Cost Benefit Analysis 2013

An update on the 2009 analysis including further analysis

Contents

1. Executive Summary

Results from Refreshed CBA

The data shows that through the life of the existing strategy we have improved the cost benefit as shown below:

Client group	**Cost (£m) 2009**	**Cost/Benefit ratio 2009**	**Net Financial Benefit 2009 (£m)**	**Cost (£M) 2012**	**Cost/Benefit ratio 2012**	**Net Financial Benefit 2012 (£m)**
Alcohol problems	0.1	12	1.2	0.1	10	1.0
Women at risk of DV	0.3	2	0.6	0.2	3.5	0.7
Drug problems	0.5	5.2	2.6	0.5	5.4	2.7
Single homeless	3.3	4.6	15.3	3.6	4.9	17.3
Learning disabilities	1.7	2.1	3.6	1.3	3.4	4.4
Mental health	2.3	2.8	6.5	1.5	4.3	6.5
Offenders	0.7	0.14	0.1	0.5	0.6	0.3
Older people	1.2	4.2	5.0	0.6	4.5	2.7
Physical or sensory	0.03	3.3	0.1	0.0	n/a	n/a
Teenage parents	0.1	0.0	0.0	0	n/a	n/a
Young People	1.2	1.3	1.6	1.1	1.64	1.8
Total	**11.3**	**3.24**	**36.6**	**10.0**	**4.1**	**41.1**

Table 1: List of client group comparing cost benefit From 2009 to 2012

The data shows that the greatest impact since 2009 has been for services for people with learning disabilities and services for people with mental health issues.

The only client group which shows a decrease in cost benefit are services for people with alcohol issues; however this was from an initially very high ratio.

We can evidence clearly the benefit of these services and having used updated costs we can show that the value for money has markedly improved in relation to the benefits to the city.

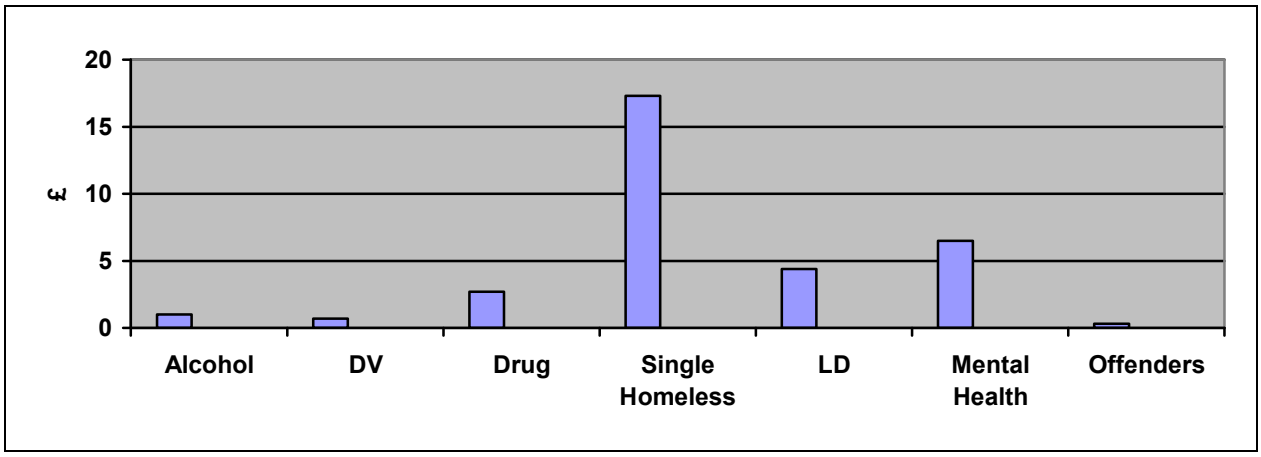


Table 2: Net cost benefit ratio by client group

We can state that for every £1 spent on housing related support services the city saves £4.11. This is 87p better than the analysis in 2009 which is equivalent to the life of the current strategy.

Rationale behind improved CBA

These are all explored in the main reports but the main explanations for improved or changed cost benefit ratios are:

- Ongoing efficiency savings made with the Integrated Support Pathway with year on year cuts
- Remodelling of services with previous accommodation or outreach services operating as floating support
- Decommissioning of services that were not value for money or delivered poor outcomes
- Increasing costs for comparison
- Lack of inflationary uplifts
- Newly commissioned services that deliver better value for money
- Change in the classification of older people alarm services
- Changed client group for major hostel
- Change in referral pathways
- Improved quality of existing services

Conclusion

The Cost Benefit Analysis is one way of examining the positive impacts of this programme but equally it shows the cost impacts if this programme was withdrawn. We can see from the model data the likely investments required to mitigate any

changes – this does not include more long term changes or immeasurable impacts such as the political impact of increase rough sleeping, the reduced provision of other services, the decreased life chances of young people etc.

This analysis shows the financial benefits of support services to the city of Brighton & Hove with clear evidence that the prevention agenda works in both achieving positive outcomes for vulnerable people and in delivering cost savings to the local authority.

Refer to main report for:

- *Analysis by client group of trends in cost benefit*
- *Financial benchmarking*
- *An in depth explanation of the methodology*

2. Methodology

The cost benefit analysis uses a method developed by Capgemini on behalf of the Department of Community and Local Government in 2009. This is a predictive peer review methodology which used evidence from existing SP programmes for the current costs plus in depth research with government experts and lead officers from representative authorities on comparable costs. This method has been validated nationally as robust and accurate.

It is predictive model which makes assumptions based on previous results about future results. This is the same way that the prescribing model used by GP's operates with likely outcomes being the guiding factor. Other models such as the negative costing tool involve looking at what has happened in a given test period and examining individual costs – this model is also valid but not practicable with a system in flux with multiple services, client groups and pathways.

How does the method work?

A good way to look at the CBA is to consider similar decision making processes.

For example, if a GP is deciding which of two drugs to prescribe then he would look at the evidence of peer reviews and clinical trials then make a professional judgment.

If you are looking at the effectiveness of one drug you would look at the outcomes in the past.

Option 1 is the CBA, option 2 is the negative costing tool. The problem with option 2 is that there is no control group so the impact is exaggerated, the problem with option 1 is that you are basing it on the evidence gathered by others.

Another way of looking at it is if you planning on employing a member of staff you would put a business case together on potential impact rather than employ them then see if it worked in retrospect.

3. Introduction

Changes in cost benefit since 2009

Client group	**Cost/Benefit ratio 2009**	**Cost/Benefit Ratio 2012**	**Change in CBA**
Alcohol problems	12	10	-2
Women at risk of DV	2	3.5	+1.5
Drug problems	5.2	5.4	+0.2
Single homeless	4.6	4.9	+0.3
Learning disabilities	2.1	3.4	+1.3
Mental health	2.8	4.3	+1.5
Offenders	0.14	0.6	0.46
Older people	4.2	4.5	+0.3
Physical or sensory	3.3	n/a	0
Teenage parents	0.0	n/a	0
Young People	1.3	1.64	+1.34
Total	**3.24**	**4.10**	**+0.86**

Table 3: Changes in cost benefit by client group

There have been some changes to the way we have classified services as well as significant cuts in funding. For example, the move from 'floating' to 'drop in' in band 4 services means that cost benefit has improved.

The move to 'alarm based' sheltered services has improved the cost benefit but does not have a clear data set so we cannot feed this into the methodology.

Whilst we still have physical disabilities services and teenage parents services the samples are too small to accurately gauge costs benefit.

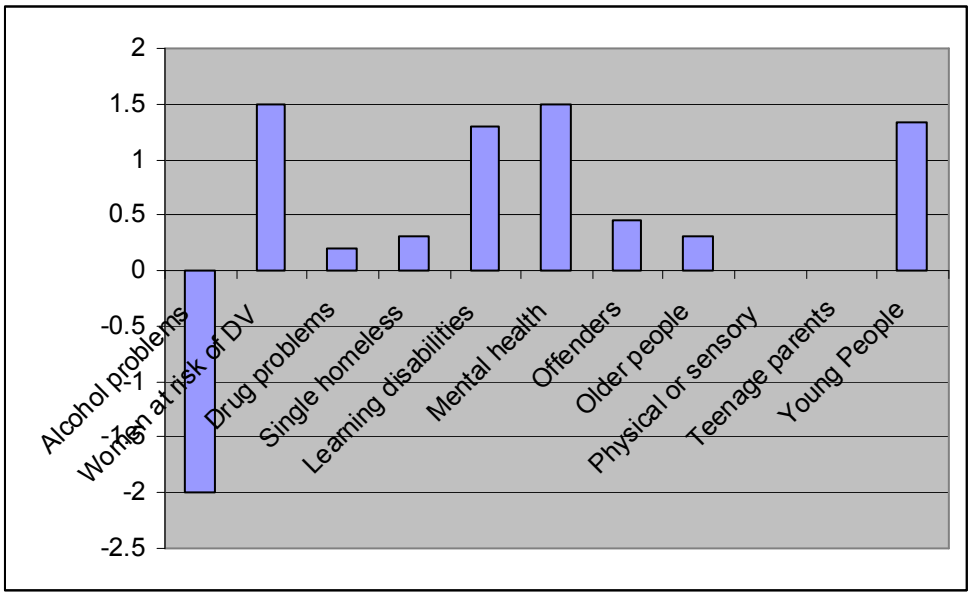


Table 4: Changes in cost benefit from 2009 to 2012

All but one client group have improved their cost benefit ratio – which given the reduction in funding of the services within the Integrated Support Pathway and the closure of other services presumes that services are operating more effectively. This is of course only a model and cannot be assumed to be completely 'real life' comparable there may be other factors not included in this study which have improved cost benefit

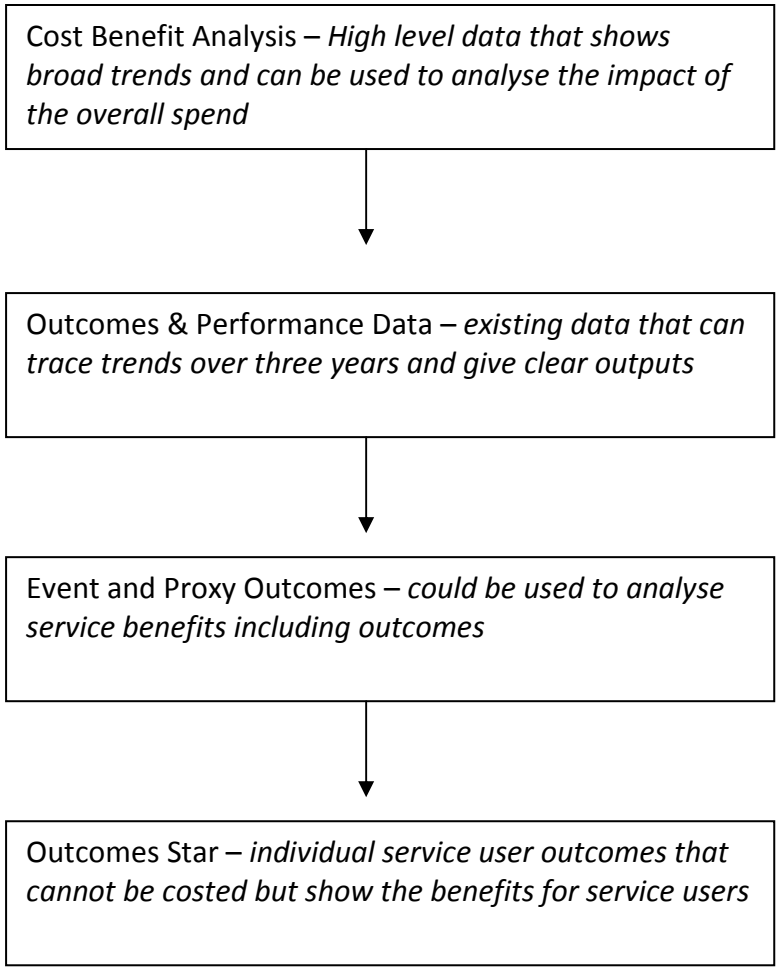
It is important to compare these outputs to the outcomes data we have collected and performance over the last three years.

It is noted that some of the perceived improvement comes from an increase in residential care costs – these were not easily obtained at the last cost benefit analysis but we now have 2012 data.

This shows the methodological flaws as we cannot see the longer term benefits of teenage parents or young people services. Thus as in 2009 we see little benefit from these services as it not certain they have prevented immediate alternative spend but there is plenty of qualitative evidence that these types of services have long term societal benefits.

This is an overview of the strategic impacts and benefits – if we want to look at service cost benefits then we will need to use another tool such as the Stronger Families Stronger Communities Costing Tool[1]

Diagram showing the levels of cost benefit & outcomes analysis



The above diagram shows the qualities and flaws of each level of analysis including the cost benefit analysis. It also illustrates that if we are to quantify the impact of housing related support there is not a single method that covers all outcomes.

[1] This would involve looking at each and every client within the client group and completing a data set.

We cannot get any clear statement as to the ratios of benefits in the city at a strategic level i.e. although we can prove that being in a hostel prevents rough sleeping we cannot show how many would be able to make alternative arrangements. Nevertheless using the 2009 rations but crucially using the 2012 costs we can gather a reasonable assessment of the high level cost benefit of housing related support in the city.

The Stronger Families Stronger Communities Costing Tool offers clear ratios for the impact of multi-agency work but cannot address the problem of allocating cost benefit to individual agencies or worker providing an intervention. Therefore, when we apply it to housing related support services rather than the integrated families teams then we cannot definitively allocate the whole benefit to the housing related support service nor the proportion of the benefit that should be allocated. However, with the above caveat we can state the overall benefit for each case and extrapolate for services though this is a highly time consuming method as it will involve providers looking at each case.

The Outcomes Star is being adopted across the Integrated Support Pathway and is already used by a number of mental health and substance misuse services (it is being adopted across the programme through working with the Outcomes Steering Group). It has been considered as unreliable because assessment is subjective as it is arrived at throughout relative assessments of change agreed by the support worker and the service user. The company that design the star state that with shared training then it can be harmonised across providers and services but this would need to be tested and validated. Providers are working together to ensure consistency of approach and assessment.

Currently we have data on the performance of our services over the lifetime of the existing strategy which helps us find out how good the services are in saving the city other costs :

- Utilisation – shows the difference between the units we pay for versus the number in use at any given time
- Throughput – a better measure of value as it show the number of people using the service each quarter rather than the units we pay for – this shows the efficiency of the service in supporting people to move on
- Move on – we can see where each service user has moved onto from our services – these can be designated as positive or negative depending on how you view the intention of the service – therefore given agreed criteria we can show the positive move on for each service[2]

There is also specific data based on client group, service type, or for specific services. As much of this is not comparable across the programme as it is applied within fixed

[2] Though given the scope of the cost benefit analysis being immediate or near immediate impacts it is worth noting that the move on data cannot track the success or failure of the move.

area then we cannot use it as part of a overall cost benefit analysis but we can use the supplementary data to add to our knowledge of services e.g. where one client group has improved cost benefit we can look at a criterion such as 'referrals refused' to see if intake has changed as more referrals refused might implied that the referrals they were receiving had a higher level of need.

Regarding the outcomes data we collect this is based on individual service user outcomes which are collated to show service outcomes. We have collected this since 2008 so we can show trends by programme, client group, provider, and service. From September 2013 we are asking provider to return service outcomes which are based on the outcomes star.

Below is an example of the data set used for short term services (note that this is similar to the outcomes star but more expansive). The data shows:

a) Which needs were identified
b) Of those which were met (split by departures and those with ongoing need)

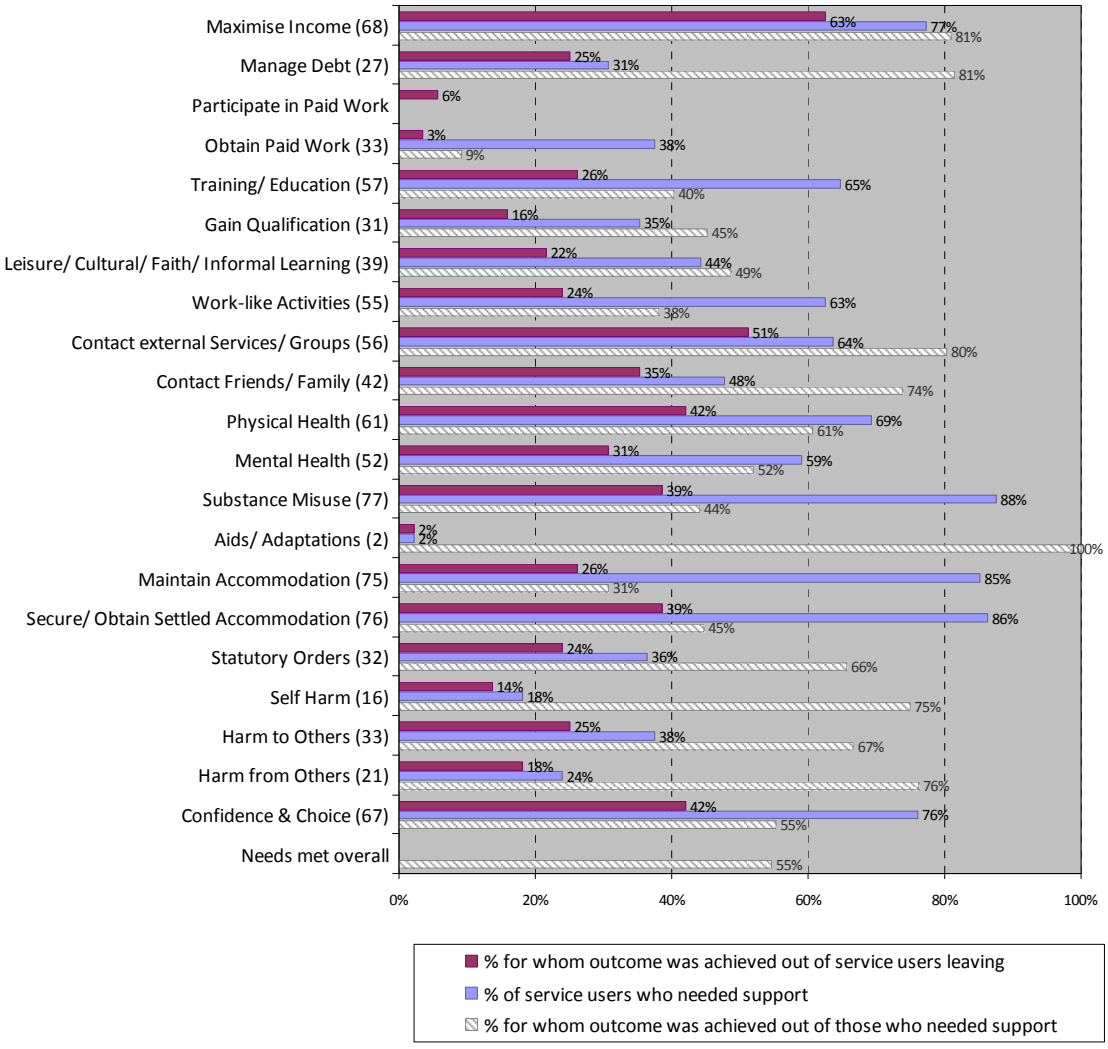


Table 5: Outcomes for a service showing those with identified need and of these if the need was met

The needs listed in the left hand column can easily be re-phrased as outcomes e.g. 'need to maximise income' = 'income maximised'.

