Ministry of Housing, Communities & Local Government

Housing Related Support Review

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Executive Summary

Housing-related Support and the policy context

Housing-related Support (HRS) is support which is usually provided alongside accommodation, to help people live safely and independently. It serves a range of vulnerable groups including older people, people with mental or physical health conditions or disabilities, people with learning disabilities, homeless adults and families, vulnerable young people, and people fleeing domestic abuse.

The term 'Housing-related Support' refers to both 'Floating Support' which is delivered to people in any kind of accommodation, as well as 'accommodation-based support' in which support is delivered in conjunction with the accommodation, Accommodation-based support is often specifically designed for the client group such as rooms with shared communal facilities or specialist accommodation for people with disabilities. HRS ranges from regular visits from a support worker, 24 hour on-site staff presence, or low level mental health support, depending on the needs of the individual or client group. Individual HRS clients may receive help, for example with accessing benefits or completing paperwork, managing their health, getting into training or employment or maintaining a tenancy or home.

Between 2003 and 2009 most Supported Housing was funded by the Supporting People Programme, under which Local Authorities (LAs) directly provided or commissioned services using a protected funding stream. The ring-fence around this funding was removed in 2009 and since 2011 funding was subsumed into wider LA budgets, meaning it was no longer mandatory to provide HRS services. This also meant that data about the sector and the support provided was no longer systematically collected[1].

The last government review of the support provided in Supported Housing was carried out in 2009[2][3] and since then evidence suggests that delivery and funding models have undergone significant changes. In returns submitted by LAs to MHCLG regarding budgeted spending[4], LAs reported total budgets for Supporting People of £359m for 2018/19[5], only around a quarter (26%) of the £1.355bn that they reported spending in

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[1] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector*: November 2016. Available at: https://www.gov.uk/government/publications/supported-accommodation-review

[2] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector*: November 2016. Available at: https://www.gov.uk/government/publications/supported-accommodation-review

[3] Department for Communities and Local Government (2009). *Research into the financial benefits of the Supporting People programme, 2009.* July 2009. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/16136/1274439.pdf

[4] ONS. (2010-2020). *Local Authority revenue expenditure and financing England: budget individual local authority data*. Available for 2019-2020 at: https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2019-to-2020-budget-individual-local-authority-data

[5] From the same source, £328m was reported by LAs as budgeted for Supporting People in 2019/20.

2010/11. However, given the changes to the funding profile of HRS, and the number of LAs reporting zero spending when at least some spending would be expected, it is believed that the data returned may not fully reflect spending on HRS provision. It was considered possible that some HRS provision might be funded in other LA budget categories. A 2018 report by the National Audit Office suggested that Supporting People funding had greatly reduced since it was subsumed into LA funding[6] and a recent consultation by the MHCLG and the Department for Work and Pensions (DWP) into Supported Housing for older people and short-term Supported Housing highlighted that there were concerns about funding streams among the sector[7].

Research objectives and methods of this review

In August 2018 MHCLG committed to undertaking research into the level and type of support being provided across the Supported Housing sector and whether it adequately meets the support needs in local areas. IFF Research were commissioned to conduct this research, with the specific objective of identifying how support is funded and commissioned and how support costs, quality and outcomes vary across local areas.

The review was supported by an Advisory Group, drawn from across the HRS sector, including providers, officials, relevant trade associations and charities. The Advisory Group discussed the brief and helped guide the direction for the research, including defining the scope for the research, and assisting with the rapid evidence review and survey design. The membership of this group is detailed in Annex G.

The research consisted of three stages. More information about each stage can be found in the main body of the report:

- Feasibility stage (February 2019 to May 2019): The study methodology and scope was developed in consultation with the Advisory Group. This stage included a rapid evidence review and series of exploratory depth interviews with stakeholders, providers of HRS, and LAs of all types.

- Online survey (August 2019 to January 2020): This was distributed by email and followed up by phone calls and reminder emails, aimed at employees of organisations that provide or commission HRS, including LAs, Private Registered Providers (PRPs), and Unregistered Providers. The survey was opened in August 2019 and closed in January 2020. In total, 326 responses were received, a response rate of 31% as calculated at the end of the research. The resulting dataset was processed to allow estimates to be made representative of PRPs or LAs providing and commissioning HRS in England[8], and to allow indicative unweighted figures to be provided for Unregistered Providers of HRS.

- Qualitative case studies (October 2019 to February 2020): This consisted of nine qualitative case studies, to provide more in-depth insight into commissioning

[6] National Audit Office (2018) *Financial Sustainability of Local Authorities.* National Audit Office
[7] Adams N., Tomlinson J. (2018). *Funding for supported housing.* Department for Work and Pensions.
[8] This survey is the source for the majority of the data presented in this report. Figures, unless otherwise stated, represent percentages and numbers of organisations, rather than of residents or clients.

structures and changes over time. Seven case studies focused on LAs, and two on PRPs. Each case study involved interviews with four to six people, including one or two interviews with senior commissioning staff as the lead LA or PRP respondent, and the rest from multiple organisations delivering HRS (including a small number of interviews with frontline staff).

For the purposes of this research[9] HRS is defined as comprising activities funded by the former Supporting People programme from 2003 to 2009, plus similar activities funded in other ways, excluding those provided commercially without subsidy. HRS delivered within Supported Housing for homeless people (e.g. hostels) and older people (i.e. HRS delivered in Sheltered Housing) were both included in the scope, as well as Floating Support. Care services, drop-in services and online or telephone advice services were not included.

Key findings

Commissioning of HRS

The research used survey data to estimate total spending by LAs on HRS in England, including spending not captured in the Supporting People category in the MHCLG Revenue Account (RA) 2018/19 data (which totalled £359m across England). It was estimated that the overall spending by LAs on HRS in 2018/19 was approximately £522m, via commissioning. Despite including spending on HRS via other LA budgets, this was still a reduction of at least 61% relative to the £1.355bn that LAs reported spending in RA 2010/11 data shortly after the abolition of the ring-fence.

However, this percentage reduction should be treated with some caution:

- The Supporting People category in the RA data is defined as "Housing welfare services provided under the Supporting People programme". Although the definition gives a broad description of these services, using the term HRS to describe them, it does not provide a definition of HRS. It could also be argued that no spending would fall into this category since the Supporting People programme no longer exists[10]. This leaves LAs with some discretion in this area. However, prior to 2010 this category was previously clearly defined by the ring-fenced funding provided by the Supporting People programme. The online survey was designed to measure provision of the types of HRS which would have been eligible for Supporting People funding.

- It is unclear to what extent HRS services might have also been funded via other budgets (outside Supporting People) prior to the abolition of the ring-fence. No data

[9] A full definition can be found in Chapter 1 of the main report.
[10] Department for Communities and Local Government (2020). *General Fund Revenue Account Outturn Guidance 2019/20.* March 2020. Accessible at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888061/General_fund_revenue_account_outturn_2019_to_2020_specific_guidance_notes_v2.pdf

is available regarding this[11]. However, if there were substantial quantities of HRS in 2010/11 that was funded from sources other than the Supporting People budget, this would make the percentage reduction in funding to 2019 larger, rather than smaller.

- The £522m figure is a survey-based estimate subject to sampling error, as described in Annex E.

It also cannot be ruled out that the £1.355bn budgeted by LAs in 2010/11 for Supporting People also excluded some funding of HRS through other LA budgets, so it is possible the decrease in spending on LA commissioning was larger than 61%.

A smaller additional amount (an estimated £91m) was spent in 2018/19 by LAs on direct provision of HRS, principally by lower-tier LAs to their own council housing tenants.

Half (50%) of LAs who commission or fund HRS said that funding had decreased since 2014, with 30% reporting a 'significant decrease'.

LAs who commission HRS spent an estimated £12,000 per 1,000 resident population in 2018/19. However, there was great variation. Among upper tier and unitary LAs, 27% spent less than £5,000 per 1,000 resident population in the same period, while eight per cent spent more than £30,000, all of them in London.

Spending on HRS

HRS is not fully funded by LAs. The estimated total spend on direct provision of HRS services was £1.2bn. An estimated £849m of this funding was spent by PRPs, £91m by LAs for direct provision, and approximately £231m by Unregistered Providers.

Survey responses indicated that funding for HRS came from a range of sources, although providers accounting for 11% of provision said that they were unable to state the source of funding. Around half (an estimated 46%) came from LA commissioning, and a quarter from Housing Benefit payments (an estimated 24%). Smaller proportions came from user charges (7%) and the NHS.

According to benefit regulations, Housing Benefit, which this survey estimates funds 24% of HRS, may not be used to pay for support. Case studies with both providers and LAs indicated that a very narrow definition of 'support' was used when determining eligibility for Housing Benefit funding. Typically, only staff time spent on delivering support in the most direct and specific sense was considered ineligible for Housing Benefit funding by LAs and providers. The definition of HRS activity that was used for this research was wider than this, as was the definition used to determine eligibility for Supporting People funding prior to 2009.

[11] However, in 2018/19 23% of LAs at upper tier or unitary level submitted zero spending on Supporting People in RA 2018/19 data. An estimated 76% of the additional spending included in the survey but not the RA 2018/19 data related to these authorities. No authorities of this type submitted zero spending on Supporting People in RA 2010/11 data, reducing the scope for additional LA spending on top of the £1,355m.

Providers reported that they were able to use Housing Benefit funding for a range of activities which were formerly funded through Supporting People commissioning, including the administrative costs of HRS, for management of certain types of facility or activities, and in particular for 'concierge' type services which might be considered to fulfil a security rather than support role.

Providers spoken to during case studies had clearly spent considerable time thinking about the rules for Housing Benefit eligibility, as had those LAs spoken to about the issue. Providers also reported that most LA benefit departments took a great interest in ensuring Housing Benefit funding was spent correctly. It therefore seems unlikely that Housing Benefit is being incorrectly claimed for support on a large scale. However, the research cannot rule out that some of the funding reported in the survey was claimed and paid from Housing Benefit incorrectly. Further research with LA Housing Benefit departments and HRS providers may be needed to determine the extent of this issue.

Support delivered

LAs commissioned for a wide range of client groups although most commonly for homeless people (84% of commissioning LAs) and vulnerable young people (83% of commissioning LAs). In terms of client numbers, older people were the largest group of clients (an estimated 273,000 clients across LA and PRP provision), followed by homeless people (72,000 clients).

The survey also asked providers (including PRPs, Unregistered Providers and LAs who directly provide support) which client groups they delivered HRS support to, capturing support that is both commissioned by LAs and funded through other means. Findings here showed that PRPs are most likely to provide HRS to older people (65%). Unregistered Providers delivered support to a wider range of client groups than LAs or PRPs and are most likely to provide to adults who are homeless or at risk of homelessness (69%). Unregistered Providers appear to be the main source of provision to groups who are considered to have very high needs (e.g. ex-offenders, people with drug or alcohol dependencies and people with multiple complex needs).

Case study interviewees suggested that over the last decade, funding reductions had often led LAs to prioritise HRS services that fulfilled a statutory duty, and services that met urgent/high level needs. This was supported by survey findings where many LAs reported a decrease in funding for clients with low level needs.

All LAs interviewed in case studies said they had to prioritise spending, and this led to gaps in services. Funding cuts manifested in different ways across different LAs, with no particular pattern. Some focused on cutting services altogether (such as the removal of Floating Support) or reducing types of provision, while others chose uniform reductions in salary rates or number of hours contracted.

The proportion of unmet need appeared highest for client groups with drug or alcohol misuse problems, and for ex-offenders. However, almost all LA HRS funding for lower needs Floating Support and HRS in Sheltered Housing had been withdrawn, due to either the perceived impact of removing provision being lesser for lower need clients, or because commissioners believed that providers might be able to source alternative funding via Housing Benefit.

When asked not to consider changes in quantity or scope of provision as part of their judgement, most providers felt the quality of the services that were being delivered had improved over the past two to three years. Improvement in staff training and the move toward more person-centred services were widely credited, as well as better understanding/engagement from clients themselves, and a commitment to continuous improvement. Approaches to measuring quality were frequently devised in-house, making it impossible to benchmark services, but qualitative interviewees often stated that this was not a high priority.

Trends in commissioning practices

The majority of LAs (88%) commissioned HRS through competitive tendering. Almost two-thirds (63%) funded services jointly or in partnership with other bodies and nearly half (44%) used spot purchasing.

Case study findings showed that responsibility for commissioning HRS services had become more dispersed since the ring-fence around Supporting People was removed. LAs have allocated commissioning responsibilities to different departments in very different ways, making it difficult for providers or other external bodies to identify a clear point of contact within LAs for HRS services.

The majority of LAs that commissioned or funded HRS did so over periods of three to five years however case study findings showed these periods often included break clauses after two or three years with repeated one-year extensions. Case study findings also suggested that these short contract lengths could impact on providers' financial stability, inhibit their planning, hinder~~ing~~ innovation and create difficulties for staff recruitment and retention.

Changes in commissioning practices and their impacts

Funding sources for commissioned HRS services had diversified away from Supporting People budgets and LAs were drawing on funding from other streams such as Public Health, Adult Social Care and homelessness prevention. Commissioners and providers reported that budgets from these other streams were less secure and ensuring funding for future services was a challenge.

Case study interviews indicated that there has been a widespread shift in recent years from funding HRS activities from LA commissioning to funding them via service charges and rents, which are in some cases paid by the respondent, but in most cases funded via Housing Benefit, as explained above.

- Case study interviews suggested that reductions in LA commissioned services had led to several challenges for providers:

- Providers reported that reduced and short-term funding meant it was difficult to retain, recruit and train staff.

- There was evidence from case study interviews that some contracts had put providers under substantial financial strain and unable to cover costs of delivering services.

Small contracts and a lack of confidence in future funding were reported by case study interviewees to have impacted on competition between providers, constraining their willingness to enter markets due to the costs of establishing new services and the risk that this would not be sufficiently long-term to warrant the initial investment.

Overall scale of HRS provision

Survey findings showed that services are predominantly commissioned by unitary or upper tier LAs. LAs also take responsibility for planning and estimating need for HRS provision in the longer term. Overall provision is detailed as follows:

- 95% of Upper Tier and Unitary LAs[12] and 58% of stock-holding[13] Lower Tier LAs commissioned HRS. A limited quantity of sub-contracting (or commissioning, although it is rarely described as such) by HRS providers also takes place.

- Survey data suggests that LA commissioning provided to an estimated 309,000 clients during 2018/19, a reduction of at least 72% relative to the 1,113,908 household units[14] served by Supporting People provision during 2010/11[15].

- This LA commissioning provided to an estimated 38% of the total 805,000[16] HRS clients in England. HRS was delivered to an estimated 76,000 clients by LA direct provision, and 551,000 by PRPs. Unregistered Providers delivered support to an estimated 177,000 people[17].

- HRS is delivered by a range of organisations: sometimes directly by LAs, but most often by independent providers or managers of social housing registered with the Regulator of Social Housing (PRPs). Other independent providers (Unregistered Providers) are also a substantial source of HRS, including charities, religious organisations, and occasionally commercial providers.

- A small number of very large providers exist, while the majority of providers deliver HRS to fewer than 1,000 clients.

Conclusions

Overall, the evidence in this report indicates that **HRS provision in 2018/19 received at least 76% less funding via LA commissioners than in 2010/11 after the Supporting People ring-fence was removed**. There is also wide variation in availability between local areas, depending on the commissioning decisions of individual LAs. The proportion of need met was reported to be lowest for client groups with drug or alcohol misuse problems, and for ex-offenders, where support is non-statutory.

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[12] Unitary LAs include councils defined by ONS as Unitary Authorities, London Boroughs or Metropolitan Districts. Upper tier LAs include Non-Metropolitan Counties (i.e. all County Councils), and Lower tier LAs include Non-Metropolitan Districts (i.e. District Councils in areas where there is also a County Council).
[13] For Lower tier LAs, only stock-holding authorities (i.e. with Council Housing) were included in the survey.
[14] The number of clients will have been slightly higher.
[15] Ministry of Housing, Communities and Local Government. (MHCLG) (2010). *Supporting people local system data: Supporting People Household Units as at 31.03.10, England.* October 2010. Available at: https://www.gov.uk/government/statistics/supporting-people-local-system-data
[16] These figures are not comparable to data provided in the 2016 Supported Accommodation Review, since this figure includes all clients served for all or part of the 2018/19 financial year, while the figures provided in the Supported Accommodation Review are a snapshot, and also exclude Floating Support clients.
[17] Data for Unregistered Providers could not be weighted due to the unknown total population of providers, so this figure is extrapolated using broad assumptions about response rate, and should therefore be treated as approximate.

Providers felt that over time **the removal of lower and medium need or more preventative HRS activity was creating longer-term issues and costs,** as a lack of support had led to clients developing higher, more complex, needs, leading them ultimately to require more resource intensive interventions**.** The research did not collect the quantitative data which would be necessary to prove this link, but many research participants were convinced that this was the case. Further research would be needed to establish this link.

There is also evidence to suggest **LA commissioned contracts are becoming increasingly unattractive for providers, reducing competition and raising concerns about the long-term sustainability of HRS services**. Funding uncertainties led to shorter-term contracts, which impacted on providers' financial stability, inhibited their planning, and created difficulties for staff morale, recruitment and retention.

In general, however, where HRS was provided it continued to cover a wide range of types of activity, and if asked to look beyond the issues around the quantity and scope of provision, **providers were positive about the quality of HRS** that they could provide and felt that the quality monitoring systems they used now were a considerable improvement on the requirements under the Supporting People Programme.

1 Introduction

1.1 This report summarises the findings of a mixed methods research study into the provision of Housing-related Support (HRS) in England, which took place between February 2019 and March 2020.

1.2 This research consisted of several elements:

- **Feasibility stage:** this formative stage involved a rapid evidence assessment and a series of depth interviews, to build an understanding of this complex subject area and assess how the second stage of the research would be best carried out, in terms of scope, definitions and survey design. This took place between February and May 2019.

- **Online survey:** a survey of commissioners and providers of HRS, principally Local Authorities (LAs), Private Registered Providers (PRPs) and Unregistered Providers. This survey was used to provide quantitative evidence to support this study, including estimates of spending on HRS. The survey was opened in August 2019 and closed in January 2020.

- **Case studies:** a series of nine case studies, carried out at LAs and PRPs around England. The interviews provided an in-depth snapshot of how provision of HRS works in a particular area, giving particular insight into relationships within organisations and assisting with the interpretation of online survey results. Interviewing took place between September 2019 and February 2020.

1.1 Research Aims

1.1 The research objectives were to:

- Explore the level and type of HRS provided across the Supported Housing sector in England, and whether it adequately meets the support needs in local areas.

- Examine how support is funded and commissioned, and how cost, quality and outcomes vary across local areas.

- Understand what information LAs and HRS providers gather and use to inform their decisions about the different types and levels of support they provide across the Supported Housing sector.

1.2 The review was supported by an Advisory Group, drawn from across the HRS sector, including providers, officials, relevant trade associations and charities. The Advisory Group discussed the brief and helped guide the direction for the research, including defining the scope for the research, and assisting with the rapid evidence review and survey design. It was agreed that the research scope should include Floating Support as well as support delivered to those living in Supported Housing. The membership of this group is detailed in Annex F.

1.2 Background

Defining Housing Related Support and Supported Housing

1.3 Stakeholders interviewed in the feasibility stage of this research were found to use a variety of terms to refer to Supported Housing and Housing Related Support, some of which were specific terms used within individual organisations, and some of which reflected wider usage. It was therefore important to set clear definitions of these terms early in the research, in order to allow consistency in data collection and interviewing.

> *Your references will be to Supported Housing, to accommodation-based support… we call it supported living. It's all essentially the same thing...*
>
> **LA, Feasibility Stage interview**

1.4 Supported Housing and HRS are closely related but different concepts. Supported Housing typically comes with an attached package of HRS (which can be referred to as 'Accommodation-based Support'), where support is provided alongside accommodation. However, HRS can also be delivered separately, to residents of any type of housing. Typically, this is referred to as Floating Support.

1.5 Supported Housing covers a range of types of accommodation; whilst the 'typical' form consists of a group of individual units that allow for independent living (with some shared facilities and support provided on-site), there is a great deal of variation. Some definitions of Supported Housing would include Sheltered Housing (or Older People's Housing), aimed principally at older people and usually with a lesser level of support; some would include Hostel accommodation with dormitory sleeping arrangements. All of these are included in the official definitions for the Statistical Data Return (SDR)[18] and the Local Authority Housing Statistics (LAHS)[19]; and therefore, are also in the scope for this research.

1.6 Definitions were discussed at length at the inception and feasibility study stage of the research, drawing on the expertise of the Advisory Group convened for the project.

1.7 For the purposes of this research, Supported Housing was defined in line with the 'top level' specified accommodation criteria[20] (although without the detail restrictions on tenure involved in the specified accommodation definition, which is contained in Annex B), primarily on the basis that this is recognisable to LAs and providers. This is the same approach taken by the Supported Accommodation review in 2016, which estimated that there were 553,500 units of Supported

[18] The mandatory data return gathered by the Housing Regulator from Registered Providers of housing
[19] The mandatory data return gathered by MHCLG for LA Housing Departments.
[20] Specified accommodation is defined in Annex B.

Housing in England[21]. The definition provided to respondents to the HRS review was:

> *Designated or purpose-built housing, provided together with support. This is in line with the definition used for the Regulator of Social Housing's Statistical Data Return (SDR) and the Welfare Reform and Work Act (WRWA), but with the addition of housing of the same type with other landlords or in other tenures.*

1.8 Housing with support provided on a wholly commercial basis without support from state subsidy through rent or benefits (for example in a commercial retirement development) is typically *not* classified as Supported Housing and has not been covered by this research.

1.9 For the purposes of this study, HRS includes the support provided to residents of Supported Housing, but not the housing itself. The definition is intended to include all of the provision covered by Supporting People until the removal of the ring-fence in 2009[22], including Floating Support, with the addition of similar activities funded by different routes:

> *All support services funded or organised by either public authorities or providers of Supported Housing to residents of Supported Housing, excluding personal care services, drop-in services, counselling or befriending. If an activity includes some support and some care, it would be classified as a support service and included in the research. The definition also includes all Floating Support services, even if provided to people who are not resident in Supported Housing.*

1.10 HRS, as a term, can be broadly taken to refer to the types of support commissioned and provided under the former Supporting People programme. This provides vulnerable groups in society with support or supervision to live safely and independently in the community. HRS in England serves a range of vulnerable groups including: older people, people with mental or physical health conditions or disabilities, people with learning disabilities, homeless adults and families, vulnerable young people, and people fleeing domestic abuse.

1.11 HRS can include a range of services such as mental health support, advice to claim benefits, help managing bills or filling in forms, weekly visits from a support worker, or a 24-hour warden service, depending on the needs of the individual or client group. HRS may be provided alongside Supported Housing, which ranges from self-contained flats with support provided by visiting staff, to specialist shared accommodation for people with disabilities.

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[21] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector: November 2016.* Available at: https://www.gov.uk/government/publications/supported-accommodation-review

[22] Albeit without the restrictions on housing tenure included in definitions used under the Supporting People programme

1.12 Drop-in, telephone or online services providing similar types of support or advice to these services (i.e. not provided in the home) were excluded from the scope of this research.

Policy Background

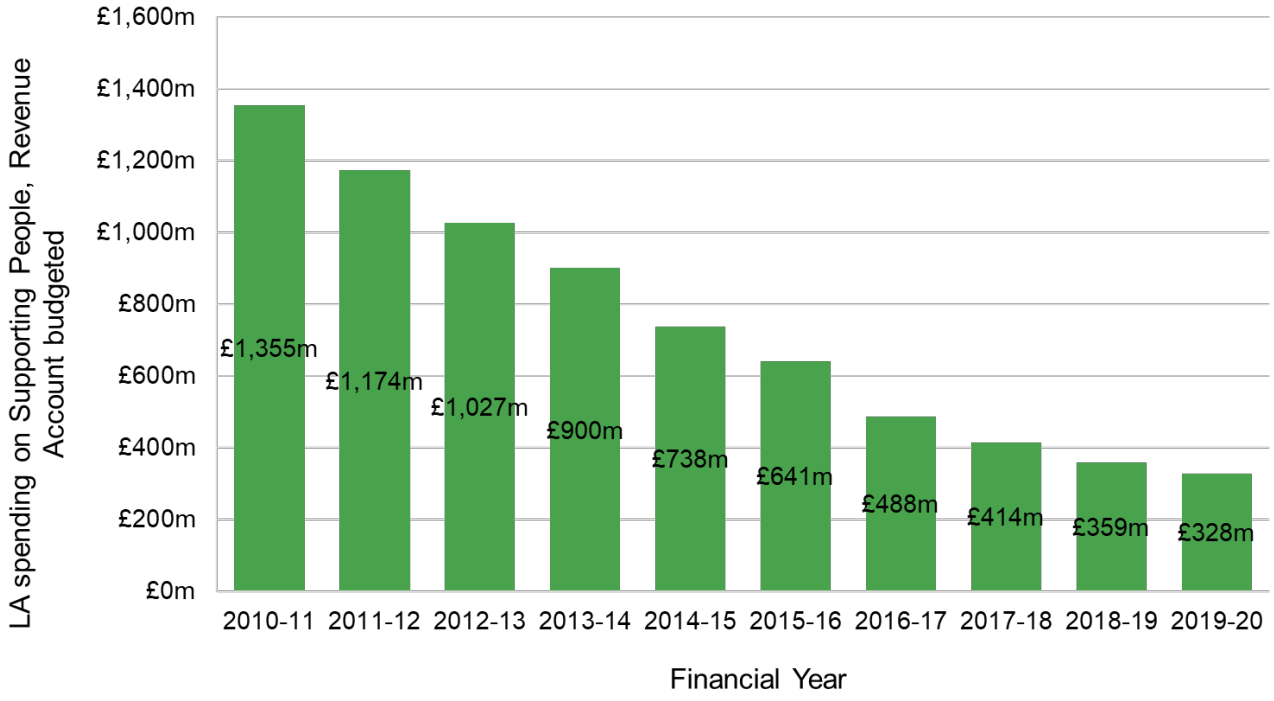
1.13 Between 2003 and 2009 most HRS, as defined above, was funded by the Supporting People programme, under which LAs were required to provide or commission services using a protected funding stream. The funding stream was accompanied by financial reporting requirements to central government, as well as monitoring forms for quantity and type of provision delivered, and client characteristics. However, outcomes for clients were not centrally monitored[23].

1.14 The ring-fence around this funding was removed in 2009, and since then authorities have had discretion over how they fund and deliver support. This also meant that data about the sector and the support provided was no longer systematically collected[24].

1.15 Central government gathers data on local government spending via Revenue Account (RA) spending monitoring. Despite the removal of the ring-fence, Supporting People still remains as a category in the RA spending returns[25]. Reported LA spending in this category in 2019/20 totalled £328m. This is a 76% reduction[26] on the spending budgeted for 2010/11 (£1,355m) when the Supporting People programme was in place. This compared to an overall reduction of nine per cent in LA budgets as a whole in the same period.

[23] Supporting People Client Record Office (University of St. Andrews). (2008). *Guidance for completing Supporting People client records, April 2008 – March 2009.* April 2008.
[24] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector*: November 2016. Available at: https://www.gov.uk/government/publications/supported-accommodation-review
[25] ONS. (2010-2020). *Local Authority revenue expenditure and financing England: budget individual local authority data*. Available for 2019-2020 at: https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2019-to-2020-budget-individual-local-authority-data
[26] Not taking account of inflation.

Chart 1.1 Budgeted spending on Supporting People registered in RA data submitted to central government by LAs.



Source: Compiled from data published at: ONS. (2010-2020). Local Authority revenue expenditure and financing England: budget individual local authority data. Available for 2019-2020 at: https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2019-to-2020-budget-individual-local-authority-data

1.16 However, these data do not provide a complete picture of the funding situation for HRS. Nearly a quarter (23%) of LAs who would be expected to have responsibilities for HRS commissioning (upper tier or unitary authorities) reported zero spending in this area. While case study interviewees agreed strongly that funding had reduced, none mentioned large numbers of LAs ceasing to fund HRS on that scale. Case studies also indicate that provision is now rarely delivered through a dedicated Supporting People department (see Chapter 5). It is possible that these figures are an underestimate due to under-reporting of spending, or spending being counted in RA under other budget headings, investigated in this research (see Chapter 3).

1.3 Key Structures

1.17 Supported Housing and HRS in England are delivered through a complex set of administrative structures. The administration of a Supported Housing unit can be divided into five roles:

- **Landlord:** Ownership (including construction).

- **Housing Manager:** Housing Management[27].
- **Support Provider (Agent):** Provision of support services.
- **Care Provider:** Provision of personal care services.
- **Commissioners** – typically but not exclusively at upper tier and unitary LAs[28] – perform a co-ordinating and planning role.

1.18 All of these roles may be provided by the same organisation; or they may be provided by five different organisations. In some cases, Supported Housing may be provided independently without the involvement of commissioners, known as 'non-commissioned Supported Housing'[29]. The chain of authority and responsibility for Supported Housing services is summarised below:

Landlords

1.19 Supported Housing is typically classified as Social Housing, and usually (although not always) rented to the resident. In practice, rents in Supported Housing are funded almost exclusively through the payment of Housing Benefit or Universal Credit, although theoretically residents could pay from their own resources. Supported Housing landlords are usually registered with the Regulator of Social Housing and are referred to as Registered Providers.

1.20 Registered Providers may be **LAs**[30], in which case the housing concerned could be referred to as Council Housing. LAs in this situation are referred to as Stock-holding Authorities.

1.21 More commonly, however, the owners of Supported Housing are **PRPs,** although not all PRPs provide Supported Housing. PRPs are often also referred to as Social Landlords. The PRP sector is primarily composed of Housing Associations, Housing Trusts and Almshouse Charities.

1.22 In relatively rare cases commercial providers may own Supported Housing. All PRPs must be registered with the Regulator of Social Housing and rent levels for

[27] The term management is also sometimes informally used to refer to management or administration of support or care services for a development. We have tried to avoid this throughout this research, to avoid confusion.
[28] Unitary Authorities here include authorities defined by ONS as Unitary Authorities, London Boroughs or Metropolitan Districts, as well as the Isles of Scilly and City of London. Upper Tier authorities include non-metropolitan counties (i.e. all County Councils), and Lower Tier authorities include non-metropolitan districts (i.e. District Councils where there is also a County Council).
[29] By this we mean that the service has not been paid for or commissioned by a commissioning authority. The support is provided by a service provider independently without any commissioning by any authority. The provider is able to resource the service independently, for example through charitable donations and through eligible service charges funded through Housing Benefit.
[30] Upper tier Local Authorities (or County Councils) very rarely own any housing, and do not have Housing Departments or Planning Departments.

these properties are set in consultation with LAs and in accordance with regulations enforced by the Regulator.

1.23 **Unregistered Providers** (who are usually Registered Charities, but may also be religious organisations or commercial companies) also own Supported Housing, although typically on a small scale. This is not subject to any regulation by the Regulator of Social Housing.

1.24 It is important to note that the funding for the physical construction of Supported Housing is not connected to the funding of the support. The construction and supply of Supported Housing is not within the scope of this research. This was covered by the Supported Accommodation review[31], published in 2016.

Housing Managers

1.25 Housing Management includes maintenance of a property, maintenance of any land or communal areas, providing security if necessary, and dealing with the turnover of residents. This may be funded through rents or service charges, both of which may be funded through Housing Benefit (HB) or Universal Credit. Housing Benefit is administered by LAs, but the funding for it comes directly from the Department for Work and Pensions (DWP). Universal Credit is administered directly by the DWP.

1.26 Typically, the housing management of a property is a matter for the landlord of that property, and in many cases, they provide this themselves. However, any landlord has the discretion to delegate this to another provider[32]. LAs are also permitted to delegate this activity, to an Arm's Length Management Organisation (ALMO) which manages the housing on their behalf.

1.27 Throughout this research, interviews and surveys were aimed at Housing Managers rather than landlords, in cases where the roles were split. This is because they are typically more involved in any HRS that may be provided in the property. Landlords who are not also Housing Managers for a property may be quite detached from the day-to-day activity in that property.

HRS Providers

1.28 HRS provision in a unit of Supported Housing, or accommodation-based support, is often provided by the landlord or the Housing Manager, but may also be provided by a third party provider. Some are PRPs, who may provide support to both their own tenants and others; some are Unregistered Providers, typically charities but sometimes commercial.

[31] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector*: November 2016. Available at: https://www.gov.uk/government/publications/supported-accommodation-review

[32] Local Authorities have no power to commission or directly influence Housing Management.

1.29 If publicly funded, HRS will most often be funded by LAs[33], via commissioning. Where an LA is a landlord or housing manager themselves, as a stock-holding LA, they may also provide HRS directly themselves to their own tenants.

1.30 HRS may also be commissioned or directly provided by an LA as Floating Support, provided to individuals deemed to be in need of support, in their homes, regardless of tenure or landlord. A landlord always retains the right to provide HRS or any other service to its tenants, if funded from their own resources.

Care Providers

1.31 Care may be provided by the same organisation (or even the same staff) as HRS, or by a different organisation. It is typically funded by LA commissioning, or via Personal Budgets, overseen by a combination of LA departments or NHS bodies. Care is outside the scope of this study as defined by MHCLG, and was specifically excluded from the survey, although in practice where services are funded or commissioned together it may be difficult to exclude, since it may be delivered by the same individual.

> *I suppose you're talking about the divide between social care support and Housing Related Support and that has long since been [an area of] debate… it can be a bit of a grey area, because actually… where does one stop and the other one start? Sometimes they are very much intertwined.*
>
> **Stakeholder interview**

1.32 Care in England is subject to mandatory inspections by the Care and Quality Commission (CQC) registration. Whether a service required CQC registration was the method of distinguishing a care service (requiring registration) and an HRS service (not requiring registration) used by this research. This was also the approach taken by the 2016 Supported Accommodation review[34].

> *So, you will have personal care arrangements which we [need to] CQC register, Care Quality Commission… [But] if it is just purely support, then it would not require [that].*
>
> **LA, feasibility study interview**

Commissioners

1.33 Commissioning of HRS (as opposed to Supported Housing) from 2003 to 2009 was carried out by Supporting People teams or departments in upper tier and unitary LAs. A smaller quantity of HRS activity may also have taken place outside this, for

[33] In a two-tier LA structure (i.e. county council and district council) feasibility stage interviews suggested that the vast majority of commissioning, although not necessarily all, takes place at an upper tier level. This was subsequently supported by online survey responses.
[34] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector: November 2016.* Available at: https://www.gov.uk/government/publications/supported-accommodation-review

example in LAs' own council housing (funded via Housing budgets) or for the wider community, funded by Homelessness budgets.

1.34 However, when the Supporting People ring-fence was removed in 2009, LAs started to diverge in how they provided these services, and slowly Supporting People teams began to be disbanded and integrated into other LA departments. This is discussed further in Chapter 5.

1.4 Feasibility Stage

Introduction

1.35 Given the complexity of the subject area, a feasibility stage was specified in the research in order to understand what information LAs and housing providers gather and use to inform their decisions about the different types and levels of support they provide across the Supported Housing sector[35].

1.36 This took place between January and May 2019, and centred on a series of depth interviews, as well as a rapid evidence assessment of the existing evidence base.

1.37 During the feasibility stage, the research methodology for the subsequent stages of the research was developed in consultation with the study's Advisory Group.

Methodology

1.38 The feasibility stage comprised

- **Stakeholder interviews:** Five semi-structured exploratory telephone interviews with sector bodies and organisations, provider membership bodies and national charities. The interviews provided an overview of the issues and insight that fed into the evidence review and subsequent primary research. They included coverage of types of HRS and funding structures, the commissioning and monitoring of HRS, and implications for future research.

- **HRS provider interviews:** Twelve semi-structured depth interviews were conducted by telephone with organisations that provide Supported Housing and HRS. A sample of PRPs was gathered using the CORE and SDR data, and a sample of Unregistered Providers was supplied by MHCLG and Advisory Group members. The sample was designed to achieve a spread of types of provider, and providers who did or did not specialise in a particular client group. Completed interviews were also monitored to ensure a mix of different funding streams and different sizes were represented. The interviews covered types and levels of HRS

[35] The scope of the research was later extended to include Floating Support delivered outside Supported Housing, and the feasibility stage's function extended to building a picture of the structures used to commission and deliver Housing-related Support, in order to provide a sound basis for the design of the subsequent research stages.

provided, funding and commissioning structures, data gathered about client outcomes and support and how providers measure quality and plan for the future.

- **LA interviews:** Eight interviews were conducted with LAs in the feasibility stage. We monitored the sample to ensure we achieved a spread across different regions, a mix of different LA structures (two tier and single tier), and a mix of those who commissioned Supported Housing and provided it directly. The topics covered in these interviews included the current provision of HRS, commissioning and management structures, data gathered from providers and how LAs plan HRS.

- **Evidence review:** This rapid evidence assessment was conducted alongside the interviewing process and included a review of published material relating to the provision of HRS. Sources were identified through several searches using key words and terms, as well as those identified by key stakeholders.

Key outcomes

Some of the key outcomes of the feasibility stage were that:

- The scope of the research was refined.

- A particular evidence gap was identified regarding monitoring of quality and outcomes.

- Definitions of Supported Housing and HRS were determined for use in the research.

- Some additional definitions and sub-group breakdowns were determined, including client groups and classifications of types of support (drawing on definitions used in the Care Act 2014, although with the clear understanding that Support and Personal Care are distinct activities).

- The population of potential respondents was defined and sized for the online survey, principally LAs and PRPs.

1.5 Methodology: Online survey

Introduction

1.39 The brief for the research set out by MHCLG required the inclusion of an online survey, in order to gather quantitative data from LAs and HRS providers regarding the variation in types of support, costs, quality and outcomes across all types of Supported Housing and Floating Support. Using an online survey offered advantages over a telephone survey, given that the costs information gathered was detailed and respondents would be expected to require substantial time to source it. Using an online survey also offered data validation and cost advantages over a postal survey.

1.40 Therefore, as part of the research, an online survey was carried out by IFF Research, distributed by email and followed up by phone calls and further emails to increase the response rate.

1.41 The survey could be completed by employees of organisations which directly provided HRS, commissioned it, or did both. Most such organisations were included in the survey – primarily LAs, PRPs and Unregistered Providers. The method of selection of organisations and individuals to take part differs for each of these groups, and is explained below.

Sample Frame

1.42 The survey was, based on information gathered at the feasibility stage, targeted both at commissioners of HRS and direct providers of HRS. These were both included because of the need for survey outputs to include elements relating to commissioning of HRS, and also elements relating to overall provision of support, not all of which is commissioned.

1.43 The sample frame included three distinct groups:

Sample Frame: LAs

1.44 The feasibility study suggested that upper tier (county) and unitary LAs, tasked with providing HRS under the former Supporting People programme, remain the main commissioners of HRS. Therefore, all LAs of this type were targeted for the survey, taking a census approach to maximise response. Arm's Length Management Organisations (ALMOs), which manage social housing on behalf of some LAs, were also contacted as part of this. Lower tier LAs were identified in the feasibility stage as having a more limited role. However (like some LAs in other tiers) they may be locally major landlords of Supported Housing, in particular Sheltered Housing for older people. Therefore, all LAs with housing stock were included in the sample frame, again taking a census approach.

1.45 Because of their relatively limited role according to the outputs from the feasibility stage, lower tier LAs who did not own housing were excluded from the sample frame. In total, 217 of the 343 LAs in England were included in the sample frame, including all 151 upper tier and unitary LAs, and 66 lower tier LAs.

1.46 Contact details were found for these organisations via a free find exercise[36], with additional email contact made by MHCLG.

Sample Frame: PRPs

1.47 The feasibility study suggested that PRPs, those providers registered with the Housing Regulator, might be the main providers of HRS in England. These therefore needed to be included in the sample frame. Again, to maximise response from this finite population of organisations, a census approach was taken. The primary source of sample was the Regulator of Social Housing's SDR (Statistical Data Return) for PRPs, which is a mandatory data return and therefore complete. Organisations were selected on the basis of having one or more unit of Supported

[36] This involved searching for the organisations on Google or other search engines, seeking publicly available contact details on their websites. If only a switchboard phone number could be found, this was called and the person on the phone asked who it would be best to contact at their organisation.

Housing under management. Organisations which owned units of Supported Housing but did not manage any were excluded, on the basis that they would be less likely to be able to contribute. In total, 589 PRPs were included in the sample frame, after taking account of organisation mergers and closures reported to the research team during the study.

1.48 Contact details were kindly supplied by the National Housing Federation (NHF) for the purposes of the research. For the remaining organisations listed on the SDR which were not NHF members, a free find exercise, sourcing information from web searches, was necessary to find initial contact details for some PRPs before fieldwork could begin.

Sample Frame: Unregistered Providers

1.49 Many stakeholders in the feasibility study emphasised the importance to the sector of HRS providers not registered with the Regulator of Social Housing. There were found to be no comprehensive listings of Unregistered Providers. A sample was therefore sourced from publicly available listings on the Homeless Link website[37], in addition to recommendations from other Advisory Group members, including the National Housing Federation (NHF). Additional contact details were sourced via a free find exercise, as for LAs and PRPs. Advisory Group members also appealed for organisations to contact researchers in order to take part. This means that it is possible some eligible organisations were not identified or contacted as part of the research, which imposes substantive limitations on the uses of the survey data for this group of organisations, which are detailed in the section below dealing with data analysis, and further explained in Annex D and Annex E.

1.50 All Unregistered Providers identified as potentially eligible were contacted. In total, 215 Unregistered Providers were identified as in scope, including branches for federal organisations that when given the choice, opted to participate at a branch level rather than head office level.

Sample Frame: Other exclusions

1.51 Commissioners other than LAs were excluded from the online survey, due to the disparate range of organisation types and structures, geographically variable level of involvement, and relatively limited role.

1.52 Organisations providing HRS on a purely commercial basis to private customers without receipt of public subsidy were also excluded, since they were out of the scope for the research defined by MHCLG.

[37] Homeless Link website, *Search Homelessness Services,* accessed July 2019, https://www.homeless.org.uk/search-homelessness-services

Survey design

1.53 The survey was designed in conjunction with MHCLG and the Advisory Group, with the intention of filling key evidence gaps.

1.54 The survey design prioritised areas where numeric data was considered most essential, in order to make best use of the limited time respondents would be able to spend on completing the online survey. Those areas where opinion-based, in-depth information was more important were instead covered via the case study interviews. It was clear at the feasibility stage that assessing the quality and outcomes of provision within the survey would not be possible, because stakeholders agreed that there were no metrics available by which to judge quality and outcomes in a comparable way; this was therefore covered instead via case study research.

1.55 The questions included in the survey covered a range of issues identified in the feasibility stage as worthy of further scrutiny:

- Direct provision of HRS.
- Commissioning of HRS.
- Planning of future provision of HRS.
- Client groups provided to (e.g. homeless, Mental Health, physical disabilities).
- Levels of need provided to (i.e. low, medium or high needs).
- Scale and broad geographical distribution of provision and commissioning.
- Cost of provision and commissioning.
- Monitoring and outcomes of directly provided HRS.
- Data availability for planning.
- For landlords, information about HRS provided to residents by third parties.

1.56 The diversity of LA structures, identified at the feasibility stage, presented challenges for the research in targeting the correct person or people within each LA. The survey therefore needed to allow multiple respondents to contribute on behalf of the same organisation, with questions designed to direct the questions to the correct individuals within the organisation. A process of bringing data from these responses together took place at the end of fieldwork.

1.57 Because of this diversity of LA structure, the job title of the appropriate person to complete the survey also varied between LAs, and could not always be identified in advance. A letter was sent to an unnamed Director of Adult Social Care at each LA included in the sampling frame. Findings from the feasibility study demonstrated that this would be the contact most likely to have an overview of HRS. The letter notified them of the survey and encouraged them to take part via a type-in web link

included in the letter. A similar letter was sent to PRPs. This was followed by an initial invitation email sent from IFF Research to the contacts identified in the sampling frame. This two-pronged approach was designed to correct for possible errors or outdated contacts in the free find process.

1.58 However, pro-active telephone and email contact over the full length of the online survey period was also required to locate the relevant people at both LAs and PRPs, and to encourage the involvement of multiple departments where necessary. The recruiters calling organisations were equipped to send emails containing a link to the survey, as well as background information and technical assistance documents. A database of contacts was maintained throughout, enabling reminder emails to be sent to the correct contact.

1.59 The online survey was open for just over 15 weeks within the period August 2019 to January 2020.

1.60 This long survey period was necessary to produce a high response rate, enabling the resulting data to be used for costs analysis. Many LAs contacting the research team during the study indicated that they needed time to identify the correct people to take part in the survey, and to source and collate the information required to complete it.

Survey response

1.61 Survey response was encouraged throughout the online fieldwork by a dedicated team calling LAs, PRPs and Unregistered Providers to encourage response, as well as a series of reminders sent via email.

1.62 In total, 369 valid responses were submitted from individuals representing 326 organisations, a response rate of 31% from the 1,055 eligible organisations identified by the end of the research process.

1.63 The respondents included 94 LAs, four ALMOs, 158 PRPs and 70 Unregistered Providers. A summary of the distribution of responses is shown in Figures 1.1 to 1.3, after the description of the analysis process used to produce the remainder of the figures in those tables.

Survey analysis

1.64 Following the data gathering process, a process of data cleaning and processing took place, including the coding of verbatim (text) responses into categorical data, the merging of responses from multiple respondents at the same organisation, and the cleaning of illogical or contradictory responses.

1.65 For LAs and PRPs, the data was then weighted to be representative of all organisations of that type. Full details, including dataset profiles before and after weighting, are provided in Annex C and Annex D:

- **LAs** were weighted by tier status (lower tier, upper tier and unitary[38]), broad region[39], and banded level of spending on Supporting People registered in the 2018/19 RA budget data.

- **PRPs** were weighted based on the number of units shown as being under housing management in Statistical Data Return (SDR) data submitted to the Regulator of Social Housing.

- **Unregistered Providers** could not be weighted, due to the absence of a known total number of organisations or any profile data on those organisations.

1.66 Percentages and numeric responses shown in this document are therefore estimates of the true situation among the population of eligible organisations, rather than based directly on numbers of survey responses. Results shown, unless otherwise stated, represent percentages and numbers of organisations, rather than of residents or clients.

