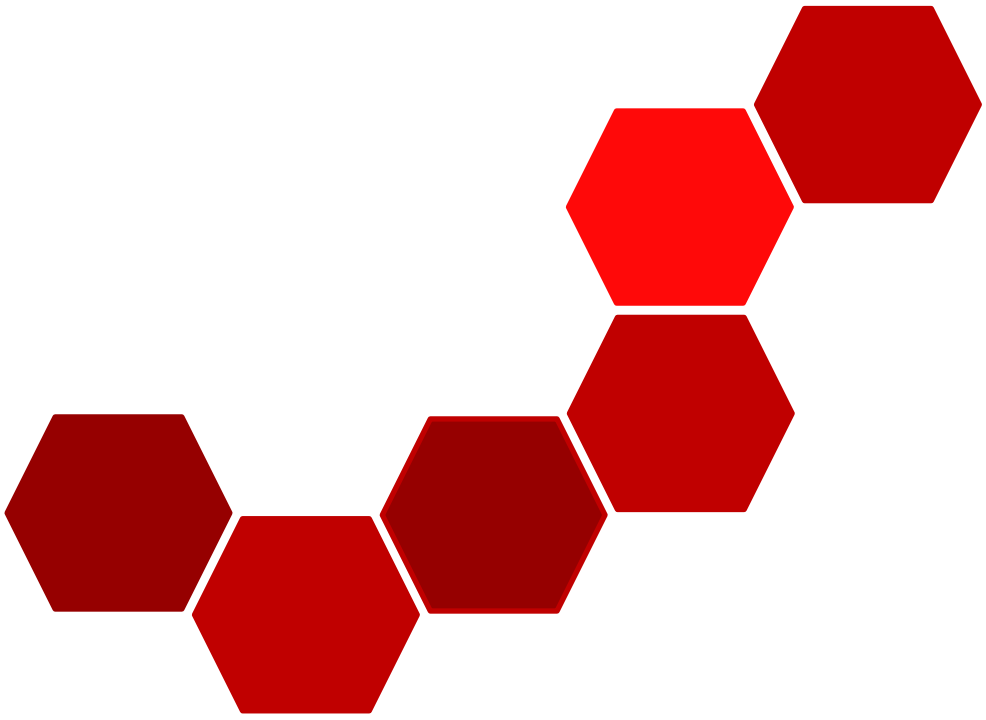
Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness

April 2024



King's College London
University of Salford Manchester
Expert Focus
The London School of Economics and Political Science

Published April 2024 by King's College London

Download this Report at: https://doi.org/10.18742/pub01-178

Suggested citation:

Cornes, M., Tinelli, M., Clark, M., Coombes, J., Harris, J., Burridge, S., Robinson, J., & Wittenberg, R. (2024). Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

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

For Integrated management Dashboards visit the website here:

Address for correspondence:

M.Tinelli@lse.ac.uk (Economic Evaluation and Integrated Management Dashboards)

M.L.Cornes@salford.ac.uk (Implementation Evaluation)

Report Authors: Michelle Cornes, Michela Tinelli, Michael Clark, Joanne Coombes, Jess Harris, Stan Burridge, Janet Robinson and Raphael Wittenberg.

Research Team: Michela Tinelli, Michael Clark, Raphael Wittenberg, Kyann Zhang, Jess Carlisle, Joanne Madridejos, Areej Malik, Jack Gibbs, Anusha Ganapathi (London School of Economics and Political Science); Elizabeth Biswell, Jess Harris, Joanne Coombes, Jill Manthorpe and Janet Robinson (King's College London), Michelle Cornes and Vanessa Heaslip (University of Salford), Stan Burridge (Expert Focus) and Sarah Dowling (LEAF).

Acknowledgements: Thank you to everyone in the test sites for your support and hospitality. Special thanks to Peter Moore, Mel Thompson, Nat Smith, Zini Charles and Alex Clift; Sarah Dowling and Lucy Stokes; Ulla Sandells, Jenn Everitt and Mike Taylor; Martha Read; Malcolm Putko; Emma Williams and Kate Moss; Sainab Jamal, Jane Wilson and Sarah D'Souza; Liz Keats and Kate Daly; Emily Ashmore; Naomi Robinson; Ellie Hobart; Caroline Townend; Sarah Feeley; and Tracy Kybert.

