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Promoting Independence: Final Evaluation Report

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This report presents the final findings of an independent evaluation of the Promoting Independence programme. The University of Sheffield has prepared it, under contract to Sheffield City Council (SCC). The findings and interpretations in this report are those of the authors and do not necessarily represent the views of the services or organisations involved in the delivery of the programme.

Executive Summary

The *Promoting Independence Programme (PI)* was designed to support individuals in residential care to transition into more independent living. Between its inception and Spring 2025, the programme demonstrated significant successes in enabling move-on, delivering financial savings, and shaping new approaches to commissioning and service delivery.

Key Outcomes

- **Client transitions:** Of 116 participants, **70 clients (60%) moved into independent tenancies**, with a potential success rate of **up to 76%** if pending transitions are completed.
- **Financial savings:** The programme generated **annual cost savings exceeding £1.86m**, evidencing the value of outcomes-based commissioning.
- **Client impact:** Participants reported greater independence and quality of life. Recovery Star data showed improvements in **Mental Health, Living Skills, Relationships, Social Networks, and Self-Care**, though **Addictive Behaviours and Responsibilities** scores declined.

Success Factors

- **Strong partnerships** between funders, commissioners, providers, and delivery teams underpinned the programme's achievements.
- **Outcomes-based commissioning** provided incentives for innovation, rigorous monitoring, and continuous improvement.
- **Housing association delivery (SYHA)** offered flexibility, personalised budgets, and longer-term engagement with clients, enabling tailored and creative support.

Challenges and Barriers

- **Cultural resistance in care homes:** Only a minority of homes engaged deeply; others reinforced a "home for life" ethos that hindered transitions.
- **Systemic constraints:** Limited statutory assessment capacity, high staff turnover among social workers, and lack of statutory authority within the programme slowed progress.
- **Client expectations:** Many participants assumed residential placements were permanent, making disengagement easy if anxieties about moving arose.
- **Equity and reach:** The programme primarily engaged men (78%) and those aged 51–60 years, with fewer women and younger/older age groups participating.

Legacy and Learning

- **Proof of concept:** The programme demonstrated that long-term residents of care homes can successfully move to independent living with the right support.
- **System impact:** It has contributed to the establishment of a **Re-enablement Team** within the local authority, tasked with embedding rehabilitative approaches more broadly.
- **Commissioning insights:** The programme highlighted the benefits of outcomes-based models but also the need to balance sustainability with appropriate incentives.

Recommendations

1. **Sustain outcomes-based commissioning** to maintain focus on results and continuous service improvement.
2. **Strengthen early assessment and expectation-setting** at referral, embedding the principle that residential care is not necessarily permanent.
3. **Address cultural barriers** within care homes through targeted engagement, incentives, and system-wide leadership on rehabilitation.
4. **Expand diversity and reach** by investigating barriers to participation for women and underrepresented age groups.
5. **Plan for client complexity** by recognising that future cohorts may have higher support needs, requiring longer engagement and more intensive resources.
6. **Balance voluntary-sector flexibility with statutory authority** to ensure efficiency while retaining creativity and personalisation.

PROMOTING INDEPENDENCE PROGRAMME

Supporting Residential Care Individuals Individuals to Executive Summary & Ling (2020-2025)

KEY OUTCOMES

- **Client Transitions:** 70/116 (60%) successful
- **Financial Savings:** £1.86m+ £1.86m+ annual savings

Improvements
Mental Health
Living Skllls
Relationships
Social Networks
Self-Care

SUCCESS FACTORS

- **Strong Partnerships**
- **Outcomes-Based Commissioning**
- **Flexible Support (SYHA)**

CHALLENGES & BARRIERS

- **Cultural Resistance** "Home for Life")
- **Systemic Constraints** (Limited Capacity)
- **Client Expectations**

LEGACY & LEARNING

- **Proof of Concept**
- **System Impact** (Re-enablement Team)
- **Commissioning Insights**

RECOMMENDATIONS

1. Sustain Outcomes-Bused Commisisming
2. Strpand Diversity & Reach
5. Balance Flemplexity

2. Strengthen Early Assessment
4. Address Cultural Barriers
5. Pxpand Diversity & Reach
6. Balance Flexiblity & Authority

Background

The aim of the 'Promoting Independence' programme was to support around 113 service users with severe mental illness (SMI) to move from 24-hour staffed accommodation to more independent tenancies, over a 5-year period, starting in 2019. The project, undertaken in partnership with South Yorkshire Housing Association (SYHA), was a key element of Sheffield City Council's (SSC) strategy to commission social care in ways that support personal recovery.

The Promoting Independence programme is highly client-centred and recovery-focused. Its rationale and progress are described elsewhere.

The Promoting Independence delivery model was co-designed with those who have direct experience of the residential care and wider mental health system. All those living in 24-hour residential care homes funded by Sheffield City Council were eligible for inclusion. Those who expressed an interest in moving and wished to take part were offered one-to-one support for up to 9 months prior to the move out of residential care, and for up to 24 months after the move.

The initial stage of the evaluation concentrated on establishing the programme theory through qualitative exploration, which formed the bulk of the interim evaluation report in October 2021. The evaluation framework and program model that resulted from this work is included in Appendix 1.

Methods

The evaluation was theory-led and has combined quantitative work, focused on tracking processes and outcomes for the cohort of service users, with qualitative investigation, exploring the views and experiences of key stakeholders. Initially, we proposed using routine clinical and service-use data collected and held by Sheffield Health and Social Care Foundation Trust (SHSC), which provides mental health treatment and care for the service users in question. However, owing to difficulties in implementing a new electronic patient record system and additional capacity issues in the Trust, we were unable to secure access to any routine data for our evaluation. We have, however, made use of data from the SYHA in the summative evaluation.

An initial, set up phase (Workstream 1) was used to design the evaluation framework, define data requirements, describe the setting and anticipated benefits, and secure permissions and governance arrangements. This consisted of qualitative evaluation work to understand the programme theory and processes. A process logic model describing the rationale, linking activities with specific anticipated outcomes, was developed and refined. As part of Workstream 1, we collaborated with the service innovators to begin to identify existing key performance indicators for evaluation and ongoing monitoring.

The monitoring workstream (Workstream 2) was delayed as the programme took some time to settle into a steady delivery state, and there were unexpected difficulties experienced regarding Covid-19 precautions.

Documentary analysis
Key documents were obtained to inform the initial programme theory development. Documents were subject to descriptive content analysis and realist synthesis to describe the intended and reported status of the programme and to inform the development of initial programme theory. The analysis was conducted to provide a description of the programme processes and to begin to understand how the programme is intended to achieve the intended outcomes. This also resulted in an evaluation framework, based on key processes and decision-points, which incorporates evaluation questions.

Documents included:

- Annual review
- Live Tracker, Monitoring framework
- Customer Journey
- Meeting minutes
- Quarterly reports
- Programme summaries
- Expression of interest/consent form
- Allocation and key milestones process document
- Modelling and budget spreadsheet

Interviews
Semi-structured interviews were conducted at two stages in the evaluation: first, during the early intervention phase, when issues were being identified and the programme was developing, and then towards the end of the programme to summarise key learning and identify what had worked and enduring problems.

Initially, 10 staff interviews were carried out during February and March 2021. Interview schedules were based on an initial programme theory, which was developed through informal discussions with the project management and documentary analysis.

Interview schedules were designed for specific groups of respondents:

- Health and wellbeing coaches
- Housing workers
- Representatives from SYHA
- Representatives from SCC
- Funders and service commissioners

These were designed to test the assumptions from the documentary analysis, elicit new areas of theory or hypotheses, and to test and refine existing hypotheses. Potential participants were identified through discussions with the project management. Recruitment was purposive and intended to provide an overall and balanced view of the programme.

Potential participants were informed of the study, provided with an information sheet and asked to contact the evaluation team if they wished to take part. The evaluation

team then re-sent a participant information sheet and consent form, by email and arrange a time and date for the interview.

Due to Covid-19 restrictions, interviews were conducted by video link. Prior to each interview a completed consent form was returned by email to the evaluation team. The interviews were focused on understanding hypotheses about how the project is intended to work in specific contexts to create desired outcomes, or the types of unintended consequences that might come about. Eight interviews were transcribed verbatim and 2 were analysed using comprehensive notes. Analysis focused on intra-case and cross-case thematic analysis. In addition, elements of programme theory were identified and synthesised.

Further brief interviews were conducted 4 years later, in February 2025. These interviews tested the validity of assumptions regarding the delivery model and explored reasons for successes and reasons for enduring barriers or difficulties. Reflections were sought from the following groups of key stakeholders:

- Commissioners
- Service providers
- Funders

Routine data analysis

The proposed evaluation questions were used to inform an investigation of routine data held by SYHA. Following approval from the University of Sheffield Research Ethics Committee, services users were consented to provide their pseudonymised data for the evaluation.

A unique ID code was assigned to the data and the code key held by SYHA. Any identifying information was redacted and data securely transferred for analysis. As of August 2024, the program had accepted 116 service-users. The following data were analysed for 49 consenting service-users:

- Demographic information (age, sex, ethnicity)
- Start and end dates in the program
- Housing outcomes
- Recovery Star data
- Goals set and final outcomes of goals

The Recovery Star (Dickens et al, 2012) is used in mental health and social care settings to support individuals in their recovery journey. It is used to track progress, identify areas needing attention, and set goals for change across a range of functional outcomes. The star focuses on 10 key areas of life, such as managing mental health, self-care, and relationships. It's a collaborative tool, used by individuals and their keyworkers to track progress and plan support. The Recovery Star method allows participants to rate areas of functioning on a scale of 1 to 10.

Anonymised, routinely collected data were also aggregated to provide an overview of the cohort as a whole, primarily to assess the representativeness of the consented clients.

Results

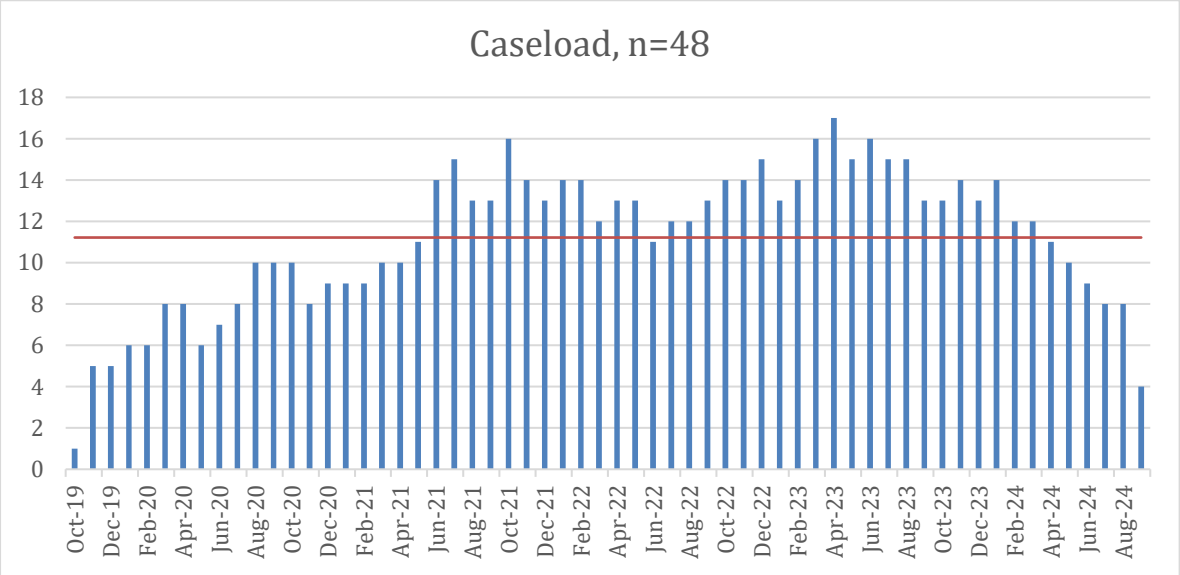
This section focuses on the programme outcomes, and the experiences of those taking part in, and delivering the Promoting Independence programme.

