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# Evaluation of the Vale of Glamorgan Dispersed Housing Scheme

## Executive Summary

### 1. Research aims and methodology

- 1.1 As part of the Welsh Government's Effective Services for Vulnerable Groups (ESVG) Delivery Board's project that explored integration between health, housing, social care and the third sector the proposed Vale of Glamorgan Dispersed Housing Scheme (DHS) for people with severe and enduring mental health needs was identified as an example of good practice in a collaborative and integrated approach to securing accommodation and support for people with mental health needs in their home community.
- 1.2 In order to support this new project the ESGV commissioned a small-scale evaluation of the DHS. The research took a participative approach, involving the project stakeholders in developing the theory of change for the service model and a logic model, which was then used as the framework for the evaluation.
- 1.3 The evaluation was designed to:
  - Examine the implementation of the scheme and to assess whether the project is operating as described by the logic model.
  - Examine the extent to which the scheme contributes to the intended outcomes identified in the logic model.
  - Draw lessons learnt for the scheme and implications for future sustainability and wider roll-out.

- 1.4 Face to face interviews were conducted with key project stakeholders, staff delivering the service and clients.

## **2. The Vale of Glamorgan Dispersed Housing Scheme**

- 2.1 The Vale of Glamorgan Dispersed Housing Scheme (DHS) consists of a multi-agency group who came together to focus on agreeing a housing and support service model appropriate to the needs of those with severe and enduring mental health problems in the Vale of Glamorgan. Gofal work alongside the Intensive Rehabilitation and Integration Service (IRIS) at Cardiff and Vale Health Board to assess suitable clients for the scheme; then work together to develop and provide care and support for clients who have been provided with their own tenancy in a one bedroom flat in Barry.
- 2.2 The multi-agency partners of the scheme came to a shared understanding of the factors facing them in the Vale and why the service is needed. These include:
- 2.3 The need to make the connections between health and housing.
  - Delayed transfer of care in NHS settings, the pressure on in-patient resources, the need to reduce costs associated with Continuing Health Care support, and the inappropriate provision of support.
  - The need for service user led care, the need to provide care for mental health service users in their own community.
  - The lack of joined-up services adversely affecting service-users care and support journey.

## **3. Key Findings**

- 3.1 The scheme's working model of delivering collaborative and integrated services has so far proved successful. There is evidence of:
  - the scheme's ability to deliver person centred and joined up care to individuals with higher level mental health needs; and
  - its ability to deliver these services within clients' home environments and without unmanageable risk to their mental health or tenancy.

3.2 From the clients' point of view there is also some evidence of positive outcomes at this early stage:

- Since the beginning of the scheme there have been no hospital readmissions due to relapse in the mental health condition of clients;
- Staff reported that the integrated nature of care allowed them to pick up issues before they escalate into crisis situations;
- the model seems to allow for more appropriate interventions in a more timely fashion and the flexibility allows potentially damaging situations to be dealt with more effectively.
- The analysis undertaken looks at a wide range of outcomes at both service and service user level and the evidence shows that the scheme appears to be meeting its intended outcomes and objectives. For example:
- Improvements in the independence and confidence of service users.
- The stabilising of environment. Many of the clients have led lives characterised by breakdown and spells in acute care. The integrated care provided is able to create a break for issues that can escalate into crisis if not caught early enough.
- Service user improvements in mental health, daily living skills, physical health and self care and taking responsibility.

3.3 The scheme could be sustainable and the service delivery model could be replicated in other areas and settings. However, there are a number of limiting factors to the sustainability of the scheme, including:

3.4 The availability of suitable accommodation (due to changes in benefits system and the bedroom tax leading to limited availability of one bed accommodation).

- The continuation of funding from Supporting People.
- The pressure on the IRIS team to deliver a wider range of services.
- The lack of a common platform for data sharing between delivery organisations.

## 4. Recommendations

4.1 Further testing of this service and other similar 'floating support' models are needed to assess the longer-term outcomes of the collaborative, integrated approach to individual care for both the service and service users. Public service organisations should consider the application of this working model to other settings where individuals with high level needs could benefit from person centred, integrated care

delivered collaboratively by health, housing and other relevant support agencies e.g. alcohol and substance misuse. Public service organisations could investigate how this working model can be replicated and adapted to work in other locations, particularly looking at integration between housing and health services, and should investigate potential funding models needed to expand this model in situ and in other areas/settings. It will also be important to consider the challenges posed by data sharing needs.

Full Research Report: Evaluation of the Vale of Glamorgan Dispersed Housing Scheme

Available at:

<http://gov.wales/statistics-and-research/evaluation-vale-glamorgan-dispersed-housing-scheme/?lang=en>

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