Department of Health & Social Care

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

Report launch & shaping future impact

30 April 2024 at King's College London

LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

University of Salford MANCHESTER

Chair's Welcome

Jemma Gilbert OBE, FRSA
Director of Transformation
Transformation Partners in Health and Care

Expert Focus just start talking

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Mobilising & Sustaining OOHCMs

Speaker:

Professor Michelle Cornes
Health and Social Policy Inequalities
University of Salford

The Out-of-Hospital Care Models (OOHCM) Programme

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).
- Out-of-hospital care came to prominence during the Covid-19 pandemic, which saw the introduction of Discharge to Assess (D2A).

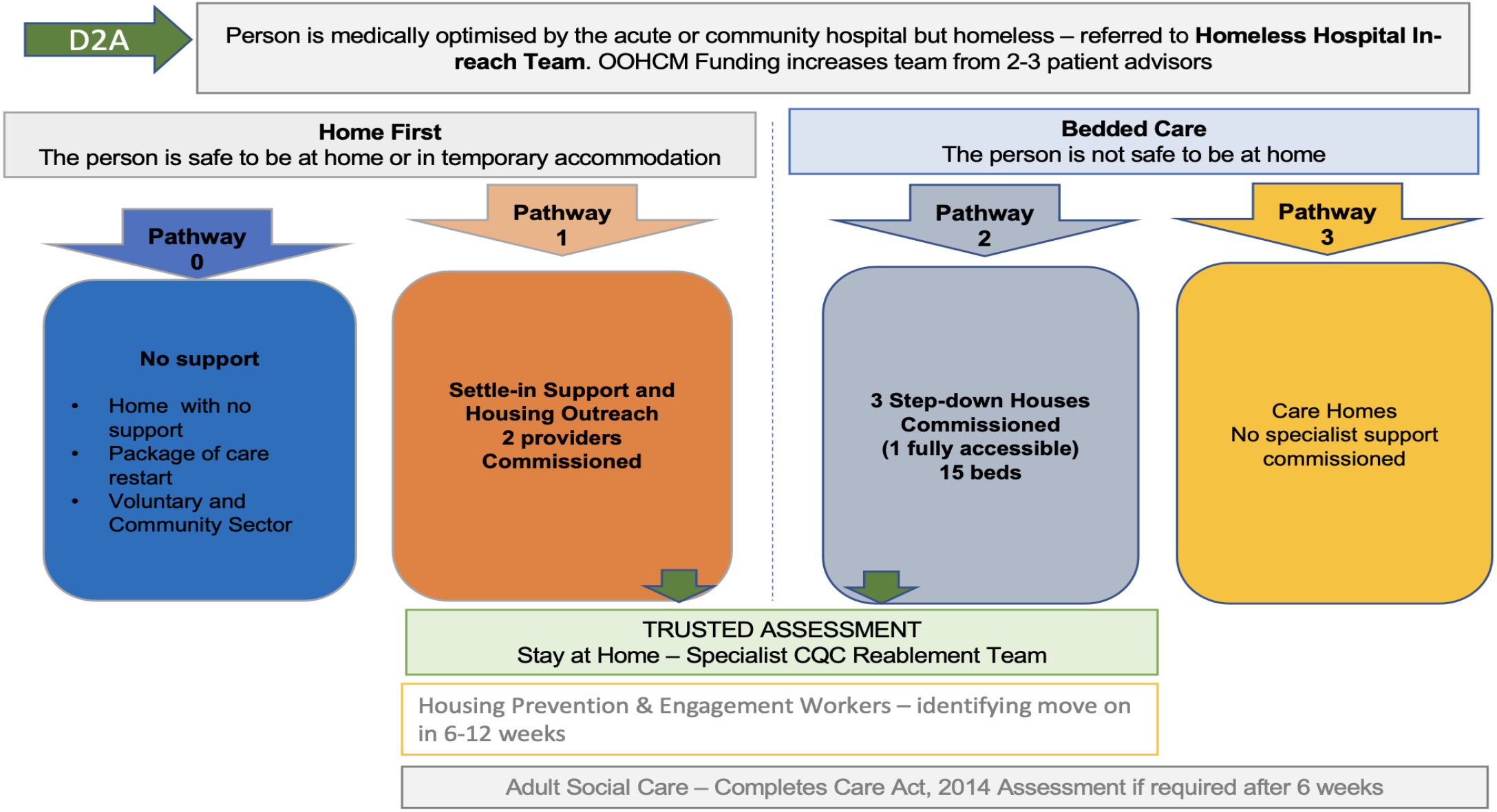
What did the OOHCM Programme Involve?