1.67 Figure 1.1 shows the error margin at a headline level for figures presented in the report for each group, calculated for a survey result of 50% with a confidence level of $p < 0.05$. So, if the data shows that 50% of large PRPs said "yes" to a particular question (with an error margin of ±7.1%), we could say with 95% confidence that the true figure lay between 42.9% and 57.1%. This error margin does not apply to costs estimates, which are more complex to calculate. The error margins on costs estimates are explored in the costs chapter and Annex E.

[38] Unitary Authorities here include authorities defined by ONS as Unitary Authorities, London Boroughs or Metropolitan Districts, as well as the Isles of Scilly and City of London. Upper Tier authorities include non-metropolitan counties (i.e. all County Councils), and Lower Tier authorities include non-metropolitan districts (i.e. District Councils where there is also a County Council).
[39] Grouped as: London, South East and East (including the standard ONS regions of East of England, London and South East), Midlands and South West (including East Midlands, South West and West Midlands), and North (including North East, North West and Yorkshire and the Humber).

Figure 1.1 Distribution of online survey responses: by broad type of organisation

Outcome	*LA***	*(PRP*	*Unregistered Provider*	*Total*
Completed	**98**	**158**	**70**	**326**
Eligible[40]	217	589	215*	1,055
Response Rate	45%	27%	33%	31%
Error margin***	±7.9%	±9.0%	±11.7%	±5.4%

** number of organisations found in search process, including in some cases multiple branches of the same organisation; may not be exhaustive. ** ALMOs were merged with LAs at the data analysis stage. *** p < 0.05 on a value of 50%; takes into account Weighting Effect (where weighting was applied) and Finite Population Correction where population data is available (see Annex D).*

Figure 1.2 Distribution of online survey responses: by size of PRP

Outcome	*Small (<100 units)*	*Medium (100-999 units)*	*Large (1000+ units)*	*Total*
Completed	**39**	**94**	**62**	**158**
Eligible[41]	288	209	92	589
Response Rate	14%	45%	67%	27%
Error margin***	±15.3%	±7.8%	±7.1%	±9.0%

*Source: HRS Review online survey. *** p < 0.05 on a value of 50%; takes into account Weighting Effect (where weighting was applied) and Finite Population Correction where population data is available (see Annex D).*

Figure 1.3 Distribution of online survey responses: by type of LA

Outcome	*LA (Upper Tier)*	*LA (Unitary)*	*LA (Upper Tier or Unitary)*	*LA (Lower Tier)*	*Total***
Completed	**13**	**61**	**74**	**24**	**98**
Eligible[42]	26	125	151	66	217
Response Rate	50%	49%	47%	33%	45%
Error margin***	±19.6%	±9.0%	±8.4%	±18.0%	±7.9%

*Source: HRS Review online survey. ** ALMOs were merged with LAs at the data analysis stage. *** p < 0.05 on a value of 50%; takes into account Weighting Effect (where weighting was applied) and Finite Population Correction where population data is available (see Annex D).*

[40] As identified at the conclusion of the online survey.
[41] As identified at the conclusion of the online survey.
[42] As identified at the conclusion of the online survey.

1.6 Case Studies

Introduction

1.68 The brief for the research set out by MHCLG required the inclusion of case studies with LAs and HRS providers in order to understand the key challenges in providing HRS, and to highlight any good practice or learning. LA case studies add value in this case by allowing the complex relationships between organisations working to deliver HRS to be examined at a local level. The HRS provider case studies also allow the extent of variation in LA practice to be examined at a wider level, supporting the findings of the online survey.

1.69 Nine qualitative case studies were included in the research to add in-depth analysis of the practical delivery of HRS. In practice the case studies acquired an additional focus on trends in quality and outcomes, due to discussion of these being excluded from the online survey due to a lack of suitable metrics or comparable measurement systems.

1.70 Seven case studies focused on one LA each, and two on individual PRPs, interviewing four to six people in each case.

Sampling Frame

1.71 A sample for lead contacts was drawn from completers of the online survey who had consented to recontact, in order to maximise response rates. Once contacted, lead contacts were asked to invite others to take part, from their own organisation and (in the case of LA case studies) other organisations. These interviewees did not need to have participated in the online survey.

Sampling Strategy

1.72 The sampling strategy for the case studies was purposive, rather than seeking to obtain a representative sample. The aim of the sample distribution was to understanding provision of HRS in England in a variety of situations. To this end, seven LAs were chosen, along with two PRPs with a national reach, to contribute their knowledge of working with a range of LAs.

1.73 For LA case studies, a split of coverage was sought, including:

- Both rural and urban areas.
- A range of regions within England (i.e. including LAs in both northern and southern England).
- A range of LA structures (i.e. two-tier, single-tier).
- At least one LA with coverage of a coastal town.

Response

1.74 The completed case studies comprised of **seven LAs** and **two PRPs,** comprising:

- A rural unitary authority in the South West.
- A rural upper tier (county) authority in the South West.
- An upper tier (county) authority in the North of England.
- An urban unitary authority in the North of England.
- An urban unitary authority covering a former seaside resort.
- Two London Boroughs.
- One large national Housing Association, with a national portfolio of both Supported Housing and General Needs housing.
- One medium size Housing Association with a national portfolio of Supported Housing.

Methodology

1.75 Interviews were carried out face to face by members of the research team in the first instance, with telephone interviews used only where this was not possible. All case studies were completed between October 2019 and February 2020.

1.76 For LA case studies, a range of individuals were interviewed; principally LA commissioners and providers from PRPs and Unregistered Providers operating locally. In all of the case studies interviews with frontline members of staff were sought, as well as management, although this was not possible in all cases. Where upper tier (county council) LAs were interviewed, an interview with at least one person from a lower tier LA operating in their area was also sought, to ensure nothing was missed.

1.77 A semi-structured topic guide was used for the case studies which was designed to be as flexible as possible to the circumstances of the respondents, given the range of people sought for interview. The topic guide covered:

- Commissioning and funding structures, including change over time.
- Types of support provided, including reasons for this.
- Measuring client outcomes and service quality, including barriers and changes to outcomes.
- Planning for current and future support needs, including ability to meet need.

1.7 Reporting conventions

Conventions for reporting on quantitative survey data

1.78 Throughout this report, survey findings reported in the text and in charts are based upon weighted data, unless otherwise stated. Therefore (as explained in Annex D) represent estimates of the true picture among the group discussed, rather than survey responses.

1.79 For unregistered providers, data could not be weighted, and represents only the respondents to the survey, unless otherwise stated.

1.80 All differences mentioned between sub-groups in the text are statistically significant at 95% confidence, unless otherwise specified. For more information on the calculation of error margins and significant differences, please see Annex D.

1.81 Base sizes shown below charts and in tables refer to the number of respondents.

Conventions for reporting on qualitative interview data

1.82 All qualitative data is based upon the opinion of case study or feasibility study interviewees, or open-ended comments made by individual respondents at the end of the online survey, at the question asking for further comments or opinions. It is important to note that in drawing conclusions based on these interviews, the research relies upon the expertise of those individuals selected for interview, on their opinions, and on the veracity of the accounts they provide to us of their experiences. If the analysis relies on a single, uncorroborated source for any point, this is flagged in the report text. These findings are not – unless otherwise stated – backed by representative, quantitative data.

1.83 Information based on the case study evidence is not intended to imply prevalence but rather to illustrate the *range* of challenges, and to provide examples of how LAs and HRS providers behave.

Key sub-groups

1.84 Throughout, LAs are divided according to their administrative structure. Some parts of England have a two-tier system of local government consisting of upper-tier LAs (counties) and lower-tier LAs (districts) serving the same area, and others have a single-tier system of Unitary LAs (including Unitary Authorities, Metropolitan Districts and London Boroughs).

1.85 PRPs are divided for purposes of this report into small, medium and large organisations. Small organisations are those which have fewer than 100 units of Supported Housing[43] registered on the Regulator of Social Housing's Statistical

[43] Including both the SDR categories for 'Supported Housing' and 'Older Person's Housing', both of which fall within the definition of Supported Housing used in this research, as detailed in the Feasibility Study.

Data Return (SDR). Medium organisations have 100 to 999 units registered, and large organisations have 1,000 or more units registered.

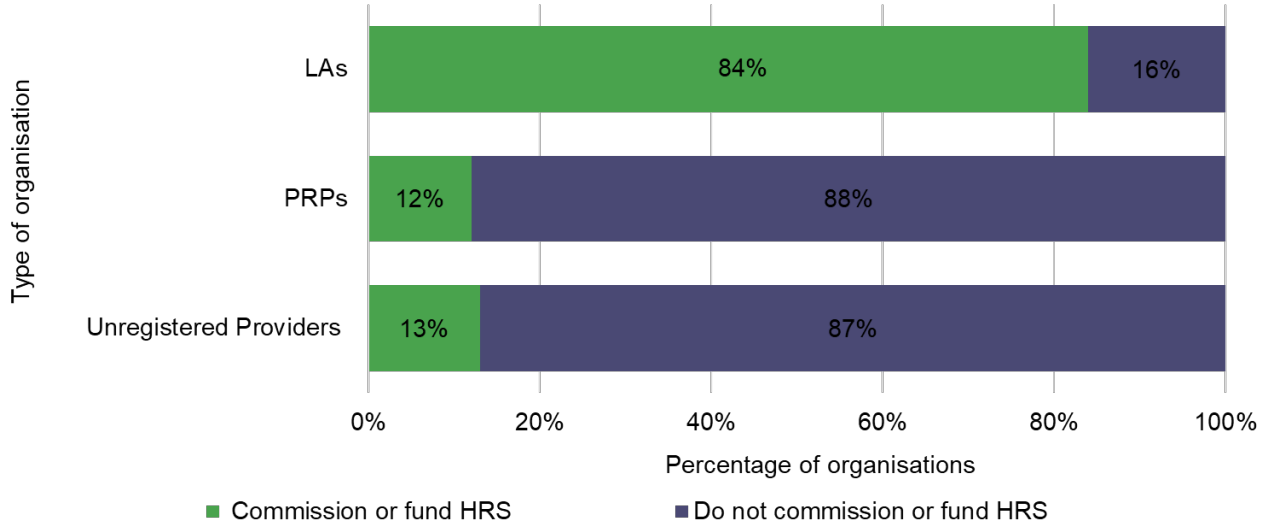
2 Overview

2.1 The lead respondent from each organisation that completed the survey was asked to give an overview of their organisation and its involvement in Supported Housing and HRS. Based on this data, information from the feasibility stage and the case study interviews, this chapter provides an overview of the commissioning and provision of Supported Housing and HRS, and the organisations involved.

2.1 Overview of organisations commissioning support

2.1 The vast majority (84%) of LAs in scope for this research[44] commissioned HRS, as shown in Chart 2.1. Commissioning HRS was far more common by LAs than by PRPs (12%) or Unregistered Providers (13%). Case study participants stated that commissioning via PRPs and Unregistered Providers was usually via a sub-contractor or partnership arrangement, most often in order to cover more specialised HRS requirements, such as multiple complex needs or mental health. In some cases, this arrangement was mandated by LA commissioners, who had tendered for a single lead provider on the basis that they (as an individual organisation or as a formal consortium) would provide some services and sub-contract others.

Chart 2.1 Organisations who commission or fund other organisations to provide HRS



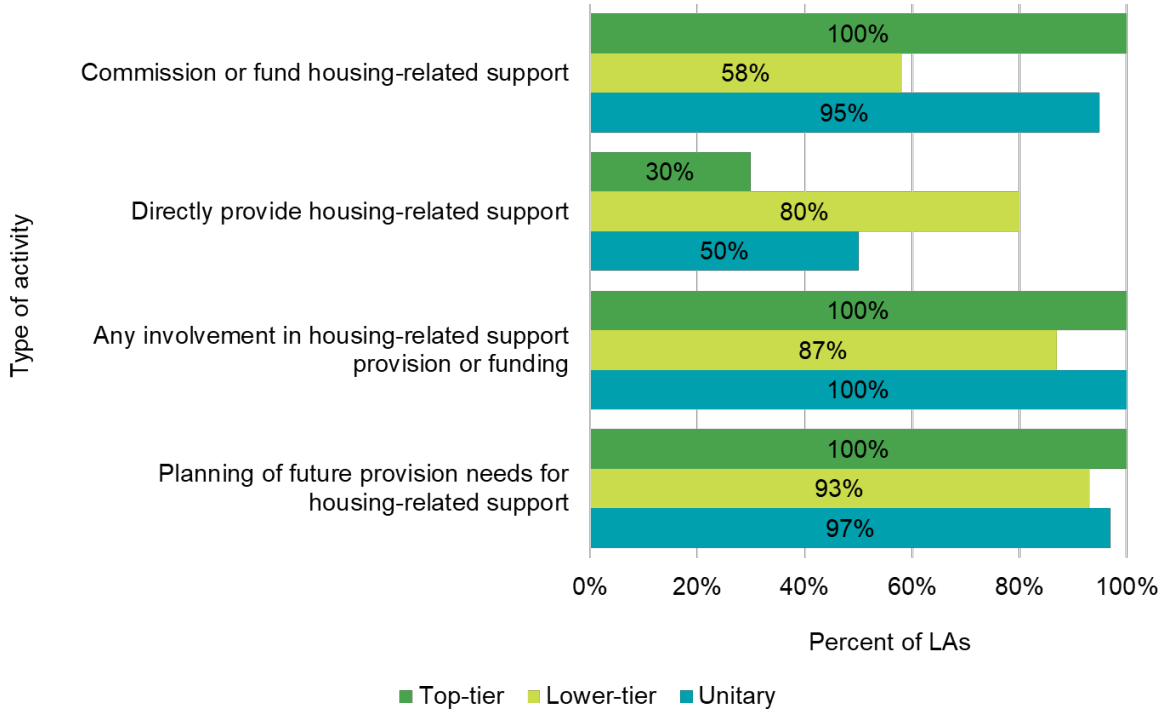
Source: HRS Review online survey. Base: All LAs (98), all PRPs (158), all unregistered providers (70)

[44] The survey scope included all unitary and top tier Local Authorities in England, but only the district councils which own Council Housing stock, as the feasibility stage suggested that district council provision or commissioning of HRS is zero or negligible.

2.2 All Upper tier LAs, and the vast majority of Unitary Authorities (95%) commissioned HRS in the financial year 2018/19, compared with only 58% of Lower tier LAs (Chart 2.2).

2.3 As illustrated in Chart 2.2, almost all LAs forecast for future need, amounting to 100% of top tier, 93% of lower tier, and 97% of unitary authorities. This confirmed the findings of the feasibility stage, where the evidence review found that where a two-tier LA system exists, data regarding need for housing and support is often gathered by Lower tier LAs but HRS is mostly commissioned by Upper tier LAs.

Chart 2.2 Percentage of LAs involved in HRS commissioning and direct delivery, by LA type



Source: HRS Review online survey. Base: All LAs (98), of which: Top tier (13), Lower tier (24), Unitary (61). Respondents could select more than one option, so percentages may add to more than 100%.

2.2 Overview of organisations delivering support

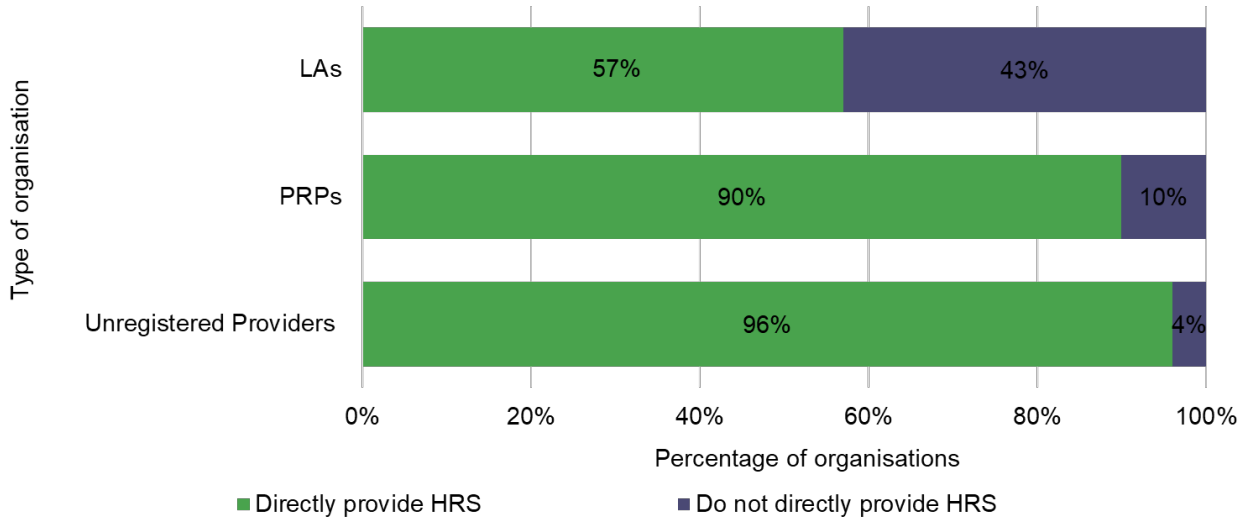
2.4 Over half (57%) of LAs directly delivered HRS, although this covered a relatively limited range of client groups in comparison to other providers (discussed in more detail in Chapter 3). Lower tier LAs[45] (80%) were by far the most likely to provide support directly. In comparison, 30% of Upper tier authorities and 50% of Unitary authorities did so. Overall, two-thirds (66%) of stock-holding LAs in all tiers directly provided support, compared with just over one-third (34%) of LAs without housing stock. This means that in many areas of England, direct HRS provision rests mostly with PRPs.

[45] It is important to note that only stock-holding Lower tier LAs (i.e. landlords of Council Housing, who would have tenants to directly provide support to) were included in the sampling frame.

2.5 Only a small minority of PRPs (10%) and Unregistered Providers (4%) surveyed were not involved in providing HRS. This small percentage is largely because of the nature of the sampling frame, which excluded the 555 PRPs in England (45% of the total) which, according to Regulator of Social Housing data, manage no Supported Housing. The vast majority of the excluded organisations were small providers, including almshouse charities and housing co-operatives. If these excluded organisations were included in the sample frame, the percentage of PRPs who were not involved in providing HRS would be much higher.

2.6 The very small percentages of PRPs (10%) and Unregistered Providers (4%) who did not provide any HRS were landlords or managers of Supported Housing. Evidence from the feasibility study suggests this may be because support was commissioned separately, although some case study interviewees also suggested that there were properties registered with the Regulator of Social Housing as Supported Housing in which no HRS is being provided.

Chart 2.3 Percentages of LAs, PRPs and Unregistered Providers which provide HRS



Source: HRS Review online survey. Base: All LAs (98), all PRPs (158), all unregistered providers (70)

2.3 Scale of provision and regional distribution

Total number of HRS clients

2.7 No secondary data was available on the level of involvement in HRS. To fill this gap, the online survey asked LAs, PRPs and unregistered providers how many clients they provided HRS to, including Floating Support.

2.8 It is estimated, from responses to the online survey, that commissioning by LAs in England funded support to approximately 309,000 clients during the 2018/19 financial year. This is around a quarter of the number of household units (1,113,908) receiving support through Supporting People funding in the year the

ring-fence was removed (2010/11)[46]. The data collected through the Supporting People programme was measured in household units, whereas this survey gathered data on the number of clients. It is therefore safe to say that the number of people served by this type of commissioning has reduced by at least 72% since 2010/11.

2.9 This estimate from the online survey assumes that the 33% of LA commissioners who were unable to state how many clients were served by their HRS commissioning delivered to the average number of clients among other authorities. However, there is a high level of uncertainty around this estimate. In comments at the end of the survey, LAs who were unable to provide client numbers sometimes stated that their services did not specify a number of clients to be served at the commissioning stage.

2.10 However, providers do continue to provide service using funding streams other than LA commissioning to a larger number of people, in total an estimated 805,000[47] during the 2018/19 financial year. This is derived from survey data on the total number of HRS clients served by each type of organisation[48], as detailed below, including provision from all sources of funding.

2.11 In total, an estimated 551,000 of these clients were served by PRPs, and 76,000 via direct provision by LAs. Unregistered Provider data is unweighted as there is no robust source of profile information, and so an overall estimate cannot be calculated in the same way. However, the 70 Unregistered Providers responding to the online survey provided support to 59,000 people between them. Making a series of assumptions regarding response rates (as detailed in Annex E) would suggest that Unregistered Providers have an estimated 177,000 HRS clients in England.

[46] Ministry of Housing, Communities and Local Government. (MHCLG) (2010). *Supporting people local system data: Supporting People Household Units as at 31.03.10, England.* October 2010. Available at: https://www.gov.uk/government/statistics/supporting-people-local-system-data

[47] These figures are not comparable to data provided in the 2016 Supported Accommodation Review, since this figure includes all clients served for all or part of the 2018/19 financial year, while the figures provided in the Supported Accommodation Review are a snapshot, and also exclude Floating Support clients.

[48] This calculation does not allow for overlap where multiple direct providers may work with the same individual client during 2018/19, but it *does not* double-count between commissioning and direct provision.

Figure 2.1: Estimated number of HRS clients

	Base	***Estimated number of clients***	***Estimated percentage of total HRS clients***
LA commissioning	*51*	309,000	38%
Total provision, LAs, PRPs and Unregistered Providers	*233*	805,000	100%
LA direct provision	*39*	76,000	9%
PRPs	*128*	551,000	68%
Unregistered Providers*	*66*	177,000*	22%

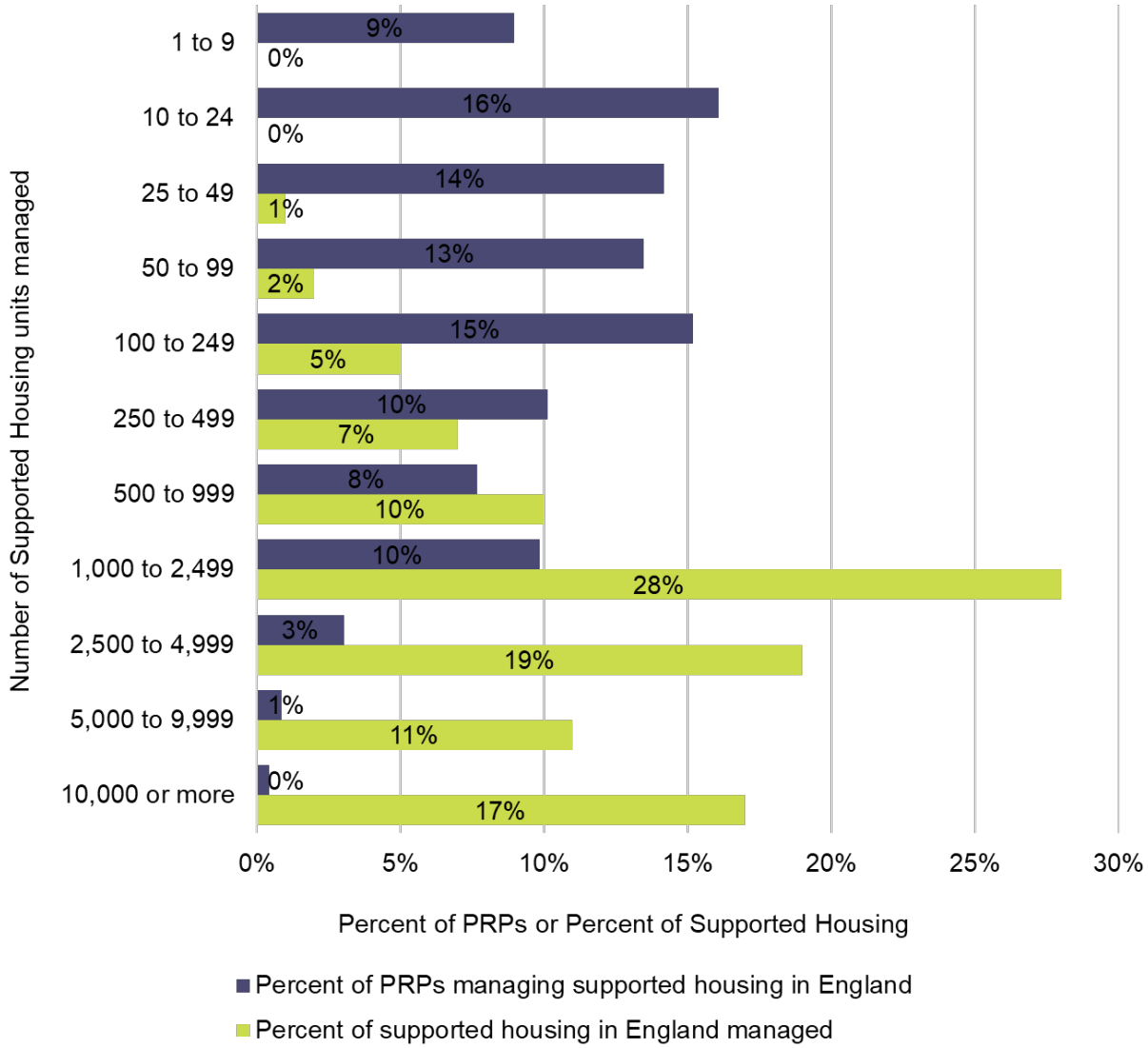
Source: HRS Review online survey.

** data could not be weighted; number of clients is extrapolated using assumptions shown in Annex E. These estimates should be treated as approximate. Figures rounded to the nearest 1,000, and summed before rounding.*

Supported Housing provision by HRS providers

2.12 According to the Housing Regulation Statistical Data Return (SDR), there are very few large PRPs in England (only 13% manage Supported Housing which has more than 1,000 units), yet these manage three-quarters (75%) of all the Supported Housing stock, as illustrated in Chart 2.4. It is worth noting that SDR data indicates that a single provider, Anchor Hanover, manages 10% of this stock, accounting for in excess of 30,000 units. Accordingly, half of PRPs (52%) each manage fewer than 100 units of Supported Housing stock, together comprising just three per cent of the total Supported Housing stock in England.

Chart 2.4 Percentages of PRPs providing banded quantities of Supported Housing units



Source: Regulator of Social Housing Statistical Data Return (SDR), March 2019

2.13 No equivalent data is available for stock-holding LAs, since information on Supported Housing stock is not gathered in MHCLG's annual Local Authority Housing Statistics (LAHS) return. Information on the number of Supported Housing lettings is provided, but it is not comparable to the PRP data.

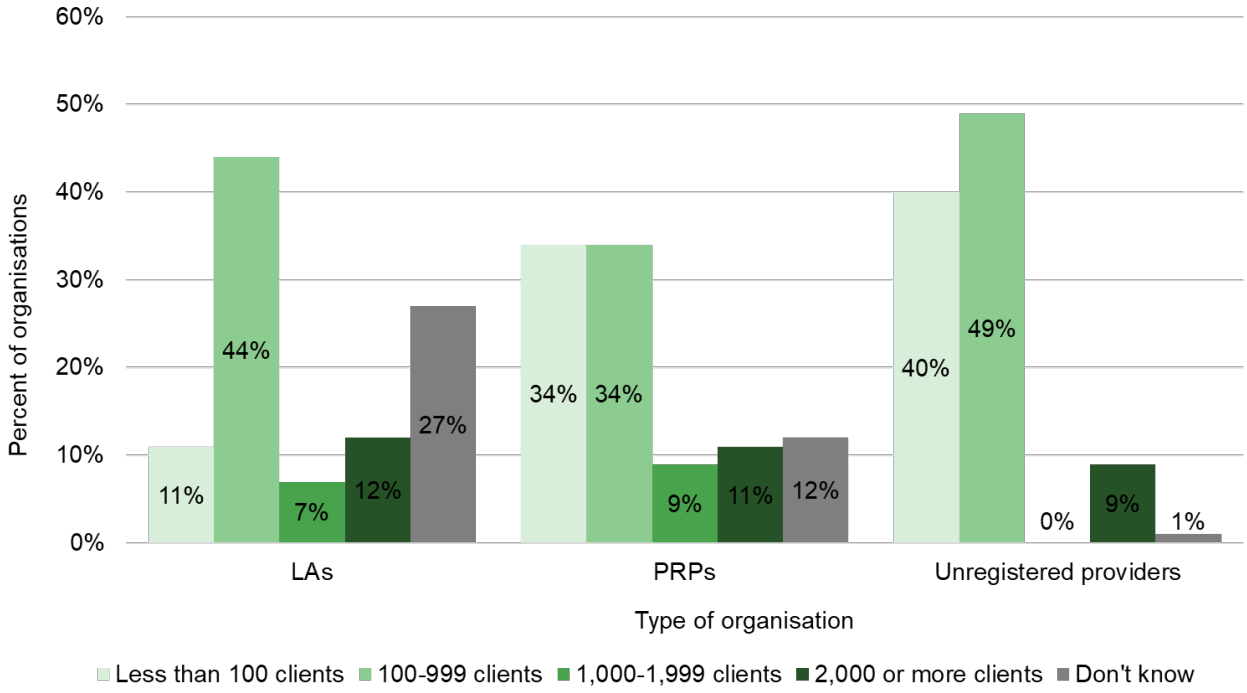
2.14 No secondary data is available on Unregistered Providers, and so a profile cannot be provided. Although nearly all (93%) of the 70 Unregistered Providers surveyed stated that they owned (70%) or managed (86%) at least some Supported Housing, only one respondent was able to state how many units they managed. Case study interviewees reported that their provision often tended to be communal and counted in terms of bed spaces rather than units.

Number of HRS clients per HRS provider

2.15 Across all three types of organisation, the majority of organisations provided HRS to less than 1,000 clients (Chart 2.5). Unregistered providers tended to be smaller,

with 89% serving less than 1,000 clients, compared with 64% of PRPs and 55% of LAs. One-quarter of LAs (27%) did not know how many clients they directly provided with support.

Chart 2.5 Number of clients HRS provided to by organisations - detailed bands



Source: HRS Review online survey.

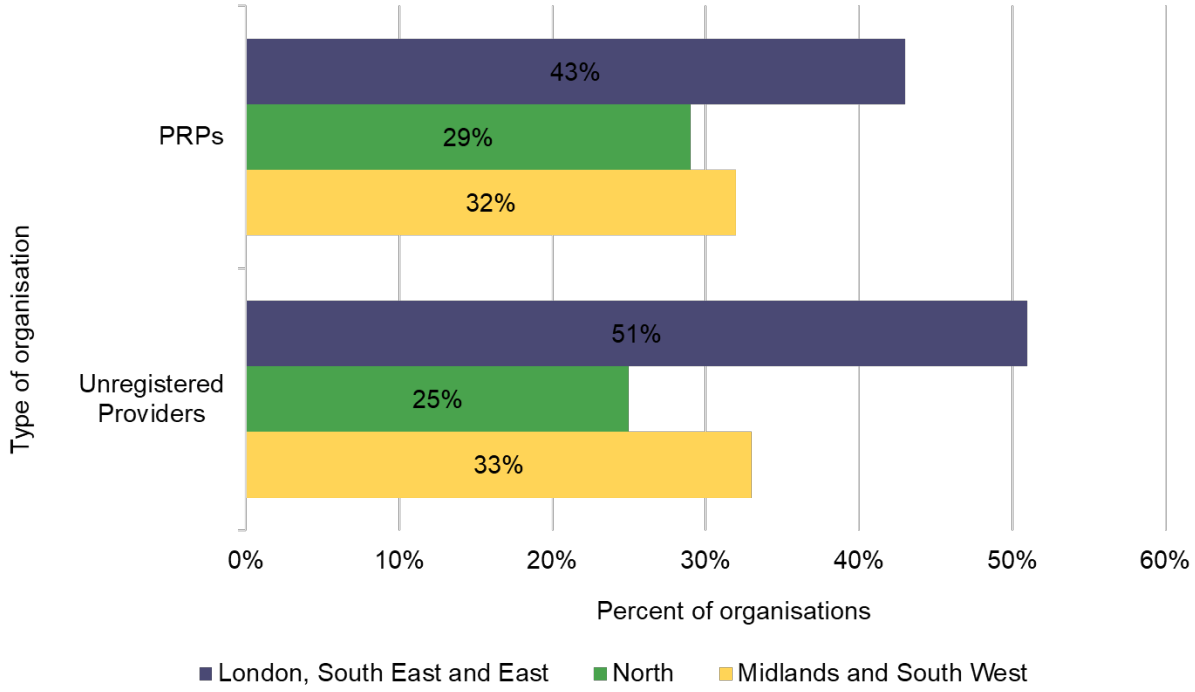
Base: All organisations that directly provide HRS services: 53 LAs. 142 PRPs, 67 Unregistered providers

Regional distribution of provision

2.16 Providers[49] are found across England. Among PRPs, it was estimated that 43% operated in London and the surrounding South East and East regions, 32% in the Midlands or South West, and 29% in the North of England. Around half (51%) of the Unregistered Providers who responded to this survey operated in London, the South East and East of England. By definition, LAs operate within their designated area. However, in the feasibility stage, some stakeholders mentioned LAs using and funding provision outside their area for their residents, if local provision was in short supply. This was borne out in the case studies, for example where a provider in one London Borough highlighted that some provision for alcohol-dependent clients was located on the South Coast.

[49] This question could be multi-coded as some PRPs covered more than one region. The percentages therefore do not sum to 100%.

Chart 2.6 Regional distribution of Registered and Unregistered providers who provide HRS and responded to the survey



Source: HRS Review online survey. Base: PRPs (158), Unregistered providers (67) that provide HRS

3 Support Delivered

3.1 This chapter examines commissioning and provision of HRS and Support Housing among different client groups, and which types of services are delivered. It also provides estimates of the volume of people supported in each client group, both in terms of direct provision of support, and commissioning.

3.1 Direct provision to client groups

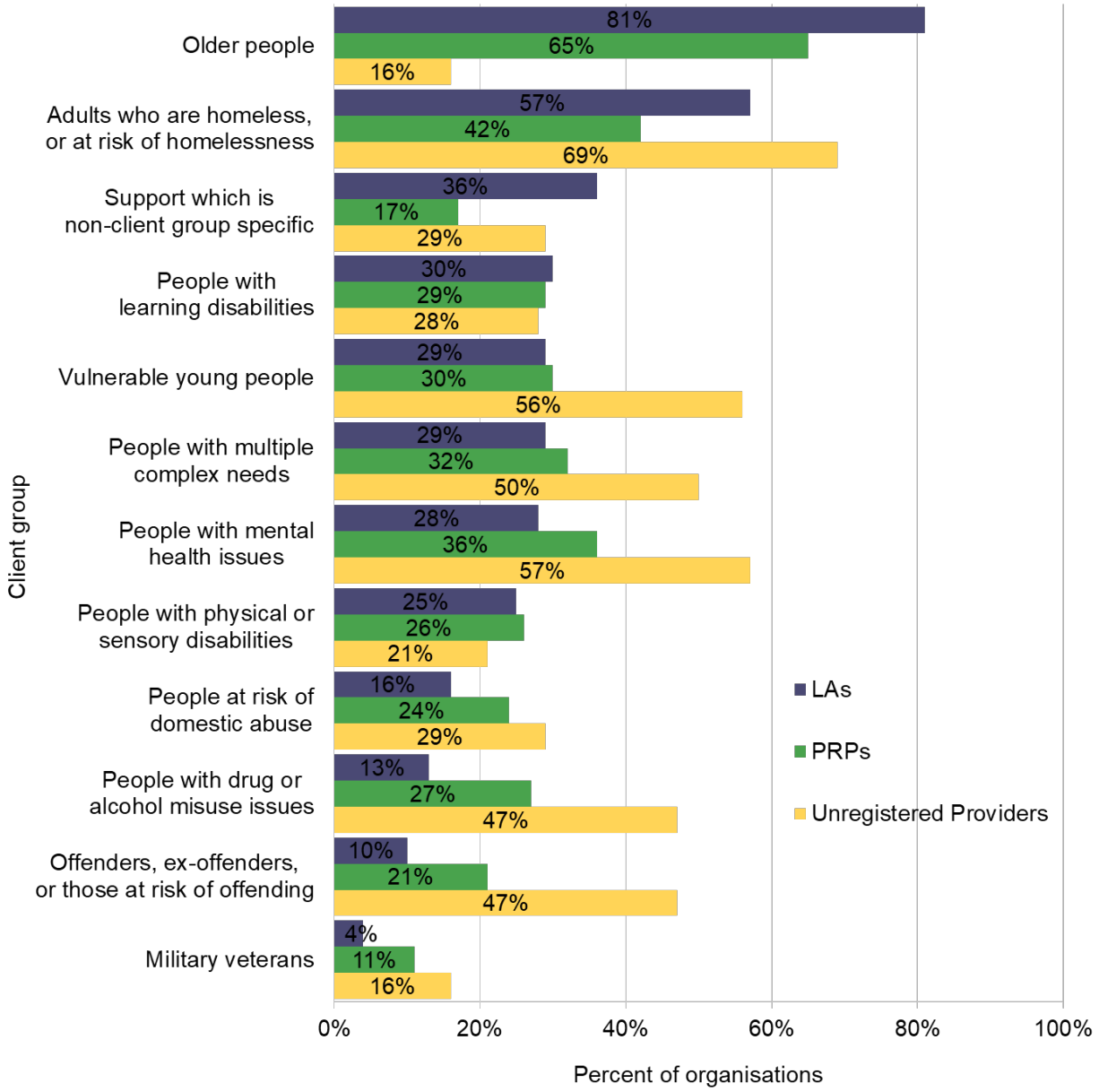
3.1 It was estimated that eight in ten LAs (81%) directly provided HRS services or Supported Housing that served older people, while almost six in ten (58%) provided such services to adults who were homeless, or at risk of homelessness, and almost four in ten (38%) provided more general support that was not specific to a particular client group. Other client groups were also supported by smaller groups of LAs, as shown in Chart 3.1.

3.2 There was a similar pattern among PRPs: two-thirds provided support for older people (65%) while just over four in ten provided support for adults who were homeless or at risk of homelessness (42%). Just over one-third (36%) provided support for people with mental health issues.

3.3 Compared with LAs and PRPs, Unregistered Providers served a wider range of client groups, and a higher percentage of Unregistered Providers provided services to groups most likely to present with high or complex support needs. Seven in ten delivered support for adults who are homeless, or at risk of homelessness (69%), followed by support for people with mental health issues (57%), support for vulnerable young people (56%), and support for people with multiple complex needs (50%).

3.4 One notable comparison between LAs and PRPs is the extent to which they provide support which is not specific to a particular client group. Over one-third (36%) of LAs provided this type of support whereas only 17% of PRPs did so. This suggests that PRPs were more likely to be commissioned to provide support for specific client groups than to provide generalised support.

Chart 3.1: Percentage of organisations that provide HRS for different client groups



Source: HRS Review online survey.

Base: Organisations who provide HRS: LAs (63), PRPs, (158), Unregistered Providers (68). Respondents could select more than one option, so percentages may add to more than 100%.

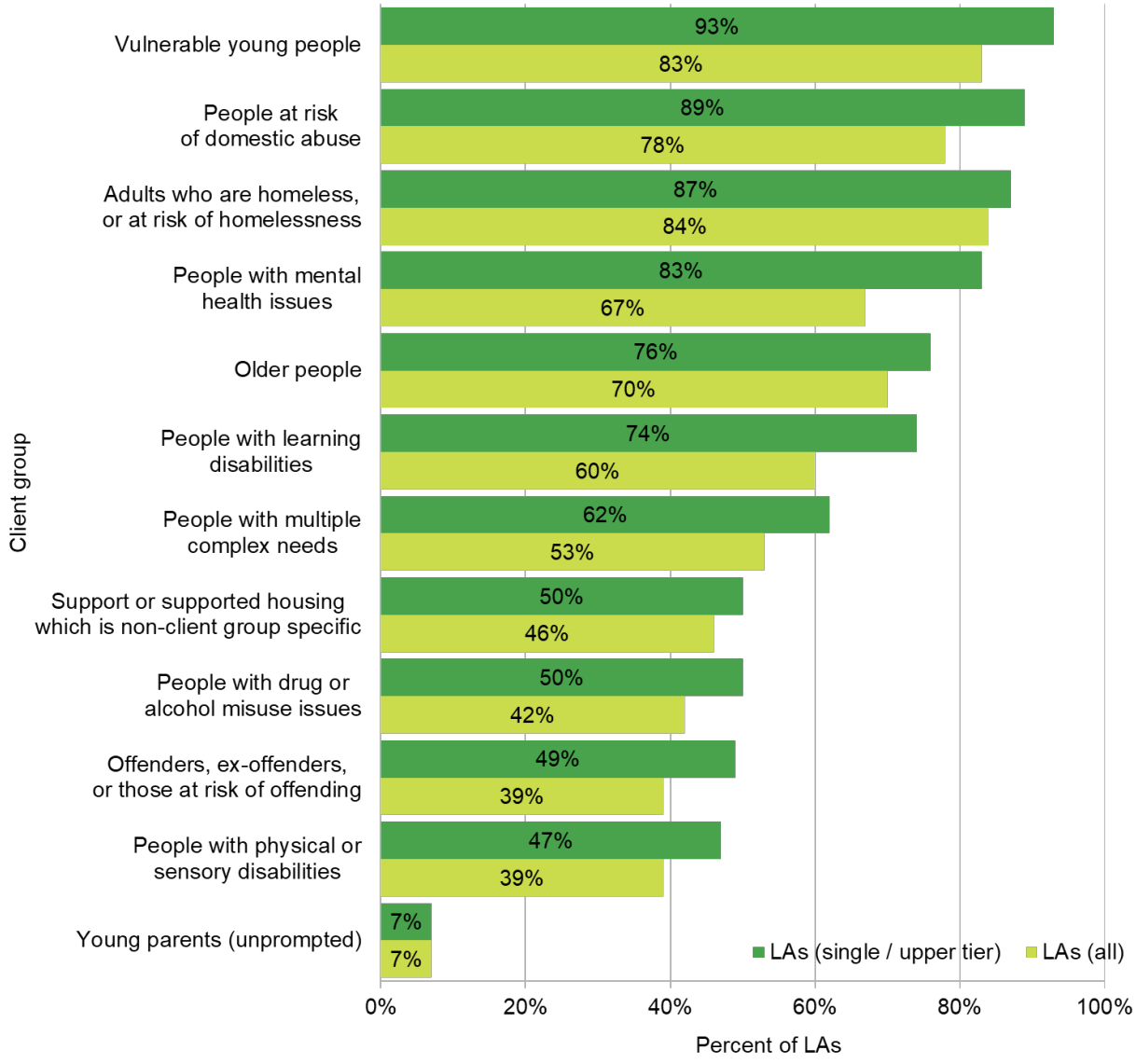
3.2 Commissioning for client groups

3.5 The online survey showed that upper tier and Unitary LAs commissioned HRS services or Supported Housing for the widest variety of client groups (Chart 3.2). Most commonly this was for vulnerable young people (93%), people at risk of domestic abuse (89%), people who were homeless or at risk of homelessness (87%) and people with mental health issues (83%). Over half of these LAs also commissioned support for older people, people with learning disabilities and people with multiple complex needs.

3.6 Although most upper-tier and Unitary LAs commissioned for a wide range of groups, the fact that not all LAs commissioned for all groups indicates that some gaps may exist in local provision. Those groups less commonly commissioned for by LAs included groups with multiple complex needs (62%), people with drug or alcohol misuse issues (50%), offenders or ex-offenders (49%) and people with physical or sensory disabilities (47%).

3.7 However, it is worth noting that half of all Upper-tier and Unitary LAs (50%) commissioned HRS or Supported Housing that was not specific to a particular client group. LAs often noted in comments at the end of the survey that they did not break down commissioning by client group. The absence of a specific group, therefore, does not necessarily mean that support for that group is entirely unavailable, as it may still *in some cases* be offered as part of more general provision. For this reason, the extent of any gaps in provision cannot be determined entirely from this data.

Chart 3.2: Percentage of organisations that commission HRS for different client groups



Source: HRS Review online survey.

Base: All organisations who commission HRS: LAs (upper and unitary tier) (71), LAs (all) (85). Prompted, except where stated. Client groups mentioned by less than five per cent not shown.

Respondents could select more than one option, so percentages may add to more than 100%.

3.8 The feasibility stage of this research found that some PRPs funded other organisations to provide services, but typically viewed this as sub-contracting rather than commissioning or tendering. It generally did not involve a formal tendering process. This was verified by the survey and case studies; comparatively few PRPs (16%, n=25) funded other organisations to provide HRS services, compared to LAs. therefore the results for this group are indicative. The three most common client groups that PRPs funded other organisations to provide services to were people with learning disabilities (47%), people with mental health issues (41%) and adults who were homeless, or at risk of homelessness (37%).

3.9 It was very rare for Unregistered Providers to commission or fund HRS services or Supported Housing (just 13%, i.e. nine organisations who responded).

3.3 Levels of need among clients

3.10 Organisations that commission or directly provide HRS or Supported Housing were asked whether their clients had high, medium or low support needs, according to their own definition of the terms[50]. Some organisations were unable to answer this question as they did not use those categories to define their clients. Determining level of need was further compounded by there being no universal definition of high, medium or low. This was a particular issue when it came to LA commissioning, with half of LAs reporting that they did not use these categories when commissioning HRS or Support Housing and a further 17% who used the categories to some extent, but were unable to break down their spending in this way.

> *You refer to high, medium and low needs, but this is open to interpretation by all - there is no universally accepted definition of these categories, so we make our own assessments. Also, a client can be categorised as low needs, then they hit a crisis and become high or medium needs for a time, then perhaps revert to low needs - so these categories have limited [usefulness].*
>
> **Unregistered provider, Survey comment**

3.11 Providers who directly provided HRS or Supported Housing were more able to categorise their clients in this way. Around one in five LAs (79%) and PRPs (84%) who provided direct support, and almost all Unregistered Providers (99%), provided client numbers broken down by level of need. Among these, over half of Unregistered Providers (57%), half of LAs (51%), and 43% of PRPs, provided HRS to clients with high support needs. Clients with medium support needs were

[50] This is because it was considered unlikely that organisations would be able to submit data to match a definition not used internally. The feasibility study indicated that a range of formal and informal definitions were in use. Any conclusions or comparisons made about the level of support needs that organisations cater for should therefore be treated with caution.

covered by 90% of Unregistered Providers and around three-fifths of LAs and PRPs (63% and 58% respectively). 78% of Unregistered Providers, 70% of LAs and 71% of PRPs served clients with low support needs.

