Staff have to manage these varied expectations.
- Most buildings had an office for on-site staff. These spaces were used in a variety of ways: from locked offices private to staff, through to a place where residents sit and talk informally to staff. On balance, residents say that they prefer to have an office on site in preference to peripatetic staffing, even if the office is staffed for only a part of the day.
- Young people's schemes need highly managed shared environments and mutually agreed expectations of how they should be used and looked after.
- Having a clean communal environment is important to residents. Cleaning should not be subject to 'cuts' in service or, if resident rotas are used, they have to be seen to be fair and be managed by staff.
- Residents express the wish to 'be involved' in who lives in the shared house, either by direct involvement in the letting (prospective residents viewing and meeting those in the house) or in setting criteria that reflect a requirement for the new person to enhance the life of the scheme, not detract from it.
- Residents express fear of any possibility that violent people or those on drugs might come to live with them.

**Theme 3: Different groups need different things from shared supported housing**

- There are transitional groups (mother and baby, ex-offenders, women fleeing domestic violence) and more permanent groups (mental health, learning disability) who need different things from their accommodation. Some need the sense of a stable 'home' while others need to feel that their stay will be as short as possible. How such differing expectations are managed has an impact on residents' motivation to develop and move forward.
- People are either drawn to shared supported housing by positive features such as the expectation of companionship and security, or are repelled by it, living there not because they want to but because it was the only accommodation on offer. How a person arrives at a project and whether they had a choice affects their attitude to the staff and other residents.
- Some groups said that they tolerated many perceived restrictions in order to improve their position in the longer term (learning new skills, getting on with people, having access to onward housing).
- The research team observed behaviours that could be termed 'communality', which is different from sharing. Communality is about people 'knowing' people, having some empathy and acting as a household for the common good. The power of peer support was evident in most of the case studies, albeit to varying degrees.

**Influences**

Perhaps surprisingly, there was little evidence that the participation of neighbours and the wider community in the life of the shared house was any different from that in an 'ordinary' house in the street. Some projects, such as women's refuges, rely on invisibility and a low profile for their very existence. The evidence from the case studies suggests that most projects live quietly next to their neighbours and that there is little overt project-based involvement in wider community life.

Although there is a school of thought that suggests that opening up projects to the community will enhance a resident's life, on the evidence of the case studies this is not
what is required or desired. Providing security and carefully constructing the conditions that enable residents to develop their life beyond shared supported housing can be a delicate process, based on the experience of staff and their detailed understanding of the residents’ requirements.

The diversity implications and impacts
There are three diversity impacts that occurred on a number of occasions that are of note.

• Women and men can and do live together in shared houses, but concerns were voiced by women worried about new males entering the house.
• Some women (especially women with mental health problems and young women) prefer the option of women-only households at times when they felt particularly vulnerable.
• Age-related lifestyles can be extremely disturbing, especially to older residents if noise and forms of anti-social behaviour (mainly drinking) are involved.

• There was also evidence of rising aspirations among younger people and young mothers with babies from a number of ethnic groups, who felt they had gained confidence from being in a positive environment where training and education was encouraged.

Differences in outcomes

Access to move-on
Staff and residents had no doubt that good and timely offers of move-on were the greatest factor in securing best outcomes for most people.

Views on self-contained accommodation
Most residents saw their accommodation as an option for a limited time, and were content with it in the knowledge that ‘their housing association would make sure they were OK’. Residents with high levels of self-contained space still regarded it as ‘not the same as’ living in independent housing, but this was not a negative comment, rather a perception that they felt they might experience more isolation in different accommodation.

Providing opportunities to aspire
On the basis of the ‘kitchen table interviews’ in three mother and baby projects and four young people’s projects, residents with more structured training and educational opportunities used more motivational and positive language about future expectations of economic and social independence.

Use of choice-based lettings
A number of projects encouraged residents to use choice-based letting systems to find their onward housing. Residents from 20% of case study projects mentioned that they expected to use, or did use, choice-based lettings systems on their own initiative. Most people using choice-based lettings were mothers and babies, and women fleeing domestic violence.

Outcomes evident for all groups and expressly mentioned can be summarised as:
• increased social confidence
• a sense of security
• expanding social networks (although some ex-offenders said that it was preferable not to mix with other ex-offenders for too long)
• a more positive outlook (directly related to move-on availability).

The views of Supporting People teams
Supporting People personnel were contacted in most areas where the case studies were located. The key themes running through Supporting People responses were as follows.

The strategic view versus pragmatism
While some Supporting People authorities had a policy statement, based on the principle that self-contained accommodation was the best option and therefore the model of the future, most respondents indicated that they were dependent on the current number of shared supported housing schemes, and for the most part were keen to see them continue to offer a service.

