

The Care Act 2014, personalisation and the new eligibility regulations: implications for homeless people

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Abstract

As government funding for housing related support (formerly Supporting People) services continues to shrink, it is timely to revisit the question as to whether 'homeless people' are eligible for publically funded care and support, including personal budgets, organised through the local authority. The Care Act 2014 which was implemented in England on April 1st 2015 may serve to provide greater entitlement to this source of funds which has rarely been used in support of 'homeless people'. However, there are questions as to how far these changes will be embraced and actively implemented on the ground. On the one hand, social workers may be reluctant to extend their reach because there is already a shortage of resources to meet the needs of existing service users. On the other hand, there is uncertainty inside homeless organisations as to the benefits of personal budgets which may lead to a reluctance to refer 'homeless people' for assessment under the Care Act 2014. We outline suggestions as to how these mutually reinforcing barriers might be overcome to ensure adult social care becomes more inclusive.

Keywords: homelessness, severe and multiple disadvantage, social inclusion, housing related support, eligibility, personal budgets

Introduction

The Care Act 2014 is the most significant reform of publicly funded care and support in England in 60 years. It fundamentally reframes local authorities' statutory duties from one of providing or commissioning services for specific user groups to promoting wellbeing. It places personalisation on a statutory footing for the first time providing those who are eligible with a legal entitlement to a personal budget. It rescinds former legislation, including the NHS and Community Act 1990, with the aim of creating a single consistent route to establishing entitlement to publically funded care and support:

To make the law fair and consistent, we want to remove many anomalies, which treat particular groups of people differently. We do not want people to be dealt with differently based on the type of service they need or where they receive it.

(Department of Health, 2013, p.1)

This paper explores the implications of the Care Act 2014 for 'homeless people', a group that was defined as 'ineligible' for publically funded care and support under the previous community care legislation. In the first section of the paper, we describe how the *Supporting People Programme* evolved to fill this gap, providing what was termed 'housing related support' to meet the needs of homeless people and other excluded groups. We then describe how the austerity measures have eroded this support, and the evidence for a retrenchment of the welfare state. In the second part of the paper, we explore the changes that have been introduced as a result of the Care Act 2014 and in what circumstances they might be used to access personalised support for 'homeless people' (including housing related support). We draw attention to the epidemiological evidence that necessitates a reconceptualisation of homelessness as a 'health risk' that extends beyond the low level preventative agenda making the case that many

'homeless people' will now fulfil the new eligibility criteria for publically funded care and support. In the second half of the paper, we turn our attention to the barriers which may hinder awareness raising and the implementation of these changes thereby limiting opportunities to enhance choice and control for some of the most severely and multiply disadvantaged people in England.

This paper was originally prepared as a briefing document on the Care Act 2014 for homelessness organisations. It was presented and discussed at a series of regional events in London, Manchester and Birmingham in 2015. The events were organised by Homeless Link (the national umbrella organisation for homelessness organisations). This updated version of the paper draws on the original review of the Care Act 2014 and associated literature, and incorporates some of the discussion arising from these regional events.

Assimilating the Supporting People Programme within adult social care

In England, support services for people who are homeless have been developed largely in isolation from local authority adult social care services and social work provision. The *Supporting People Programme* (Department of Social Security, 1998) provided separate management arrangements and 'ringfenced' or protected funding from 2003 onwards for a range of services designed to act as a bridge between general housing services and local authority social services (formerly personal social services). Whilst social services departments refocused their resources on crises intervention and on meeting high level needs (mostly for personal care), with population ageing being a prime reason, housing providers met the needs of tenants requiring lower levels of support (Foord, 2005). *Supporting People* services were termed 'Housing Related Support' (HRS) and encompassed wide ranging activities linked to helping people to obtain suitable housing, sustain their tenancy, and gain skills and confidence. A key stipulation of the *Supporting People Programme* was that funding should not be used to provide direct 'care' but should focus on prevention and enabling people to maintain their independence.

