Learning from the Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness

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Ending Discharge to the Street - A long-term project

2012 -2015

- **70%** of patients who are homeless discharged to the street
- Intermediate care seen as an “elderly care model”
- First Homeless Hospital Discharge Fund (£10 million)

2016-2020

- Evaluations confirm specialist homeless hospital discharge teams and step-down intermediate care are effective and cost effective (compared to standard care).

2021-2023

- NICE Guideline 214 confirms specialist intermediate care is “value for money”
- Hospital Discharge Operating Model recommends the commissioning of specialist homeless intermediate care services – Local Government Association Guidance Published
- Out-of-Hospital Care Models (OOHCM) Programme - £16 million to “roll out” specialist intermediate care in 17 test sites across England.
- **5%** discharged to street
- New intermediate care framework published – Therapy led but flags importance of housing and homelessness
- OOHCM projects scaling back not up
- Media reports discharge to street increasing

2024 – What next?

Evaluation of the Out-of-Hospital Care* Models Programme (OOHCM) for People Experiencing Homelessness

Aims and Objectives of the OOHCM Programme and Evaluation

The overall aim of the OOHCM Programme was to *'roll-out'* models of out-of-hospital care that could be sustainably financed and incentivise collaboration. The objectives were:

- Provide an understanding of the most effective way of implementing (scaling) specialist out-of-hospital care
- Describe how models are being integrated into the new D2A hospital discharge operating model
- Identify the challenges that remain to systems and service delivery that require changes outside the direct control of organisations in the locality.
- Further test the key components of effective and cost-effective models especially where they have not previously been brought together into a single system.

***What is out-of-hospital care?** A range of services that support people to leave hospital quickly and safely. Includes discharge teams in hospitals and short-term support in the community (called step-down intermediate care).*

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What did the test sites deliver? Integrating specialist care as part of the new Discharge to Assess (D2A) operating model

On the Wards
Clinical In-reach

Care Transfer Hubs
Includes housing and homeless professionals – Duty to Refer

Discharge to Assess (D2A) Umbrella

INTERMEDIATE CARE

Pathway 0 - Discharge to Street

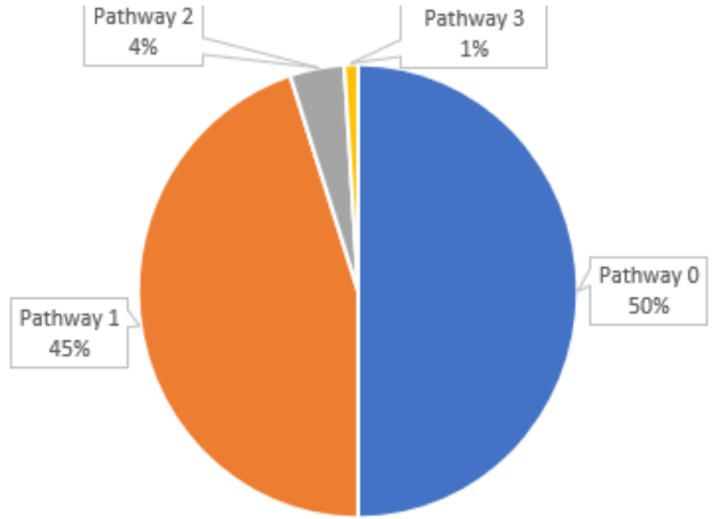
Pathway 1: Home First	**Pathway 2: Bed-based**	**Pathway 3: Nursing Home**
Local authority reablement teams	Community hospitals	Admissions that are likely to be permanent.
Specialist P1 Red Cross Settle-in Support Cornwall "Stay at Home"	**Specialist P2** Oxfordshire Step-Down Houses Mildmay Hospital London	**Specialist P1/P2/P3** The North Central London Specialist Homeless Intermediate Care Team