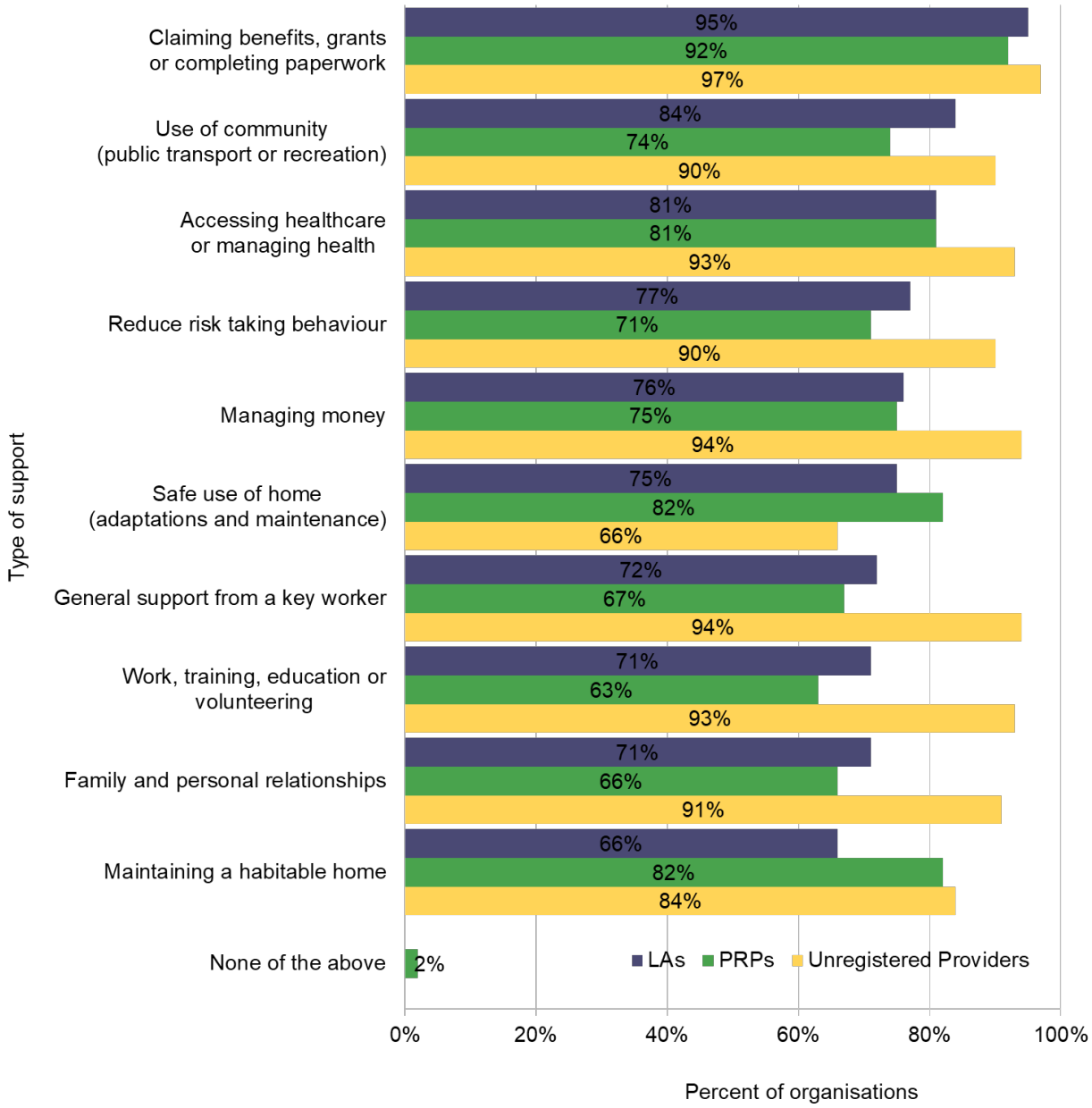
3.4 Directly provided types of support

3.12 Almost all providers offered multiple types of support (96%), and most provided more than four types (83%). Chart 3.3 shows that, overall, Unregistered Providers offered the widest range of support to their clients. At least nine in ten unregistered providers offered each of the ten services prompted in the survey except for help with the safe use of home (66%) and maintaining a habitable home (84%), as shown in Chart 3.3. Two per cent of PRPs said they provided no specific service mentioned despite stating that they provided support.

3.13 Unregistered providers were more likely than both LAs and PRPs to offer the following types of support, indicating the wider range of support services that they reported providing:

- Accessing healthcare (93%).
- Managing money (94%).
- General support from a key worker (94%).
- Work / education / volunteering (93%).
- Family relationships (91%).

Chart 3.3: Support services that are provided by each type of HRS provider



Source: HRS Review online survey. Base: Organisations who directly provided HRS services, LAs (53), PRPs (142), unregistered providers (67). Respondents could select more than one option, so percentages may add to more than 100%.

3.14 Services helping clients to claim benefits or complete paperwork were the most frequently offered by all types of provider (95% by LAs, 92% by PRPs and 97% by Unregistered Providers; groups not significantly different to each other). In part, this could be because it is beneficial for all types of organisation to make sure the client is claiming the correct benefits and not falling behind on their rent. In one case study, a respondent mentioned that providing this support (often referred to by landlords as Tenancy Support) was proven to be cost-efficient for them as a landlord, since it reduced rent arrears.

3.15 Large PRPs that managed more than 1,000 units were more likely to offer each type of service compared to very small PRPs that managed fewer than 99 units. Furthermore, medium-sized PRPs (those that managed between 100 and 999 units) were also more likely than small providers to offer each type of service, except general support from a key worker, but beyond this no specific pattern was seen regarding any particular service or services.

3.16 The qualitative findings reinforced the survey findings on the diversity of services provided beyond the ten categories prompted in the online survey, detailing schemes ranging from the very specialist to the most general purpose. One large provider interviewed offered services ranging from general purpose Floating Support services, to accommodation-based support for female offenders (funded by the National Offender Management Service (NOMS)), to a series of clusters of residential mental health provision.

3.17 Another LA commissioned providers to offer a range of services to different client groups. For example, one of their providers provided specialist support to young people with budgeting (i.e. managing money), as well as maintaining a habitable home. Another of their providers offered support to homeless people that included help with budgeting and finance (managing money) and one-to-one sessions with a key worker.

3.18 Often, LAs and PRPs were looking for ways to cut costs whilst still providing important support. One LA discussed a new type of innovative provision where they have introduced a 'gateway site' for single homeless people to access services such as GPs, benefit advice and relationship support, all in one space.

3.19 Organisations were asked what percentage of their clients lived in Supported Housing, and this information was used to produce estimates of the total number of HRS clients living in each type of housing[51]. Figures 3.1 and 3.2 show that around two-thirds of directly-provided HRS clients of LAs and PRPs (62% and 66% respectively) resided in Supported Housing, reducing to one-third (33%) among Unregistered Providers. This comparison is affected by a substantial percentage of providers who were unable to provide an estimate, which was highest among Unregistered Providers (40%).

[51] The total number of HRS clients in each type of housing in England was estimated, via the data weighting process for LAs and PRPs, but the data for Unregistered Providers is not weighted due to the lack of population data.

Figure 3.1: Estimated number of HRS clients that reside in Supported Housing, for LAs (as direct providers), PRPs and Unregistered Providers

Estimated number of HRS clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Residents of Supported Housing	47,000	374,000	20,000*
Not residents of Supported Housing	7,000	99,000	15,000*
Provider unable to state (don't know)	22,000	78,000	24,000*
Total	76,000	551,000	59,000*
Base size	53	142	67

*Source: HRS Review online survey. * data could not be weighted; number of clients is the number served by those responding to the online survey only (i.e. not grossed up).*

Figure 3.2: Estimated percentage of HRS clients that reside in Supported Housing for LAs (as direct providers), PRPs and Unregistered Providers

Estimated percentage of HRS clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Residents of Supported Housing	62%	68%	33%
Not residents of Supported Housing	9%	18%	26%
Provider unable to state (don't know)	29%	14%	40%
Total	100%	100%	100%
Base size	53	142	67

Source: HRS Review online survey.

3.20 Figures 3.3 and 3.4 shows similar estimates for the total number of clients who were residents of housing owned or managed by the provider of the HRS[52]. Again, there are a large number of organisations, especially Unregistered Providers, who do not know the status of their clients' accommodation.

3.21 However, this does illustrate that for LAs and PRPs, the majority of HRS clients (54% and 63% respectively) are their residents; this is much less likely for Unregistered Providers (23%), who predominantly deliver services to people residing in other organisations' housing, a view confirmed by case study interviews.

[52] These estimates are again based on weighted figures for LAs and PRPs, and unweighted figures for Unregistered Providers.

3.22 Some case study interviewees mentioned that this gives a provider fewer funding options, due to the lack of access to funding from rent or service charge sources.

Figure 3.3: Estimated number of HRS clients who are residents of housing either owned or managed by the HRS provider, for LAs (as direct providers), PRPs and Unregistered Providers

Estimated number of HRS clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Residents of housing owned or managed by the HRS provider	47,000	374,000	14,000*
Not residents of housing owned or managed by the HRS provider	13,000	125,000	21,000*
Provider unable to state (don't know)	22,000	82,000	24,000*
Total	76,000	551,000	59,000*
Base size	53	142	67

*Source: HRS Review online survey. * data could not be weighted; number of clients is the number served by those responding to the online survey only*

Figure 3.4: Estimated percentage of HRS clients who are residents of housing either owned or managed by the HRS provider, within each of LAs (as direct providers), PRPs and Unregistered Providers

Estimated percentage of HRS clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Residents of housing owned by the provider	54%	63%	23%
Not residents of housing owned by the provider	17%	23%	37%
Provider unable to state (don't know)	29%	15%	40%
Total	100%	100%	100%
Base size	53	142	67

Source: HRS Review online survey.

3.23 Figures 3.5 and 3.6 show the estimated number of clients for organisations that directly provided HRS services, by client group, according to their primary need. Just over half (52%) of clients among LAs that directly provided HRS were older people, as well as two-fifths (42%) clients among PRPs. In contrast, just three per cent of clients among Unregistered Providers were older people. The most common client group for Unregistered Providers was adults who were homeless or at risk of homelessness (27%).

3.24 The distribution shown for each of LAs, PRPs and Unregistered Providers in Figure 3.3 illustrates the differing roles found for each of these types of provider. LA direct

providers of HRS had a particularly strong focus on older people (52% of clients, even though 21% were of unknown client groups), and to a lesser extent provision for homeless people (14% of clients).

3.25 While PRPs provided to a larger absolute number of older people than LAs as direct providers (233,000 vs. 40,000), they made up a smaller proportion of PRP clients, at 42%. This was because PRPs also provided to a wider range of client groups, the largest being those with mental health issues (15% of clients), homeless people (11% of clients), those at risk of domestic abuse (8% of clients), and vulnerable young people (6% of clients).

3.26 Unregistered Providers showed a different pattern of provision; only a small proportion of their clients (3%) were older people. Homeless people (27% of clients) were a key group that Unregistered Providers provided support for, but they did not comprise the majority of their clients. People with multiple complex needs (13% of clients), and vulnerable young people (8%) were also substantial groups served. Around a third of clients were not classified by providers as being in any particular client group (31%). Unregistered providers sometimes stated in comments at the end of the survey that they did not divide clients into groups by primary need in this way.

Figure 3.5: Estimated number of HRS clients who are in each client group, for LAs (as direct providers), PRPs and Unregistered Providers

Estimated number of clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Older people	40,000	233,000	2,000*
Homeless, or at risk of homelessness	10,000	62,000	16,000*
People with learning disabilities	2,000	82,000	**
People with mental health issues	1,000	31,000	3,000*
People with multiple complex needs	600	14,000	8,000*
People at risk of domestic abuse	200	45,000	3,000*
Offenders, ex-offenders or people at risk of offending	100	3,000	3,000*
Vulnerable young people	400	33,000	5,000*
People with drug or alcohol misuse issues	300	7,000	500*
People with physical or sensory disabilities	100	4,000	**
Military Veterans	**	2,000	**
Provider unable to state (don't know)	21,000	35,000	19,000
Total	76,000	551,000	59,000*
Base size	53	142	67

*Source: HRS Review online survey. * data could not be weighted and is therefore not grossed up; number of clients is the number served by those responding to the online survey only. ** numbers are too small to report (less than 100 but more than 0.*

Figure 3.6: Estimated percentage of HRS clients who are in each client group, calculated separately within each of LAs (as direct providers), PRPs and Unregistered Providers

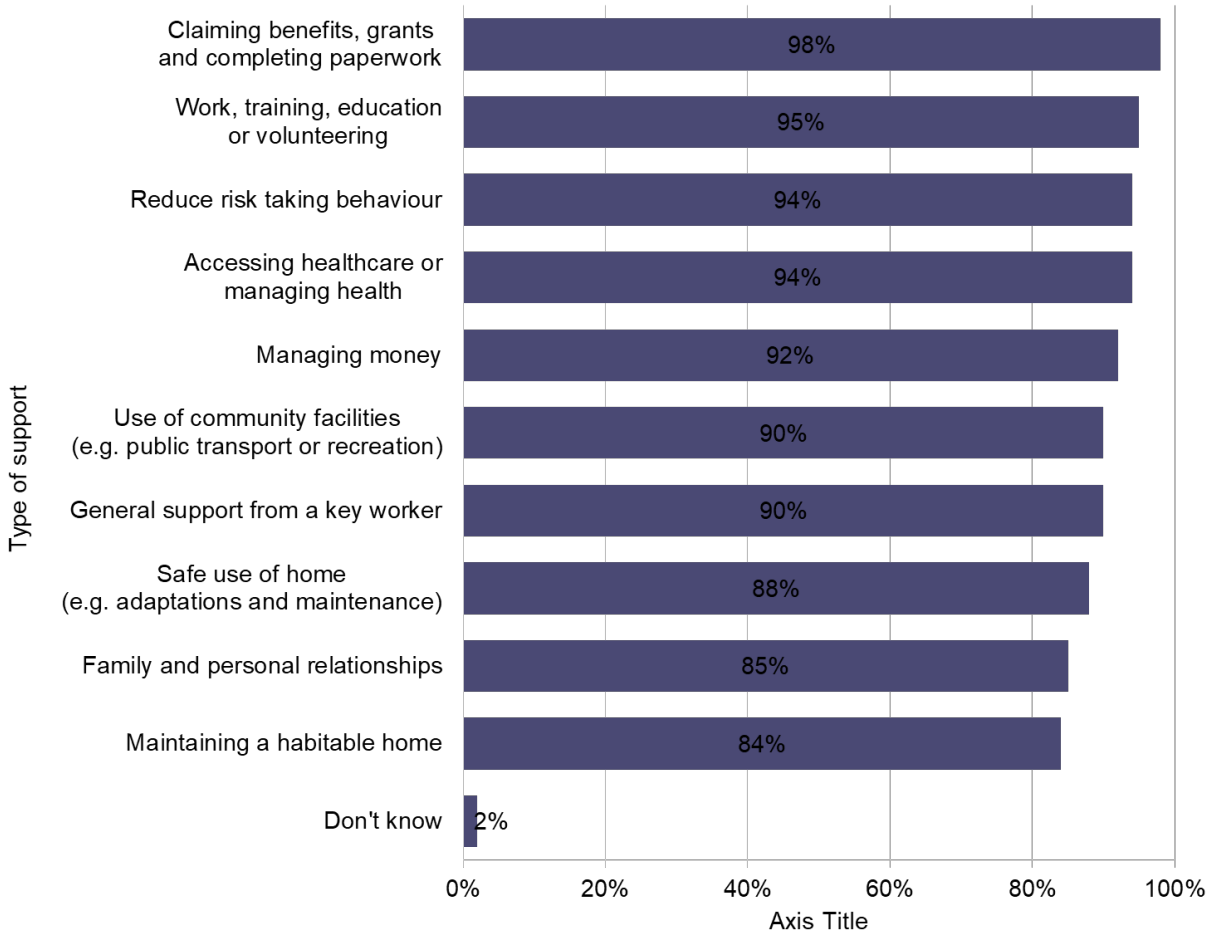
Estimated percentage of clients who are…	*LAs*	*PRPs*	*Unregistered Providers*
Older people	52%	42%	3%
Homeless, or at risk of homelessness	14%	11%	27%
People with learning disabilities	2%	15%	<1%
People with mental health issues	2%	6%	5%
People with multiple complex needs	1%	3%	13%
People at risk of domestic abuse	<1%	8%	4%
Offenders, ex-offenders or people at risk of offending	<1%	1%	4%
Vulnerable young people	<1%	6%	8%
People with drug or alcohol misuse issues	<1%	1%	1%
People with physical or sensory disabilities	<1%	1%	<1%
Military Veterans	<1%	<1%	<1%
Provider unable to state (don't know)	28%	6%	31%
Total	100%	100%	100%
Base size	53	142	67

Source: HRS Review online survey.

3.5 Commissioned types of support

3.27 As noted in Chapter 2, LAs were estimated to have commissioned HRS for around 309,000 HRS clients in 2018/19. Almost all LAs that commissioned HRS did so for multiple types of support activity (98%), and 95% commissioned for five or more different types. The specific services they commissioned are shown in Chart 3.4. The most common type of service was claiming benefits (98%) and the least common was maintaining a habitable home (still mentioned by 84%).

Chart 3.4: Percentage of LAs that commission HRS which commissioned each type of HRS service (prompted)



Source: HRS Review online survey. Base: LAs that commission or fund HRS (75). Respondents could select more than one option, so percentages may add to more than 100%.

3.28 Commissioning catered to a variety of types of support, although in many cases, LAs were unable to state which groups they commissioned for. These LAs accounted for 53% of all HRS clients commissioned for, as shown in Figure 3.7. In addition, an estimated third of LAs who commissioned HRS in 2018/19 did not know the number of clients served at an overall level. For these reasons, total estimated numbers of clients are not given in the table.

3.29 In some cases, LAs who declined to give figures for client groups explained that they did not split down commissioning on this basis, and that funding allocated to providers was not ring-fenced for client groups nor monitored on this basis. This is a notable change from Supporting People practice prior to the removal of the ring-

fence, when all provision was monitored by LAs and central government on the basis of primary client group[53].

3.30 No single client group dominated, but in client number terms, homelessness was the single largest group commissioned for (16%) by LAs. These results also demonstrate the differences between the client groups that support is commissioned and directly provided for by LAs and PRPs.

3.31 While the single largest group directly provided for by both LAs (52%) and PRPs (42%) was older people, only 12% of the clients that support was commissioned for by LAs were older people. Supporting the survey findings, in the case studies carried out for this research, PRPs reported that HRS in Sheltered Housing had been widely decommissioned by LAs as a low priority for funding and was now funded via other routes such as service charges. It also reflects the finding from the feasibility study that much of LA direct provision takes the form of Sheltered Housing. A couple of lower-tier (district) LAs specifically mentioned in comments at the end of the survey that they had maintained funding for direct support to their tenants via HRA budgets, after Supporting People funding had been withdrawn by the relevant upper-tier (county) authority.

3.32 Similarly, there were several client groups, as shown in Figure 3.4, which made up a higher proportion in LA commissioning than in direct provision, suggesting a greater focus in these areas by commissioners. This particularly applies to HRS clients with multiple complex needs, who make up eight per cent of commissioning in terms of client numbers, but only two per cent of PRP provision and one per cent of LA direct provision. These are the highest need groups, identified elsewhere in the report as priorities for LAs to cover with limited funding (see Chapter 8 for a more detailed overview of funding gaps).

[53] Ministry of Housing, Communities and Local Government. (MHCLG) (2010). *Supporting people local system data: Supporting People Household Units as at 31.03.10,* England. October 2010. Available at: https://www.gov.uk/government/statistics/supporting-people-local-system-data

Figure 3.7: Estimated percentage of HRS clients commissioned for by LAs who are in each client group, with percentages of client groups in direct provision by LAs and PRPs included for comparison

Estimated number of clients who are…	*LA commissioning*	*LA direct provision*	*PRP direct provision*
Adults who are homeless, or at risk of homelessness	16%	14%	11%
Older people	12%	52%	42%
Non-client group specific HRS	11%	*	*
People with multiple complex needs	8%	1%	3%
People with mental health issues	7%	2%	6%
Vulnerable young people	5%	*	6%
People with learning disabilities	4%	2%	7%
People at risk of domestic abuse	4%	*	8%
Offenders, ex-offenders or people at risk of offending	1%	*	1%
People with physical or sensory disabilities	2%	*	1%
People with drug or alcohol misuse issues	*	*	1%
Military veterans	1%	*	*
Commissioner or provider unable to state (don't know)	53%	28%	6%
Total	100%	100%	100%
Base	75	53	142

*Source: HRS Review online survey. Base: LAs that commission or fund HRS (75) * Less than one per cent.*

3.6 Summary of key findings

- LAs, PRPs and Unregistered Providers all covered a wide range of client groups either in their commissioning, their provision, or both.
- LAs and PRPs were most likely to provide for older people, while Unregistered Providers were most likely to provide for adults who were homeless, or at risk of homelessness. Unregistered Providers were also more likely to provide for more specific (generally higher need) client groups, and this is reflected in the smaller and more specialist nature of the providers themselves.

- Almost all LAs, PRPs and Unregistered Providers that directly provided HRS offered more than one type of service (96%), with the most common amongst each of the provider types being help claiming benefits or grants or completing paperwork.

- In terms of the number of HRS clients in commissioned provision, older people were the largest group in numeric terms, followed by people who are homeless or at risk of homelessness. However, people who are homeless or at risk of homelessness are served by the largest number of providers.

- The vast majority of LAs commissioned services for most groups, but for many client groups, commissioning was absent in at least some LAs. This may indicate that in some geographical areas there were client groups not served at all by commissioning, although the practice of non-client group specific commissioning makes the scale of gaps difficult to determine. However, this does suggest a degree of unmet need (discussed in more detail in Chapter 8).

4 Costs of Support and Funding Sources for Providers

4.1 This chapter explores the costs of providing HRS, and the extent to which those costs are met by LA commissioning activity, or from other sources.

4.2 Spending figures provided in this chapter are extrapolated from survey data to produce estimated spending for the population of commissioners and providers as a whole. While useful and plausible estimates, they are based on a survey, and therefore subject to statistical error. The extrapolations made also require a series of assumptions to be made, which by their nature cannot be verified as correct with absolute certainty. It is best to treat figures of this type, as they do not derive from mandatory financial returns, as approximate. Detail on error margins and the method used is provided in Annex E.

4.1 Estimated spending

Inclusions and exclusions

4.1 The estimates here represent spending on HRS in the 2018/19 financial year (as defined in the Introduction), by the providers and commissioners of support.

4.2 These figures include **all** spending on HRS from **all** funding sources, and are not limited to LA spending or commissioning. RA data published by MHCLG only includes spending by LAs.

4.3 The figures presented here also include spending on support provided to clients who do not live in Supported Housing. Finally, these figures include spending by all types of organisation that may be delivering HRS, including LAs themselves.

4.4 The figures **do not** include spending on Supported Housing more generally, for example spending on its construction, or spending on activities which would equally be carried out in ordinary housing, such as general maintenance.

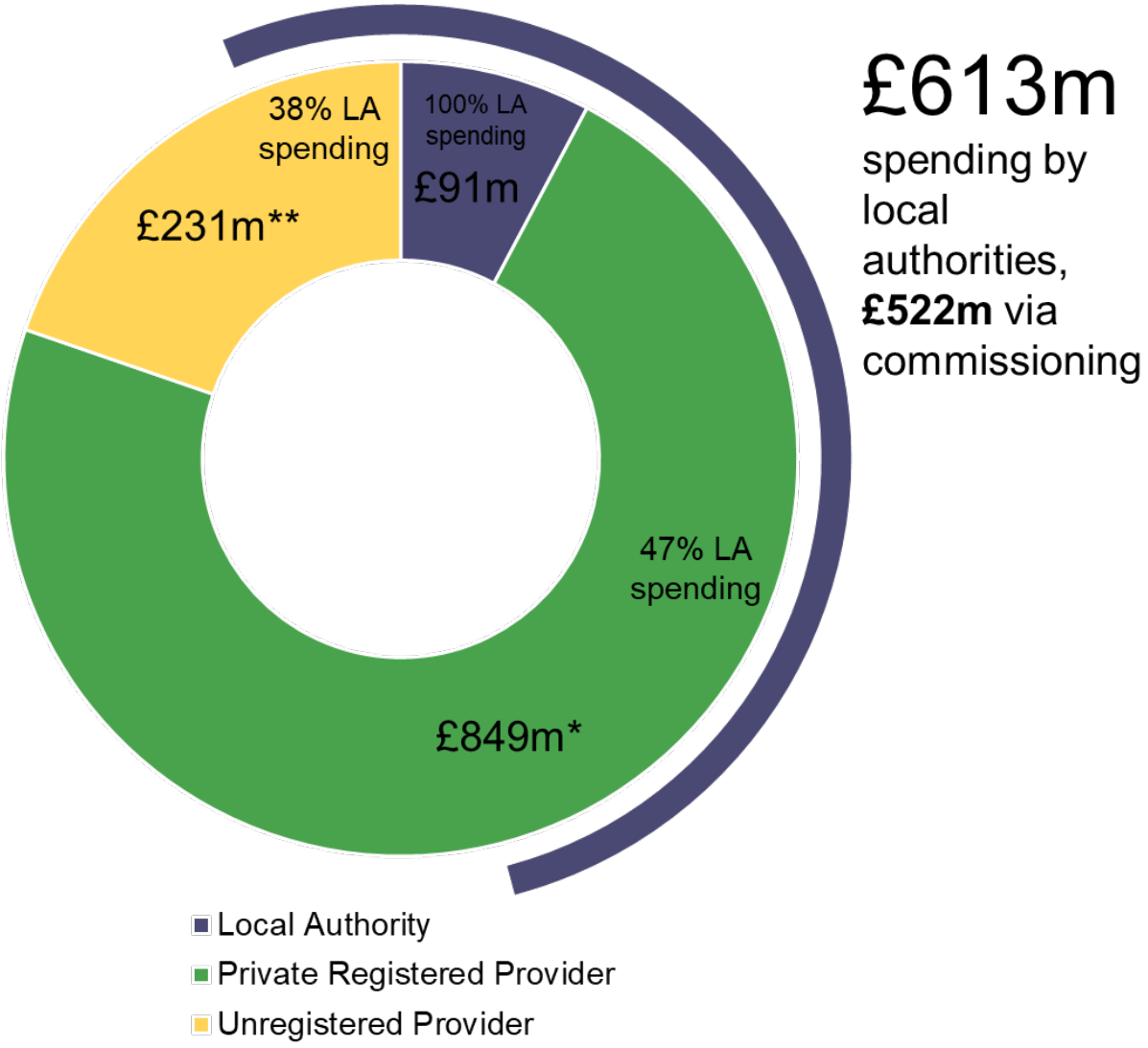
Overall estimates

4.5 As shown in Chart 4.1, LAs in England were estimated to have spent around £613m on HRS in the 2018/19 financial year, most of this on commissioning (around £522m), rather than direct provision (around £91m). This includes all HRS, which is defined to include Floating Support, but not drop-in services.

4.6 Taking into account other sources of funding, including housing benefits, an estimated £1,061m was spent on HRS in England by LAs and PRPs combined in the 2018/19 financial year. Due to data limitations, it is not possible to estimate the

element of spending by Unregistered Providers directly from the data[54]. However, it is no less than £77m (the amount reported as being spent by respondents to the survey). Making a reasonable allowance for non-response as detailed in Annex E means an estimated £231m was spent on provision from Unregistered Providers in the same time period. This should be treated with caution due to the method used to produce it.

Chart 4.1: Estimated spending on HRS in the financial year 2018/19: visual summary



*Source: HRS Review online survey. * Medium and Large PRPs (registered as housing managers for 100+ units of Supported Housing) only ** Indicative estimate*

[54] This is because the sample frame for the survey of Unregistered Providers was incomplete, in that there may have been organisations providing HRS which the databases, free find exercise and promotional activity did not locate. This means that there is no estimate for the total number of Unregistered Providers providing HRS, and so the data cannot be weighted as is necessary to produce representative estimates.

4.2 Rationale for calculating a new estimate

4.7 No reliable estimates existed of spending on HRS prior to the production of this report, since the removal of Supporting People financial data collection requirements in 2010.

4.8 Data is gathered by MHCLG on spending on Supporting People from LAs, as part of the RA returns which are mandatory for LAs to supply. However, the definition used for 'Supporting People' in this data source is ambiguous since the abolition of the Supporting People ring-fence and central direction for the programme in 2009. The definition states that the category in the RA comprises "Housing welfare services provided under the Supporting People programme", alongside a list of types of HRS included. However, the term HRS is not defined in the guidance, and it could be argued that because the Supporting People programme no longer exists, no spending should be registered in this category[55].

4.9 The data might, therefore, exclude some HRS activity and include some other activities. In addition, 23% of all commissioning-level LAs reported zero spending under this heading in 2018/19. In this research, case study interviews with providers suggested that few LAs had ceased spending altogether, which lent support to the view that further work was needed to arrive at a better estimate of spending on HRS.

4.10 The Supported Accommodation Review[56], carried out in 2015/16 for MHCLG, sought to arrive at an estimate of spending on Supported Housing, including spending on the HRS provided to residents (although excluding Floating Support, which is within the scope of this study). However, the research found it difficult to estimate spending arising from LA commissioning. The report suggested, using data from 61 LAs in England, that they might be spending in the region of around £1,582m per annum in 2015 in addition to Housing Benefit spending in England, excluding Floating Support. However, the report does highlight the difficulty that respondents had in providing information, casting some doubt upon the estimate:

[55] Department for Communities and Local Government (2020). *General Fund Revenue Account Outturn Guidance 2019/20.* March 2020. Accessible at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888061/General_fund_revenue_account_outturn_2019_to_2020_specific_guidance_notes_v2.pdf

[56] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector: November 2016.* Available at: https://www.gov.uk/government/publications/supported-accommodation-review

Qualitative evidence from research participants highlighted the difficulty that some local authorities had in identifying this data for all client groups, and the variability of survey responses from Local Authority commissioners, suggests that it is likely that this amount is an underestimate of the actual amount of additional funding. In addition, it is possible that some respondents may have included funding for some client groups that may not be specifically linked to accommodation-based Supported Housing services.

Supported Accommodation Review, pp.63

4.3 Arriving at an estimate of overall spending

4.11 For the purposes of estimating total spending, spending was divided into several sub-types, listed below, a value for each of which could be calculated from the survey (as detailed in Annex E). These were then added together to create estimates. The data gathered from the HRS survey included two broad types of spending, with information about each gathered separately for each organisation:

- Spending on direct provision of support, by PRPs, Unregistered Providers and LAs.
- Spending on commissioning or subcontracting of support, primarily by LAs.

4.12 These two types of spending overlapped. A substantial proportion of the spending by providers was commissioned by authorities, and then delivered by providers which needed to be taken into account to avoid double-counting. To avoid this, spending shown in Figure 4.1 was classified into four groups, or elements of spending, which could be combined to create overall estimates:

1 Spending on **commissioning or subcontracting of support**, by LAs.

2 Spending on **direct provision of support by LAs**.

3 Spending on **direct provision of support,** by PRPs and Unregistered Providers, **funded via LA commissioning**.

4 Spending on **direct provision of support,** by PRPs and Unregistered Providers, **funded from other sources** (e.g. Housing Benefit or charitable funding).

4.13 A small number of PRPs (four respondents) also mentioned that they sub-contracted or commissioned some provision. This small amount of spending was excluded as spending on this HRS would also be included in element 4, via the direct providers.

Figure 4.1: Estimated spend on HRS in the financial year 2018/19: tabulated summary

	Estimated total spending in £ in 2018/19	*Exclusions and notes*
1) LA commissioning	£522m £395m-£649m (±24.4%)	Excluding lower tier LAs without housing stock; also does not include extrapolated figures for authorities reporting between £1 and £1m of Supporting People funding
2) LA direct provision	£91m £61m-£121m (±32.5%)	Excluding lower tier LAs without housing stock
3A) PRP provision, funded by LAs	£401m*	Excludes small Registered Providers with less than 100 Supported Housing or Older People's units under management
4A) PRP provision, not funded by LAs	£448m*	Excludes small Registered Providers with less than 100 Supported Housing or Older People's units under management
3B) Unregistered Provider provision, funded by LAs	~£88m	Amount of funding mentioned in unweighted survey responses was £29m; approximate extrapolation (see above)
4B) Unregistered Provider provision, not funded by LAs	~£143m	Amount of funding mentioned in unweighted survey responses was £48m; approximate extrapolation (see above)
Best estimate of total spending by LAs	£613m £476m-£750m (±22.3%)	Total of estimates (1) and (2) – subject to caveats shown above. Includes both commissioning and direct spending.
Best estimate of total spending by PRPs	£849m £543m-£1,154m (±36.0%)	Total of estimates (3A) and (4A) – subject to caveats shown above. Includes funding received from LAs and all other sources.
Best estimate of total spending by PRPs and LAs	£1,061m	Total of estimates (1), (2) and (4A) – subject to caveats shown above.
Best estimate of total spending	~£1.2bn	Total of estimates (1), (2), (4A) and (4B) – subject to caveats shown above.

*Source: HRS Review online survey. * Medium and Large PRPs (registered as housing managers for 100+ units of Supported Housing) only*

4.14 In terms of the likely direction of any over-estimate or under-estimate in these figures, the evidence is inconclusive. On the one hand, it seems likely that some LAs were making additional spending on HRS which they did not include. Many mentioned in comments submitted with the survey that there were difficulties collating data, or that they were unable to submit costs data for specific services, which could not be compensated for in the calculation.

4.15 On the other hand, some respondents also mentioned that they had included elements of activity not considered HRS in submitted spending figures, due to the

difficulty of splitting out the figures. This usually occurred when care and support commissioning had been combined into a single package.

4.4 Comparison of results with Revenue Account data

Differences in overall spending

4.16 It was possible to compare the HRS spending calculated above with Supporting People spending by LAs reported to central government in the Revenue Account (RA) budget 2018/19 data. In the same period, RA 2018/19 budget data showed budgeted spend on Supporting People activity of £359m.

4.17 As shown in Figure 4.2, the estimates produced from survey data suggested £522m in commissioning for HRS took place by LAs in 2018/19. This is a 61% reduction on the £1,355m of budgeted spending reported in the year 2010/11 in MHCLG Revenue Account data, immediately after the removal of the Supporting People ring-fence. However, this percentage reduction should be treated with some caution:

- The Supporting People category in the Revenue Account data has a definition attached to it which has become ambiguous since the Supporting People programme was abolished, and is therefore filled in to some extent at the discretion of LAs. However, prior to 2010 it was previously clearly defined by the ring-fence, and the online survey was designed to measure provision of the types of HRS which would have been eligible for Supporting People funding.

- It is unclear to what extent HRS services might have also been funded via other budgets (outside Supporting People) prior to the abolition of the ring-fence. No data is available regarding this. However, if there were substantial quantities of HRS in 2010/11 that was funded from sources other than the Supporting People budget, this would make the percentage reduction in funding to 2019 larger, rather than smaller.

- The £522m figure is a survey-based estimate subject to sampling error, as described in Annex E.

4.18 The estimated LA spending on commissioning of £522m is £163m (45%) more than reported in the Revenue Account data for the same period (2018/19). The majority of this additional spending – an estimated £124m, or about 76% of the additional spend – related to survey responses from LAs who registered no Supporting People spending at all in the RA 2018/19 data. This suggests that most LAs who report zero funding in the Revenue Accounts return are spending on HRS to at least some extent.

4.19 The remaining £39m (24%) of the additional estimated funding for HRS identified in the survey estimates relates to potential under-reporting of Supporting People spending, or to spending on HRS which has not been reported as Supporting People activity.

Figure 4.2: Estimated volume of spending on HRS by Upper-tier, Unitary and Lower-tier LAs from the online survey: comparison with MHCLG Revenue Account budget 2018/19 data

Description of value shown in right hand column	*Value*
Total estimated spend on commissioning	£522m
SP spending reported in RA 2018/19 data	£359m
Difference between estimated spend on commissioning from the HRS online survey, relative to SP spending reported in RA 2018/19 data, as a value in pounds	+£163m
Difference between estimated spend on commissioning from the HRS online survey, relative to SP spending reported in RA 2018/19 data, as a percentage	+45%
Base size	*65*

Sources: HRS Review online survey, MHCLG RA 2018/19 budget data

Differences at individual authority level

4.20 Finally, it was possible to analyse differences in spending case-by-case, matching RA 2018/19 budget data with individual survey responses, and comparing the figures provided. A number of groups needed to be excluded, in addition to outliers in the survey data. Those LAs where RA 2018/19 budget data was zero or negative were excluded, due to the mathematical impossibility of calculating a change in percentage terms. Those where funding was very low (<£10,000) were also excluded, due to the likelihood of producing very high percentage change figures. After these exclusions were made comparisons of this type were possible for 49 LAs.

4.21 About a quarter of these LAs (25%) reported substantively higher funding levels (by more than 15%), while eight per cent reported substantively lower funding levels (by more than 15%). Around 15% reported that the funding level was broadly the same.

4.22 Among those LAs that reported any budgeted spending for Supporting People in the RA 2018/19 data, the median level of spending reported in the survey was quite close, at +13%. However, the mean difference in spending was +65%, just over one and a half times the level in RA 2018/19 data. This was similar to the overall spending difference figure reported above.

4.23 This difference in the median and mean is primarily because a very small number of respondents reported very high levels of spending in comparison to RA 2018/19 data. These tended to be larger authorities, including a number of London Boroughs.

Figure 4.3 Total estimated spending on HRS from the HRS online survey: LA-by-LA comparison with RA 2018/19 data, for LAs where spending registered in RA 2018/19 data is greater than zero*

Description of value shown in right hand column	*Value*
% of LAs claiming spending less than 85% of RA 2018/19 figure	8%
% of LAs claiming spending within 15% of RA 2018/19 figure	15%
% of LAs claiming spending more than 115% of RA 2018/19 figure	25%
Median difference in spending among those reporting, %	+21%
Mean difference in spending among those reporting, %	+65%
Base size	*45*

Source: HRS Review online survey.

4.24 From the numeric data alone, collected through the HRS review online survey, it is difficult to suggest reasons for these reported differences in spend levels. It seems likely that some LAs have decided to exclude certain services in their reporting of Supporting People spend in RA 2018/19 data, although to say this with certainty would require a further survey of LAs regarding their RA data completion process. Others (among the eight per cent reporting lower spending) may have excluded services from their HRS online survey return.

4.25 However, comments reported in the survey by individuals who could not provide costs data provides some insight into the reasons why there may be differences between the two sources. In the survey, some respondents not included in the figure above provided explanations for why they could not submit costs data. In summary, commissioners felt that since the removal of the Supporting People ring-fence services are less clearly definable as HRS now. This meant that it was not always possible – or that it was very difficult – to break down spending in these terms when completing the HRS online survey. Similar issues may affect LAs when submitting RA budget data.

The focus on individual client numbers is out of kilter in respect of current commissioning practice. [Our authority] has a number of drop-in duty Housing Related Support [services] for instant access which were not in [the] scope of this survey.

Survey respondent, Unitary Authority

The survey has been broad and, unfortunately, even with input from other colleagues in other directorates, it has been difficult to respond fully, as each area has a different approach to commissioning.

Survey respondent, Unitary Authority

With the demise of the ring-fenced Supporting People grant… services have merged and become less clearly definable as Housing-related Support, and many remaining services include elements of general information, advice and ad-hoc support.

Survey respondent, London Borough

Due to major cuts in local government funding, data and information are no longer collected on a regular basis. [Housing-related] Support has been fragmented across many departments… so although still provided, at lower levels than previously, [data] is difficult to collate. To provide the information required by this survey would require additional resource.

Survey respondent, Unitary Authority

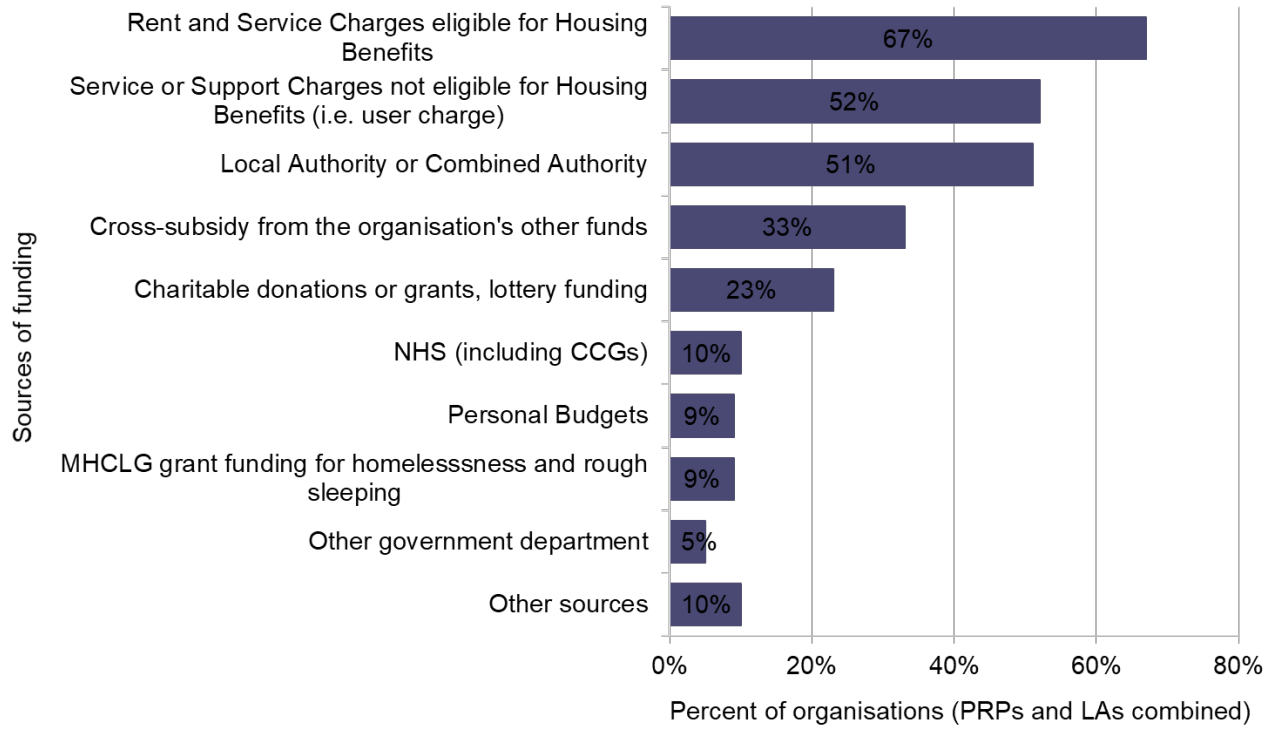
4.5 Sources of spending for direct provision

Sources of funding used

4.26 The survey asked how providers funded their HRS provision, asking which sources were used, in part or in full, to fund these services. As shown in Chart 4.2, among PRPs, and those LAs directly providing HRS, the most widespread (although not the largest in terms of value) source of funding was Housing Benefit (67%), followed by user charges (52%, including service charges not eligible for Housing Benefit) and LA or Combined Authority budgets (51%), via commissioning or allocation of funds within a LA.

4.27 A small number of providers used cross-subsidy (33%) or charitable donations (23%). Central government sources had a relatively niche role, with leading sources being the NHS (10%) and MHCLG (9%), including grants for homelessness and domestic abuse services. Personal Budgets, although mentioned by interviewees in case studies, were not widely used by HRS providers (mentioned by nine per cent).

Chart 4.2: Sources of funding used for HRS provision, in whole or in part, by both PRPs and LAs combined



Source: HRS Review online survey. Base: LAs and PRPs able to specify if each source of funding was used (111 to 122 depending on source of funding, due to exclusion of 'Don't know' responses)

4.28 As shown in Figure 4.4, an estimated 46%[57] of funding for HRS provided by PRPs and LAs came from LA or Combined Authority budgets.

4.29 The only other public body to account for more than one per cent of total HRS funding among PRPs and LAs was the NHS (combining CCGs and Foundation Trusts), which funded an estimated four per cent of provision. Whilst MHCLG and Personal Budgets, were each used as a source of funding by an estimated nine per cent of providers, each accounted for less than one per cent of total funding and are therefore included in 'Other sources' in the chart.

4.30 It was estimated that Housing Benefits, covering rent or service charges (including Intensive Housing Management) were the second largest source of funding for HRS, at 24% of all funding. This was followed by user charges (7%), which make up only a small proportion of total funding despite being in widespread use.

[57] This varies from the figure of 47% used for PRPs in the calculation of overall funding; this is because this figure includes LA direct spending and spending by small PRPs.

Figure 4.4: Sources of funding for HRS: PRP and LA direct provision combined

Name of source	*Category of source*	*% of HRS provision funded by this route*	*Estimated value (£)*
LA / Combined Authority	Commissioning	46%	£488m
NHS	Commissioning	4%	£42m
Housing Benefits*	Benefits	24%	£255m
User charges**	Other sources	7%	£74m
Charitable donation	Other sources	3%	£32m
Cross-subsidy***	Other sources	2%	£21m
Other sources	Other sources	3%	£32m
Don't know	-	11%	£117m
Total	-	100%	£1,061m
Base size		195	195

*Source: HRS Review online survey. *Including rent and service charges within standard Housing Benefit payments, and Intensive Housing Management Payments. This category cannot be further broken down. ** 'User charges' includes only charges which are not payable using Housing Benefit. *** From other departments or activities of the organisation providing the HRS.*

Note on the use of Housing Benefit to fund HRS

4.31 According to benefit regulations, Housing Benefit may not be used to pay for support. However, this survey found 24% of HRS is funded in this way.

4.32 Case studies with both providers and LAs indicated that (as detailed in Chapter 6) a very narrow definition of 'support' was used when determining eligibility for Housing Benefit funding. Typically, only staff time spent on delivering support in the most direct and specific sense was considered ineligible for Housing Benefit funding. The definition of HRS activity that was used for this research was wider than this, as was the definition used to determine eligibility for Supporting People funding prior to the abolition of the ring-fence in 2009.

4.33 To give examples, providers taking part in the case studies reported that they were able to claim Housing Benefit funding for the administrative costs of HRS, for management of certain types of facility or activity, and in particular for 'concierge' type services which might be considered to fulfil a security rather than support role. All of these activities would have been eligible for funding from the Supporting

People programme, and would therefore be included in the definition of HRS given to respondents in the HRS online survey:

> *Please note that for the purposes of this research, we want to include all of the broad types of support services formerly funded by the Supporting People programme, however they are funded today.*

4.34 Providers spoken to during case studies had clearly spent considerable time thinking about the rules for Housing Benefit eligibility, as had those LAs spoken to about the issue. Providers also reported in case study interviews that most LA benefit departments took a great interest in ensuring Housing Benefit funding was spent correctly. It therefore seems unlikely that Housing Benefit is being incorrectly claimed for support on a large scale. However, the research cannot rule out that some of the funding reported in the survey was claimed and paid from Housing Benefit incorrectly. Further research with LA Housing Benefit departments and HRS providers might be justified to determine the extent of this issue.

