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

Summary Report

Background

Following the Covid-19 pandemic a new hospital discharge and community operating model was introduced in England. This included the evidence-based recommendation that Home First Discharge to Assess (D2A) should incorporate specialist step-down intermediate care services for people experiencing homelessness.[1] *Specialist* step-down intermediate care provides short-term accommodation and aftercare to prevent discharge to the street and hospital readmissions. It allows time for recovery and recuperation before undertaking assessments and making any decisions about longer-term housing, care and support.

In 2020, the Department of Health and Social Care (DHSC) launched the '*Out-of-Hospital Care Models (OOHCM) Programme for People Experiencing Homelessness.'* This provided improvement support and £16 million funding to 17 test sites across England. The aim was to facilitate learning around how to ***mobilise, integrate, scale*** and ***sustain*** specialist services as part of the D2A hospital discharge and community operating model.

Audit framework and evaluation

Working in tandem with NHS England (NHSE) and the *'Intermediate Care Sounding Board'* the OOHCM Programme developed an audit and evaluation framework that standardised over 50 metrics, encompassing patient demographics, process outcomes (e.g., the flow of individuals in and out of care services, staff composition, workload, and more), economic outcomes concerning the NHS and broader public sector budgets, investment costs, quality of life outcomes, housing outcomes and care experiences.

Data from the audit is presented as the first *National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness 2021/23* (see Figure 1). This captures the progress made to *'roll out'* services across the 17 test sites and is a baseline against which future progress can be measured. To capture the learning from the test sites, the DHSC also commissioned an implementation evaluation. This included in-depth qualitative fieldwork, an economic evaluation and a quantitative study of people's preferences for different types of intermediate care.

Findings

This evaluation supports the findings of other studies[2] that have repeatedly demonstrated the considerable benefits of providing specialist out-of-hospital care services for people experiencing homelessness. The audit shows that test site services improved outcomes for most patients and were associated with very positive patient experiences. A stay in step-down significantly reduced the numbers of people discharged to the street. One earlier study suggested that 70% of patients were discharged to the street.[3] In test sites, where specialist step-down intermediate care was in place, the figure was between 4% and 5%. Despite these benefits, the Programme did not deliver sustainable services. This evaluation explores why.

'I was not allowed to go back to my own flat… and remember laying in my hospital bed sobbing, then I was told about step-down, and that I could go there just till I was able to look after myself, and that they would help me get the help I needed, and believe me they did just that.' (Service User Perspective)