Because the *Supporting People Programme* was positioned outside community care legislation (NHS and Community Care Act 1990) this enabled many new individuals who were not previously eligible for statutory support to receive some form of assistance (in addition to income related benefits and the universal National Health Service). A defining feature of the *Supporting People Programme* was the proliferation of many innovative schemes and local services designed to meet the needs of homeless people, people with substance misuse issues, ex-offenders, lone teenage parents, asylum seekers, refugees, gypsies and travellers, and other socially excluded or 'unpopular groups' (Foord, 2005, p.6). Although many of these schemes were constructed by local funders or commissioners as providing preventative or lower levels of support, they often addressed multiple needs and complex social issues linked to mental health issues and drug and alcohol dependencies. In the homelessness sector, this complexity became characterised as 'multiple exclusion homelessness' (Fitzpatrick et al., 2011; Cornes et al., 2011).

The end of the *Supporting People Programme* was signalled by the removal of the funding 'ringfence' in April 2009. This was justified on the grounds of enabling local authorities to decide where best to target resources to enable efficiency savings (Chartered Institute of Housing & Local Government Association, 2010). Assessing the risks associated with this devolution, the Department for Communities and Local Government (DCLG, 2008) noted the concerns of local commissioners that the *Supporting People Programme* might be absorbed and then 'dissolved' within wider strategic planning and commissioning structures. In a recent survey of 83 commissioners from different areas across England, 45 reported that their dedicated *Supporting People* commissioning and procurement teams 'have either dispersed or integrated into the adult social care commissioning teams, or have physically moved into closer geographical proximity within the same building' (SITRA, 2014, p.22).

Retrenchment of welfare provision for homeless people

Following the removal of the *Supporting People* 'ringfence', homelessness and other housing related support services have been subject to funding cuts (House of Commons Library, 2012). The most recent estimate based on a forthcoming Joseph Rowntree Foundation study by Hastings *et al.* suggests that the sums committed to the *Supporting People* overall spending budget by local government in England reduced by nearly half (48.8%) in real terms between 2010/11 (original budget) and 2014/15 (cited in Bramley & Fitzpatrick, 2015).

The homelessness sector advocacy group, SITRA, has voiced concerns that housing related support funding in some areas may be engulfed:

[Supporting People] commissioners reported facing round after round of funding cuts to [housing related support] services, resulting in energy and attention being solely directed to sustaining some level of housing related support activity. (SITRA, 2014, p.3)

The impact of these changes on the homelessness sector was investigated by Homeless Link in an annual survey of providers. Homeless Link (2014) reported that although many accommodation projects had experienced a reduction in funding, the number of 'beds' provided had not dramatically reduced. The main changes resulting from funding reductions appeared to be reductions in the range of services offered and the level of support available. About one fifth (19%) of projects with less funding reported reducing 'key working' and a third (33%) reported reductions of 'meaningful' activities. Half (48%) of the projects receiving less funding had reduced the numbers of their frontline staff, while 41% had cut back office or administrative support. These changes suggest that projects are operating with fewer staff to support the same number of service users. This finding mirrored that of an earlier survey in which 40% of respondents reported handling the same number of cases with fewer staff (McCabe, 2012).

One important consequence of this reduced capacity may be the tightening of access criteria for housing related support services. Three quarters (74% compared to 63% in the previous year) of accommodation providers reported 'turning away' people whose needs were perceived as too high for them to manage. This is often referred to as the 'inverse care law' (Keene, 2001), whereby:

Those who need support the most are at greatest risk of not being able to access this.
(Homeless Link, 2014, p.52)

While these findings may suggest that homelessness services have made significant efficiencies, Homeless Link (2014) cautioned that there will be a limit as to how much further this can happen before core services are affected. It concluded that localised funding decisions have left homelessness services vulnerable and argued for a nationally coordinated, long-term homelessness strategy with accompanying investment and secure funding base (Homeless Link, 2014). According to Whiteford this may be justified on the grounds that:

Supporting People has been shown to have produced savings of more than 3.4 billion for the Treasury by intervening early to prevent more severe problems from developing... These significant and substantive gains were guided by the powerful locomotive of record funding levels to local authorities, charitable organisations and social enterprises.
(Whiteford, 2013, p.14)

Future strategic management of homelessness and housing related support services

While the cuts to homelessness and housing related support services are part of the reductions in public expenditure made by the Coalition and Conservative governments, they are taking place in the context of changes in the commissioning and delivery of adult social care. From

2007 onwards, the policy of personalisation has been pursued by successive governments (DH, 2007) especially in England. While its meaning is contested, it has come to be most strongly associated with the devolution of budgets down to the individual or a nominated budget holder (Needham, 2011) or management of a known 'budget' by the local authority or a social care provider. In England, 'personal budgets' are designed to facilitate micro or individualised commissioning and to enable people to have greater choice and control over their care and support. Personal budgets encompass direct payments (cash for care) and a range of managed options, including Individual Service Funds (ISFs) (Miller & Sanderson, 2014) or Managed Personal Budgets. ISFs enable people to nominate a provider of their choice to manage their personal budget on their behalf. Providers can then make a charge for both the support they provide and, subject to the discretion of the individual local authority, for managing the personal budget itself.

To facilitate increases in the purchasing of care and support by individual personal budget holders the bulk purchasing of services by local authorities and the use of block contracts, such as those associated with the former *Supporting People Programme*, are declining. As confirmed in the Care Act Guidance (DH, 2014) social care and support commissioning are to become a force for 'market shaping' ensuring that users and carers will have choice of support and provider and can be assured of quality. In many areas this is being achieved through the development of Framework Agreements, whereby local authorities establish a list of 'preferred providers' and set prices but do not give providers any guarantee of hours or custom, unlike block contracts where these elements were often guaranteed and service user choice limited to these providers (Rabiee, Glendinning & Baxter, 2013).

Significantly, the Care Act guidance (DH, 2014) confirms that adult social care in England is to have a broad 'care **and support**' function (and should not be confined to the provision of personal care services). This encompasses meeting needs relating to 'housing related support'. While a clear boundary is to be maintained between the local authorities' 'care and support function' and their 'housing function' (e.g. to meet accommodation needs under the Housing Act 1996):

There is nothing to stop local authorities in the care and support role from providing more specific services such as housing adaptations. (DH, 2014, p.295, s15.52)

The 'care and support' function is also envisaged as encompassing many of the activities which were once in the domain of the *Supporting People Programme*, for example:

Enabling individuals to recognise their own skills, ambitions and priorities and developing personal and community connections in relation to housing needs. (DH, 2014, p.295, s15.55)

Under the Care Act 2014 it is envisaged that 'housing related support' will be integrated with other forms of care and support as part of a personalised support plan. In Scotland, where 'cash for care' schemes have been implemented as part of the policy of 'Self-Directed Support' (SDS), Rosengard, Ridley & Manthorpe (2013) report that in 2011-2012, while personal care was the main form of support purchased through individualised SDS budgets in Scotland, 11% of packages also included the purchase of housing related support services.

Indeed, one of the benefits of using a personal budget is the potential for greater flexibility and integration of support. One major disadvantage of the *Supporting People Programme* was that, in creating an artificial split between 'care' and 'support', it contributed to systemic problems which were not conducive to seamless services (Foord, 2005; Cornes et al., 2011). For example, older homeless people were often reported as falling through the 'cracks' in provision as their needs straddled both Adult Social Care and *Supporting People*, leading to disputes between agencies as to who was responsible (Crane & Warnes, 2001). Personal budgets have the potential to overcome these problems by removing some of the artificial barriers imposed by

services. For example, where a person employs their own worker (a 'Personal Assistant' [PA]) they can expect integrated care in the sense that a PA can carry out both personal care and other support tasks such as assistance with management of household finances so long as this meets the outcomes agreed with the local authority.