- The OOHCM Programme aimed to provide an understanding of the most effective way of 'rolling out' specialist out-of-hospital care services for people experiencing homelessness.

  There was lots of evidence that these services were effective – but they were not being routinely implemented – people were still being discharged to the street

- £16m of investment across 17 tests sites in England.
- Resources for improvement support (from Local Government Association and Healthy London Partnership) and for evaluation to capture the learning.
- Ran from October 2021 until March 2023.

Test Site 6 – A Very Comprehensive Well Integrated Model



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

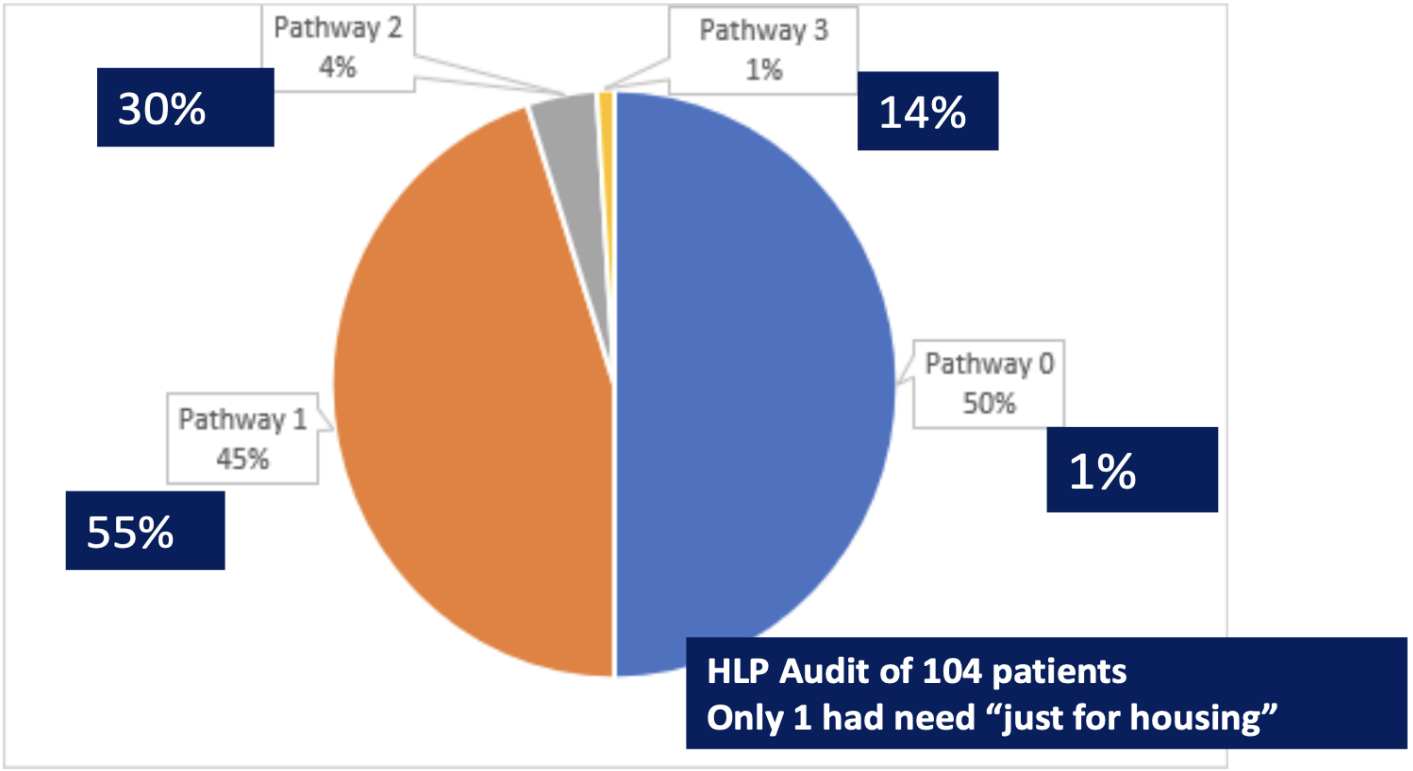
What were the barriers* to successful mobilisation?

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.
- 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**

Healthy London Partnership (HLP) audit suggests not enough Intermediate Care was rolled out



OOHCM Audit

11,030 patients seen by homeless in-reach teams in hospital..

79% discharged on Pathway 0

P1 = 12%
P2 = 5%
P3 = 3%

Audits suggest OOHCM Programme *'roll out'* has significantly **under catered** for homeless patients across D2A Pathways 1-3. As a result, many of the homeless patients seen in the hospital are unlikely to have received the right support to maximise their outcomes. In terms of scaling-up, indicative modelling using HLP figures suggest the need for a three and fourfold increases across P1 and P2/3 services respectively

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.*

How sustainable are these models?