Thus based on national guidance the needs/outcomes are categorised under strategic priorities:

i. Achieve economic independence
ii. Enjoy and achieve (ETE)
iii. Be healthy
iv. Stay safe
v. Make a positive contribution

For each category the question is asked of each client as to whether they need help in each area, and whether this was a successful outcome. If the outcome was not successful then the service is required to provide an explanation.

Example for short term services – Achieve Economic independence

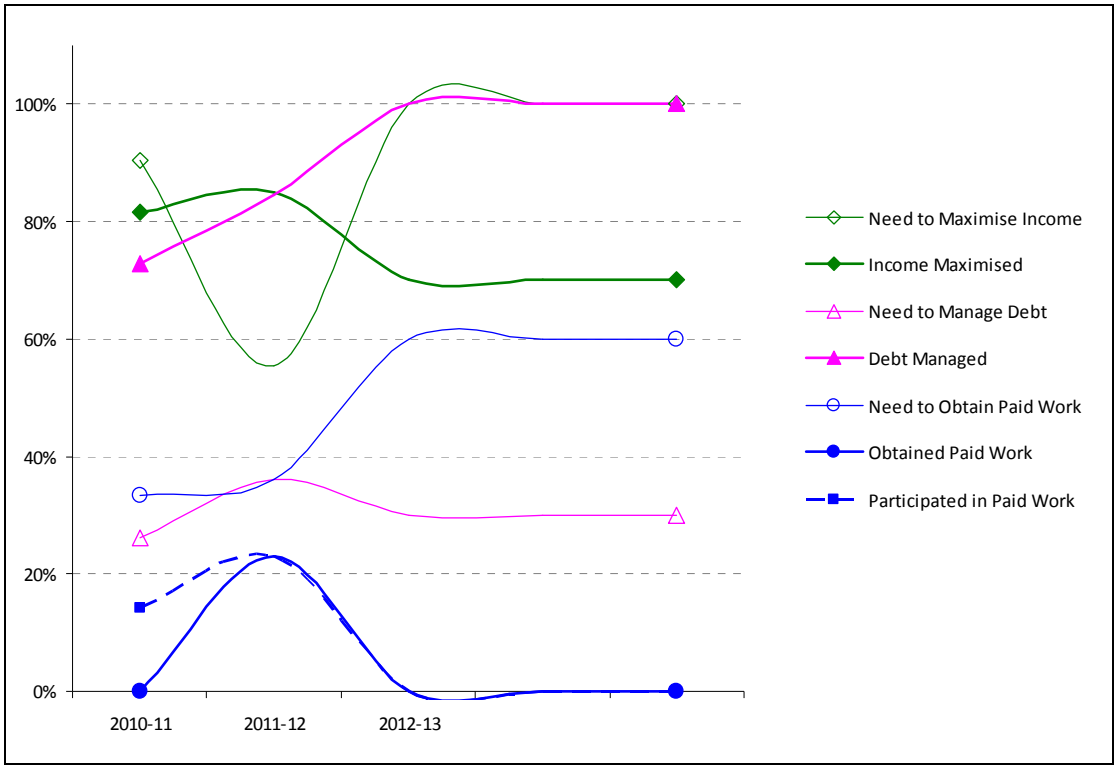


Table 6: The above diagram shows the trends over a three year period in the outcomes around income and debt for a short term hostel service

1) Achieve Economic Wellbeing in 2010-13

1a) Did the client need support to maximise their income, including receipt of the correct welfare benefits?	Need		Achieved	
	Number	%	Number	%
Example Project	68	77%	55	81%
All Adult Homeless Band 2	342	65%	277	81%
All Adult Homeless services	747	64%	639	86%
Comparator Authorities	4740	70%	4276	90%
Kent, Sussex & Surrey	2962	66%	2668	90%
National	55806	75%	50434	90%

Reason Outcome not achieved	Count	% of Total
Client unable to engage with support	1	8%
Client unwilling to engage with support	7	54%
Client ceased to receive support service before outcome was achieved	5	38%
Factors relating to staff skills and experience	0	0%
Factors relating to overall staffing levels	0	0%
Funding difficulties within organisation	0	0%
Difficulties with support planning	0	0%
Service restrictions due to local eligibility criteria	0	0%
Client did not qualify for benefit after being assessed	0	0%
Problems with benefit agencies	0	0%
Limited funds for benefits award within benefit agencies (limited discretionary funds)	0	0%
Problems as a result of rules relating to access to public funds (common in DV provision)	0	0%
Assessment of benefits pending	0	0%
Long waiting lists for Benefit Agency or welfare rights advice	0	0%
Other	0	0%
Missing	0	0%

Table 7: The above table shows how each outcome is marked as positive or negative and the clarification required if negative

From the above example we can see the positives of the locally collected outcomes:

- Based on actual clients
- Contains its own analysis
- Based on strategic priorities

There are also some concerns:

- Can be subjective as provider is required to assess the need and the resolution
- Does not show long term success or failure

The concerns regarding subjectivity was highlighted in the Joint Strategic Needs Assessment for Dual Diagnosis where the inconsistency between what constitutes a

'mental health' issue or a 'substance misuse' issues varied dramatically between services and partner agencies. This means that although we can evidence the positive outcomes for housing related support services we may not be able to extrapolate that other services have been prevented.

Example

A service user assessed as having a substance misuse need at a hostel due to regular cannabis use manages to reduce his smoking significant which is seen as a positive outcome by the service user and support worker.

In the above example the raw data would seem to indicate that we have prevented the use of statutory drug service but the case study shows that they would be unlikely to have been eligible.

Example

A service user at a single homeless Band 3 service need help with their anxiety levels they are supported with managing this by their housing support worker and they consider that they are better able to deal with triggers as a result.

Again from this example we could extrapolate to say that statutory services have been avoided but again eligibility is unlikely. However, in this second case we can reasonably assume that we have avoided pressure on primary care services.

Example

A client enters a hostel and reduces their use of heroin which results in mental health needs being identified which the service user had been self-medicating. The hostel manages both these needs and they move on successfully within the ISP.

This is a clear example of how housing related support services can work with clients with a dual diagnosis (even though in this case they have not been diagnosed with both issues). We can legitimately estimate that a quantity of statutory services have been prevented due to the intervention.

From the above examples though we can see the issue in using the existing outcomes framework to calculate costs benefit; we run the risk of vastly overestimating the prevented services as the severity and eligibility of the issue is not included.

So having examined the methods we can conclude that the most robust method of calculating cost benefit is the Capgemini tool with updated data.

To re-iterate though, we will use the other tools to provide qualitative data as well as using case studies and testimonials from providers and service users.

Outcomes & the Strategy

When we measure outcomes for services we need to be mindful of the strategic outcomes for the city.

From the Supporting People Strategy 2010-2015 the main areas for services to deliver upon were:

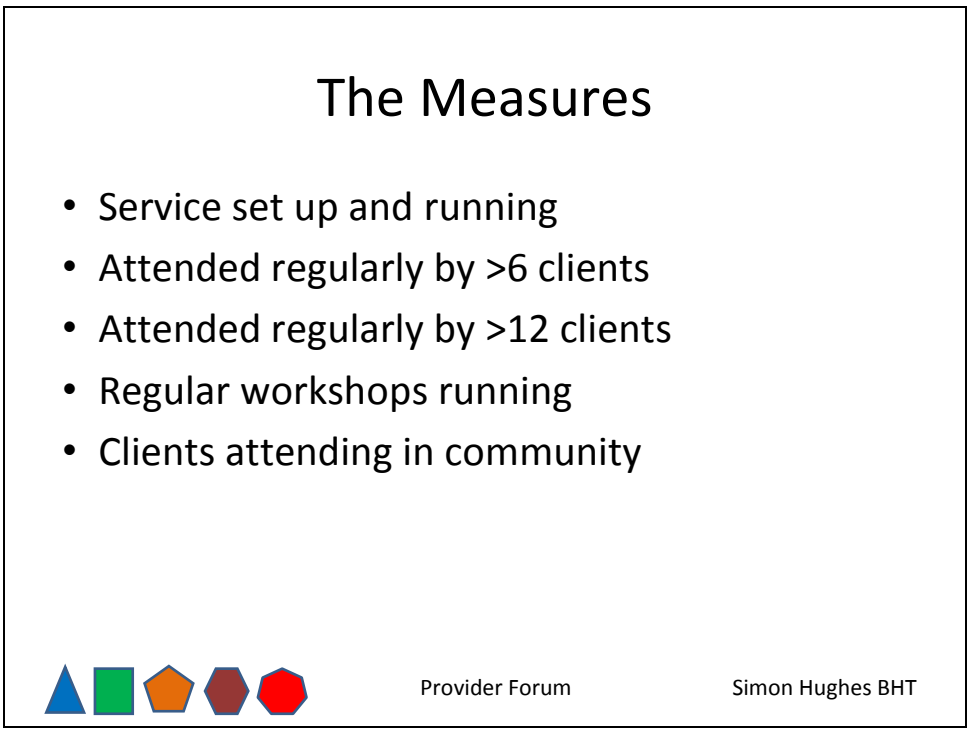
a. Improving Access to Services
b. Flexible services with positive outcomes
c. Working towards greater independence
d. Sustaining Independence
e. Value for Money

The first four can clearly be modelled on services to see whether the outcomes we currently ask them to measure can quantify how they have met these.

1. Achieve economic independence
2. Enjoy and achieve (ETE)
3. Be healthy
4. Stay safe
5. Make a positive contribution

All of these can be classed under the strategic aims to see how each service has met the aims so we can quantify the success of the strategy using the outcomes framework.

Each level of intervention would require a different threshold of evidence to 'meet' the outcome e.g. a band 1 service would be expected to support people to discuss their health, a band 2 service would support them or provide group work to improve their health, a band 3 service would support users to improve their own health, and lower band services would expect people to engage with community resources.



BHT First Base proposed these standards as to whether they were meeting any given outcome. This is for a day centre so it will be different for supported accommodation, sheltered housing, or floating support.

For example, the stages for supported accommodation may well be:

1. Client has support plan with this area included
2. Client has attended support planning sessions and completed action for three months
3. Client has attended support planning sessions and completed actions for six months
4. Client is seeking further community support with keyworker
5. Client is independent of the service in this matter

To use this as part of the cost benefit analysis would require a long term analysis of all the submitted outcomes (including sub-outcomes and explanations as to missing outcomes) mapped against cost. This is not practical given the number of clients and services we commission.

This model also works by looking at an entire pathway with each step of the pathway moving the service user towards full independence. This shows the service user journey but does not show the cost benefit.

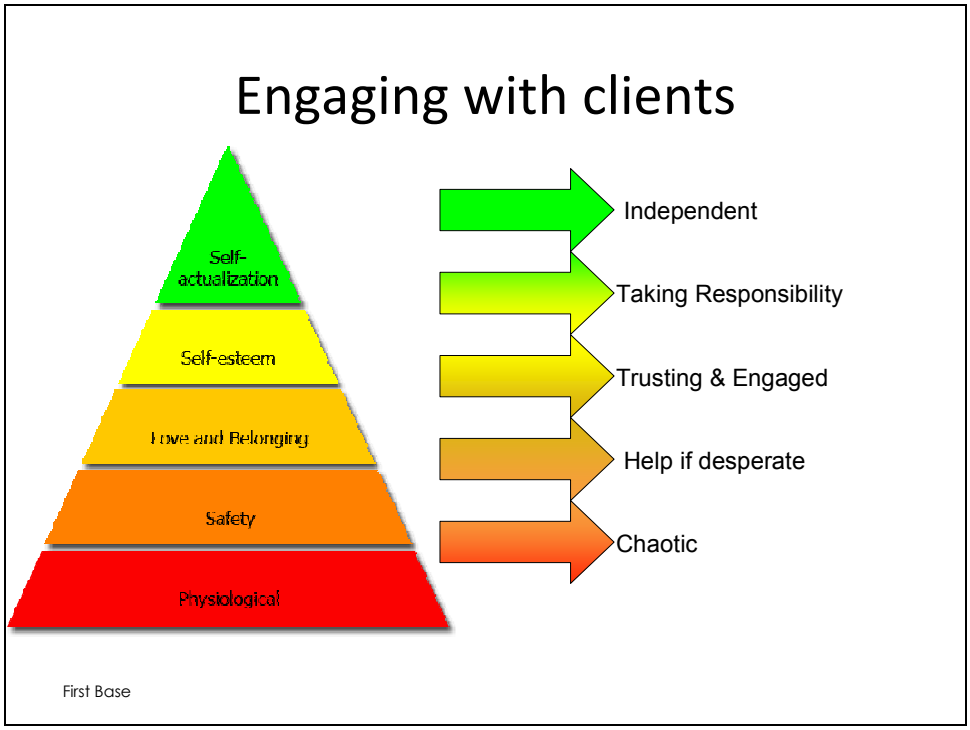
It is essential to note the concept of this model varying the way cost benefit is measured.

Spend on the service will be highest at the first stage (where the client is least independent) whereas there is potential for spend on statutory and community

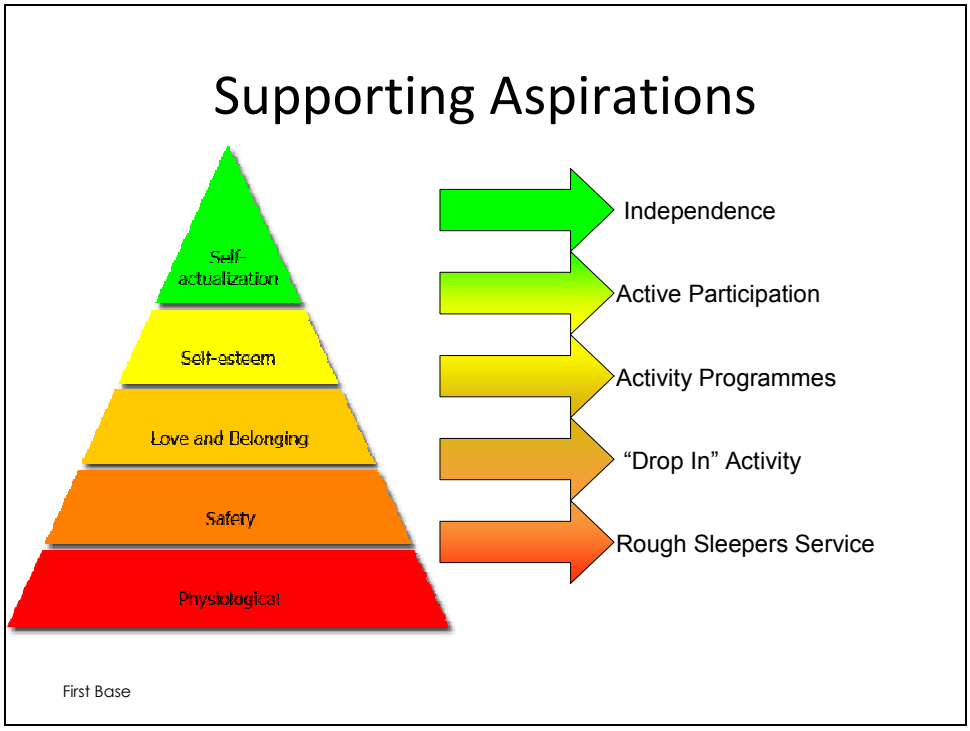
services to be highest at the last stage (if the provider is successful in supporting clients to access the services they need). There is also the fact that the issues and incidents prevented change in nature and thus the type of cost benefit.

At the initial intervention short term services are mainly preventing crisis – visits to A&E, crime, drug related deaths, admissions, homelessness. This is immediate but hard to cost – the report methodology assumptions do assume that a percentage of these will be prevented but does not break down the benefit by time.

At the later stage the service is preventing longer term services (such as residential care) but also enabling people to contribute positively to the community. These benefits are built in to the cost benefit analysis.



From the above we can state that the cost for Housing is highest at the bottom of the pyramid but the cost benefit is also likely to be highest as the counter factual scenarios are the most expensive. However, savings (rather than cost benefit) are likely to increase as you go up the pyramid until they are support at the final stage as this may incur costs to the city as they start to use universal services they are entitled to.



Although this model was developed by BHT to evidence the outcomes of the First Base Day Centre is clear that it can be applied to the Integrated Support Pathway as a whole as well as a modified version applying to 'social care' client groups.

The difference for mental health and learning disabilities services would be:

- *Optimum Independence with support*
- *Active Participation*
- *Engaging positively in activities*
- *Starting to link in with support activities*
- *Primary mental health or LD services*

Outcomes and the Housing Commissioning Strategy Review

Throughout 2012 and 2013 we have worked with providers and stakeholders to establish over-arching outcomes that establish a framework for the strategy plus clear and measurable quality standards to attain.