Thank you to Sam Dorney-Smith, Dee O'Connel, Theo Jackson, Alex Bax and Jaquie Conaty (Pathway); JJ Nadicksbernd and Jemma Gilbert (Transformation Partners in Health and Social Care), Jane Cook (Groundswell), Victoria Bennet (NHSE) and most of all to Gill Leng who is the driving force behind the Programme and all that it has achieved.

A special thank you to everyone who is committed to work with the evaluation team on future enhancements of the integrated management dashboards. In particular, Daniel Leveson (NHS Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board) leading the future partnership with local commissioning groups with the support of colleagues from Oxford City and Oxfordshire County Councils, Ian Bottomley, Peter Moore and Andrew Chequers.

Finally, thank you to colleagues at the DHSC in particular Jez Stannard for his patience and helpful comments on earlier drafts of the report.

In Memory of Kunle Daniel Osinaike

Contents

List of Figures, Tables and Boxes

Figures

Tables

Boxes

List of Acronyms

Better Care Fund (BCF)

Care Act (CA)

Care and Health Improvement Programme (CHIP)

Department of Health and Social Care (DHSC)

Discharge to assess (D2A)

Discrete Choice Experiment (DCE)

Department for Levelling-up, Housing and Communities and Housing (DLUHC)

Euroqol 5 Dimension 5 levels (EQ-5D-5L)

Health Home Treatment Team (HHT)

Healthy London Partnership (HLP)

Health Related Quality of Life (HRQoL)

Homeless Hospital Discharge Fund (HHDF)

Hospital Episode Statistics (HES)

Homeless Hospital In-reach Teams (HHIRTs)

Homeless Intermediate Care Team (HICT)

Implementation Science Research Development (ImpRes)

Integrated Care Board (ICB)

Integrated Care Partnership (ICP)

King's College London (KCL)

Local Government Association's (LGA)

London School of Economics and Political Science (LSE)

Modified Barthel Index' (MBI)

National audits of intermediate care (NAIC)

National Institute of Health Research (NIHR)

National Institute for Health and Social Care Excellence (NICE)

NHS England (NHSE)

Out-of-Hospital Care (OOHC)

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

Patient and Public Involvement (PPI)

Person Reported Experience Measure (PREM)

Voluntary and Community Sector (VCS)

Preface

The *Out-of-Hospital Care Models Programme for People Experiencing Homelessness* gave local health systems an unprecedented opportunity to invest in new services and specialist support. It enabled data gathering to evidence the populations high health needs and gaps in health equity. Local systems took strides forward in testing, learning and evaluating new models of care. It delivered on new care pathways that are better in terms of experience, safety, clinical outcomes and quality as well as alleviating acute hospital pressures.

This resulted in a massive step change in the number of Homeless Hospital in Reach Teams (HHIRTs), the addition of specialist discharge beds and better care coordination across those boundaries through discharge hubs. Through this programme systems reduced lengths of stay and found more appropriate solutions that prevented readmissions. The proof of concept was overwhelmingly met but maintaining progress has been challenging.

Whilst a significant number of services were maintained, not all could be funded ongoing. Where services have been maintained there is annual uncertainty about for how long. Many of the providers are on annual contracts with annual workforce uncertainty. Funding is not protected or ringfenced for inclusion populations. Whilst this population has the highest health needs and early age mortality, they are largely absent in health datasets and poorly reflected in funding formula. Homeless health does not hold a 'top priority' position in the list of strategic challenges in NHS recovery and the bar to decommission is therefore low.

They are a population that struggles to access generic services, and those services are not designed to address their complex needs. Inclusion health is specialised (at a higher cost per head) but it's an extremely small population (low cost overall) and the health gain potential can yield a significant financial return.