Will scaling-up be possible?

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
  - Rolling back
  - Fragmentation and watering down
  - Decommissioning / services ending
- 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…

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The OOHC step-down house model

Speaker: Mr Peter Moore, Programme Manager, Oxford City Council

Oxfordshire's Step Down Story

History

- Four SD beds in Oxfordshire Trailblazer Homelessness Prevention initiative.
- Additional six beds with OOHC Programme (now 27 beds).

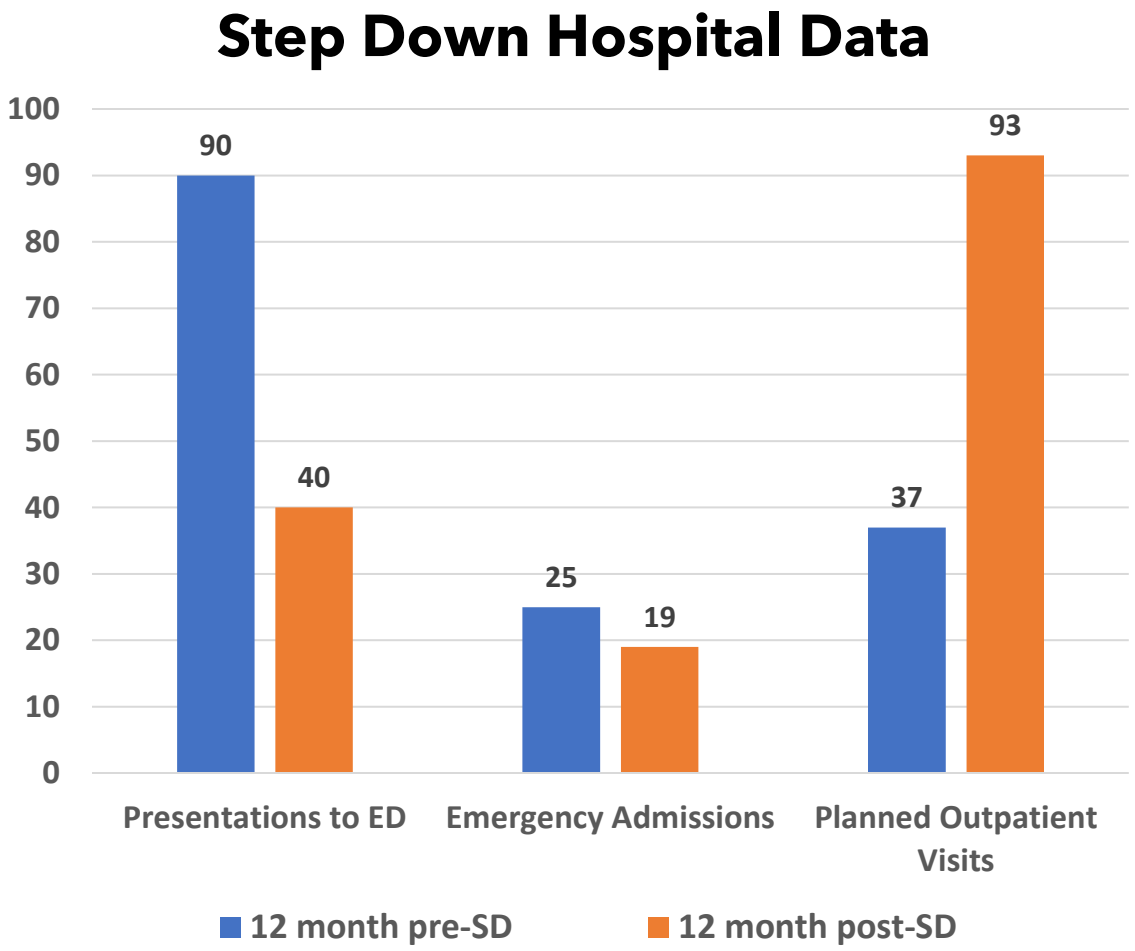
Model

- Integrated partnership from conception – Oxford City Council, Oxford Health, Adult Social Care.
- Clinical input – D2A, peer support & reflective space, model partnership working.
- Homely – shared space, not institutional, compare to DCE feedback.

Challenges

- Finding property – accessible, neighbour engagement.
- Short-term funding – recruitment and retention, stakeholder commitment.
- Complexity and risk – occupancy, move on options.