The agreed outcomes are:

- Reducing deaths from suicide
- Reducing homelessness
- Reducing drug related deaths
- Reducing incidence of domestic violence

It is noted that there is sufficient correlation between these and the priorities of the **Joint Health and Well-being Strategy**

The strategy is a key piece of work for the city's Health and Well-Being board to implement and contains five priority areas that if tackled will make the biggest difference to the city. The areas are:

- Emotional health and wellbeing (including mental health)
- Dementia
- Healthy weight and good nutrition
- Cancer and access to cancer screening
- Smoking

By taking these over-lapping headlines we can 'drill down' the operational actions regarding delivery actions shared across the city:

Prevent	Detect	Treat	Recover
Prevent young people from leaving family home when safe to do so. Support around welfare reforms. Prevent evictions. Money advice. Accessing housing assessment Greater housing provision Information around housing and tenants rights Access to employment/training/education	Early identification of young people who may be at risk of homelessness Mediation service linking with Options Support with issues causing homelessness; relationship breakdown, ASB, Offending, Substance Misuse Improved information sharing across different agencies on levels of need/risk to regular monitoring Flagging ASB that may put accommodation at risk Link to non-contracted services who are supporting people in housing crisis	Offer support to prevent homelessness More smaller band 2 provision Greater personalisation with accommodation and housing choices/support Emergency accommodation Hostel provision Temporary accommodation Landlord mediation Deposit guarantee schemes Discharge planning from acute services Planned move on from recovery and treatment accommodation	Tenancy support HRS Maintain tenancy support/crisis intervention Community support to sustain acc. Involvement in wider community Meaningful occupation Peer Support ETE Universal services with self-referral routes Flags from social care and health services

	Reports from Rough Sleepers Team on numbers in street communities Information from community groups representing diversity groups who may be at greater risk due to barriers in accessing services Liaison with Revenue and Benefits to show where people may struggle to meet housing costs especially in light on welfare changes		

Table 8: Strategy Map for SP Outcomes

The above strategy map shows how outcomes can be developed into actions but also it illustrates the inter-linked nature of housing related support. This validates the assumptions of the cost benefit analysis that city wide are influence the need/demand for social care and health.

Housing related support can be perceived as a preventative agenda but we can see from the strategy map that it has horizontal equity with all stages of the service user journey.

This is vital in displaying the ethos of the cots/benefit as well as the raw financial data: housing related support benefits the city.

In fact the national mental health strategy for England – No health without mental health gave the following priority list for interventions;

Interventions

The interventions available are based on five levels of independence:

1. People living in their own home and able to access information, advice and support.
2. People living in their own home who require minimum intervention provided by floating support.
3. People who need specialist accommodation with medium level support, short to medium term.
4. People who need specialist high support accommodation or rehabilitation, medium term.
5. People who need high support provided by residential or long stay care, medium to long-term.

In this model HRS is the primary intervention and the highest priority thus preventing the need for secondary or tertiary input.

Cost Benefit by client group

Client group	**Cost (£M) 2012**	**Cost/Benefit ratio 2012**	**Net Financial Benefit 2012 (£m)**	**Change in CBA**
Alcohol problems	0.1	10	1.0	-2
Women at risk of DV	0.2	3.5	0.7	+1.5
Drug problems	0.5	5.4	2.7	+0.2
Single homeless	3.6	4.9	17.3	+0.3
Learning disabilities	1.3	3.4	4.4	+1.3
Mental health	1.5	4.3	6.5	+1.5
Offenders	0.5	0.6	0.3	+0.46
Older people	0.6	4.5	2.7	+0.3
Physical or sensory	0.0	n/a	n/a	0

Teenage parents	0	n/a	n/a	0
Young People	1.1	1.64	1.8	+1.34
Total	**10.0**	**4.1**	**41.1**	**+0.86**

Mental Health

Client group	**Cost (£M) 2012**	**Cost/Benefit ratio 2012**	**Net Financial Benefit 2012 (£m)**	**Change in CBA**
Mental Health	1.5	4.3	6.5	+1.5

There has been a marked improvement in the cost benefit ratio since the last analysis and there may be a number of reasons for this.

The cost of residential care and acute care services in the city has been increasing year on year since the last study. This is shown by the increase in the cost of new placements against the cost of existing placements. The current average new placement is now around £700 whilst the average of existing placements is £200 less. This highlights a paradox for Adult Social Care that if they are successful with moving people on from residential care, costs may actually increase as they

are replaced higher funded placements i.e. while we continue to fill all voids in residential care homes then we cannot make savings as we are adding the cost of initial placement. The dearth of care home placements means that often cost is not negotiable as providers are aware of the strength of their position.

This provides further evidence that the current mental health accommodation provision does not meet local need i.e. if alternative options were available there would be less reliance on high cost residential care.

The fact that the pathway does not function as it is intended due to blockages in system affects the real cost benefit (as opposed to the modelled cost benefit).

Issues for residential care include:

- 33% of service users in out of area placements could move on given alternative supported accommodation
- 36% of in area residential care service users could move on given alternative supported accommodation
- 64% of people in in-area residential have no personal care needs
- 43% of people in mental health specific care homes have significant substance misuse issues
- 73% of people waiting for mental health specific supported accommodation have a significant substance misuse issue
- Of the 21 delayed discharges over the last year – 12 could have been reduced if alternative supported accommodation had been available
- Of the frequent attendees at A&E seen by the Mental Health Liaison Team – 89% had a significant substance misuse issue
- A marked rise (100%) in the number of people housed in temporary accommodation by ASC panel

All of these contribute to the improve cost benefit of housing related support services as the counter factual scenarios have become poorer value for money.

Research completed in the last year has shown that we need to redirect funding towards housing related support services which will change the cost benefit once more.

Working with the local Primary Care Trust (soon to be Clinical Commissioning Group) we are supporting the commissioning of 57 units of accommodation and 70 units of community support. These changes will be cost neutral to the local authority and will show and increase of 107 units (with 20 being re-provided).

If we model the changes we can see that the cost benefit for this client group that the cost benefit improves to £8.9m for the city.

Client group	Cost (£M) 2012	Cost/Benefit ratio 2012	Net Financial Benefit 2012 (£m)	Change in CBA
Mental Health	1.5	5.93	8.9	3.13

This means that when we implement the new commissioning plans for this client group the cost benefit will improve immediately by £1.63 per £1. This validates the commissioning plans and the research that evidenced the need for these changes.

The reasons that these changes will improve our cost benefit are clear:

- Increased number of units at the same cost
- Lowered average costs
- Improved move on

However, if the change in provision is successful we should see the cost benefit evening out as the costs of acute and residential care reduce. This in turn should reduce the costs of our counterfactual scenarios and thus the ratio of benefit. It should be noted that this change will reduce the overall spend by the local authority as well as improved service user outcomes.

As shown in the below diagram the current provision is 'top heavy' and has clear barriers to move on:

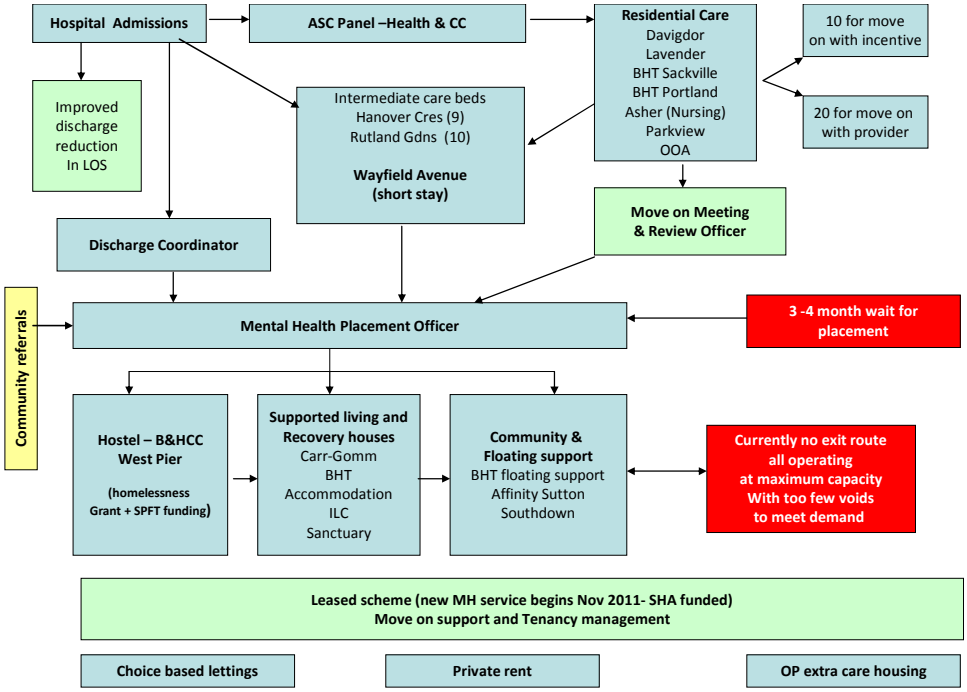


Table 9: Previous Map of Mental Health Services

Whereas the model from September 2013 which improves cost moves the investment to more recovery based models ensuring greater throughput and better value for money.

The change in provision is based on commissioning and strategic plans, and also meets the essence of cost benefit in that it is based on throughput and improving service user outcomes by preventing the need for higher cost high need services.

The diagram below shows how the new model will work from September 2013 with a greater emphasis on a pathway.

We will need to reassess cost benefit when residential costs begin to reduce.

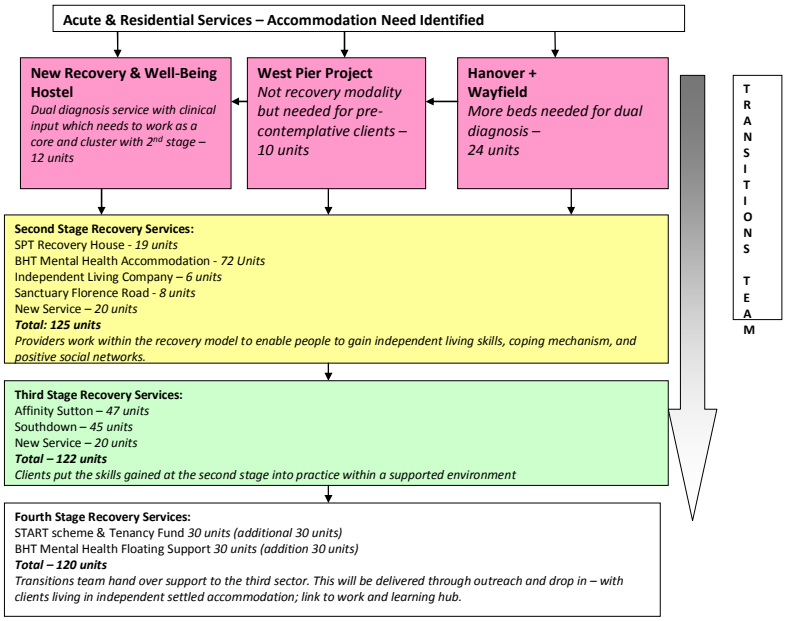


Table 10: Mental Health Accommodation Services from 2013

Whether our cost benefit improves or reduces will depend on a number of factors affecting out counter factual scenarios (plus the successful implementation of the new provision).

Research in the market in Brighton & Hove was carried out to examine barriers and issues with mental health services. This involved data analysis, interviewing providers, looking at clients needs, examining costs, and interviewing practitioners.

The following issues affect the cost benefit and market stability:

- Lack of financial stability of providers

Feedback from in-area providers was mainly positive but several raised concerns that due to the lack financial uplift any significant move on would generate voids and cause financial losses.

It is noted that as one of the main factors in the cost of a placement is length of stay; more recently placed the higher the cost; then the fact we are prioritising people who have not been institutionalised for move on will mean that we will be disproportionately affecting income.

We found that although services were very willing to engage with move on planning they often reported that the overall care providers had concerns around profit margins being affected. This meant whilst local service managers were keen to implement change that needed reassurance that we had referrals to fill potential voids.

This could be resolved through the use of set fees agreed with providers, framework contracts, and brokerage; rather than spot purchases

- No existing process

Due to the previous lack of planned move on from residential there was no agreed process to how this would be done.

There was a Move On Meeting in place but this discussed an incomplete list of placements and focussed on where placements had 'broken down'. There were few considerations of value for money as a factor in move on, and decisions were based on past experience of working with clients (often several years ago). These views often assumed that presentations hadn't changed and that providers were unable to work with our clients. This is an internal SPFT issue that affects cost benefit throughout the system. Move on must be linked to costs *and* need for throughput to benefit all.

- Lack of move on accommodation

This was flagged up as a problem in the original cost benefit analysis and again in the last Supporting People Commissioning Strategy; and remained an issue throughout. With a three month waiting list for supported accommodation, increased pressure to house people under the SLA with the housing department, reduction in acute bed capacity; there is pressure on the whole mental health accommodation sector as a result of this.

Compared to similar authorities a disproportionate amount of supported accommodation is specifically for single people with a history of homelessness.

Therefore as part of the initial scoping exercise recovery professionals were interviewed to establish how the market needed to be reshaped and the following themes were evident throughout:

Lack of dual diagnosis supported accommodation or hostel provision
Lack of long term tenancy related floating support
Lack of step down from residential care
No exit route from supported accommodation into long term settled accommodation

The tiered model was designed to resolve these issues as well as meeting the evidenced gaps from the needs analysis by moving resources from residential care to supported accommodation to achieve better value for money and increase capacity in the system.

From the evidence (delayed discharges, inappropriate placements in residential care, waiting list for supported, needs analysis, interviews with professionals) we deduced that we required:

Thirteen hostel beds for people with chaotic lifestyles
Ten additional 24hr staffed dual diagnosis and recovery model units
Twenty move on units with in-reach support
Thirty units of long term floating support in the community
Forty units of tenancy support with links to the PRS

Therefore the recommendations of this report continue to state that we require a phased and pro-active commissioning plan to restructure the mental health accommodation sector in this way. This is due to be completed by September 2013.

- Service user expectations

There are issues with the fact that service users often consider that they were placed in residential care 'for life', and that they have right to remain. This has resulted in service users refusing to engage with life skills or move on work.

Staff at care homes and care co-ordinators have struggled with this and we have not yet tested whether we can evict people who do not require ongoing care.

We could resolve this through joint working between housing, care co-ordinators, and providers.

Any progress would involve meeting with the service users and their families to explain move on options but also emphasising that move on is expected from residential care and that there is no right to remain. We will progress to eviction only when other options have been exhausted.

There remains a need to prioritise move on to those capable of thriving in more independent accommodation but this should not be at the detriment of longer term residents.

- Abilities of staff

In residential care services where unit cost is lower than £400 p.p.p.w. we cannot reasonably consider that this covers more than rent, utilities, and food. Therefore, there are serious concerns that staff at these services can deliver recovery based support.

More seriously we also have experience of collusion between staff and service users to prevent move on. This can take the form of support planning meeting that reinforce the need for residential care, or providers undermining existing plans.

- Length of stay

This is the most significant indicator of unit cost but also a clear indicator of readiness to move on: the longer the stay the less likely someone is to move on.

With our poor record of moving people on from residential care we have a large population who cannot move on without drastic and expensive intervention.

This is in part due to institutionalisation (service users who have been 'deskilled' by a long stay in residential care where food preparation and other daily life skills are provided) and in part due to cost (existing placements have no increased by inflation whereas new placements have increased beyond inflation).

- Low level of placement reviews

In 2012 we reviewed a low number of our residential care placement with even less reviewed more than once over the course of the placement.

When we consider the above issues we may find that the cost benefit improves gradually as the residential care spend reduces in line with process change and cultural change.

The main impact may well be the reduced delayed discharges and transfers of care. The end result being less time spent in Millview in line with the local bed reduction plans.

If we successfully implement the remodelled mental health pathway with the newly commissioned service overall cost benefit for the programme will markedly improve from **£1 saves £4.11 to £1 saves £4.34**

Learning Disabilities

Client group	**Cost (£M) 2012**	**Cost/Benefit ratio 2012**	**Net Financial Benefit 2012 (£m)**	**Change in CBA**
Learning Disabilities	1.3	3.4	4.4	+1.3

This client group shows another improvement in cost benefit which can be attributed to a number of factors and changes:

- The decision to decommission a floating support service which was not 'supporting people eligible'
- Significant reductions in the housing related support budget for B&HCC LD services
- The initial success of the LD Access service (preventing people with learning disabilities losing their accommodation)
- The increase in the average cost of residential care placements

The *Review of Accommodation Services for Adults with Learning Disabilities* completed in 2008 by Mark Hendriks and Daniel Parsonage researched the value for money of current residential care provision and supported living accommodation available to people with learning disabilities:

Summary of conclusions

- *Most of these services were more expensive than national and local averages*
- *B&HCC provides the most expensive services.*
  The main factors accounting for this are:
  I. *The size and models of its services*
  II. *The terms and conditions of its staff*
  III. *The high level of direct staff support given to service users*
  IV. *There may be a greater disparity as central overheads are not shown in the B&HCC budgets which were used to calculate unit costs*
- *The clearest variable was size of service – two or three unit services had significantly higher unit costs*
- *Services offering independent living arrangements were generally less expensive than shared group homes)*
- *Savings can be made by creatively remodelling existing services*
- *B&HCC services did less well in terms of quality and outcomes*
- *B&HCC services were overall the least 'fit for purpose'*

Summary of recommendations

- *Smaller services should be considered for remodelling to share costs (e.g. management costs)*
- *Services should be considered for remodelling to improve efficiency (e.g. adding additional services such as floating support to existing services)*
- *Options to develop services that offer independent living arrangements should be explored as alternatives to group homes.*
- *Levels of direct staff support should be regularly reviewed and all options should be explored when supporting complex needs.*
- *Clear targets are needed for B&HCC services to bridge the gap in quality and outcomes.*

- *Particular services are highlighted where there are serious concerns about their suitability for purpose*

As part of the action plan from this report we have remodelled in-house into three separate services:

1. Long term supported living
2. Short Term supported living
3. Crisis Intervention and Prevention

With the efficiency savings taken from this budget (in line with the recommendations of the report quoted above) this means that subject to performance and quality monitoring this should now be fit for purpose by increasing independent living and removing outlying costs. As we can see below the B&HCC services were more likely to not have costs in line with need and thus poor value for money.