Providing national pump-prime funds is a valuable way to introduce and test new innovations in services. Traditionally those have been evaluated and handed over to the system to maintain investment and continue the improvement journey. That's a change-path national policy leaders have deployed over many years, and it has worked. However, it isn't the catalyst it used to be in the current context of financial deficits. There is a risk that the long-term returns will not be realised from this programme.

The number of people experiencing rough sleeping has been rapidly increasing due to cost of living, housing option shortages and an asylum system under strain. The pilots have been successful and transformational. We now have so much learning about what works and what services are needed. We have the potential to be global leaders in the development of services for homeless health. To do that, we need to build on this progress with dedicated investment in inclusion health that is protected over a more extended period.

Jemma Gilbert OBE FRSA
Director of Transformation in London

Summary

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.

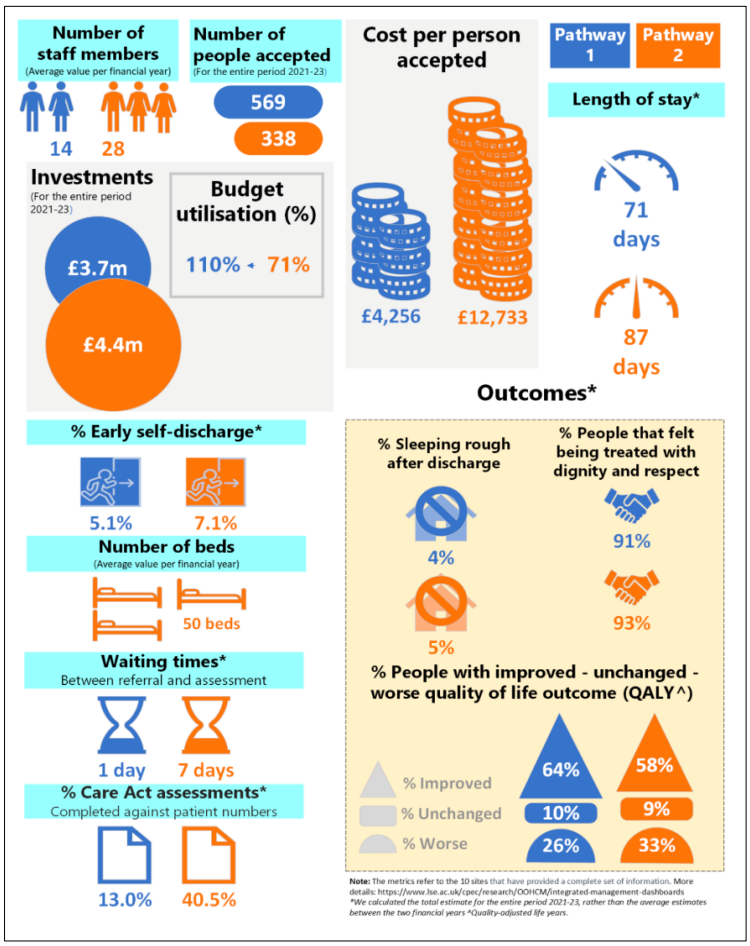
'I was not allowed to go back to my own flat… and remember laying in my hospital bed sobbing, then I was told about step-down, and that I could go there just till I was able to look after myself, and that they would help me get the help I needed, and believe me they did just that.' (Service User Perspective)

[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

[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.

this service was that care homes (on D2A Pathway 2/3) that had previously excluded homeless patients (for being too young or 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 sites 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.

1: Introduction

1:1 Background

People experiencing homelessness have significantly poorer health and die much earlier than the general population.[5] One of the key moments for intervention is a health crisis, which often results in admittance to hospital. While hospitals have a statutory duty to refer those they believe to be at risk of homelessness to the relevant authorities, the practicality of delivering assessments in a timely manner, the lack of appropriate accommodation, care and support options, and the pressure on hospital beds create significant challenges. In 2012, it was reported that 77% of homeless patients were discharged to the street without having their care and support needs addressed (St Mungo's and Homeless Link, 2012).