April 2021 – December 2023



- **214 planned discharges** from hospital (43% from Mental Health wards)
- Avg length of stay in Step Down **29 days 2021-22**. Now up to 58 (due to: *more complex admissions, lack of housing options and a congested system*)
- 16% of people in Step Down rough sleeping prior to hospital; **only one person returned to rough sleeping**
- **Substance and Mental health**
  - 58% had substance issues
  - 68% had a mental health diagnosis
  - **46% had a dual diagnosis** of substance issues and mental health illness
- **Hospital data**
  - 24% reduction in emergency admissions
  - **56% reduction in presentations to ED**
  - 155% increase in Outpatient visits

Oxfordshire's Step Down Story continued...

Value

- Relatively low numbers – it is the quality of the interventions.
- How people are treated – dignity and respect.
- Life-changing outcomes:
  - Breaking cycles (decades) of readmissions
  - Move on to stable home with care and support (if needed)
  - Reconnect with family & community, enter employment, training or volunteering
- System-wide:
  - Practically eliminated discharge to street (or to homeless services)
  - Impact on Health, Care, Housing, Police & Criminal Justice, Third-Sector
  - Longer-term outcomes

Growth

- From four Step Down beds to 27 (and seven Step Up beds):
  - 2022-23: RSI, COMF, U&E Care, BCF (additional discharge funding)
  - 2023-25: Better Care Fund and ICB Health Inequalities funding
- Robust data that stood up to scrutiny - system impact and cost savings.
- Power of stories – compelling.
- BCF and ICB teams – receptive, pragmatic, easy to work with.
- Programme Manager – coordinate data collection, perseverance.

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Data driven improvement

Speakers:

Dr Michela Tinelli Care Policy Evaluation at the LSE

Peter Moore, Oxford City Council

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The problem

- **Care systems are disconnected**, and there is limited sharing of information and collaboration between doctors and health and care professionals.
- **Data Collection and Quality:** Varying data quality, consistency, and standardisation across different locations and services.
- **Standardisation:** Achieving standardisation in data collection and reporting across diverse metrics, demographics, process outcomes, and economic outcomes can be complex.
- **Engaging with Stakeholders:** Communicating the insights with policymakers and practitioners can be challenging, especially when the research findings may challenge existing practices or policies.

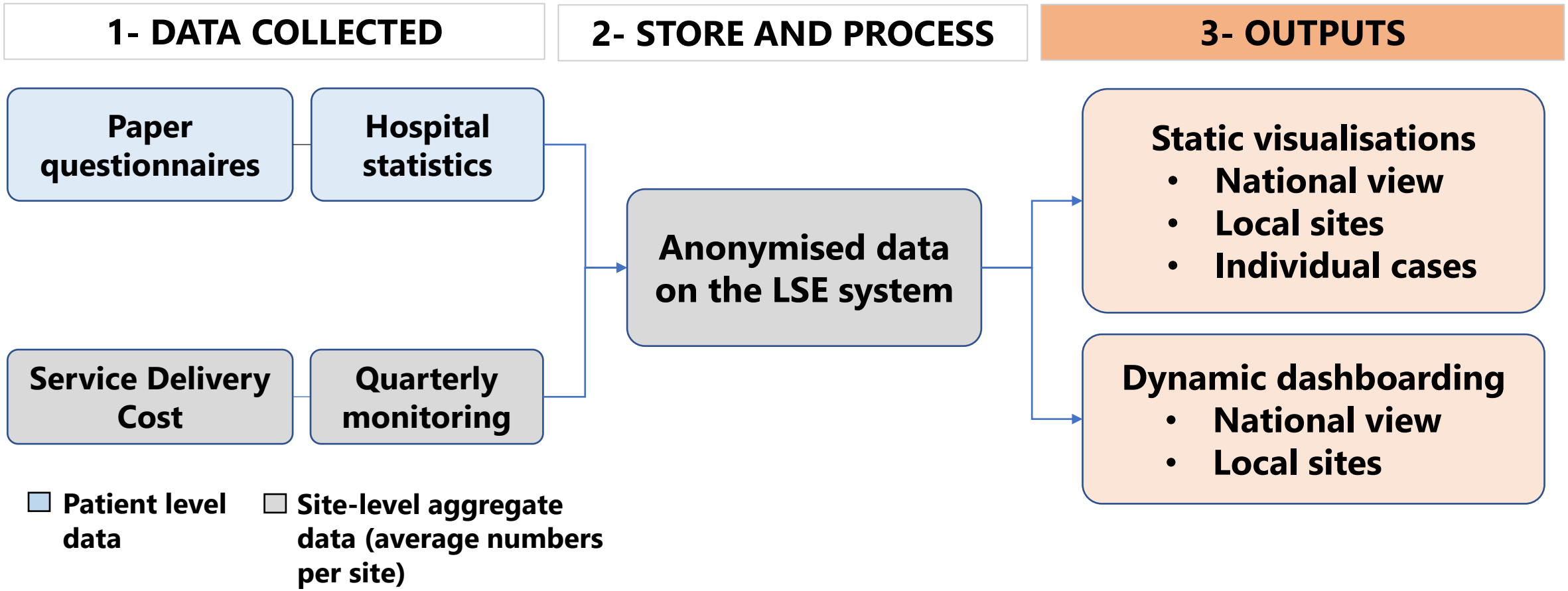
- **The results are poor person outcomes and waste of money**