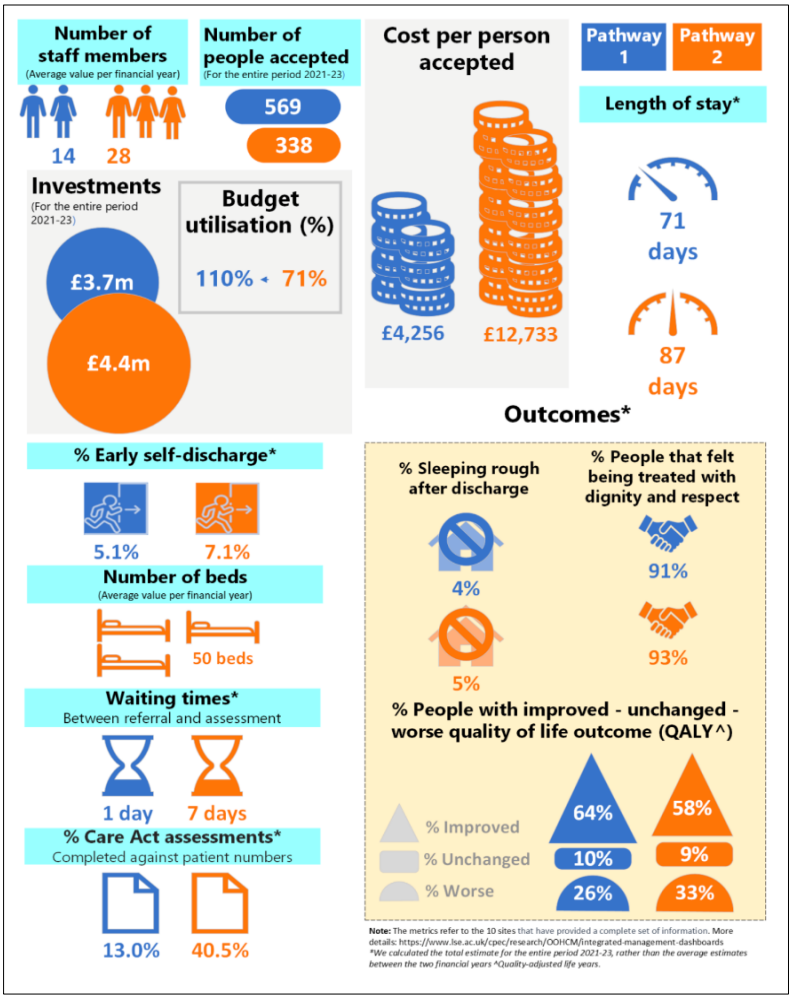
---

[1] Guidance about the integration of specialist homeless intermediate care in the D2A operating model can be found at: www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness#:~:text=Pathway%201%3A%20discharge%20to%20usual,are%20being%20used%20for%20discharge)

[2] The evidence for specialist intermediate care is summarised by NICE www.nice.org.uk/guidance/ng214

[3] St Mungo's and Homeless Link (2012) *Improving Hospital Admission and Discharge for People who are Homeless*. London: Homeless Link. www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Improving_hospital_admission_and_discharge_for_people_who_are_homeless.PDF

Figure 1: National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness (2021/23).



Mobilisation and integration

The OOHCM Programme saw a step-change in the number of '*Homeless Hospital In-reach Teams' (HHIRTs)* working inside hospitals to provide housing advice and support safe, timely discharge. The Programme also supported the development of many new and innovative specialist out-of-hospital care services. New developments in the community included the first Home from Hospital "*settle-in*" services led by the voluntary and community sector. These services offer short-term peripatetic (floating) support to people discharged to temporary accommodation and hotels and align with D2A Pathway 1.[4] The economic evaluation showed these services to be cost-effective, achieving a £10.4k public budget release for every 20 patients per year. The main drawback of this typology was that hotels and poor quality temporary accommodation were often not conducive to recovery. Also, because people were often placed across large geographical areas, 'settle-in' workers could spend a lot of their time travelling between patients.

Housing-led "*step-down houses*" also represent a newer typology developed through the Programme. These services offer a short-term stay in homely accommodation with a small number of *'guests'* - and are an alternative to the larger more institutionalised independent living or residential care home settings. The *"step down houses"* sit on the boundaries of D2A Pathways 1 and 2 by offering patients (with no home to be discharged to) an alternative pathway out-of-hospital. There were strong preferences for this Home First model among patients/service users and there were many efficiency gains that flowed from having support workers on site. In Test Site 12, a site with two step-down houses and a specialist multi-disciplinary *'wrap around'* team, emergency admissions and A&E attendances were significantly reduced. This service was also cost effective with a £42k NHS budget release for 52 clients per year.

For patients with higher levels of need, a D2A Pathway 2 medical respite service offering 24 hour nursing care was commissioned on a block contract basis to provide 14 beds in a hospital setting. This innovative development could be accessed by many London boroughs and was the first pan-London intermediate care facility.

In one test site, a new *'Homeless Intermediate Care Team'* (HICT) provided both housing and clinical support - meeting people in hospital and then following them up in the community. A key advantage of this service was that care homes (on D2A Pathway 2/3) that had previously excluded homeless patients (for being too young or

[4] D2A services are defined as sitting on Pathways 0-3. Pathway 0 is a simple discharge with no new care and support. Pathway 1 is Home First with reablement support in the community and Pathway 2 offers short term residential placements. Pathway 3 is permanent move to a care home.

not having an address to discharge to) were more likely to accept them, knowing that they had the *'back-up'* of a specialist team to advise on housing and trauma informed care.