Following the Covid-19 pandemic a new hospital discharge and community operating model was introduced in England (DHSC, 2022). This included the evidence-based recommendation[6] that Home First Discharge to Assess (D2A) should include short-term aftercare (step-down intermediate care) for people experiencing homelessness. D2A aims to ensure that people can leave hospital as quickly as possible by facilitating recovery in the community before assessments are carried out for any longer-term care and support.

> 'Implementing discharge to assess (D2A) where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do' *(*NHSE et al. 2016 p2).

Specialist homeless hospital discharge schemes were first piloted in England in 2013. Fifty-two schemes were established with £10 million funding from the Department of Health and Social Care (DHSC). The schemes were evaluated through a large scale study funded by the National Institute of Health Research (NIHR) (Cornes et al., 2021). Specialist discharge arrangements were shown to reduce delayed transfers of care. Accident and emergency visits were also 18% lower among homeless patients discharged at a site with step-down support.

As part of this first evaluation a cohort study was carried out that linked Hospital Episode Statistics (HES) and Civil Registration death data for 3,882 homeless patients[7] seen by a specialist discharge scheme (Aldridge et al., 2019). Compared to the comparator group (matched housed individuals), patients in the homeless cohort had much higher levels of multiple-morbidity or combinations of long-term conditions or illnesses, with 8% having 5 or more conditions compared to 3% in the comparator group. The median age of death was 52 for the homeless cohort and 72 for the matched cohort. The analysis found that nearly one in three of deaths in the homeless group could have been prevented. This highlighted that homeless patients were not only dying earlier than the housed population, but they were more likely to die of causes that could be avoided with better health and care provision. Overall, the results confirmed that the patients seen by specialist homeless hospital discharge schemes were an excluded population at extreme risk of death.

Despite evidence of need and efficacy, the NIHR study reported how once the original pilot funding ended many of the schemes were not continued. According to the National Institute for Health and Social Care Excellence (NICE),

> 'Intermediate care, including step-down and step-up care, would represent a change in practice because this service is currently rare for people experiencing homelessness. This would need some funding but there is evidence that intermediate care represents value for money' (NICE, 2022 p65).

[5] ONS Deaths of homeless people in England and Wales, accessible here.
[6] The evidence for specialist intermediate care for people experiencing homelessness is reviewed by NICE, accessible here.
[7] Hereafter we use the term *'patient'* throughout the report, recognising that this is not unproblematic. However, we prefer to use this term rather than referring to *'PEH'* (commonly used acronym for 'people experiencing homelessness').

1:2 Aims and Objectives

As part of the wider measures to support people experiencing homelessness during the Covid-19 pandemic, the Department of Health and Social Care, Ministry for Housing, Communities and Local Government (now the Department for Levelling Up, Housing and Communities) and Ministry of Justice announced £16 million funding for specialist discharge services. The '*Out-of-Hospital Care Models Programme for People Experiencing Homelessness'* (OOHCM) included 17 test sites across England and ran from 1st January 2020 to 31st March 2022. Out-of-hospital care (OOHC) encompasses arrangements inside the hospital that facilitate transfers of care (e.g., transfer of care hubs) and step-down intermediate care in the community. The overall aim of the OOHCM Programme was twofold. First, to build on the evidence of *'what works'* and second, to support the *'roll-out'* of models that could be sustainably financed and that could incentivise collaboration.

The objectives of the Programme were to:

1. Provide an understanding of the most effective way of implementing (scaling) OOHC across a wider range of areas (than were included in the original effectiveness study[8]) – including how to shift to this position and the conditions needed to maximise the effectiveness and sustainability of the services.
2. Describe how models are being integrated as part of Discharge to Assess (D2A) (the NHS hospital discharge and community operating model that was introduced during the Covid-19 pandemic).
3. Further test the key components of effective and cost-effective models especially where they have not previously been brought together into a single system.
4. Identify the challenges that remain to systems and service delivery that require changes outside the direct control of organisations in the locality.