Value for money, scale and location
In areas where Supporting People services were stretched due to geography, it was important that shared supported housing in areas of concentrated population should be used as bases for outreach services.

The problem of move-on
Securing adequate move-on accommodation was an issue for all respondents. This has prompted a number of initiatives to ensure that the detrimental
effects that arise when residents outstay their optimal time in a shared house are minimised.

**Suitability of client groups**
A majority of Supporting People respondents mentioned the benefits of peer support which they attributed to the shared model and which they thought had a number of advantages for moving to more independent living and building capacity to feel engaged and confident. There was acknowledgment that people with different support requirements derived different benefits from the shared nature of projects, and that the most pronounced division is between those who intend the accommodation to be short-stay from the outset (domestic violence, ex-offenders and young people) and those who derive security from the notion of a longer stay (mental health and learning disability).

**Supporting new developments and best practice**
There were a number of suggestions for improvement.
• Supporting bids for refurbishment of existing properties or development of new projects where the element of sharing was carefully constructed to retain the peer group and communal support but where private living space was really self-contained – the best of both worlds.
• Interest in the overall standard of accommodation, which did not preclude new shared accommodation per se. Smaller project units (up to eight people) are generally considered beneficial, though this depended on client groups and the practicality of development costs.
• Client feedback on design and service delivery for new developments should be conducted formally by Supporting People teams where clients’ overwhelming requirement is to obtain self-contained accommodation with continued support and access to facilities/mechanisms that help retain valuable social networks. Core and cluster developments were felt to be a useful and fundable design for new developments.

**The chief executives’ views**
Five of the six chief executives/senior officers of the Partner housing associations were contacted to give their perspective on SSH in their organisation.

**Re-thinking the business case**
Most Partner’s business plans had developed strategies to reduce shared supported housing, designed:
• to reduce dependence on Supporting People funding where it was uncertain whether current projects would be recommissioned
• to reduce stock as part of an investment-led asset management strategy
• to plan for organisational change in advance of expected changes in revenue
• to respond to aspirations as seen in resident feedback exercises demanding more access to self-contained accommodation and move-on
• to look for savings in management costs by linking projects
• to reduce catering costs by building in kitchens (in the individual units or as training kitchens) to enable residents to cater for themselves.

**New development and upgrading of stock**
All five Partners anticipated or were involved in new development for their traditional client groups, and were using their experience of shared housing (positive and negative) to think through new approaches that sought to continue the benefits of sharing (peer support, space for communal activity, security) while maximising self-containment. Models such as core and cluster and self-contained units with communal shared facilities such as training kitchens, meeting areas and a computer/homework area were very much ‘on the agenda’

Not all redevelopment plans involved total overhaul of buildings. Partial upgrades with a minimum standard of providing individual units to offer en suite bathrooms were popular.

While some Partners wished to increase their turnover by contracting for ‘support only’ contracts, their property base continues to be crucial to the long-term business profile and identity.

**Growing dependence on mutual understanding and partnerships**
Specialist supported housing providers are, in the main, dependent on other housing organisations to secure move-on
accommodation. As with the comments from Supporting People representatives, this is cited as a key strategic business development and operational factor which is preventing some projects from achieving their best outcomes.

**A business approach to evaluating supported shared housing**

The research suggested a model for evaluating shared supported housing as part of the business case for continued use, development or rationalisation of the stock *(Figure 1, below). Figure 1 shows a model that brings together the strategic and operational facets of an organisation that wishes to review and act on the future of its shared supported housing.

The key to this approach is to ask questions in a systematic way to build confident business decisions on whether shared supported housing has a place in the 21st century.

The model is based on the simple process of SWOT analysis (strengths, weaknesses, opportunities and threats) and/or PEST analysis (political, economic, social and technological), focused on shared supported housing. Most organisations will be familiar with these analytical tools, and SWOT can usefully be applied at scheme level while more strategic staff might wish to use PEST to broaden their business thinking.

The model requires a project management approach to co-ordinate the SWOT and PEST analysis at all levels in the organisation, starting with the staff and residents of SSH, through local management teams looking at shared supported housing in the locality/region, then involving central and senior staff concerned with the impact of shared supported housing on the overall business. Finally, the governing body endorses a new policy based on a well-researched review of the future of their SSH portfolio.

The model requires feedback between the strategic and the operational, by regular briefing notes or meetings where operational and strategic staff share progress. The more feedback between the two, the more likely that new ideas and options will emerge. (The research papers suggest a series of questions that can be used to aid the evaluation.)

![Figure 1](image-url)
Contextual factors for the business case
There are a number of issues that organisations should consider in the next period, say 2008-2012:
• economic factors on new-build costs to provide new housing under the Government’s growth targets
• projects that are revenue-neutral or result in revenue savings through saving on overheads
• asset improvement to the social rented stock
• proven added value through partnerships.