4.35 The survey did not distinguish between Housing Benefit funding via rent and via service charges. It also did not distinguish ordinary Housing Benefit, which can be paid for any type of housing, and claims made for additional service charges via Intensive Housing Management (IHM), which may be applied for by PRPs managing accommodation which could be argued to have a requirement for more intensive management, for example a Homeless Hostel. Funding from IHM is subject to the same rules regarding funding of support as funding from other Housing Benefit.

4.36 Indicatively it seems unlikely that funding via rent is a substantial component relative to service charges and IHM. It is notable that status as a landlord or non-landlord manager of Supported Housing did not affect use of these funds. HRS providers who manage Supported Housing sourced the same proportion of their funding from Housing Benefit as HRS providers who have no Supported Housing under management (24% vs. 25%). Since case study interviews suggest that organisations which are not landlords of Supported Housing would not have direct access to rental income, this may suggest that income from rent, as opposed to service charges, was not a large component of this.

4.6 Spending on direct provision: detail

Overall spending on direct provision per client

4.37 Most organisations that directly provided HRS supplied figures for the number of clients they provided support for and the associated costs, enabling analysis of spending per client in about two thirds of cases. PRPs reported spending the most per HRS client served in 2018/19, and LAs (where they were direct providers) the least. Figure 4.5 shows the distribution of funding.

Figure 4.5: Level of spending on HRS provision by providers of HRS, from all sources of funding, per HRS client served during 2018/19

	LAs	*PRPs*	*Unregistered Providers*
Under £500	8%	13%	4%
£500 - £1,499	24%	19%	18%
£1,500 - £2,999	12%	20%	19%
£3,000 or more	4%	13%	27%
Don't know	51%	36%	31%
Average (Mean)	£1,700	£2,000	£3,100
Base size	*53*	*142*	*67*

Source: HRS Review online survey.

4.38 Within this, funding per HRS client served varied by organisation size. Unitary LAs spent far more on support per HRS client served (£2,300 in 2018/19) than lower tier authorities (£800 per HRS client served in 2018/19).

4.39 Those providing support to more than 1,000 clients spent less (about £1,600 per HRS client in 2018/19) than small providers (about £2,700 per HRS client in 2018/19) with mid-sized providers of support falling between the two (about £1,700 per HRS client in 2018/19).

4.40 Similarly, those only working with older people tended to spend less per HRS client (about £1,200 in 2018/19) than those working with a range of groups (about £2,200 per HRS client in 2018/19).

Spending on direct provision by level of need

4.41 Although the level of need classification is not consistently used by organisations in the sector, questions were asked regarding the amount of funding by level of need. Among the minority able to answer questions in this format, funding was found to vary substantially by level of need. For LAs and PRPs, the mean spending per HRS client in 2018/19 on high need customers was approximately £2,000 (where this could be given), falling to £1,200 per HRS client among medium need customers, and £800 per HRS client among lower need customers.

Spending on direct provision by location of client residence

4.42 As discussed in Chapter 3, almost all of the organisations directly providing HRS provided it to residents of Supported Housing (defined here to include Sheltered Housing), while a minority provided it to people living in other forms of accommodation. This is reflected in the spending levels shown in Figures 4.6 and 4.7. These are estimated from the proportion of clients stated to be in each form of accommodation (i.e. assuming equal spending on these types of client), and therefore should be treated with caution:

Figure 4.6: Estimated amount of spending on direct provision of HRS to residents and non-residents of Supported Housing

Estimated spending on HRS for…	*LAs*	*PRPs*	*Unregistered Providers*
Supported Housing residents	£84m	£602m	£42m*
Residents of other types of housing	£8m	£247m	£35m*
Total	£91m	£849m	£77m*
Base size	21	95	43

*Source: HRS Review online survey. * Unweighted and not extrapolated*

Figure 4.7: Estimated percentage of spending on direct provision of HRS for each of residents and non-residents of Supported Housing

Estimated spending on HRS for…	*LAs*	*PRPs*	*Unregistered Providers*
Supported Housing residents	90%	71%	55%
Residents of other types of housing	10%	29%	45%
Total	100%	100%	100%
Base size	21	95	43

Source: HRS Review online survey.

4.43 Similarly, nearly all organisations with housing stock provided support to their own residents, while a minority provided to non-residents. For unregistered providers, this amounts to a large proportion of clients, assumed in Figures 4.8 and 4.9 to link to an equivalent proportion of spending.

Figure 4.8: Estimated amount of spending on of direct provision to residents and non-residents of their own housing

Estimated spending on HRS for…	*LAs*	*PRPs*	*Unregistered Providers*
Residents of housing owned or managed by the HRS provider	£77m	£577m	£27m
Residents of housing not owned or managed by the HRS provider	£16m	£272m	£50m
Total	£91m	£849m	£77m*
Base size	21	95	43

*Source: HRS Review online survey. * Unweighted and not extrapolated*

Figure 4.9: Estimated percentage of spending on of direct provision to each of residents of housing owned or managed by the HRS and residents of other housing

	LAs	*PRPs*	*Unregistered Providers*
Estimated spending on HRS for residents of own housing	83%	68%	36%
Estimated spending on HRS for residents of other landlords	17%	32%	64%
Total	100%	100%	100%
Base size	21	95	43

Source: HRS Review online survey.

4.7 Spending on commissioning: detail

Spending on commissioning per client

4.44 Around half of LAs surveyed (46% of respondents) carrying out commissioning provided detailed figures for both the number of clients and the costs of provision, enabling analysis of spending per client.

4.45 On average, LAs commissioned HRS costing about £2,500 per HRS client served in 2018/19. There is substantial variation in commissioning volumes; 15% provided £3,000 or more in total per HRS client served in 2018/19, while 13% provided less than £1,500 per HRS client served.

Figure 4.10: Level of commissioned funding by LAs for HRS, per client served during 2018/19

	All LAs	*LAs with housing stock*	*LAs without housing stock*
Under £500	2%	0%	7%
£500 - £1,499	13%	14%	16%
£1,500 - £2,999	28%	19%	31%
£3,000 or more	15%	22%	7%
Don't know	42%	46%	38%
Total	100%	100%	100%
Average (mean)	£2,500	£2,900	£2,000
Base size	75	46	29

Source: HRS Review online survey. Base: LAs who commission HRS: LAs (75), Stock-holding LAs (46), Other LAs (29)

4.46 It was also possible to assess spending relative to the population of the LAs (using ONS Census 2011 data). The population data from this source, although accurate, is eight years old and the resulting analysis must therefore be treated with caution.

This was possible for just over half of commissioning LAs taking part in the survey, wherever total spending on commissioning was given.

4.47 On average, LAs who commissioned any HRS spent about £12,000 per 1,000 residents on this in 2018/19. This amounted to £13,300 per 1,000 residents among Unitary and Upper Tier authorities combined[58].

4.48 However, there is great geographical variation; among Upper tier and Unitary Authorities, 27% spent less than £5,000 per 1,000 residents in 2018/19, while eight per cent spent more than £30,000 per 1,000 residents. The sample was too small to draw out a clear pattern here.

4.49 All of the LAs that took part in the survey and stated that they spent more than £30,000 per 1,000 residents on HRS in 2018/19 were London boroughs.

Spending on commissioning by level of need

4.50 As previously mentioned, the level of need classification is not consistently used by organisations in the sector. Therefore, it was not possible to establish robust estimates of commissioning variation.

4.51 The consensus from qualitative interviewing and additional information provided from survey responses indicates that commissioning for low need groups (particularly older people living in Sheltered Housing without additional needs) is very rare, with LA commissioning now very strongly focused on those with the highest level of need. This is explored in more detail in Chapter 8, together with other issues regarding gaps in provision.

Spending on commissioning by client group and location of residence

4.52 Qualitative interviews suggest that monitoring of services has reduced since Supporting People, and that there is no longer a consensus that it is appropriate to classify individuals receiving HRS according to a singular client-group.

4.53 Service which cater to multiple client groups are typically funded within a single contract (which may not be itemised by client group), and case-by-case detail monitoring of HRS has reduced greatly since Supporting People. One reported impact of this is that many LAs are likely to be unaware of the exact client group usage for each service.

> *The way we gather our statistics, our service users fall into more than one of these classifications, e.g.: 62% of our service users overall have alcohol or substance abuse issues, 62% have mental issues and many have both.*
>
> **Survey respondent, registered provider**

[58] The small sample size of Lower tier authorities who participated in this research means it is not possible to provide a separate estimate for this group.

A lot of the survey was client group and need level specific which is totally understandable, but our services are more generic. Providers are expected to be person-centred, and not look at categorising people.

Survey respondent, unitary authority

4.8 Summary of key findings

- LAs in England spent an estimated £522m on HRS commissioning in the 2018/19 financial year. This is at least a 61% reduction on the £1,355m budgeted for 2010/11 according to Revenue Account 2018/19 data just after the abolition of the Supporting People ring-fence.

- Taken together with £91m of direct provision by LAs in 2018/19, this amounts to an average of £2,500 spent by LAs per HRS client served in 2018/19.

- There was wide variation from place to place, with no clear pattern. About a fifth (27%) of LAs spent less than £5,000 per 1,000 residents in 2018/19, while eight per cent spent more than £30,000 per 1,000 residents.

- Total spending on HRS (including that not funded by LA commissioning) amounted to £1,061m, by LAs and PRPs combined; including a very approximate figure for Unregistered Providers of £231m brings overall spending on HRS to around £1.2bn.

- LA budgets funded around half of all HRS; Housing Benefits covered another quarter, primarily through Housing Benefit funded service charges. These tended to fund administration and security relating to support, because Housing Benefit rules preclude spending on the staff time spent on the support itself.

- The majority of spending on HRS relates to Supported Housing residents – ranging from 55% for Unregistered Providers to 90% for LA direct provision. LA direct provision goes mostly (83%) to their own tenants, as does a majority of PRP provision (68%), but not Unregistered Provider provision (36%).

5 Commissioning Structures

5.1 This chapter explores the ways in which LAs commission HRS services, including who was involved in commissioning and what types of methods and contracts were used. The chapter is split into three sections. It begins by detailing the range and complexity of commissioning practices that were taking place at the time of the research; the second section discusses the drivers behind different structures and practices as emerged from the case study findings; and the third reports on the impacts that different commissioning structures had on support providers and clients.

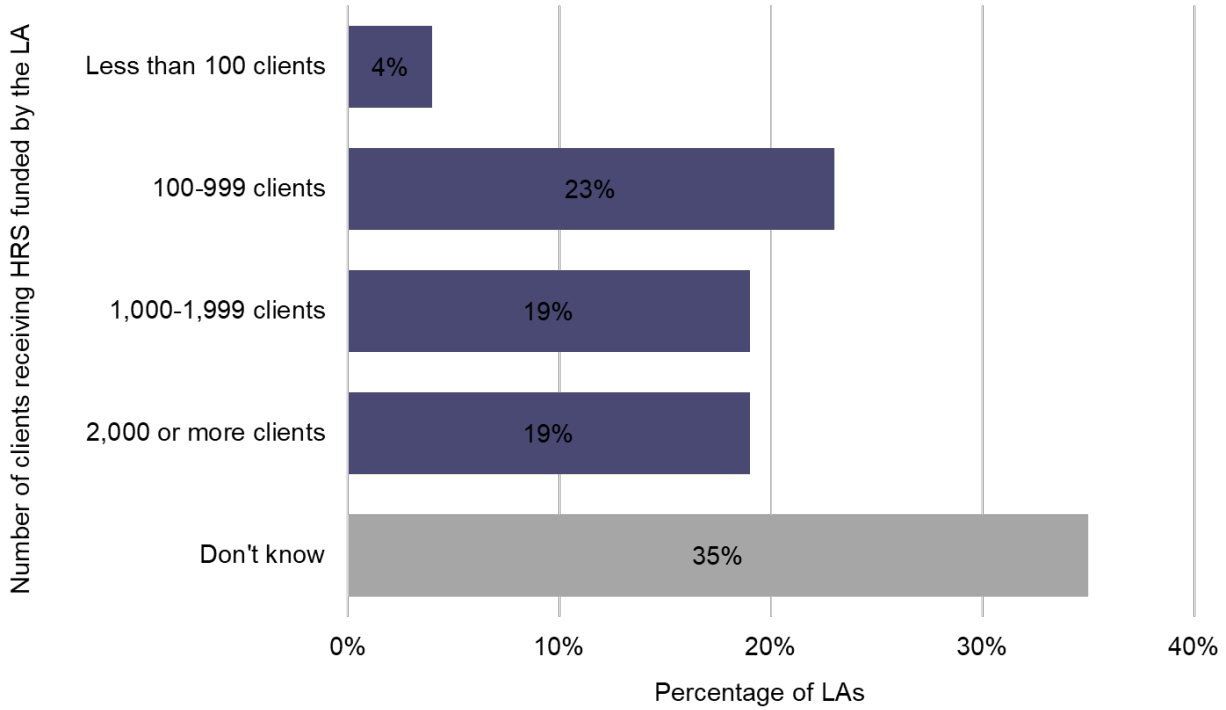
5.1 Variety and complexity of commissioning structures and provision

5.1 As shown in Chapter 2, nearly all LAs commissioned or channelled funding to external organisations for the provision of HRS, and they were far more likely to be involved in commissioning or funding support provision than to deliver the support directly themselves (84% of all LAs commissioned or funded HRS, while 57% provided it directly).

5.2 The volume of HRS provision that was funded or commissioned by LAs varied greatly both by financial spending and the number of clients that received support. The mean number of clients supported by LAs that commissioned or funded support was 2,001, and the median was 1,110. The distribution by size band is shown in Chart 5.1. The range of spending by LAs is detailed in Chapter 4.

5.3 A high proportion of LAs responded ‘don’t know’ to this question because, as stated by some respondents at the end of the survey, many did not commission services for a specific number of clients, or record monitoring data in terms of client numbers.

Chart 5.1: Estimated number of clients who received HRS services commissioned or funded by LAs, per LA



Source: HRS Review online survey. Base: All LAs who commission or fund HRS (75)

How HRS services are commissioned and funded

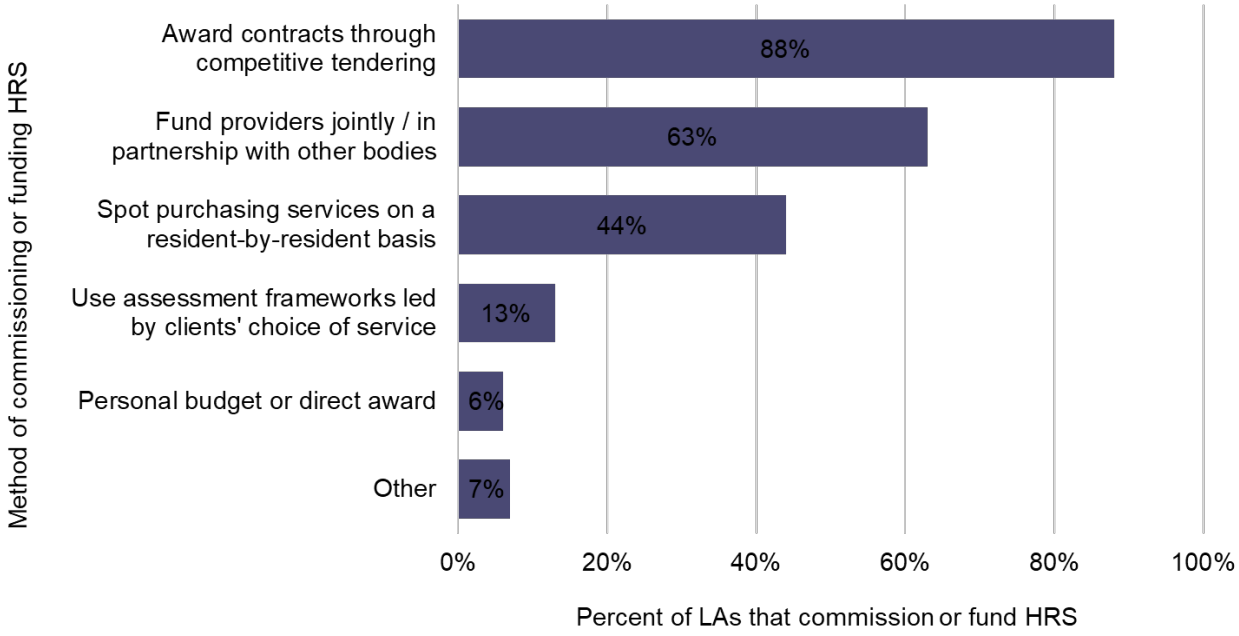
5.4 Since the ring-fence around the Supporting People programme was removed in 2009, LAs have had control over their approach to funding and commissioning, which has led to a variety of models of Supported Housing resource management. The approaches taken are shown in Chart 5.2.

5.5 Nearly all authorities commissioned at least some provision through competitive tendering (88%). It was much more common for unitary and top tier authorities to commission provision rather than fund it in other ways (100% of top tier and 93% of unitary authorities said they commission support compared to 60% of top tier and 55% of unitary authorities who said they provide or channel funding).

5.6 Commissioners commonly purchased support using block contracts in which providers committed to delivering support for a set number of clients in a particular client group or type of accommodation. These contracts were typically awarded through a competitive tendering process while spot purchasing was commonly used as a 'top up' where need exceeded the number of places provided by block contracts.

5.7 As shown in Chart 5.2, when asked how they provided funding for HRS services nearly nine in ten authorities (88%) did so through competitive tendering. Almost two thirds (63%) funded services jointly or in partnership with other bodies and nearly half (44%) used spot purchasing.

Chart 5.2: How services are commissioned and funded



Source: HRS Review online survey.

Base: All LAs who commission or fund HRS (75). Respondents could select more than one option, so percentages may add to more than 100%.

Who commissions HRS services?

5.8 In two-tier LAs, it was the upper tier that was most likely to lead commissioning processes. The survey found that 100% of top tier LAs commissioned or funded other organisations to deliver HRS, compared to only 58% of lower tier authorities. Nearly all unitary authorities (95%) commissioned or funded provision. [59]

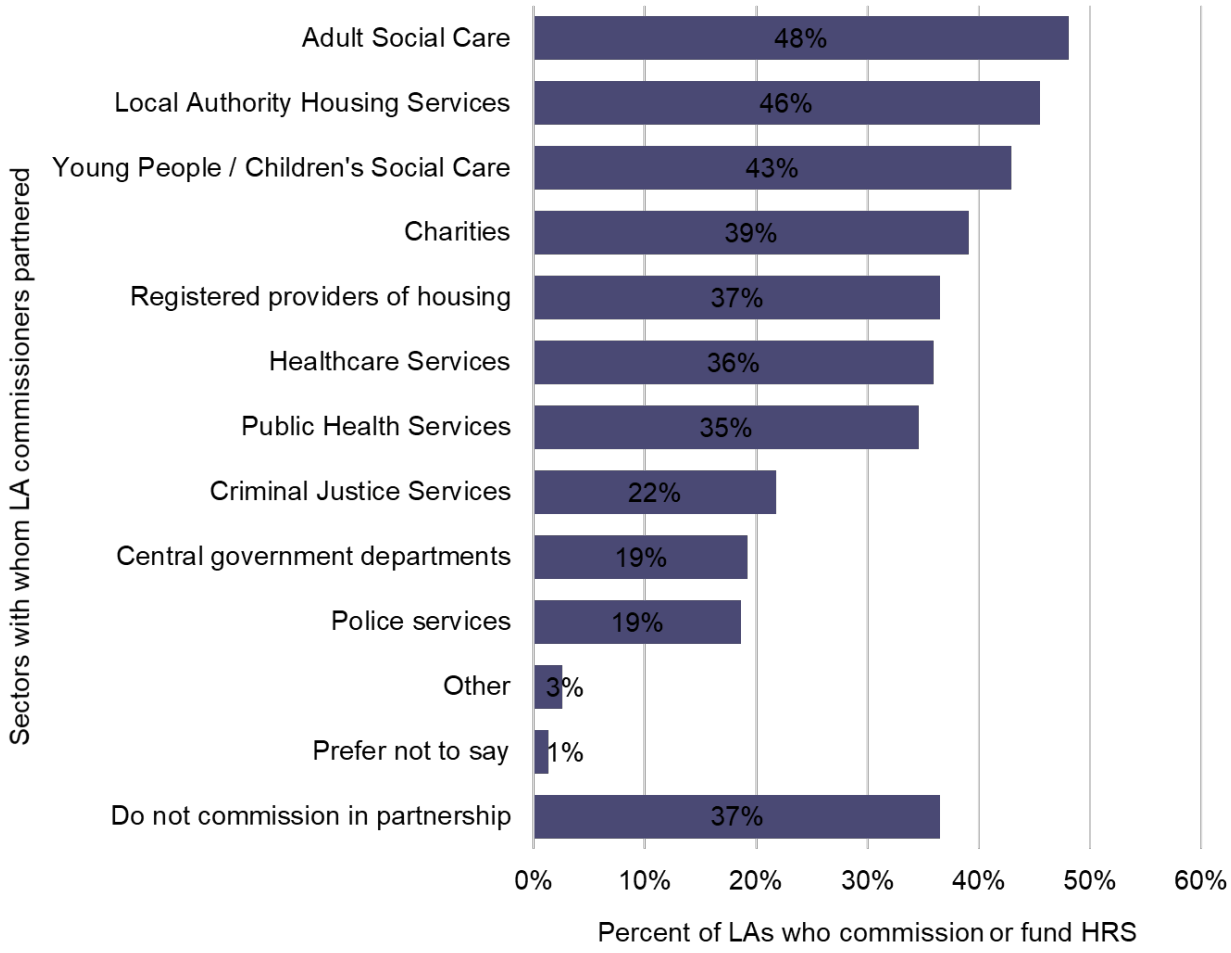
5.9 Qualitative interviews with stakeholders during the feasibility stage and case studies suggested that lower tier authorities are more likely to work in partnership with top tier authorities in commissioning but take a secondary role.

5.10 Commissioning decisions around the provision of HRS were often made through various different departments and teams, typically organised by client group. Departments often worked in partnership with each other or used joint funding sources. LAs reported that moving commissioning responsibilities for certain client groups to another team and taking joint commissioning approaches enabled the delivery of more client-centred, joined up services. However, several providers reported in the case studies that it had led to a more disaggregated and complex system which was difficult to navigate. They sometimes did not know who to contact in the LA, spent more time meeting different commissioning and procurement requirements, and found that some commissioners lacked knowledge about their service due to high staff turnover in LAs. These implications are discussed further below in sections 5.3 and Chapter 6. Of the 63% of LAs that

[59] Weighted data based on an unweighted base of 13 upper tier, 24 lower tier and 61 unitary LAs.

funded providers jointly with other bodies, most worked with departments that would traditionally fall inside their own LA: Adult Social Care, LA Housing services, Young People or Children's services, and a smaller proportion with Public Health, as shown in Chart 5.3. A large proportion however also worked with organisations that are traditionally external to LAs. Over a third said that they worked with charities (39%), registered housing providers (37%) and healthcare services (36%).

Chart 5.3: Sectors with whom commissioners partnered



Source: HRS Review online survey. Base: All LAs who commission or fund HRS (75). Respondents could select more than one option, so percentages may add to more than 100%.

5.11 Case study findings showed that LAs have allocated commissioning responsibilities to different departments in very different ways. As reflected in the survey findings shown in Chart 5.3, four main sectors of LA activity were repeatedly referenced:

- Adult Social Care
- Housing Services
- Young People/Children's Social Care
- Public Health Services.

5.12 In some LAs, all commissioning was carried out within one of these areas, in others it was split across three or four and in one case study nearly all commissioning had been transferred to an integrated Health and Social Care Trust led by an NHS Foundation Trust. The way in which services were commissioned was typically under the discretion of the sector. This suggests that there has been a proliferation of commissioning structures in HRS. Further work would need to be carried out to establish a clearer nation-wide picture of that.

5.13 Figure 5.1 shows a summary of how HRS services were commissioned in each of the six LA case studies. How LAs made decisions about their resourcing structures and commissioning practices is discussed in Section 5.2 below.

Figure 5.1: LA case studies resourcing and commissioning structures

Case study	*Description of LA commissioning*	*Departments and teams involved in commissioning*	*Commissioning methods used*
Case study 1	Three departments conduct commissioning depending on the client group, and services were delivered by seven main providers. Each LA department commissioned through competitive tendering for both accommodation based and floating support.	Service Development & Enabling team in the Housing Directorate, Public Health Team, Specialist Commissioning Team	Predominantly block purchasing of accommodation-based and floating support through competitive tendering, with some additional spot purchasing
Case Study 2	Provision was commissioned by a single team and was split across nine contracts including both floating support and accommodation-based support. They also carried out spot purchasing for individual clients where need exceeds commissioned provision. Provision for people with learning disabilities was managed by Adult Social Care through care packages.	Housing Options team, with support from the Commissioning & Strategic Support Team. Adult Social Care commission support for people with learning disabilities.	Predominantly block purchasing of accommodation-based and floating support through competitive tendering, topped-up with spot purchasing. Adult Social Care deliver support through care packages
Case Study 3	Commissioning sat in a combined Adult Social Services, Commissioning and Public Health Directorate. Provision was split into seven 'Pathways' within which multiple providers deliver support. Each pathway is characterised either by a client group or specialist type or provision e.g. floating support for people with mental health.	Combined Adult Social Services Commissioning and Public Health Directorate	Predominantly block purchasing
Case Study 4	Commissioning occurred within three departments depending on the client group. Two used block purchasing with some 'topping up' by spot purchasing, while the Adult Social Care team commissioned HRS through a County wide framework, using Personal Budgets.	Public Health, Children & Young People, Adult Social Care.	Adult Social Care uses a commissioning framework through Personal Budgets, other departments use Block purchasing with some additional spot purchasing,
Case Study 5	All provision was commissioned through the Adult Social Care department using competitive tendering of both block and spot purchasing depending on the service.	Adult Social Care department	Block and spot purchasing depending on the service
Case Study 6	Most commissioning is conducted by an NHS Foundation Trust, which operates an Integrated Health and Care Trust and holds responsibility for adult social care provision. Services are commissioned through block purchasing, 'topped up' with spot purchasing. The Authority also operate an alliance-based contract for homelessness provision.	Integrated Health and Social Care Trust led by NHS Foundation Trust	Integrated Health and Social Care Trust use block purchasing and some additional spot purchasing. Alliance-based contract for homelessness provision

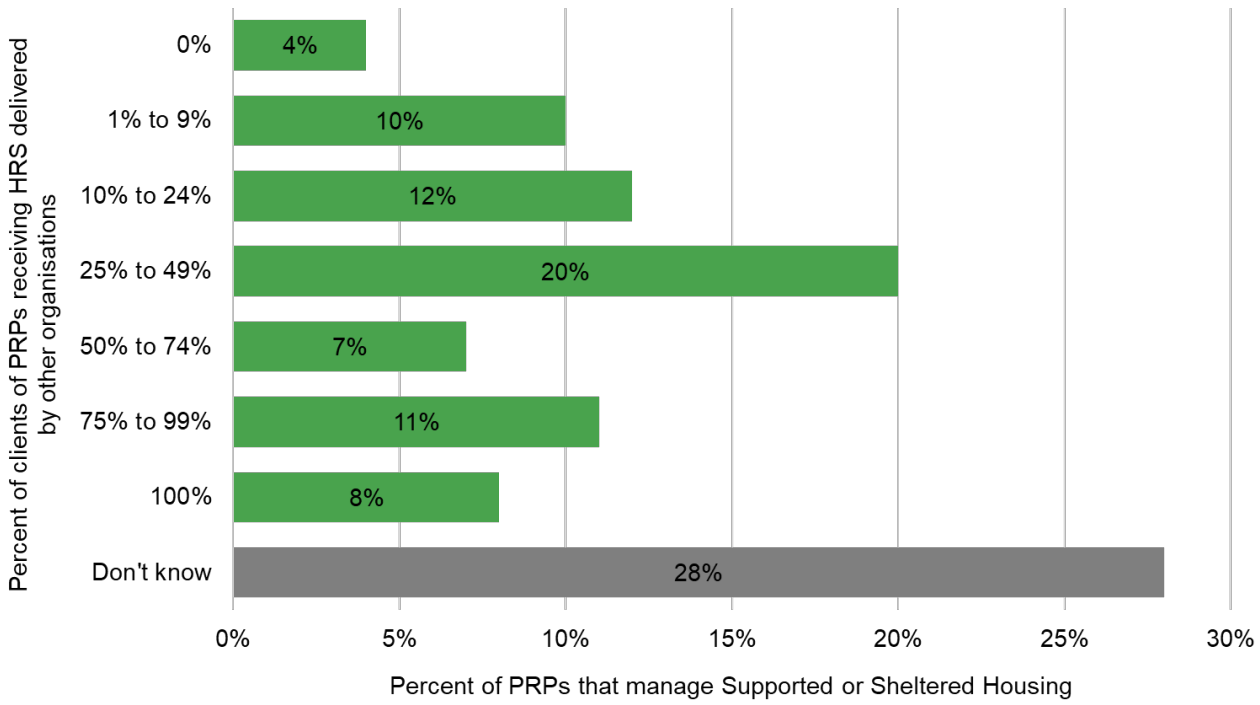
Services commissioned: housing management and HRS

5.14 The number of providers commissioned to deliver the various types of support contracts in each LA case study ranged from six to thirty.[60] Most providers were either large or medium sized Housing Associations, or national /local charities. Only one LA mentioned using a commercial support provider to deliver Floating Support to residents in Sheltered Housing.

5.15 It should be noted that not all organisations that LAs commissioned to deliver HRS owned or managed the accommodation in which support was delivered. It was common for the housing provider to own and/or manage the accommodation (and charge rent and service charges for the individual to live there), and for a third party to provide the HRS to the clients living there. Sometimes the housing provider had also bid to deliver the support function but was unsuccessful while in other cases the housing provider did not offer support at all.

5.16 Chart 5.4 shows data collected from PRPs who managed Supported Housing and presents the proportion of their housing where support is delivered by an organisation other than themselves. One in five (20%) PRPs reported that support is provided by other organisations in 25% to 49% of their housing. Similarly, a quarter (26%) of PRPs reported that for more than 50% of their Supported Housing stock, support is provided by a different organisation.

Chart 5.4: Proportion of Supported or Sheltered Housing managed by PRPs where support is delivered by a different organisation

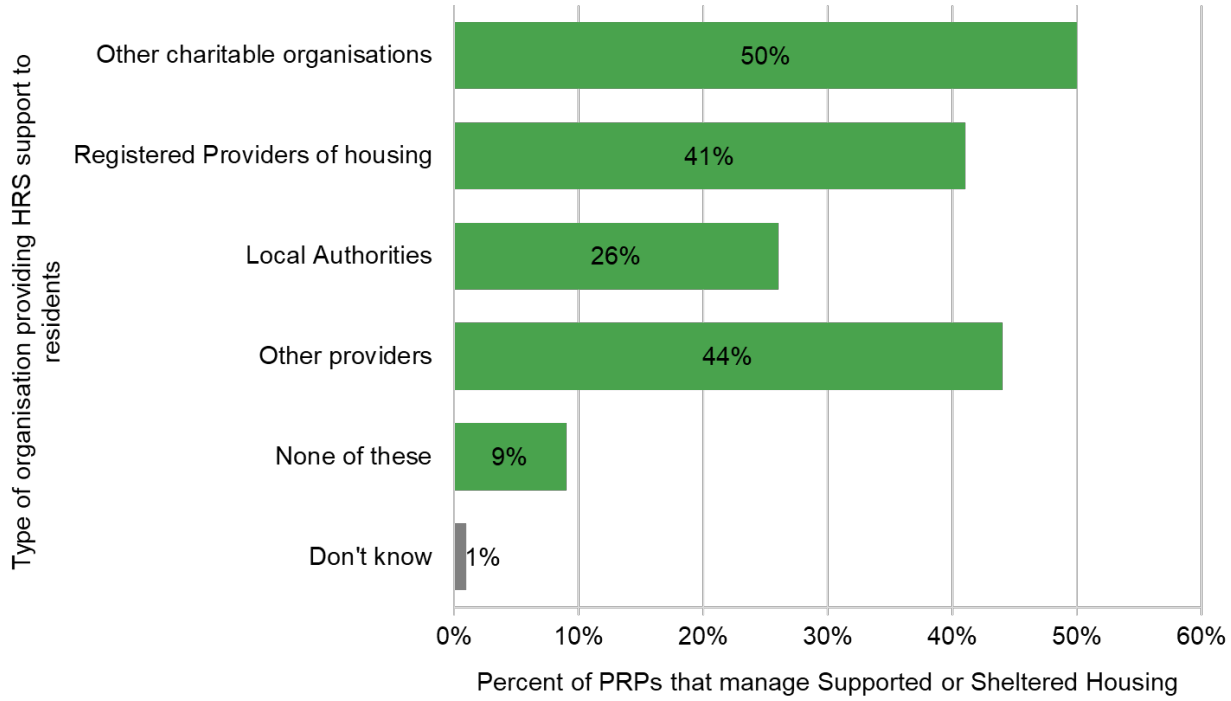


[60] The case study LAs were chosen to cover a range of structures, sizes and geographical locations, so this range of numbers of contracts could be taken to be broadly typical, although it is not a statistical estimate.

Source: HRS Review online survey. Base: All PRPs who manage Supported Housing (46)

5.17 Outcomes from case study interviews suggested that the reason why there was a high proportion of providers who answered 'don't know' (28%) to this question is because providers are sometimes not made aware of services that are commissioned in their housing. The most common type of these 'third party' support providers were charities. As shown in Chart 5.5, half of PRPs reported that some or all of the support element in their supported accommodation was delivered by a charitable organisation (50%), while 26% said support was delivered by the LA and 44% said it was delivered by other organisations.

Chart 5.5: Types of providers who deliver support in supported or Sheltered Housing managed by PRPs



Source: HRS Review online survey. Base: All PRPs who manage Supported Housing (46)

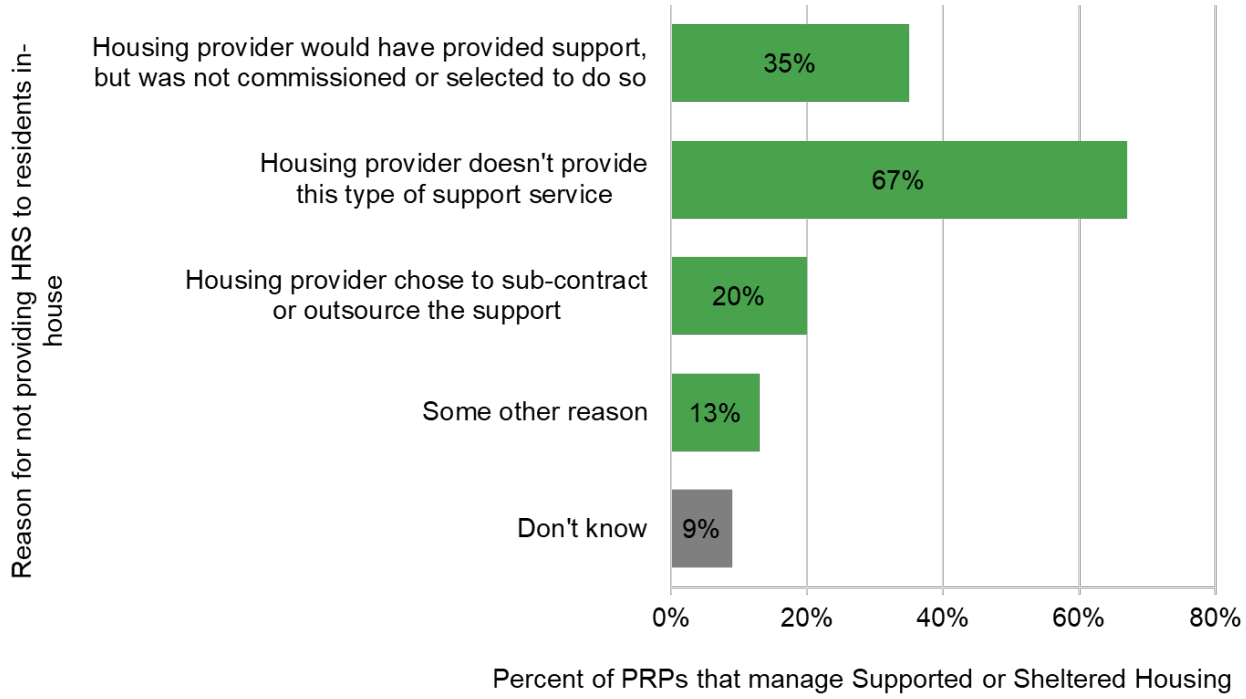
5.18 A similar trend was found amongst Supported Housing managed by stock-holding LAs, of whom 76% managed accommodation where support was delivered by charitable organisations and 50% managed accommodation where support was delivered by PRPs.

5.19 The reasons for the split between the housing management and support functions are shown in Chart 5.6.[61] The majority (67%) of PRPs said they did not provide the support element because their organisation did not deliver the particular type of support. A third (35%) said they would have provided the support but were not commissioned or selected to do so and 20% said they chose to subcontract or

[61] As there can be multiple reasons behind the decision to only manage housing stock and opt for another organisation to provide the support, respondents were allowed to select more than one answer. This is why the percentages shown above add up to more than 100%.

outsource the support to another organisation. By contrast, most stock-holding LAs had chosen to subcontract or outsource the support to another organisation. Only a few said they did not provide the support service. Findings for stock-holding LAs are not presented quantitatively due to a low base size (15).

Chart 5.6: Reported reasons that support is delivered by an organisation other than the housing manager



Source: HRS Review online survey. Base: All PRPs who manage Supported Housing where other organisations provide support (46)

5.2 Drivers behind different LA commissioning structures

5.20 Decisions about the structures and responsibilities of different departments in the six LAs that took part in the case studies were often made by senior personnel, in line with strategic objectives of the authority beyond the provision of HRS. Individual commissioners interviewed were therefore not always fully aware of why their departments were structured in a particular way.

Drivers behind who commissions HRS, and joint commissioning

5.21 Figure 5.1 in the first part of this chapter showed the different departments within the six case study LAs that commissioned HRS. The next section looks at the decisions behind how commissioning responsibilities were allocated across these different departments and why some LAs used joint commissioning approaches.

5.22 Commissioners from LAs who spread provision across several different internal departments, reported that they had diversified in this way because other departments could deliver a more specialised approach that was appropriate to the client group. For example, provision for people with drug and alcohol addictions moved to the Public Health team because the same team also delivered relevant

community services such as drug and alcohol treatment services and understood the complexities and needs of the client, which could inform their commissioning choices.

5.23 Two LAs had diversified provision into three different internal departments. In both of these cases the public health team was responsible for commissioning services for victims of domestic abuse, and people with drug and alcohol addictions. One had different commissioning teams for both of these client groups who understood the needs and demands of the particular groups. For example, a commissioner for victims of domestic abuse worked closely with children's services to ensure that HRS provision was joined up with both preventative support for families and specialist support for children. The other LA also did 'joint working' with the Office of Police and Crime Commissioning for victims of domestic abuse. Under their public health team, they also commissioned HRS provision for homelessness, ex-offenders and drug and alcohol addictions under one service for people with 'complex needs'. This was funded through a separate 'prevention budget' to make services more efficient.

5.24 All case studies commissioned some HRS provision through departments responsible for adult social care, although they varied greatly in how much provision fell under this department and for what purpose.

5.25 In some cases, HRS commissioning for certain client groups sat within Adult Social Care but was commissioned separately to other social care services. In other cases, HRS provision was combined within individuals' care and support packages and funded through Personal Budgets. There were differences between what client groups commissioners included within care and support packages. One LA included people with learning disabilities and mental health problems, while for another, only people with learning disabilities were included and HRS for people with mental health problems was commissioned in their Housing Options team.

5.26 One large support provider who worked with multiple LAs reflected that the joining of HRS and Adult Social Care had contributed greatly to the complexity of the sector.

> *Many commissioners are still commissioning what was a Supporting People service, but it's just not called that any more… generally it's through Social Care budgets that it's done… and I think that's… [one] reason why the complexity has increased, pushing resources to where they are most needed.*
>
> **Provider**

5.27 Two LAs delivered a large proportion of HRS through joint commissioning.

5.28 The first was an inner-city LA with a high number of HRS places. They had undergone a large restructure to strategically align all of their HRS services with Adult Social Care, in the creation of a combined Adult Social Services, Commissioning and Public Health Directorate. This was motivated by the need to take a more strategic approach and bring together related areas to allow the LA to invest more in early intervention and prevention in order to head-off a potential future 'crisis' in adult social care finances. The broad aim was to improve outcomes

in a sustainable way by bringing together key services and 'de-escalating' the need for social care.

Housing Related Support used to 'sit' under the Housing division but bringing it under Adult Care and Public Health has enabled a focus on the individual rather than the housing.

Commissioner

5.29 The safeguarding of vulnerable adults had become a higher priority and they were trying to gather evidence around what savings could be made using this approach.

5.30 The second was a rural / coastal authority which commissioned homelessness services through an alliance-based contract for homelessness provision, and all remaining services through an NHS Foundation Trust which held responsibility for all adult social care provision. The alliance-based contract made up the LA's only homelessness provision and included a Rough Sleeper Scheme which was commissioned through the Housing Options service, and a Housing First style scheme which was delivered in partnership with a European-wide project to end street homelessness. The latter operated with local homelessness organisations focusing on people with complex needs. The alliance included commissioners, partners and providers who worked together to agree a higher-level set of outcomes, determine how to best deliver Supported Housing, and how to allocate the block of funding to deliver the agreed outcomes.

5.31 The approach brought several benefits including a collaborative decision-making process, agreed shared outcomes and it helped to remove structural frustrations. The capacity it took to sustain however posed a challenge.

We meet once a week and that's quite a draw on time, but it's prioritised so we can get together and ask where we are, what are we doing, what do we need to change. We can have those development and strategy conversations all the time.

Provider

5.32 Other LAs who did not commission jointly worked in partnership with other internal and external departments to coordinate provision but the ways and reasons for doing this depended greatly on the individual service.

If we were reviewing a service, we'd obviously engage with stakeholders to ensure that we were going to be delivering the service people wanted, within what housing support needs to do. Providers would be involved, and [we'd consult] professionals, service users, for example the Learning Disability Partnership Board… It depends on what we need to do; we [might convene] a working group.

Commissioner

5.33 A different LA split their accommodation based commissioning and Floating Support for victims of domestic abuse with the Office of Police and Crime Commissioning.

So, there is this arbitrary line down commissioning and between public health in [name of LA] and the OPCC [Office of Police and Crime Commissioning] and we all try to work together but it's not formalised. Community service is very much ad hoc; joint working but not joint commissioning.

Commissioner

Drivers behind the size and allocation of HRS contracts

5.34 Most of the case study LAs split their commissioning contracts thematically by client group and/or support type such as floating or accommodation-based support. An example of these groupings is shown in Figure 5.2 which details the different contracts that were awarded to providers and the number of placements per contract in one rural/urban LA. In this example, support was provided by six different external providers.

Figure 5.2: Example of provision split by contract type in one rural/urban LA case study

Title	*Units*
Accommodation based - offenders/multiple & complex	12 accommodation, 10 floating support
Accommodation based – general, over 25's	22
Accommodation based – domestic abuse	35
Floating - domestic abuse	15 refuge, 60 floating support
Accommodation based – young people*	103
Accommodation based – young people*	79
Floating support – young people	45
Floating support – singles and families, multiple/complex needs	245
Floating support – older people	833
Floating support – mental health	119

*Source: LA data submitted as part of an HRS Review case study. *Accommodation based support for young people was split between two contracts because it was delivered by different support providers*

5.35 By contrast, another case study LA used 30 different providers which were grouped under seven different pathways such as 'Young People's Supported Housing Pathway' and 'Single Homeless Pathway'.

5.36 Most LAs interviewed had gone through a retendering process in recent years, since the lengths of contracts are generally around three to five years. When retendering they usually aimed to design their contract allocation and size to reflect local need, and to improve the efficiency with which the available funding was spent, in terms of the type of support or accommodation required and/or geographic spread. The processes LAs use to determine local need are discussed in Chapter 7 of this report.

5.37 A rural LA had recommissioned their HRS contracts for homelessness accommodation in part to reallocate the supported accommodation more evenly across the major towns in the County. Before this, the amount of accommodation was fairly uneven across the different regions because they had transitioned from being a two-tier authority to a unitary authority, and under the two-tier system the four different boroughs had commissioned varying amounts of provision.

5.38 One inner city LA had reviewed and overhauled their HRS commissioning, motivated in part because their monitoring systems had revealed high demand relative to supply for some services, yet at the same time some other services were relatively lightly used. While a key aim was to achieve efficiency savings, at the same time, the rate of pay for some of those delivering the support had to increase due to the commitment by the council to pay the Living Wage. The process had proved quite complex and was ongoing at the time of the research.

> *I don't think [cutting services] is something that [our LA]… want to do, but we do need to make sure that we're more efficient in what we do… That's why we did… do a review of Housing Related Support services… we wanted to make sure that actually, that [budget] was actually… delivering services to the people we'd identified.*
>
> **Commissioner**

5.39 There was one instance in which one department within an LA had not yet undergone a recommissioning process and contractual arrangements with providers for that client group had remained as they were before the ring-fence around the Supporting People programme was removed in 2009, and were renewed on an annual basis. Commissioners had difficulty monitoring these contracts and could not be sure that they were meeting the current level of need in the area, although they knew they were meeting a need as accommodation was in high demand. The Authority intended to recommission those services in the near future.

5.40 Another consideration when allocating contracts was ensuring control over the quality of support delivered and consistency of specifications across different providers. For this reason, it was beneficial to have fewer providers and contracts to manage. One large rural LA had reduced the number of providers they worked with from 100 to ten. They moved to a commissioning 'framework' structure (a 'pseudo dynamic purchasing system') five years ago after seeing a substantial increase in demand. Their aim in reducing the number of private providers they worked with was to instil better control of quality and have more consistent service specifications.