The findings from the routinely collected data are based on two groups of clients: (i) a sub-sample of 48 clients who provided consent for their detailed anonymised information to be used for the evaluation, and (ii) anonymised aggregated reporting data for the entire cohort of clients who used the programme until January 2025 (n=116). The more detailed findings are therefore from a broadly representative sub-sample of all clients.

Overall caseload

The following graph shows the number of clients in the program for each whole month between October 2019 and September 2024. Dates included are from the start date on the program to either moving out or withdrawal. The mean monthly caseload over 60 months was 11.2 clients.

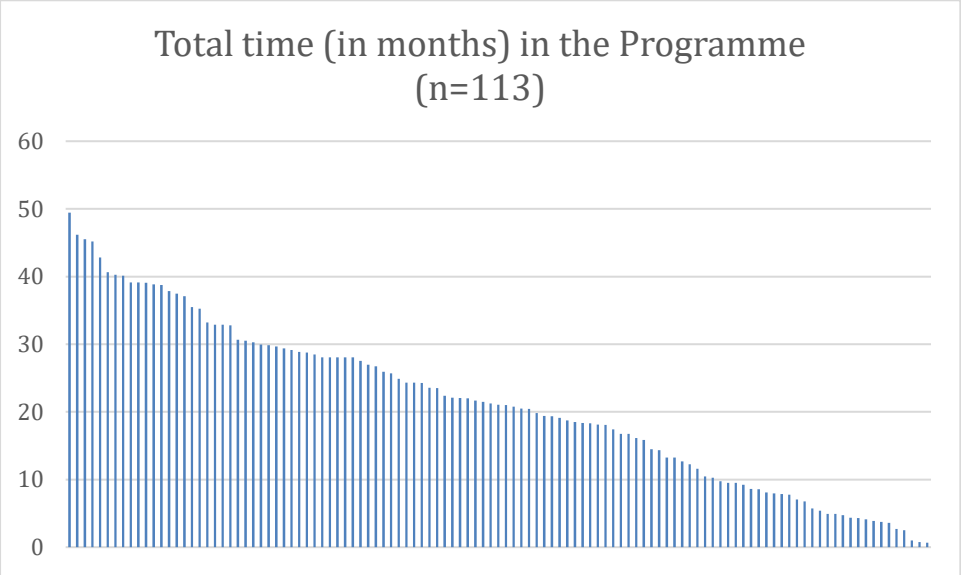
Figure 1: *Caseload of clients providing consent for the use of their data (Oct 2019-Aug 2024)*



Time in the program

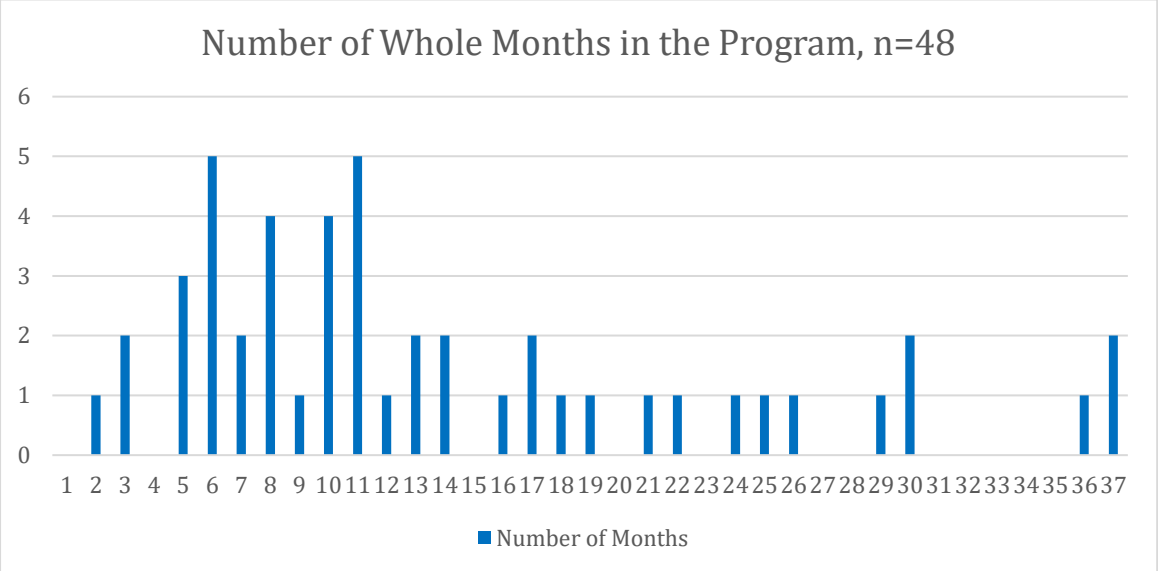
The following figure shows the total months in the programme for all programme clients. The range is from under 1-month to over 49 months. The mean was slightly over 21-months.

Figure 2: *Total time (in months) in the programme for all individual clients*



Eleven of the consenting sub-sample led clients (23%) were in the program for more than 20 months and nine clients (19%) were in the program for 24 months or more before moving on or withdrawing. The range of time that these clients spent in the program was between 2 and 37 months. Twenty-eight clients (58%) moved on or withdrew from the program within 12 months (3 withdrawals). This sub-sample did not have as a wide range of time in the programme as the whole cohort and tended to be in the programme for less time (mean 14 months).

Figure 3: *Number of months in the program per consenting service-user (sub-sample)*



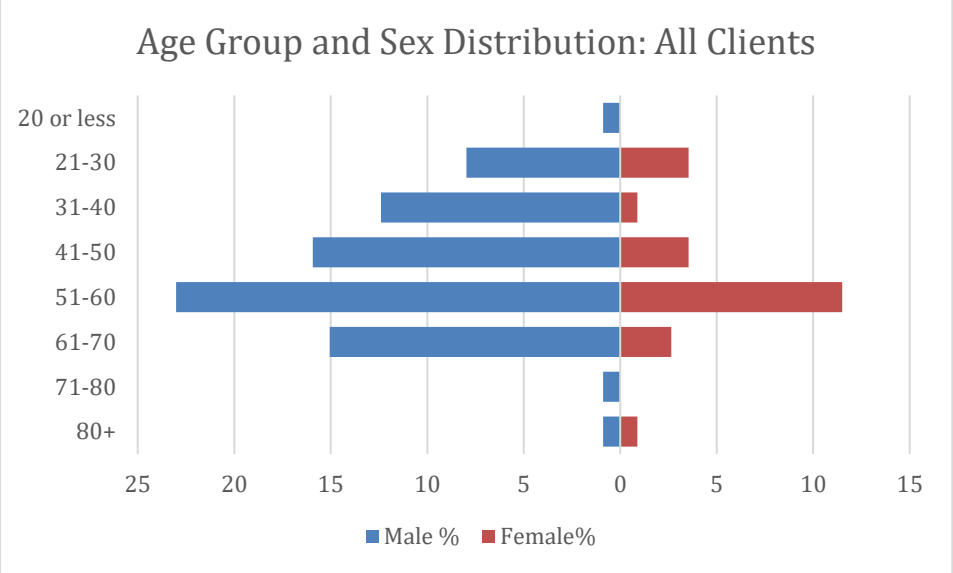
Of the total cohort, 72 were white British sample (65.5%) and 38 were from other ethnic groups (including not listed or unknown) 38 (34.5%). The sub-sample of participants were broadly representative of the full cohort in terms of ethnicity, with 30 (61%) identifying as white British. Five clients identified as 'other ethnic group', three as 'Asian or Asian British – Pakistani' and three as 'Black or Black British – Caribbean'. The following table gives a breakdown of consenting service-users by ethnic groups:

Table 1: *Ethnicity of Promoting Independence clients*

	Sub-sample	All service users
White British	30 (61.2%)	72 (65.5%)
Other ethnic group	5	9
Asian or Asian British	4	9
Black or Black British	5	9
White other	2	3
Arab	0	1
Not known or not listed	3	7
Total	**49**	**110**

The figure below shows the age and sex distribution of all programme clients. The largest groups of both male and females clients were those aged 51-60 years. However, they were relatively under-represented in the sub-sample, with those in the 41-50 year old group being more likely to consent to use of their data for the evaluation. The cohort for which we have complete data (n=114) was, like the cohort as a whole, predominantly male (n=88, 78%).

Figure 4*: Age group and sex distribution of all programme clients*



Housing Outcomes

At the time of final data analysis (Spring 2025), 116 clients had been accepted onto the programme in total. Of these, 28 (24.1%) withdrew whilst still in residential care and so did not move on. Of the remainder, 70 (60.3%) entered into independent tenancy

(moved on), while 18 clients (15.5%) were still in residential care and in the process of preparing to move. Hence the current 'success' rate for the programme (at the time of writing) was 70 out of 116 (around 60%) but may have risen to as high as 88 out 116 (76%) if those whose moves were in train completed the transition to independent tenancies.

Withdrawal rates indicate that once people move on, withdrawal rates are relatively low. Four clients (out of 70) (5.7%) withdrew from the programme within 6 months of moving into their own accommodation; 3 clients (out of 59) (5.1%) withdrew between 6 and 12 months of moving on, while a further 4 clients (out of 50) (8.0%) withdrew after living independently for longer than 12 months.

Hence, a minimum of 70 (and a maximum of 88) clients have moved out of 24-hour supported accommodation into independent tenancies in the first 5 years of the programme, out of a total of 116 people who were accepted as eligible and interested. Our results indicate that, in addition to the 28 clients who withdrew while still in residential care, a further 11 clients (around 16% of those who moved out) withdrew (or were withdrawn) from the programme after moving into their new homes. It is of note that the rate of withdrawals did not appear to fall with the length of time since leaving residential care and may have increased with time.

Financial savings

The following figures used client data from the Council's Adult Social Care, case management system, Liquid Logic (LAS), to calculate the savings achieved. Savings are calculated per individual that has moved on from residential placements into their own tenancy arrangements within the community because of being supported by the Project. The review took place between 29 September 2019 and 22 July 24 and is based on a sample of 35 people who had left residential care.