At social level, shared supported housing will have to show that:
• it can survive the local area agreement’s devolved governance and budgetary arrangements
• it is an understood and accepted model for specific vulnerable groups
• it is increasingly associated with a better quality of life for all.

At resident level SSH will have to show that:
• it is a model of choice within a range of options
• it provides a consistent standard of facility and management.

Supported housing organisations can respond or react to these issues and changing policy environments in either an ad hoc or a considered way. Shared supported housing has to earn its place in the range of housing options available.

Remembering the focus of this study – the impact of shared supported housing on those who live in it – we suggest that the way forward must be based on rigorous, imaginative and inclusive evaluation for every housing organisation with SSH. That means focusing on this housing type in a comprehensive way.

The final chance for the shared supported housing model?

If shared supported housing is to become as accepted as, say, sheltered housing for older people, the brand needs a makeover; it must have integrity, and provide what the customer wants.

If shared supported housing is to survive and develop, a definition is needed of the model and clarity about what it offers that is distinct from other forms of housing and support. Saying or believing it is a second-best option does not do the model justice.

Housing organisations should make a robust, well-informed, comprehensive business case for the model, before making decisions to dispose or develop.

Ironically, it may be the new approaches to individual budget holding that will determine the next phase of shared housing (who will choose to leave and who will choose to stay), and perhaps provide the impetus and the encouragement for new designs and innovative forms of management to mark out this model as a real housing choice.

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Unmet needs for low-level services

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Abstract
This article draws on consultations with older people produced for a Joseph Rowntree Foundation (JRF) study on the unmet need for low-level services among older people in England. This was published in 2007 (Clough et al, 2007). Since it was published there have been significant changes to the social care scene. The Government has given further emphasis to individual budgets (now termed personal budgets), many local authorities have further restricted the criteria for eligibility to social care services, and publications such as Time to Care (CSCI, 2007) have highlighted the shortcomings of home care services, as well as their strengths and importance. We also know more about older people’s views of health and social care services (Health Care Commission, Audit Commission and Commission for Social Care Inspection, 2006). In this article we set out to relate findings from our research to current realities.

Keywords
unmet needs; low-level services; older people
Messages for service provision

Living to the full
The first point is that it is often assumed that the major problem is shortage of funds. Of course there is a shortage of funds, but an increase in funding alone will not solve some of the problems that we encountered. Perhaps the over-riding impression from our study is that many older people do not know what they want from public services, or what would best meet their needs. Services are premised on the rational view that there are things that people cannot do and the task is to find the best solution. The problem is that people do not live their lives, or assess their situations, solely in this way.

Older people talk about their lives, not services. Someone may talk about the joys of seeing children and grandchildren and yet feeling lonely, not bothering much with meals since the death of a partner. Alongside this, they may have problems with practicalities: payment of bills, getting the rubbish out in the proper recycling bins or putting drops in their eyes. ‘We all want ordinary living’, as one person commented in the end-of-project consultation (Clough et al, 2007).

There is also abundant evidence that many older people set their sights low, accept lack of services, do not know the services that might be appropriate and are unsure where to go for advice. Thus there may well be a discrepancy between a person’s situation and the support that is available or offered. Participants at the end-of-project seminar argued that some older people led restricted lives and that there were opportunities to expand horizons: ‘groups that went to theatres, museums, walks or swimming and aqua-aerobics’(Clough et al, 2007 p71).

There are important messages for public services and the third sector of voluntary and community groups.

Assessment
The first of these messages is related to assessment. The task of assessment seems to be constructed around an examination of daily living, consideration of the tasks that people cannot manage, and working out how best to compensate or to rehabilitate. Such an approach does not allow the older person to reflect on their life, which in turn might help someone to think about their present condition in relation to their past and future. This would have been a part of the best of former social work assessments, but is not likely to take place currently (Manthorpe, Moriarty et al, 2007). Some of the support that people want is to think about their lives and how best to live today. A second-tier consideration is to search for how to get what is wanted, including thinking about what the state will provide. Indeed, one person spoke of wanting to be remembered as a person amid the focus on providing services.

What are older people concerned about?
Older people’s comments to researchers in this project showed that their worries – and thus their wants and needs – do not fall into neat boxes.

The increase in home ownership meant that people worried about how they would cope in the future with doing all the things to maintain a house that they had carried out before, in particular repairs and maintenance. The concerns about home management were real for all householders. How, they pondered, were they to manage:

• cleaning generally, and vacuuming in particular
• laundry
• minor household tasks like replacing light bulbs, tacking down unruly carpets and other floor coverings, and ‘odd jobs’
• putting out the ‘wheelie bin’
• clearing snow
• safety and security: fitting smoke alarms, peep holes, additional locks to windows and gates
• grab rails, ramps and other aids to mobility (not subject to occupational therapist assessment) (Clough et al, 2007 p5)?