As part of the OOHCM evaluation, we wanted to:

- **Support the DHSC to design and implement audit framework**
- **Undertake economic and outcomes evaluation**
- **Find a way to keep the audit and evaluation going longer term**

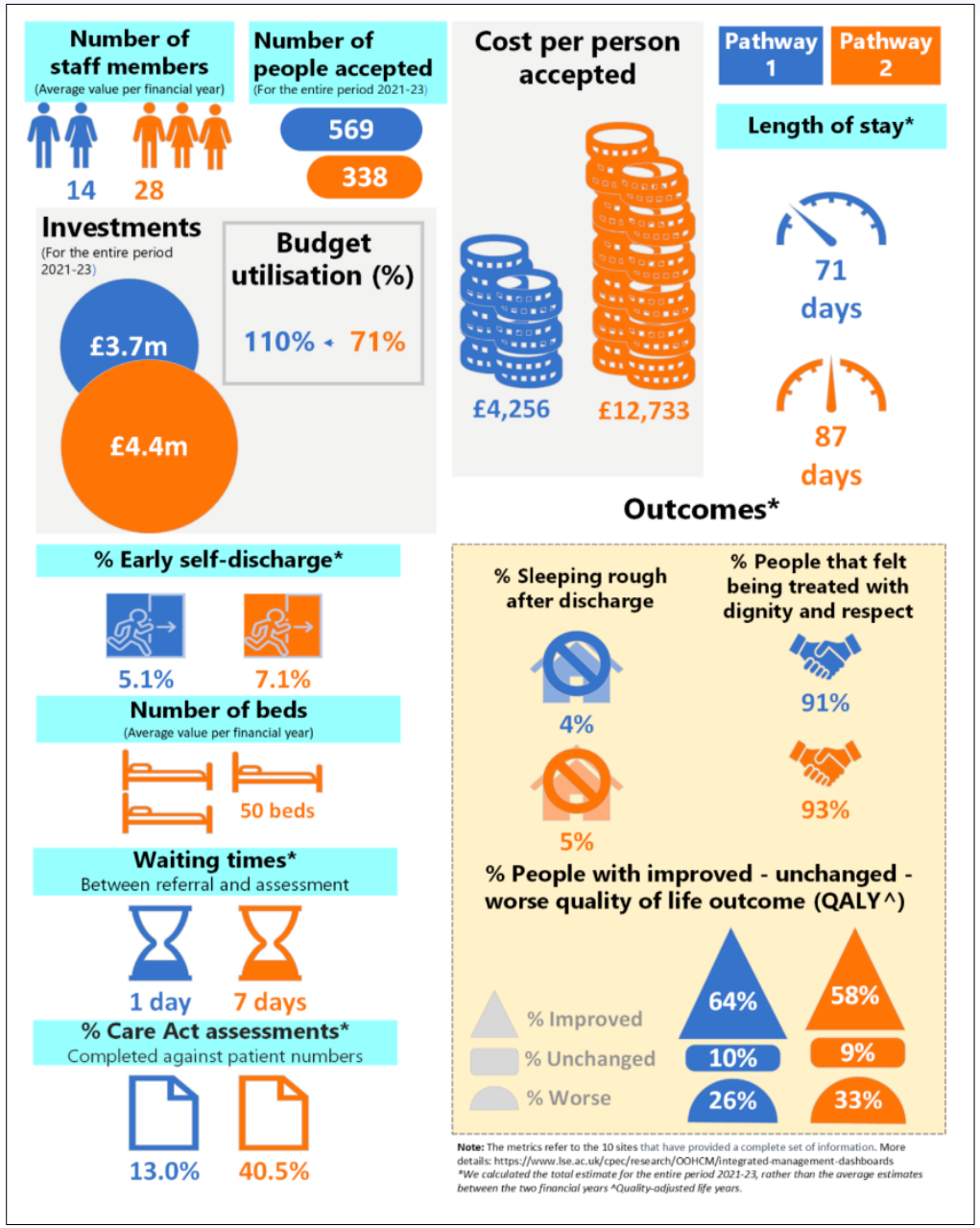
METRICS: Access, flow, demographics, service delivery investments, economic consequences, outcomes, care experience and preferences