Table 2: *Full Year Effective Savings 29 September 2019 – 22 July 24 (n=35)*

	Costs/savings (£)
Total annual residential costs saved	2,516,049
Care and support costs incurred	654,207
Full-year effective savings	**1,861,842**

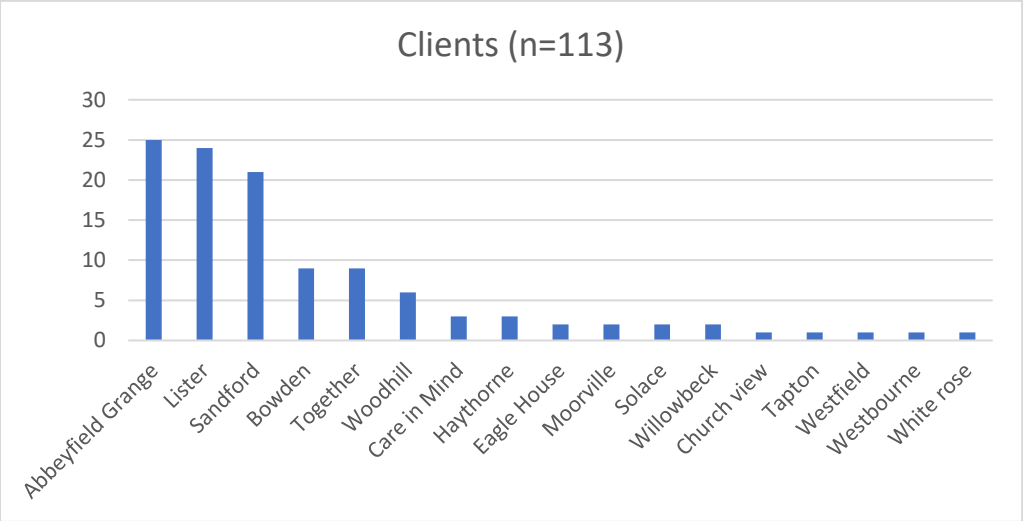
Care home participation

An important high-level aim of the Promoting Independence programme was achieving 'a recovery mind-set and philosophy across the system', which could be evidenced by increased engagement of care homes with relocation.

The figure below shows the number of clients that used the programme and the homes that they moved on from. This clearly demonstrates that there were 3 homes that were very engaged with the project, providing a total of 70 clients for the programme (range

21-25 clients). A further 3-homes also provided a total of 24 clients to the programme (range 6-9 clients). Other homes provided only 1, 2 or 3 clients each.

Figure 5: *Number of clients accepted into the programme by care home*



Functional Outcomes and Service Users' Needs

Mean baseline Recovery Star scores for the consented sub-sample are reported (Table 3), with low scores the top of the table, demonstrating areas where clients might require greater support. The work category scores are particularly low (3.80) and social networks are the next lowest score (5.35). Trust and hope (7.10) and Responsibilities (8.10) scores are relatively high and might therefore reflect a ceiling effect where little improvement is possible.

Table 3: *Baseline Recovery Star scores*

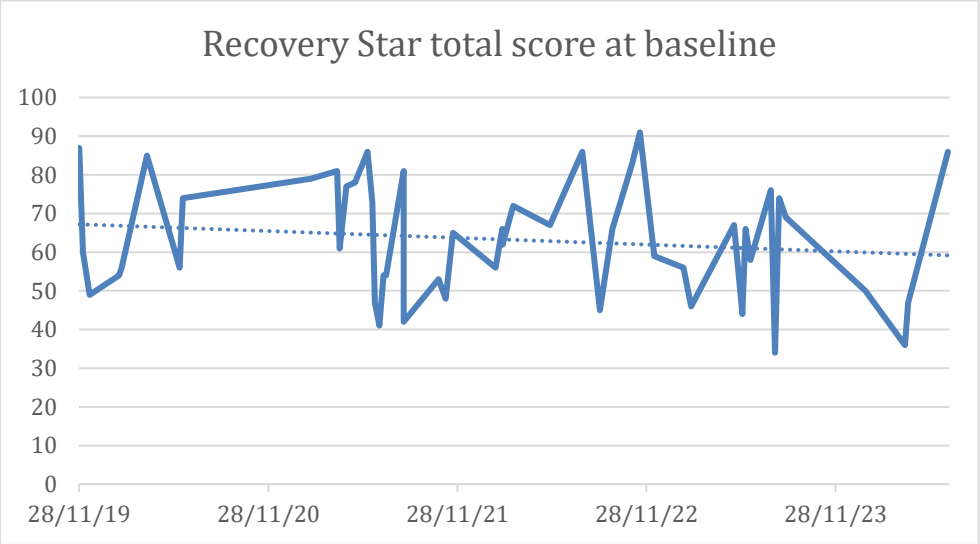
Category	Baseline score
Work	3.80
Social networks	5.35
Living skills	6.18
Relationships	6.22
Mental health	6.24
Self-care	6.78
Addictive behaviour	6.78
Identity, self esteem	6.78
Trust & hope	7.10
Responsibilities	8.10

Category	Baseline score
Mean	6.33

Changes in baseline Recovery Star scores over the course of the programme
Figure 6 below shows the baseline Recovery Star scores for people entering the programme over the course of the programme. The trendline demonstrates a decline in baseline scores over time, indicating that over time clients entering the programme had increasing levels of functional care needs.

The trend for baseline scores to decline over the course of the programme was also found across individual Recovery Star domains. Mental Health, Living Skills and particularly Addictive Behaviour all showed the same declining trend in baseline score over time. This means that the Promoting Independence participants recruited later in the programme were likely to have greater needs in general and on some specific domains than those joining at the beginning of the programme. This supports the view that the first clients to enter the programme were most likely to have the skills necessary to make the intended transition to independent living, and those entering later were potentially less well equipped in terms of their functional abilities.

Figure 6: *Baseline total Recovery Star score over time, showing linear forecast trend-line.*



Goals completed, abandoned, in-progress or overdue were compared for the clients that had the longest (24 months or longer) and the shortest (12 months or less) lengths of time in the programme before moving on or withdrawing (Table 4). The percentage of goals completed were similar at just over 50% (54.7% and 51.1%, respectively). Clients in the program for 24 month or longer had around 10% fewer 'Overdue' goals (25.6% compared to 35.3%). However, this group had a far larger percentage of 'Abandoned' goals (20% compared to 5.9%). Goals set for the cohort that stayed in the program for the longest before moving on were more than three times more likely to be abandoned.

Table 4: *Comparison of outcomes of goals by time spent in the programme*

12 months or less (n=24)	Count	%	24 months or longer (n=9)	Count	%
Abandoned	10	5.9	Abandoned	18	20.0
Completed	93	54.7	Completed	46	51.1
In progress	7	4.1	In progress	3	3.3
Overdue	60	35.3	Overdue	23	25.6
Total	170	100	Grand total	90	100

Changes in Recovery Star scores

The following analysis (Table 5) includes outcome star data for 49 service-users. A total of 172 outcome stars were analysed (mean 3.5 stars per service-user, range 1-5). Changes in mean scores are indicated by the difference and % change for each domain. The mean improvement between first and last scores in scores across all domains was 0.67.

Table 5: *Change in Recovery Star scores showing changes and % change by domain.*

Domain	First score (n=49)	Final score (n=45)	Difference	% change
Mental health	6.24	7.58	1.33	21.34
Living skills	6.18	7.49	1.31	21.11
Relationships	6.22	7.53	1.31	21.03
Social networks	5.35	6.42	1.08	20.11
Self-care	6.78	7.56	0.78	11.51
Work	3.80	4.16	0.36	9.47
Identity, self esteem	6.78	7.29	0.51	7.58
Trust & hope	7.10	7.73	0.43	6.07
Addictive behaviour	6.78	6.69	-0.09	-1.28
Responsibilities	8.10	7.80	-0.30	-3.73
Total	63.33	70.04	6.72	
Mean (all domains)	6.33	7.00	0.67	

Summative Interview Findings

The following is the thematic analysis of interviews conducted towards the end of the programme (February 2025). Whilst there are a number of areas of agreement and similar themes, the various stakeholder groups offer unique perspectives. The findings are therefore organised according to responses from funders, local authority commissioners of adult services and Promoting Independence programme providers and team members.

Funders

Successes

From the perspective of the programme funders, Promoting Independence was considered a success, and the money was well-spent. The programme was considered to stand out from other programmes, despite early difficulties.

> *"if you look at the scale of the investment and the repayment, if you look at the challenges that we had to overcome collectively, you know as a partnership between provider and Commissioner, as investor. It's been a really good and positive investment."*

> *"So, in terms of impact in terms of outcomes, system change, the finance, you know, partnership relations between supplier, investor and delivery partner, I think it's it's really successful you know, so it stands out as one of probably three or four [funded SIBs] where it ticks the box across a range of criteria"*

The programme was considered to have achieved a great deal for the population, and there was regret that further funding could not be secured to continue the programme.

Good partnership working

The success of the programme was largely attributed to the close working of all partners.

> *"the stakeholders have worked really well in this one … in terms of sort of lessons learned from this one, it would be that you have to stick together through the adversity when it's not going too well and work at sort of fixing it … And I think everyone's still very invested in the project"*

Learning

Early problems were attributed to the lack of current knowledge about how to commission and deliver this type of programme. However, one of the key benefits of the programme has been the knowledge developed around price discovery and about how to commission and deliver this type of service. This knowledge is considered important to inform future developments of this type of service.

> "There's lots to like about this and lots to say. You know, how do you make that next step actually, in terms of these types of investments and moving them on and beyond the kind of SIB model into something which looks and feels different?"

Funders identified four key areas of learning:

1. *Using "… social investment… can be used as a catalyst … to drive change… external investment to try new and different ways of solving what are quite persistent, local and national problems."*
2. *"Co-development and evolution. Using data to learn and using data to adjust a programme."*
3. *"the extent to which Sheffield Council has been able to use this journey to inform not only the way to support this cohort but perhaps think about the wider service system and costs."*
4. *"the complexity … of the outcome contracts and you know the great work that the Sheffield Council team has done. The …cost savings … and the extent to which now we understand …how do you look at multi-year savings? How do you look at new service models? How do you contrast that with more expensive and different services for a cohort and therefore how do you continue to commission this type of stuff and use this experience to commission in different areas? To me, I think there's some really good learning in that."*

Commissioners

Good partnership working

There was recognition that the success of the programme relied largely on the dedication and close working of all of the partners.

> *"the strength of the project is is people's invested in it. So, the people who are around the table at the end of the project were the right people to be around that table, to make this project work."*

> *"A lot of success of this leans on the good partnership. And I think without that real open communication and joint approach to trying to problem resolve it, none of this would have got off the ground. And I imagine there's been failures in other places that have tried to implement this... it's a testament to the actual people that have run this, it goes a long way."*

Outcomes-based commissioning

There were positive and negative experiences of the outcome-based commissioning through the social impact bond. The ability to be innovative was welcomed, although the structure and processes could be difficult at times.

> *"it's allowed us to meet the needs where we probably wouldn't have been able to identify resources to meet that need. And it's given us an opportunity and an innovative way to trial something which I think if the local authority had trialled it, we wouldn't have that as much autonomy or flexibility."*

> *"I think the negative of negative side is… I just feel as having a three-way agreement, I find it really clunky, when we probably could have done things differently."*

Difficulties

Covid

Problems encountered when delivering the programme included the Covid pandemic, preventing access to care homes, and difficulties engaging with adult care services, when they were part of the Care Trust. Delays in assessment through adult social care services could also be a problem.

Resistance to culture change

A key theme throughout most interviews is the difficulty in changing culture and practice in care homes. This was related to managers' attitudes to rehabilitation, which were also influenced by the additional work and potential risk regarding the care of individuals of promoting independence as well as financial risk.