Why, some asked, did nobody take a holistic view? It was not just that those we talked to did not know what to do when situations arose; the concerns were heightened by worrying in advance. They sought peace of mind.

The respondents spoke also of how different aspects of their lives intermeshed. Some referred to being alone, to feeling alone, to wanting to go out and meet friends, to feeling safe, to the lack of public conveniences and the difficulties with transport.

Unmet needs for low-level services
There is increasing evidence from research of the links between state of mind, activity, sense of well-being and health (Wistow et al, 2003).

Management of personal affairs or 'business' was another area that caused concern: interpreting official correspondence, corresponding with utilities and others, writing Christmas cards, being advised/seeking advice, PIN numbers and pets (Clough et al, 2007 pp8–9). Others said that they were anxious about:

- staying informed about benefits and filling in forms
- managing shopping (choice, control, collecting prescriptions, Christmas presents, nutritional information and advice, help in selecting and trying on clothes, hairdressing)
- transport (cost, accessibility, fit with planned destinations, their capacity to drive)
- socialising (staying in touch, community participation)

Finite resources, changing expectations and provision of services.

All this must be put in context. The people we spoke to knew that resources were not limitless, and were not arguing that the state should take over responsibility for all these aspects of their lives. They stated that sometimes they did not know how they would cope; worries preyed on their minds. They did not know what they were entitled to. This is not surprising, as there is a lack of clarity about what is available from central government, and a confusing array of local variations. Yet notions of 'staying in control' are predicated on having sufficient information to make decisions.

The points that have been made so far should be put also in the context of what is known about ageing. There are the obvious truths that people are living longer and expect to be fitter and possibly to do more than did previous generations. In addition there are higher expectations for themselves and for their lifestyles. Yet alongside this there are less recognised factors. Some do not want to take responsibility for sorting out the services that they want and then managing their provision, others are confused by the systems that they have to negotiate, another group may be depressed. Our point is that the solutions to services that have not been sufficiently individually focused are not to be found in a single model of service delivery.

The framework for better services

The terms 'low-level' and 'that little bit of help' have been important in promoting the ordinary and practical services that people want. Our conclusion is that they must now be scrapped because they suggest that some services are less important than others.

We favour greater clarity in the terminology for what public funding should do to help people who need support, whether it is termed 'eligible' and 'ineligible' services or becomes part of self-directed support or personal budgets.

- Alongside terms such as treatment and prevention, we want to give primacy to well-being. In later life, as at other life stages, citizens should be supported to lead full lives.
- Rather than talking of older people's needs, we should focus on their rights as citizens.

What older people told us was that they wanted public services to provide:

- sources of information that are easily accessible and up to date
- someone to talk to about options
- a system that alerts people to the possibility of support services, rather than one which relies on people not asserting themselves, a hidden form of rationing
- monitoring, or occasional visiting for some older people – a mix of oversight and assessment
- easier access to council or local authority offices, especially by telephone.

The implications for support services

There were some over-arching themes from our discussions with older people.

- Older people stressed their individuality, with different histories, hopes and dreams, and different priorities in the management of their lives.
- People from black and minority ethnic groups equally wanted access to individualised services,
Unmet needs for low-level services

but might have particular needs, for example for interpretation, opportunities to share experiences in community centres or specific information. Other people share some of these possible access problems but in different ways, among them those who have disabilities such as hearing or visual impairment.

- Older people want to be involved in debating the level of resources to be made available and how resources are to be allocated.
- Meeting the needs of older people, whether by relatives, friends, volunteers or paid staff, must be grounded in local communities. Planning at community level must find ways to deal with the realities of people's lives, however they cross service or organisational boundaries.

Other themes emerged from the survey of local authorities that we also undertook for this project.

- Recording of wants and needs – whether services were provided or not – varied hugely between authorities. Many had no records of the needs of those to whom they did not supply services, and it was very rare to find any authority following up those who had been directed to other sources of help to see how they had got on. So if a local authority wants to know what needs are not being met, it is difficult to gather, rely on, collate and use this information.
- Practitioners are anxious not to raise people's expectations.

Developing support that people want

As we have noted, older people talk about their lives, not services.

It is immediately apparent that this sort of mix of life circumstances and feelings is unlikely to be met by any one service. Yet it is equally obvious that simply dealing with a number of practical matters may do little to improve a person's quality of life. There has to be a wider vision of developing opportunities for older people to lead fuller lives.

One policy approach that promotes a focus on fuller living is that of maintaining healthy living; if people remain fit they will be able to do more and are likely to feel better about themselves. Thus there are developments to promote use of swimming pools and gyms, to encourage older people to think about planning their environment to reduce the risk of falls and to think about their diet. All of which are proper and positive. Yet such programmes run the risk of ignoring the comment from an older person:

'We all want ordinary living.'