Data collection and dashboard development process



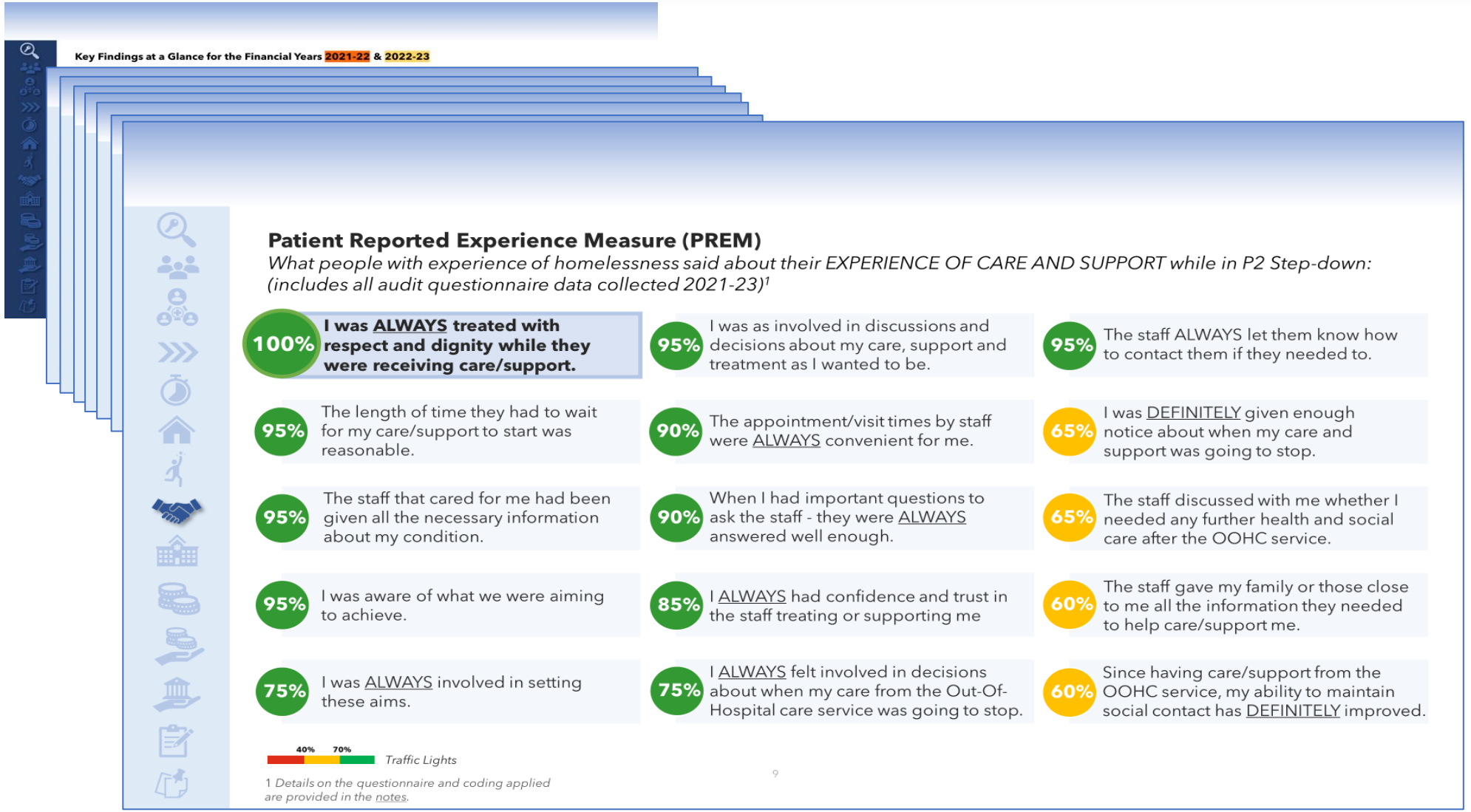
Static visualisations

1 - National Dashboard



Static visualisations

2 – Power Point
(for those sites providing audit data)