> *"When somebody comes into residential care, historically they've stayed there for life. And I think the culture is just so ingrained in the care homes, and obviously the social work teams and hospital discharge teams. I think it's so ingrained that actually because people are safe, there's not been that urgency to move people on"*

> *"I think we really need some focused resource into working with those care homes… So, I think there needs to be a piece of work with mental health homes about what our expectations are…."*

> *"I also think there's some work needed with actually somebody working with the individual care homes to say 'look, come on, this is this is what's happening. We want you to be more in re enablement focus to support people to move on and move flow through the system.'"*

> *"To try and support people, to be aspirational and gain skills towards independent living, it is a lot. It requires a lot more, and it requires a lot more risk taking, and I think some environments struggled to understand how they could accommodate that within their set up."*

> *"And there's also financial concerns from them, …you take a service that might be 90 plus percent occupancy rate down to 80, 75% occupancy rate, it hits in the pocket."*

Legacy

The Promoting Independence programme has created a legacy through the re-enablement team, which will have a broader remit, to look at moving people to less intensive care packages as well as moving to different settings for more independent living. There is potential through this work to continue to alter the culture across the system to a more rehabilitative focus.

> *"I'd like to see that work with care home managers as part of that work with the enablement team… I think if we start that message early with social workers and with the hospital discharge team… we have a very clear support plan from when a person's being discharged from hospital into a residential care. People are told clients are told, 'actually this is not a home for life, you're here for as long as you need to be, but then … the vision is for you to move on.' I think if we start that bit there, things start filtering through."*

Key learning from the programme has been that *"having a dedicated resource and focused resource, …can really transform people's lives, who have been in residential for a long time."* Also, *"the flexibility of a local VCSE organisation together with the approach from local authority to try and support move on… bringing it together under a focused programme is absolutely the key."*

Barriers

Some of the main barriers were "trying to make decision-makers in the local authority to understand what the project's about" and difficulties finding supported accommodation.

> *"we have no social housing, so we have no Council properties…. I think what's really, really hard is actually finding quality providers of supported accommodation"*

Another key barrier was the lack of continuity of care regarding social workers.

> *"I think the problem we have now is, which is no fault of, it's just where the system is, because individuals don't have named workers, more often than not, when it's coming to moving on, we're then having to get a new social workers who's probably never been involved with the person, never really know the project, having to move the person on and undertaking those reviews. Which is not, for me, it's not always the best, because they don't fully understand that person and understand that person's needs."*

Programme service providers

Good partnership working

A consistent theme was the strengths of the partners and delivery team.

> *"having a real sort of social purpose, strong stakeholder engagement, I think that's a critical one."*

> *"a really consistent team… a real passion to see the project succeed. There's been some give on sort of all sides from us as a provider from Sheffield City Council's commissioner and obviously with big issue invest as the funder."*

Benefits

Independent living for individuals

Regarding the main benefits from the programme, service providers acknowledged the difference that the programme had made for the individual clients.

> *"So many people, have managed to kind of live a full or more independent life by kind of having this project in place otherwise without it, they'd have probably stayed in residential care for potentially rest of the life. They've kind of got a new, new lease life."*

> *"The way we've worked with people to, you know, have those real successful outcomes and low failure rates. You know, they're far lower than the model sort of anticipated. So that's a real success as well."*

Recognised cost-savings
The outcome-based contracting has allowed cost-savings to be identified and monitored on a continual basis and also provided incentive for the programme to succeed. The lack of knowledge about what to expect from the programme was also an important consideration for the providers, and this encouraged a cautious approach to contractual risk. Importantly, despite the limited reach, the programme has been a successful 'proof of concept', demonstrating that the ambition can work.

Some success in creating culture change
The need for sector-wide culture change was recognised from the beginning. Whilst the success of this has been somewhat limited, the gains that have been made are considerable and have demonstrated that new ways of working can be implemented. This is despite a system that does not incentivise providers to promote independence. Within the system, care homes are critical settings for culture change.

> *"Simply having that shift of mentality in some of those projects was, yeah, very good… I thought that was tremendous… It gave me that sort of a bit of, I don't know, a surge of optimism about the sorts of things that could be that could be achieved."*

Barriers to culture change (care homes)
The potential for disruption, increased risk and additional work for care homes was cited as a key barrier to wide-scale culture change.

> *"It's just easier to keep hold of people, especially when they know them…if they have a quicker turn around and it's going to be a lot more work, it's a lot more paperwork. It's probably more risk assessments, more kind of contact with all the social workers."*

The lack of sector-wide engagement of care homes with the programme, meant that involvement in the programme was variable.

> *"…the care homes that we've actually managed to engage well with, we've had some really good outcomes. With the ones that we've not managed to engage very well with, we've not had hardly any or any at all… the culture change happened within those services who are willing for that culture change."*

> *"The others have still been a real challenge to actually work with."*

> *"So, I think the key would be the actual managers of the home. You know whether they themselves are buying into it."*

The potential for a rehabilitation ethos to impact on profitability (e.g. creating 'voids' or empty places in homes), was considered a significant barrier. Regarding this, the size of the care home organisation was considered to be a contributing factor to variability of engagement, as larger organisations were considered to be more profit-driven and have less flexibility.

> *"You're more likely I supposed to get buy in from a smaller provider rather than a national company… they're far more profit orientated, so why would they buy into? Yeah. Something that's going to, you know, affect their profits."*

Barriers to culture change (social work)
The potential for further culture change amongst social workers was also identified, regarding the equal consideration of what services a person doesn't need as well as what they do need. This could have the effect of reducing dependence and promoting independence.

> *"I think if somebody showed that there was like deteriorating, they think, oh, what more support can we put in? But I don't think they think as much how can we take support away. So, I think it is a work in progress still."*

Caution around moving from outcomes-based commissioning
Regarding recommendations for future services, there were some concerns that the move to providing services through the re-enablement team might not achieve similar benefits, if the implementation is not correctly incentivised to succeed. Key incentives could be such elements as the length of staff contracts and staff pay, and connecting these to outcomes, rather than activity. Importantly, a key driver for success of the programme was the outcomes-based commissioning and its success in monitoring outcomes and using this information to adjust and improve the programme.

> *"…promoting independence project had that sort of 'oh, come on. You need to demonstrate that this works. You've got to save money.' …I think if you take that away with the Re-enablement team and … appoint people on permanent contracts rather than temporary ones… I think it would have been better to pay people more, but…you have to show results. And if you take that away, yeah, I'm a little bit worried that things might slide. That the pressure, if you like, won't be there to demonstrate its efficacy and savings… it won't achieve as much as I think it ought to… I'd love to see more of that kind of thing, where, you know, the financial aspects are not ignored…"*

Further consideration of destination settings and continued support for moving-on
A critique of the service suggested that a more diverse range of destination settings for clients could have been developed as there was a perceived reliance on a small number of places to move people on to.

The length of support provided after the client moved on, was considered an element of the programme that could be reduced, by being more flexible related to the client's needs.

Reasons for failure to move-on and potential solutions
The main reason stated for failure of individuals to successfully move-on to more independent settings was an expectation that they could stay in their current setting. This meant that setbacks or anxieties around moving could easily translate into a refusal to engage with the programme.

> *"People just think they can stay in residential. ... So, if somebody thinks 'actually, I don't want to live a more independent life'. They start to get a bit anxious or worried. They just think that they can just stay there forever... I think they need to know going into it, this is not my home forever. … I think a lot of people when they decided they maybe*

didn't want to move on or they got cold feet, they just kind of disengaged from PI and they just thought it was a bit optional."

It was suggested that expectations could be managed better by embedding a culture of temporary rehabilitation into the service from first contact with clients.

"When somebody first comes onto the programme or is referred, I think the social worker who's kind of done the review … I think they need to be quite straight with the person and say, 'look, you no longer require this level of support, I am referring you on to this service, who're going to support you to the next step of your life', and not kind of make it seem such an optional thing… if they don't need that level of support, then somebody else does. … So, I think that kind of needs to be embedded early on at the referral point."

The optional nature of engagement with the programme for people that might be living in inappropriate settings with high-levels of support was recognised as a barrier, which might be alleviated by either moving the service into statutory provision, embedding culture change (as discussed above) or having closer working relationships with statutory providers that are responsible for determining the appropriateness of services.

"been a big challenge …working within care homes as sort of an add on not a statutory service. You know as a kind of a bolt-on."

"I don't think they actually ended up moving somebody who was in one of the nursing homes, who I think may still be there …. one of the shortcomings with the project was, as I said, they didn't have that sort of muscle."

Difficulties around assessment capacity

The lack of statutory assessment was described as a surprise and is reported to be an enduring barrier to the efficiency of the programme. The separation of the programme from statutory provision and mental health services, is again cited as a barrier and an area where the programme lacks control.

"Some people haven't been seen for five years over that, not been assessed, not had any workers… wasn't meant to be our role to find referrals that was meant to come from statutory provisions; it never, never has… It's come mainly through our kind of engagement work."

"I think the challenges within the sector of people in residential not having named workers not having people who we could actually work with to help move on was, and still is, a real challenge… we had no kind of a clout or no kind of ownership to change that we because we don't hold that function."

Benefits of delivery through the Housing Association

However, despite some drawbacks, setting the programme within the South Yorkshire Housing Association, was reported to have benefits, such as flexibility regarding the time in the programme, discretionary budgets and the type of support provided.

"Having allied health workers or those that work, you know within OT and trained psychotherapists… just have a different approach to working with people that isn't clinical, I think that's been a real kind of strength for the project as well"

"not always having to talk about someone's mental health is a positive thing. Just talk about other stuff. You're not there just for a review. You're not there just to kind of see how they're going"

"people have £20 a month to do something independently with their health and well-being coach or their key worker… it has to be linked to independence. But you wouldn't have that in a statutory system… like gyms, memberships, you know, cinemas, just getting people out swimming, you know horse riding."

"Another thing we've £250 … to help somebody on that transition to move buy them a little something that's nice for them to have in their home as early sort of things, not something that you get I don't think in a statutory function"

"So, although the programme had like nine-month move on … that didn't generally happen with most people. It sometimes it was short, sometimes it was longer. … there's just so many variables … it's a lot harder to do a project like this, which is based on set outcomes in set periods of time. You just need to be a lot more fluid with mental health, as hard as that is from a kind of business perspective…. because it's like it was South Yorkshire Housing that did it, we were so flexible. … we didn't have like the the pressures."

"Because it's not a local authority project or because it's not a trust project, we have a bit more leeway on certain things… there's somebody who's been on our programme 1400 days before they've moved. That wouldn't happen in statutory services. They would discharge within, you know, a certain period of time about whether or not they're ready to move."

"I think with PI being having that flexibility to support people for, we know people have been in there for four years in the programme, and they stuck with them like glue and being able to support them through when they see them moving through. I'll be honest with you, I'm not 100% sure we'll be able to do that in the local authority."

Drawbacks of delivery through the Housing Association

However, being set in the voluntary sector might have contributed to some of the delays that required people to have longer time in the programme.

"Some of those didn't need to be that long. If we'd have had the right support and the right sort of pushes and the right communication from the sector, we could have moved those people quicker."

Tools and processes to support a rehabilitation focus

A number of problems were encountered over the course of the programme. Whilst some were overcome, other persisted. New tools and processes were developed, for example to understand gaps in living skills.

"We didn't have an accurate understanding of their living skills. … we developed like an assessment tool. … that seemed to work really effectively because then we could assess them ourselves and get a better judgement of what we needed to work on for them to be successful in the community."

Associated with this practical assessment and development of living skills, one problem that could not be overcome was the access to appropriate facilities to enable rehabilitation. For example, kitchen and laundry facilities are often out-of-bounds for care home residents. This is indicative of the extent of culture change that is required to promote a rehabilitation ethos across the care home sector.

The programme has created a significant legacy, in terms of helping to define the new re-enablement team, initiating a pathway out of high dependency care, which is becoming more widely recognised, and clearly demonstrating savings. In addition, the care homes that have been working closely with the programme have had an important culture change, towards a more rehabilitative focus.