6 WEEKS

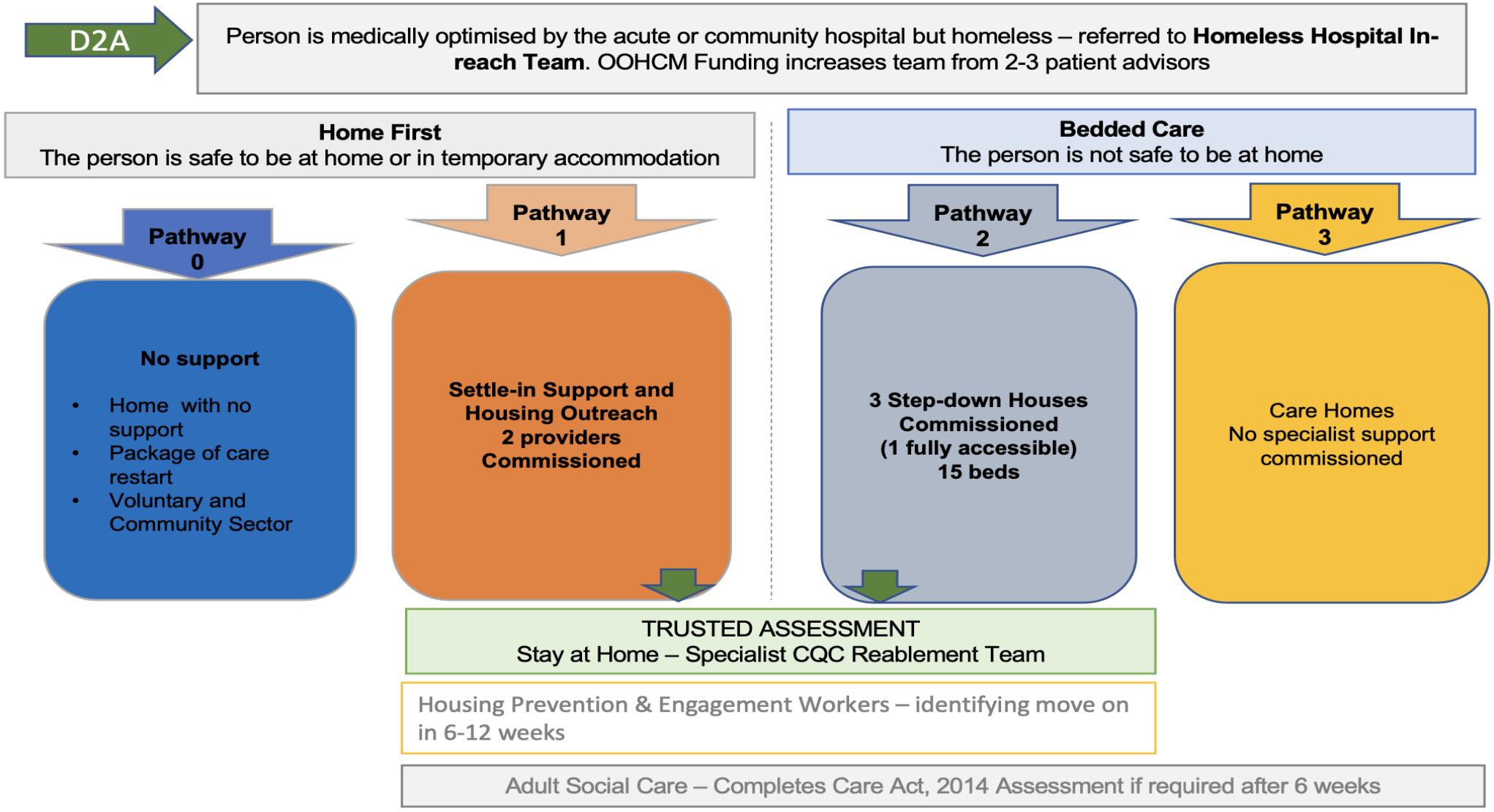
Assessment under the Care Act 2014
After time for recovery and when active rehabilitation is completed