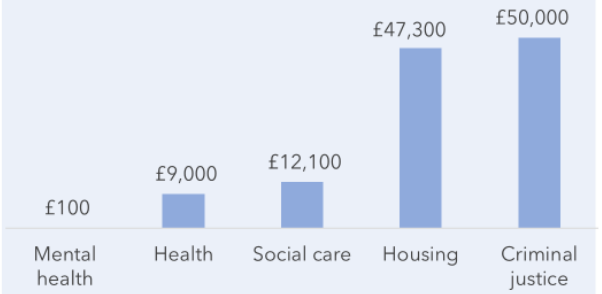
Static visualisations

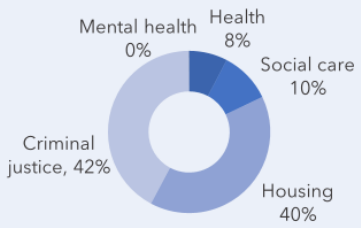
Key Findings at a Glance for the Financial Years 2021-22 & 2022-23

3- Case story (also when audit data not available)

Economic Analysis of Mr. J.D. Case Story (considering broader public perspective)

Year before moving in OOHC
Total annual public costs: **£118,500**

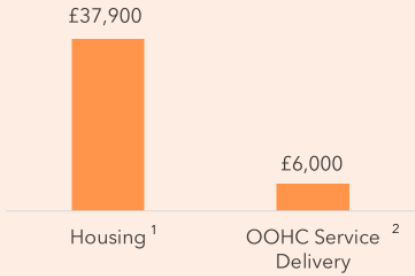


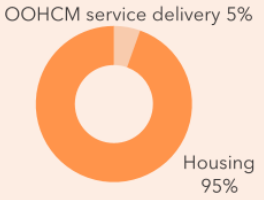


If you provide specialist OOHC you can do more with public money: free up £74,600 for this individual case story in one year

With the same investment, you can provide support for three people instead of just one, securing improved outcomes for each of them.