5.41 Having a large number of providers could also pose problems around new clients being accepted into services. A different LA described how in the preceding commissioning period providers had often refused to take on new or difficult cases and 'bounced' referrals between themselves. The Authority had therefore tendered new contracts with the hope of attracting consortium bids through which providers would cooperate better. In fact, they did not attract any consortium bids but instead reduced the number or providers to six, most of whom were locally based charitable organisations who cooperated well together. One of the providers had the

impression that the tendering process had focused on local need and knowledge which enabled them to compete fairly against larger national providers.

5.42 The use of smaller local providers however posed a risk of suppliers being heavily dependent on a single contract. The provider described above had had concerns over the viability of the contract as funding had been reduced and they had to cut staff (this is discussed further in Chapter 6). Another LA tried to balance the risk of giving too much provision to a single provider with the ease and cost-saving it bought through reduced administration costs.

> *It's much easier to manage one contract… because if we had a contract for each of those five elements, we'd have five different contracts, we may have five different commissioners, five different sets of outcomes… and five different payments to chase if anything went wrong. So yes, it's much easier to have one contract, administratively... [But] if you lose a huge single contract, it's a big hit to the organisation, whereas if you have six or seven contracts, you're probably going to keep three or four of them… but for us it's much easier to have large contracts.*
>
> **Provider**

5.43 Findings here suggest that LAs tended to split their commissioning contracts by client group and/or support type (floating support or accommodation-based support). Several LAs we spoke to had recently gone through a recommissioning process to ensure the allocation of contracts enabled needs to be met as efficiently as possible, both in terms of geographic spread and types of support per client group.

5.44 Another consideration when allocating contracts was ensuring control over the quality of support delivered and consistency of specifications across different providers. Using a smaller number of large providers, made it easier to monitor quality and efficiently allocate new referrals, however it also involved risking suppliers becoming heavily dependent on single contracts.

Drivers behind the length of HRS contracts

5.45 Figure 5.3, based on survey findings, shows that the majority of LAs who commissioned or funded HRS services did so over periods of three to five years, and that this was the same across all client groups. It was marginally more common for commissioning for older people to be over a longer period, with a quarter (24%) using commissioning or funding periods of over five years, compared to homelessness (11%) and domestic abuse commissioning (7%), and non-client group specific commissioning (none gave this response in the survey)..

Figure 5.3: Length of time support services were typically commissioned or funded by LAs per client group

Client group	*Base*	*Less than 1 year*	*1 to 2 years*	*2 to 3 years*	*3 to 5 years*	*More than 5 years*	*Don't know*
Support which is non-client group specific	*27*	-	21%	-	66%	-	7%
Older People	*42*	-	9%	5%	51%	24%	9%
Adults who are homeless, or at risk of homelessness	*59*	-	13%	6%	65%	11%	-
People at risk of domestic abuse	*46*	6%	-	-	76%	7%	-
Offenders, ex-offenders, or those at risk of offending	*25*	-	12%	5%	67%	13%	-
Vulnerable young people, including care leavers	*53*	-	9%	11%	69%	7%	-
People with drug or alcohol misuse issues	*31*	10%	10%	7%	62%	11%	-
People with learning disabilities	*40*	-	-	5%	66%	18%	9%
People with physical or sensory disabilities	*21*	-	-	-	82%	18%	-
People with mental health issues	*48*	-	-	-	74%	17%	-
People with multiple complex needs	*34*	-	-	-	77%	16%	-

Source: HRS Review online survey. Base: All LAs who commission or fund HRS (varying bases). Figures in bold signify most frequently selected period per client group. The dashes represent percentages lower that 5, as they would have a very low base.

5.46 Case study findings however illustrated a more nuanced picture. As different departments or commissioners within LAs often commissioned HRS contracts separately, it was possible for the length of contracts to vary depending on the service. In one example, most contracts ranged from three to five years except for rough sleeping services, which were only awarded one year at a time. In another, the commissioning period was traditionally four years but has moved to between two and three years with the possibility of an extension for a further two.

5.47 It was felt that a flexible approach was important for the LA:

> *It's difficult to say at this moment because how we'll commission through the new DPS* [Dynamic Purchasing System] *is on an individual accommodation basis. We may see that what's come out of the strategic review is something different than what we had planned so we may have a shorter contract duration within parts of the county than other parts of the county. We're tendering the new contracts in the next few months so by that time we need to have made a decision on contract duration, but I wouldn't say they'd be set in stone.*
>
> **Commissioner**

5.48 All but one of the case study LAs said that most or all of their contracts had an initial period (of usually between two and three years) with the possibility of several one-year extensions. The disadvantages of shorter contracts were that it provided less financial security for providers, and additional time and costs for the LA in going through a recommissioning process (which could take up to 18 months to complete). A structure that allowed for a break and a series of extensions therefore gave LAs the option of avoiding the recommissioning process and retaining some control so that they could manage the risk if a provider was underperforming.

5.3 Impacts of different commissioning structures

5.49 This section details some of the impacts that current commissioning structures had on providers of HRS. Other impacts are discussed in Section 5B, which focuses on changes that have occurred in commissioning and funding since the 'ring fence' around Supporting People funding was removed in 2009.

The impact of commissioning approaches on providers

5.50 Tendering processes were often resource-intensive for both the LA and providers. Completing background documents and compliance and governance checks and uploading to procurement portals could be particularly time-consuming for providers.

> *I know that's for scoring and parity of documents going in. For providers it's just how do you have the right people submitting the documents and securing the tendering when you know you've already been providing the services*
>
> **Provider**

5.51 Multiple commissioners and providers commented on the advantages that large providers have over smaller ones in this process and some commissioners had made efforts to try to 'even the playing field' in this regard.

Some of the bigger providers… they'll probably have a team of bid-writers in their office, and they throw the tender to them… and they wax lyrical, and they just know how to get the marks. But a smaller, specialist provider, who's not used to bid writing, to tendering in the same way, can sometimes fall at the first hurdle. And the impact is that you might not always get the best provider…

Commissioner

5.52 Providers also found that the common approach to contract lengths of between three and five years left them with little stability in terms of their future income, which impacted negatively on their ability to plan, recruit and retain staff or invest in innovative practices.

[Most services] tend to be commissioned on a 3+1+1 [year] basis – and that's a real challenge for us… We're trying to develop [property]… to meet those Local Authority needs. But because they can't project too far into the future, there's that lack of commitment, which means in terms of the real innovation you want to do, you're limited… If a commissioner commits to something for 7 to 8 years, you're in it for the long term, and you can develop and innovate in that more certain future.

Provider

5.53 However, where commissioning practices were merged with Adult Social Care and used Personal Budgets, there were no contracts or fixed contract lengths which one large provider found had substantial advantages over a contract-based approach, because it offered them the financial stability they needed to invest in the longer term.

[This approach] means more lifetime [contracts] for customers, which builds a stability in what we do… [It] means that we're able to project further ahead in terms of what we develop, from an asset point of view… it gives us that long-term sustainability, and stops that churn of services, the constant changes of direction based on changes of priorities from local authorities.

Provider

The impact of complexity and variation

5.54 Many of the LAs who took part in the case studies had undergone a restructuring process in recent years which involved staff moving around or out of the LA, and responsibilities for HRS provision being transferred to different departments. This created challenges for providers in some LAs in keeping track of which individual or department they needed to communicate with. It also posed a challenge for conducting research into HRS as it was difficult to locate individuals with relevant knowledge and responsibilities.

When I think of [places where we have the best relationships], the commissioners are the same commissioners who have been around since the beginning of Supporting People… Elsewhere we've seen levels of commissioner [turnover] that has been unprecedented… you might have seen 6 or 7 different commissioners in the space of 3 or 4 years. They don't know the history, they haven't got that background, and they don't understand the nature of the services, so it tends to be more of a paper-based exercise [there].

Provider

5.55 For one national provider of HRS, the move from a more standardised approach under Supporting People to a more diverse and variable commissioning environment required them to be more flexible. They found that there was great geographical variation but no particular pattern or regional trends in how services were commissioned. Although some of the changes to commissioning introduced LAs were welcome, the lack of a standardised approach was a substantial drain on resources.

5.56 Qualitative findings suggest that since the ring-fence around Supporting People was removed in 2009 the landscape of provision has diversified, although we acknowledge that this may not have been the only driving factor behind the changes. Quantitative data also shows that in many LAs responsibility for commissioning is spread across several departments. The variety of the different approaches, departments and external bodies involved in LA commissioning of HRS services, and the complexity of the different provision structures and organisations delivering it demonstrate that there is no single, universal way of cataloguing or monitoring services across England from a central government perspective.

5.4 Summary of key findings

- Nearly all unitary authorities (95%) commissioned or funded provision. In two tier LAs, 100% of top tier LAs commissioned or funded provision compared to 58% of lower tier authorities. Lower tier authorities were more likely to work in partnership with top tier authorities but take a secondary role in commissioning

- Nearly nine in ten LAs (88%) who commissioned or funded HRS did so through competitive tendering, almost two-thirds (63%) funded services jointly or in partnership with other bodies and nearly half (44%) used spot purchasing

- Case study findings showed that responsibility for commissioning HRS services have become more dispersed since the ring-fence around Supporting People was removed. LAs have allocated commissioning responsibilities to different departments in very different ways, making it difficult for providers or other external bodies to identify a clear point of contact within LAs for HRS services.

- Commissioning responsibilities typically fell under one or more of the following sectors: Adult Social Care, Housing Services, Young People/Children's Social Care, Public Health Services although in some LAs all commissioning had been

transferred to a joint health and social care department or trust, in collaboration with the NHS

- Contracts were often split between different client groups and/or support type such as floating or accommodation-based support, with key considerations being to ensure the quality of support delivered and consistency of specifications across different providers.

- The majority of LAs that commissioned or funded HRS did so over periods of three to five years however case study findings showed these periods often included break clauses after two or three years with repeated one-year extensions. These short contract lengths could impact on providers' financial stability and inhibit their planning, thus hindering innovation and creating difficulties for staff recruitment and retention.

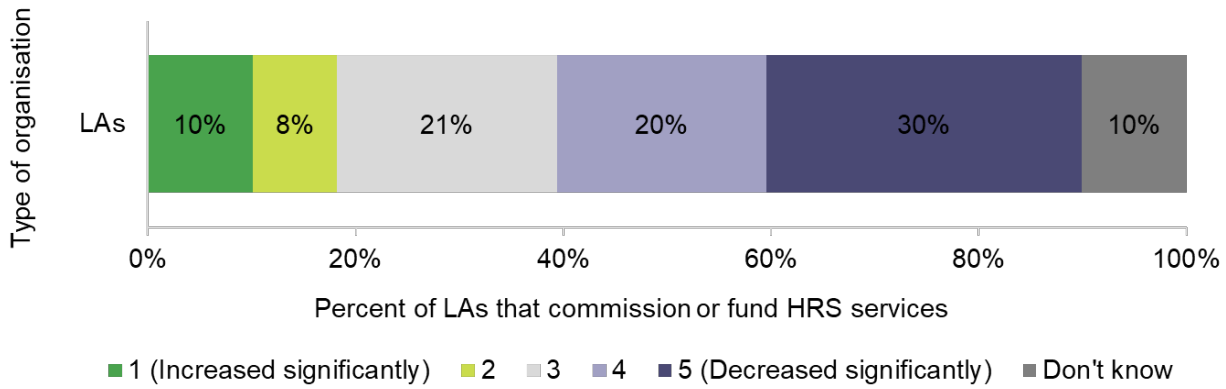
6 Changes in funding and perceived impacts on commissioning practices

6.1 This section examines changes to LA funding and commissioning practices since the removal of the 'ring fence' around Supporting People budgets. Sections 6.1 and 6.2 describe how overall funding levels of LA commissioned services are reported to have changed and the various impacts that these changes may have had on the types of services that LAs commissioned. Sections 6.3 and 6.4 examine how providers have become more reliant on Housing Benefit and Intensive Housing Management, and how changes in LA commissioning practices look to have impacted the staffing of providers and the wider market of HRS.

6.1 Changes in overall funding delivered LAs

6.1 Survey responses show that half of LAs reported an overall decrease in spending on HRS including Floating Support since 2014. Chart 6.1 shows that 50% of LAs had experienced a reduction in funding, with 30% reporting that funding had 'decreased significantly'. Meanwhile, 21% of LAs suggested there was no change in funding, and 18% had experienced an increase in spending.

Chart 6.1: Reported trends in the amount of funding LAs direct to HRS services since 2014[62]



Source: HRS Review online survey. Base: LAs who commission or fund HRS services (70)

6.2 All but one of the seven LAs that took part in the case studies reported undergoing funding reductions over recent years or since the ring-fence around Supporting People funding was removed. Examples given included:

- a reduction of overall spending from around £20million in 2003/2004 to around £3.5million (in an inner-city unitary Authority)

[62] Where responses from individuals in the same LA conflicted, this chart reflects the most positive responses.

- a budget reduction of 73% a few years ago (rural/coastal top tier Authority)
- a reduction of overall Supporting People program to around three quarters of its previous provision since the Supporting People 'ring fence' was removed (mixed urban/rural unitary Authority)

6.3 Case study findings suggested that some reductions had been made around the time that the ring-fence was first removed in 2009, but substantial reductions had also occurred in recent years. The following quotation is from a national HRS provider:

> *Just three years ago… just under 50% of our Supported Housing revenue was from [LA commissioning] and now it's just under 45%...*
>
> **Provider**

6.4 As with commissioning practices, the reported level of reduction in spending varied substantially by local area. It was very rare for LAs to report that funding had been entirely removed; some did decline to take part in the HRS online survey on this basis, but it could not be conclusively determined whether those declining the survey were fully informed regarding the full range of their organisation's activities. However, funding was sometimes collapsed into other budgets. As detailed in Chapter 5, in some instances LAs reported that services for certain client groups had been moved into Adult Social Care and funded through individuals' care and support packages, meaning that reductions in overall funding were difficult to quantify. Some interviewees from a national provider, however, did believe that LA funding had been removed entirely in some areas. However, this view was only reported by one provider case study who operated over a wide geographic area and further research would need to be carried out to determine whether this is the case.

6.5 In addition to overall reductions being commonly reported, case study and survey findings also suggested that sources of funding had diversified away from Supporting People budgets. Upper tier/unitary Authorities often stated that they had diversified through the Public Health team and Adult Social Care (as discussed in Section 5A), while lower tier Authorities also reported they had to diversify funding, with several using their homelessness prevention budgets for HRS functions.

> *The Council uses a combination of MHCLG, [name of County Council] and its own funding to fund Homeless Link Workers who provide Floating Support to currently homeless customers and to formerly homeless customers to ensure that they are able to sustain a tenancy when rehoused.*
>
> **Survey respondent, District Authority**

> *[HRS] withdrawal also meant a mother and baby hostel in our District was set to close, meaning a loss of eight bed spaces for those who might otherwise be homeless. We have funded the support provided in the service for the past two years at over 50k per year in order to keep the*

premises open. We have used our homelessness prevention grant to cover the costs.

Survey respondent, District Authority

We have used homeless prevention funding to set up a Housing First Model, which does provide Supported Housing for adults who are homeless with drug and alcohol issues.

Survey respondent, District Authority

6.6 One case study LA explained that their funding was under pressure from general funding cuts to the LA budget as their provision was a non-statutory requirement, which meant that the funding remaining to them tended to be short-term and drawn from multiple sources. They also stated that it was partly contingent on making successful bids. The pressure to secure funding from different sources and make funding bids was reported to be a challenge for commissioners.

The challenge is pulling together from different funding streams. We have to bid for some funds and it always feels like a temporary solution.

Commissioner

6.7 This LA was working to try to put funding on a more sustainable footing, as their view was that longer-term funding allocations which were ring-fenced for HRS would enable them to provide better quality services, earlier intervention, and ease difficulties in recruiting and retaining staff (challenges in these areas are examined in more detail below). They cited the NHS's Ten-Year Plan as a good example of longer-term strategic planning which they felt should be emulated for HRS provision. Their aim was to conduct longer-term planning to enable them to work in partnership with others more effectively and build a more place-based approach to developing support services in socially deprived areas, focusing on prevention rather than crisis intervention.

It should mirror the Local Authority's financial planning cycle which is planned across five years and then annually reviewed. That level of commitment would be really useful.

Commissioner

6.8 In response to uncertainty around future funding, LAs reported making more use of contracts with break clauses, which meant for example, that a typical three-year contract model with the possibility of two, one-year extensions only offered providers financial security for the initial three years. It was clear from the case studies that as reductions in funding became more commonplace, these break clauses had become very real review points in contracts, and extensions at the same level of funding, could not be assumed. One case study LA commissioner was uncertain whether their current contracts would be extended beyond the break points as funding had become less secure than they had first envisaged, and another had reduced the hours of support delivered in the contract before extending it due to funding cuts.

6.2 Changes to the types of services commissioned by LAs

6.9 LAs reported that changes in funding led to a variety of changes in the HRS services they commissioned. This section describes some key trends and common changes that have occurred, based on findings from case study research and open text survey responses. Changes to specific client groups that led to gaps in support provision are discussed in detail in Chapter 8.

Changes to the type of support delivered

6.10 Nearly all case study LAs suggested that decisions around how to implement funding reductions were driven in many cases by which services fulfilled a statutory duty for the LA and which did not. For example, one commissioner said that they decided what services to deliver by prioritising statutory duties, and choosing other provision based on demand and what funding they had remaining. In several LAs this meant that Floating Support services were reduced or removed entirely.

> *So, when services like this aren't ring-fenced and aren't mandatory, I mean the housing element probably is but for the Floating Support element, there is nothing in statute to say we have to deliver it, it makes it likely to get cut unfortunately.*
>
> **Commissioner**

6.11 Another Authority which underwent substantial reductions in spending described the impacts of the removal of their Floating Support service to young people. They observed that young people often had complex needs and were not achieving the desired outcomes of supported accommodation. Interviewees reported that they were *"bounced around the system"*, often ending up in rough sleepers' provision when they were older because the Authority was unable to offer them sustainable long-term independent living. The authority had previously delivered two Floating Support services which were worth about £300,000 each for 18-25-year olds. Now they were still providing housing units but all outreach work (which they felt was important to achieving positive outcomes) had stopped.

6.12 Some LAs reported that they had shifted their provision towards crisis intervention or clients with high needs rather than delivering support to those with lower level need that may prevent the onset of a crisis. This is discussed further below and at the end of Chapter 8.

6.13 There was mixed evidence from the case studies around whether reductions in funding had encouraged or hampered innovation. One LA who commissioned a large amount of provision said that funding reductions had forced them to do more with the services they had. They had developed a scheme for young care leavers who had children, living alongside older people to build inter-generational networks and encourage learning from each other. They also had another project where eight 'local connectors' build links with over-55s in their locality to reduce social isolation and loneliness. Commissioners felt that this innovation had become more important as adult social care reached a 'crunch point' in terms of funding and demand, which demanded a shift to an early intervention focus where possible.

We have to think about innovation in terms of how do we reduce the need for spend? Austerity is a painful process, but it has forced the need to think more creatively about how we spend.

Commissioner

6.14 Conversely, it was reported that the reduced amount of funding available had meant that commissioners and providers had less freedom to try new ideas or think creatively about how to deliver better quality services. Another LA, for example, witnessed an increasing need for higher levels of support for young people but reported that they did not have enough funding to develop models of service to meet that need.

The demand in terms of young people is for services the deliver higher levels of support and that costs money. They need overnight cover. With more money we could innovate and develop different models of service provision and our providers are good at looking at what they can do in that regard. The providers are restricted, by what we can offer them.

Commissioner

6.15 Even the LA referenced above which had successfully found more creative ways of delivering their services felt that they had then been put at risk for further reductions. They were concerned that because they had been relatively successful in improving client outcomes with limited funding, this in turn meant they had attracted greater scrutiny from senior roles and further austerity pressure.

We can flex funding across services to an extent – the real challenge is when the funding ends and what the fallout is then for the service, the clients and the staff. Continuity of funding is a key issue from our perspective. This LA is keen to keep services going so we have had to review and re-galvanise contracts and manage them across different pots of funding, which is very challenging.

Provider

Changes to support in sheltered accommodation

6.16 HRS to residents of Sheltered Housing for older people had commonly ceased to be funded in support terms, causing a reduction in the support available in these schemes. Case study LAs reported that these were often among the first services to be lost when the ring-fence around Supporting People funding was removed, although there was evidence of reductions in more recent years as well. Instead, LAs reported that there had been a widespread shift in the funding of older people's services from LA support grants to charging additional service and rent charges which could be funded through Housing Benefit (this is discussed in more detail in section 6.3 below).

We've a [number] of older people's services [formerly with low level support], but of course they don't get funding from local authorities anymore. They used to, but that's all fallen away…

Provider

In adult social care, we only commission Housing Related Support services for socially excluded groups. In 2017/18, we undertook a large review of all HRS services and decommissioned all Sheltered Housing schemes and support for people with a physical or sensory impairment, and most of LD services (apart from Floating Support).

Survey respondent, County Council

Funding for our Sheltered Housing support was completely withdrawn a couple of years ago and we have been subsidising the service from our Housing Revenue Account since. We are now looking at ways we can charge a greater proportion of the service to housing benefits. The range of older persons requiring support in our district is increasing so this is not a service we and safely scale back.

Survey respondent, District Authority

6.17 Case study respondents reported that the type of services delivered through these rent and service charges varied. They often included either an on or off-site warden and a call system through which residents could call for warden help from their homes, so that they could receive help in an emergency. Other providers of Sheltered Housing used off-site 'Tenancy Support Officers' to deliver intensive housing management services.

The Council decided to continue to offer Housing Related Support to sheltered tenants following the withdrawal of Supporting People Grant funding from [County]. The service is funded through a support service charge and cross subsidy from rents. The service is focused on supporting independence and is provided by Tenancy Support Officers rather than on site wardens.

Survey respondent, District Authority

6.18 Despite the reallocation of funding into Housing Benefit-eligible charges, case study respondents reported that this did not always avoid the need for user charges or withdrawal of support. One case study provider, for example, felt they had no option but to make a non-HB eligible user charge for support to Sheltered Housing residents. In addition, commercial providers cannot charge Intensive Housing Management and therefore often need to make charges to residents or cut support:

This top-up is usually paid using other DWP benefits not designed for rent payments (PIP, ESA etc.). This is unfair and penalises already vulnerable tenants because they often have no other choice but to use a for-profit provider.

Survey respondent, Commercial Supported Housing Provider

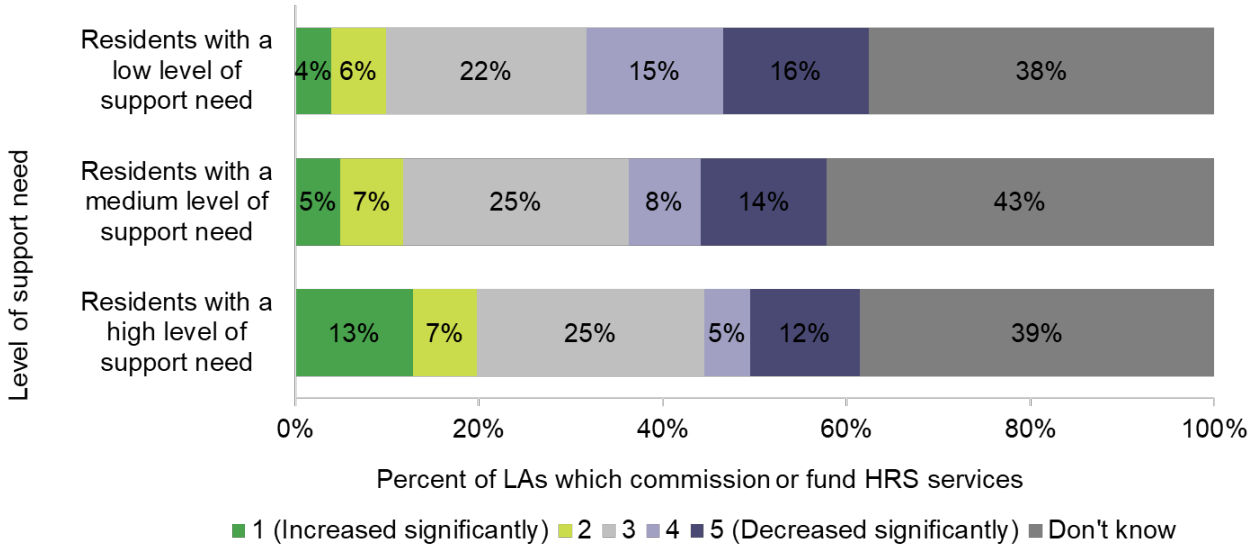
Low versus high levels of need

6.19 Survey and case study findings suggested a general trend towards delivering less support for clients with low levels of need and more for clients with high levels of need since 2014. As shown in Chart 6.2, 31% of LAs said that the amount of funding they directed towards those with low needs had decreased and 10% said it

had increased. By contrast, only 17% said that support had decreased for clients with high needs, compared to 20% who said it had increased.

6.20 High levels of 'don't know' responses here were often caused by LAs not collecting data categorised by levels of need.

Chart 6.2: Trends in the amount of funding LAs direct to HRS services since 2014 by level of need[63]



Source: HRS Review online survey. Base: LAs who commission or fund HRS services (70)

6.21 Case study findings showed that several LAs had observed a shift in the referrals they received in the period since the Supporting People ring-fence was removed, with an increasing number of clients presenting with high or complex needs. One national provider reported an increase in clients where the support delivered was not sufficient for their complexity of support needs.

> *We've seen people coming [to] what are supposed to be Housing Related Support services, that are fairly light touch [services], really… they're not supposed to be intensive… that actually had… much more complex, higher needs, multiple needs… people that probably should be in the Social Care system but aren't. So, I think we saw a lot less funding… [coupled] with increased risk and need.*
>
> **Provider**

6.22 The implications of changes to commissioning for different levels of need are discussed further in Chapter 8.

[63] Where responses from individuals in the same LA conflicted, this chart shows the most positive responses.

6.3 Impact on providers: Use of Housing Benefit and Intensive Housing Management

6.23 As funding from commissioning has reduced, many providers reported that they have turned to increasing rents and service charges to fund activities to assist their residents. Numerous providers reported that activities formerly funded by Supporting People commissioning were now funded via this source, and the survey of providers indicated that around 33% of all HRS activity is now funded through service charges. This was particularly true for Sheltered Housing as discussed in more detail in Section 6.2.

6.24 Service charges fall into two broad types; those which, together with rent payments, are eligible for Housing Benefit (accounting for 24% of HRS funding according to findings from the survey) and those which are not eligible for Housing Benefit (which survey findings indicate is around seven per cent of HRS funding). Landlords of some properties may also apply for Intensive Housing Management (IHM), allowing additional Housing Benefit eligible charges to be made. IHM was designed to allow for the fact that housing management and maintenance costs are higher for some types of tenants – in particular those who move on more quickly, or have higher needs which make them more likely to damage the property, but it is often in practice also used to cover additional services.

6.25 In law, Housing Benefit payments cannot be used to fund support. There is clearly a tacit acceptance in the sector that this type of funding has taken over from Supporting People commissioning of HRS in many cases. Case study interviewees mentioned that some LAs encouraged providers to carefully review the boundaries between housing and support with the aim of rolling decommissioned support services into rents or service charges. This use of Housing Benefit relies on what respondents often called 'grey areas'; essentially a combination of redefining some HRS activities as housing management activities, and also ring-fencing one-to-one support activity as narrowly as possible and charging other related activity to Housing Benefit. The most common example given of a service which could be funded through Housing Benefit was a 'concierge service', or overnight cover to ensure safety in a housing scheme; but many other activities or perhaps more commonly *parts* of activities have also been reclassified:

> *We did go through this exercise, [where] we looked at the job description of each member of staff to decide which were Housing-related Support, and which were… housing management… Originally it used to be 80% support and 20% Housing Management functions; but now these days it's… nearer 60% Housing Management and 40% support.*
>
> **Provider**

6.26 However, it is important to note that local government departments approving Housing Benefit payments vary in the detail of what they will fund, and that the fine detail of these definitions can have quite substantial consequences in terms of what is funded. In many parts of England, the departments involved are in wholly separate organisations, since Social Care is an upper tier authority activity, but Housing Benefit payment approvals are a lower tier authority activity; it is also

frequently outsourced to a commercial provider which will use its own interpretation. There is therefore a risk that when services are decommissioned on the assumption that Housing Benefit will cover the support provided, that this is not necessarily the case. For national providers the variation in policies, which can often only be determined by decisions made retrospectively on challenge to payments already made, are a problem.

6.27 Case study respondents reported that some larger organisations have therefore taken a great deal of time to determine accurate budgetary and staffing boundaries between services to avoid challenges. However, they felt that some small organisations were less aware of the need to maintain a robust distinction:

The Housing Benefit might have increased… when you look at the service charges, they've undoubtedly inflated. Originally Housing Related Support was paying for some housing management time… and that's gone to the [Housing Benefit] side… One of our providers makes a loss on the Housing -related Support side, and then [makes that up] from the Housing Benefit side, so actually when it comes together it evens itself out.

Commissioner

6.28 Providers interviewed in case studies reported that some Housing Benefit departments took quite an aggressive approach to ensuring Housing Benefit payments were not spent on support, leading to substantial administrative costs on both sides, for example being required to detail time to be spent by individual named staff on ineligible activities.

[Some LAs] will… if there's anything in your job description that refers to support, they will cap the amount of money that they'll give you towards it, so we have to be quite stringent… They may come back to challenge… we have had a couple of local authorities who have said they really want it down to the minute [of individual staff members' time]… but some [local authorities] just say we trust you.

Provider

6.29 In practice, case study respondents reported that, as well as bringing administrative costs, enforcing this boundary has some important side-effects. They reported that it meant staff who were not employed on the basis of providing support could not offer help to a resident which might be classified as support, and providers could not give training in support to these staff:

It's very cut and dried who does what elements – so the concierge can't deliver support, which obviously presents challenges in itself, if someone is [unexpectedly] presenting with a support need…

Provider

6.30 It is important to note that under Supporting People there was – and still is where services are commissioned – a strong boundary distinction between Support and Care. Many providers reported that they had taken advantage of the removal of this boundary to improve efficiency of services (e.g. allowing the same staff to deliver both) but some commissioners in one case study LA, and reportedly in others, still

sought to retain and monitor this boundary. It is likely that this presents challenges to providers working across authorities taking these differing approaches.

6.31 Case study respondents stated that one side-effect of reliance on Housing Benefit is that where a provider is providing support only and not accommodation and does not receive Housing Benefit or service charge income, it tends to be more difficult for them to maintain the service. They stated that this was because they do not have this additional source of funds to draw upon, and also need to apply to another organisation for maintenance. Case study respondents reported that, since commissioning payment tend not to vary on the basis of whether the property is Housing Benefit eligible, this means some services received less funding per resident for the same service:

> *We claim Housing Benefit… so from the three properties, two we claim [service charge] within Housing Benefit, and one we don't have any Housing Benefit, we just have to support it [ourselves]. That property… is a lot tighter – the Housing Benefit gives us a little extra in the budget.*
>
> **Provider**

6.32 In some cases, it was reported that support ceased to be provided entirely. Some landlords and LAs reported that they now had nominally Supported Housing schemes which did not offer any provision of HRS, although many residents might receive Social Care packages.

6.4 Impact on providers: staffing and market viability

Provider staffing: recruitment and salaries

6.33 Case study respondents reported that one of the key challenges short term and reduced funding levels generated was pressure on the recruitment and retention of staff. Good quality, consistent staff were often viewed as a key factor in delivering a high quality support service, however providers and commissioners had reduced salaries which they stated made it difficult to retain and recruit people with the right skills particularly for non-manager posts.

> *I see that salaries of staff have been affected… And that's not good because the managers say 'we've got staff who go to support people in communities who want help with benefits advice and benefit maximisation as well as debt, who, because of benefits are getting paid more than they [the support workers] are, for not working… and they struggle with that. So, I do think that is a big challenge and I do think of myself as a guilty instrument of that*
>
> **Commissioner**

6.34 Commissioners and providers reported that they experienced tension between making funding reductions and wanting to pay the Living Wage for frontline staff. One national provider of HRS had decided not to bid for certain contracts that LAs had tendered on the basis that the contracts required staff salaries to be too low. This provider had sought to address low salaries by taking on apprenticeships.

A number of them have then ended up getting permanent jobs with us, which is a real success story, and is something we're particularly proud of. The apprenticeship lasts about 15 months, they get qualifications, they end up with an NVQ in Health and Social Care, Level 2 or Level 3, including a care certificate, so that they could go and work… in another organisation.

Provider

6.35 In a separate case, an LA had reduced the number of hours of support delivered per client within their contracts to enable them to commit to providers paying the Living Wage to their staff. One provider interviewed in that area said they had dealt with this by reducing their staff numbers.

6.36 Another Authority spoke of the general anxiety that providers felt when under pressure to evidence that services should be retained in the face of funding reductions, and a high turnover of staff had also increased instability and continuity of leadership.

We see problems with staff retention, especially among care and housing staff, people move around the sector a lot and this can affect continuity and leadership, even if they aren't leaving the sector or system altogether.

Commissioner

Financial Impacts on providers and market viability

6.37 Case studies provided some evidence of funding cuts causing a strain on providers finances and in one case the service becoming unsustainable. In one example, the level of funding given to deliver support had fluctuated from between £18 and £19 per hour, to between £14 and £15 per hour. At the lower point, one provider explained that they had struggled to deliver the service and had resorted to using their reserves to cover costs, which eventually reduced to the regulatory minimum. At this point the LA had increased funding levels again and they were able to continue with provision.

6.38 Similar findings were reported by the National Audit Office in 2018 in an investigation into the financial sustainability of LAs which found that a substantial proportion of authorities had had to use their reserves to cover their spending commitments (on all services). The findings showed that 10.6% of LAs with social care responsibilities would have the equivalent of less than three years' worth of reserves left if they continued to use their reserves at the rate they did in 2016-17. [64]

6.39 In the example of the provider in the case study that had covered their costs with reserves, the LA's different departments had been able to make different decisions

[64] Report by the Comptroller and Auditor General, *Financial Sustainability of local authorities 2018*. National Audit Office. Available at: https://www.nao.org.uk/wp-content/uploads/2018/03/Financial-sustainabilty-of-local-authorites-2018.pdf

regarding their grant levels. During a recommissioning exercise in recent years the LA introduced a guideline support fee per hour to address this, recognizing that providers were providing broadly similar services but for historical reasons receiving varying rates.

6.40 In a second example, commissioners were aware that reductions in funding levels were a challenge for providers and that some were delivering more support than the contract costed for, in order to ensure clients received a sufficient level of support.

It doesn't contribute towards some of our organisational overheads. Whereas if I was to put a funding bid in for a project, then I would try to recoup the core costs to the organisation. That's not possible to recoup all of the core costs associated with delivering a service under the current structure.

Provider

I think locally we're very lucky in that our providers go above and beyond and often deliver more than what we pay for which I think is interesting. I personally think that that's because of the mix of the providers that we've got, they're all not for profit types where it sort of fits with their ethos as an organisation anyway… we're put under an awful lot of pressure when cuts come through, that puts an awful lot of pressure on the providers.

Commissioner

6.41 This LA had reduced funding for all HRS services by £300,000 during one year. They stated that, as a result, one of their support providers had removed a staff post and reduced a supported lodging scheme (in which people volunteer to give a room in their home to young people) from ten placements to five, but had otherwise made efforts to avoid clients being affected by the reduction.

[Impact on the client?] I would hope that the client doesn't feel that at all, that's our intention in delivering the services, but that just makes it more of a strain within the organization, it creaks a bit, but at the front end I would hope that nobody has noticed the effect of the cuts.

Provider

6.42 There was also evidence that funding levels had affected providers willingness to enter markets either in a new type of support provision or a new geographical area. Case study evidence from commissioners and providers suggested that some areas were experiencing a reluctance from providers to deliver a service and therefore a lack of competition and in some instances, provision.

It always goes back to financial sustainability of services. We've been working with the Local Authority recently explaining how, for the residential provision at least, the funding doesn't quite cover the costs of the provision, especially in terms of the hourly rating. As an organisation, we're having to look at all of our services, see if they are financially sustainable, if we can make them financially sustainable, and if not, then we will have some difficult conversations and decisions to make. Particularly for the services with vacancies in.

Provider

6.43 This occurred in a number of situations. One suggestion made was that it could be because the amount of support required for a particular type of service was so small that it was not worth providers delivering it.

We're going out to re-procure the 16+ accommodation, but to be honest the money isn't really there. With so little money we're asking ourselves whether there is a market out there to deliver it.

Commissioner

6.44 Case study respondents also felt that providers may also be put off by the location of an LA or have a lack of confidence that contracts would be sustained in the future.

I think that the cuts affect the wider markets response to wanting to work with us. We're stuck, because we're down at the bottom of the [name of location], we've not got a good reputation… and we've got a massive reputation for cutting. New providers didn't want to work for us because we can't guarantee a two plus one plus one contract and providers don't want to commit to that.

Commissioner

6.45 One national provider interviewed explained that, although it was not their preferred approach, they had sometimes chosen not to bid for contracts that they felt they could not deliver without having a substantial impact on the organisation as a whole. They were able to do this because they were not dependent on individual LAs, as local providers were.

We've got to deliver high quality services, and that quality can't drop below a threshold – we can't get caught in a race to the bottom – we've got to protect the integrity of what we do… we're not interested… in delivering services which don't make a real difference to communities and to individuals.

Provider

6.46 Furthermore, it was reported that when the demand for certain types of support was slim, reducing or reorganising services in order to make efficiency savings caused providers substantial disruption and reduced their interest in providing the service.

6.5 Summary of key findings

- Half (50%) of LAs who commission or fund HRS said that funding had decreased since 2014, with 30% reporting a ‘significant decrease’.

- Funding sources for commissioned HRS services had diversified away from Supporting People budgets, and funding from other streams such as Public Health, Adult Social Care and homelessness prevention had been drawn on. Commissioners and providers reported that budgets from these other streams were less secure and ensuring funding for future services was a challenge.

- To accommodate reductions in funding for HRS commissioning, LAs reported that they had often prioritised HRS services that fulfilled a statutory duty, and services that met urgent/high level needs, and decreased the number of services delivered to clients with low level needs which had a preventative role.

- There has been a widespread shift to charging additional service and rent charges which could be funded through Housing Benefit. Numerous providers reported that activities formerly funded by Supporting People commissioning were now funded via this source, and the survey indicated that around 33% of all HRS activity is now funded through service charges.

- Accommodation-based HRS services to residents of sheltered accommodation had largely ceased. In some cases, they were replaced by Floating Support delivered to a minority of residents, and/or housing management services that were chargeable to Housing Benefit.

- Reductions in LA commissioned services had led to several challenges for providers. Reduced and short-term funding meant it was difficult to recruit and train staff, and there was evidence that some contracts had put providers under substantial financial strain and unable to cover costs of delivering services.

- Small contracts and a lack of confidence in future funding has impacted on competition between providers, constraining their willingness to enter markets due to the costs of establishing new services and the risk that this would not be sufficiently long-term to warrant the initial investment.

7 Planning and Future Provision

7.1 This chapter looks at how LAs plan HRS provision. It covers the information sources used and the extent to which LAs feel that they have the necessary skills and time to plan effectively.

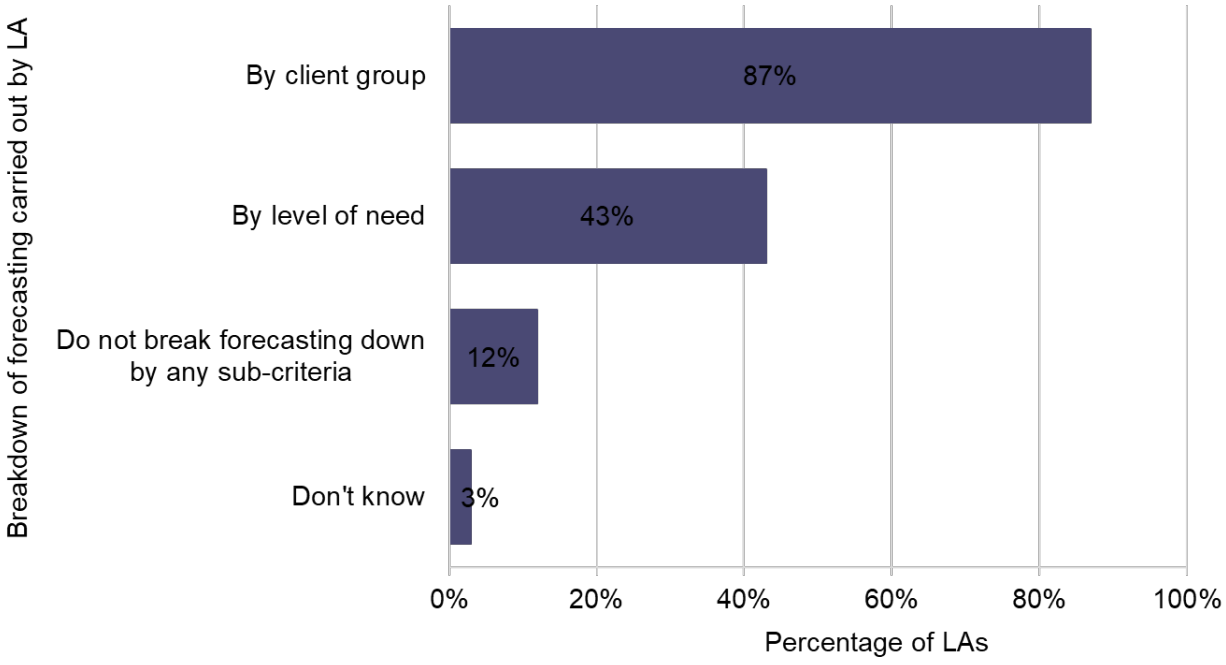
7.1 Planning and future provision

7.1 Of the 59 LAs who were able to comment on the planning process in the HRS Review online survey, 84% stated that they conducted some planning for future provision needs for Floating Support services and 96% stated that they conducted some planning for Supported Housing.

7.2 From the case study interviews, it was clear that most LAs set out some form of short-term (up to three years) planning for resources. However, they spoke about the difficulty of longer-term planning due to unpredictable cuts to budgets which have been ongoing since the ring-fence on Supporting People was removed.

7.3 LAs generally looked to break down their forecasting of need by client group (87% worked in this way) as shown in Chart 7.1. It was much less common to break down predictions by level of need. A small proportion of LAs stated they did not break down their forecasts by any sub-groups at all.

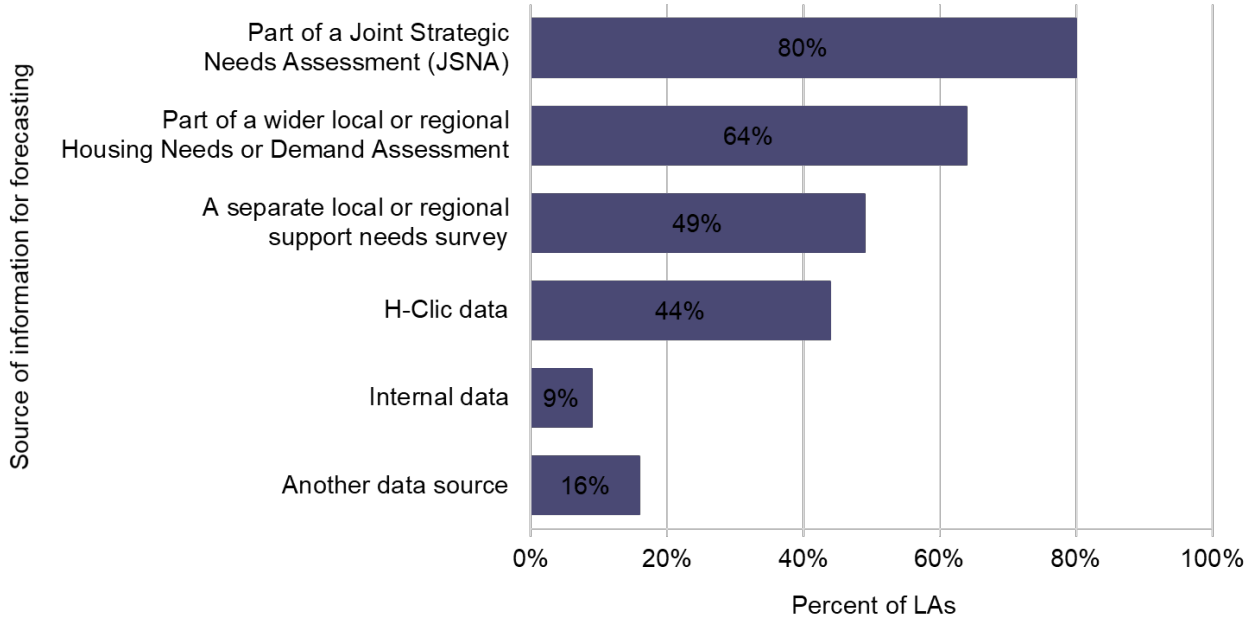
Chart 7.1: Sub-groups for which forecasts of need are produced



Source: HRS Review online survey. Base: All LAs able to discuss planning for HRS or Supported Housing (59). Respondents could select more than one option, so percentages may add to more than 100%.

7.4 A range of sources were used for the purposes of forecasting need for Floating Support and Supported Housing (Chart 7.2). Most used several sources of information, and only 18% stated that they were using just a single source of data.

Chart 7.2: Information sources used for forecasting



Source: HRS Review online survey. Base: All LAs able to discuss planning for HRS or Supported Housing (59). Respondents could select more than one option, so percentages may add to more than 100%.