(OOHCM Business Case, DHSC, 2020)

This report captures the learning from the evaluation of the OOHCM Programme:

PART 1: The evaluation of the OOHCM Programme (2021-23)

Section 1: Provides an overview of the OOHCM Programme. It summarises the business case and the anticipated outcomes of the Programme. It introduces the test sites and how they were selected. It also describes the development of an audit framework that was planned by the DHSC to monitor performance and outcomes across the test sites. We present the main output from the audit - the first national picture of progress to implement specialist intermediate care for people experiencing homelessness.[9] In the main body of the report, we then draw on data from the qualitative work package to discuss how this ***'baseline'*** position was arrived at and what it means for the *'roll-out'* of specialist care for people experiencing homelessness.

Section 2: sets out the evaluation methodology.

Section 3 and 4: Describe the barriers and facilitators to the mobilisation and integration of specialist OOHC services in the post-Covid hospital discharge operating arrangements. Section 3 focusses on services delivered inside the hospital and Section 4 on step-down intermediate care in the community (Objective 1 and 2). These sections also pinpoint the main challenges that remain to systems and service delivery that require changes outside the direct control of organisations in the locality (Objective 4).

Section 5: Presents three economic case studies demonstrating the outcomes that can be achieved through mature levels of integrated single system working (Objective 3). It showcases

[8] This refers to the NIHR study by Cornes et al, (2021)

[9] Hereafter we use the term *'patient'* throughout the report, recognising that this is not unproblematic. However, we prefer to use this term rather than the *'PEH'* acronym (the commonly used shorthand for 'people experiencing homelessness').

the individualised management dashboards that were created for the test sites through the audit process and describes the challenges associated with their development.

Section 6: This section explores the experiences and preferences of people who use specialist OOHC.

Section 7: Describes the challenges of sustaining and scaling specialist OOHC in the current economic climate. It focusses on business planning and the strategies employed by test site managers to secure longer term sustainable funding.

Section 8: Describes the overall impact of the OOHCM Programme and summarises the main findings of the implementation evaluation. It outlines the key challenges for policy makers and commissioners in terms of sustaining the impact of the Programme longer term.

PART 2: A Data-Driven Strategy to Inform Future Service Implementation

Section 9: Introduces the project website that can be accessed by different stakeholders to access the interactive management dashboards and other Programme resources. It also outlines next steps, including the feasibility of producing real time data through *'live'* interactive modelling in line with NHS England's frameworks for supporting rapid discharge into intermediate care and health inclusion.

1:3 Programme design

The OOHCM Programme was instigated as part of a range of measures designed to respond to the Covid-19 pandemic and to support the Conservative government's manifesto to end rough sleeping by 2024. *'Everyone In'* saw 15,000 people – many of whom had been sleeping rough – accommodated in emergency accommodation. When the initiative ended it was recognised that joint action between health and housing was necessary on many fronts to ensure that people sleeping rough continued to be supported off the street. Discussing hospital discharge, the business case for the OOHCM reported that in many areas, existing funding mechanisms for intermediate care, such as the Better Care Fund (BCF), prioritised support for older people rather than people sleeping rough, and that alternative funding sources were needed. It was planned that the OOHCM would target people sleeping rough or people at risk of rough sleeping.

> 'Without implementing models of OOHC it is likely that people experiencing rough sleeping will continue to be discharged onto the street or other unsuitable accommodation, in the absence of other viable options, contributing to readmissions, poor health outcomes and early deaths' (DHSC 2020 p3).