ADULT SAFEGUARDING CONCERN

Target Numbers of Patients to be Discharged on Each D2A Pathway



Cornwall – A Very Comprehensive Well Integrated Model



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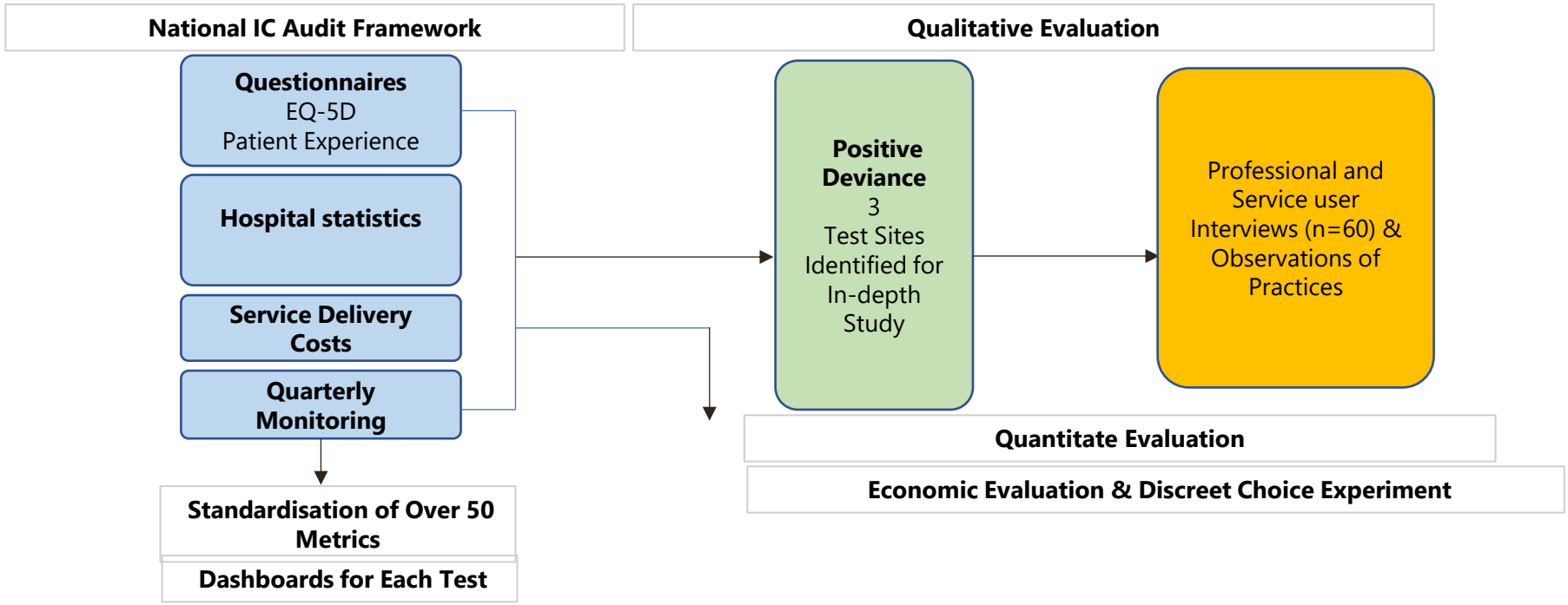
Methodology



First National Dashboard for Specialist Intermediate Care 2022/23

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National Audit of Specialist Intermediate Care for People who are Homeless

Financial Years 2021-22 & 2022-23

OXFORDSHIRE (Pathway 2 Step-down Services)

Impact Dashboard for 2 houses (10 beds) operational 2021/22

Key Findings at a Glance for the Financial Years 2021-22 & 2022-23

Investment and Budget Release

£196K / **£161K** — Investment for service delivery in Pathway 2 services per year

£3.7K / **£3.1K** — Costs per person per accepted

£42K — Total NHS budget release for financial years 2021-2023 (re-allocatable resources)

Overall impact of public investments

- ✓ Providing specialist step-down services for people who are homeless is value for money
- ✓ It frees up resources for the NHS (**£42K**) and other public budgets[1]
- ✓ It improves or prevents a deterioration in health and wellbeing outcomes

Pathway 2 Outcomes

85% / **69%** — Acceptance rate (51/58 referrals)

Aggregate Figures for 2021-2023

61% — People experienced better or unchanged QALY[2]

100 % — People reported being treated with dignity and respect

98% — People did not sleep rough after leaving step-down

25% — Decrease in emergency admissions

56% — Decrease in A&E visits

7 — Beds across 2 houses

12 — People accepted in Pathway 2 step-down services (2021-23)

29 days — Length of Stay

For further information on the Oxfordshire (and the nation wide) dashboards please email