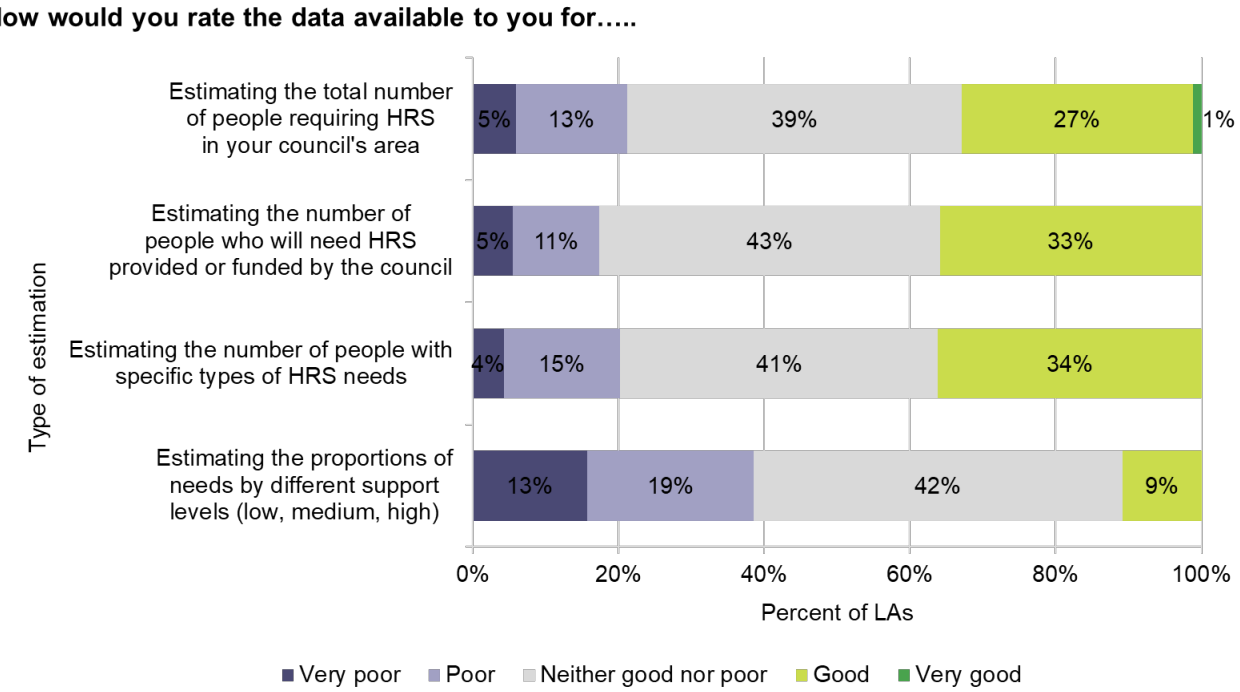
7.5 The case studies point towards there being no singular, consistent approach to planning. Some LAs participating in the case studies chose to rely purely upon data they sourced from the ONS, or from internal sources. Others used a combination of internal data and the shared expertise within their own organisations.

7.6 One LA we spoke to explained how they used a market position statement - a Joint Strategic Needs Assessment. They worked closely with their Public Health Department to analyse current demand and needs as clients enter the system. They were also using the The Housing Learning and Improvement Network (Housing LIN) work they conducted to report on housing needs.

7.7 Another LA spoke about their use of data collected through a Support Gateway that they have had in place since 2016. This is a central system for all Supported Housing referrals. This system provides them with a holistic view of where demand is coming from, from what areas, and the associated needs to inform what the breakdown of the service contracts should be in the future. The authority used a combination of data from the Gateway alongside carrying out detailed sense-check conversations with clients.

7.8 In the survey, LAs were asked about the extent to which they felt that the information available to them for planning was fit for purpose from a number of different perspectives (Chart 7.3).

Chart 7.3: Opinions on data available for planning and forecasting



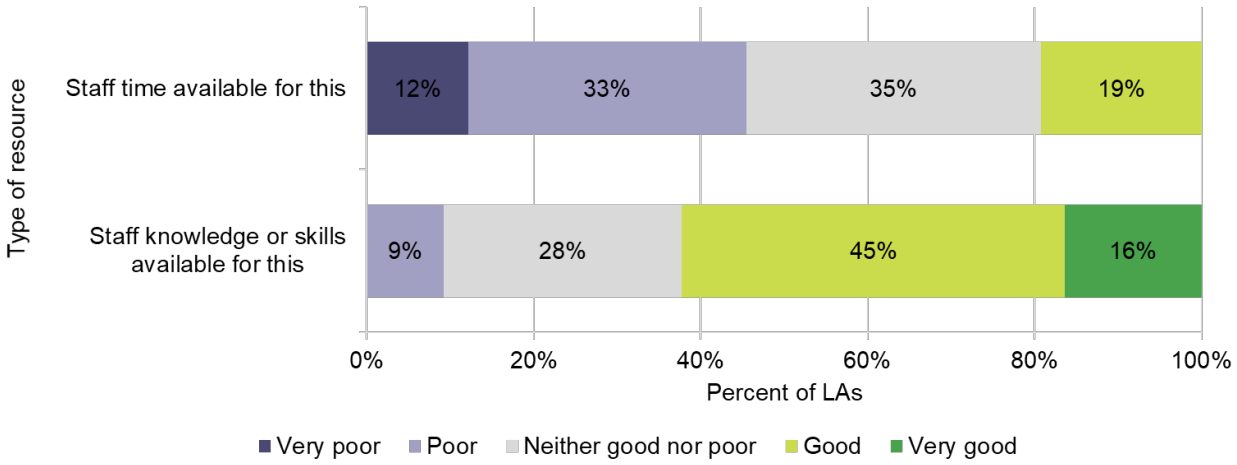
Source: HRS Review online survey. Base: All LAs able to discuss planning for HRS or Supported Housing (59)

7.9 Across all the areas explored in the online survey questions, only a minority of LAs felt that the data available to them was good or very good. In terms of the volume of people needing HRS – overall, specifically provided/funded by the council and by different types of HRS needs – between a quarter and a third of LAs felt that the data available was good and just under a fifth felt it was poor (with the rest either saying the data was neither good nor poor or being unsure). However, confidence in the data available was much lower for estimating the proportions of need by different support levels (i.e. low, medium or high). Only nine per cent stated that they had good information available for this and about a third (32%) felt their data was poor. Due to limitations on survey length, the questionnaire did not ask about reasons for rating data poorly; further research would be needed to establish what improvements could be made to the data available.

7.10 As discussed in Chapter 3, many providers and LAs did not use a classification of needs levels for clients, or did not recognise that it was possible to classify clients in this way, and so they were not able to break down their answers by level of need.

7.11 As well as being asked about the quality of data available in the survey, LAs were also asked to comment about the extent to which they felt they had the resources available to make use of the data (Chart 7.4). Around two-thirds of LAs felt that the level or knowledge within their organisation to carry out forecasting of need was good; however, the proportion who felt that the availability of staff time for this exercise was good was considerably smaller (only 19% stated that this was the case).

Chart 7.4: Opinions on data available for planning and forecasting



Source: HRS Review online survey. Base: All LAs able to discuss planning for HRS or Supported Housing (59)

7.12 In case study interviews, respondents mentioned issues around data availability, quality and a reduction in the number of specialist analytical support staff.

> *We almost have too much data in terms of being able to help us for the future. A university used to manage all the data but now all these… monitoring tools the council has had to replicate as Excel spreadsheets, so that then causes loads of problems because we've got these 20 odd unruly complicated spreadsheets coming in.*
>
> **Commissioner**

7.13 HRS providers interviewed for case studies had also noticed the reduction in expertise at LAs; in some cases, they found that they could not contact anyone in some LAs who had adequate knowledge of HRS:

> *We've seen levels of commissioner [turnover] that [are] unprecedented… you might have seen six or seven different commissioners in the space of three or four years. They don't know the history, they haven't got that background, they don't understand the nature of the services, so it tends to be more of a paper-based exercise [there]. Even when we need to speak to [some LAs] we struggle to get hold of anybody who will actually engage with us…*
>
> **Provider**

7.14 This was particularly challenging for providers whose portfolio was split into small schemes across a large number of LAs, and therefore had infrequent contact with individual LAs:

It's simply that there are [funding] issues in local authorities… it seems that the person that you talked to last week isn't here, and then when you do [manage to] talk to somebody, you try to get hold of them the next week, and [you find] they'll have moved on to something else as well.

Provider

7.2 Improving planning

7.15 In the case study interviews, most LAs expressed a desire to continue to improve their planning processes. Often this was expressed as a desire to plan over longer timeframes. One Commissioner explained how ideally their planning cycle for HRS should mirror the LA's Financial Planning cycle, which is planned across five years and then annually reviewed.

7.16 In terms of anticipating future needs, one LA interviewed had an external long-term Strategic Review under way, which will look at gaps in provision, funding pressures, how the joint protocol is working, and good practice benchmarking.

7.17 Some LAs also spoke about developing new Housing Strategies, action plans and developing models that could combine quantitative data with more qualitative understanding of 'what works' through in-depth conversations with clients around their experiences. However, they acknowledged that there can be challenges in accessing this more qualitative nature as it is often stored in case histories and analysis can be labour-intensive.

7.3 Barriers to better planning

7.18 Generally, a number of LAs felt their capacity to innovate and develop new approaches to planning was hampered by reduced funds and uncertainty of future budgets. One LA stated, *"We can't really plan, there is no point as we don't have our budget until the end of the year, the same rush happens every year".*

7.19 There was also acknowledgement from many LAs and service providers that it was difficult to anticipate the 'knock-on' impacts of cuts or changes to other public services. In particular, the demand for HRS for clients with mental health issues was felt to be rising rapidly, as was the number of clients with multiple complex needs (mental health plus alcohol / drug dependency). LAs felt that this demand has been compounded by gaps in other provision such as Child and Adult Mental Health Services (CAMHS) making it challenging to plan or make future projections of service need.

7.20 One service provider also explained how they do not plan their Supported Housing provision as they believe that national studies show such a large shortfall in this type of housing that there is no realistic possibility that they could over-provide it. They also reported that they were unable to meet demand for HRS from tenants and new people coming in.

7.4 Summary of key findings

- Most LAs (84%) carried out future planning around the need for Floating Support and nearly all (96%) did this for accommodation-based support.

- Most conducted future planning by client group (87%), but few did so by level of need (43%). A minority (12%) did not break down their forecasts by any groups.

- Most LAs used multiple data sources and only 18% used just one, however there was no ‘standard’ approach to future planning

- The data available was generally felt to be sub-optimal for producing estimates of need. A third (33%) of LAs rated the data they had access to as good or very good for estimating the total number of people requiring HRS funded by the council. A fifth of LAs (18%) rated it poor or very poor.

- LAs rated their skills for planning and forecasting well (62% good or very good) but were more negative about the time available (only 19% good or very good).

- A key barrier to planning was reported to be the difficulty in predicting ‘knock-on’ effects of cuts to services elsewhere, within and outside the LA. LAs interviewed in the case studies also frequently said they found planning and forecasting difficult due to late setting of budgets.

8 Gaps in provision

8.1 This chapter addresses any areas in which the commissioned and provided HRS services might not be enough to cover local need. This may sometimes be caused by the changing profile of need in the area, and the delay in adapting to that need, but more often, it was reported to be due to reduced LA budgets and the removal of the Supporting People ring-fence. In response to this, some LAs decided to cut certain services while others felt that uniformly decreasing the number of hours contracted for each client group would be the best way to minimise the impact of reduced funding, across the board. In this chapter we discuss the implications of these two approaches on the services provided.

8.1 Gaps in provision by client groups / support types

8.1 As detailed in Chapter 6, case study interviewees believed that much HRS provision was non-statutory (i.e. LAs are not legally obliged to fund it), and therefore particularly likely to be cut in response to cuts to overall LA budgets:

> *It's non-statutory, so [some see it as] 'low hanging fruit' when it comes to savings.*
>
> **Commissioner**

8.2 LAs had to make compromises about prioritising provision, leading to some gaps and/or insufficiencies. Some LAs decided to cut Floating Support in order to make more funds available for accommodation-based support, while others opted to do the opposite. However, in part due to making efficiencies, LAs believed that the overall reduction in service provision was lesser than would be anticipated given the reduction in funding.

> *I don't think [cutting services] is something that we want to do, but we do need to make sure that we're more efficient in what we do… That's why we did do a review of Housing Related Support services. We wanted to make sure that actually that [budget] was actually delivering services to the people we'd identified.*
>
> **Commissioner**

8.3 In LAs which decided to remove or reduce Floating Support in order to protect accommodation-based services, a gap in provision emerged for people with lower needs living outside Supported Housing schemes. These clients either no longer received any support or had to live in Supported Housing when they might not otherwise have needed to, leading to a higher cost per person. Some LAs preferred to prioritise accommodation-based support, as they regarded this as more appropriate for clients with complex needs, due to the specific design of the property and access to 24-hour support.

It's about somebody being kept an eye on. I know that's not what we're here for. But if somebody has a crisis in the middle of the night and wants to wake the whole building and cause a bit of a ruckus then unless there's somebody on-site there to help them, support them, talk them down then things can get a bit testy.

Commissioner

8.4 In the survey, LAs were asked to estimate what percentage of the identified need they were able to cover with their commissioning budget. They were asked to break these estimates down by level of need, or by client group, depending on their internal practices. Only seven per cent of LAs (n=14) commissioned support, planned need and were also able to break down provision by client group. Due to the low base size the following analysis should be treated with caution.

8.5 The biggest gaps (where LAs believed less than 30% of identified need was covered by the commissioned services) were in services for ex-offenders, people with drug or alcohol misuse problems, and people with physical or sensory disabilities. LAs believed there was better coverage for people with learning disabilities (60%), homelessness (53%), and people with mental health issues (52%), but even these address hardly more than half of the estimated need.

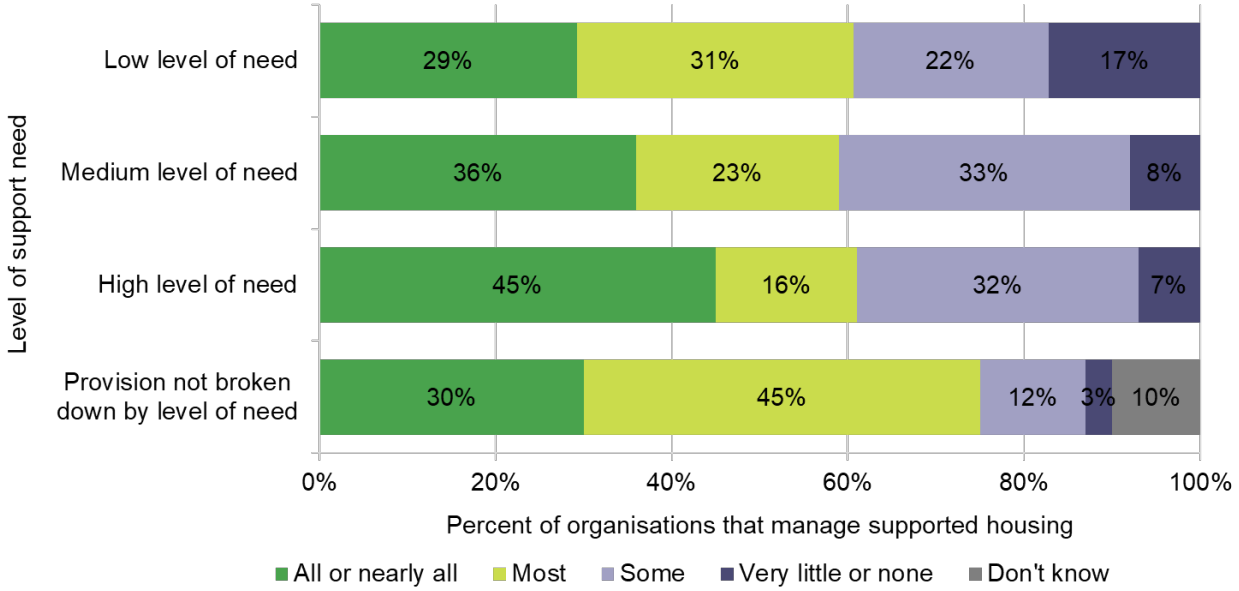
8.6 Case study LAs mentioned having had to reduce spending on services which were identified as the least critical, most costly, or most likely to attract other sources of funding. Among these were Domestic Violence services, ex-offenders, adults with 'mild' disabilities and homeless clients.

8.7 In some cases, services were aggregated to retain as much provision as possible while reducing expenditure. For example, in one case study, separate homelessness, ex-offenders and substance misuse services were replaced by more general "complex needs" provision.

8.8 Some case study LAs also mentioned having to cut services altogether, such as HRS provided in Sheltered Housing. This was supported by the provider case studies where PRPs identified that LAs were no longer commissioning Sheltered Housing. In the survey, two Lower tier LAs had decided to fund Sheltered Housing from their HRA budgets, after the Upper tier LA in their area withdrew funding for it.

8.9 Aside from gaps in provision caused by budget constraints, commissioners identified several other areas of unmet need. The key gaps they identified were for better and more localised provision for people with mental health needs, and. increased substance abuse provision, which were felt to have the potential to alleviate pressures on non-specialist provision. Similarly, case study LAs emphasised the difficulty of finding and funding provision for clients with multiple complex needs, which often remained unmet because they did not fit easily into historic service categories or commissioning structures.

Chart 8.1 Proportion of residents' needs covered by the provider's services, LA providers and PRPs combined



Source: HRS Review online survey. Base: All who manage Supported Housing and gave a number of clients with provision not broken down (38); with a high level of need (21), with a medium level of need (21) or with a low level of need (21).

8.10 Providers were more confident in their ability to meet the needs of their clients through commissioned services[65]. Three quarters (75%) of LA providers and PRPs combined said that they could meet all (30%) or most (45%) of their residents' needs. This may to some extent reflect an obligation to show confidence in their own services as an organisation. In these circumstances, the fact that a proportion (15%) say either that only some needs are met, or very little or no needs are met is a serious concern.

8.11 To this end, some PRPs interviewed in case studies reported deciding not to bid for new contracts or contract renewals, on the basis that they could not safely deliver the provision for the allocated budget.

8.2 Areas of overprovision

8.12 Despite careful budget allocations, and the lack of available provision for some client groups, the case studies identified that there were still areas of provision with multiple vacancies, as discussed below.

8.13 One of the main reasons quoted for this was the geographical location of some HRS. Two LAs said that there was a shortage of Supported Housing with good access to communities and services, but an excess of developments in rural locations. According to case study interviewees in two locations (and supported by

[65] Providers were asked what percentage of the need of their clients they are able to provide for, rather than the general need identified in the area for the client groups relevant to them, as was asked of the Local Authorities.

comments left at the end of the online survey by some further LAs), Supported Housing was often constructed speculatively by providers or commercial developers, with variable quality and limited relevance to local need. These locations were often selected due to lower land prices, and construction was thought to be motivated by the availability of construction subsidies outside LA control. LAs reported that this was a long standing issue.

8.14 As a result of statutory changes, vacancies in these properties can also no longer be filled with clients from outside the area (as they used to be before the Care Act 2014), which was reported by one case study interviewee to have led to units remaining empty. Providers who reported finding themselves in this situation have made it one of their development priorities to relocate their accommodation provision. One provider interviewed said they understand the importance of having Supported Housing within easy access of a community setting. Having to run services with vacancies for some time was reported to reduce the amount of funding available for new builds and relocation, making the process slower.

8.15 There are also issues around mismatches of supply and demand within LA boundaries. For one of the case study LAs, the biggest challenge they faced in meeting local need was the geographical distribution of the provision available across their districts.

> *I think it's fair to say that we have enough provision, but it's how we access that provision, isn't it… in some areas it's tighter. I think we've got issues in terms of the private provider market, the accommodation settings that are out there are not necessarily in areas that we'd like them to be, because, understandably, a provider is picking a place with a lower cost… But because we haven't been monitoring the services as closely as we used to in the past, I think that it's difficult for us to know with a lot of confidence how closely our commissioning meets the local needs in each part of the county.*
>
> **Commissioner**

8.16 According to case study interviewees, other services which sometimes operated with vacancies tended to be the highly specialised ones, which are not needed all the time but are critical when they are required. Mental health provision for clients with high support needs is one such example. There are several factors contributing to this. One is compatibility with other tenants' needs and personalities. Another important aspect is that rooms in these types of services tend to need refurbishing more often, during which they cannot be occupied. Therefore, this does not necessarily represent over-provision, although perhaps it does highlight the inefficiencies of providing small schemes. In this case it caused the provider to operate at the limit of financial sustainability for this service, as it is only spot purchased:

> *For example, I've had, in one of my properties, a fire. Now, I can't put a new person into that room, because… there's a lot going on to make that room ready for the next tenant. But effectively that's income I'm missing – and I've got my staff still that I need to pay*.
>
> **Provider**

8.17 The shortage or irregular location of Social Housing or lower need Supported Housing means that there are limited move-on options, other than expensive, low quality private rented housing, which people may not be able to afford due to only being entitled to 'room rate' housing benefits. People moving out of Supported Housing, even if the support intervention has been highly successful, may not be ready to move into an ordinary shared house, especially if no Floating Support is funded locally.

8.18 A lack of viable move-on options results in many clients remaining in supported accommodation for longer than the original timeframe or for longer than they need to. This issue is widespread according to some PRPs:

> *Move-on is one of our biggest issues for young people. It's meant to be a limited stay; it's meant to be two years – the number of young people that's been there three or four years... There is nowhere to move young people onto, there's no properties. There's just no general accommodation, because of the cap on Housing Benefit. They can only get a room - they cannot get a flat.*
>
> **Provider**

8.19 To address this issue, some LAs have started looking into the Housing First model, since this provides housing to clients from the start of their journey and avoids the use of dedicated Supported Housing developments altogether. However, this option does not address the overall shortage of affordable housing options for clients.

8.3 Reductions and challenges in how support is delivered

8.20 Some LA commissioners have made budget cuts across the board, either through lowering "cost per hour" rates, or alternatively in terms of number of hours commissioned, in an attempt to maintain provider staff wage levels at the Living Wage. This approach posed challenges for providers in delivering and accessing the necessary support.

8.21 One such challenge is that, in light of LAs having to prioritise statutory duties, most services affected by reduced budgets are the non-statutory ones. One case study provider believed the scale of the cuts they had experienced was due to the fact that their services were non-statutory, which opened up a gap in the availability of lower need provision.

> *There is a risk that these people can fall through the gaps as they are not at a critical point to be able to access certain services like mental health support.*
>
> **Commissioner**

8.22 Some cases study interviewees said that it was challenging to access HRS from some specific routes. One LA case study highlighted that more consideration needs to be paid to the pathways into provision and how that changes depending on client group, potentially creating an unplanned prioritisation of one person above another without reference to their individual need. In this case, the respondent highlighted

differences in eligibility between a care leaver pathway and the young parents' pathway.

There's probably a lot of over 18-year olds who are struggling because they only engage with us after they turn 18 and they are therefore a lower priority

Commissioner

8.23 Similar pathway-related access restrictions were flagged by another LA who identified issues at the boundaries between services, when individuals had to be moved to another service managed under a different contract, for example when their needs suddenly increase. This is partly due to unavailability in the service that they need to move into, and partly to slow moving systems which are not equipped to accommodate unexpected changes in client needs:

If someone becomes unwell, it sometimes takes a long time… if we feel that someone is breaking down, there needs to be a review, medication needs to be changed… if they're not safe… That is a real challenge because… beds are scarce. So, we sometimes have to manage people who really should be in higher support, and this is when I request additional staffing for example... I do have a little bit of flexibility within my budget, if someone becomes really unwell… but that is really limited.

Provider

8.24 Among the small number of LAs able to respond (n=23) to this question in the survey, just under half of the demand for higher needs provision was being met through commissioning. However, these findings should be treated with caution, as many LAs did not use this type of classification when commissioning services.

8.25 The case studies suggested that the lack of high need provision is partly a result of an increase in high and complex need clients, or in crisis situations, rather than a lack of focus among LAs on high need provision. In fact, the case studies suggested that some LAs chose to focus almost exclusively on addressing crisis or acute provision, for those with the highest levels of need. Respondents in several case study areas reported that this was often to the detriment of preventative services. Indeed, some providers pointed out that the removal of lower need and preventative services had, over the last several years, compounded the volume of clients who needed more acute, higher level support. In short, it may be that cutting low need and preventative services on the basis of minimising harm while reducing costs in the short term, has increased long-term support needs and therefore long-term costs.

I think that a lot of [the increased need] is because those preventative pots of money were taken away, and only people in real dire crisis are receiving the support… so the preventative sort of stuff that stops somebody from losing their job, from losing their home, that may have seemed very low level and almost… unnecessary…, but actually those little services were the things that kept people off the streets and on the straight and narrow…

Provider

8.26 The commissioners in this situation expressed a desire to be able to fund more early intervention and more community-based support for lower needs. In one case study LA, commissioning services went through a recent restructuring in order to be more cost effective and to allow them to invest in some prevention as well, because currently for non-statutory, non-crisis cases, like adults leaving prison or adults with 'mild' disabilities, options and availability are limited:

> *They have to be in crisis before they get an adult social care package.*
>
> **Commissioner**

8.4 Summary of key findings

- LAs interviewed have tried to minimise the impact of budget cuts on the provision they commissioned by implementing internal efficiency savings.
- Despite this, LAs had to make compromises about prioritising provision. Some LAs cut Floating Support in order to make more funds available for accommodation-based support, while others opted to do the opposite.
- In LAs which decided to remove or reduce Floating Support in order to protect accommodation-based services, a gap in provision emerged for people with lower needs living outside Supported Housing schemes.
- The biggest gaps were in services for ex-offenders, people with drug or alcohol misuse problems, and people with physical or sensory disabilities. Mental health and substance abuse services were also identified as gaps.
- Where the case studies identified areas of overprovision this was usually caused by mismatches between supply and demand, often because of the location of provision.
- A lack of viable move-on options (due to limited supply and affordability) resulted in clients remaining in supported accommodation for longer than they needed to, a point also highlighted in the 2018 Homeless Link Annual Review.[66]
- A common response to funding reductions was to reduce or cut non-statutory services, but some case study respondents regarded this as false economy in the longer-term, because it led to gaps in lower need, more preventative provision.

[66] Homeless Link (March 2019) *Support for Single Homelessness in England: Annual Review 2018*

9 Quality and assurance

9.1 This chapter investigates how HRS commissioners and providers assess quality. It draws on both the survey and the case studies to explore whether and how organisations collect data on client outcomes and quality. It explores perceived trends in the quality of the HRS that is delivered (based on the views of survey and case study participants). Finally, it examines the challenges in delivering quality, from the perspective of the case study organisations.

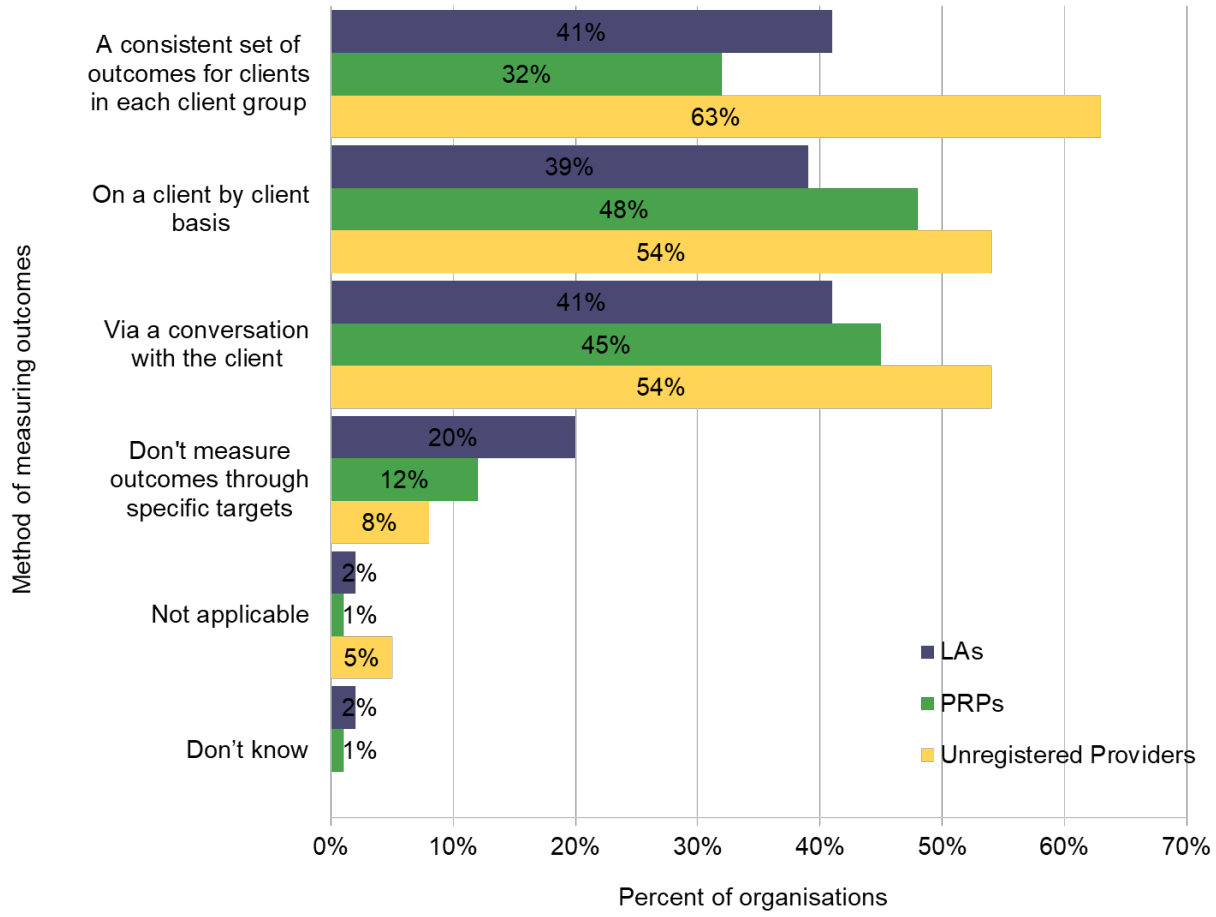
9.1 Quality measures and monitoring client outcomes

Group and individual-based approaches to setting outcomes

9.1 Chart 9.2 shows that the majority of organisations that provided HRS services conducted some form of systematic monitoring of client outcomes: four in five LAs (80%), two-thirds of PRPs (65%) and over nine in ten unregistered providers (93%). Although still the majority, fewer took an individually tailored approach to monitoring client outcomes (around three in five LAs (63%) and PRPs (60%), and seven in ten unregistered provided (71%)). It is notable that unregistered providers were the group most likely to do both.

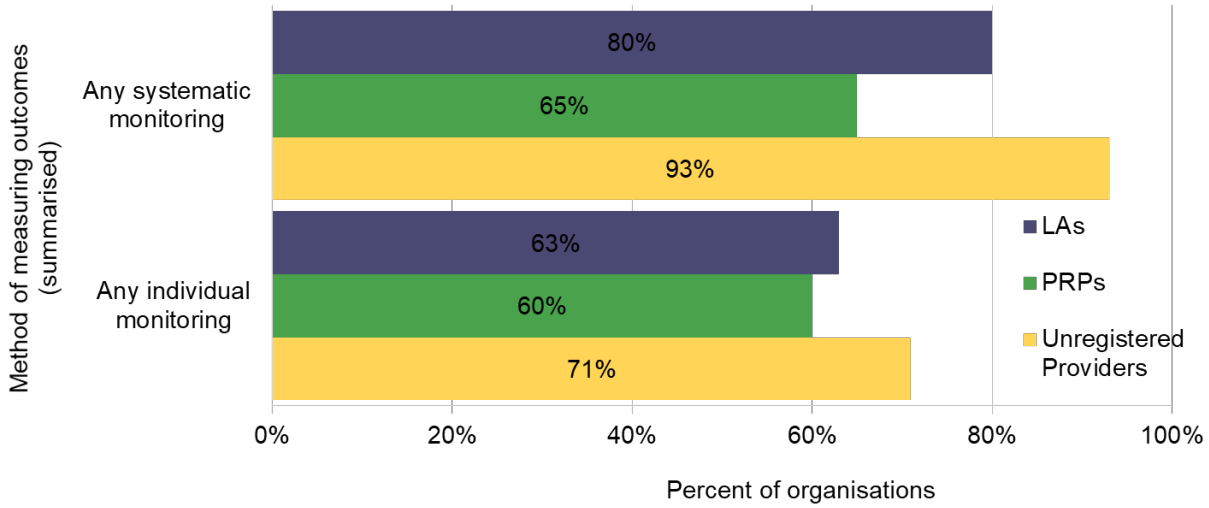
9.2 In terms of *how* providers went about measuring client outcomes, Chart 9.1 shows that the majority of unregistered providers set and monitored a consistent set of outcomes for all clients of the same group (63%), more commonly than in LAs (41%) and PRPs (32%).

Chart 9.1: How organisations who provide HRS measure outcomes for their clients (detail)



Source: HRS Review online survey. Base: All who provide HRS services: LAs (47), PRPs (81), Unregistered providers (59). Respondents could select more than one option, so percentages may add to more than 100%.

Chart 9.2: How organisations who provide HRS measure outcomes for their clients (summarised)



Source: HRS Review online survey. Base: All who provide HRS services: LAs (47), PRPs (81), Unregistered providers (59). Respondents could select more than one option, so percentages may add to more than 100%.

9.3 The case study providers claimed that they used a variety of measures to monitor quality and outcomes. They could be broken down into two main areas:

- Personal outcomes: Behaviour, education, training, employment, and engagement in specialist support such as mental health or substance misuse, managing money and bills, numeracy and literacy, physical and mental health, ability and confidence to access other services, family and relationships.

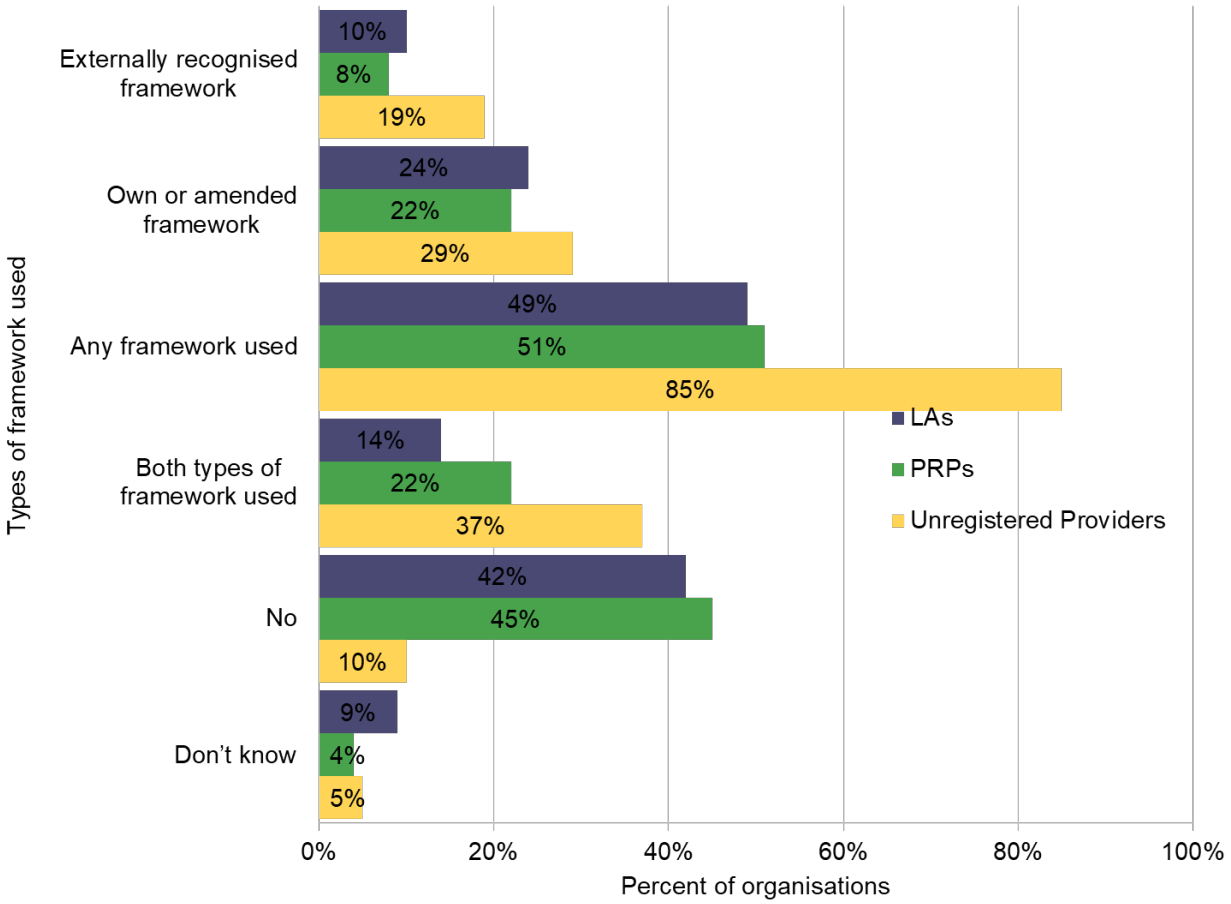
- Housing-focused outcomes: move-ons, those who remained in Supported Housing, as well as overcoming barriers to housing for those who had issues such as rent arrears, antisocial behaviour or lack of validation papers (e.g. birth certificate).

Use of frameworks to monitor client outcomes

9.4 Roughly half of LAs and PRPs who directly provided HRS used a framework to monitor client outcomes (49% and 51% respectively) as shown in Chart 9.3. Similar proportions used an externally recognised framework (10% and eight per cent respectively), or a framework which they had devised or adapted themselves (24% and 22% respectively). Using both of these approaches was more common among PRPs (22%, compared with 14% of LAs).

9.5 Using a framework to monitor client outcomes was far more prevalent among unregistered providers (85%), in particular using both an externally recognised framework and their own adapted or amended version (37%). This is likely to relate to the earlier finding that unregistered providers were most likely to use both a ‘top-down’ consistent approach to monitoring client outcomes as well as a more individualised approach.

Chart 9.3: Use of frameworks among providers who deliver HRS services



Source: HRS Review online survey. Base: All who provide HRS services: LAs (51), PRPs (131), Unregistered providers (59). Respondents could select more than one option, so percentages may add to more than 100%.

9.6 In the case studies one of the most common frameworks being used was Outcome Stars, which present outcomes in a 'star' shape, measured based on a 'Journey of Change' which is usually determined through conversations between individuals receiving support and support practitioners[67]. There are different Outcomes Stars used for different services such as homeless shelters and domestic abuse provision, so while these methods are in theory comparable with other Outcome Star assessments for similar services around the area, there are likely to be substantive differences in approach. One case study provider used Outcomes Stars to measure outcomes and movement towards positive move on and were considering becoming Ofsted registered so that they can be regulated to higher standards. Another provider also confirmed using Outcome Stars paired with techniques such as motivational interviewing, for example agreeing clear milestones and targets with the clients themselves so that they own the assessment process.

[67] Triangle (2017), *What is the Outcomes Star™?* https://www.outcomesstar.org.uk/about-the-star/what-is-the-outcomes-star/

9.7 Some of the case study providers reflected that independent living housing, when it was funded by Supporting People funding, had quite a complex commissioning and quality monitoring system. They felt there were some good practices lost when this ended, such as the CHS Code of Accreditation, but overall the scale of data gathering was felt to have been a problem; in particular, the skillset of support and care workers did not always include dealing with large-scale data collection, so they often found it very time-consuming. When the funding was removed, some of the case study providers sought a simpler approach and would not want to return to the former system, for reasons of efficiency:

> *The [last of the funding] was withdrawn in 2017; that was when we reviewed all the paperwork that was actually necessary. We found that the Support Plan that was being asked for as part of Supporting People funding was quite onerous, wasn't all relevant, some of the residents weren't willing to complete… Obviously I needed it in order to carry out doing the quarterly workbooks for Supporting People, but really the critical information could be done in the six pages we have now - originally it was 20-something pages.*
>
> **Provider**

9.8 Similarly, one case study provider has moved away from the Supporting People Quality Assessment Framework (QAF), and instead taken a more outcome-based approach:

> *We look at… [whether] people [are] being able to maintain their accommodation; we're measuring people's emotional health and well-being at the beginning and end of support. We're look at what people say about the support that they've received… It varies depending on the contract.*
>
> **Provider**

9.9 The system this provider uses is not derived from the QAF, and has been designed in-house, which means that it is a good fit for their needs but does not lend itself to benchmarking externally. The provider follows up support outcomes if possible, to provide more qualitative information which they feel brings the data more to life:

> *I like a mixture of numbers and stories, because I think numbers can say a lot, but… I think having numbers and stories together has much more strength… I always say that our work can never be just about numbers, because it's about people. People have got to be at the heart of what we do, and unless you hear their stories, to me the numbers on their own just don't hold enough weight.*
>
> **Provider**

9.10 One case study provider previously used the Supporting People outcomes and continued this after it ended. As they have changed how they commission services they have had to adapt some of those outcomes as well. Currently, baseline Key Performance Indicators (KPIs) go out in the tender during the procurement process, but the final measures are agreed between commissioners and the successful bidder as part of the implementation plan. A number of case study providers

mentioned reporting back to the LAs on KPI and service specifications set out in the contract, alongside the use of various outcome frameworks and principles which they used with clients and for internal monitoring purposes.

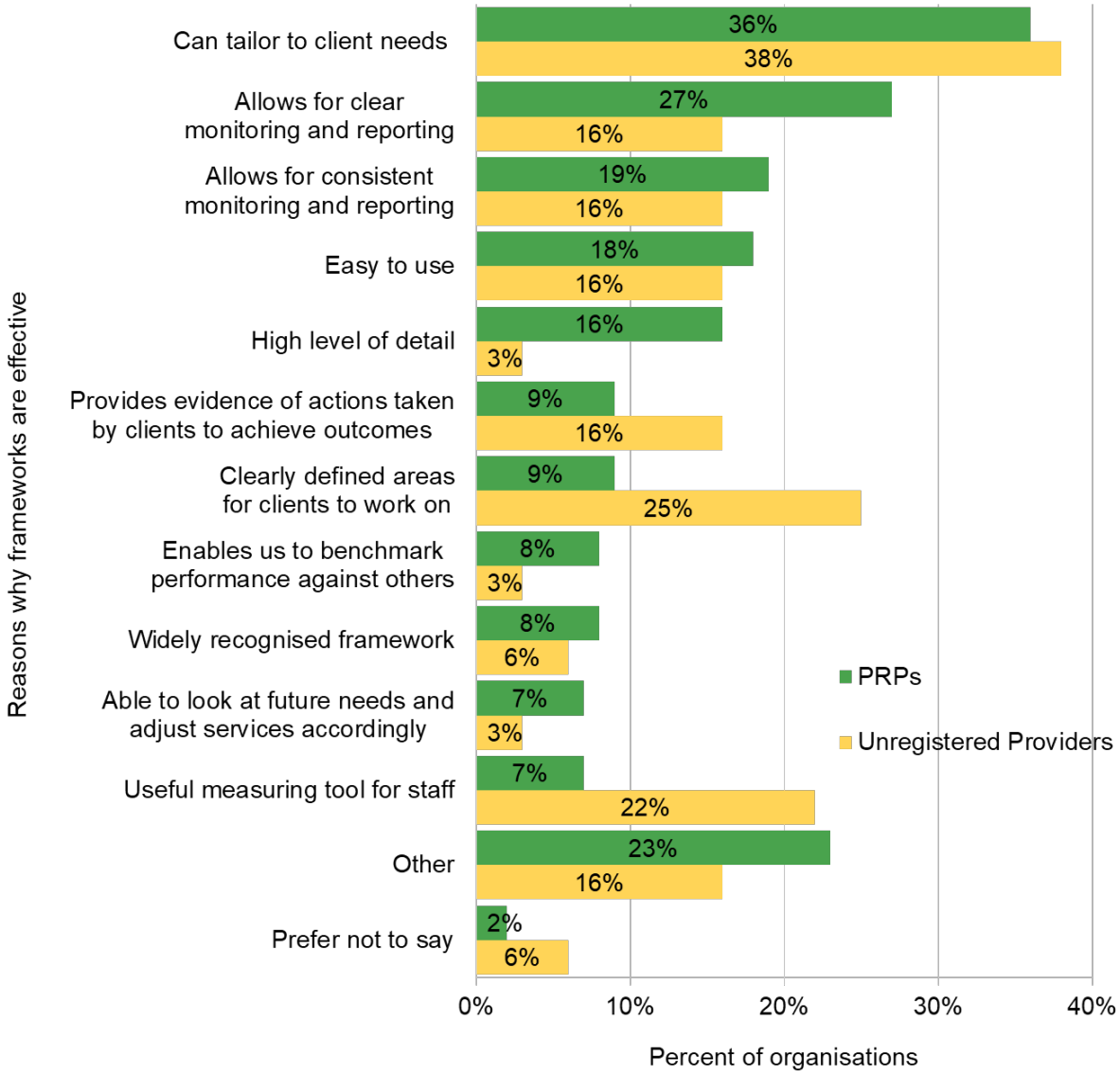
Views on the effectiveness of frameworks

9.11 The vast majority of LAs, PRPs and unregistered providers who provided support and used frameworks regarded the ones they used to be very or somewhat effective. This ranged from 96% effective, in the most positive instance, to 86%, in the least positive (where multiple respondents answered for the same organisation). Even in these cases, hardly any deemed their frameworks to be ineffective (six per cent of respondents in unregistered providers, five per cent in LAs and three per cent in PRPs).

Why are frameworks considered to be effective or not effective?

9.12 Notably, although organisations held similarly positive views on the effectiveness of the frameworks they used, there were differences in *why* they deemed these frameworks to be effective. As shown in Chart 9.4, for the most part these centred around whether the framework primarily met the needs of the provider – in terms of features such as being consistent, sufficiently detailed and allowing clear reporting – or the needs of the client, in terms of being suitable for tailoring and easy for staff and the client themselves to use and understand. Findings are indicative given the small base for LAs (n=15) and therefore percentages for LAs have not been shown.

Chart 9.4: Reasons why frameworks are effective, among PRPs and unregistered providers who use them



Source: HRS Review online survey. Base: All who provided HRS, used outcomes frameworks and thought these were effective: PRPs (60), Unregistered providers (32). Respondents could select more than one option, so percentages may add to more than 100%.

9.13 Overall, the element most valued by PRPs and unregistered providers was the flexibility afforded by being able to tailor frameworks to client needs (mentioned by 36% and 38% respectively, as well as 28% of LAs). On the other hand, LAs were most likely to value frameworks for facilitating clear reporting and monitoring and providing consistency of monitoring and reporting. Responses to the open-ended question about why frameworks were effective showed that some providers highlighted the importance of being able to apply different frameworks in conjunction with one another. This could help them to capture different types of outcome for different purposes: reporting to external commissioners, monitoring KPIs internally, and working directly with clients to build ownership of their own goals and objectives.

The frameworks are effective because they're clear and people are familiar with their requirements. There's also a benefit in using self-reporting measures, such as the Outcomes Star, in conjunction with measures that allow for professional assessment, such as outcomes from the former Supporting People programme. This offers a good mixture of reporting methods, which allow for assessments from different perspectives and using different kinds of evidence.

Commissioner

9.14 PRPs and unregistered providers were more likely than LAs to value frameworks that were easy for clients to understand, enabling them to monitor progress (25% and 23% respectively, compared with six per cent of LAs). Unregistered providers were also more likely than others to value frameworks which identified clearly defined areas for clients to work on, in line with the greater emphasis they placed on individually tailored monitoring (25% compared with nine per cent of PRPs and no LAs).