"The main thing is getting a wider understanding throughout Sheffield and obviously well, much wider eventually, but of a pathway out of residential care. …So, I think the main the legacy is it's starting now, do you know people are aware of it, it's growing"

"I think legacy wise… The actual saving to the system and pathway is actually a real positive thing… I'm sure there will be other local authorities who have people in residential who don't need to be in there. So, I think kind of legacy wise is we've created a new pathway for people… a whole new way of working… a lot of local authorities, they don't have a generic pathway out."

"There are plans for a re-enablement team, which is going to be within the Council. So, it's again, it's been successful in… helping embed the idea that people people's conditions … don't have to be static, don't have to be quite pessimistic, and that you can actually feel that you're contributing to helping somebody become less reliant on services."

"The best legacy of it is to hopefully have changed the mindsets of [3 care homes]… Plus, others must have to a certain extent, … to make them go, 'oh', you know, 'oh, there's something different going on'."

Legacy (Re-enablement team)

In terms of the legacy of the programme a Re-enablement team is being set up. Regarding the function that will be provided by the re-enablement team, it is possible that having more control over eligibility of people for services could alleviate some of the problems encountered by the programme in relying on culture change, goodwill and willingness for individuals to engage with the programme.

"…it'd be interesting for the enablement service, how they get on with more statutory arm of they, they do actually have a more of a 'right you're eligible, you're moving' type of approach which has been a challenge."

The Re-enablement team, as a legacy of the Promoting Independence programme, will have a broader scope to look at reducing care packages across the board in cases of inappropriate dependence.

> *"I think the scope of it is a lot better… re-enablement team will have a a broader, a broader remit… it's Step-down from nursing to residential to residential to supported. Also looking at reducing support packages as well, where appropriate. So, I think, yeah, I think this is all good news. You know, having a broader remit is very good."*

Caution around balancing capacity with need

There is a word of caution that there is a possibility that the capacity of the programme might outstrip appropriate referrals. This could result in increasingly more difficult and complex cases to manage, inappropriate referrals and poorer outcomes. With this in mind, time might be needed to replenish the numbers of people that are eligible referrals.

> *"When you move somebody out who is recovery focused, and they move the the people coming into residential care are not similar… probably in the last 6 to 12 months, we have seen a a reduction in referrals… we've definitely seen a reduction in in kind of, I would say, referrals that are appropriate"*

> *"Part of me thinks it would probably need a period of time to replenish a little bit… we're just not getting the referrals and people again aren't ready to move… is there needed a period of time to settle and then go again."*

An ideal service

Regarding an ideal service, there were clear barriers that, if addressed, could help to develop the Promoting Independence programme to something approaching an ideal service. For instance, a firmer and more integrated approach to statutory provision, which aligns with the programme, and adjustments to care home services to incentivise a rehabilitation approach. The identification and early engagement with a cohort of potential clients could also be beneficial and create a more efficient and effective programme.

> *"It probably wouldn't look too dissimilar… so, there'll be a cohort, you know in place that we would then know who they are, where they are. We would probably want more of a firmer approach from either the Trust or the Council about provisions, like residential care still hold a lot of cards within somebody staying within their provision."*

> *"I'd love it that the system was in a place that the system decided, you know, with the person, right, you, you know, I've assessed you, you don't need to live in residential. Right, let's work on a six-month, three-month transition plan for you to move out, work with promoting independence. Here's a referral. Work with them. Move out in this period take the actual home out of the equation a little bit."*

> *"If there was some form of agreement in that way with the cost savings that are made through those changes, those moves that those services that work in a recovery-based*

way are more incentivized to do that and a lot of it is monetary, you know voids cost a fortune."

"Reviews and that side of things happening quicker, a pool of people that we could work with and a bit more, a bit more of a clout for care homes to work in this way to help us."

"If people have been identified from the beginning, then I think that really would have shaped the model a bit better. So I think if I was going to say if you're going to set it up again, that is a key piece of work that needs to be done prior to a provider or an investor or local authority trust getting involved."

There is optimism that the more people that are working with a rehabilitation remit, the more that this will become recognised, and the culture might spread across the system.

Summary and Synthesis

Housing outcomes

By Spring 2025, 116 clients had been accepted onto the programme. Of these, 28 (24.1%) withdrew whilst still in residential care and so did not move on. Of the remainder, 70 (60.3%) entered into independent tenancy (moved on), while 18 clients (15.5%) were still in residential care and in the process of preparing to move. Hence the current 'success' rate for the programme (at the time of writing) was 70 out of 116 (around 60%) but may have risen to as high as 88 out 116 (76%) if those whose moves were in train completed the transition to independent tenancies. Once people move on, withdrawal rates are relatively low.

The programme achieved highly significant costs savings equivalent to more than £1.86m per annum.

Client characteristics and process measures

Regarding the length of time in the programme, the range is from under 1-month to over 49 months. The mean average is slightly over 21-months. The most common length of time in the programme (mode) was 22 months.

The number of white British clients in the whole cohort was 72 (65.5%) and non-white British is 38 (34.5%). The cohort of Promoting Independence clients (n=112) was predominantly male (n=88, 78%), and the largest age group (both male and female) was 51-60 years old. It was not clear why fewer females than expected have engaged with the programme.

An exploration of the provider homes for programme clients showed that there were 3 homes that were very engaged with the project, recruiting 70 clients for the programme (range 21-25 clients per home). A further 3 homes also provided 24 clients to the programme (range 6-9 clients). The other 8 care homes only recruited only 1-3 clients each.

Recovery Star scores at baseline fell slightly over the course of the programme. This meant that clients who entered the programme later were likely to have greater care

and support needs than those joining earlier in the programme. Mental Health, Living Skills and particularly Addictive Behaviour all showed this declining trend.

We explored whether the length of time in the programme was related to the setting and achievement of recovery goals. Despite a much longer period in the program, service users who remained in the programme for over 24-months set an average of fewer than 3 additional goals compared with those who were only in the programme for 12 months or less. The percentage of goals 'Completed' were similar at just over 50% (54.7% and 51.1%) for both groups. Clients in the program for 24 month or more had around 10% fewer 'Overdue' goals (25.6% compared to 35.3%), though this group had a far larger percentage of 'Abandoned' goals (20% compared to 5.9%).

We explored the extent to which Recovery Star scores changed between the first and last measurement for all domains. There was mean improvement in scores of 0.67 points across all domains. Scores on Mental Health, Living Skills, Relationships, Social networks and Self-Care all increased significantly, while scores on the Addictive Behaviours and Responsibilities domains fell over time.

Qualitative findings

The initial interviews highlighted a number of concerns and difficulties that the programme was seeking to overcome in early 2021, as presented in our previous report. Some of these concerns were overcome and others proved to be more enduring.

A key reason for the successes of the programme were the close working, determined and flexible approach of the partnership of stakeholders. For many, this was a novel way of working and, at the outset, there was very little known about how the programme would work. It was evident that many significant issues had been addressed over the course of the programme.

The funders regarded the programme as standing out from other similar projects as being highly successful and a good example of Social Investment Bonds and outcomes-based commissioning. This was seen as an effective catalyst for change, and a strength was the use of outcomes data to identify problems and drive programme improvements.

The need for wholesale culture change to a rehabilitative mind-set across the sector was an enduring barrier to success. Only three care homes demonstrated high levels of engagement by recruiting large numbers of clients, while a further three also added to the steady stream of individuals moving through the programme. There were also enduring barriers regarding statutory services, such as lack of assessment capacity, lack of relationship continuity with social workers, and lack of statutory powers (within the programme) to determine the type of support that is appropriate for individuals.

The main reason for failure for clients to move on was regularly stated to be around the expectations of clients, and the reinforcement of the concept of their residential placement as being permanent. This made it very easy for clients to disengage with the programme, and this disengagement often aligned with the ethos of their care home, in being resistant to change. The importance of setting expectations at first contact was emphasised as a way to begin to overcome this barrier.

The key legacy of the programme is the demonstration of the proof of concept, the potential for acknowledgement that the sector can change and the possibility of awareness spreading, and inroads being made towards removing some of the systemic barriers to rehabilitative culture. The re-enablement team has been set up to continue some of the work of the programme, albeit with a broader remit. However, the loss of the link between outcomes and commissioning was flagged as a possible limitation to effectiveness, as this was one element of the PI programme that drove success and improvement.

There were benefits and drawbacks recognised of the delivery through the housing association (SYHA). Some benefits were the flexibility regarding the time in the programme, discretionary budgets and the type of support provided. However, a lack of influence over the assessment of clients and provision of services could be frustrating.

A notable and enduring success of the programme, from the perspective of all stakeholders is the difference that the programme had made for the individual clients.

> *"So many people have managed to kind of live a full or more independent life by kind of having this project in place otherwise without it, they'd have probably stayed in residential care for potentially rest of the life. They've kind of got a new lease on life."*

Conclusions and Recommendations

Promoting Independence has proven highly successful, demonstrating both proof of concept and significant financial savings. The success rate of the programme was between 60% and 76% (depending on outcomes of clients still in the programme at the time of writing).

Achieving wider cultural change around a recovery and rehabilitation agenda has proven harder. Whilst the programme succeeded in creating large changes in the culture and practices of three care homes and marginal changes in a further three homes. Our findings suggest that There may be an enduring resistance to engagement across the sector as a whole. Some care homes clearly have a rehabilitative focus while others may be fostering a belief that they are 'homes for life'. The programme or its successors will need to consider how best to address this, for example by more thorough assessment of clients before they are placed in particular homes. Long-term dependency on residential care is necessary for some, but others may be limited in their subsequent life and recovery journeys if these views remain widespread.

Initial assumptions regarding the length of time in the programme for clients may require further consideration and possible extension. Whilst the most common time for clients to remain in the programme was around 22 months, others required over 49 months to complete. The reasons for this variation need to be better understood.

It is also worth reflecting on the demographic variation in uptake of the programme. While men and those aged 51-60 years were well represented, women and other age groups were not. There may be important reasons for this, which should be explored. It may be, for example, that these differences reflect difficulties with social functioning, physical comorbidity/frailty, or concerns about safety when living independently.

In the interviews, caution was recognised regarding the potential pool of eligible and appropriate future clients. We found that Recovery Star scores at baseline fell with time, suggesting that clients with the highest levels of functioning took part at the start of the programme. Those who remain in care homes may be more disabled and hence in need significantly more support with daily living and personal skills than those who took part in the early years of the programme.

The increase in Recovery Star scores between the first and last measurements demonstrated that scores on the Mental Health, Social Networks, Living Skills, Relationships, and Self-Care domains all increased substantially. This indicates that these are areas where the programme can most easily effect a positive change. More attention is needed to understand why scores fell on the Addictions Behaviours and Responsibilities domains.

Other key recommendations include the consideration of the benefits of outcomes-based commissioning for programme sustainability, creating momentum and driving service improvement. Another consideration is the benefit of flexible support available through the voluntary and community sector (such as housing associations), balanced against the lack of influence over assessment and statutory provision.

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Appendix 1: Evaluation Framework and Programme Model

The following table has been adapted from the program descriptions in the analysed documents. It is separated into the three customer engagement phases (Preparation, Resettlement & Transition) and by the two main program roles (Health and Wellbeing Coach (HW Coach) and Housing worker). In addition to the information extracted from the documentation, we have added columns for Theory/Questions, Contextual Variables and Indicators/Outcomes.