Michela Tinelli (m.tinelli@lse.ac.uk; London School of Economics and Political Science) **and Michelle Cornes** (michelle.cornes@kcl.ac.uk; Kings College London and the University of Salford). **Link to the project case stories and dashboards:** https://www.lse.ac.uk/cpec/integrated-management-dashboards

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National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness (2021-23)

Number of staff members
(Average value per financial year)

14 | 28

Number of people accepted
(For the entire period 2021-23)

569
338

Cost per person accepted

Pathway 1 | Pathway 2

£4,256 | £12,733

Length of stay*

71 days
87 days

Investments
(For the entire period 2021-23)

£3.7m
£4.4m

Budget utilisation (%)

110% ◂ 71%

% Early self-discharge*

5.1% | 7.1%

Number of beds
(Average value per financial year)

50 beds

Waiting times*
Between referral and assessment

1 day | 9 days

% Care Act assessments*
Completed against patient numbers

13.0% | 40.5%

Outcomes*

% Sleeping rough after discharge

4%
5%

% People that felt being treated with dignity and respect

91%
93%

% People with improved - unchanged - worse quality of life outcome (QALY^)

Note: The metrics refer to the 10 sites that have provided a complete set of information. More details: https://www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards
**We calculated the total estimate for the entire period 2021-23, rather than the average estimates between the two financial years ^Quality-adjusted life years.*

What were the facilitators of successful mobilisation?

- Ambitious planning and visionary leadership
- Appointing a skilled test site manager who adopted the role of ‘single system coordinator’ and integration mechanic
- Embedding standard ‘patient flow’ measures such as ‘trusted assessment’ and ‘escalation’
- Prioritising support for front line staff though reflective practice, training, good supervision and personal budgets

What were the barriers* to successful mobilisation?

Overcoming the main barriers to effective implementation all require changes outside the direct control or organisations in the locality.

- Improving workforce planning at a national policy level to address the recruitment and retention crises in health, housing and social care.
- Increasing capacity in mainstream health and social care services to ensure better access to assessment in step-down, particularly Care Act, 2014 assessments and therapy-led assessments.
- Increasing capacity in longer-term care and support to prevent specialist services from ‘silting-up’.
- Addressing the housing shortage and complex underpinning legislation (e.g. local connection rules) that further contribute to services silting up.
- Poor quality data/lack of capacity and demand modelling.

* **Most are already acknowledged as priorities for action in NHSE’s (2023a) intermediate care framework**

Light House Effect

- Challenging economic climate meant no scope for new service developments to be ‘routinised’ in baseline budgets.
- Continued reliance on short-term funding: many services ‘limping along’.

Little scope to scale-up despite need for 3-4 fold increases in provision

- Rolling back
- Watering down
- Fragmentation
- Decommissioning
  - Health inequalities still not being tackled as part of routine transformation work around delayed discharges.
  - A ‘nice to have’ that commissioners will only fund once they have tackled what they perceive to be other more pressing pressures.
  - No evidence that Better Care Fund (BCF) tackled health inequalities through the OOHCM Programme – but some hope for the future…

Summary – Still more to do!

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2024 – What next?

Recommendations

- Funding should be multi-year and recurrent, ending, as far as possible, the use of small in-year funding pots such as winter pressures funding (so called ‘penny packets’).
- To achieve a decisive shift ‘upstream’, towards prevention, proactive population health management and **tackling health inequalities**, there is a need to establish a baseline of current investment in prevention, broadly defined, within each ICS from which progress can be measured.
- Pooled and aligned budgets such as the BCF need to be more transparent and inclusive.
- Challenge the view that specialist intermediate care for homeless patients is a ‘**nice to have’**. In the current challenging economic climate, this might be best achieved through a data-driven approach

(Hewett Review 2023)

Evaluation of the Out-of-Hospital Care Models (OOHCMs) Programme for people experiencing homelessness

Final Report and Project website:
https://www.kcl.ac.uk/research/oohcm-evaluation

LGA&DASS report (2023):
https://www.local.gov.uk/publications/home-first-discharge-assess-and-homelessness

NIHR Effectiveness Study (Cornes et al., 2021)
https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170 abstract