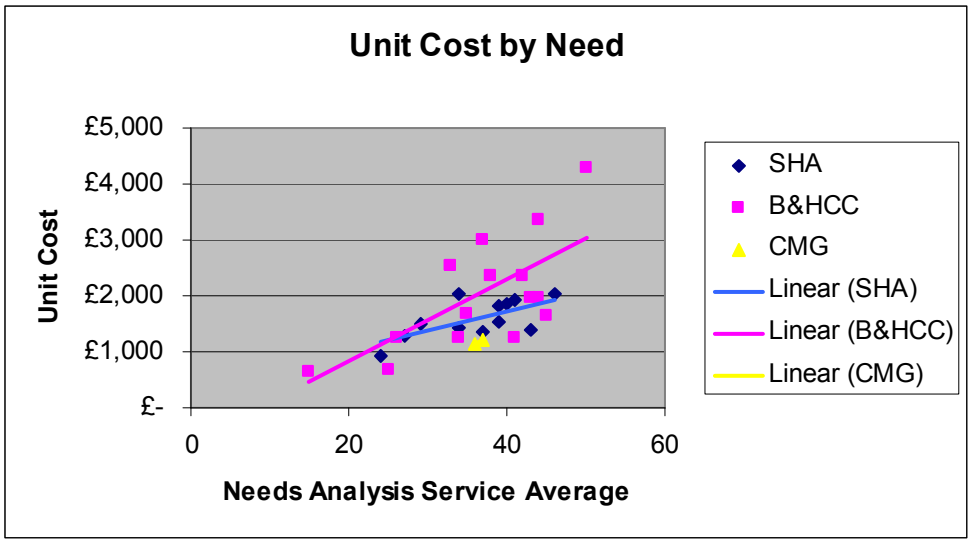


Table 11: Map of Unit Costs of LD services by level of client need

Therefore, we have improved value for money in line with evidence and strategic aims.

We will be working with Adult Social Care and the Learning Disabilities Commissioner to look at the current housing provision and spend for people with learning disabilities. This has become vital as we are confident that there are social care services being paid for from housing monies, and supported housing being paid for from social care. Harmonising the spend will enable further remodelling which will be done in line with the cost benefit projections.

Since this report there have been significant changes in residential care provision with in-house services being rationalised, and the negotiation with existing providers being prioritised. Adult Social Care are currently initiating a project to

set care home fees based on need which should reduce their costs and reduce cost benefit for housing related support.

Young People

Client group	Cost (£M) 2012	Cost/Benefit ratio 2012	Net Financial Benefit 2012 (£m)	Change in CBA
Young People	1.1	1.64	1.8	+1.34

These services have been primarily delivered through the Integrated Support Pathway which was analysed separately in the previous Cost Benefit Analysis (and will be covered in the Single Homeless needs analysis).

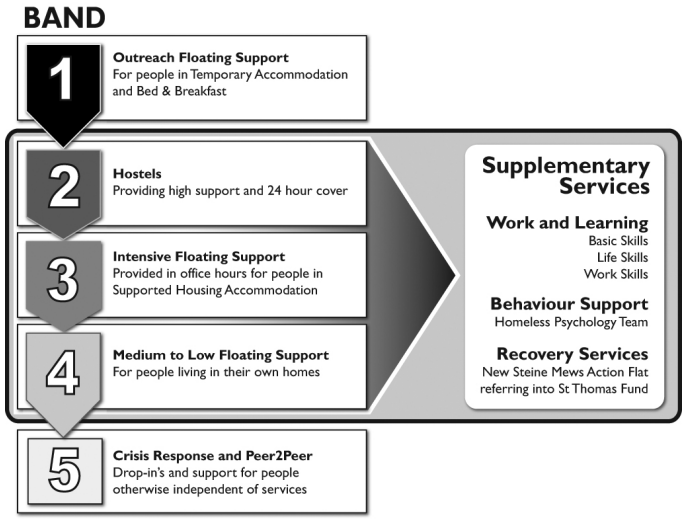


Table 12: Diagram showing the Integrated Support Pathway

The Integrated Support Pathway is made up of services that provide housing support for homeless people in Brighton & Hove. Each service provides support for a particular group of people. These groups include people who have been rough sleeping, those who are single and homeless, young people at risk of homelessness and ex-offenders.

Young People's services have not always been a good fit for the ISP due to the statutory responsibilities to under 18 year olds.

Jo Sharp recently completed the Young People's Housing and Support Joint Commissioning Strategy 2013 which outlined key themes for how these services should be re-focussed:

- Prevention of homelessness
- Create a housing pathway for young people
- Joint commissioning, pooled budgets, co-production, and partnership

The implementation of this strategy is likely to further improve cost benefit as will be focussing on prevent high cost counter-factual scenarios.

Evictions Protocol

By agreeing a system to reduce eviction sin young people's services we have reduced the number of high cost crises such as crime and ASB whilst improving the number of positive outcomes that enable people to contribute to the local community.

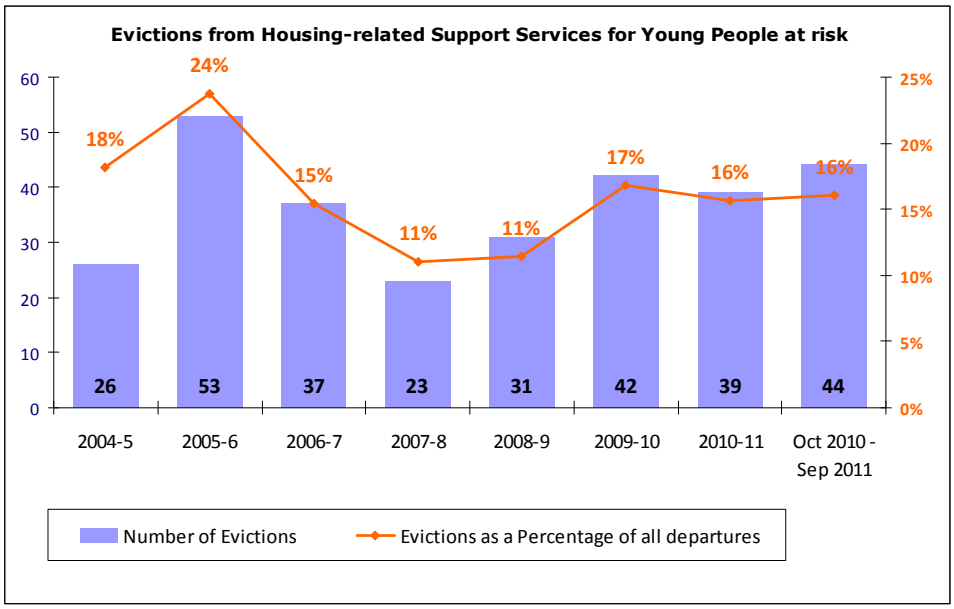


Table 13: Graph showing number of annual evictions from housing related support services for young people

This will improve the cost benefit for these services as will be ensuring that the pressure on social a care and criminal justice services are reduced.

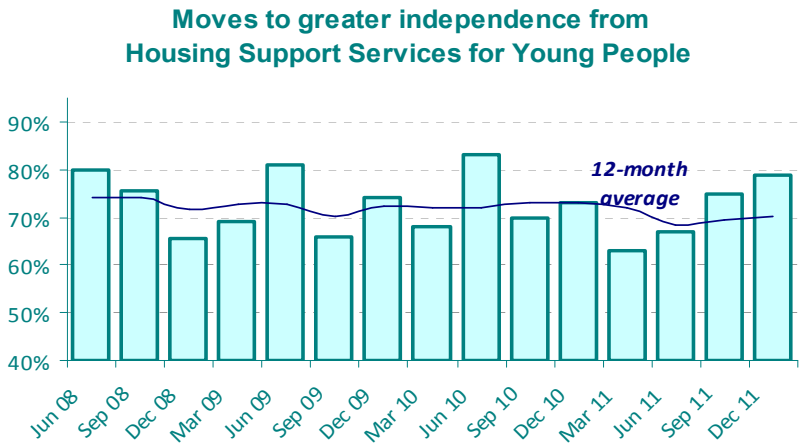


Table 14: Graph showing positive moves from housing related support services for young people

There has been no marked increase in positive move on but given that presentations to the local authority have increased each quarter but these services are still achieving the same high level of positive move on given the increased complexity of need; we can infer that they are preventing greater costs elsewhere than in 2009 (above and beyond the improved cost benefit ratio).

As part of the budget planning as part of the strategy in 2010 we agree a programme of efficiency savings for all young people services with a % cut each year with no inflationary uplift. Given that outcomes have remained positive this has had a positive impact on cost benefit.

The remodelling of the Foyer has improved cost benefit as there is a higher ratio for hostel provision rather than move on accommodation as these services prevent higher cost alternatives such as residential care, crime, and homelessness.

Alcohol Misuse Services

Client group	Cost (£M) 2012	Cost/Benefit ratio 2012	Net Financial Benefit 2012 (£m)	Change in CBA
Alcohol problems	0.1	10	1.0	-2

There has been a slight decrease in the cost benefit ratio for this client group but although we commission the same services we have re-classified some from solely

drug services to drug/alcohol services, and the only alcohol services (delivered by Equinox) have merged from an accommodation services and an outreach service to a solely floating support service. These changes will have superficially affected the cost benefit ratio without actually changing the outcomes; rather acknowledging the dual use of drug services will include tier 4 outcomes into this client group for the first time.

It is also worth noting that the extremely high cost benefit ratio for alcohol services means that even small changes are likely to have an impact.

One of the reasons that alcohol services present such a high cost benefit ratio is the high costs relating to the counter factual scenarios. With most alcohol detox being in-patient stays at Millview (cost £6000) they are much higher cost than the equivalent community detox for drugs (drug treatment appointment £243). There is less acquisitive crime associated with this client group but increased levels of physical health needs (alcohol is a key indicator to other health factors such as coronary disease) and anti-social behaviour out-weigh this.

Although this is an analysis of our alcohol services we also acknowledge that problematic alcohol use is an issue within other client groups:

- 41% of people in the ISP accommodation have an alcohol misuse issue
- 13% of people receiving floating support from pathway services have an alcohol misuse issue

Overall costs to the city from alcohol are high:

- Health costs - £10.1m
- Economic costs – £24.5m
- Crime costs – £71.8m

These are costs not just solely linked to vulnerable people and including the night-time culture associated with Brighton & Hove (From Alcohol Needs Survey 2011).

ACS Supported Living & Housing Supported Living

Adult Social Care are working throughout 2013/14 to establish the outcomes of their supported living (this is all for people with learning disabilities). Current costs range between £1283 (high level 24hr staffed accommodation) and £298 (lower level for people with LD and social pathologies). Because these are all spot purchased they do not have an agreed quality framework nor an establish set of outcomes, therefore we cannot agree clear cost benefit for these services.

As part of the actions from this cost benefit analysis we need to rationalise the ongoing outcomes process for Housing and Adult Social Care. This could be done as a critical friend approach with Adult Social Care building on our work with outcomes but if necessary running a independent system – joint funded services will not be required to duplicate.

The remodelling action within the team plan shows a commitment to rationalising the LD supported living services (both ASC and Housing funded)

Integrating CBA and the SP Commissioning Strategy 2011-2015

In order to establish cost benefit as central to the ongoing strategy and outcomes framework we need to embed it within the strategy.

To do this we need to understand how we will be assessing the success or failure of services in meeting our strategic objectives and action plan.

There are three main methods of links the strategy to cost benefit:

- Outcome based commissioning e.g. looking at the JSNA and using gap analysis to commissioning services to affect certain signifiers
- Establishing achievements that contribute to strategic aims e.g. If we have an aim of 'improving health' then we could state that for a learning disabilities supported accommodation service the achievements would be; having a dentist appointment; visiting the chiropodist; having a health action plan.
- Establishing levels of quality linked to outcomes e.g. if we choose 'improving health' again we could state that the level of perceived improvement on a indicative scale from pre-contemplative to independent

As part of agreeing the best method of assessing the link between these issues we need to assess the success of the ongoing strategy from 2011-2015. If we look at the agreed action plan we can assess whether these actions have been fully met, partially met, or not met at this stage.

We also need to show how these actions link to the overall aims and whether we have successfully contributed to these citywide aims.

From the Supporting People Strategy 2010-2015 the main areas for services to deliver upon were:

1. Improving Access to Services
2. Flexible services with positive outcomes
3. Working towards greater independence
4. Sustaining Independence
5. Value for Money

As a mid point review of the strategy we looked at each action we committed to as part of the strategy and assessed whether we had fully met, partially met, or not met the desired outcome.

1. Provide support for people with learning disabilities to access mainstream services and make housing choices ***– partially met through the Learning***

Disabilities Housing Officer but there remain serious concerns raised by CLDT

2. Commission a tenancy access project to support tenants and landlords to reduce stigma around vulnerable people and promote move-on access into the private rented sector – ***Fully met through START***

3. Review current move on arrangements to improve take up of the deposit guarantee scheme, moves into the Private Rented Sector and facilitate appropriate move on options for clients with complex needs – ***Partially met through START and the mental health procurement plan***

4. Commission a mental health transitions team to support people to move on from acute and residential care – ***Not met and currently sits as an ongoing responsibility of the SPFT but fully supported through the mental health procurement plan***

5. Develop greater personalisation and choice through a review of how clients can access different approaches to substance misuse in hostels – ***Partially met through the nurse led pilots in BHT Phase 1***

6. Work with Sussex Partnership Trust to ensure that clients in the Single Homeless Integrated Support Pathway are able to access psychological interventions available in the community ***– Partially met – Check with JK***

7. Via the DV forum and Housing Options, ensure that all professionals working in Domestic Violence are aware of housing issues, and address gaps in knowledge – ***Check if this was covered through the DV pilot***

8. As part of the YHWG action plan, review how Lesbian, Gay, Bisexual and Trans needs are being met within support provision for young people – ***Not met – serious concern that this remains a gap***

9. Work with the Domestic Violence co-ordinator and supported accommodation providers in developing local guidelines for dealing with domestic violence within supported housing that link with Safeguarding Children and Adults procedures - ***Check if this was covered through the DV pilot***

10. Commission services that are able to respond to crisis situations to support people with learning disabilities in the community – ***Not met – looking to work with ASC in 2013 to remedy this***

11. Support the implementation of an alcohol pathway across services so that 'revolving door' clients can receive personalised and specialist support with alcohol issues ***– Look to see if this was covered by the alcohol pilot***

12. Enable people with multiple needs such as mental health, substance misuse, learning disabilities, forensic history, physical needs, etc. to get the support and housing that they need ***– Not met but may be addressed through the mental health procurement plan***

13. Commission more low-level supported accommodation for people with learning disabilities – ***Not met but looking to work with ASC in 2013 to address this***

14. Commission a tiered service to support people with complex mental health needs – ***Partially met through the mental health procurement plan***

15. Commission a floating support service for clients with learning disabilities who are living in hostels (who do not qualify for statutory learning disability services) ***– Not met but looking to work with ASC in 2013 to address this***

16. Establish a multi-agency panel to deliver move on solutions for older people and clients with complex needs – ***Not met – Talk to KD***

17. Develop greater personalisation and choice through a review of how clients can access different work and learning opportunities and access support to maintain independence when working, including housing – ***See if this was addressed through the review of work and learning services***

18. As part of the Housing and Domestic Violence Working Group work to improve access to 'move on' for people who are experiencing domestic violence – ***See if this was covered in the DV pilot***

19. Explore commissioning of accommodation and support for high need clients / 16 and 17 year olds – ***Talk to JS***

20. Review current provision to ensure young people are supported to move to the private rented sector, and that provision of floating support for young people is adequate to ensure private rented tenancies are sustained – ***Talk to JS***

21. Monitor changes to the Young People Eviction Protocol exploring other methods of effectively managing breaches of licenses/house rules – ***Talk to JS***

22. As part of the YHWG, (Youth Homeless Working Group) ensure all providers work in partnership with the NEET action plan to ensure all young parents achieve a minimum of level 1 qualification – ***Talk to JS***

23. Work with partners to manage the changes in provision expected in year one of the strategies to ensure need the need of the city is met within the restricted resources – ***Fully met***

24. Retain dispersed alarm service with efficiency savings – ***Ask KD***

25. Further integrate and develop services for Older People (sheltered housing and outreach services) to improve access to information about housing and support options. Services will work more closely within the SP sector and beyond to improve flexibility, value for money, accessibility, and sign-posting to other services, and offer a more streamlined and efficient experience for people using them – ***Ask KD***

26. Remodel long term learning disability services to include a re-ablement element that promotes independence ***– Partially met but further work needed with ASC to address gaps***

27. Retain (with small efficiency savings) 90% of sheltered/extra care sheltered housing, which offers good value for money and strategic relevance – ***Ask KD***

28. Reconfigure one small accommodation-based service for older people with mental health needs with low utilisation/strategic relevance – ***Ask KD***

29. Supporting People to implement the recommendations of the Intelligent Commissioning Pilots for domestic violence and alcohol to address gaps in provision – ***Fully met but need to review outcomes***

30. Prioritise support within sheltered by reviewing and clarifying eligibility criteria. – ***Ask KD***

31. Explore options for bringing SP services in line with the Adult Social Care charging policy – ***Not met – ongoing with AM***

32. Working with longer and flexible contracts with agreed outcomes working with social care and health – ***Team discussion***

Cost Calculator

This method differs from all those above in being entirely retrospective meaning that we could not instigate a full cost calculator analysis until we had collate sufficient data.

As part of the outcome planning group we need to agree which events we can allocated as measurable outputs so that we can use the Manchester Model (validated by CLG)to cost the positive impacts of our commissioning plan and the services directly.

To do this successfully we need to agree the events allocated by April 2013. These can be service specific or attached to client groups, or universal.

The *Stronger Families, Stronger Communities* project intends to use this method to validate the savings made by the interventions of their family coaches over the three-year term of the project.

They have agreed the events and costed them using the Manchester Model (or local data where it differs significantly). They have also allocated each saving against the public body which would have incurred the costs otherwise.

Example

Baseline	***Method of confirming data***	***Expected Outcomes***	***How and when we know if outcome achieved***	***Beneficiary***	***Savings attached to the outcome***
U18 year old with a proven offence in the last six months	*YOS data (collected by SFSC MI Team)* *Number of offences*	*Reduced offending*	*YOS data* *When the case is closed – last six months*	*Police*	*£542 per event*

Table 15: Example of a costing tool method

Thus the baseline is the number of offences committed in the six months prior to engaging with the family coaches and this is compared to the number of offences after the intervention. Then the cost per event is multiplied by the number of events before and after then the differential is the saving delivered by the service.

This is then replicated for the agreed events across the service then the total of the differentials is the total cost benefit of the commissioned service.