- The 'Theory/Questions' column includes elements of program theories and evaluation questions. These contributed to the development of interview schedules.
- The 'Contextual Variables' column includes factors that might influence outcomes for individual customers.
- The 'Indicators/Outcomes' column describes what data might be useful for ongoing evaluation and monitoring of the key program activities. Some of these are expressed as questions to be explored.

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
Preparation: HW Coach	Assess ADLs (How? Barthel?)	-Thresholds for inclusion -How are ADL deficits addressed	-Types of ADLs that might be more of a barrier than others	Raising competence/ ability for ADLs or providing appropriate support
Preparation: HW Coach	Co-design action plan: customer, provider, S117 co-ordinator	-Co-design method -Any conflict of interests & how resolved	-How do customers' individual contexts define/ influence the plan	Having an action plan that is successful: requires minimal adjustment
Preparation: HW Coach	Baseline recovery star	-How is the star assessment used	-Are there specific domains that are easier or more difficult to improve on -Are there some domains that have a greater or lesser effect on successful outcomes	Improvements in star domains
Preparation: HW Coach	3-monthly review	-The reviews should pick up on progress and identify any changes to the plan	-Are there patterns in any issues recognised	How the 3-month review effects the success of interventions
Preparation: HW Coach	Assess and arrange for ongoing social care/SDS	-Ongoing social care could be critical for independent living -How is this assessed	-Any barriers in addressing specific care needs for certain customers	Putting appropriate social care SDS packages in place
Preparation: HW Coach	Engage in education/training	-How are education/training needs assessed -What resources are available	-Any barriers in addressing specific needs -Are there patterns of needs recognised	Successful engagement and completion of appropriate education or training
Preparation: Housing Worker	Establish housing	-There will be an improved potential for	-Individual preferences	Variety of preferences and options

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
	preferences and options	successful resettlement if preferences are met and appropriate options are chosen -Possibly customers' preferences might not align with professional opinion	-Local availability -Professional opinions	taken into account and acted upon
Preparation: Housing Worker	Identify and address barriers to access	-How are barriers identified and addressed -Assumption that addressing barriers to access will improve success of resettlement	-Types of barriers identified -Ease of identifying specific barriers -Ease of addressing barriers	Record of identified barriers and actions taken
Preparation: Housing Worker	Begin housing registration process/arrange log on process for bidding	-Are there any elements of this process that might determine success		
Preparation: Housing Worker	Apply for any grants/ furnishing arrangements	-Financial input will assist in making housing fit for purpose	-Eligibility for grants -Furnishing needs/ preferences	Grant success Record of furnishing
Preparation: Housing Worker	Financial inclusion work	-Independence depends on being able to independently manage finances	-Extent and type of work required for financial inclusion	Possible checklist of financial inclusion topics
Preparation: Housing Worker	Familiarisation with the area /assets	-Independence depends on feeling comfortable in the area and understanding what it has to offer	-Previous associations with the area/ social environment -Personal preferences and requirements for the area	Are any changes or recommendations regarding suitability of the area made at this stage

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
Preparation: Housing Worker	Viewing properties & support with tenancy agreements	-Customers might be lacking in competence/ confidence -Mediation with housing providers might help to improve outcomes from these interactions	-Do customers have specific problems with these interactions -Are there specific aspects of agreements that are problematic for specific customers	Recorded difficulty of property viewing or managing tenancy agreements at this stage
Preparation: Housing Worker	Set-up utilities	-Customers might be lacking in competence/ confidence to manage this independently	Is this a notable difficulty for any individuals	Success in setting up utilities as anticipated
Resettlement: HW Coach	Agree phasing of move with commissioners and current provider	-To ensure that the pace of change is appropriate	-The priorities and processes of commissioners and current providers might not coincide with customers' needs	Are there indicators of alignment between stakeholders Are delays or accelerated progress of customers recorded
Resettlement: HW Coach	Review plan	-To ensure learning and customer development or changing status are acted upon	-Customers might experience setbacks or negative reactions to the project as well as improvements	Is this a point where any negative impacts or difficulties in transitioning can be recognised
Resettlement: HW Coach	Register with primary health care (PHC)	-To provide independent access to health services and reduce reliance on intermediaries	-Customers will have variable PHC needs and styles of engagement	Registration and use of PHC services Independent access (referral through GP or self-referral) to other health services

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
Resettlement: HW Coach	Agree ongoing HW coach support	-This longer-term use of resources will impact on throughput but also could be protective against failure of the placement or deterioration of health and wellbeing - Could any ongoing needs be addressed earlier	-To what extent is ongoing support expected - What types of ongoing support are required/able to be provided - Availability will reduce towards the end of the project	- Hours of ongoing support planned and provided - Distribution of support amongst customers
Resettlement: HW Coach	Confirm social care/SDS support	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Failures due to lack of adequate ongoing care/ support
Resettlement: HW Coach	Develop Wellbeing Recovery Action Plan	-To manage any exacerbation in condition	- Concordance with action plan in case of exacerbation	- Service-use post resettlement
Resettlement: HW Coach	Continued engagement in education/ training	- What suitable education and training is available		- Training or education undertaken
Resettlement: HW Coach	5 ways to wellbeing assessment	- How is this assessment used to create transition plans		- Inclusion of assessment in Transition plans
Resettlement: HW Coach	Signpost Individual Placement Support	- What placement support is available - How are customers signposted	- Possibly variable uptake of signposting	
Resettlement: HW Coach	Recovery Star	- How is this assessment used		
Resettlement: Housing Worker	Set up rent account & landlord transactions	- Supporting relationships and interactions can help to prevent difficulties		

Phase & responsible person	Activities	Theory/ Questions	Contextual Variables	Indicators/ Outcomes
Resettlement: Housing Worker	Tenancy-ready training	- Addressing final competencies to support independent living	- Variety of different training required	
Resettlement: Housing Worker	Respond to any housing management needs that arise	- Contingency for arising issues		
Transition: HW Coach	Agree further support outside the project	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Engagement with further support - Failures due to lack of adequate ongoing care/ support
Transition: HW Coach	Referral for future support	- How well does ongoing statutory support meet customers' needs	- Ability to meet longer-term requirements for care might determine success	- Engagement with further support - Failures due to lack of adequate ongoing care/ support
Transition: HW Coach	Customer designed transition plan built on 5 ways to wellbeing	- How well suited is the 5 ways to wellbeing assessment for designing transition plans		
Transition: HW Coach	IPS employment support (through other provider)	- Integration/ collaboration with other provider		
Transition: HW Coach	Final recover star	- How is this assessment used		
Transition: Housing Worker	Customer understands how to access future support for any tenancy related matters	- How is future support accessed - What support is available	- How is access and understanding facilitated	- Records of access to future support for tenancy related matters

Appendix 2: Qualitative Evaluation: Additional Quotations

The following is an extended version of the qualitative findings summarised in the main report. These have additional quotations, which might be of use in exploring some of the key themes in greater depth.

Funders

From the perspective of the programme funders, Promoting Independence was considered a success, and the money was well-spent.

> *"If you look at the scale of the investment and the repayment, if you look at the challenges that we had to overcome collectively, you know as a partnership between provider and Commissioner, as investor. It's been a really good and positive investment."*

> *"So, in terms of impact in terms of outcomes, system change, the finance, you know, partnership relations between supplier, investor and delivery partner, I think it's it's really successful you know, so it stands out as one of probably three or four [funded SIBs] where it ticks the box across a range of criteria."*

> *"I'd say, across all the metrics that you'd look at for, for a SIB, to say, you know these are the type of positive progressions that we'd like to see across a range of measures. I think you know this ticks the box across all of them. So, I think it's very positive comparison."*

The programme was considered to have achieved a great deal for the population.

> *"People entering residential Care now do so with a plan to work on how they can, you know, live independently or semi independently. You know there's there's just lots of good things about this in terms of impact in terms of investment, in terms of system change. So, I think yes, you know it's achieved very significantly."*

There was regret that further funding could not be secured to continue the programme.

> *"I guess from my perspective that's, you know potentially an opportunity lost because I think you know there's so much good learning from this. And , this one in particular, because it's been a key component actually of system change within the way the Sheffield Council was, looked at the way it delivered services in this space."*

Promoting Independence was considered to stand out from other programmes, despite early difficulties. The success was largely attributed to the close working of all partners.

> *"It's definitely been one of the more successful ones…. maybe they could have modelled it a bit better in the beginning, but you don't know at the beginning."*

"The stakeholders have worked really well in this one … everyone attended the meetings, everyone worked towards thinking about what can we do. Whereas in some of the others … we've got commissioners over here who are never speaking to the providers, and we've got providers who don't know who the investors are into the project, and it's all been very disparate … So, I think in terms of sort of lessons learned from this one, it would be that you have to stick together through the adversity when it's not going too well and work at sort of fixing it … And I think everyone's still very invested in the project."

"Sheffield stayed there as a strong Commissioning partner and you know, worked through the tough times… Sheffield Housing Association did exactly the same…If people can stick together over a longer term and ride the way through some of the challenges and find a way forward. You can get good things out."

Early problems were attributed to the lack of current knowledge about how to commission and deliver this type of programme.

"…the key learning not just for this project but for an awful lot of them was sort of not fully understanding the cohort when they sort of set these projects up… maybe the financial modelling didn't really suit again the needs of the cohort… that probably came from maybe a lack of understanding about how complex the needs of these people were… it took an awful lot longer to sort of get people ready to move out."

However, one of the key benefits of the programme has been the knowledge developed around price discovery and about how to commission and deliver this type of service.

"I often use this particular investment as one of price discovery. In that you had no idea what it might cost to deliver this service? You could estimate the type of financial savings you might make, and now, you know several years on, you understand exactly what it costs."

"You understand exactly what the cohort of people is that you can support… You understand, you know, why it's been positive in sustaining many clients over the longer-term and actually have some learning from those clients who it hasn't supported."

This knowledge is considered important to inform future developments of this type of service.

"There's lots to like about this and lots to say. You know, how do you make that next step actually, in terms of these types of investments and moving them on and beyond the kind of SIB model into something which looks and feels different?"

Some key outcomes from the programme have been:

Using "… social investment… can be used as a catalyst … to drive change… external investment to try new and different ways of solving what are quite persistent, local and national problems."

"Co-development and evolution. Using data to learn and using data to adjust a programme."
"The extent to which Sheffield Council has been able to use this journey to inform not only the way to support this cohort but perhaps think about the wider service system and costs."

"The complexity … of the outcome contracts and you know the great work that the Sheffield Council team has done. The …cost savings … and the extent to which now we understand …how do you look at multi-year savings? How do you look at new service models? How do you contrast that with more expensive and different services for a cohort and therefore how do you continue to Commission this type of stuff and use this experience to Commission in different areas? To me, I think there's some really good learning in that."

Service Providers
Regarding the main benefits from the programme, service providers acknowledged the difference that the programme had made for the individual clients.

"So many people, have managed to kind of live a full or more independent life by kind of having this project in place otherwise without it, they'd have probably stayed in residential care for potentially rest of the life. They've kind of got a new, new lease of life."

"That customer story is really good feedback from people about how they're doing now and where they were…"

"It's been really fulfilling. You know those people that are living independently? Great because they wouldn't have happened without our programme… they wouldn't have had that kind of leg up that they needed just to help them on their way."

"The way we've worked with people to, you know, have those real successful outcomes and low failure rates. You know, they're far lower than the model sort of anticipated. So that's a real success as well."