In conceptualising *'what works'*, the OOHCM Programme drew on the learning from the implementation of the *'Homeless Hospital Discharge Fund'* (HHDF) (Cornes et al., 2019 & 2021). The HHDF provided £10 million funding to the voluntary and community sector (VCS) to work in partnership with the NHS and local authorities to address problems such as 'discharge to the street' (when a homeless person is discharged in the knowledge that they have nowhere to live). This resulted in 52 schemes which tested a variety of models. The evaluation confirmed the overall benefit of having a multi-disciplinary '*Homeless Hospital In-Reach Team'* (HHIRT), offering clinical and housing expertise to ward staff, and having step-down intermediate care. Having one element without the other was shown to be less effective. For example, without an HHIRT inside the hospital some of the intermediate care services did not receive enough referrals, leading them to shut. In the HHDF it was reported that sites that included all the *'jigsaw pieces'* were rare (Cornes et al., 2019). A key aspiration of this later Programme was,

> 'To test the key elements of an effective and cost-effective model, which have not previously been brought together into a **single scheme** – exploring how this model can be rolled out at a larger scale, with a longer lead time and across a wider variety of areas' (DHSC, 2020 p19)

For the purposes of communicating with potential test sites, the DHSC conceptualised the OOHC ***'model'*** as comprising the following key elements:

- Multi-disciplinary (health and social care and housing expertise) offering patient in-reach and specialist discharge co-ordination.
- Inclusive of access to step-down intermediate care facilities (this could include short-term care/re-enablement within hostel accommodation) – with clinical in-reach into the facility to ensure continuity of multidisciplinary support.
- Housing support workers also providing patient in-reach and discharge co-ordination and supporting patients in the community (floating support) until longer term services in place and working well (DHSC, 2020 p4).

The £16 million *'Shared Outcomes Funding'* was distributed via a closed competitive grant process.[10] In late 2020, the DHSC approached areas across England known to have high numbers of people sleeping rough (based on the then Ministry of Housing, Communities and Local Government yearly count). Prospective sites were given a very short time frame (a matter of weeks) to submit a proposal detailing plans for their OOHCM.[11] This programme differed to the earlier HHDF in that the money was allocated to local authorities instead of the community and voluntary sector. It was assumed that this would be more facilitative of longer-term sustainability, with local commissioners of health and social care services having a greater sense of ownership over the proposals. In London, four Integrated Care Systems (ICSs[12]) comprising multiple local authority boroughs were invited to submit proposals.

The Local Government Association's (LGA) *Care and Health Improvement Programme* was commissioned to provide bespoke consultancy support to each prospective Test Site to help them develop their proposal. The LGA published practice guidance to support the implementation of the model (LGA, 2023)[13] and organised a range of learning events and activities during the first year of the programme. For the London test sites, additional support was also commissioned from the *'Healthy London Partnership.'* [14] This provided support to commissioners working in Integrated Care Systems and undertook a range of project-based activities including an audit of 104 homeless patients conducted across 19 London hospitals to understand and quantify needs in relation to safe-discharge (Nguyen et al., 2022).*[15]*

In total, 19 proposals were submitted (12 out-of-London and 5 for Greater London). A Governance Board was convened by the DHSC Programme Team[16] to assess the proposals and make recommendations for improvement. Ability to mobilise rapidly and fidelity to the evidence base were important considerations. Fidelity was assessed as the extent to which the proposed models were inclusive of the three elements described above. Two local authorities outside of London did not proceed with their applications, leaving 17 tests sites in total. Three of

[10] Funding was awarded to Local Authorities under Section 31 of the Local Government Act 2003 ("section 31"), which enables any Minister of the Crown, with the consent of the Treasury, to pay grant to any local authority in England towards expenditure incurred or to be incurred by the authority. The grant determination included conditions so that the funding was targeted for the purposes of providing intermediate / step down and care for people who sleep rough or who are homeless.

[11] The OOHCM Programme comprised two application stages. In the first round (October/November 2020) sites were invited to outline proposals for three months funding that was to be used for Covid-response services (monies to be spent by the end of the 20/21 financial year). In late December 2020, once the next tranche of funding was confirmed by HM Treasury, proposals were invited for OOHC.

[12] ICSs are partnerships that bring together local government, the NHS, social care providers, voluntary, community, faith and social enterprise organisations and other partners to improve the lives of people who live and work in their area. Each ICS includes a statutory integrated care partnership (ICP) and integrated care board (ICB). The ICP is a statutory committee jointly formed between the ICB and the relevant local authorities within the ICS area. The ICP brings together the broad alliance of partners and is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area. The ICB is the statutory NHS organisation responsible for bringing NHS and partners together to plan and deliver integrated health and care services and accountable for the finances and performance of the local NHS as a whole.