Recent discussions of diet and eating habits (Pollan, 2008) have highlighted the way in which increasingly foods are sold as health supplements, and demanded instead that we return to eating good foods. The same has to be the hallmark of people's lives – it is essential not to medicalise the whole of life. So the key question becomes:

In what ways can support services help individuals to live well?

We return to that later, in the meantime summarising key factors.

Finding out about services

People want it to be easier for them to find out what services are available, and people who will take the trouble to tell them about them.

Assessment

Elements of assessment important to older people are:

- help to review their circumstances and options
- for some, continuing contact with a worker, rather than a rushed single interview
- account taken of all who are living together, including carers
- individual focused work.

Are advocates widely available to support older people to express their own views and/or act on their behalf? Do workers take the initiative to make contacts and sort things out? Do practitioners seem to want to help? Too often, people have felt that hurdles have been placed in their way, hurdles that they cannot get over.

The key factors

The older people who participated in this study identified the key factors in the development of better services as:

- involving older people
- involving the whole community
- working with workers
- flexible, individual-focused services
Unmet needs for low-level services

• expanding choice of what is available
• being responsive.

The report cites some impressive examples of developments that change people's lives. Often they have occurred when those in a community have led or been centrally involved in thinking about what is wanted and how to provide it. Services that are rooted in the community have a far greater chance of ensuring that they match what is wanted, and also allow members to play multiple roles (for example to be both using and contributing to the management of a service). This last factor has been widely ignored; many of the examples of services that we saw and read about which were most valued were those where different events happened, individuals used the places differently and had different experiences. Often they had developed in places that might be called day centres, clubs or lunch groups. The title did not matter, but the structure and ethos of the place, together with its impact on those who went there, did.

Such places served various functions and became places:
• to meet others, with a drink or a meal
• to do things informally with others, perhaps to play cards
• to plan events, such as talks or outings
• to have access to services such as bathing, chiropody or 'flu injections
• to talk to staff or other older people about their circumstances and the available options
• to have hard to reach services coming into the centre – these will differ from area to area but might be welfare rights or a mobile library.

A characteristic of such places was that people could opt in to different activities, rather than be persuaded to join something that everybody was doing.

When services are inadequate, a frequent riposte is to blame the workers, to see practitioners as getting in the way. Many of the social care and nursing staff who responded to our survey were working hard to find ways to offer the best possible service. They were generally highly appreciated by older people. Practitioners have essential expertise that is wanted by older people; they must be seen as partners in the enterprise.

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The Strategic Commissioner's box of tricks

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Abstract

Commissioning is the Government's preferred method of driving improvement in both health and local government. Commissioning occurs at several levels, from strategic, high-level visioning to more intimate purchase by or on behalf of individuals who need services. While there is much written about commissioning as an organisational concept, the skills, knowledge and attitudes required to aid strategic commissioners do an excellent job are still not well articulated. This article looks at some of the key knowledge to be acquired in the near future that will assist strategic commissioners in getting to grips with their massive agenda. It charts key moments in recent policy development to reiterate their strategic role, acknowledges cross-cutting themes and seeks to define some of the more developed thinking that commissioning strategists will have in their box of tricks.

Keywords
strategic commissioning; procuring; social and housing services

The policy outline

Commissioning is not new, and local government has been both procuring and commissioning for many years. Procurement forms one part of the complex commissioning framework that for some time has tended to apply to social and housing services for children, young people and adults. This is described in the Institute of Public Care's Commissioning Framework set out in a number of documents and most recently in Key Activities in Commissioning Social Care (1997; see Figure 1, opposite).

In 1990 the National Health Service and Community Care Act formalised a purchaser/provider split in social care markets, introducing commissioning into care services on a much larger scale than previously. Services in the NHS were less affected. By 1999 the Health Act of that year had formalised an enabling framework to allow pooling of resources by health and local authorities. This still stands, the original guidance being amended in the NHS Act 2006. The legislation was designed to assist joint approaches to service
delivery and commissioning arrangements.

Children’s services were also undergoing change, and *Every Child Matters* (DfES, 2003) also laid great emphasis on commissioned services.

By the time the *White Paper Our Health, Our Care, Our Say* (DoH, 2006a) was published in January 2006, the Government was able to spell out its commitment for future health and social care services, again with commissioning as a pivotal influence. Indeed, by March of that year the *Joint Planning and Commissioning Framework for Children, Young People and Maternity Services* (DCSF, 2006) had established a commissioning framework for these services, signed by Ministers for both children’s and care services.