Year after moving out of OOHC
Total public costs: **£43,900**

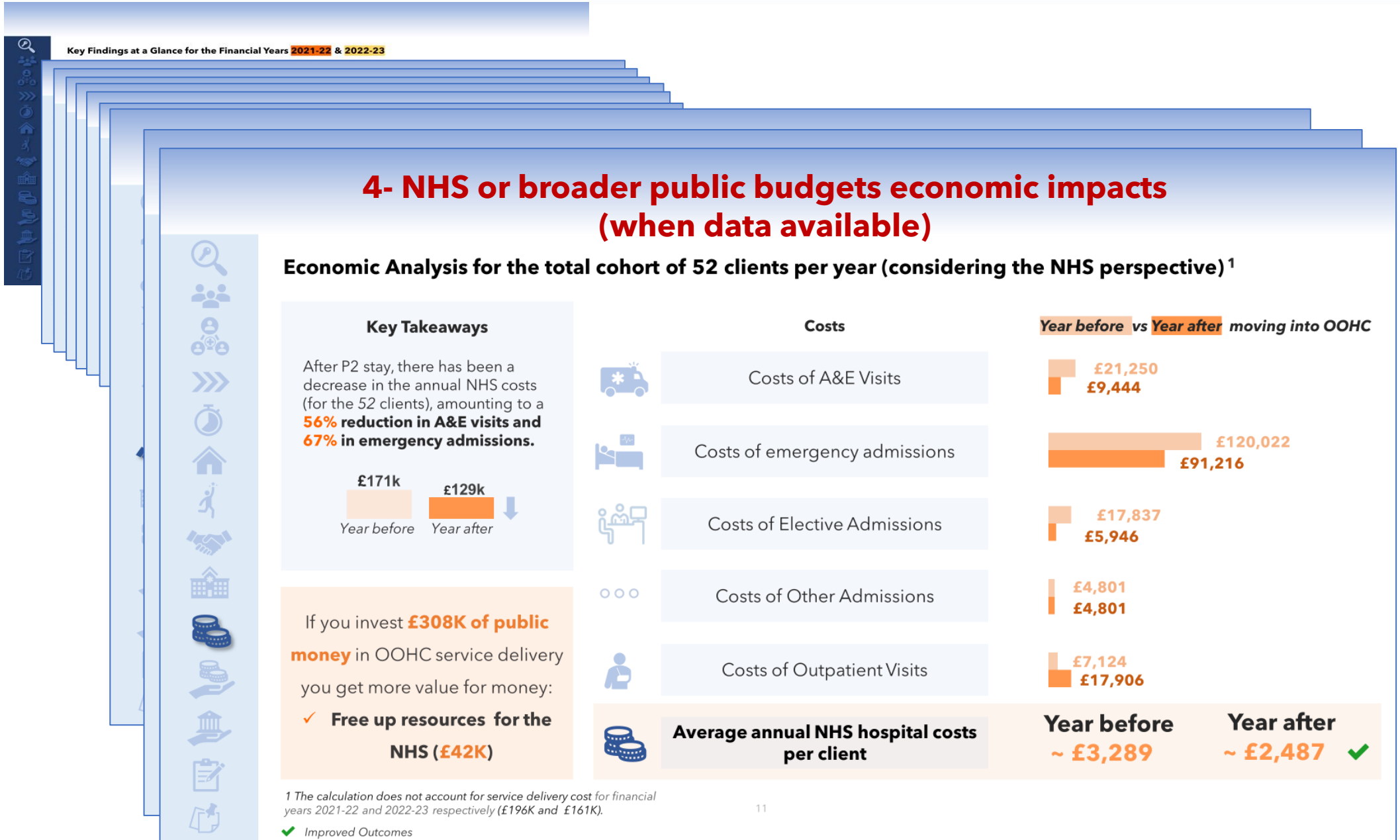




Limited to one case story

1, 2 More details on housing and OOHCM service delivery are reported in the notes

Static visualisations



Dynamic dashboarding

- Available upon request (LSE website, ask the team cpec.imd@lse.ac.uk)
- Simple to use, very functional tool
- Apply different lenses

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NOTE: OOHCM outputs were available only at the end of the programme and stakeholders did not have enough time to use dynamic dashboards for operational and management purposes.

More work is underway now at the LSE in collaboration with Oxford

1. Data template and process
2. Data Collection
3. Dynamic dashboard production
4. Test and Validate outcomes with the partnership to be led by Oxfordshire for 12 months

A sneak peek of current dashboards based on Oxford template

Actions for you

If you represent a service provider, local authority, integrated care board, NHS trust, charity, government department or arm's length body:

We welcome you to join the collaboration led by Oxfordshire

- **Join working group meeting at LSE today at 2pm (leaving King's College London at 1.40pm)**
- **Email the team: cpec.imd@lse.ac.uk**
- **Join the LSE hub**

- **Agree data requirement**
- **Provide us with data and test the dashboards for free for 12 months (starting spring 2024).**

Scan me to join the LSE hub

Share this video with your network: https://youtu.be/6kPioBiYKNo

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Lived experience of OOHCM

In conversation

Joanne Coombes, Peer Researcher, King's College London and Sarah Dowling, Oxfordshire Lived Experience Forum

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Expert Panel: Mobilising OOHCM evidence and impact

Sam Dorney-Smith - Queens Nurse and Nursing Fellow, Pathway

Victoria Bennett - Deputy Director, Intermediate Care Programme Team, NHS England

Bola Akinwale – Deputy Director, Drugs Misuse Data and Improvement Support, Office for Health Improvement and Disparities, Department of Health and Social Care

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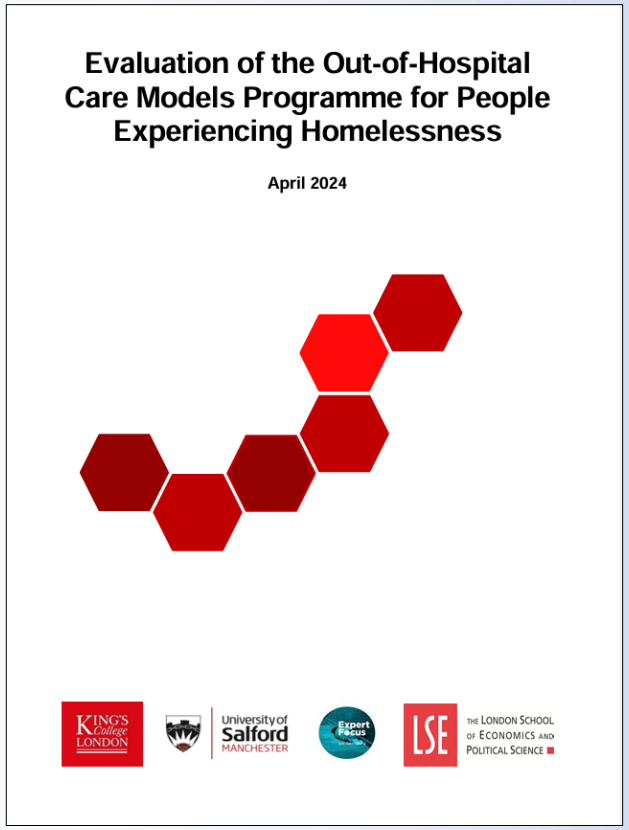

Download the full and summary reports:

https://doi.org/10.18742/pub01-178