[13] This updated an earlier Support Tool (Cornes et. al., 2019).

[14] Healthy London Partnership (HLP) was renamed 'Transforming Partners in Health and Care' in 2022. It delivers consultancy programmes and projects to the NHS, accessible here.

[15] Accessible here.

[16] This comprised a programme manager, administrator and junior civil servant.

the London ICSs delegated resources across groups of boroughs that were then responsible for developing their own independent programmes of work – effectively creating 21 test sites. Appendix 2 provides a detailed overview of the plans submitted and the resources allocated by the DHSC.

Originally the Programme was planned to run for 15 months (from 1 January 2021 to 31 March 2022) however, it was extended for a further 12 months. This was because of slower mobilisation than anticipated, meaning that many of the test sites had underspends at the end of the 21/22 financial year. However, much of the programme architecture (the Programme Manager and the LGA support) did not continue into the second year. In the first year, the Programme Team met with each individual test site on a quarterly basis. In the second year, the DHSC organised quarterly regional meetings (covering north, south and London tests sites).

1:4 Anticipated outcomes

The impacts that the DHSC expected to see from the Programme (as detailed in the Business Case) were both a reduction in public service sector costs and improved outcomes. It was assumed that by providing people who were rough sleeping or at risk of rough sleeping with appropriate care and accommodation while they recover from illness or injury that this would in turn help prevent readmission to hospital. Time spent in step-down intermediate care was also assumed to confer opportunities for a wider range of housing options to be considered, as well as an avenue through which other services can be channelled including, for example, peer support and employment services. It was hoped that this could reduce impact on the demand for local accommodation and services and ultimately work towards the reduction of rough sleeping by reducing the effect that poor health has on a person's ability to access stable housing. The anticipated outcomes for the programme are summarised in Table 1.1 below. In the Business Case, the DHSC also anticipated a number of risks that might prevent successful Programme delivery, outlining various actions through which these might be mitigated (see Table 1.2 below).

Table 1.1: Anticipated Outcomes of OOHCM Programme (DHSC 2020)

Cash releasing outcomes	**[A]** Reduction in A&E costs and fewer emergency (non-elective) admissions. **[B]** Reductions in operating costs (hospital bed versus out of hospital care).
Other outcomes	**[C]** Reduction in average length of stay in hospital (homeless people are more likely to be discharged sooner if their housing and next steps are adequately catered for). **[D]** Lower rates of delayed transfers of care. Measured as reduction in numbers of people staying 14 days/21 days + without criteria to reside (for the reason that they are XII Homelessness/no right of recourse to public funds/no place to discharge to). **[E]** Improved collaboration between health and social care – including integration of housing authorities and homeless services. **[F]** More efficient referrals to the correct D2A pathways/services. **[G]** Increased access to safe accommodation and community services - reduction in the number of patients discharged to the street and/or unsuitable accommodation. **[H]** Potential reduction in overall number of rough sleepers and associated costs to the health and care system, local authorities, the criminal justice system and probation system. **[I]** Improved person experience. **[J]** Quicker recovery times. **[K]** Quality-Adjusted Life Years (QALYs).

Table 1.2: Risks and Mitigations Identified in the Business Case

Risks	Mitigations
A lack of local system leadership and partnership working to drive implementation to make the approach sustainable.	Governance arrangements – will include holding local sites to account for partnership working. Developing a success criterion for sites that will require evidence of senior leader buy-in by all local partners (including NHS, police, housing, VCS). Ensuring support from local BCF managers.
Detrimental effect on other services due to staff leaving to join the new project.	Assurance of no disruption of local services and sustainability plan which supports local priorities and need. Requirement that each site produces a workforce plan.
Suitable premises or beds not being available to support service users.	Test sites required to evidence that the proposal is supported by all local partners with responsibility for providing different bits of the pathway.
Difficulties collecting data on specialist services and on the homeless population.	Develop a robust audit framework.
Covid-19	There will be a requirement to ensure that the service / pathway is covid-safe and compliant with all relevant guidance and standards (DHSC, 2020).