The outcome-based contracting has allowed cost-savings to be identified and monitored on a continual basis and also provided incentive for the programme to succeed.

"Obviously the cost savings to the system is another one and we are a project that is more outcome-based. So, there needs to be savings within the system."

"With it being an outcome-based model, it's helped drive … success."

The lack of knowledge about what to expect from the programme was also an important consideration for the providers, and this encouraged a cautious approach to contractual risk.

"We thought we could do it well, but equally… we didn't know our cohort, we didn't know what other response would be from care homes. We didn't know what the response would be from people and customers within the sector… There were people in residential care homes who wanted to leave, and had a desire to do that, but the number and you know that's it within that were sort of unknown."

Importantly, despite the limited reach, the programme has been a successful 'proof of concept', demonstrating that the ambition can work.

Q: Do you think it's kind of demonstrated that like the concept can work?

"I think definitely … within the people who know about it. Yeah, I think it's definitely done a good job of doing that. I just think it just needs to be wider in the future … some of the places, they're always … thinking like, 'oh, could this person live more independent? Should we refer them on to Promoting Independence?'…"

Culture change

The need for sector-wide culture change was recognised from the beginning. Whilst the success of this has been somewhat limited, the gains that have been made are considerable and have demonstrated that new ways of working can be implemented. This is despite a system that does not incentivise providers to promote independence. Care homes are critical settings for culture change.

"It's been a big culture shift for care homes."

"I think the project has hopefully had a lasting… impact on the residential sector in mental health. In bedding down the idea that people would move through the projects…"

"simply having that shift of mentality in some of those projects was, yeah, very good… I thought that was tremendous… It gave me that sort of a bit of, I don't know, a surge of optimism about the sorts of things that could be that could be achieved."

"I think as well the culture change … [residential care] should be for people who who need that kind of requirement. So yeah, I suppose it's just more really informative to other people to kind of get that in their head that it's it's not permanent. It's there while somebody needs that level of support and then move on from it."

The potential for disruption, increased risk and additional work for care homes was cited as a key barrier to wide-scale culture change.

> *"…providers need like people there, so I think that's a big one. I think that that's like the culture of residential for people who work there as well is still very much they see a as person long-term. I don't think they really think of people on short-term kind of placements…. It's just easier to keep hold of people, especially when they know them…if they have a quicker turn around and it's going to be a lot more work, it's a lot more paperwork. It's probably more risk assessments, more kind of contact with all the social workers. They probably think of more like potential, like CQC."*

The lack of sector-wide engagement of care homes with the programme, meant that involvement in the programme was variable.

> *"…the care homes that we've actually managed to engage well with, we've had some really good outcomes. With the ones that we've not managed to engage very well with, we've not had hardly any or any at all… the culture change happened within those services who are willing for that culture change."*

> *"The others have still been a real challenge to actually work with,…the whole sort of 'you don't want to move because you're in the right place'. 'We care for you.' You know, 'you're doing well here, why do you want to sort of move somewhere else?' Type of discussion… It's been a challenge still to create any form of culture within some service or people willing to engage in this type of move on activity, which creates voids and things like that."*

> *"So, I think the key would be the actual managers of the home. You know whether they themselves are buying into it."*

The potential for a rehabilitation ethos to impact on profitability (e.g. creating 'voids' or empty places in homes), was considered a significant barrier. Regarding this, the size of the care home organisation was considered to be a contributing factor to variability of engagement.

> *"You're more likely I supposed to get buy in from a smaller provider rather than a national company… they're far more profit orientated, so why would they buy into? Yeah. Something that's going to, you know, affect their profits."*

The potential for further culture change amongst social workers was also identified, regarding the equal consideration of what services a person doesn't need as well as what they do need. This could have the effect of reducing dependence and promoting independence.

> *Q: Do you think it's had much of an influence on the culture, across the system?*

> *"…I think within the care homes that we've kind of had the most referrals from, definitely! But I think it does need to be wider kind of understood, …the social workers who, kind of, need to be the ones who are considering*

when they do a review, if somebody still needs residential. … Even if somebody shows independent living skills, I don't think it naturally comes to their head. 'Oh, they could move out of here'."

"I think if somebody showed that there was like deteriorating, they think, oh, what more support can we put in? But I don't think they think as much how can we take support away. So, I think it is a work in progress still."

Strengths

"Having a real sort of social purpose, strong stakeholder engagement, I think that's a critical one"

"A really consistent team… a real passion to see the project succeed. There's been some give on sort of all sides from us as a provider from Sheffield City Council's commissioner and obviously with big issue invest as the funder."

Regarding recommendations for future services, there were some concerns that the move to providing services through the re-enablement team might not achieve similar benefits, if the implementation is not correctly incentivised to succeed. Key incentives could be such elements as the length of staff contracts and staff pay, and connecting these to outcomes, rather than activity.

"…promoting independence project had that sort of 'oh, come on. You need to demonstrate that this works. You've got to save money.' …I think if you take that away with the Re-enablement team and … appoint people on permanent contracts rather than temporary ones… I think it would have been better to pay people more, but…you have to show results. And if you take that away, yeah, I'm a little bit worried that things might slide. That the pressure, if you like, won't be there to demonstrate its efficacy and savings… it won't achieve as much as I think it ought to… I'd love to see more of that kind of thing, where, you know, the financial aspects are not ignored… Too much of public service… doesn't even relate to the marketplace of the world."

"I don't know how many support workers there envisaging, but … if you don't pay good wages, then what you get is people hopping around, and looking for other jobs. So, I think the team might struggle if it's appointing lots of support workers on low wage. … I'd rather have smaller number of people on better wages than a lot of people on lower wages. 'Cause, I think people need to be invested this thing, in in making something a success."

A critique of the service suggested that a more diverse range of destination settings for clients could have been developed.

"I was a little bit disappointed in the promoting independence project not generating, I thought, too many creative ideas about where to move people on, or particularly seemingly discovering new places… they seem to lean quite heavily on the already established things."

The length of support provided after the client moved on, was considered an element of the programme that could be reduced, by being more flexible related to the client's needs.

> *"I think the changes I'd make is there was very, very few people who required the 18-month support after… I think that could be shortened down to potentially 12-months … the last six-months definitely like people start to disengage and it was positive really… They were doing their own thing. They didn't need the support every week… it did differ us from everywhere else that we could provide that, but yeah, I don't think it was necessarily needed as an essential thing."*

The main reason stated for failure of individuals to successfully move-on to more independent settings was an expectation that they could stay in their current setting. This meant that setbacks or anxieties around moving could easily translate into a refusal to engage with the programme.

> *"The main pattern would be, people just think they can stay in residential. ... So, if somebody thinks 'actually, I don't want to live a more independent life'. They start to get a bit anxious or worried. They just think that they can just stay there forever and that that's like their choice kind of thing, which to some extent it is. Obviously, it is about what they're comfortable with ... I think they need to know going into it, this is not my home forever. … I think a lot of people when they decided they maybe didn't want to move on or they got cold feet, they just kind of disengaged from PI and they just thought it was a bit optional."*

It was suggested that expectations could be managed better by embedding a culture of temporary rehabilitation into the service from first contact with clients.

> *"When somebody first comes onto the programme or is referred, I think the social worker who's kind of done the review … I think they need to be quite straight with the person and say, 'look, you no longer require this level of support, I am referring you on to this service, who're going to support you to the next step of your life', and not kind of make it seem such an optional thing… if they don't need that level of support, then somebody else does. … So, I think that kind of needs to be embedded early on at the referral point."*

The optional nature of engagement with the programme for people that might be living in inappropriate settings with high-levels of support was recognised as a barrier, which might be alleviated by either moving the service into statutory provision, embedding culture change (as discussed above) or having closer working relationships with statutory providers that are responsible for determining the appropriateness of services.

> *"Been a big challenge …working within care homes as sort of an add on not a statutory service. You know as a kind of a bolt-on."*

"I don't think they actually ended up moving somebody who was in one of the nursing homes, who I think may still be there…. The Promoting Independence project weren't able to… do anything about it. They didn't have sufficient number of visits to be able to go and see the person or… the clients themselves could just disengage…. one of the shortcomings with the project was, as I said, they didn't have that sort of muscle…. That's why, yes, I thought it was slightly Ill conceived in the first point place to have a voluntary agency doing this work and not a statutory one."

Regarding the function that will be provided by the re-enablement team, it is possible that having more control over eligibility of people for services could alleviate some of the problems encountered by the programme in relying on culture change, goodwill and willingness for individuals to engage with the programme.

"…it'd be interesting for the enablement service, how they get on with more statutory arm of they, they do actually have a more of a 'right you're eligible, you're moving' type of approach which has been a challenge."

The lack of statutory assessment was a surprise and is reported to be an enduring barrier to the efficiency of the programme. The separation of the programme from statutory provision and mental health services, is again cited as a barrier and an area where the programme lacks control.

"How I looked at the beginning was that people are assessed… They have a social care assessment annually. Are they in the right provision? If they're not, then… that means that they are either referred into our programme or steps are made to try and help them to move on… some people haven't been seen for five years over that, not been assessed, not had any workers… wasn't meant to be our role to find referrals that was meant to come from statutory provisions; it never, never has… It's come mainly through our kind of engagement work."

"I think the challenges within the sector of people in residential not having named workers not having people who we could actually work with to help move on was, and still is, a real challenge… I'd also say some of the practise within those services are still quite deficit based, still very risk averse… we had no kind of a clout or no kind of ownership to change that we because we don't hold that function."

"…somebody might have withdrawn because somebody's not offering the right support, which has led to a decline in the mental health. There's a lot of things in this programme which are out of our control…"

"The promoting independence project [didn't have the] statutory service muscle to …move people based on assessed need, and say 'effectively you no longer need this level of care and therefore I am telling you we are no longer going to fund this level of care and therefore we will be moving you'. …they were then reliant on statutory services, saying that on their behalf and statutory services were

never fully invested in promoting independence project to the extent that they could work that sort of situation."

However, despite some drawbacks, setting the programme within the South Yorkshire Housing Association, was reported to have benefits, such as flexibility regarding the time in the programme, discretionary budgets and the type of support provided.

"Having allied health workers or those that work, you know within OT and trained psychotherapists… just have a different approach to working with people that isn't clinical, I think that's been a real kind of strength for the project as well."

"Not always having to talk about someone's mental health is a positive thing. Just talk about other stuff. You're not there just for a review. You're not there just to kind of see how they're going."

"People have £20 a month to do something independently with their health and well-being coach or their key worker… it has to be linked to independence. But you wouldn't have that in a statutory system… like gyms, memberships, you know, cinemas, just getting people out swimming, you know horse riding."

"Another thing we've £250 … to help somebody on that transition to move buy them a little something that's nice for them to have in their home as early sort of things, not something that you get I don't think in a statutory function."

"So, although the programme had like nine-month move on … that didn't generally happen with most people. It sometimes it was short, sometimes it was longer. … there's just so many variables … it's a lot harder to do a project like this, which is based on set outcomes in set periods of time. You just need to be a lot more fluid with mental health, as hard as that is from a kind of business perspective…. because it's like it was South Yorkshire Housing that did it, we were so flexible. … we didn't have like the pressures."

"Because it's not a local authority project or because it's not a trust project, we have a bit more leeway on certain things… there's somebody who's been on our programme 1400 days before they've moved. That wouldn't happen in statutory services. They would discharge within, you know, a certain period of time about whether or not they're ready to move."