*Initial cost of events to the city **minus** subsequent cost of events to the city **equals** cost benefit of any commission*

The events included in the *Stronger Families,* Stronger Communities include:

- Arrests
- ASB incidents
- School exclusions
- Unauthorised absences
- Receipt of out of work benefits
- Child at Risk on CAF
- Police call outs
- Homelessness

The difference between this model and the CBA can be stated the following analogy:

> *If a GP is deciding which of two drugs to prescribe then he would look at the evidence of peer reviews and clinical trials then make a professional judgment.*
>
> *If you are looking at the effectiveness of one drug you would look at the outcomes in the past and peer reviews.*
>
> *Option 1 is the CBA, option 2 is the SFSC tool. The problem with option 2 is that there is no control group so the impact is exaggerated, the problem with option 1 is that you are basing it on the evidence gathered by others.*
>
> *Another way of looking at it is if you planning on employing a member of staff you would put a business case together on potential impact rather than employ them then see if it worked in retrospect.*

For the Housing Related Support Commissioning Strategy from 2013 we need measurable number of events that can be clearly costed:

- Section 2 admissions to Millview
- Section 3 admissions to Millview
- Recalls to custody
- Arrests – acquisitive, drug related, DV etc.
- Admissions to RSCH

The Outcomes Steering Group will have ownership of these events in agreeing costs and benchmarks.

Notes from the JSNA

The cost benefit analysis, cost calculator, and refreshed strategy should all be taken in the context of the overall joint strategic needs assessment and the specific needs assessment for each area.

Mental Health JSNA (published in 2007)

Brighton & Hove has the highest serious mental health needs index (MINI) of any authority in the South East Strategic Health Authority. From this it is estimated that the city will have between 16% and 39% more serious mental illness that the nationwide average.

The suicide rate in Brighton & Hove is 1.7 times the national average.

Links to:

- High levels of alcohol dependency
- High levels of serious drug misuse
- High levels of homelessness

Rates of incidence (from JSNA):

The table below shows the prevalence and number of working age individuals estimated to be suffering from each condition adjusted for local need. The population base is 181,800 (2006 registered population reconciled to 2005 ONS estimates aged 16 to 64)

	% prevalence		Number (to nearest 100)
Neurotic Disorder (one week prev)	17.0*	1 in 6	30,500*
Psychosis (annual prev)	0.6**	1 in 170	1,100**
Schizophrenia (annual prev)	0.40**	1 in 250	700**
Schizophrenic disorder (annual prev)	0.70**	1 in 150	1,300**
Bipolar-I (annual prev)	0.70**	1 in 150	1,300**
Bipolar-II (annual prev)	0.93**	1 in 100	1,700**
Personality Disorder (annual prev)	5.1**	1 in 20	9,300**
Antisocial and Borderline PD (annual prev)	1.5**	1 in 70	2,700**

*need index of 1.18
**need index of 1.17

Table 16: Table showing prevalence of mental health issues in Brighton & Hove

As part of the parallel outcomes work we are implementing the recommendation of the JSNA that all service users will be screened for depression, psychosis, alcohol misuse, and drug misuse. This will use health screening tools to form a common language between housing providers and health services.

Brighton & Hove has extremely high levels of benzodiazepine prescribing which is significant due to the risk of dependency and dual diagnosis:

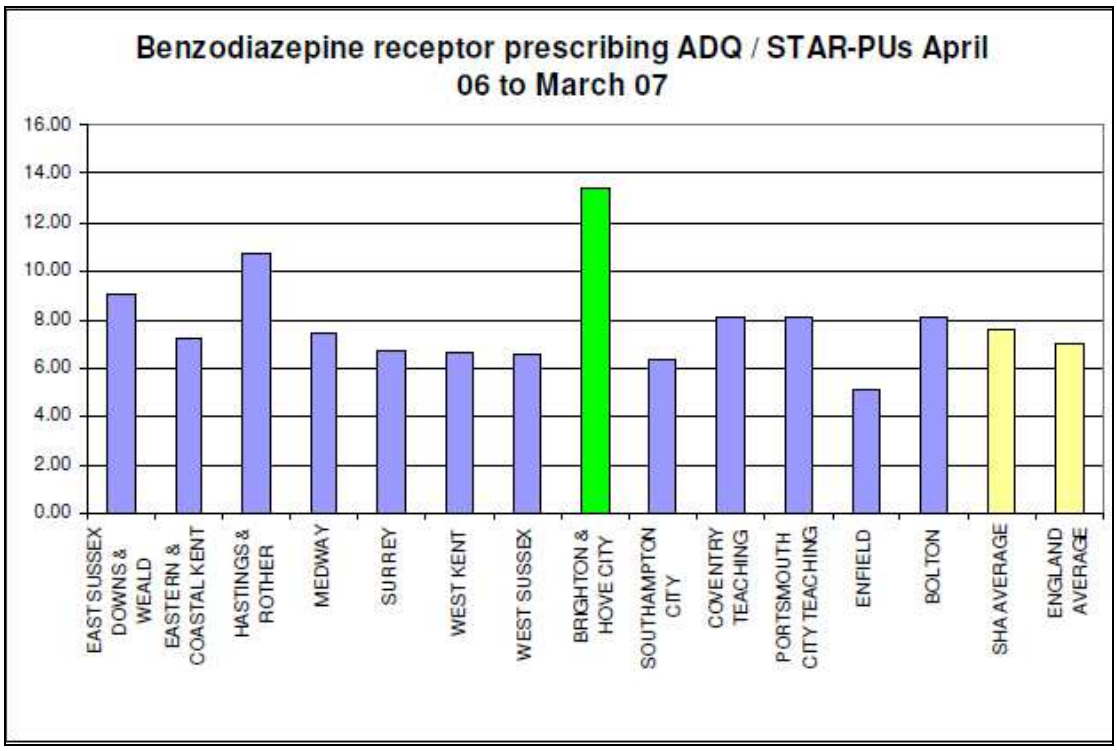


Table 17: Benzodiazepine use by local authority

There is a significant disparity between all rates of prevalence of serious mental illness in general practices and the Morley Street practice. This is exemplified by the rates of admissions with the city average being 480 per 100,000 compared to 4753 per 100,000 at Morley Street. This shows the disparity of need for the client group most likely to access housing related support services.

At the time of the JSNA the average length of admission to an acute setting was 6 days longer than the rest of the region. This length of stay should be addressed by commissioning further step down options in the city.

The JSNA consistently highlights gaps in provision for people with autistic spectrum conditions, personality disorders with social pathologies, and dual diagnosis. This should be addressed through the 2013 commissioning plan.

The JSNA contains an incomplete analysis of the provision of supported accommodation and its value for money. This should not detract from the fact that the need is evidenced through ongoing work (such as the Dual Diagnosis JSNA) for further supported accommodation meeting complex needs.

Learning Disabilities (published in 2011)

The number of people with learning disabilities is expected to increase by 5.1% over the next ten years. This is particularly evident amongst older people and those with the most severe needs.

In 2010 there were 798 people funded through Adult Social Care due to eligible needs relating to their learning disability. This is estimated to increase by approximately 100 people by 2015.

Age group	Learning disability: mild, moderate and severe	Learning disability: Moderate or severe
18-24	1,005	229
25-34	1,006	198
35-44	1,031	259
45-54	748	169
55-64	530	115
65-74	358	58
75-84	250	26
85+	124	12
18+	**5,053**	**1,065**

Table 18: Prevalence of learning disabilities in Brighton & Hove

It is estimated that 70% of the existing client base have additional social care needs:

• Challenging behaviour	25%	(200 people)
• Severe challenging behaviour	6%	(50 people)
• Autism	20%	(160 people)
• Mental health needs	15-20%	(120-160 people at any one time)
• Early onset dementia	> 1.6%	(at least 13 people)
• Substance misuse	> 1.2%	(not known, at least 10)
• A history of offending	7-14%	(according to national surveys)
• Parenting responsibilities		(not known)

Table 19: Prevalence of complex needs amongst people with learning disabilities

The JSNA complements the evidence from the cost benefit analysis by recommending that greater resources are spent on supported accommodation rather than residential care. With only 8% of the LF commissioning budget spent of supported living there is clear scope for further benefit through changed commissioning plans.

	General population (nationally)	People with learning disabilities (nationally)	People with learning disabilities in Brighton & Hove*
Own their own home	70	No data	0.3
Rented accommodation	29	15	22
Live in the family home	No data	50-55	28
Shared lives placements (settled accommodation)	No data	No data	9
Residential care or other unsettled accommodation	No data	30	33

Table 20: Comparison of the housing situation of people with learning disabilities

The JSNA also highlights specific barriers in accessing mainstream housing services. Housing related support can often either bridge the gap or directly facilitate access. For example, the remodelled LD Access service based within the Housing Options department is designed to help people access the most suitable housing or sustain accommodation if in crisis.

Whilst there is not an exact number we are aware of a small proportion of clients with learning disabilities and a significant substance misuse issue (estimated at 8 last year). There clients can often be excluded from services due to this dual diagnosis and can be at very high risk. Currently these clients are housed with the Integrated Support Pathway with additional support from the CLDT. Without this option they would likely need bespoke care services outside the borough.

The small proportion of funding that going to housing related support is shown below:

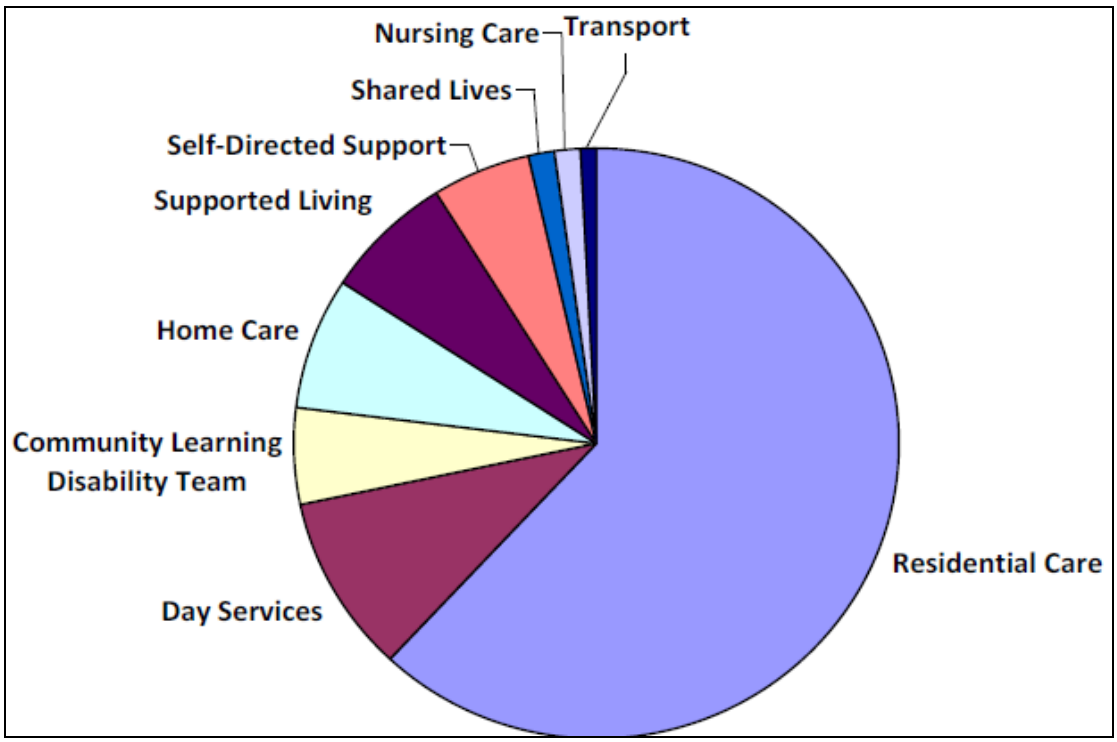


Table 21: Chart showing where funding is spent on learning disabilities services

Given the high ratio of cost benefit for this client group we will be working with commissioners to look at re-focussing resources to ensure that we are making best use of investment.

The project increase of those with profound multiple learning disabilities means that the social budget will need to be focussed on those with specific care needs so that the nest value can be delivered through housing related support for people with more moderate needs.

Young People (published 2012)

The city has fewer young people than the national average, with 22% or 55,000 compared to nationally 24%.

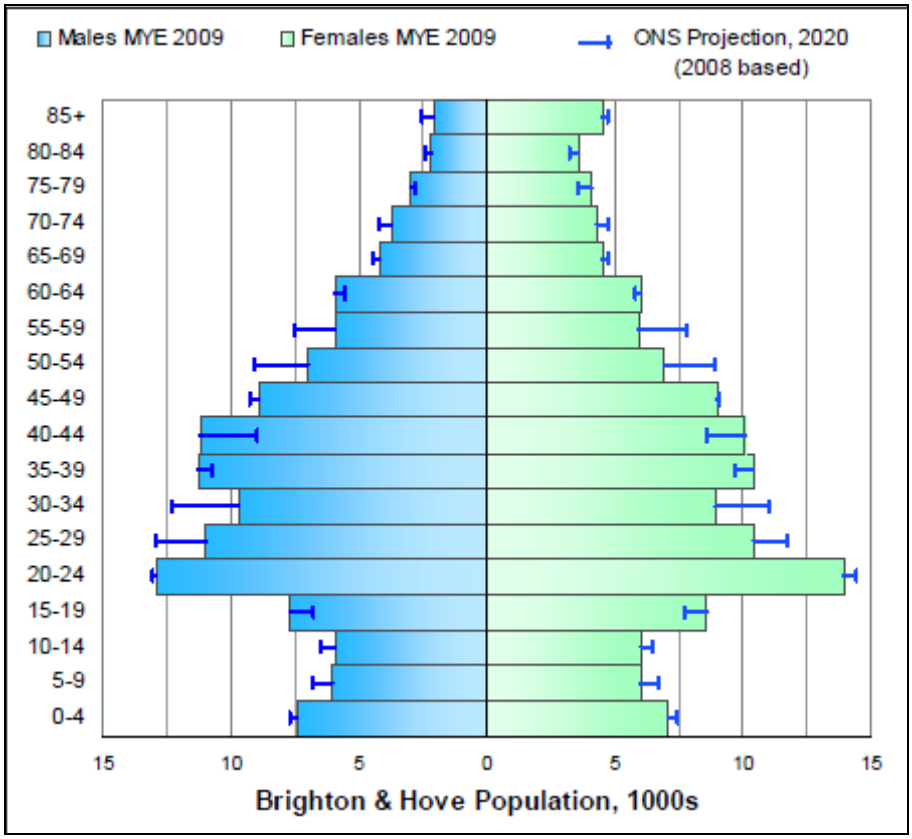


Table 22: Chart showing age range of people in the city

22% of the children in the city are classed as living in poverty compared to the regional level of 15%.

7.5% of 16-18 year olds are classed as not in educations, employment, or training.

We are 26 out of 150 (1 being the worst) for authorities with young people and substance misuse issues.

In 2012 nearly half of all services and authorities reported an increase in demand for housing related support for young people.

Alcohol Misuse (Published 2011)

The Alcohol Needs Survey looks at all issues relating to alcohol in the city including licensing, social drinking, and public drinking, as well as hazardous drinking.

- 27% of adults in the city are classed as 'binge drinkers' – more than twice the daily recommended amount at least once a week
- 24% are hazardous drinkers
- 6% are harmful drinkers
- Over 50% of male prisoners have alcohol misuse issues – this is important for the cost benefit for the alcohol, homelessness, and offender services

- Women who are experiencing domestic violence are 15 times more likely to abuse alcohol than the general population – this is relevant to both alcohol services and domestic violence services and their cost benefit

Street drinking remains a problem in the city with an average of 29 in 2009/10. This is a significant reduction on the previous year from 48. This may show the cost benefit impact of our commissioned services for street drinkers delivered by Equinox.

Of the street drinkers identified in counts over the last year: 27% live in social housing, 51% live in HRS funded hostels, 14% are NFA, and 3% are sleeping rough.

Someone with a serious mental illness is three times more likely to be alcohol dependant than the general population.

Alcohol is the identified cause of 10% of early onset dementia cases. People with Korsakoff's syndrome are some of the hardest to place as we lack specialised accommodation in the city. Those with early symptoms are most likely to be in their own accommodation or hostel accommodation rather than care services.

Amongst problem drinkers 50% have a personality disorder. This is evidence for the cost benefit of our hostel accommodation where this kind of dual diagnosis is prevalent (as shown by the Dual Diagnosis JSNA).

National Housing Federation Research

The NHF are currently actively lobbying Health & Wellbeing Boards and Clinical Commissioning Groups to show the value of housing associations and housing related support.

In March 2013 they surveyed GP's nationally to ascertain the understanding of housing related support. The intention behind this was to promote the value of HRS but also to forge links between new commissioners and this type of service.

They are also looking at developing a 'common language' between CCG's and housing associations – this is similar to the work being led local by the Dual Diagnosis Steering Group to introduce the Universal Screening Tool.

Helping to Build Better Health, NHF 2012

This report looked at a joint approach between housing associations and the NHS is achieving better health outcomes.

> The contribution housing associations make is clear – better health outcomes, fewer demands on NHS services and lower costs
>
> *Andrew Lansley, Former Secretary of State for Health*

It uses case studies from health professionals to show how they support the impact of housing in improving health outcomes.

It also offers clear guidance for housing association on how to engage with the new commissioning network, with examples of opportunities for new services and directions of travel including housing association being part of Health & Wellbeing Boards.

Specifically relevant to the CBA the report looks at how providers can offer value for money solutions by evidencing the impact of their services.

For the full report follow the link to the NHF website below:

http://www.housing.org.uk/our_regions/south_west_region/south_west_publications/building_better_health.aspx

Providing an Alternative Pathway

> A well funded, fully integrated system of care, support, health, housing, and other services is essential, not just to provide high quality support for individuals, carers, and families, but also to provide good value to the exchequer and the taxpayer
>
> Health Select Committee 2012

This report, again from the NHF in 2012, looks at individual case studies where housing related support have either enable move on from statutory services, supplement and thus reduced the need for statutory services, or prevented the need to access statutory services.

The report details five specific cases that address different areas of the impact of housing related support in both improving outcomes and reducing costs.