[The framework] captures needs, identifies milestones, goals and targets, and measures progress against agreed objectives. The fact that these are jointly agreed with clients provides ownership and improves buy-in. They are relatable to the client groups, easily understood and can be used to monitor contract performance, which commissioners can use as evaluation in re-tendering of services.

Provider

The [framework] has been designed in consultation with young people and is very successful in drawing out, through conversation, what a young person is good at and how we build on their strengths to develop personal goals. It is fully asset based and gaining popularity with other client groups. It is both paper based and online and we are developing an app to work with the concepts.

Provider

9.15 Very few organisations deemed the frameworks they used to be ineffective (n=4 LAs, 27 PRPs and three unregistered providers). Among these, the main reason was that the framework was too generic and would benefit from more tailoring to individual clients, although other factors arose as well including not sufficiently capturing 'distance travelled'. Looking at the open-ended survey responses provided at this question offers some illustrative examples of the broader range of reasons given:

Some frameworks are too binary – either achieved or not. They do not take account of progress towards an outcome or capture events that are a measure of progress towards an outcome. They are too simple and don't really work for customers with very complex needs where a relatively small outcome can be very [substantial] for that individual. Others can be quite subjective. We have one outcomes monitoring framework yet support a number of customer specialisms. Also, Local Authority and NHS trust reporting requirements differ greatly, so there are discrepancies in what we need to monitor and record, resulting in localised solutions being created.

Provider

"It makes a worker and client fit the client into a 'box' as the choices are too restrictive. And for a chaotic client, it can be intimidating.

Provider

9.2 Judgements of and perceived trends in the quality of support

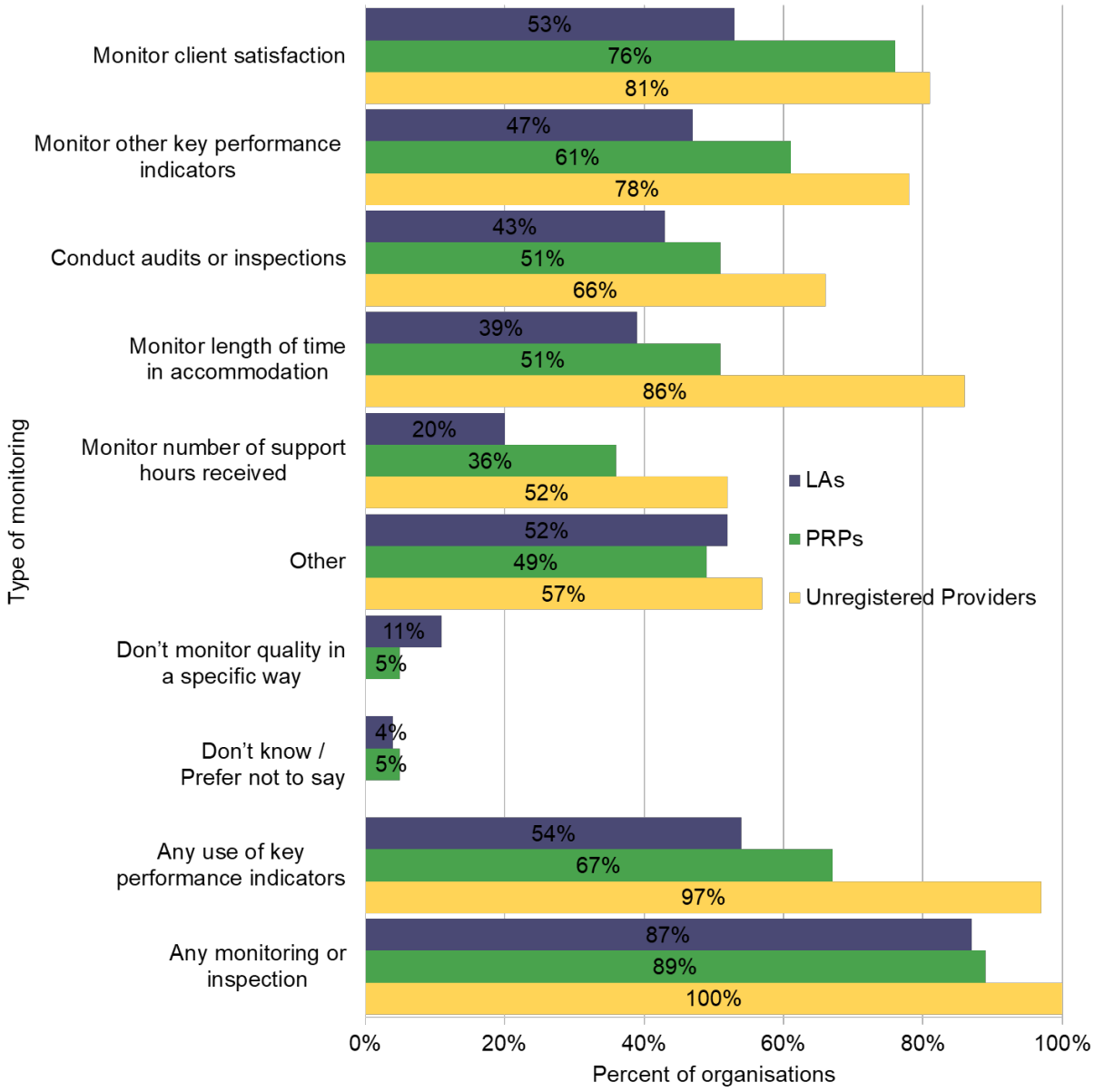
How providers assess quality

9.16 All organisations directly providing HRS services were asked how they monitored the quality of their services (Chart 9.5). Overall, nine in ten LAs and PRPs (87% and 89% respectively) and 100% of unregistered providers conducted at least some monitoring or inspection of the quality of their HRS services. Two-thirds of PRPs (67%), just over half of LAs (54%) and almost all unregistered providers (97%) monitored using any form of Key Performance Indicators (KPIs).

9.17 The most common individual measure overall was monitoring client satisfaction, in particular among unregistered providers (81%) and PRPs (76%) compared with LAs (53%). Monitoring the length of time that clients spent in accommodation was also much higher in unregistered providers (86%) than in PRPs (51%) and LAs (39%). In order of prevalence the other common measures were: monitoring of other key performance indicators, conducting audits or inspections, and monitoring the number of support hours received. All of these approaches tended to be more common among unregistered providers, especially compared with LAs.

9.18 Only one in twenty registered providers (5%) and one in ten LAs (11%) did not monitor quality in a specific way.

Chart 9.5: Ways used to assess quality, by provider type



Source: HRS Review online survey. Base: All who directly provide HRS: LAs (50), PRPs (131), Unregistered providers (58). Respondents could select more than one option, so percentages may add to more than 100%.

9.19 The case studies identified a range of activities that commissioners and providers undertook to assess quality. One LA had a quality assurance team and safeguarding review processes to monitor the quality of support being delivered to clients. A number of commissioners monitored the services being provided through quarterly review meetings with each provider, or more regular meetings if services were under-performing in some way, and by doing random checks on each clients' support file which they had access to.

They definitely want to know that I have my eye on the ball, and there is an expectation as a provider that we should be able to know what is going on in our services. There's definitely an expectation that these audits and these checks happen; but nothing more formalised than that. We sometimes work with council's quality and improvement team; they'll come in, look at what we're doing, and give us ideas of what we could do to improve in some areas.

Provider

We've got our contract review meetings and we've pretty much carried on using most of the Supporting People frameworks. We meet quarterly with providers, or in some cases we'll meet monthly if there's improvement plans in place.

Commissioner

9.20 One Commissioner talked about an 'Alliance Contract' which requires weekly short meetings where all of the providers and the commissioner come together and collaboratively decide how the outcomes are being met and what can be improved across HRS overall, and whether money needs to be shifted.

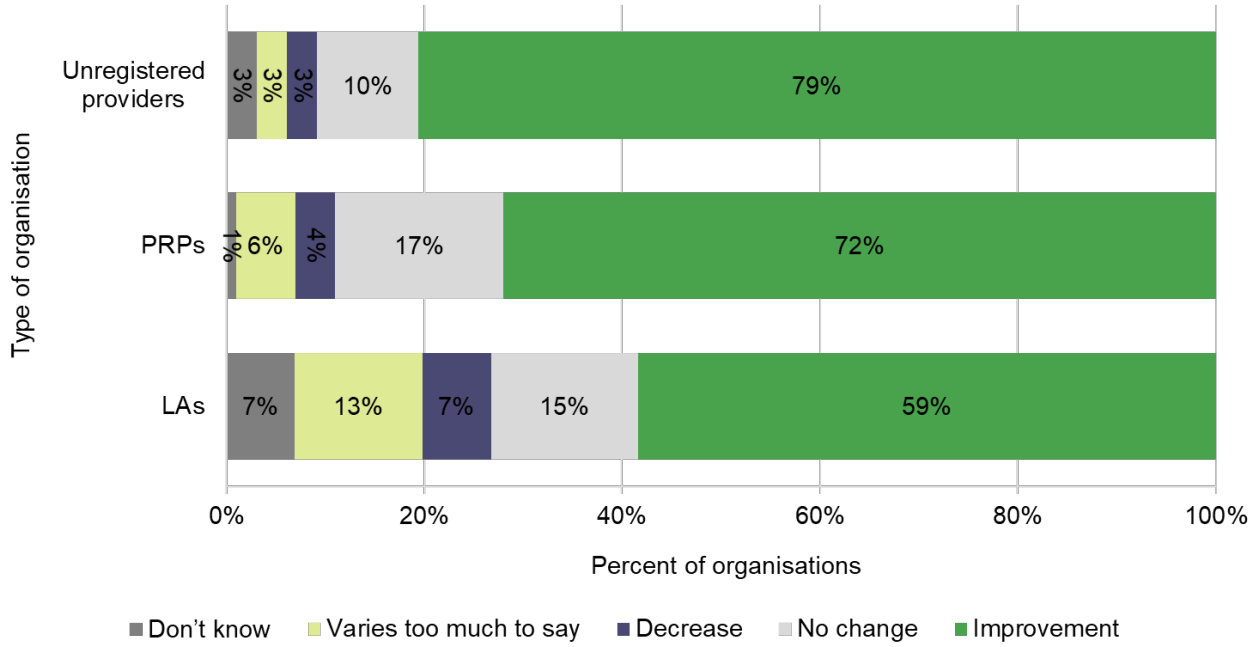
The alliance is the right way to go, but there is a lot of nervousness about it as we are talking about applying it across wider complex needs groups. It takes a lot of capacity to be an influencer rather than a contract manager which is tricky during the current time period.

Commissioner

Perceptions of quality over time

9.21 When asked their view on whether the *quality* of support services had improved or declined in the past two to three years, six in ten LAs (59%), seven in ten PRPs (72%), and eight in ten unregistered providers (79%) who used formal outcome or quality measures considered this had improved (Chart 9.6). This is based on the 'most optimistic' assessment where multiple respondents from the same provider submitted a response: indeed, there was very little difference in views, with the 'most pessimistic' ratings almost identical. Providers were more likely to consider there had been no change, than a decline in quality. It should be noted that providers were judging the quality of their own services and doing so based on the services they delivered, irrespective of changes relating to the quantity or scope of services over time.

Chart 9.6: Providers' views on changes in the quality of their services over the past 2 to 3 years

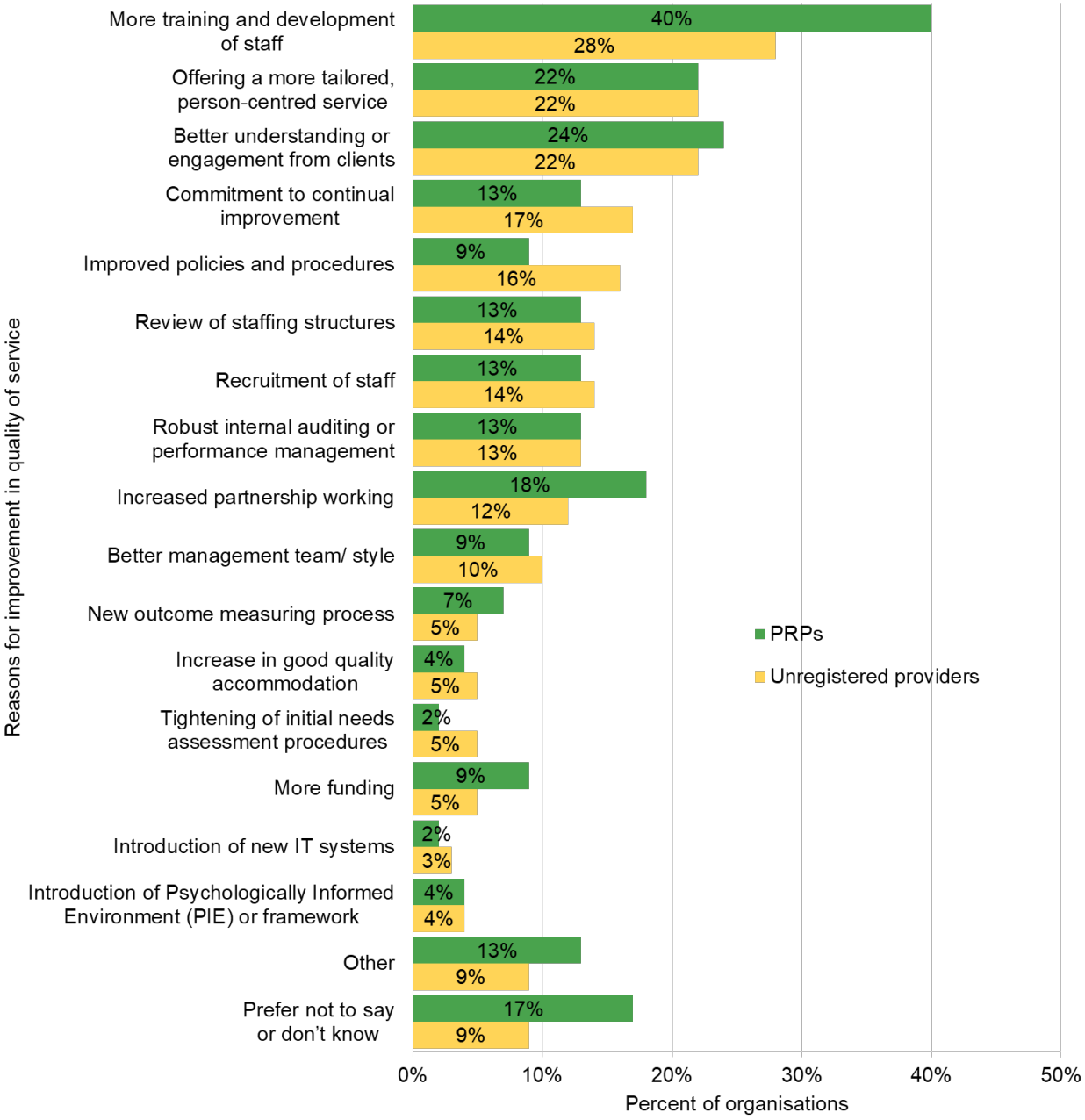


Source: HRS Review online survey. Base: All who directly provide HRS and use formal outcomes or quality measures: LAs (41), PRPs (125), Unregistered providers (58)

Views on why quality has improved or declined

9.22 Those who used formal outcome or quality measures and who considered quality to have improved over the past two to three years, were asked what had caused this. Overall, training and development of staff (mentioned by 28% of LAs and registered providers, and 40% of unregistered providers) was most commonly attributed as the reason for higher quality services. This was followed by offering a more tailored, person-centred service and better understanding/ engagement from clients themselves among PRPs and unregistered providers. In LAs there tended to be a heavier focus on improved policies and procedures and reviewed staffing structures/ the creation of new roles, than the more client-based reasons. However, the base size for LAs (n=24) is too low to report percentages and therefore Chart 9.7 only shows the results for PRPs and unregistered providers.

Chart 9.7: Views on the reasons why quality has improved by type of provider.



Source: HRS Review online survey. Base: All who directly provide HRS and said service quality improved: PRPs (83), Unregistered providers (45)

9.23 Very few LAs, PRPs or Unregistered Providers who formally monitored outcomes judged that quality had decreased over the past two to three years. Among those who reported this, however, the main reason overwhelmingly related to reduced funding and the resulting cuts to services, and (related to this) being able to offer less individual support or time for residents.

Perceived quality by level of need

9.24 Providers who managed support and were able to say whether their clients had high, medium or low levels of need were asked to rate how good or poor the

services were for those clients. As very few providers categorised by level of need, including hardly any unregistered providers, this section is only based on findings from LAs and PRPs. As even the combined base is very low, these findings should be treated with caution.

9.25 For each level of need, a majority of providers regarded services as being very good or good. This amounted to 87% for high need clients (n=18); 74% for medium need clients (n=18); and 61% for low need clients (n=21). Broadly speaking, the proportion who regarded services as being good declined as the level of need did, which is in line with what some of the case study participants identified about there being gaps in services, or lower quality services, for clients with low need, while reduced resources became more concentrated on high-need clients.

9.26 All those who classified clients by level of need and who said that the quality of any support was good, were asked why. The three top reasons for this were client/tenant feedback (mentioned by 40% of all relevant providers), outcomes data (30%); and internal auditing/ performance monitoring (30%). The base for providers who monitored quality and who said any of the services were poor means that it is too small to report their reasons (n=1).

9.3 Challenges in delivering quality

9.27 Overall, commissioners and providers described good quality HRS as support that offered consistency and flexibility which often came from providers having a perceived good level of capacity and low staff turnover and being responsive to the client. However, they identified a range of challenges in assessing and delivering quality, in the face of the increasing volume and complexity of demand. The primary challenges they identified are discussed below. As this is based on the case study evidence it is not intended to imply prevalence but rather to illustrate the *range* of challenges and examples of how these were being addressed where possible.

Different approaches to assessing and monitoring quality

9.28 Benchmarking quality against other LAs and providers is currently regarded as difficult; the main obstacle being the lack of a common set of standards, which stems partly from the lack of an obvious “right answer” to the question of how standards should be designed:

> *Yes, I think we could [benchmark]… if we all used the same model. [But] obviously people are using different adaptations of the Quality Assessment Framework … until we’ve got consistent methodology to use, I think it would be difficult.*
>
> **Commissioner**

9.29 However, even when the QAF was used there were differences in interpretation, partly because different LAs had different expectations. More than one commissioning LA said that both they and their providers felt that the QAF was overly complex, and that its removal had been one element of the abolition of the Supporting People ring-fence that they welcomed. Providers in particular welcomed the flexibility to select or devise their own approaches to assessing outcomes,

which could be tailored to and informed by clients themselves, alongside meeting the requirements of commissioners.

9.30 Many of the service providers talked about how they took more of a qualitative approach, looking at successes relative to the individual clients' goals and expectations. Some services for higher need clients were also small in terms of client numbers, meaning that any metrics set in terms of percentages of clients achieving a particular outcome would vary greatly from year to year, potentially producing misleading results. They therefore relied on more qualitative assessments:

> *Comparing is really difficult… because it depends on the individual people you're accepting. If it [were] all just about positive outcome, people moving on after two years, then you [would] not accept the challenging and more difficult clients.*
>
> **Provider**

9.31 One provider for young people monitored quality by assessing their staff and how quickly they got to know their clients, as they felt it was important to develop a trusting relationship with clients consistently and through that, show there was a movement in the client's situation which was difficult to measure.

9.32 One LA providing support for young people explained how they utilised a pseudo DPS which includes a new, more detailed specification which is more young people-oriented than the former Supporting People Quality Assessment Framework. They believe that their new approach ensures the quality of the service is up to par and enough emphasis is put on safeguarding. The quality checks are done by their dedicated team for contract management, which can be shared with the region through an information-sharing protocol.

Getting the right data and outcomes

9.33 The scale and nature of data being collected had to be proportionate, in terms of its level of detail and how frequently it was collected and analysed. At the start of their current round of contracts. one case study commissioner had asked providers to record data and client outcomes on an IT system, but they found they were asking them to provide more data than was useful and it was too onerous for the frontline workers to complete on an ongoing basis. They therefore rationalised their data recording and moved to only asking for this data when a client moved in or out of their service.

9.34 Some commissioners had also moved away from framing success in terms of 'positive' and 'negative' move-ons because they did not feel this was appropriate for very challenging cases. For an individual who had a history of frequent offending, for example, a six-month stay in a hostel without offending could be viewed as a success in relative terms, despite it perhaps ending with the client re-offending which would be classed as a negative move on. Having inappropriate or what were deemed as unrealistic outcomes could deter providers from taking on more challenging clients because it would end in a negative move on. The commissioners therefore created a list of nine outcome areas which encouraged

more realistic objectives for each individual. These nine outcomes are monitored in order to frame discussions with clients rather than setting targets. Commissioners observed that more clients were joining their services who had higher needs and that even these nine outcome areas were too ambitious for some of that group, raising the challenge of developing and measuring more 'distance travelled' type outcomes which would by necessity require tailoring to individual clients.

The client needs have increased and there are more challenges out there with regard to the services we need to provide, and the people we need to provide them for. When we commissioned, we asked for providers to look at nine outcomes… which is all about maintaining a tenancy and being able to engage with other services and family and whatever else. But [for] some of our people actually getting them out of bed in the morning is an outcome and an achievement. So… I think when we commission again, we need to look at our 'harder to accommodate client group'…. Keeping someone in a hostel actually is an achievement for someone who is quite chaotic. So actually, we need to move the outcomes back a bit.

Commissioner

Cost-effectiveness and sustainability of services

9.35 One of the key issues raised by case study commissioners and providers alike was the continuing viability of services where declining contract values may not cover all their delivery costs (including overheads and all the funding that goes into providing a good quality service such as time for reflective practice):

Sometimes the contract values don't reflect the real cost of delivering the service, and that needs reflecting in the value of the contract. For example, if we get referrals through for clients who have too high a level of need [compared with that specified under the contract] we will still aim to support that client because the worst thing for the clients is to move them around between different services. This means that we are holding greater risks than we should because there are not enough specialised services for high need clients.

Provider

9.36 This issue was echoed by another provider in the same area who highlighted that many of their clients have very complex needs and therefore they need more time from support workers that is 'costed' under the contract:

These people have complex needs and if the contract is funded on the basis of say three hours of support per week per client, if someone is in crisis we can't just up and leave them after they've used their three hours. It means something has to give.

Provider

9.37 One commissioner had assessed whether the support provided was saving money overall in terms of rent paid and non-rental related costs. They had assessed this against a control group, which they regarded as worthwhile despite the complexity of the exercise, since it provided evidence to support them funding their service. In

general, they believed that the quality of their services has improved, as has the efficiency of delivery over the past two to three years, and that clients are satisfied with the support they receive, but there is a much greater issue now with demand for those services outweighing supply, and – in the future – with maintaining services where funding has recently been reduced or removed.

> *It has reduced. We can't kid ourselves that we're providing the same service we did ten years ago – because we can't. But it is a flexible service.*
>
> **Provider**

9.38 Commissioners in the case studies often reported that the quality of service was good because providers worked well together, and all parties were clear about what the reason was for giving support, which was to maintain tenancies and independence or to move clients closer to this ultimate goal. However, outcomes for clients who had more complex needs could be poorer and there was a need to commission more intensive services for those people, despite it being more expensive, squeezing other areas of their budget when overall reductions were being made.

9.4 Summary of key findings

- There were a very wide range of approaches used for monitoring quality and outcomes, as providers and commissioners alike tended to move toward proprietary systems, some based on former Supporting People practice, and some not. Few of these systems produced comparable outputs. This means it is not possible to assess the quality of current HRS provision beyond the broad perceptions reported among research participants.

- Four in five LAs (80%), two-thirds of PRPs (65%) and over nine in ten unregistered providers (93%) systematically monitored client outcomes.

- Around half of LAs (49%) and PRPs (51%), and over four in five (85%) of unregistered providers, used an outcomes framework.

- Almost all LAs, PRPs and unregistered providers who used frameworks regarded these to be effective. Valued features were the flexibility of being able to tailor frameworks to client needs, ease of use by staff and clients alike, facilitating clear monitoring and enabling consistent reporting.

- The vast majority of providers conducted at least some monitoring or inspection of the quality of their HRS services. The most common method was monitoring client satisfaction.

- Six in ten LAs (59%), seven in ten PRPs (72%), and eight in ten unregistered providers (79%) who used formal outcome or quality measures considered that the quality of the services they delivered had improved over the past two to three years.

- The main reasons that providers cited for better quality services were improved training and development of staff, followed by offering a more tailored, person-centred service.

- Key challenges identified by case study participants were the lack of a common set of standards which limited benchmarking; challenges in collecting the most appropriate outcome data, especially for clients with complex long-term needs; and challenges in evaluating cost-effectiveness.

10 Conclusions

10.1 This chapter draws together the results from the various elements of the research.

10.2 **The research shows that there has been at least a 61% reduction in spending on commissioning of Housing-related Support (HRS) since 2010/11, shortly after the ring-fence around Supporting People funding was removed.** The survey data indicated that the level of commissioning on HRS by Local Authorities (LAs) was around £522m in 2018/19 in England, including commissioning through budgets other than Supporting People.

10.3 While this is higher than indicated by the Revenue Account returns to MHCLG in the Supporting People category, the overall level of spending by LAs[68] (even after including direct provision, which has always been funded via a range of budgets as well as Supporting People) was still at least 61% lower than that reported in 2010/11 MHCLG Revenue Account budget data (£1,355m), just after the ring-fence was removed.

10.4 **There was evidence that commissioning of HRS had become more dispersed since the removal of the Supporting People ring-fence.** Partnership commissioning was common, with increasing involvement of NHS bodies in particular (although *funding* from NHS sources remains marginal). Within LAs, a range of departments were usually involved in commissioning HRS, including Adult Social Care, Public Health, and Housing Services. There was no particular pattern to which type of authority adopted which structure.

10.5 **Staffing cuts are reported to have left gaps in HRS knowledge in LAs.** Providers reported that expertise regarding HRS at LAs had reduced markedly, with high turnover of staff, and that at some LAs it was difficult to contact someone with knowledge of their work.

10.6 **It was rare for individual LAs to have stopped commissioning HRS altogether, although a few had done so.** HRS was commissioned by LAs in the vast majority of areas across England, and the survey indicated that it in total HRS serves around 309,000[69] clients in 2018/19. This compares to LAs reporting funding

[68] At approximately £522m of commissioning by LAs, and £91m of direct spending, relative to the £359m reported in the Revenue Account 2018/19 budgeted spend, compared to £1,355m RA budgeted spend in 2010/11.

[69] This is not comparable with numbers of housing units or residents in the 2016 Supported Accommodation Review, which were compiled on a snapshot rather than full year basis.

support via Supporting People for about 1,113,908 household units in 2010/11[70], a reduction of at least[71] 72%.

10.7 **The research indicates that the volume of support commissioned has reduced considerably since 2010/11, and providers and commissioners often believed that it was much lower than needed by clients. Decisions to decommission some types of provision or provision for some client groups had left gaps.** The survey showed that many LAs with responsibility for commissioning did not commission support at all for some client groups. Among these LAs, only around half mentioned commissioning HRS for people with drug or alcohol misuse issues (50%), ex-offenders or those at risk of offending (49%) and people with physical or sensory disabilities (47%). This suggests that for many people with these needs living in England, they are not eligible to be referred to any HRS relevant to their needs. This finding was supported by in-depth interviews with both commissioners and providers.

10.8 Providers of HRS interviewed reported that, with some exceptions involving charitable grants, cross-subsidy and temporary use of reserves, **decommissioned support services which could not be funded through user charge or Housing Benefit had been generally closed down rather than funded via other routes**.

10.9 The proportion of need met was reported to be lowest for client groups with drug or alcohol misuse problems, and for ex-offenders. However, **there were also indications that almost all commissioned LA HRS funding for lower needs, Floating Support and HRS in Sheltered Housing had been withdrawn.** Given that the Supported Accommodation review[72] in 2016 indicated that there were 395,000 units of such housing for older people, the impact of this may have been widespread. This was due to either the perceived impact of removing provision being lesser for lower need clients, or because commissioners believed that providers might be able to fund the provision via service charges. In many cases, LA commissioners felt that at the funding level available they could only deliver HRS pertaining to statutory services or obligations, for example which had a direct impact on their ability to house homeless people. **There may be a case for further research in this field** specifically with sheltered housing providers and residents to assess the changes that have taken place in more detail and what the impact has been on residents.

10.10 **The data available to LAs was generally felt to be sub-optimal for producing estimates of need.** LAs rated their skills for planning and forecasting well, but were

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[70] Ministry of Housing, Communities and Local Government. (MHCLG) (2010). *Supporting people local system data: Supporting People Household Units as at 31.03.10,* England. October 2010. Available at: https://www.gov.uk/government/statistics/supporting-people-local-system-data

[71] Although the unit of measurement of the 2010/11 Supporting People data is household units, while the unit of measurement for the survey was individual clients, it can safely be said that if the measure for the 2010/11 Supporting People data were individual clients it would be higher than 1,113,908 since a household unit served can only contain one or more clients.

[72] Department for Work and Pensions. (2016). *Supported Accommodation Review: The scale, scope and cost of the supported housing sector: November 2016.* Available at: https://www.gov.uk/government/publications/supported-accommodation-review

more negative about the time available to do this. A key challenge to planning was the difficulty in predicting 'knock-on' effects of cuts to services elsewhere, both within and outside the LA. Those LAs interviewed in the case studies also frequently said they found planning and forecasting difficult due to late setting of budgets. This created an element of reactiveness in the system which generated concerns about longer-term sustainability.

10.11 **As funding from commissioning has reduced, many providers have turned to increasing rents and service charges to fund activities to assist their residents.** Many providers reported that activities formerly funded by Supporting People commissioning were now funded via this source. Of direct provision of HRS by LAs and PRPs combined, around half was funded through LA commissioning or departmental budgets, while around a third came from service charges eligible for Housing Benefit (accounting for 24% of all HRS funding[73]) and those which are not eligible for Housing Benefit (7% of all HRS funding). Other minority sources of funding included commissioning via other government departments. Although many providers are charities, charitable fundraising is a marginal source of funding for HRS (only three to four per cent).

10.12 **This shift to increased use of Housing Benefit to fund HRS has meant that providers have to pay careful attention to the division between support activities and housing management activities**. Providers reported differing approaches within LAs to maintaining this boundary. Some felt that this was creating inefficiencies within the sector with artificial distinctions drawn between staff roles and/or excessive reporting/accounting for time spent between the two activities. The geographical differences in LA approaches were creating challenges for large providers that worked across several different areas.

10.13 **There is evidence to suggest LA commissioned contracts are becoming increasingly unattractive for providers, reducing competition and potentially raising concerns about the long-term sustainability of HRS services.** Some providers reported falling funding per hour for support, and shorter contracts. Both of these caused some not to bid for contracts offered by LA commissioners on grounds of safety or viability, including for renewal of existing contracts. LAs also reported that they sometimes had very few bidders for some contracts.

10.14 The majority of LAs that commissioned or funded HRS did so over periods of three to five years. However, in the case studies a number of commissioners and providers referred to funding uncertainties leading to short-term contracts of two years plus repeated one-year extensions. This impacted on providers' financial

[73] Although 'support' may not be funded by Housing Benefit, as discussed in Chapter 4 case study participants (both LAs and providers) believe that the definition used for 'support' is much narrower than the eligibility criteria for funding under the former Supporting People programme, and thus providers have been able to transfer substantial quantities of non-core HRS activity formerly funded by LA commissioning to Housing Benefit funding. Although providers reported spending significant time ensuring their Housing Benefit claims were not for ineligible activity, the extent to which Housing Benefit was being claimed for ineligible activities could not be determined. Further research would be required to determine this.

stability, inhibited their planning, and created difficulties for staff morale, recruitment and retention.

10.15 **Providers felt that over time the removal of lower need or more preventative HRS activity was creating longer-term issues and costs, as a lack of support led to clients developing higher, more complex, needs leading them ultimately to require more resource intensive interventions.** The research did not collect any quantitative evidence to establish a causal relationship, but many research participants were convinced that this was the case. **There may be a case for carrying out further research on the impact and cost-efficiency of lower need and preventative HRS activity, to inform decisions in this area going forward.**

10.16 In general, where HRS was provided it continued to cover a wide range of types of activity, and notwithstanding issues around the quantity of provision, **providers were positive about the quality of the provision which does exist**. Providers themselves usually conducted systematic monitoring of outcomes of HRS delivery, and around half of PRPs and LA providers, and nearly all Unregistered Providers, used formal frameworks to monitor client outcomes. Most providers rated their internal monitoring systems highly. Generally, the quality monitoring systems being used now were felt to be considerable improvements on the rigid requirements under the Supporting People Programme.

10.17 **There is a shortage of numerical evidence regarding the sector at the current time;** in particular:

- The number and range of providers and commissioners of HRS remains poorly documented. This could be addressed through including a small number of questions in a survey covering wider topics aimed at housing organisations and/or LAs.

- There are an unknown number of unregistered providers operating in the market. To establish the number of these with certainty would require a registration scheme for these providers, or commissioners being required to collate information regarding the organisations they select to deliver services, ideally including sub-contractors.

10.18 **This report has focused on the perspectives of providers and LAs;** however, it did not include a survey of recipients of HRS. Given that clients could receive HRS from multiple sources, this might be considered as a method of measuring the quality of services delivered holistically, and (if conducted on a sufficient scale) measuring the impact of future changes in services over time.

Annex A List of Abbreviations

ABI	Acquired Brain Injury
ALMO	Arm's Length Management Organisation
CA	Combined Authority
CAMHS	Child and Adult Mental Health Services
CCG	Clinical Commissioning Group
CHS	Centre for Housing and Support
CORE	COntinuous REcording system of social housing lettings (data collected by MHCLG from Registered Providers)
DPS	Dynamic Purchasing System
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GDPR	General Data Protection Regulation
GP	General Practitioner
HB	Housing Benefits
Housing LIN	The Housing Learning and Improvement Network
HRA	Housing Revenue Account
HRS	Housing-Related Support
IHM	Intensive Housing Management
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicators
LA (LAs)	Local Authority (Local Authorities)
LAHS	Local Authority Housing Statistics
LD	Learning Disabilities
MHCLG	Ministry of Housing, Communities and Local Government
NHF	National Housing Federation
NHS	National Health Service
NOMS	National Offender Management Service
NVQ	National Vocational Qualification
Ofsted	Office for Standards in Education, Children's Services and Skills
ONS	Office for National Statistics
OPCC	Office of the Police and Crime Commissioner
PIE	Psychologically Informed Environments
PIP	Personal Independence Payment
PRP	Private Registered Provider
QAF	Quality Assessment Framework (for Supporting People)
RA	Revenue Account (data collected by MHCLG from LAs)
SDR	Statistical Data Return (data collected by the Regulator of Social Housing from Registered Providers)
SH	Supported Housing
SP	Supporting People
WRWA	Welfare Reform and Work Act 2016

Annex B Glossary of terms

Accommodation-based Support

For the purposes of this research, HRS provided to someone resident in Supported Housing.

Almshouse Charity

A charity for the relief of financial hardship by the provision of housing and associated services or benefits, managing one or more almshouses, functioning under the jurisdiction of the Charity Commission.

Arm's Length Management Organisation

A public sector organisation set up by an LA to manage housing they own. This type of organisation is not required to be a PRP with the Regulator of Social Housing, but may voluntarily choose to register.

Combined Authority

A public sector organisation that is officially responsible for public services and publicly funded facilities in a wide area, taking on these functions from LAs within its geographical area, which is typically but not always a former Metropolitan County. Examples include the Greater London Authority (GLA) and WMCA (West Midlands Combined Authority).

Exempt accommodation

Exempt accommodation under Housing Benefit regulations means accommodation which is:

(a) a resettlement place provided by persons to whom the Secretary of State has given assistance by way of grant pursuant to section 30 of the Jobseekers Act 1995(b) (grants for resettlement places); and for this purpose "resettlement place" shall have the same meaning as it has in that section; or

(b) provided by a non-metropolitan county council in England within the meaning of section 1 of the Local Government Act 1972(c), a housing association, a registered charity or voluntary organisation where that body or a person acting on its behalf also provides the claimant with care, support or supervision

This definition was intended to include supported accommodation that was directly provided by LAs and by housing associations, registered charities and voluntary organisations. The 'care, support or supervision' element here could be provided by the landlord or another body acting on its behalf. The regulations did not give any further explanation of what 'care, support or supervision' is other than that it is more than 'minimal'.

Floating Support

For the purposes of this research, HRS provided to someone not resident in Supported Housing. This does not include drop-in services, where the client must visit to receive a service.

Housing Association

A specific type of Registered Social Landlord or Registered Provider; these are private (since privatisation in 1988) and independent of government, but are non-profit making by constitution, and regulated by the Regulator of Social Housing in England.

Housing Benefit

A means-tested benefit funded by Department for Work and Pensions (DWP), and administered by LAs, for the purpose of supporting individuals to afford housing who would not otherwise be able to do so. Housing Benefit is payable to cover rent and service charges relating to Housing Management, but not support. The amount payable will depend on the level of rent charged and the claimant's circumstances and income.

Housing Manager

An organisation in charge of the maintenance of a property, maintenance of any land or communal areas, providing security if necessary, and dealing with the turnover of residents, ensuring a pleasant living environment for the tenants, as well as liaising with the LA when necessary.

Housing Related Support (HRS)

Defined in this report to include all support services funded or organised by either public authorities or providers of Supported Housing to residents of Supported Housing, excluding personal care services, drop-in services, counselling or befriending. If an activity includes some support and some care, it would be classified as a support service and included in the research. The definition also includes all Floating Support services, even if provided to people who are not resident in Supported Housing.

Landlord

The legal owner of a property via leasehold or freehold. In the context of this report an owner of Supported Housing.

Local Authority (LA)

A public sector organisation that is officially responsible for public services and publicly funded facilities in a particular local area, including but not limited to HRS.

Lower-tier Local Authority

Lower-tier LAs are a sub-type of LA which operates in conjunction with an upper-tier LA serving a wider area to provide services. Lower-tier LAs are all non-metropolitan districts, and the LA bodies are referred to as district councils. Some lower-tier LAs may hold borough, city or royal status, but these are ceremonial titles and do not affect the administrative responsibilities of the organisation.

Older People's Housing

The term by which the SDR dataset refers to Sheltered and Extra Care Housing, and for the purposes of this research considered to be a subset of Supported Housing.

Outcome Stars

A method of monitoring progress toward goals for individuals receiving support services of all types. The method presents outcomes in a 'star' shape, measured based on a 'Journey of Change' which is usually determined through conversations between individuals receiving support and support practitioners[74]. The detail, however, is not prescriptive, and so 'Stars' created in different contexts, or by different organisations, are not comparable.

Personal Budget

Allocated alongside a personal Care and Support plan, it is a fixed amount of money allocated to a person by their LA, calculated to cover all their care and support needs, allowing for flexibility in the way the support is provided.

Private Registered Provider (PRP)

In England, a provider of affordable housing registered with the Regulator of Social Housing which is not a LA or government agency – for example a Housing Association or Almshouse Charity.

Registered Provider (RP)

In England, a provider of affordable housing registered with the Regulator of Social Housing – for example a Housing Association or Almshouse Charity. LAs can be Registered Providers (RPs) if they own council housing, but cannot be Private Registered Providers (PRPs).

Regulator of Social Housing (The)

An executive non-departmental public body, sponsored by the Ministry of Housing, Communities and Local Government (MHCLG), which regulates registered providers of social housing to promote a viable, efficient and well-governed social housing sector able to deliver homes that meet a range of needs.

Sheltered Housing and Extra Care Housing

Housing usually designated for older people with support needs, which helps them stay independent for longer. However, working-age tenants can and do reside in this accommodation, where appropriate. This provision is often described as on a 'continuum', with sheltered housing used to describe housing for residents with lower-level support needs. Extra care is accommodation that has been designed for older people with higher care and support needs. For the purposes of this report, this is considered to be a subset of Supported Housing.

[74] Triangle (2017), *What is the Outcomes Star™?* https://www.outcomesstar.org.uk/about-the-star/what-is-the-outcomes-star/

Supported Housing

For the purposes of this research, in line with the WRWA (Welfare Reform and Work Act), we define Supported Housing as designated or purpose-built housing, provided together with support. Supported Housing is accommodation which:

(a) is made available only in conjunction with the supply of support,

(b) is made available exclusively to residents who have been identified as needing support, and

(c) falls into one or both of the following categories—

(i) accommodation that has been designed, structurally altered or refurbished in order to enable residents to live independently,

(ii) accommodation that has been designated as being available only to individuals within an identified group with specific support needs.

This is also the definition used for the purposes of the Regulator of Social Housing's Statistical Data Return, as a basis for counting the number of units of housing of particular types.

Specified Accommodation

This includes all housing that meets the criteria given in the glossary above for 'exempt accommodation', as well as the following three groups:

- accommodation provided by a county council, housing association, registered charity or voluntary organisation in which the claimant has been placed in order to meet an identifiable need for care, support or supervision and where the claimant receives that care, support or supervision;

- refuges for victims of domestic violence where these are managed by LAs, county councils, housing associations, registered charities or voluntary organisations;

- hostel accommodation provided by LAs where care, support or supervision is also provided

The first of these three groups reflects the definition of exempt accommodation but does not limit it to being provided by the landlord or someone acting on the landlord's behalf. This means that care, support or supervision can be commissioned and provided by a third party. For example, it includes instances where the LA commissions support to be delivered by an independent support provider, in properties owned by a Housing Association. The second two groups add LA-owned domestic violence refuges and hostel accommodation to the criteria for supported accommodation under Housing Benefit regulations.

Supported Housing

Supported Housing, for the purposes of this research, is designated or purpose-built housing, provided together with support. This is in line with the definition used for the Regulator of Social Housing's Statistical Data Return (SDR) and the Welfare Reform and Work Act (WRWA) displayed below, but with the addition of housing of the same type with other landlords or in other tenures. The definition excludes care homes and nursing homes. We do include floating support in this research, but not as a form of Supported Housing.

The SDR and WRWA definition states that Supported Housing is accommodation which:

- is made available only in conjunction with the supply of support;
- is made available exclusively to residents who have been identified as needing support; and
- falls into one or both of the following categories:
- accommodation that has been designed, structurally altered or refurbished in order to enable residents to live independently;
- accommodation that has been designated as being available only to individuals within an identified group with specific support needs.

Supporting People

Supporting People was a UK government programme helping vulnerable people in England and Wales live independently and help them to remain in their home. Support was provided in particular to residents of Supported Housing, but also, in the form of Floating Support, to people living in other tenures of housing. The programme was administered by LAs and funded by ring-fenced central government funding. Monitoring of provision and funding was maintained by central government. The ring-fence was removed in 2009, but LAs continued to be permitted to provide or commission this type of service.

Unitary Local Authority

Unitary LAs are a sub-type of LA which encompasses the functions of both lower-tier and upper-tier LAs. It may be referred to as a single-tier LA. Unitary Authorities include authorities defined by ONS in the Code History Database as Unitary Authorities, London Boroughs or Metropolitan Districts, as well as the Isles of Scilly and City of London. Some unitary LAs may hold borough, city or royal status, and in some cases take the title of ‘county’ as part of their name, but these are ceremonial titles and do not affect the administrative responsibilities of the organisation.

Upper-tier Local Authority

Upper-tier LAs are a sub-type of LA which operates in conjunction with a series of lower-tier LAs operating within the same geographical area to deliver services. Upper-tier LAs are all administrative counties, and the LA bodies are all referred to as county councils.

Tenancy Support

Support, advice and advocacy provided to tenants of any tenure of rented housing, typically but not exclusively by a social landlord, to help them to maintain their tenancy. This may cover non-financial support with managing rent arrears, benefits, domestic budgeting including debt counselling, repair issues, neighbour disputes, anti-social behaviour issues that are related to the tenancy, and advice in accessing other services.

Unregistered Providers

In England, and for the purposes of this report only, a provider of HRS and/or Supported Housing not registered with the Regulator of Social Housing.

Annex C Online survey response rate

C.1 Survey response

C.1 The online survey was conducted using IFF Research's in-house online survey systems, enabling a high degree of detail regarding survey outcomes to be gathered. The sampling frame changed throughout the course of the research, as more organisations were identified through organisations contacting IFF Research to ask to be included as a result of promotional activity, or being identified by the advisory group. Through contact with organisations, mergers, splits and closures also came to light.

C.2 A group of PRPs (99 in total, almost all small) were excluded from the fieldwork because on inspection they were administratively part of other organisations included in the fieldwork, although not formally a corporate part of those organisations. These were mostly branches of federally structured organisations, which were contacted where possible at HQ level.

C.3 This resulted in an overall sample size of 1,021 organisations at the end of the survey, as shown in Figure C.1.

C.4 In total, there were 326 responses, a headline response rate of 32%. A further 73 respondents completed the first section of the survey, but did not proceed to submit key data about HRS, and 30 more logged in but did not complete the first section of the survey.

Figure C.1 Response rate detail: numbers

Type of response	*LA*	*PRPs*	*Unregistered Providers*	*Total*
Completed	**98***	**158**	**70**	**326**
Partial complete (not usable)	22	39	12	**73**
Logged in, but went no further	10	15	5	**30**
Did not respond	85	375	127	**621**
Screened out	2	2	1	**5**
Total sample	**217**	**589**	**215****	**1,021****
Federal organisation branches	-	99	-	99
Total	**217**	**688**	**215****	**1,120****

**ALMO, LA or both **Total number identified via searches and therefore included in the sampling frame*

Figure C.2 Response rate detail: percentages

Type of response	*LA*	*PRPs*	*Unregistered Providers*	*Total*
Completed	**45%***	**27%**	**33%****	**32%****
Partial complete (not usable)	10%	7%	6%**	**7%****
Logged in, but went no further	5%	3%	2%**	**3%****
Did not respond	39%	64%	59%**	**61%****
Screened out	1%	0%	0%**	**0%****
Total	**100%**	**100%**	**100%****	**1,021****

**ALMO, LA or both **of total number identified via searches and therefore included in the sampling frame*

C.2 Response rates by sub-group

C.5 The response rate for the various key sub-groups is shown in Figure C.3. As illustrated in this table, some groups had a much lower response rate than others ranging from 14% to 67%. To make the sample more representative of organisations providing HRS in England, this was corrected for through the weighting process, outlined in the next section. Without this weighting process, the answers (and spending levels) of groups shown below with a high response rate would be over-represented, while the answers (and spending levels) of groups with a low response rate would be under-represented.