Commissioning was now firmly described as the method of accelerating and securing significant change and improvement, and a number of documents followed setting out the Government’s commitment to commissioning and service reform. These included:

- A *Stronger Local Voice* (DoH, 2006b)
- *Health Reform in England: Update and Commissioning Framework* (DoH, 2006c)
- *Partnership in Public Services: An action plan for third sector involvement* (Cabinet Office, 2006)

The expectations and details resulting from all these documents were then most clearly spelt out in the DoH consultation document *Commissioning Framework for Health and Wellbeing* (2007a), jointly signed off also by Communities and Local Government (CLG).

The clear message was that local government and health bodies should work more closely together. Local government was also asked to demonstrate its commitment to helping improve health and well-being through more than just social care services, important as they were. Housing, community safety, leisure services, education and transport were also obvious partners in painting a much wider picture. Two other important parts of the jigsaw were put in place in early December 2007, with the publication of guidance on both *Joint Strategic Needs Assessments* (DoH, 2007b) and *Local Involvement Networks* (DoH, 2007c), as a result of the enactment of the Local Government and Public Involvement in Health Bill in 2007.

As part of the drive to establish exemplary commissioning in PCTs, a paper establishing the vision and competencies for ‘world class commissioning’ was published in December 2007 (DoH, 2007d). While the main focus is on health commissioning, it echoes and supports the aspirations of

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**Figure 1 THE CARE COMMISSIONING FRAMEWORK**

- **COMMISSIONING**
  - analyse
  - purpose, demand & supply review, analysis of data
  - consult, conduct cost benefit analysis, design commissioning strategy
  - implement the purchasing process, contract management
  - budget & market management

- **PURCHASING/CONTRACTING**
  - review market performance, feedback into strategy
  - devise a purchase plan from commissioning strategy
  - contract monitoring & review
  - do

- **MONITORING & REVIEW**
  - strategy monitoring & review
  - review
The Strategic Commissioner’s box of tricks

The Commissioning Framework. To give further support to PCT commissioners, a Framework for External Support for Commissioners (FESC) (DoH, 2007e) allows PCTs to buy in commissioning expertise where they feel that their skills are particularly weak. Sadly, perhaps, the FESC process does not include local authorities as possible partners in commissioning improvement, and local government has no equivalent.

The 2008/09 NHS Operating Framework also re-iterates the importance of Practice Based Commissioning (PBC) in Health (DoH, 2007f). This encourages consortia of GP practices to purchase services directly to reflect local need, with PCT support. There is speculation as to how this might be developed to enable people with health problems, especially those with long-term conditions, to use health budgets more flexibly in the future.

In adult social services, the move towards greater choice and plurality by use of Individual Budgets (IBs) has taken policy on a parallel journey to health. While the aims are not dissimilar, the methods are. Through existing Direct Payment (DP) schemes and the developing framework for IBs, people are now being allocated budgets according to assessed need and given greater control of how services are purchased, with a variety of methods of assistance available to navigate systems. A number of pilot sites report their results formally to government in Spring 2008, when decisions will be made on this emerging policy.

Clearly, it will have a number of implications for the future development of strategic commissioning, not only in local government but also across the organisational boundaries between government departments, including the Department of Work and Pensions. Commissioning in all its forms has become a cross-cutting theme for government.

The eight big tricks for commissioners

The following brief descriptions outline eight areas of developing thinking for strategic commissioning, in the light of policy development thus far.

Using information

You can’t commission without knowing what you need to purchase. For that you need information.

Data is plentiful. The question is whether it is the right data, and whether the analysis and understanding of it are correct. The JSNA guidance, mentioned earlier, begins to set out what it sees as the key data. However, the purpose of understanding local information is to respond to local needs. It is important, therefore, that information is not only about understanding current activity. It must also set this against the changing demographics of the area and the expressed needs of the population. It will be the continuing engagement of communities and people using services that significantly aids commissioners to understand the change required and how the local market must develop.

Consultation is no longer sufficient. Some excellent examples of this are given in the Care Services Improvement Partnership (CSIP) publication Key Activities in Commissioning Social Care (2007) already mentioned.

Nor is activity data the only source of information. Complaints and compliments can give a good idea of quality, as can monitoring information from existing provision (which rarely seems to find its way back into commissioning intentions). The view of regulatory bodies is important, and national surveys can indicate trends and common requirements.

This means new skills in data collection and analysis (skills more usually found among the actuarial profession), new skills in continuous public engagement at all levels and new skills in developing providers, a theme returned to later in this article. In turn, this will feed the requirements of local area agreements and the local performance framework. As both PCTs and local government will be judged on this, development of good data and subsequent JSNAs is really important as a first step in commissioning.