Discussing what these changes are likely to mean for homeless people and other former *Supporting People* service users in England, SITRA observe that:

For those who are eligible [for personal budgets organised through adult social care], care packages can still address many of the different [housing related support] needs of individuals and can be personalised. However, for service users, who do not fit the criteria, there is not any plan [in the five local authority areas they studied] to deliver any direct support services, let alone personalised services. (SITRA, 2014, p.24)

The new eligibility regulations

To summarise so far, policies impinging on care and support for homeless people are at a critical juncture. On the one hand, there is evidence that the end of the *Supporting People Programme* has signalled a retrenchment of the welfare state and the withdrawal of support from 'unpopular groups':

If you are homeless, with a drug and alcohol problem and a criminal past, your chances of finding help are becoming much slimmer. As homeless services continue to experience savage funding cuts they are increasingly being forced to turn away the most vulnerable. (Twinch, 2014, p.1)

On the other hand, the Care Act 2014 opens up new opportunities for increased choice and control through personal budgets, including integration of supports that were previously provided in parallel. However, these benefits will only be accrued for those assessed as eligible for publically funded care and support under the Care Act 2014. We now turn our attention to the question of eligibility and how 'homeless people' are likely to fare under new regulations.

The Care Act 2014 introduced a new set of regulations about eligibility with effect from April 2015 (see SCIE, 2015: <http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/outcomes-care-support-needs.asp>). These regulations replaced the previous eligibility criteria and guidance, often referred to as 'FACS' (Fair Access to Care Services) (DH, 2010). The new regulations are designed to be more inclusive in that they remove reference to 'eligible' and 'ineligible groups' so that any adult with any level of need will have a right to an assessment (DH, 2013, 1.9). In the previous legislation (under the 1990 NHS and Community Care Act) people's eligibility for help depended first on them falling within a defined category such as disability, age or mental disorder. Removing reference to particular groups was a specific recommendation of the Law Commission (Law Commission, 2011) on the grounds that this would make it easier to understand when the duty of assessment was triggered. As a result:

It also follows that the ambit of the [Care Act] legislation will be in principle wider than that of the [previous] legislation. This might mean that certain vulnerable adults [e.g. homeless people] who previously have been passed over by social services – on the grounds that they did not come within a certain user group defined in legislation – will in future not be excluded. (Mandelstam, 2013, p.80)

Under the Care Act 2014 determining eligibility now hinges on 'identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing' (DH, 2014, p.96). Indeed, it is difficult to think of a situation in which being homeless would not have a significantly negative impact on a person's wellbeing. However, the regulations are specific and nuanced, and for advocacy purposes, what counts is not the fact of being

'homeless' *per se*. but the associated consequences which might give rise to physical and/or mental impairments. To access publically funded care and support (i.e. a personal budget), the new eligibility regulations put in place three hurdles. [1] The first is that 'the adult's needs must arise from or be related to physical or mental impairment or illness' (DH, 2014, 2(1)a). Helpfully, for many homeless people, the Care Act guidance (DH, 2014) then makes it clear that relevant conditions include 'substance misuse' (2014, p.96) and with regard to mental impairment that, 'a formal diagnosis of the condition should not be required' (2014, p.96). This latter point is especially relevant to people who are homeless and who may be experiencing 'complex trauma' or 'personality disorder' since some may have been excluded from treatment and support on the grounds that they do not have a formal diagnosis (St Mungo's, 2009).

[2] Once a physical or mental impairment has been identified, the second hurdle is to determine if as a result of this, the person is unable to achieve two or more of the outcomes listed in the regulations. There are ten specified outcomes and these lie across a broad spectrum encompassing personal care, inclusion and housing related support. Specified outcomes include 'maintaining a habitable home environment' and 'accessing and engaging in work, training, education and volunteering'. In the guidance, maintaining a habitable home environment encompasses tasks that will be familiar to many homelessness workers including 'support to sustain occupancy of the home and to maintain amenities, such as water, electricity and gas' (DH, 2014, p.98). [3] Finally, the third hurdle involves the local authority making a decision as to whether the adult's needs and their inability to achieve the specified outcomes cause or risk causing a significant impact on their wellbeing. According to the guidance:

The term 'significant' is not defined by the regulations, and must therefore be understood to have its everyday meaning. (DH, 2014, p.99)

Determining the risks posed by homelessness to health and wellbeing

While decisions about eligibility for publically funded care and support are always made on an individual 'case by case' basis via the local authority assessment process, the epidemiological evidence base on the homeless population gives a very strong indication that many 'homeless people' will meet the new national minimum eligibility thresholds outlined above. First, there is considerable evidence of the ways in which experiences of homelessness (e.g. the failure to maintain a habitable home environment and the associated difficulties of maintaining personal hygiene, nutrition and the ability to engage in work, training, etc), impact or risk impacting significantly on wellbeing (see Hewett *et al.*, 2012, for an overview of the epidemiological evidence). In summary, homeless individuals have worse physical and emotional health status than the general population, including those from deprived neighbourhoods. Homelessness is characterised by 'tri-morbidity' (linked to physical, mental ill-health and drug and alcohol problems) and other risk factors including poor nutrition, exposure to communicable diseases, harsh living environments, high rates of victimisation and unintentional injuries. Homeless people in England attend the emergency department five times more often as those people who are not homeless and are admitted to hospital 3.2 times as often. Despite high expenditure on unscheduled care for homeless people, the clinical outcomes are 'generally appalling' (Hewett *et al.*, 2012, p.1). In the language of the old FACS guidance, homeless people frequently have needs which are 'critical' (i.e. life threatening). The average age at death of a homeless person is 40.5 years. Homelessness is an independent risk factor for premature mortality. According to Hewett *et al.* (2015, p.4), this evidence should lead us to 're-examine the inverse care law and rebalance the provision of health [and social care]'.

As an indicative figure on the numbers of homeless people likely to be eligible for publically funded care and support under the new regulations, research on severe and multiple disadvantage in England, which uses data linkage to quantify the number of individuals who have overlapping experiences of homelessness, substance misuse and offending (where mental ill-health and complex trauma are common complicating factors) suggests that the 'average' local authority might expect to receive around 1,470 referrals over the course of a

year (Bramley & Fitzpatrick, 2015).

Barriers to more inclusive practices

Under the Care Act 2014, while local authorities have a statutory duty to carry out an assessment on any adult with any level of need, support remains very firmly a welfare entitlement subject to the 'gift' (or denial) of the local state. Slasberg (2013) has warned that the Care Act 2014 could potentially amount to 'no change at all' if the underpinning resource allocation system remains unchanged wherein only those needs that can be afforded by the local authority will be considered as sufficiently 'significant'.

Such a scenario is highly likely if there is to be a continuation of the underfunding of adult social care relative to need (Glendinning, 2012). Social workers are already under considerable pressure and overworked (Unison, 2014) and there are questions as to how far they will be willing to extend their case loads to reach out to homeless people and other people in formerly excluded groups.

As social workers may have limited experience of working with homeless people, achieving greater inclusion will also depend on training. In particular, local authorities will need to raise awareness among frontline staff about the need to move beyond traditional conceptualisations of homelessness. Under the community care legislation, homeless people were often denied access to assessment because it was *assumed* that their needs would not be high enough to meet the substantial and critical thresholds required (Cornes *et al.*, 2011). Homeless was often considered to be a 'housing issue' or a 'poor lifestyle choice' and something that might be best accommodated elsewhere (i.e. in the preventative/low level agenda managed by the *Supporting People Programme*). Cameron (2015) for example describes how despite the complex nature of their needs, none of the homeless women in their study were in contact with social workers from adult services.