Figure C.3 Response rate detail: percentages

Sub-group	*Number of organisations responding (n)*	*Response rate*
All organisations	**326**	**32%****
LAs*, of which	98	45%
Upper Tier / Unitary, of which	*74*	*47%*
Upper Tier	*13*	*50%*
Unitary	*61*	*49%*
Lower Tier	*24*	*33%*
PRPs, of which	158	27%
Small, <100 units	*39*	*14%*
Medium, 100-999 units	*94*	*45%*
Large, 1000+ units	*62*	*67%*
Unregistered Providers	70	33%**

**ALMO, LA or both **of total number identified via searches and therefore included in the sampling frame*

Annex D Online survey analysis methodology

D.1 Data gathering

D.1 The data was gathered via IFF Research's online survey systems. Data was gathered via a secure HTTPS connection to the respondent's computer or smartphone, and stored on IFF Research's secure servers, located on the IFF Research premises. IFF Research was ISO27001 accredited for data security throughout the research process.

D.2 IFF provided commitments to respondents not to pass on any of their contact details or personal details on to any other organisation, and not to include any personal name or the name of any organisation in the data transferred to MHCLG.

D.3 All respondents were reminded, as required by law and the MRS Code of Conduct, that under GDPR legislation they retained the right to have a copy of their data, change their data, or withdraw from the research at any time without providing a reason. They were provided with contact details necessary to do this.

D.4 Data was anonymised before transfer to MHCLG, with all personal details and all organisation-level names and identifiers removed. All personal data and non-anonymised data were securely deleted by IFF six months after the conclusion of the research.

D.2 Coding

D.5 The questionnaire collected both quantitative and qualitative data. There were several open ended questions in the survey which needed to be coded for analysis. Respondents were also able to specify responses when an 'Other' option was provided within a closed question, which also needed to be coded.

D.6 A coding frame was constructed during fieldwork by IFF Research's dedicated coding team. The coding frame was agreed following an iterative process with the research team. This was used to classify responses for analysis purposes.

D.7 Data derived from coding was then extensively checked by the research team, with a minimum of 10% of open text responses and codes attached checked for each question. In practice given the level of detail required, a much higher proportion of open text questions were checked, at over 50% in many cases. Further revisions were made to the codeframe based on this, and the open text responses and codes re-checked at each stage. The resulting coded data was incorporated in the final tables and dataset.

D.3 Data Processing

Data Adjustments

D.8 In a number of situations, it was necessary to adjust the data collected through the survey. This was carried out where it was clear that the data provided by respondents was incorrect in specific ways described in the list below. In all cases, adjustments were made and carried through to all derived variables based on the questions concerned.

D.9 These were:

- Where, at a question asking for a breakdown of costs in pounds, numbers totalling 100 had been entered instead of totalling to the overall cost given at the previous question. For example, an organisation might report several million pounds in spending, and then enter costs totalling £100 at each question asking for the cost to be broken down in £ terms. It was assumed that in these cases, percentages had been entered in error rather than costs and figures were amended accordingly.[75]

- Where, a question which asked for a breakdown of clients or costs in percentage terms, percentages that totalled 100 had been entered in some options, but all other options coded to 'don't know'. In these cases, 'don't know' was amended to zero.[76]

- If a respondent provided percentages that exceeded 100% to a question that asked about the breakdown of clients or costs in percentage terms In these cases, the response was adjusted from a percentage to 'don't know' or modified if the intention was clear (typically when 100% were stated to have multiple complex needs and then other percentages entered to show needs within that; in this case only the multiple complex needs value was retained).[71]

- Any large outliers to questions on overall client numbers and overall spending were sense checked against the organisation's website to ensure that they were plausible relative to the organisation's size, and edited to 'don't know' if implausible. This would typically be caused by the respondent typing the incorrect number of zeroes on a large number.[77]

- If more than one person in an organisation reported to be answering for 100% of an organisation's HRS delivery or commissioning, the less complete response, assessed by the number of 'don't know' responses, was excluded[78].

Data merging

D.10 Multiple individuals from organisations could take part in the survey. Each individual received a separate copy of all sections of the survey excluding Section A, which

[75] 22 instances, affecting 20 cases.
[76] 49 instances, affecting 41 cases, were forced to 100% in total.
[77] 4 instances, affecting 4 cases
[78] 6 instances, affecting 6 cases

covered general information about the organisation as a whole and was filled out by the lead respondent only. This was to enable different departments in the same organisation to submit responses which the feasibility study had identified as being a necessary requirement due to the involvement of multiple LA and PRP teams in commissioning and delivering HRS.

D.11 In the sections of the survey regarding spending, individuals could either respond regarding all of the provision they had an overview of, or for individual projects or teams. This flexibility was provided to maximise the ability of respondents to submit figures which might not be available in a consistent format between organisations.

D.12 This meant that multiple sets of responses to some questions were made for some organisations. This data needed to be merged to allow analysis at an organisation level. The data was merged in the final dataset according to the following steps:

- Questions allowing multiple responses were merged by including all responses selected by the multiple respondents;
- numeric questions (for example numbers of clients and amounts of spending) were added together; and
- for single response opinion questions, the most optimistic and most pessimistic values given by any respondent across the organisation were both retained in the final dataset in separate variables.

D.4 Weighting

D.13 After the data was coded and adjustments were made, the dataset was weighted.

D.14 Applying weights to the survey data was necessary because response rates varied between organisational groups in the dataset, in particular between sizes of PRP and tiers of LA. Without weighting, the answers (and spending levels) of groups with a high response rate would be over-represented, while the answers (and spending levels) of groups with a low response rate would be under-represented.

D.15 In a weighted dataset, some responses are treated as if they are more than one response, and others are treated as if they are less than one response.

D.16 Organisations who responded to the survey were weighted up to account for organisations that did not respond. To give an example, the 62 large PRPs who responded to the survey were weighted up to represent the 96 large PRPs, who were in scope and on the sampling frame, which SDR data indicates operate in England. So, at the end of the process each large PRP responding was taken to represent 1.484 organisations. The figure of 96, in this case, could be referred to as the weighting target, being the desired number of PRPs to be shown when estimates are produced using the final dataset.

D.17 A different approach was taken to each type of organisation in the sample, due to the differing availability of secondary data to use as a basis for weighting, and the differing methods of construction of the sampling frame.

LAs

D.18 The weighting design for LAs took the form of a grid of region by tier status, as shown in Figure D.1. The population data to construct this weighting grid was obtained from the ONS Code History Database, the official register of administrative areas in the UK. Regions shown are grouped from combined ONS standard regions.

Figure D.1 Weighting grid for LAs and unweighted values

Region	*Lower tier (district) with housing stock*	*Upper tier (county)*	*Unitary*	*Total*
Weighting Targets				
London, South East and East of England	36	12	51	**99**
East Midlands, West Midlands and South West	26	11	27	**64**
North East, North West and Yorkshire and the Humber	4	3	47	**54**
Total	**66**	**26**	**125**	**217**
Unweighted Responses (number of actual responses, at an organisation level)				
London, South East and East of England	17	5	21	**43**
East Midlands, West Midlands and South West	6	6	13	**25**
North East, North West and Yorkshire and the Humber	1	2	27	**30**
Total	**24**	**13**	**61**	**98**

Source: ONS Code History Database, July 2019

D.19 Together with the above grid, an additional weight was also applied based upon MHCLG Revenue Account budget data for 2018/19, using the spending reported on Supporting People, grouped into five broad bands.

D.20 The MHCLG Revenue Account budget data, as noted in Chapter 4 of this report, is not a direct comparison to the spending figures collected in this survey. However, it does correspond to the level of HRS activity which was reported by LAs in the survey.

Figure D.2 Rim weight for LAs, based on Revenue Account budget data 2018/19

Supporting People budget 2018/19	*Weighting targets*	*Unweighted response*
None	88	38
£1 to £999	35	13
£1,000 to £1,999	28	13
£2,000 to £2,999	33	19
£4,000 or more	33	15
Total	**217**	**98**

Source: MHCLG Revenue Account 2018/19 budget data, individual LAs

PRPs

D.21 The weighting design for PRPs took the form of a simple weight by size of organisation, as shown in Figure D.3. Weighting by region was not possible because many organisations are national or cover several regions. The size of the organisation, for the purposes of the research, was assessed using the number of units of Supported Housing and Older People's Housing (included in this research within Supported Housing) registered as being under Housing Management in the Regulator of Social Housing's SDR (Statistical Data Return) in March 2019. Narrow bands were used here toward the top of the size scale, due to the need for volumetric data to be produced.

Figure D.3 Weighting profile for LAs, based on SDR data, March 2019

Region	*Weighting targets*	*Unweighted response*
Very large (3000+)	22	13
Large (1000-2999)	74	42
Mid to large (500-999)	54	20
Small to mid (100-499)	174	47
Small (50-99)	93	12
Very small (1-49)	271	24
Total	**688**	**158**

Source: Regulator of Social Housing SDR return, April 2019

Unregistered Providers

D.22 Survey data on unregistered providers was not weighted. This was because there is no data available on the profile of unregistered providers. There is no mandatory

register of HRS providers or any comprehensive voluntary register or trade association able to provide information which would allow the population of providers to profiled. This also prevented the data for unregistered providers being grossed up for costs and client number estimates, although an approximation based on assumptions regarding the likely maximum response rate among this group was used to produce cost estimates, as detailed in Annex E.

D.5 Sources of error

Sampling error and error margins

D.23 All survey estimates are subject to sampling error because they are derived from a sample of a population rather than the whole population. This means that all survey results are subject some to inaccuracy, since due to random variation the distribution of responses among the organisations participating in the research may have varied from the distribution among non-respondents. This is referred to as 'sampling error', and due to this, every result presented in this report has a margin of error. The extent of the variation from the population value depends on the size of the sample and the sample design.

D.24 A margin of error expresses the amount of random sampling error in a survey, describing how close the survey result is to the true population value. The error margin varies for every figure produced in the report. The margin of error is usually expressed as a percentage variation around the result. A survey result of 50% (i.e. where 50% of organisations were estimated to take a particular view) would have the largest error margin, and values close to 0% and 100% would have the narrowest error margin. Error margins are calculated from the base size (n) achieved, taking into account the weighting profile (the 'weighting effect' or 'weff'), and, optionally, for a finite population of a known size (such as LAs or PRPs) the total population size can also be used to narrow the error margin, a technique known as 'Finite Population Correction'.

D.25 Margins of error are calculated to a level of certainty, known as the confidence interval. Results in this report, unless otherwise stated, are shown to a 95% confidence interval, which is a convention in most social research. For example, if a value of 50% is given, with an error margin of ±5%, this means there is a 95% level of confidence that the true value lies between 45% and 55%. Figures D.4 and D.5 show the error margins on key sub-groups used for the research, at a headline level. These error margins apply only to percentage values; for volumetric estimates, such as costs, different error margins apply, which are detailed in Annex E.

Figure D.4 Error margins for organisational groups, on a percentage of 50%

Region	*LAs*	*PRPs*	*Unregistered Providers*
Sample size	98	158	70
Effective sample size (after weighting)	90	98	-
Population size	217	688	Unknown
Error margin*	**±7.9%**	**±9.2%**	**±11.7%**

*Source: ONS Code History Database, July 2019 *on a value of 50%, at 95% confidence*

Figure D.5 Error margins for size of PRPs, on a percentage of 50%

Region	*Small*	*Medium*	*Large*
Sample size	39	94	62
Effective sample size (after weighting)	36	90	62
Population size	364	228	96
Error margin*	**±15.5%**	**±8.1%**	**±7.4%**

*Source: ONS Code History Database, July 2019 *on a value of 50%, at 95% confidence*

Figure D.6 Error margins for type of LAs, on a percentage of 50% (worst case)

Region	*Upper tier*	*Unitary*	*Upper tier and Unitary*	*Lower tier*
Sample size	13	61	74	24
Effective sample size (after weighting)	13	59	72	21
Population size	26	125	151	66
Error margin*	**±19.6%**	**±9.3%**	**±8.4%**	**±17.8%**

*Source: ONS Code History Database, July 2019 *on a value of 50%, at 95% confidence*

Coverage error

D.26 If a survey design does not allow all members of the population eligible to take part to do so, this is referred to as coverage error. In the case of this research, the sampling frame was designed to include all providers and commissioners of services defined for the purposes of the survey as HRS, as detailed in Chapter 1 of the report.

D.27 The sample frame was well documented for LAs, from the ONS Code History Database, and for PRPs, from the SDR (Statistical Data Return) database held by the Regulator of Social Housing. Inclusion on these two databases is mandatory for LAs and PRPs respectively, and therefore the sample frame can be determined with confidence and coverage error due to incomplete information ruled out.

D.28 There were some of these organisations, however, which were excluded from the sample frame. Estimates provided in the report therefore necessarily omit any provision which is commissioned or provided by these organisations. These were:

- Lower-tier LAs without their own housing stock; in the feasibility study stakeholders advised that this type of LA was unlikely to either provide or commission HRS on a scale sufficient to warrant their inclusion.

- PRPs without Supported Housing or Older People's Housing under management, according to the SDR database. Organisations which owned units of Supported Housing but did not manage any were excluded, on the basis that they would be less likely to be able to contribute.

D.29 For Unregistered Providers, there were found to be no comprehensive listings of eligible organisations. A sample was therefore sourced from publicly available listings on the Homeless Link website, in addition to recommendations from other Advisory Group members, including the National Housing Federation (NHF). Additional contact details were sourced via a free find exercise, as for LAs and PRPs. Advisory Group members also appealed for organisations to contact researchers in order to take part. This means that it is possible some eligible organisations were not identified or contacted as part of the research, which imposes substantive limitations on the uses of the survey data for this group of organisations. In particular, estimates cannot be provided using conventional weighting techniques due to the absence of a known total population of this type of organisation.

D.30 There were also two other exclusions:

- Commissioners other than LAs were excluded from the online survey, due to the disparate range of organisation types and structures, geographically variable level of involvement, and relatively limited role, as evidenced from the feasibility study.

- Organisations providing HRS on a purely commercial basis to private customers without receipt of public subsidy were also excluded, since they were out of the scope for the research defined by MHCLG.

Measurement error

D.31 Measurement error refers to errors made due to the method of measurement of data. In the case of this research, data was gathered via an online survey. The online survey was self-completed by respondents, and thus potentially subject to human error, misunderstanding of questions or how to answer, and submission of incorrect responses.

Misunderstanding of questions or how to answer

D.32 A number of measures were taken to reduce this issue:

- Survey design was overseen by the advisory group, covering a range of groups in the industry, to ensure that terminology used was familiar to respondents to the extent possible.
- The survey was extensively tested and checked against specifications internally at IFF, by multiple members of the research team, prior to launch, and also tested 'live' by two members of the advisory group.
- Instructions regarding how to complete the survey were provided on the first screen.
- Help was provided to those uncertain how to complete the survey on request, by IFF Research, via email and phone.
- Finally, a number of common misunderstandings of survey questions which could be identified in survey data were addressed via data amendments, as detailed in the section of Annex E dealing with data processing.

Error relating to multiple respondents

D.33 The survey was designed to be completed by multiple people per organisation, which were then combined in data processing to produce one record in the data per organisation. This presented the possibility of respondents giving responses relating to the same provision, and thus duplicating responses, potentially resulting in overestimates being produced of costs and client numbers.

D.34 To mitigate against this:

- An approach of identifying a lead respondent within each organisation to co-ordinate responses was taken, rather than allowing multiple respondents to complete the survey without communicating with each other.
- The issue was mentioned in survey guidance material, with both lead respondents and other respondents for an organisation strongly advised to liaise to avoid responding regarding the same provision.
- Finally, a check question was included in each section regarding the estimated percentage of the organisation's HRS provision or Supported Housing (whichever was relevant to the section) which the individual respondent was responding regarding. If this exceeded 100, the most complete response was used, and the less complete response discarded.

Submission of data not according to specified definitions

D.35 Another form of measurement error is the possibility that respondents might submit data which was easier to gather or readily available rather than exactly correct in relation to the definitions outlined in the survey. To an extent this cannot be wholly prevented; however, the following measures were taken to reduce this:

- Respondents were enabled through the survey design to give responses regarding costs and client numbers on a per activity basis, for grouped activities, or for all relevant activity combined. This enabled those who might have data available at only one of these levels to submit data with less difficulty.

- Respondents were enabled through the survey design to provide data for a relevant financial year, calendar year, or another period. If data was provided for a period other than the 2018/19 financial year, an adjustment for inflation was applied, using ONS CPI data, at the data processing stage.

Submission of incorrect data

D.36 It is possible that due to human error or deliberate action, incorrect data might be submitted. There is little that can be done regarding human error; however, the following measures were taken to reduce this:

- Respondents were assured in materials that responses for an individual organisation would not be passed to MHCLG, nor published at an organisational level. Assuming respondents read these materials, this should have substantively reduced the incentive to bias answers to present the organisation positively.

- Outliers were excluded from costs calculations throughout, as detailed in Annex E.

- Anomalous data was amended, where this related to common survey completion errors, as detailed in Annex E.

Non-response error

D.37 All voluntary surveys are subject to non-response error, where some groups of organisations might not be as likely to respond as others. There are several groups here:

- Those organisations not providing HRS might be less likely to respond, resulting in overestimates of provision. The likely extent and impact of this issue is discussion in the costs estimates, in Annex E.

- Some other sub-types of organisation might have a lesser capacity or inclination to respond for a range of reasons (constraints on time, or complexity of data required).

D.38 This latter issue was addressed through weighting the data, allowing estimates to be made from the dataset that compensate for non-response bias to the extent possible given the secondary data available for the purpose. This process is explained and detailed in the weighting section above. For Unregistered Providers, no correction for non-response error was possible since no secondary data exists on the profile of these organisations. This means that the data provided regarding Unregistered Providers should be treated with greater caution than that regarding LAs and PRPs.

Annex E Calculation of HRS Spending

E.1 This chapter provides additional detail on how the costs of HRS outlined in the main report were calculated.

E.1 Arriving at an estimate of overall spending

E.2 As outlined in Chapter 4 of the main report, spending on HRS by both providers and commissioners was estimated using results from the online survey. To facilitate this, spending was divided into four sub-types, outlined below, which could be calculated from the survey data and combined to produce a total amount of spending by each organisation.

E.3 The data gathered from the HRS survey included two broad types of spending, with information about each gathered separately for each organisation:

- Spending on direct provision of support, by PRPs, Unregistered Providers and LAs
- Spending on commissioning or subcontracting of support, primarily by LAs

E.4 These two types of spending overlapped. A proportion of the spending by providers was commissioned by LAs, and this needed to be taken into account to avoid double-counting. To do this, spending was classified into four groups, or types of spending:

1. Spending on **commissioning of support,** by LAs.
2. Spending on **direct provision of support** by LAs.
3. Spending on **direct provision of support** by (A) PRPs and (B) Unregistered Providers, funded via LA commissioning.
4. Spending on **direct provision of support** by (A) PRPs and (B) Unregistered Providers, funded from any other source (e.g. Housing Benefit or charitable funding).

E.5 Total spending was calculated by adding together elements 1, 2 and 4 from the list above, but not element 3.

E.6 In theory, elements 1 and 3 should be of equal size, but element 1 was used for the total calculation, since it is possible to calculate this with greater accuracy than element 3. However, element 3 was also calculated for sense-checking purposes.

E.7 A small number of PRPs (four respondents) also mentioned that they sub-contracted or commissioned some provision. This small amount of spending was excluded, because spending on this HRS would also be included in element 4, via the direct providers.

Data processing and weighting

E.8 As part of the wider research process, detailed in Annex D, online survey data was processed and cleaned. The data was then weighted to make it as representative of the population as possible, enabling extrapolation from the survey data to produce estimates of how the wider population might have responded. For unregistered providers, survey data could not be weighted due to the uncertain total population size, and therefore cannot be extrapolated from to produce estimated spending for the wider population in the usual way; the issues around this are discussed throughout the analysis where relevant.

Response bias

E.9 Response bias refers to a wide range of biases that may impact the responses that are provided to a survey, leading to systematic inaccuracies in the survey data. For example, respondents may provide incorrect or false answers. This is discussed more widely in Annex D which describes the survey methodology; only those issues most directly relevant to costs estimates are discussed here.

E.10 MHCLG compiles figures on LA spending, including spend on Supporting People, in the annual Revenue Account (RA) data on LA budgets. As discussed in Chapter 1 of the main report, 23% of all commissioning-level LAs reported zero spending under this heading in 2018/19. In this research, case study interviews with providers suggested that few LAs had ceased spending altogether, which lent support to the view that further work was needed to arrive at a better estimate of spending on HRS.

E.11 However, it was possible to use this data to assess the potential for survey response bias toward organisations who reported high levels of spending. The results of this analysis are shown in Figure E.1. The table profiles LAs by their level of spending reported in the RA 2018/19 data and shows survey response rates among those authorities, and the similarity of the second (population of LAs) and fourth columns (Survey responses, unweighted) indicates that survey response was broadly similar for LAs reporting all levels of spending to MHCLG.

E.12 Through comparing the second and fourth columns of this table, it can be seen that LAs reporting zero spending in the RA returns were no less likely to respond than any other type of LA. Therefore, this source of bias is unlikely to have had an impact on the results of the survey.

E.13 It is possible other biases exist in the survey data. Because these are not specific to the costs calculation, these are detailed in Annex D.

Figure E.1: Survey response rate, by Supporting People budgeted spending reported in Revenue Account (RA) 2018/19 data, upper tier and unitary LAs

Spending level reported on SP, RA 2018/19	*Population of LAs (numbers)*	*Population of LAs (%)*	*Survey responses (unweighted, numbers)*	*Survey responses (unweighted, %)*	*Survey dataset (weighted, %)*
Zero spending	34	23%	18	25%	26%
£1 to £1m	23	15%	7	10%	10%
£1m to £2m	28	19%	13	18%	19%
£2m to £4m	33	22%	19	26%	22%
£4m or more	33	22%	15	21%	22%
Total	151	100%	72	100%	100%

E.14 Figure E.2 shows the same information for lower tier (district level) authorities; it does show a higher response rate among those reporting Supporting People spend in RA 2018/19 data, but not (considering the small overall sample) by a large margin.

Figure E.2: Survey response rate, by Supporting People budgeted spending reported in Revenue Account (RA) 2018/19 data, stock-holding lower tier LAs

Spending level reported on SP, RA 2018/19	*Population (numbers)*	*Population (%)*	*Survey responses (unweighted, numbers)*	*Survey responses (unweighted, %)*	*Survey dataset (weighted, %)*
Zero spending	54	82%	17	74%	71%
£1 to £1m	12	18%	6	26%	29%
Total	66	100%	23	100%	100%

E.2 Estimation process for LA Commissioning

LA commissioning: general approach

E.15 All LAs who commissioned HRS were asked to provide a total spending figure on HRS in the financial year 2018/19 in the survey[79].

F8 **And what was the total spending in the same time period on the Housing-related Support services** (including floating support) **commissione**d, **in pounds, for the client groups you are answering regarding?**

If possible, please try to avoid responding regarding the same services as colleagues, to avoid double-counting of spending. Please include only spending which your organisation provides or controls.

Please note that here we are asking about funds spent on Housing-related Support, ***not*** *funds spent on the provision of Supported Housing as a whole. By Housing-related Support we mean the support services provided to residents of Supported Housing or Floating Support services delivered clients who may live in Supported Housing or in other accommodation.*

E.16 This was the primary data used to establish spending on LA commissioning. However, two further groups also needed to be taken into account to produce an estimate:

- those who did not commission HRS and so were not asked the question; and
- those who did commission HRS but did not know how much is spent.

LA commissioning: those with no commissioning

E.17 An estimated 84% of all LAs (around 182 of 217) commissioned HRS, rising to 95% among unitary and top tier authorities (around 144 of 151). The survey data would therefore suggest that around five per cent of unitary or top-tier authorities with responsibility for HRS commissioning did not commission HRS at all in 2018/19.

E.18 It was possible to sense check this against the findings from qualitative interviews with providers, who did report that a handful of LAs had ceased funding HRS entirely, at least via traditional commissioning routes. However, this was not reported to be common or widespread, a view which would also support the accuracy of the figures collected through the survey.

[79] The survey also allowed respondents to give costs for any other 12 month time period for their convenience, for example the calendar year 2018. Where this option was taken by a respondent, costs data they provided at all questions was adjusted according to inflation, as measured by the Consumer Price Index (CPI) published by the Office for National Statistics (ONS), and calculated between the mid-point of the period for which information was given and the mid-point of the 2018/19 financial year. CPI data is available at https://www.ons.gov.uk/economy/inflationandpriceindices/datasets/consumerpriceindices.

Figure E.3. Estimated extent of commissioning by LAs

	LAs (lower tier)	*LAs (upper and single tier)*	*LAs (all in England)*
Total number of LAs	66	151	217
% not commissioning HRS	42%	5%	16%
% commissioning HRS	58%	95%	84%
Number of LAs carrying out commissioning (estimated)	38	144	182
Base size (n)	*24*	*74*	*98*

E.19 For the LAs surveyed who did not report commissioning HRS, a value of zero was inserted into the dataset, for the purposes of calculation.

LA commissioning: 'don't know' responses

E.20 In total, 34% of respondents who commissioned HRS stated that they did not know how much was spent overall, although most of these were in lower tier authorities. After weighting, this group of respondents accounted for 37% of all LAs who commissioned HRS. In order to create an estimate applying to England as a whole, responses for these LAs had to be extrapolated from the available data.

E.21 This was done by imputing likely responses for this group, based on responses submitted by similar organisations. Similar organisations were identified by the level of spending reported to MHCLG. A mean value was calculated for each group of commissioning LAs from those who submitted a figure for spending on commissioning, split by spending band, according to MHCLG Revenue Account budget data for 2018/19.

E.22 These mean values were inserted into a new variable in the dataset for those LAs who said they commissioned HRS but gave a 'Don't know' response to the question on total commissioning spend. This new variable also contained the values provided by respondents who were able to answer this question and zero values for those who stated they did not commission HRS. This derived variable was used for subsequent analysis.

LA commissioning: final estimate

E.23 The final calculation, the results of which are shown in Figure E.4, produced an overall estimate of £522m for spending on HRS commissioning in England by LAs, including an estimated £124m of commissioning by authorities who had reported no spending in RA 2018/19 data. A discussion of the accuracy of these figures follows after the analysis of direct spending. Base sizes (n) in Figure E.4 are those for organisations giving a response to the relevant survey questions, or confirming a zero figure; imputed responses are not included, and were not used for to calculate margins of error.

Figure E.4: Estimated volume of commissioning among LAs, including extrapolation and those with no commissioning

	LAs (lower tier)	*LAs (upper and single tier)*	*LAs (all in England)*	*LAs reporting no SP spending in RA 2018/19*
Unweighted	£1m	£213m	£215m	£48m
Weighted	£3m	£435m	£438m	£94m
Extrapolated	£3m	£519m	£522m	£124m
Base size (n)	*15*	*53*	*68*	*23*

E.3 Estimation Process for LA Direct Provision

LA direct provision: general approach

E.24 The estimation process shown above for LA Commissioning was repeated for LA direct provision. Direct provision was primarily found among stock-holding LAs (i.e. those which own and/or manage a stock of council housing).

E.25 Results were generally based on responses at question C8 in the online survey, which asked about spending on direct provision of HRS in the financial year 2018/19.

C8 **In the 2018/19 financial year how much in total did your organisation spend on Housing-related Support (including floating support), in pounds**? *To be clear, we mean the total spend by your organisation for providing the support irrespective of the funding source for the cost incurred (so including but not limited to the amount of external funding received). Please only include the cost of support, rather than the housing itself.*

FOR LOCAL AUTHORITIES ONLY: Please only include costs of support for residents of your own authority and not people who hold residency in other authorities who are placed in supported accommodation in your area.

FOR ALL: (If you cannot give an accurate figure, an estimate is fine)

E.26 However, two further groups were taken into account:

- those who did not directly deliver HRS and so were not asked the question; and
- those who did directly deliver HRS but did not know how much was spent.

LA direct provision: those with no direct provision

E.27 An estimated 57% of all LAs in scope (around 123 of 217) directly provided a service they considered to be HRS, rising to 80% among lower tier LAs who are

stock-holding (i.e. own or manage social housing)[80]. The feasibility stage interviews also confirmed the plausibility of less than half (46%) of upper tier and unitary LAs directly providing HRS; the consensus among interviewees was that these authorities' primary involvement, unless they held a large council housing stock, would be in commissioning rather than direct provision.

Figure E.5: Estimated extent of direct provision among LAs

	LAs (lower tier)	*LAs (upper and single tier)*	*LAs (all in England)*
Total number of LAs	66	151	217
% not directly providing HRS	20%	54%	43%
% directly providing HRS	80%	46%	57%
Number of LAs carrying out direct provision (estimated)	53	70	123
Base size (n)	*24*	*74*	*98*

E.28 For the LAs surveyed not directly providing HRS, a value was inserted into the dataset of zero, for the purposes of calculation.

LA direct provision: 'don't know' responses

E.29 About half (50%) of those LA respondents who stated that they provided HRS directly were unable to say how much they spent. After weighting, this group of respondents accounted for 51% of all LAs who provided HRS directly. In order to create an estimate applying to England as a whole, responses for these LAs had to be extrapolated from the available data.

E.30 This was done by imputing likely responses for this group, based on mean responses among other organisations of a similar type. Imputation is the assignment of a value to a variable where a survey response is not provided by a respondent, by inference from the value of other responses.

E.31 Unlike for commissioning, there was no link observed between volume of spending reported and Supporting People spending reported in the Revenue Account 2018/19 budget data. This is likely to be because reported spending was dominated by commissioned spending. This data was therefore not used for imputation. Instead the average spending, computed separately from data submitted by respondents for each of lower-tier and top-tier LAs (due to their differing size and spend levels), was used for imputation for each of these types of LA where respondents stated that they did not know how much they spent on direct provision. LAs with no social housing stock were excluded from imputation since they showed

[80] Lower tier LAs that were not stockholding were not in scope, because feedback at the feasibility stage indicated that their role in HRS provision and commissioning was marginal.

much greater variation in spending levels, and there were very few able to respond. Only five of 31 LAs surveyed without housing stock were able to put a value on their direct spending on HRS. A mean value was calculated for each group of stock-holding LAs from those who did submit a spending figure, split by type of LA (upper tier or unitary, or lower tier).

E.32 The mean values were inserted into a new variable in the dataset for those LAs who said they directly provided HRS but gave a 'Don't know' response at the question asking about total direct spending. This variable also contained the values provided by respondents who were able to answer regarding total direct spending, and zero values for those who stated they did not directly provide HRS. This derived variable was used for subsequent analysis.

LA direct provision: final estimate

E.33 The final result is shown in Figure E.6. In total, £91m of LA direct provision was estimated, after compensating for non-response and don't know responses. This may be a slight overestimate, since some LAs stated in comments given at the end of the survey, that they found it difficult to separate support activities from care activities in terms of costs. It is not possible to determine how much of this could be spend on care activities rather than support; in order to determine the extent of this issue, LAs would need to be mandated or otherwise incentivised to sub-divide spending figures internally between care and support.

Figure E.6: Estimated volume of direct provision among LAs, including extrapolation and those with no commissioning

	LAs (lower tier)	*LAs (upper and single tier)*	*LAs (all in England)*	*LAs reporting no SP spending (RA 2018/19)*
Unweighted	£4m	£18m	£23m	£5m
Weighted	£11m	£41m	£51m	£11m
Extrapolated	£22m	£69m	£91m	£35m
Base size (n)	*14*	*57*	*71*	*21*

E.4 PRP direct provision (Elements 3A/4A): Estimation Process

PRP direct provision: general approach

E.34 A similar estimation process was carried out for direct HRS provision by PRPs. All PRPs were asked to provide a total spending figure on direct provision on HRS in the financial year 2018/19 in the survey.

C8 **In the 2018/19 financial year how much in total did your organisation spend on Housing-related Support (including Floating Support), in pounds**? *To be clear, we mean the total spend by your organisation for providing the support irrespective of the funding source for the cost incurred (so including but not limited to the amount of external funding received). Please only include the cost of support, rather than the housing itself.*

FOR LOCAL AUTHORITIES ONLY: Please only include costs of support for residents of your own authority and not people who hold residency in other authorities who are placed in supported accommodation in your area.

FOR ALL: (If you cannot give an accurate figure, an estimate is fine)

E.35 However, two further groups were taken into account:

- those who did not directly deliver HRS and so were not asked the question; and
- those who did directly deliver HRS but did not know how much was spent.

PRP direct provision: those with no direct provision

E.36 In total, an estimated nine per cent of PRPs (14 respondents) stated that their organisation did not provide HRS. Because the survey targeted only PRPs who provided housing management services to Supported Housing, this figure is an underestimate if a figure for all PRPs rather than all PRP providers of HRS is sought.

E.37 Although the survey targeted only those registered as providing HRS, a common reason given to researchers by PRPs for non-completion of the survey was that they were not involved in HRS. This could result in an overestimate of provision being made. This is because the weighting process implicitly assumes that respondents are similar to non-respondents in terms of their HRS provision. If non-respondents were much less likely to provide HRS, this would invalidate the assumptions made which allow weighting to take place.

E.38 For LA commissioning, this problem did not occur; it was known from case study and feasibility study interviews that the vast majority of upper tier and unitary LAs continued to commission HRS.

E.39 As a result of this discrepancy, it was not possible to tell with certainty the difference between a PRP not replying due to not providing HRS, and an organisation not replying because they did not have the time to complete the online survey.

E.40 It was not possible to entirely remove this uncertainty from the calculation of total spend. However, PRPs with large quantities of Supported Housing stock were considered likely to provide support or to have others providing support to some residents. A provider with a large number of units registered as Supported Housing with the Regulator of Social Housing is likely to hold at least a somewhat diverse portfolio of this housing, and therefore quite unlikely to have zero residents who do not require any HRS living in that housing. However, this is quite possible for a small provider with a few units.

E.41 These types of PRPs also had a much higher response rate compared to Small PRPs, despite the same contacting approach being used for all. Therefore, the smaller PRPs (those with fewer than 100 units of Supported Housing registered with the Regulator of Social Housing via the Statistical Data Return in March 2019) have not been included in the estimates.

Figure E.7: Estimated extent of direct provision among PRPs

	*Small***	*Medium***	*Large***	*All PRPs*
Total number of PRPs	364	228	96	688
% not providing HRS	10%	9%	9%	9%
% providing HRS	90%	91%	91%	91%
Number of PRPs carrying out provision (estimated)	n/a	208	87	n/a
Base size (n)	*36*	*66*	*56*	*158*

*** Small = fewer than 100 units; Medium = 100 to 999 units; Large = 1,000 or more units.*

E.42 For medium and large sized PRPs surveyed not directly providing HRS, a value was inserted into the dataset of zero, for the purposes of calculation. Small sized PRPs were excluded from subsequent calculations.

PRP direct provision: 'don't know' responses

E.43 About a fifth (20%) of respondents for medium or large PRPs who stated that they provided HRS directly were unable to say how much they spent. After weighting, these represent an estimated 26% of all medium and large PRPs combined. In order to create an estimate applying to England as a whole, responses for these PRPs had to be extrapolated from the available data.

E.44 This was done by imputing likely responses for this group, based on mean responses among other organisations of a similar type. In this case, the best data available to identify similar organisations was the scale of the organisation's management of Supported Housing, available from the Regulator of Social Housing's Statistical Data Return (SDR) data for March 2019. A mean value was calculated for each group of PRPs from those who did submit a spending figure, split by size band.

E.45 The mean values were inserted into a new variable in the dataset for those PRPs who said they directly provided HRS but gave a 'Don't know' response at C8. This variable also contained the values provided by respondents who were able to answer question C8, and zero values for those who stated they did not directly provide HRS. This derived variable was used for subsequent analysis.

PRP direct provision: final estimate

E.46 The results are shown in Figure E.8. In total, it was estimated that £849m was spent by PRPs on direct provision, after controlling for non-response and don't know responses. This excludes small PRPs. However, this exclusion is likely to only amount for a small proportion of spending, because March 2019 SDR data shows that all of these small PRPs taken together account for only three per cent of England's Supported Housing provision.

Figure E.8: Estimated spending on HRS among PRPs, including extrapolation

	Small	Medium	Large	All PRPs
Unweighted	£8m	£80m	£251m	£340m
Weighted	n/a	£253m	£422m	£675m*
Extrapolated	n/a	£328m	£521m	£849m*
Base size (n)	*21*	*52*	*46*	*119 / 98**

** Medium and Large PRPs (registered as housing managers for 100+ units of Supported Housing) only*

PRP direct provision: estimating overlap with commissioning spending

E.47 Medium and Large PRPs estimated that just under half (47%) of their funding overall (by volume) came from LA (and CA) sources. This indicated LA funding of PRPs of around £401m. This compared to £522m estimated total spending on commissioning by LAs; however, some of this commissioning will have been to Unregistered Providers, rather than to PRPs.

Figure E.9: Estimated spending on provision among PRPs, by broad source of funding

	Small	Medium	Large	All PRPs
Extrapolated total spending	n/a	£328m	£521m	£849m*
% from LA or CA commissioning**	32%	38%	53%	47%*
Estimated funding from LA or CA commissioning (Element 3A)**	n/a	£125m	£276m	£401m*
Estimated funding from other sources (Element 4A)	n/a	£203m	£245m	£448m*
Base size (n)	*21*	*52*	*46*	*98**

** Medium and Large PRPs (registered as housing managers for 100+ units of Supported Housing) only ** Combined Authority*

E.48 A discussion of the accuracy of these figures follows after the analysis of direct spending.

E.5 Estimation Process of Unregistered Provider provision

E.49 It is not possible to provide a full representative estimate of spending on provision for Unregistered Providers. This is because there is no base estimate of how many of these providers exist, so we do not know what proportion of all providers have been interviewed. A full sampling frame for unregistered providers does not exist. However, it was possible to make some estimates regarding spending by this type of provider.

E.50 In total, unregistered providers taking part in the survey reported £77m of spending on HRS, £29m of which (or 38%) was stated to have come from LA or Combined Authority commissioning, and £48m from other sources.

E.51 While it was not possible to use conventional weighting techniques, because of the reasons outlined above, to provide an estimate, the following assumptions were made to make some estimates of total spending.

- Spending cannot be below £77m from this group, since the respondents to the survey mentioned £77m of spending, and clearly not all Unregistered Providers that exist will have responded to the survey.

- A total of 215 Unregistered Providers were located by the research team during the survey process. This group of 215 Unregistered Providers were identified by the research team via web searches and publicly available databases taking place in July 2019, and exhaustively checked for duplicates and updated over the following months as contact with more organisations took place. Although it is possible that some providers were misidentified, it was considered more likely that 215 was an underestimate of the total number of Unregistered Providers in July 2019 than an overestimate. Given 70 Unregistered Providers responded, this suggests a response rate of *at most* 33%.

- If it is assumed that the response rate is *at most* 33%, this indicates that the figure of £77m could be assumed to represent at least a third of real spending, taking into account non-response.

E.52 This would tentatively, subject to the assumptions outlined above, indicate total spending of about three times £77m, or £231m in total, of which about 38% (representing around £88m) was stated by Unregistered Providers to come from LA sources.

E.53 As a further sense check, adding together the total amount of commissioned income reported from LAs by providers (£88m from Unregistered Providers and £401m from PRPs) comes to approximately £489m, similar to the amount that LAs were estimated to commission from their own responses (£522m).

E.6 Total estimated spending on HRS

E.54 Earlier in this chapter, funding for HRS was divided into four elements, which were calculated in the sections above. A summary of these best estimates for provision are shown in Figure E.10.

E.55 The estimate of total LA commissioning spending on HRS from the survey, using the method outlined above, is **£522m**. The estimate of total spending in England on HRS from the survey, including all sources of funding, is **£1,061m,** or **£1.1bn**, across LAs and PRPs. Indicatively, results for Unregistered Providers suggest that total spend would be close to **£1.2bn** if unregistered providers were to be added to the total. Error margins are shown, where these could be calculated, in the table; these are further discussed below.

Figure E.10: Best estimates of spending on HRS: summary

	Estimated total spending in £ in 2018/19	*Exclusions and notes*
1) LA commissioning	£522m £395m-£649m (±24.4%)	Excluding lower tier LAs without housing stock; also does not include extrapolated figures for authorities reporting between £1 and £1m of Supporting People funding
2) LA direct provision	£91m £61m-£121m (±32.5%)	Excluding lower tier LAs without housing stock
3A) PRP provision, funded by LAs	£401m*	Excludes small Registered Providers with less than 100 Supported Housing or Older People's units under management
4A) PRP provision, not funded by LAs	£448m*	Excludes small Registered Providers with less than 100 Supported Housing or Older People's units under management
3B) Unregistered Provider provision, funded by LAs	~£88m**	Amount of funding mentioned in unweighted survey responses was £29m; rough extrapolation (see above)
4B) Unregistered Provider provision, not funded by LAs	~£143m**	Amount of funding mentioned in unweighted survey responses was £48m; rough extrapolation (see above)
Best estimate of total spending by LAs	£613m £476m-£750m (±22.3%)	Total of estimates (1) and (2) – subject to caveats shown above. Includes both commissioning and direct spending.
Best estimate of total spending by PRPs	£849m £543m-£1,154m (±36.0%)	Total of estimates (3A) and (4A) – subject to caveats shown above. Includes funding received from LAs and all other sources.
Best estimate of total spending by PRPs and LAs	£1,061m	Total of estimates (1), (2) and (4A) – subject to caveats shown above.
Best estimate of total spending	~£1.2bn**	Total of estimates (1), (2), (4A) and (4B) – subject to caveats shown above.

** Medium and Large PRPs (registered as housing managers for 100+ units of Supported Housing) only ** Indicative estimate*

E.7 Error margins on HRS spending

E.56 Calculating margins of error on HRS spending was a more complex process than calculating these for standard survey results, which was outlined in Annex D. This is because the data is volumetric, and therefore not subject to the same statistical tests. For an initial explanation of the terminology and reasons for using error

margins, please see Annex D dealing with weighting and error margins more generally.

E.57 The margins of error for the estimates have been calculated using the Standard Error of the Mean. The formula for this requires a base size (n), mean value, and standard deviation. In addition, the calculations take into account Finite Population Correction (*FPC*), which is an adjustment made where the number of respondents is relatively close to the total estimated population. The population used here is simply the total number of organisations (LAs or PRPs) in the sampling frame.

E.58 The base size (n) used for the calculations includes zero values added where an organisation was known to have no spending in that category by their answers in the first part of the survey, but does not include imputed values to avoid these giving a misleading impression of accuracy. In this case, due to the use of weighted data, the base size (n) used for the error margin calculation also took into account the weighting effect (*weff*), as explained in Annex D.

E.59 The value for which the error margin was required to be calculated was a sum of survey responses rather than the mean. However, the sum of a variable can be calculated as the mean of that variable, multiplied by the known population size. Therefore, the error margin can be calculated in the same way, and remains the same if expressed as a percentage.

E.60 Figure E.11 summarises the calculation. Unrounded figures were used throughout, although, for legibility, rounded figures are shown in the table. The errors shown are at a 95% confidence interval, which indicates we can be 95% certain (assuming that assumptions made in the calculations hold true) that the true spending level lies within this distance of the estimated spend figure.

Figure E.11: Error margins on key estimates, 95% confidence interval

	Estimated spend	*Base size (n)*	*Effective base size*	*Popn. size*	*Mean spend*	*Standard Deviation*	*Error at 95%*
LA commissioning	£522m	*68*	62.56	217	£2.87m	£3.63m	±22.3%
LA direct provision	£91m	*71*	65.51	217	£0.44m	£0.71m	±32.5%
LA overall spending	£613m	*85*	78.61	217	£3.07m	£3.58m	±24.4%
PRP direct provision	£849m	*98*	87.80	324	£2.62m	£5.28m	±36.0%

E.61 Due to the importance of these figures to the research, the error margin calculations have also been carried out at a 75% confidence interval, as shown in Figure E.12, together with the lower and upper bounds associated with each spending estimate.

Figure E.12: Error margins on key estimates and bounds of error, 95% and 75% confidence intervals

	Estimated spend	*Error at 95%*	*Lower bound*	*Upper bound*	*Error at 75%*	*Lower bound*	*Upper bound*
LA commissioning	£522m	±22.3%	£406m	£638m	±13.1%	£454m	£590m
LA direct provision	£91m	±32.5%	£61m	£121m	±19.1%	£74m	£108m
LA overall spending	£613m	±24.4%	£463m	£763m	±14.3%	£525m	£701m
PRP direct provision	£849m	±36.0%	£543m	£1,155m	±21.1%	£670m	£1,028m

Annex F Case Studies

F.1 Case studies were carried out with nine organisations involved in the provision of HRS in England.

F.2 After interviews with the lead respondent from each case-study area, researchers asked whether the respondent wanted the organisation to be identified in the report, in accordance with data protection guidelines. Four of the case-study areas gave their consent to be identified in the research. The remaining five, all of whom were LAs, declined to be identified to MHCLG.

F.3 The case studies completed comprised seven LAs and two PRPs with national reach. The LA respondents could be broken down as follows:

LA type

- Two upper-tier LAs (county councils). In each case a representative from a lower-tier LA operating within the upper-tier LA geographical area was included in the interviewees.
- Three Unitary Authorities
- Two London Boroughs

Regions

- London: 2
- North West: 1
- South West: 3
- Yorkshire and the Humber: 1

Urban / Rural

- Urban: 2
- Suburban: 3
- Rural: 2

Coastal Town

- Coastal town: 1
- Not coastal town: 6

Annex G Advisory Board

G.1 The purpose of the advisory group was to provide critical support and guidance to the research project on HRS commissioned by MHCLG. The group was made up of government officials, PRPs, LAs, trade or sectoral associations and unregistered providers.

G.1 Role

G.2 The role of the individual members of the advisory group included:

- attending regular meetings as required and actively participating in the group's work
- using their expertise to critically review draft topic guides and the survey questions
- advising on literature review sources and technical matters
- providing background on policy issues affecting the sector

G.2 Membership

G.3 Membership consisted of PRPs, Unregistered Providers, LAs, trade or sectoral associations and cross-government stakeholders:

- National Housing Federation (NHF)
- Salvation Army
- Riverside Housing
- YMCA
- St. Mungo's
- SHiP
- LGA
- Homeless Link
- Hanover Group
- Home Group
- L&Q Living
- Kirklees Council
- DWP policy officials
- MHCLG policy officials