Working with communities and people using services

Commissioning controls the value of investment (expenditure) in service areas. Changing the emphasis from requiring outputs (activity), which has been the most common result of spending in the past, to outcomes (results) can help drive the management of change through considering the success of the investment.
Thinking about expenditure as an investment is a significantly different way of thinking about how services operate for commissioners. Communities fund services, ultimately. They may well want to know what the return on their investment might be. Consultation and involvement in commissioning activity for the public are therefore viewed as absolutes, not only because they encourage participation, but also because they encourage discussion. Engagement in debate about the model of service commissioned for communities can help improve understanding and trust, and thus gain public support for tackling inequalities and increasing value. When based on good information (such as a mature JSNA), this will be a compelling exchange. Professionals use their knowledge and skills to develop thinking in line with good information and public wishes, and help people gain control through improved understanding. This does not prevent professionals from making commissioning decisions, and indeed they must. However, they do so with the broad support of their communities as they move towards articulation of the communities’ expressed needs.

New skills in communication, working with the press and media, the ability to inform the public of issues involved in decision making and asking for views (which are demonstrably listened to) are all key skills to be developed in this area of commissioning. Voice of the customer (VOC) approaches should be developed, and used to ensure a disciplined methodology for collecting, analysing and acting on feedback from priority community groups and service users. The Integrated Care Network’s Commissioning ebook\(^1\) contains a number of articles that relate to this topic.

**Developing markets**

Procurement has usually been about managing markets, which has often meant controlling suppliers by tough contracts, specifications and pricing policies. In provision of human services, while value for money is important, a different set of values have begun to emerge. They recognise that recipients of services do not want a service that is bought in bulk and delivered by an agency controlled by price and time constraints (even though they will always be a reality), but one that values them as individuals, over which they can exert greater control and which, ultimately, recognises their individuality. To enable micro commissioning that will help this become a reality, significant changes in relationships between providers and commissioners are required. This means a shift from managed markets to collaboration.

So how will strategic commissioners begin to develop markets that are less controlled by the established paraphernalia of procurement and more responsive to individual control, while still remaining affordable? The answer will lie in strategic commissioning:

- setting wider boundaries for providers
- demonstrating greater understanding of the financial frameworks and business implications for providers
- providing much better information on need within their communities
- developing outcomes frameworks that are mutually understood and that drive innovation
- being more open to a wider range of providers, including new providers and the third sector.

This last point may include lowering entry barriers to developing markets for some providers. Commissioners truly need to develop better understanding of their markets and of the motivations of those providing services. The most widely used business tool in this respect is Porter’s Five Forces (Porter, 1979).

Strategic commissioners need to be more aware of who is in the market, know what they can offer, challenge existing providers and use different but equally challenging methods of procurement. Most market development will be conducted outside the procurement process (which will be subjected to competition rules and requirements), but the right...
participants will enter the competitive phase with a clear idea of what is needed. New contractual arrangements may mean rolling contracts with regular reviews, opening the way to non-financial rewards.

Some future decisions on price will be made at the micro level, as individuals negotiate within the broad framework of strategically commissioned providers. Providers will be more accountable through open book accounting processes (to give true indications to the local community of cost, including for self-funding service users) and an emphasis on commissioning for outcomes, as well as their relationships with individuals who use money to purchase services directly.

The question will be how providers and commissioners arrive at this more trusting and open relationship. It will need improved understanding and motivation on both sides, including greater appreciation of what makes providers provide and why commissioners commission as they do. This will not be easy. However, first steps need to include regular forums and contacts between all concerned, a common agenda and methodology, excellent information, ways of sharing ideas and innovations, commissioners to ensure that legal and finance teams are closely hooked into the process and understand the changes required, and greater honesty between both sides as to what is important and a priority. Building Bridges (DoH, 2005) gives a tested methodology for starting this work.

Working the money
Many people will fail to qualify for publicly funded care unless there are significant changes in policy during the next few years. It is probable that there will be a tighter fiscal framework for both local government and health, if for no other reason than Britain’s demography, so working the money becomes more important. The Green Paper on social care, due for consultation later in 2008, is likely to consider this in the light of Wanless, and we will have to wait and see how it alters government policy on funding arrangements. This should not stop commissioners and providers from finding ways of reconfiguring services to be more efficient and looking for new approaches which use technology in positive ways.

Both administration and care oversight (as in assistive technology) can begin to ensure that every penny spent works for those receiving care, at the same time as care is improved.

Commissioners need to find ways of getting the most effective outcomes (results) for investment made. This calls for a significantly different approach to using money and the framework for working with the market. For instance, it would not be unreasonable for commissioners to ask providers to submit bids in relation to specific identified and required outcomes. Providers would then be required to tell commissioners how they would arrive at those outcomes, and would be held to account for them, with relevant rewards and penalties for success or failure. Rewards might not be financial, but access to different work or extended contracts.