Barriers to more inclusive practices may also emanate from inside the homelessness sector itself, pointing to the need for awareness raising and proactive implementation of the Care Act 2014 by local authorities. First, many housing and homelessness workers have little experience of working with adult social care and often the concept of 'social care' is not well understood. While the FACS guidance was clear that 'social care' should encompass needs relating to social inclusion and participation (DH, 2010, p.61), local authorities have increasingly restricted funding to personal care services (Raibee, Glendinning & Baxter, 2013). This has worked to discourage many homelessness workers from referring their clients who may have a need for support work targeted at inclusion, but not necessarily personal care.

The second factor relates to a question of readiness on the part of homelessness service providers to fully embrace the 'cash for care' agenda and to be in a position to contract directly with individual 'personal budget' holders. We now turn to consider this issue in more detail.

Readiness to contract with individual 'homeless' service users

Given the end of the *Supporting People Programme* and the reduced number of 'block contracts', the continued survival of many homeless and housing related support organisations will depend on their ability to contract directly with individual 'personal budget' holders or their proxies. A recent review of personalisation in the homelessness sector carried out by Homeless Link (2014) suggested that many organisations remain largely ill-prepared in this respect. At the regional events, there was great interest in the potential use of mechanisms such as ISFs, which were not well known about. SITRA (2014) has also found with regard to all client groups that personal budgets are still not commonly used in England to purchase housing related support services.

This lack of preparedness may in part be explained by the fact that the protected funding afforded through the *Supporting People Programme* enabled homelessness organisations to pursue their own approaches to personalisation, which are in some respects at odds with those developed in adult social care. In the homelessness and housing related support sector, personalisation is often assumed to be analogous with 'person centred care'. Therein personal budgets are 'recognised as one of the many ways of delivering personalised services, but not the central one' (SITRA, 2014, p.15). In adult social care, the Care Act 2014 affirms that everyone eligible should be offered a personal budget.

Where personal budgets exist in homelessness services these tend to be financially managed by the service provider. This means that while people who are homeless may be offered a choice of worker, or even a 'menu' of support activities from which to choose, they may not have the same choices as other adults to opt out of services altogether, or to employ their own workers or other means of having their care and support needs met. The personal budgets provided through homeless services are usually limited to either a one-off amount to enable a specific resettlement outcome, or otherwise set at the level of 'pocket money' with the workers often remaining in control of the cash without individuals necessarily knowing the amount that is available to them (Homeless Link, 2014). Discussing an evaluation of a personal budgets pilot for 'rough sleepers' in London, Hough & Rice (2010) stated that unlike the 'personalisation model' in social care, there is no specific resource allocation system and no formal assessment of individual needs. Personal budgets for the resettlement of 'rough sleepers' (currently a Pan London scheme in 2016) have been set at a one-off payment of up to £3,000 (Blackender & Prestige, 2014).

Indeed, while particular attention has been drawn to the slow uptake of personal budgets among people with mental health problems (Royal College of Psychiatrists & Association of Directors of Social Services, 2013; Larsen *et al.*, 2013), there has been very little awareness raising or campaigning about the rights of people who are homeless. In particular, this may reflect the need for staff skills development in the homelessness sector, especially as regards challenging stereotypical views about who can 'manage' personal budgets (Royal College of Psychiatrists & Association of Directors of Social Services, 2013).

However, while the possible unwillingness to put people who are homeless in control of their personal budget could be construed as evidence of paternalism, evaluations of the personalisation pilots in the homelessness sector have consistently argued that 'personalised support is just as, if not more important as the budget' (Blackender & Prestige, 2014, p.23). One advantage of the personalisation 'pilots' in the sector seems to have been that they enabled workers to spend more time with service users and to deliver the continuous, more relational and non-conditional kinds of support that are most acceptable to them, thus:

Personalised approaches seem to be most effective where workers are given time and flexibility to support clients as they require, with no time-bound targets to achieve results with small case loads. (Homeless Link, 2013, p.30)

The argument that it is 'person-centred care' and not 'personal budgets' that people want is increasingly finding expression elsewhere in adult social care where there is a growing critique of the government's highly individualist and consumerist approach. The Association of Directors of Adult Social Services (ADASS, 2012), for example, suggested that what matters most to older people is not so much who provides care and support, but what is available and when, and whether, they feel they have a rapport and a relationship with a particular care worker.