Regional Benchmarking Database
Summary March 2013

Brighton & Hove (B&H) have led on collating data from other Local Authorities (LA's) to produce a Regional Benchmarking database (RBD) that is categorised by client groups and support services. Benchmarking is used as part of Value for Money (VFM) assessments. The information shared between authorities are per service user and broken down into hourly rates; weekly costs and support hours. The data is based on 2011/12 and this is due to be refreshed by end of 2013. The regional quartiles calculations include B&H data. The support types used are:

24 hour cover with waking night staff
24 hour cover with sleep in staff
Day time staff on site with emergency call out
Floating/Visiting support
Live in landlady/landlord
Warden on site

It should be noted that the information used is reliant on LA's submitting accurate data and there are some small anomalies where data may have been calculated differently. There is ongoing consultation with other LA's to ensure that the same calculations have been used and data is correct. Hourly rates that are below £5 and above £30 may be erroneous and therefore the number of services falling in this category has been identified in each client group.

There can be differences of services within the support types for example; the type of floating support service being provided can vary dramatically from money advice, visiting support worker and work & learning services and this should be noted when making comparisons.

The two indicators that are best to benchmark against, are the, hourly rate and number of support hours provided. This is because the hourly rate is the most accurate data to make a like for like comparison, whereas the weekly unit cost will vary depending on the number of hours of support being provided. It is therefore useful to include the average number of support hours in order to evaluate if the service being provided is similar.

Services that are paid from the **Homeless Prevention Grant** are not included in the calculations as there is not sufficient information (such as number of hours of support).

The authorities that took part may not necessarily be like for like. If this comparison is required the database can be filtered to do this.

LA's that are considered most like B&H are Blackpool, Bournemouth, Bristol, Coventry, North Tyneside, Plymouth, Portsmouth, Southampton, Southend on Sea.

Local authorities that provided data are as follows:

Barnsley	Doncaster	NE Lincolnshire	Rotherham	Wakefield
Bath and NE Somerset	East Sussex	N Lincolnshire	Sheffield	West Sussex
Bedford	Kirklees	North Tyneside	Slough	York
Bracknell	Leeds	North York	Surrey	
Bradford	Newcastle	Portsmouth	Torbay	

Table 23: Authorities involved in benchmarking

The following are summaries of the hourly rates and support costs, Not all client groups are included in the summary, as B&H do not have these types of services and they are: HIV; Homeless families; generic; extra care; refugees and travellers

Summary of Hourly Rates by Client Group

Client Group	1st Quartile	3rd Quartile	Brighton & Hove
Older People with Support Needs	£8	£18	£10
People with Mental Health issues	£14	£20	£13
People with Learning Disabilities	£10	£16	£14
Rough Sleepers	£15	£18	£16
Single Homeless with Support Needs	£14	£19	£16
Young People at risk *	£15	£20	£15
Offenders	£17	£22	£18
Teenage Parents	£16	£19	£18
People with Physical/ sensory disabilities	£14	£18	£22
People with substance misuse	£15	£20	£13
Women at risk of domestic violence	£17	£19	£18
Total Averages	**£12**	**£19**	**£15**

Summary by Support Type

Support Type	1st Quartile	3rd Quartile	Brighton & Hove
24 hour cover with waking night staff	£12	£17	£16
24 hour cover with sleep in staff	£11	£18	£11
Day time staff on site with emergency call out	£12	£19	£14
Floating/Visiting support	£15	£21	£16
Live in landlady/landlord	£18	£19	£16
Warden support on site without alarm	£11	£18	£10
Warden support on site with alarm	£10	£30	None
Peripatetic warden with alarm	£11	£21	None
Peripatetic warden without alarm	£13	£19	None
Total Averages	**£12**	**£19**	**£15**

Summary of Weekly Alarm Costs

Client Group	1st Quartile	3rd Quartile	Brighton & Hove
Older People with Support Needs	£2	£6	£1
People with Physical/ sensory disabilities	£4	£4	£4

Support Hours by Client Group

Client Group	1st Quartile	3rd Quartile	Brighton & Hove
Older People with Support Needs	¼	1	1
People with Mental Health issues	3	9	17
People with Learning Disabilities	6	19	12
Rough Sleepers	3	15	16
Single Homeless with Support Needs	3	11	3
Young People at risk *	4	12	7
Offenders	3	6	10
Teenage Parents	3	9	5
People with Physical/ sensory disabilities	3	6	3
People with substance misuse	3	9	8
Women at risk of domestic violence	3	13	8
Total Averages	**1**	**10**	**4**

By Support Type

Support Type	1st Quartile	3rd Quartile	Brighton & Hove
24 hour cover with waking night staff	8	20	10
24 hour cover with sleep in staff	6	16	23
Day time staff on site with emergency call out	1	10	7
Floating/Visiting support	2	5	3
Live in landlady/landlord	10	11	18
Warden support on site without alarm	½	5	1
Warden support on site with alarm	¼	1	None
Peripatetic warden with alarm	½	1	None
Peripatetic warden without alarm	1	1	None
Total Averages	**1**	**10**	**4**

The overall benchmark quartiles for hourly rates across all client groups and support types are:

Hourly rates Cost *		Support Hours		Weekly	
Lower Quartile	£12	Lower Quartile	1	Lower Quartile	£10
Upper Quartile	£19	Upper Quartile	10	Upper Quartile	£137
B&H	£15	B&H	4	B&H	£57

*There is no breakdown of weekly costs in this report as stated in the introduction

Throughout the benchmarking B&H compare very well often at the lower end of the quartiles.

Breakdown of support type by client group

Older People with Support Needs

The majority of services are warden with an alarm call system, however the alarm element is contracted separately and therefore these services are classified in the report as warden without alarms. There are only two floating support services.

There are 424 services, with 25 being B&H, included in the benchmarking data of which 7 are over £30 per hour and 37 under £5. It is feasible that weekly alarm costs, which should be under £5, have been calculated as hourly rates as 80% of the 37 are alarm only.

The average hourly cost for sheltered housing is £10 which is at the lower end of the quartiles. It's difficult to benchmark against other floating support services without knowing more about the type of service they are, however the average of B&H cost is £11 which is good. Alarm costs do not have support hours and therefore are compared by weekly unit cost. Separate contracts were set up with two rates of alarm costs of 80p and £1.50 although one service was able to provide alarm for 30p. Other LA's have also followed this model. Some hourly rates in the data provided by LA's for floating support services are over £25, this is considered very high and may have been an error in the calculation thereby skewing the figures.

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	Floating/Visiting support	£25	£29	£11
Support Hours		2	2	2
Hourly Rate	Warden support on site without alarm call	£9	£15	£10
Support Hours		½	1	1
Hourly Rate	Warden support on site with alarm	£11	£20	N/A
Support Hours		¼	1	
Hourly Rate	Day time staff on site with emergency call out	£10	£17	N/A
Support Hours		½	1	
Hourly Rate	24 hour cover with sleep in staff	£6	£13	N/A
Support Hours		1	2	
Hourly Rate	24 hour cover with waking night staff	£10	£11	N/A
Support Hours		½	1	
Hourly Rate	Peripatetic warden with alarm	£11	£22	N/A
Support Hours		½	1	
Hourly Rate	Peripatetic warden without alarm	£13	£19	N/A
Support Hours		½	1	
Hourly Rate	Alarm/on call system	£2	£6	N/A
Support Hours		½	½	
Weekly unit cost		£2	£6	£1

People with Mental Health Issues

These services compare favourably with the regional benchmarks; hourly rates for accommodation are below the quartiles and floating support services which is within the quartiles; support hours are both within the quartiles

There are 117 services, 11 in B&H, included in the benchmark with 5 under £5 and 4 over £30

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	Day time staff on site with emergency call out	£14	£19	£12
Support Hours		5	11	7
Hourly Rate	Floating/Visiting support	£14	£20	£17
Support Hours		2	5	5
Hourly Rate	24 hour cover with sleep in staff	£16	£19	N/A
Support Hours		5	15	
Hourly Rate	24 hour cover with waking night staff	£12	£19	N/A
Support Hours		27	41	

People with Learning Disabilities

For each category we have one service and two for floating support. There are no regional services for live in landlord to compare with, the service for B&H is a shared lives scheme and the lack of comparison may be due to the categorisation of services as it would be expected that other authorities would have shared lives for people with learning disabilities.

There are 170 services, 6 in B&H, included in the benchmarking and of this 7 are under £5 and 6 over £30.

At a cost of £11 per hour for Day time staff this within the quartiles and they provide 30 hrs of support per service user, which is more than the average regional authorities. Sleep in staff is £16 per hour and although at the higher end of the quartiles is still a good hourly rate, again with 25 hours this service provides more

support than the average regionally. Floating support is £17 and is within the quartiles, providing 8 hours. Finally Live in Landlord is £17 and 18 hours of support but this is being compared to only one other service

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	24 hour cover with sleep in staff	£9	£16	£16
Support Hours		9	22	24
Hourly Rate	Day time staff on site with emergency call out	£10	£14	£11
Support Hours		4	15	30
Hourly Rate	Floating/Visiting support	£13	£19	£17
Support Hours		3	11	18
Hourly Rate	Live in landlady/landlord	£16	£16	£16
Support Hours		17	17	17
Hourly Rate	24 hour cover with waking night staff	£10	£14	N/A
Support Hours		12	28	

Rough Sleepers

24 hour staff at £16 is at the high end of the quartiles but is not considered a high hourly rate with 16 hours of support being provided. Hourly rate of £15 for day time staff is within the quartiles and 4 hours support is the average. Floating support is also within the quartiles and 2 hours support also average number of hours. There are 16 services included in the benchmarking with 9 from B&H.

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	24 hour cover with waking night staff	£13	£18	£16
Support Hours		12	17	16
Hourly Rate	Day time staff on site with emergency call out	£14	£17	£15
Support Hours		4	6	4
Hourly Rate	Floating/Visiting support	£16	£18	£17
Support Hours		2	3	2
Hourly Rate	24 hour cover with sleep in staff	£12	£14	N/A
Support Hours		20	27	

Single Homeless with support needs

Floating Support services are mainly for work and learning and tend to have a higher hourly rate than other floating support services due extra costs such as training and venue hire. The average hourly rate is £17 and is at the bottom of the quartiles with 2 hours of support per service user.

There are 81 services with only 1 over £30, with 17 in B&H.

24 hour cover with sleep in staff is within the quartiles at £16 per hour although at 6 hours of support per week this is below the average. The hour rate for Day time staff with emergency call out is £14 and this is below the lower the quartile and provides on average 4 hours of support

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	24 hour cover with waking night	£13	£17	£16
Support Hours		5	16	6
Hourly Rate	Day time staff on site with emergency call out	£16	£19	£14
Support Hours		3	6	4
Hourly Rate	Floating/Visiting support	£17	£20	£17
Support Hours		2	3	2
Hourly Rate	Warden support with alarm	£25	£25	N/A
Support Hours		5	5	
Hourly Rate	24 hour cover with sleep in staff	£13	£19	N/A
Support Hours		10	12	
Hourly Rate	Alarm/ on call	£16	£20	N/A
Support Hours		5	7	

Young People at Risk

All the services are within the regional quartiles. B&H do not have any services for alarm only/ live in Landlord or warden for young people; these are included in the table below for information only.

There are 132 services with only 1 over £30; there are 10 services in B&H.

Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	24 hour cover with waking night staff	£15	£17	£17
Support Hours		7	17	6
Hourly Rate	Day time staff on site with emergency call out	£15	£20	£18
Support Hours		4	8	4
Hourly Rate	Floating/Visiting support	£15	£20	£18
Support Hours		4	8	4
Hourly Rate	24 hour cover with sleep in staff	£13	£19	£13
Support Hours		8	15	15
Hourly Rate	Live in Landlady/landlord	£19	£22	N/A
Support Hours		2	5	
Hourly Rate	Warden on site without alarm call	£17	£19	N/A
Support Hours		5	11	
Hourly Rate	Alarm/on call system	£20	£21	N/A
Support Hours		3	4	
Weekly unit		£6	£11	

cost				

Offenders or People at Risk of Offending

There are no regional services to compare against waking night staff and therefore the B&H service should make comparisons with other similar homeless service, however, the hourly rate for this type of client group would be expected to be slightly higher than other types, due to the nature of the client group for offenders. This type of service is £17 per hour with 12 hours support. Day time staff services cost £23 per hour which is above the quartiles with 9 hours support and finally the floating support is £18 per hour which is within the quartiles and gives 3 hours a week support. The majority of services in other LA's are floating support.

There are 31 services, 3 in B&H, included in the benchmark, 70% being floating support.

Regional Benchmark	**Support Type**	**1st Quartile**	**3rd Quartile**	**B&H Average**
Hourly Rate	24 hour cover with waking night staff	£17	£17	£17
Support Hours		12	12	12
Hourly Rate	Day time staff on site with emergency call out	£18	£22	£23
Support Hours		4	9	9
Hourly Rate	Floating/Visiting support	£17	£23	£18
Support Hours		3	6	3
Hourly Rate	24 hour cover with sleep in staff	£12	£12	N/A
Support Hours		20	20	

Teenage Parents

There is only one B&H service for this client group, at a cost of £18 per hour which is within the regional quartiles. The service gives 5 hours support per week which is slightly more than the regional average.

There are 20 services in the benchmark with 55% being floating support

Regional Benchmark	**Support Type**	**1st Quartile**	**3rd Quartile**	**B&H Average**
Hourly Rate	Floating/Visiting support	£17	£20	£18
Support Hours		2	4	5
Hourly Rate	Warden support without alarm	£15	£15	N/A
Support Hours		7	7	
Hourly	Day time staff with emergency call	£16	£18	N/A

Rate	out			
Support Hours		5	9	
Hourly Rate	24 hour cover with sleep in staff	£14	£18	N/A
Support Hours		13	19	
Hourly Rate	24 hour cover with waking night staff	£21	£21	N/A
Support Hours		15	15	

People with Physical and Sensory Disabilities

The main services for this client group are alarm services which cost £4 per week but there are no other services of this type in other LA's to compare. However this is comparable to the alarm only costs within the Older People's services.

There are 22 services in the benchmark and 3 in B&H.

The floating support is £21 per hour with 3 hours of support per week. There are no other floating support services locally and only a few regionally. The cost does appear high and is at the high end of the quartiles. This does however the importance of using benchmarking as a tool in assessing the value of money and not the result. The service provided is vital to service users accessing services and the staff are highly trained particularly in the use of sign language and other interpreting skills

Regional Benchmark	**Support Type**	**1st Quartile**	**3rd Quartile**	**B&H Average**
Hourly Rate	Floating/Visiting support	£15	£21	£21
Support Hours		1	4	3
Hourly Rate	Day time staff with emergency call out	£19	£22	N/A
Support Hours		4	5	
Hourly Rate	24 hour cover with sleep in staff	£14	£18	N/A
Support Hours		5	11	
Hourly Rate	Peripatetic warden with alarm	£11	£11	N/A
Support Hours		½	½	

Unit cost	Alarm/on call system	£3	£5	£4

People with Substance Misuse

There are 2 support types that are funded by B&H: Day time staff on site with emergency call out and Floating/Visiting support. Within the RBD other LA's also have the majority of their services as these.

The accommodation services also receive funding from Health but this has not been used when calculating the hourly rate as there is not enough information with regards to the use of the funding.

There are 31 services, 5 services in B&H, with 1 under £5 and 1 over £30. 32% are day time with emergency call out and 51% floating support.

The average hourly rate for accommodation services is £12; one of the services at £9 per hour is quite a bit below the quartile, being cheap is not necessary good and this would be cause of concern with regards to the financial sustainability of the service. The average support hours provided is 13 with one service providing 33 hrs per service user; this is much more than the average regionally. For floating support the average is £15 and the support hours of 4 is within the quartiles. These services compare favourably with the regional data.

Regional Benchmark	**Support Type**	**1st Quartile**	**3rd Quartile**	**B&H Average**
Hourly Rate	Day time staff on site with emergency call out	£16	£19	£12
Support Hours		4	10	13
Hourly Rate	Floating/Visiting support	£16	£21	£15
Support Hours		3	4	4
Hourly Rate	Warden support with alarm	£5	£5	N/A
Support Hours		12	12	
Hourly Rate	24 hour cover with sleep in staff	£16	£20	N/A
Support Hours		12	15	
Hourly Rate	24 hour cover with waking night	£15	£18	N/A
Support Hours		13	20	

Women at Risk of Domestic Violence

There are 2 support types: £17 for accommodation based service with 14 hours of support and £18 per hour for floating support service with 4 hours per week of support. There are no other services to compare locally. They are within the regional quartiles.

There are 53 services with only 1 over £30; 45% are floating support and 45% day time with emergency call out.