Most test sites concentrated on delivering a single service; fewer were able to integrate specialist services across all the D2A Pathways. Test site 6 was a beacon of good practice in this respect, offering both Pathway 1 'settle-in' and Pathway 2 residential step-down services. This site also commissioned a Care Quality Commission (CQC) registered reablement service to work with people experiencing homelessness across all D2A pathways. Overall, services demonstrating high levels of single system integration (with the right data to evidence this) were shown to be value for money.

***Barriers to mobilisation*:** Staff recruitment and retention problems were the main barriers to mobilisation across all the test sites. Many test site had large underspends at the end of the first year of the Programme as they were unable to recruit and retain the numbers of clinical and support staff anticipated in their project plans. Pathway 2 residential step-down services were particularly challenging to mobilise due to difficulties finding the right premises. Many test sites compromised on the buildings they used, meaning that people with disabilities were often excluded due to a lack of disabled access.

***Facilitators of rapid / effective mobilisation and integration**:* Having a highly skilled and passionate test site manager who practiced *'single system coordination'* was key. This involved building strong cross-sector partnerships and having sufficient seniority to escalate cases where barriers to safe, timely discharge were identified. Single system coordination was also protective of front-line staff by tackling systemic and cultural challenges higher up the management ladder. In some hospitals, specialist housing and clinical staff experienced high levels of *'burn out'* due to poor collaborative cultures and the pressures of needing to advocate for individual patients on a case-by-case basis.

Scaling and sustainability

The main finding of the evaluation is that not enough step-down intermediate care was rolled-out through the Programme. D2A national policy provides guidelines on the numbers of patients that should be discharged on each pathway. Using these as a basis for modelling we found too many patients were being discharged to a setting that would not be able to maximise their outcomes. We calculated a need for three and fourfold increases across Pathway 1 and Pathway 2 services respectively. Not rolling out sufficient capacity was due to several factors. First, test sites had little real understanding of the level of need for OOHC. As a result, the scale of provision was often determined by the size of the funding envelope. The need to build capability around all types of data collection, including capacity and demand modelling, was acknowledged by many test sites. Second, commissioners were concerned that step-down was not viable, due to its propensity to *'silt-up"*. As a result, most investment went into developing the HHIRTs.

The D2A guidance contains an expectation that step-down intermediate care will last for no longer than 42 days (6 weeks). However, the average length of stay in specialist Pathway 1 services was 71 days and in Pathway 2 services it was 87. Many test sites reported that lack of capacity in longer term housing, care and support services, due to the current challenging economic climate, was causing step-down to become blocked. One site reported how what had been a six week service had become a six month service due to a 'perfect storm' of Covid and people relocating to the countryside meaning the loss of the private rental stock that had facilitated the move out of step-down. Accessing Care Act, 2014 and occupational and physiotherapy assessments was also challenging in many test sites. This could lead to *'warehousing'* where people did not receive the reablement and rehabilitation that they needed.

Test sites achieving shorter lengths of stay practiced single system coordination to find ways round blockages. In one site, 'trusted assessment' meant service providers could deliver personal care without the approval of a social worker. Sites with shorter lengths of stay also aligned their models with D2A principles – seeing the primary goal of the service as time for recovery and assessment. Some services, although badged as step-down, were offering a more traditional supported housing model where goals were linked to longer-term resettlement outcomes. Some services kept hold of people well beyond the target time-limit because they felt the only accommodation and support options on offer would likely set the person back. Many practitioners questioned the six week timeframe, given the trauma and complexity of need experienced by many people using specialist OOHC services.

By the end of the Programme, many test sites were struggling to secure the funding they needed to sustain existing services and in many areas things had started to *'roll backwards'* as provision closed down or was curtailed. The main reason for this was that in the current economic climate there was very limited scope for incorporating new service developments in the baseline budgets of Integrated Care Systems (ICSs). This meant that test sites were forced to seek further short-term funding. Where this was linked to new programme funding, such as the Rough Sleeping Initiative (RSI) or Changing Futures, this usually came with caveats about adopting new objectives that meant that hospital discharge work was no longer the primary focus.