As touched upon above, while homelessness organisations have tended to view adult social care practices as an 'alternative model' of personalisation, often acknowledging the need for greater integration and more shared learning (Homeless Link, 2014; SITRA, 2014), the Care Act 2014 gives eligible people new rights to personal budgets (the adult social care model). This means that:

Everyone whose needs are met by the local authority... must receive a personal budget as part of the care and support plan, or support plan. The personal budget is an important tool that gives the person clear information regarding the money that has been allocated to meet the needs identified in the assessment and recorded in the plan. An indicative amount should be shared with the person, and anybody else involved, at the start of care and support planning, with the final amount of the personal budget confirmed through this process. (DH, 2014, p.188)

This poses a dilemma for homelessness organisations, especially those with an advocacy role. Namely, how to reconcile the need to increase the uptake of (local authority) personal budgets so that homeless people continue to receive some form of support with the belief (that is widely held across the sector) that it is actually well resourced collective services that are the way forward.

Indeed, there is already some evidence that redirecting resources to promote individualised commissioning can impact negatively on the sustainability and quality of collective services (Needham, 2013). There have been, for example, reports of home care services becoming destabilised due to the increased use of zero hour contracts since lack of certainty about business income means that companies are unwilling to offer staff guaranteed hours of work and are only able to pay staff for hours worked (Baxter *et al.*, 2011). Although probably not ideal in any sector, these isolating arrangements may pose particular challenges for the homelessness workforce where there is a recognised need for support staff to have clinical supervision and the wider collegiate infrastructure embedded as part of 'Psychologically Informed Environments' (PIEs) (DCLG *et al.*, 2012). The distressing and emotionally challenging nature of this work means that a lack of support and supervision for frontline staff may foster poor practices and high levels of staff burnout and turnover (Scanlon & Adlam, 2012).

Increased individualisation also threatens the sustainability of some collective services and has already been linked to the closure of day centres and other buildings-based resources which may find it difficult to meet necessary running costs. Touching on a report by the charity Mencap (itself a day centre provider) which claimed that the closure of day centres was leading to many personal budget holders 'being stuck at home', Needham concluded:

Certainly the roll out of personalisation in a context of fiscal austerity... ensures that as local authority services are withdrawn, it can be difficult for people to access or even know what about is replacing them. (Needham, 2014, p.4)

Conclusion

In summary, forging new gateways and pathways of support for adults who have care and support needs entwined with experiences of homelessness, is necessary given the end of the *Supporting People Programme* and the advent of the Care Act 2014. In the current climate of austerity, it may be helpful to view the Care Act 2014 as a potential window of opportunity through which it may be possible to renegotiate how professional social work discretion is applied when it comes to understandings of homelessness, thereby potentially rebalancing the provision of health and social care and addressing the inverse care law. How to manage the 'moral imperative' to practice more equitably with high case loads and already overstretched social work teams will be a key challenge for those with leadership responsibilities.

Homeless organisations and their workers will also have a key role to place in this transformation. They will need to forge more collegiate working relationships with social workers and to become more actively engaged in the implementation phases of the Care Act to ensure that their expertise around working with homeless people is shared. There is a need for example to raise awareness in adult social care about concepts such as 'multiple exclusion

homelessness', which have broadened understandings of homelessness beyond issues of prevention, housing accessibility and poor lifestyle choices.

For frontline workers in homelessness organisations, it will also be important that they receive training and become well-versed and confident in the application of the new eligibility regulations and have the skills and knowledge to undertake advocacy in this area, so as to be able to actively promote personal budgets. There is also a need for closer integration with colleagues in 'homeless health' services to ensure that the impact of homelessness on health and wellbeing is managed beyond the confines of social care and housing related support. Finally, changes will need to be closely monitored as regards the uptake of personal budgets among those adults previously considered unpopular and undeserving.

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