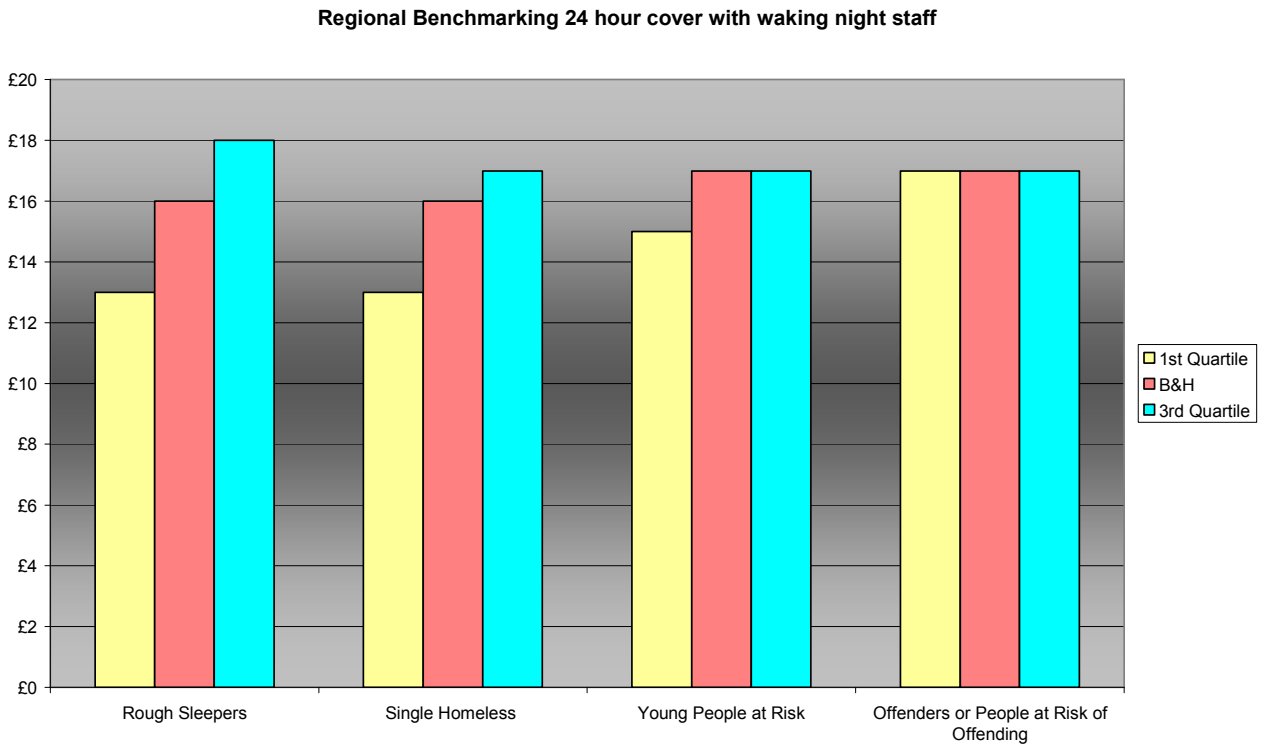
Regional Benchmark	Support Type	1st Quartile	3rd Quartile	B&H Average
Hourly Rate	Day time staff on site with emergency call out	£17	£20	£18
Support Hours		8	16	12
Hourly Rate	Floating/Visiting support	£16	£20	£18
Support Hours		2	3	2
Hourly Rate	24 hour cover with sleep in staff	£18	£19	N/A
Support Hours		8	13	
Hourly Rate	24 hour cover with waking night staff	£20	£20	N/A
Support Hours		14	14	

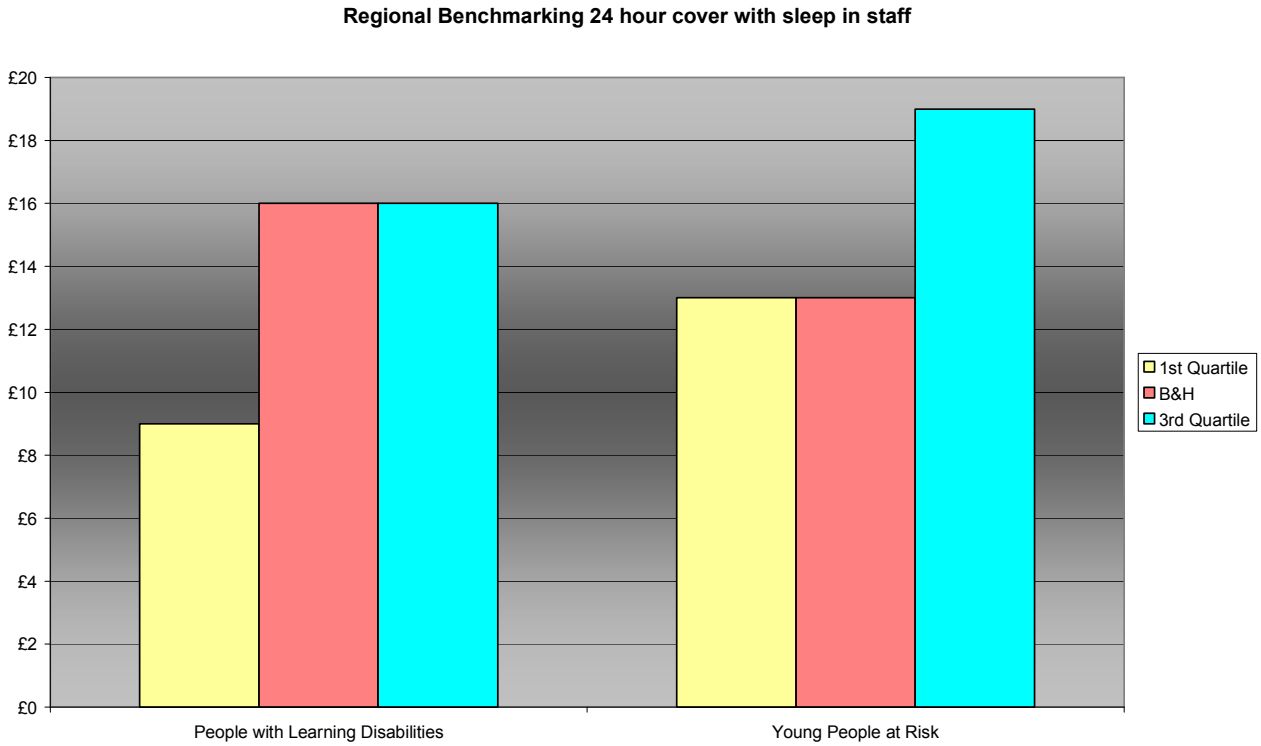
HIA

There are 14 services in the benchmark, with B&H only funding 1. The calculations for HIA are dealt with differently from other clients and are based on the number of jobs and cost of jobs rather than an hourly rate which is difficult to calculate.

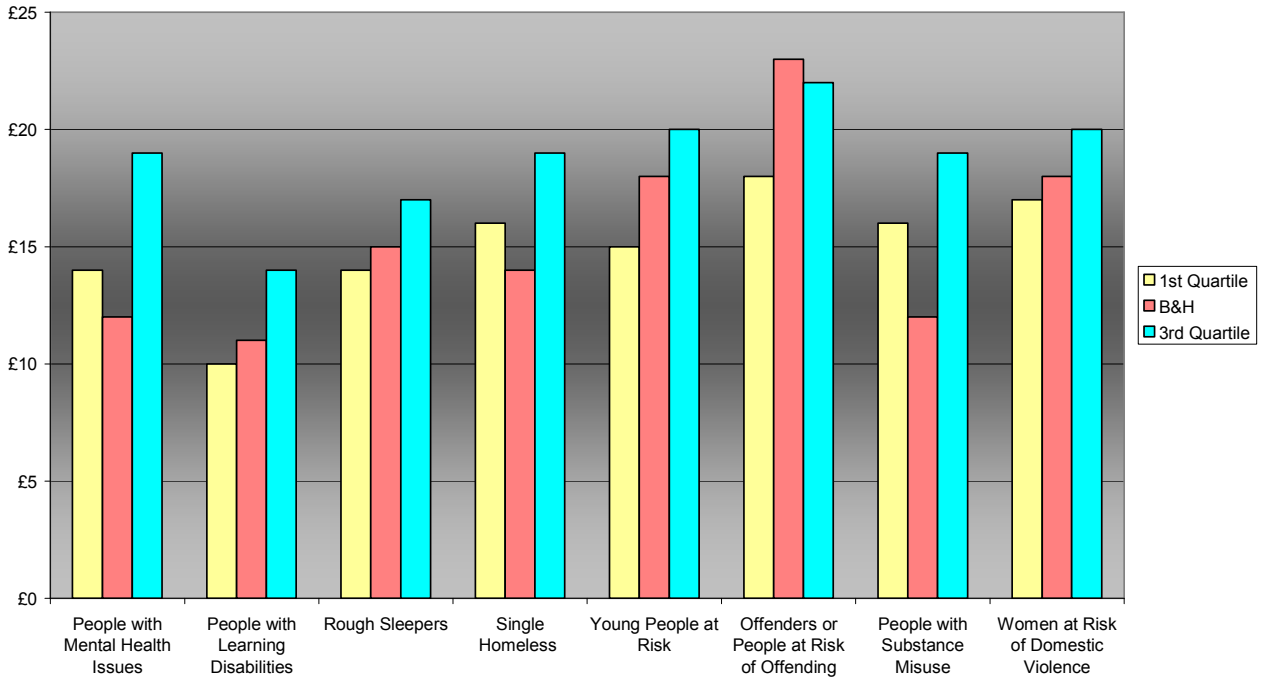
Regional Benchmark	1st Quartile	3rd Quartile	B&H Average
Annual contract price	£23,471	£65,705	£111,667
Number of jobs	65	31	158
Cost per job	£128.70	£513.40	£706.75

Regional Benchmarking comparisons for hourly rates by support types

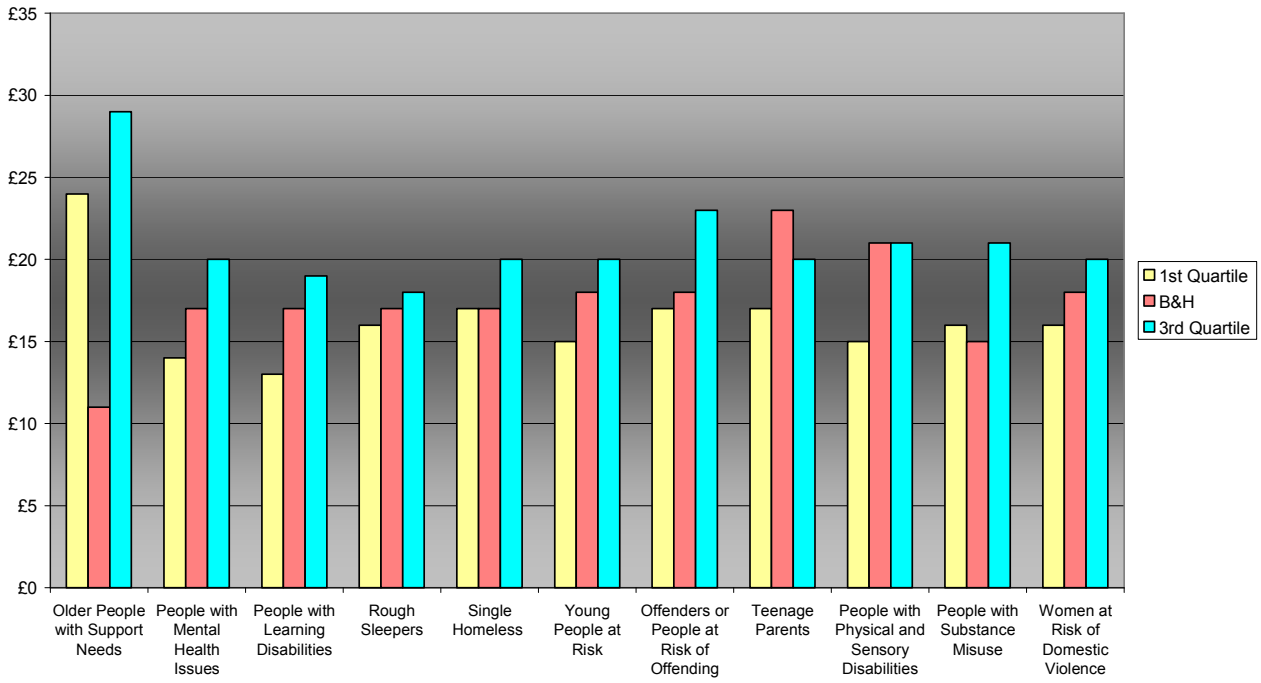


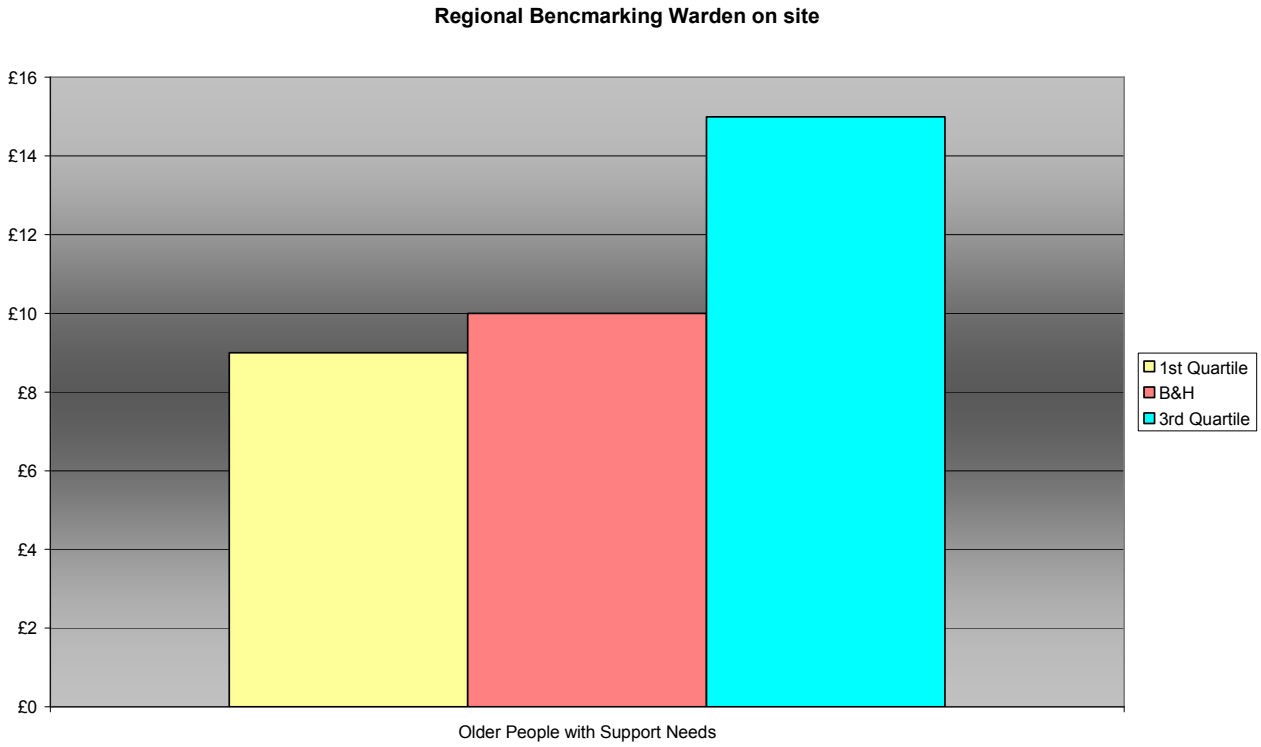


Regional Benchmarking Day time sraff on site with emergency call out



Regional Benchmarking Floating/ Visiting Support




Regional Bencmarking Warden on site
£16
£14
£12
£10
£8
£6
£4
£2
£0
1st Quartile
B&H
3rd Quartile
Older People with Support Needs

Case Studies for the Cost Benefit Analysis

Brighton YMCA Case Studies

Band 3

Case Study 1

PS had a fifteen year history of substance abuse and criminal activity, he had spent many years in prison with sentences varying from 6 months to 4 years, PS states the only life he knew was centred around crime and drugs. While PS was living at the hostel he and his keyworker worked on reestablishing contact with his family and PS now has regular contact with his three children.
PS has sustained regular contact with Substance Misuse Services (SMS) and both key workers (SMS & Brighton YMCA) jointly worked in order to give appropriate support. PS is nearly two years abstinent without using replacement drug therapies.
PS began volunteering for Fareshare whilst waiting for a place on the Crime Reduction Initiative (CRI) Peer Mentoring Course. PS went on to do the peer mentoring course but found the written course work difficult due to poor literacy skills. His keyworker referred him to Step By Step at the Friends Centre. In the meantime PS and his Keyworker worked through the written elements of the course in keyworking. PS eventually completed the course and went on to do Drug and Alcohol Hostel Outreach work with CRI in New Steine Mews, William Collier House and Glenwood Lodge. PS continues hostel outreach work three days a week and has progressed to interviewer and referrer to CRI services for hostel residents and his literacy skills have greatly improved.
During his stay PS and his keyworker compiled an impressive move on portfolio and explored both the private rented sector and the local authority move on options. PS has now secured a flat via Homemove and was referred to Support 4 Housing for floating support.

Case Study 2

RK moved to Stanley Court from Glenwood Lodge. He was diagnosed with a personality disorder and had historically self harmed, resulting in an admission to intensive care in 2011. He also had difficulties engaging with others particularly in group situations.
Whilst at Stanley Court RK started engaging well in keyworking and was encouraged by his keyworker to take more responsibility in his life and started setting goals accordingly.
RK was linked-in with mental health services and had engaged well with Southdown Employment Services via the Community Mental Health Team. As per his action plan, he secured funding for a gym instructor course due to start 5 months after he moved in.
During keyworking RK and his keyworker agreed that he needed more structure in his day. He was encouraged to do the life skills course but strongly maintained he

could not do group work. Meanwhile his gym instructor course started at the Falmer Campus. RK was extremely anxious about having to work in a group and was worried about the other people on the course and if he would get on with them. He doubted his abilities and nearly gave up. RK worked with his keyworker to establish strategies to alleviate his anxieties and they also met with his tutors so that they could provide extra support during the course.

RK thrived on his course; he began to enjoy the company of his peers and started making friends. He achieved high marks in his coursework and passed the course with ease. He now holds a level 1 Diploma in gym instruction and is hoping to move on to level 2.

RK's life changed dramatically over a 12 month period, he no longer needs medication to manage his mental health and no longer requires support from the mental health team, although he can access the SMILES team on a "call us if you need us" basis.

To widen his options for move on he agreed to complete the life skills course which he felt able to do due to the confidence he had built while attending the fitness instructor course. Whilst doing the life skills course, New Steine Mews asked him to become a volunteer helping them deliver parts of the course that involve fitness and healthy lifestyle choices.

RK has now moved on, is living independently and is looking for work in the health and fitness industry.

Case Study 3

PE is a 56 year old male client who once worked full time for a well-known insurance company. PE believes that the pressure and demands of the job led to him having problems with alcohol which resulted in him suffering a "breakdown". PE could not manage his privately owned flat, was evicted and subsequently was street homeless.

When PE moved to Stanley Court he would self isolate during the winter months. He would not wash, change his clothes or manage everyday simple tasks. He suffered from anxiety, panic attacks and at times misused alcohol. PE was not linked into any outside services and because he would isolate himself he would avoid meetings.

With the support of his keyworker, PE felt able to access the GP and as a result was referred for a Cognitive Behaviour Therapy workshop for anxiety and sleep problems; he also received Cognitive Behaviour Therapy counselling. This led to a meeting with a nurse who conducted a health MOT with him which enabled him to reduce his alcohol, taught him to eat healthily and he helped him to stop smoking. PE also completed a life skills programme and made some new friends along the way. Next, PE completed a Business Action on Homelessness workshop and as his confidence grew he was keen to find a volunteer placement.