"I think with PI being having that flexibility to support people for, we know people have been in there for four years in the programme, and they stuck with them like glue and being able to support them through when they see them moving through. I'll be honest with you, I'm not 100% sure we'll be able to do that in the local authority."

However, being set in the voluntary sector might have contributed to some of the delays that required people to have longer time in the programme.

"Say some of those didn't need to be that long. If we'd have had the right support and the right sort of pushes and the right communication from the sector, we could have moved those people quicker."

A number of problems were encountered. Whilst some were overcome, other persisted. New tools and processes were developed, for example to understand gaps in living skills.

"We didn't have an accurate understanding of their living skills. … we developed like an assessment tool. … that seemed to work really effectively because then we could assess them ourselves and get a better judgement of what we needed to work on for them to be successful in the community."

Associated with this practical assessment and development of living skills, one problem that could not be overcome was the access to appropriate facilities to enable rehabilitation. For example, kitchen and laundry facilities are often out-of-bounds for care home residents. This is indicative of the extent of culture change that is required to promote a rehabilitation ethos across the care home sector.

"…they didn't have the facilities to work on any independent living skills. Like in, in most of them staff do all the washing and like the service-users don't get to access a washing machine, they don't get to access a kitchen and we couldn't go in and use that bit just because of obviously policies and procedures, safety… There was nowhere to kind of develop on these skills…. people are literally restricted, they can't do these things for themselves while they're living there… there's no option to, in most places."

Legacy

"The main thing is getting a wider understanding throughout Sheffield and obviously well, much more wider eventually, but of a pathway out of residential care. …So, I think the main the legacy is it's starting now, do you know people are aware of it, it's growing"

"I think legacy wise… The actual saving to the system and pathway is actually a real positive thing… I'm sure there will be other local authorities who have people in residential who don't need to be in there. So, I think kind of legacy wise is we've created a new pathway for people… a whole new way of working… a lot of local authorities, they don't have a generic pathway out."

"there are plans for a re-enablement team, which is going to be within the Council. So, it's again, it's been successful in… helping embed the idea that people people's conditions … don't have to be static, don't have to be quite pessimistic, and that you can actually feel that you're contributing to helping somebody become less reliant on services."

"The best legacy of it is to hopefully have changed the mindsets of [3 care homes]… Plus, others must have to a certain extent, … to make them go, 'oh', you know, 'oh, there's something different going on'."

The re-enablement team, as a legacy of the Promoting Independence programme, will have a broader scope to look at reducing care packages across the board in cases of inappropriate dependence.

> *"I think the scope of it is a lot better… re-enablement team will have a a broader, a broader remit… it's Step-down from nursing to residential to residential to supported. Also looking at reducing support packages as well, where appropriate. So, I think, yeah, I think this is all good news. You know, having a broader remit is very good."*

There is optimism that the more people that are working with a rehabilitation remit, the more that this will become recognised and the culture might spread across the system.

> *"I think the idea is to still have, say, like mental health, social care teams…you need people to be invested in this way of thinking. Looking at sort of healthier outcomes for clients. And if you have enough of those people…, I can't help but think colleagues would then start clocking and going oh, … I see what you're doing… I would like to think it would be helpful in that way."*

There is a possibility that the capacity of the programme might outstrip appropriate referrals and time might be needed to replenish the numbers of people that are eligible referrals.

> *"When you move somebody out who is recovery focused, and they move the the people coming into residential care are not similar… probably in the last 6 to 12 months, we have seen a a reduction in referrals… we've definitely seen a reduction in in kind of, I would say, referrals that are appropriate."*

> *"Part of me thinks it would probably need a period of time to replenish a little bit… we're just not getting the referrals and people again aren't ready to move… is there needed a period of time to settle and then go again."*

The ideal service

> *"It probably wouldn't look too dissimilar… So, there'll be a cohort, you know in place that we would then know who they are, where they are. We would probably want more of a firmer approach from either the trust or the Council about provisions, like residential care still hold a lot of cards within somebody staying within their provision."*

> *"I'd love it that the system was in a place that the system decided, you know, with the person, right, you, you know, I've assessed you, you don't need to live in residential. Right, let's work on a six-month, three-month transition plan for you to move out, work with promoting independence. Here's a referral. Work with them. Move out in this period take the actual home out of the equation a little bit."*

"If there was some form of agreement in that way with the cost savings that are made through those changes, those moves that those services that work in a recovery based way are more incentivized to do that and a lot of it is monetary, you know voids cost a fortune."

"Reviews and that side of things happening quicker, a pool of people that we could work with and a bit more, a bit more of a clout for care homes to work in this way to help us"
"if people have been identified from the beginning, then I think that really would have shaped the model a bit better. So I think if I was going to say if you're going to set it up again, that is a key piece of work that needs to be done prior to a provider or an investor or local authority trust getting involved."

Commissioners
Positive and negative experiences of the outcome-based commissioning through the social impact bond.

"I suppose the positives has been that it's allowed us to divert spend in an area which I think probably the local authority wouldn't have funded… it's allowed us to meet the needs where we probably wouldn't have been able to identify resources to meet that need. And it's given us an opportunity and an innovative way to trial something which I think if the local authority had trialled it, we wouldn't have that as much autonomy or flexibility."

"I think the negative of negative side is… I just feel as having a three-way agreement, I find it really clunky, when we probably could have done things differently, but then that aside, we wouldn't have got that investment. So, we needed that investment to enable us to do the programme."

Problems encountered when delivering the programme
"COVID. We know how that impacted because Sheffield was unable to really work within care homes for two years."

"… when the adult social care function was part of the care trust, it was really difficult to engage and get support from the team, for them to understand. Because they've got other priorities and so there was issues of referrals."

"We [adult social care services] were a barrier a lot of times, social care. Yeah. Because when people moved… into supported accommodation, for instance, they still needed assessments of packages of support. But we didn't really have the capacity, nor really be able to see these individuals as a priority to allocate social workers. So, a lot of the time, I mean to date some of the move-ons are delayed because of us in social care, and that's a real problem… We've looked to address it, … with looking at a dedicated social care team who link in to kind of enablement …, but without having that dedicated role …we were a barrier a lot of times."

Problems identified that that haven't been solved

"When somebody comes into residential care, historically they've stayed there for life. And I think the culture is just so ingrained in the care homes, and obviously the social work teams and hospital discharge teams. I think it's so ingrained that actually because people are safe, there's not been that urgency to move people on."

"… I can see the cultures within the social work teams changing, and people are, and workers are slowly seeing, actually, it's not a home for life, it's just the next step. It's just a holding point until they move, a person moves on to move into the community and lives their life as best as they can. But we've still got some way to go and that still needs a bit of work."

"I think we really need some focused resource into working with those care homes… So, I think there needs to be a piece of work with mental health homes about what our expectations are…."

"I also think there's some work needed with actually people actually somebody working with the individual care homes to say 'look, come on, this is this is what's happening. We want you to be more in re enablement focus to support people to move on and move flow through the system.'"

"I think a lot of the care homes are not set up for enablement because obviously the handful what we do have, they have got communal facilities, they've got, you know. They've got facilities, what they're able to support the client with their daily living skills, but that's very rare. So, and I think a lot of the other care homes that model is very much 'we will do for rather than do with', so there's there's still work to be done there."

"… as part of the legacy we are going to have some sort of centre somewhere… where it does have like kitchens and things like that… if they are in sort of those sort of residential homes which don't have that facility, there is somewhere for them to go. … we're currently trying to eradicate as many barriers."

Legacy

"We're going to establish the enablement team and part of that role will be to continue a little bit of this work. So, we will continue with supporting people to move on from residential care. We will also be looking at, looking at our supported accommodation provision and how we work with clients there. So, we will sort of operate the same sort of approach but, diversifying it, using it in different areas."

"…I'd like to see that work with care home managers as part of that work with the enablement team… I think if we start that message early with social workers and with the hospital discharge team… we have a very clear support plan from when a person's being discharged from hospital into a residential care. People are told clients are told, 'actually this is not a home for life, you're here for as long as you need to be, but then the the, the, the, the vision is for you to move on.' I think if we start that bit there, things start filtering through."

"what we will have with the legacy is, is that social work function will be involved sooner... So, they'll know when it comes to reviews. They know that person, they've worked with that person, so they know where the best place where the person should be placed."

Key learning

"Being able to be adaptable, I think it's key to have clear and open transparent conversations with stakeholders. I think it's admitting when things aren't working well and trying to then come up with other approaches to try and meet, meet the need."

"I think the key learning is that we, with a dedicated resource and focused resource, I think it can really transform people's lives, who have been in residential for a long time."

"we weren't able to put this externally again, but this is why we brought it internally, but the flexibility of a local VCSE organisation together with the approach from local authority to try and support move on… bringing it together under a focused programme is absolutely the key. Dedicate the resource for this, frame it as a very specific project. Because trying to integrate this to to business as usual becomes less of a priority … So, that'd be my key learning is, keep this as separate to business as usual."

Strength of programme

"Residential care is a need for people in mental health. Some people will always need that support, because they're not able to live independently within the community. However, it shouldn't be somewhere where somebody should be for years and then becoming institutionalised. They should have that option to always move on."
"the strength of the project is is people's invested in it. So, the people who are around the table at the end of the project were the right people to be around that table, to make this project work."

Barriers

"Trying to make decision-makers in the local authority to understand what the project's about. Because I think that's, one of, been a bit of a barrier. This project is put in place, but the key decision-makers wasn't really sure what it was, wasn't sure if it was actually working."

"Years ago, there was an abundance of supported accommodation. I think what we're finding now, as times going on, and I know this is national picture is not just local picture, we're struggling with finding supported accommodation."
"we have no social housing, so we have no Council properties…. I think what's really, really hard is actually finding quality providers of supported accommodation."
"I think the problem we have now is, which is no fault of, it's just where the system is, because individuals don't have named workers, more often than not, when it's coming to moving on, we're then having to get a new social workers who's probably never been involved with the person, never

really know the project, having to move the person on and undertaking those reviews. Which is not, for me, it's not always the best, because they don't fully understand that person and understand that person's needs."

Strengths

"We have been passionate… we want to see a system change and we want to see people move through the system, I think yeah, I think that's been a real strength."

"the outcome payments were based on sustainable move out and that means that there's periodic checking and evaluations. And that was really important, to keep that element of consistency throughout. And I think that really promoted the success, longevity, success rate of it."

"… it's difficult sometimes to structure it, but something as clear as you've moved out the defined you've moved out for X amount of time makes it very clear and easy to measure".

The teamwork

"A lot of success of this leans on the good partnership. And I think without that real open communication and joint approach to trying to problem resolve it, none of this would have got off the ground. And I imagine there's been failures in other places that have tried to implement this... it's a testament to the actual people that have have run this, it goes a long way."

Systemic lack of incentives for care homes

"To try and support people, to be aspirational and gain skills towards independent living, it is a lot. It requires a lot more, and it requires a lot more risk taking, and I think some environments struggled to understand how they could accommodate that within their set up."

"And there's also financial concerns from them, …you take a service that might be 90 plus percent occupancy rate down to 80, 75% occupancy rate, it hits in the pocket."

Ideal service

"It would be a move on environment that was, that was kind of a three stage Co-located, so you'd have your residential and then not far… from the footprint of the of the space, you'd have a supported block of flats for instance, which would be an interim point and then you'd have moving out into the community… having that that initial stage co-located and then supported throughout and having the same provider being consistent through those stages is really important for individuals… a model like that …, if I had the time and a magic wand, that's what we would do."