The wider use of personal budgets will give individuals much more control over how money is spent, both by them and on their behalf. Strategic commissioners have the job of ensuring that this is understood, fair and equitable.

This will be challenging, and require new approaches to finance and audit regimes that have sometimes found difficulty in responding to new thinking in this area. Commissioners at all levels need to consider more transparent and understood costing methodologies in order to fix service delivery at a sustainable and economically viable level. This is an issue for providers, too, and a key issue in the strategy of developing markets will be for providers to be far more transparent about costs and margins, as part of their risk management framework.

Developing excellent skills
Commissioning organisations need to understand their role and purpose and reconfigure themselves to enable every chance of success for them and their staff. This means thinking through the skills, knowledge and attitudes that will have to be displayed, both collectively and by individuals. They will not be the same for everyone, although some over-arching principles, such as good financial knowledge and control, high levels of negotiation skills, data analysis and market development, will be important and relevant to many in
Commissioning organisations, even where the purpose is widespread.

The World Class Commissioning competencies mentioned earlier are a start to realising this. Skills for Care have also developed a document setting out individual commissioning competencies which is currently awaiting approval. Details (and the final documents once agreed) can be found at www.cwdcouncil.org.uk/projects/nos_cpc.htm.

Government needs to consider the role of commissioning in all sectors, and consider how it can best develop a single, responsive gateway to giving commissioners professional recognition and skills of the highest order. This is not yet sufficiently advanced, and sometimes still concerned with debating differences in perception of procurement and commissioning.

Smarter procurement
Procurement is the formal means of placing specific work (and consequently money) in the hands of providers. It is highly prescribed and legally regulated in how it is conducted. It can entail long-term commitments that tie up many millions of pounds (for instance in acute health care and housing projects), as well as shorter-term arrangements costing only thousands a year. Nonetheless, the financial axiom that you can only spend money once means that it is important to make the right decisions, however large or small.

The methods of procurement themselves need examination, with much more online activity to minimise paperwork. Ensuring that entry levels for new and alternative providers are appropriate is important. Relevant information should be requested only if required, and be germane to the decision. Methodologies for assessing content can also usually be improved.

When making decisions, few commissioners now ask routinely for providers’ risk assessments of potential contracts, and therefore miss the opportunity to discuss margins. Normally these should always be tied to risk, and commissioners may be able to reduce that risk and thereby lower cost.

Some commissioners may decide to procure collaboratively (sometimes called group purchasing) in order to use their bulk buying power to influence or change markets.

Interoperability
In the electronics industry this inelegant word has meaning as a customer requirement. The recent Apple iPhone is a realisation of interoperability, where you can play music, exchange emails and files, reference the internet and many other things as well as make phone calls. TVs and computers are moving in the same direction. It requires people in their separate businesses to sit down and say ‘we want to be better at what we do. We know that people don’t want to carry around different pieces of kit that don’t work together. We know that if we don’t get it right someone else will and we will not be in business. So how can we best co-operate to make this work?’.

Leadership
Leadership is essential. While charismatic leaders can be impressive and are sometimes needed to move situations on, this is not always the case. Many leaders are not well known because they steer organisations or movements or ideas by using their understanding and skill, and inspire trust and respect by
their behaviour. Nonetheless, there are skills that can be learnt to assist people in their roles.

While it is important that senior managers, boards and elected officials have these skills, it is also important to understand that leadership is a skill required throughout organisations. Many leaders are not senior managers, but much lower down in organisations, but they drive ideas and people in a way that is positive and rewarding for those around them and the organisation. They can often be identified because they exhibit the following skills:

• getting and giving information
• understanding group needs and characteristics
• knowing and understanding group resources
• controlling the group
• counselling
• setting the example
• representing the group
• problem-solving
• evaluation
• shared leadership
• management of learning.

There should be greater emphasis on consistent development of these skills for managers. Those who are doing them well in organisations need to be sought out and recognised, not necessarily through promotion, as this could make them, or parts of the organisation, ineffective, but by asking them to lead on new or developing pieces of work.

It is also important that leadership is seen as ethical, as this sets the tone for the whole organisation. A good (and quick) website to help you think about leadership is www.businessballs.com/leadership.htm.

**A closing thought**

Commissioning is complex and all-embracing. Local authorities and primary care trusts are, essentially, commissioning organisations. Their chief executives and directors, their scrutiny committees and boards are all commissioners. Understanding of the commissioning task and the roles that everyone inside organisations plays is by no means universal, but nor is it entirely new. Encouraging exchanges of information, helping those who are both commissioning and providing to take calculated and managed risks and learn more, is as important as sticking with what is known. We must not be afraid to work across boundaries for the sake of our service recipients. Nor must we be afraid of saying that we don’t know. Acknowledgement of our inability to see a way forward is the first step to seeking a resolution.

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