PE now volunteers for a young offender charity and is an ambassador for Business Action On Homelessness and attends their employment workshops monthly. Furthermore PE volunteers for a gardening project in the area. PE claims that living in the supportive environment of Stanley Court gave him the security and confidence to move on with his life. PE is now living independently again in his own flat.

Case Study 4

AP came to Fred Emery Court after completing the St Thomas Fund rehabilitation programme due to alcohol dependency. AP suffers with bouts of depression and anxiety which he previously managed with alcohol. The programme at St Thomas gave AP more insight into his dependency to alcohol alongside skills and strategies to cope. The step to band 3 accommodation gave AP an opportunity to put what he had learnt into practice in a more independent environment so that he could ultimately move on to independent housing.
When he first moved to Fred Emery Court AP did struggle to adjust to the lower support and had lapses with alcohol. He has however been proactively engaging in support and accepting input from his keyworker. AP was prescribed medication for his anxiety and was able to develop a good day structure by volunteering at The Martlets three days a week. With the help of his keyworker, using a budget planner, AP addressed and cleared his past debts and arrears. AP also re-established relationships with his family and developed positive social and support networks. In the longer term his goal is to develop his own business as a painter and decorator.
Over time AP has required less input from staff gaining confidence in his own inner resources. AP went on to be assessed as "ready to move on"; he is now living in an assured tenancy with a housing association.

Case Study 5

GS experienced his first period of homelessness before going to the night shelter and was there for 4 months before moving to Leslie Best House (LBH).
GS had £600 worth of debt and was receiving letters from the bank with charges on a regular basis. His keyworker referred him to St Luke's Money Advice Service and a repayment plan of £10 per month was agreed and monitored via keyworking at the hostel. GS was encouraged by his keyworker to complete a number of courses through the Job Centre which he did. He eventually obtained a full time job as a security guard and needed support from his keyworker around the changes with housing benefit, paying rent, obtaining references, etc. GS has now moved into independent accommodation and is still in full-time employment.

Case Study 6

Prior to moving in JD this she was evicted from a council tenancy due to rent arrears; at this time JD was using large quantities of cocaine. During her stay, JD found it difficult to budget her money and as a result started to accrue service charge arrears. JD's keyworker supported her to setup a rent repayment plan and a budget plan so that she could pay her debts off and learn how to budget her money appropriately.
During her stay JD's keyworker encouraged her to apply for volunteering positions in order to improve her confidence with a view to obtaining paid employment. JD completed a catering course with TASTE and became a volunteer with Brighton YMCA. JD continues to volunteer and is also working in a paid position for Age UK. With regards to move on, JD is now using the drop in service at START and is actively looking for a Private Rented Sector flat.

Band 2

Case Study 8

AJ moved to William Collier House from a young people's project. Her referral risk assessment pointed out a long history of self-harm that was probably directly linked to abuse she suffered at the ages of 15 and 17. AJ also has a long history of using young people's services for counselling around self-harm and her increasing levels of alcohol consumption. AJ stopped drinking on a regular basis when she moved to the hostel. A level of engagement with services was agreed between her and her keyworker and AJ was supported to disengage herself from her previous circle of friends who seemed to have a negative influence on her.
Staff at the hostel were concerned about how AJ managed her self-harm; which happened quite frequently and was usually linked to high levels of stress following an altercation with a family member. Hostel staff were able to build a trusting, supportive relationship with AJ and overtime she learnt to identify the signs that led to self-harm and to request hostel staff support when she was at risk of harming. She was also supported to continue counselling during her stay at WCH.
While at WCH AJ completed the Prince's Trust Programme and started attending a young people's programme called 'Work It Out' in order to access paid employment. She has since moved on to lower supported housing.

Case Study 9

Since he moved into the hostel JC has complied fully with his probation order and has met with his probation officer, his drug worker and his allocated PC every week as advised.
JC has also kept away from drugs and controlled medication which he cited as the reason for his offending. In order to support this JC and his keyworker looked at ways he could be positively active in the community; for example, by attending an IT course to gain an ECDL qualification and a Math and English course to be able to apply for some GCSEs next year. JC has also been going to the gym every week which has helped him give him structure and focus to help him avoid a relapse and therefore re-offend.
JC now has greater control over his life and he is working towards starting a university course in 3 years time. He is also about to move on to lower supported, Band 3 accommodation.

BHT Case Studies

Client B – Phase One Hostel

Client B was referred to Phase One by the Mental Health for Homelessness Team. Client B had been itinerant for approximately 20 years and had been diagnosed with long enduring mental health issues. Following his acceptance for a place at Phase One the project's Mental Health Supported Housing Worker alongside his MHT worker began the work to support the client in the transition from being a long term rough sleeper to acclimatizing to being housed and engaging in support. This work was undertaken through careful support planning and CPA reviews to ensure that

the client's needs were being met during this difficult period for the client and planning for future housing options.
Client B resided at the project for 15 months and was referred to Route 1 services for move on accommodation and was accepted and has maintained his tenancy with them.

Client T – Lewes to Brighton

The Project works with T a 22 year old male with mental and physical health issues, a history of homelessness and a long standing alcohol dependency. He has accrued 18 convictions for 35 separate offences. His recent offending is domestic violence offences, breaching court orders and public order offences. In the last 12 months he has served 2 custodial sentences, has been arrested 8 times, has presented at A&E on 26 separate occasions and been admitted to hospital on 4 occasions.
In the 12 months prior to working with the Project T's relationship with his Ex-Partner broke down. TA was convicted of an assault and made subject to a Restraining Order. He was prohibited from contacting her and could no longer reside at her property. T was subsequently street homeless. He did work with the Rough Sleepers Street Services Team and they were able to place him in emergency accommodation because of his mental health diagnosis. However, he was evicted from the accommodation after 2 months for breaking the terms of his license agreement and was once again rough sleeping. The Council had to discharge their duty to house him as he was deemed to have made himself intentionally homeless. T then spent 2 months rough sleeping. During this period his alcohol use increased significantly and he became well known to emergency services because his street presence increased. He was arrested on a number of occasions for public order offences and was regularly presenting at A&E suicidal or with physical health problems. On one occasion he was admitted to hospital after an overdose, triggered by the anniversary of a family member's death. On another occasion T was admitted to hospital because of liver damage. He had to be transferred to a specialist liver hospital in Ipswich for treatment before he was discharged after 1 week. T was eventually sentenced to 14 weeks custody for Battery and Criminal Damage, on arrival he had to undergo an alcohol detox and was in poor physical health.
The Project worked intensively with T for the duration of his sentence. Working in collaboration with HMP Lewes Health Care, his GP and the Mental Health Team attached to the A&E Dept, the Project was able to advocate on the T's behalf and build a case around him being in Priority Need on the grounds of his physical and mental health. The aim was to secure T emergency accommodation on release. The information was submitted to the Local Authority and they agreed to place him in emergency accommodation on the day he was released. However, given T had previously been found intentionally homeless it was highly likely he would be homeless again after 28 days, as he was likely to be assessed as intentionally homeless again. The Project therefore referred T to supported housing as a non-statutory client and through the Project's intervention he would be able to secure permanent accommodation, despite being found intentionally homeless. In addition to this T was referred to both the Community Alcohol Team and MENDOS mental health service.

T was placed in emergency accommodation on release. The Project and partnership agencies worked with him assertively for the 3 weeks whilst he resided in emergency accommodation. To his credit he attended regular appointments with support agencies and presented as highly motivated. He started attending appointments with Alcoholic Anonymous and was allocated a Sponsor whose support he valued. T did relapse with drinking but with the support of his Alcohol Worker was not drinking at dependency levels. He was then successful at a housing interview and moved into supported housing.
Since residing at the supported housing project he has been allocated a Housing Support Worker, she is assisting with housing move on and more general support needs. T continues engage with existing support services however, his alcohol use did increase which resulted in him receiving 2 warnings for aggressive behaviour towards staff and residents. He was subsequently issued with a 7 day notice to quit. The Project Coordinator was able to call a multi-agency meeting and working in collaboration with T and existing support agencies, put in place a risk management acceptable plan to the accommodation provider and this prevented T's eviction. T was worried that he would be evicted losing not only his accommodation but also the support network he had built up. He is now working with the Hostel Alcohol Worker and is motivated to address his drinking by way of residential rehab.

T moved in Residential Rehab in April 2013, he is attending regular appointments with his GP and Support Workers. There has been significant reduction in the number of presentations at A&E (4 in total) compared to the 12 months prior to custody. To date there are no records of him re-offending.

Client B – Olympus House Project

Brett arrived at Olympus House having spent the previous three months sleeping in a car. He had a long history of heroin use and many of the emotional scars that go with this addiction. "I was homeless, vulnerable, overwhelmed, you name it I was an emotional wreck".
The first couple of weeks at Olympus House were very difficult for Brett and there were a number of times that he felt like ending it all. However, with some gentle persuasion from staff, Brett took up the offer to come down and discuss his obvious distress.
"We had a good chat which saved me in many ways; I believe that chat was a turning point in my journey." During his stay at Olympus House Brett used the calm environment and supportive atmosphere to address some of his long standing issues and began to make some positive, lasting changes.
"My life has improved tenfold. I have some structure, I have goals, targets, and have in my own way, become wiser. The Olympus House team have helped me rebuild my life and I will be sad to see that you are not there in my everyday life. I give you ten out of ten and will always be thankful to you".

Client X – BHT Mental Health Services

X moved into Dorset Gardens in October 2010 having been resident at Hanover Crescent (ward in the community). This was following discharge from Mill View Hospital. His hospitalisation was as a result of a mental health breakdown while he was in prison. He states that he did not receive proper care and treatment for his mental health condition (paranoid schizophrenia and dissocial personality disorder) whilst in prison. The prison sentence was as a result of a drugs-related offence. He has spent over half his adult life in prison.
When X came to Dorset Gardens he was under Probation. This lasted until August 2011. He was good about keeping his Probation appointments. He was also linked in with the local SMS service. He did relapse at times and admits to having used some illegal substances, but overall his progress was in the right direction.
To start with X made slow progress at Dorset Gardens. He did not always keep to the house rules and the terms and conditions of his Licence Agreement. His difficulties lead to formal Warnings (including a Final Warning) and a Contract for Change. He states that there were times when he was being falsely accused of doing things that he did not do. After about a year and a half he got the move he wanted to a self-contained studio at 38 Carlisle Rd. The move came as a result of a formal assessment meeting at which he stated his need for more independence. He now sees the recent move as a good opportunity for him to take greater control of his life so that he can look forward to his own independent accommodation without the need for constant support and monitoring. He has stated his desire to be drug-free and to change some of the damaging behaviours of the past. He manages his mental health better. He is very organised, competent and maintains a clean, tidy living space. He describes his progress while at Route 1 Project as “long and daunting”. However, he is now positive about the future, stating that he is not going to get lead astray again. He describes the improvement in his mental health as being as a result of an improvement in his confidence. He acknowledges that there is more help of the type that he needs on offer now. Mark takes medication willingly and is well linked in with GP and mental health services.
X is a sociable man. He has a good social network. At the age of 39 he feels that his life has reached a cross-roads. He states his goals as: “move on, and starting a family. When I came to Route One in July 2010 I was very depressed, they thought I might have a personality disorder. I hadn't worked in years and I seemed to be in and out of hospitals because I felt so unstable. Since moving into Route One I felt less lonely, I liked talking to my Support Worker, it stopped me being so impulsive. I think having stable accommodation made such a difference for me. I started a full time job at the AMEX Stadium which I love because I am a big Albion Fan. I was promoted from the food stalls into hospitality and now i work on big events, they are letting me do a Diploma in Hospitality and Management. I no longer receive Housing Benefits or DLA, I can support myself. I am looking forward to saving money and moving to my own accommodation.

Client B – BHT Mental Health Services

B moved into R1 after having a serious mental health breakdown leading to a very serious suicide attempt and being in hospital for over a year. Before his breakdown B worked as a carpenter and lived independently in the community, a series of difficult

circumstances including some health issues which meant he was unable to work and difficulty sorting out any benefits and then losing his accommodation which he had lived in for 30yrs lead to his breakdown. B came out of hospital and moved into R1. He had completely lost a lot of his previous skills and confidence and was still struggling with feelings of suicide and depression. Over the last year B has had weekly support from R1 to look at his mental health issues and build up his resilience, confidence, self-worth and esteem. To do this X was supported to attend a furniture restoration course at a local charitable workshop, this built on his previous skills and encouraged him to engage with the wider community and meet people. It built his confidence and gave him the confidence to attend other courses at Buckingham Road. He has really enjoyed these and is now attending three courses there. He has settled in very well and has been encouraged to make the flat his own which has contributed to him feeling more stable and settled which is important for his mental health. We have supported B to develop the garden and he has done amazing work there, planting lots of vegetables and using his wood skills to build fences and dividers. B has developed a lot of skills over the last year which mean he is better equipped to manage his mental health he has had two episodes where things have happened that he has found difficult to cope with and he has become quite unwell, he has not been readmitted to hospital because of the extra support that was put in place for him at these times. B stated that 'he has found it so helpful to have someone to talk to and does not feel alone now'

Client J – First Base

When J first came into our service, he had never before been in the position of rough sleeping. He was 45 years of age, had worked fairly consistently and always had friends or partners he could rely on if work dried up and he found himself in between jobs. The recession had meant that he had faced a longer period of not working, his relationship had succumbed to stress and he found himself sleeping on the beach.

J had made a claim for Job Seekers Allowance, but had not received a payment after several weeks. He had eaten nothing for two days and was embarrassed, he said that he had not washed or changed his clothes for a week. We made sure that J had a hot meal, a change of clothes and was able to use the shower at First Base.

J was assigned a caseworker who met with J every day for the following week and it became clear that he was feeling overwhelmed by his difficulties, ashamed and hopeless about his future. He said that he had visited a railway bridge on several nights in the previous month and had considered throwing himself under a passing train. J disclosed the difficulties that he experienced throughout his life and that these experiences were re-visiting him on a nightly basis and tormenting him.

J's caseworker referred him to the Mental Health Team, contacted his GP and made J an emergency appointment. The Doctor was sympathetic and offered medication and follow-up visits.

It was obvious that J was in no position to be actively seeking work and he needed a new claim for a sickness related benefit. J was very anxious and physically shaking while he spoke with the Department for Work and Pensions on the phone so his caseworker supported him with the call. It was a further two weeks and many phone calls later that J received any benefit payment.

J met with the Mental Health Team at First Base and they agreed to offer some on-going support, seeing J fortnightly, alongside regular contact with his GP and daily support from his caseworker.

With the support of his caseworker, J arranged an appointment with a BHT housing adviser who suggested that he make a homeless application. His application was rejected due to lack of medical information supporting his case. As J did not have a local connection to Brighton and Hove it was not possible for him to be referred into one of the City's hostels, so we began to explore the possibility of privately rented housing with support from another BHT project, Firm Foundations.

Throughout this time, J was continuing to sleep on the beach and his mental and emotional state would fluctuate greatly on a daily basis. J made very good use of services at First Base, including volunteering and on good days was able to plan the direction of casework himself.

Over time, we collected letters from his GP and from mental health specialists involved in his care and re-submitted his homeless application. With the additional evidence gathered Brighton and Hove City Council accepted J's application for housing.

J is now living in BHT supported accommodation for people experiencing mental health difficulties. He has Key work support from this project alongside specialist mental health support for Complex Post Traumatic Stress Disorder. He is engaging

with alcohol support services and still calls in periodically to let us know how things are for him.

Client S - Intern

S suffered from mental health problems for a number of years, and these have been exacerbated by alcohol addiction. S had been a client of BHT's Recovery Project in 2011 and she had successfully addressed her addiction. After spending some months in the Recovery Project S transferred into BHT's Move-On Project in May 2012, where she continued to receive support around her recovery and her mental health. S had not worked for a number of years and felt that she did not have the skills or confidence to return to work. She had been claiming benefits for some time and had recently been referred to the Work Programme, she was struggling on the work programme as she felt that she could not reveal the personal information about her support needs to her Work Programme advisor; as such she felt unsupported. There was limited flexibility within the structure of Work Programme provider S had been assigned to with her being mandated to attend all appointments or lose entitlement to benefits. S often struggled to make appointments and had gotten to the stage where she "dreaded going in to see them". She was committed to getting back to work but felt misunderstood and under-supported and was finding it increasingly difficult to engage. S had been given a warning letter about a missed appointment, which she hadn't attended as she felt it necessary to go to an alcohol support group meeting.

S had heard about the Intern Programme form her BHT Move-on Project support worker, she came along to an information session, where she was able to find out how the project could support her and work with the support needs she had. S felt able to divulge information about her needs and was pleased that the Intern Project would work alongside her support worker so that important information about her support needs could be shared.

The assessment process allowed S to think about the skills she had attained in the past and the skills she felt she wanted to gain. S was accepted onto the programme and the Intern Programme was able to contact her Work Programme provider and agree that she be suspended on that programme to allow her to focus on completing an internship.

S attended induction training along with a number of other applicants and was able to share experiences and gain support from her peers, she was given the opportunity to visit her placement and meet her mentor twice before the placement began, which allayed many of the fears she had about going on placement. "I immediately felt that you got me, got what I was all about, I felt that I could tell you anything and I'd get helped, the support from everyone was great, I could tell they really wanted me to do well"

We negotiated the days and time she would attend placement with the service and built these around her alcohol support meetings, three-way meetings with S , the Intern Programme Co-ordinator and her mentor ensured that her placement understood the support needs she had and was able to work to support her.

S quickly got to grips with her placement; she was placed as an Intern Administrative assistant in our Brighton based legal advice service. S had worked as a legal secretary

some years previously and placing her in a familiar environment enabled her to build her confidence more quickly.
Half way through the placement S attended Personal and Professional Development Sessions and began IT training. She completed sessions on CV's Application forms and Interview Skills. "The placement gave me the confidence and the sessions gave me the knowledge"
S applied for a full-time position as a legal secretary with a local firm of solicitors two months before her placement was due to end, The intern programme was able to support her with references, bus fares to and from her interview, proof reading of her application form and interview practice sessions.
S was successful at interview and has been in employment since August 2012 and is doing well. With her new job she has been able to move out of the Move-on accommodation she was in and has her own flat. "The programme was the best thing that's happened to me, you kept believing in me and in the end I started to believe as well, now look at me, I've done it"