"It's like watering down, if I'm honest… So something might still exist, but it certainly won't be the thing that holds true to those OOHC models we were trying to implement at the beginning' (Lead Commissioner 1)

Difficulties accessing the baseline budgets of the ICSs is not limited to specialist care, but all types of intermediate care. The main source of funding for OOHC is the Better Care Fund (BCF). The BCF offers short-term 'pooled budget' funding designed specifically to support integration across health, housing and social care services. While tackling health inequalities was a stated priority for the BCF in its 2022/23 prospectus, there was limited evidence that this was happening through the vehicle of the OOHCM Programme. At the point at which the Programme ended all the evidence pointed to the BCF continuing to prioritise support for older people rather than people experiencing homelessness.

Overall, it seemed that specialist services were still considered as a *"nice to have*" that commissioners would only fund once they had tackled what they perceived to be priority NHS pressures. While good progress was being made in some areas to *"get on the BCF radar*" the OOHCM Programme was not long enough in duration to see this work come to fruition. We later learned of one test site (that was able to evidence impact and value for money through the integrated management dashboards) securing significant BCF funding for 23/25 two year funding cycle. It is important to find ways to keep this momentum going, especially now that the OOHCM Programme has ended.

Conclusion

The OOHCM Programme made good progress in supporting the integration of specialist step-down services in the wider roll-out of D2A, with the installation of new models and services that were effective and cost effective. The Programme raised the profile of homelessness, gave people permission to think differently and was a *'call to arms'*. The funding acted as a catalyst to get people talking and planning together *("Nothing brings people to the table like a million pounds")* and to shift some resources into different forms of action. It gave a framework to help test sites plan for a complex set of interacting issues crossing many disciplines and boundaries, and created opportunities for peer learning and sharing that were appreciated as much as the more formally contracted improvement support. However, by the end of the Programme, it was clear that insufficient capacity had been rolled out and that there was still a *"lighthouse effect*" where services were scaled-up for a time only to be scaled back down once short term funding ended. While Programmes can paper over cracks for a time, they are no substitute for recurrent investment in the baseline budgets of Integrated Care Systems (ICSs).

Main messages

- The evaluation adds to the growing body of evidence that specialist out-of-hospital care (OOHC) services for people experiencing homelessness are effective and cost-effective.
- As a typology, *"step-down houses*" tick many boxes for patient preferences, improved outcomes, patient flow and value for money.
- However, too few step-down services (of all types) means that many homeless patients are still being discharged to a setting that will not maximise their outcomes or improve their lives.
- OOHCM Programmes bring many benefits to systems (facilitating learning, collaboration, single system coordination and improved data quality) but struggle to deliver sustainable transformative change in challenging economic climates.
- More integrated cross government working is needed to enhance the impact of Programmes, ensuring that different Programmes are aligned and have shared investment goals. Aligning the Better Care Fund (BCF) and the OOHCM would have opened-up opportunities for health inequalities to be addressed as part of routine transformation work to address hospital discharge.
- There is a need to move beyond one-off 'Programme evaluations' and to support the integration of real-time data into daily operations. This empowers commissioners to allocate resources, monitor performance and advocate for impactful policies. A roadmap for achieving this is outlined here.

Published 30 April 2024 by the Homelessness Research Programme within HSCWRU at King's College London.

Download this **Summary Report** and the full **Evaluation Report** at: https://doi.org/10.18742/pub01-178

Research Team: Michelle Cornes and Michela Tinelli (Joint Principal Investigators), Michael Clark, Joanne Coombes, Jess Harris, Stan Burridge, Janet Robinson & Raphael Wittenberg (Co-applicants).

For information about **integrated management dashboards** contact m.tinelli@lse.ac.uk.

For more information about the **OOHCM Evaluation** see the project webpage here.