1:5 Programme Audit

The DHSC Team worked with the evaluation team to design and implement the '*OOHCM Programme Audit'*. This had the twin objective of enabling the DHSC to monitor activity in the test sites (assessing to what extent the OOHCM funding was delivering the outcomes specified in the Business Case) and additionally to support the test sites to produce a more robust argument for continuation of funding at a local level once the national funding ended. As noted above, many of the services developed through the first hospital discharge programme were not sustained once pilot funding ended. It was thought that one reason for this may have been that the services had not collected the information that commissioners needed to make informed decisions about future funding (Cornes et al., 2019). While services had collected a wide range of information on potential benefits, such as if the person had registered with a GP or had improved their housing status on discharge, they had not collected standardised information on person outcomes and experiences that could help improve local service delivery.

Improving data quality is a key aspiration of NHS England's (NHSE) Intermediate Care (NHSE 2023a) and Health Inclusion (NHSE 2023b) frameworks. It is noted that capture of ongoing data by area is needed to enable routine gathering, analysis, and comparison of trend data for individual providers, ICSs, local government areas and the nation against benchmarks and targets (NHSE 2023a). National audits of intermediate care (NAIC) in England commenced in 2013 and were paused in 2018.[17] Up until 2018, a NAIC report was published annually along with a national summary infographic.[18] This longitudinal approach enabled a comprehensive analysis of models and performance of services, including year on year changes in capacity and demand. It provided policy makers, commissioners and researchers with crucial data on the

[17] The audits recommenced briefly in 2020 as a subscription (pay to enter) service manged by NHS Benchmarking (NHS Benchmarking, 2022). NHSE and NHS Benchmarking are currently working together to agree the way forward, based on learning from the Front Runner Programme.
[18] See here.

comparative costs and outcomes of intermediate care, supported learning and reduced unwarranted variations in practice. More recently, through its Front Runners Programme, NHSE has piloted live dashboards and is testing ways of embedding visible, real-time data into day-to-day operational management of local systems (NHSE, 2023a). Reducing the data burden is also a priority and a new minimum data set is planned for rapid discharge into intermediate care.

The '*OOHCM Programme Audit'* was linked to this wider work programme via the *Intermediate Care Sounding Board* run by NHSE. An important goal was to ensure that the audit of specialist care was integrated as part of the wider mainstream reporting arrangements for intermediate care. The ambitious plan was that the OOHCM Programme would produce the first **National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness 2021/23** and would also explore the feasibility of interactive digital modelling, whereby individual test sites would be able to access a digital platform (a website) to see *'real time'* data and to benchmark their own performance against others. DHSC and other national stakeholders would be able to monitor the performance of different care models, as well as specific areas and more, against national averages / targets and across time.

The data set for the '*OOHCM Programme Audit'* was built on the 2018 NAIC data set (NHS Benchmarking, 2018) with the inclusion of additional metrics linked to outcomes specified in the OOHCM Business Case (see Table 1:1 above). In total, the OOHCM audit standardised over 50 metrics, encompassing demographics of the individuals, process outcomes (e.g., the flow of individuals in and out of care, staff composition, workload, and more), economic outcomes concerning the NHS and broader public budgets, investment costs, health outcomes, housing outcomes and care experiences.

Data for the *'OOHCM Programme Audit'* was collected using a Quarterly Monitoring Proforma. The test site project manager completed this at the end of each quarter. Returns to the DHSC were made for a total eight quarters, commencing 1 April 2021). The quarterly monitoring data is presented in a series of audit tables that can viewed here.

Data on person-relevant outcomes were collected separately by means of a questionnaire.[19] Questionnaire 1 (Q1) was administered by frontline staff (key workers) when individuals entered the step-down service. This captured a baseline measurement of health-related quality of life (using the EQ-5D[20] validated outcome measure), and this was the repeated at exit from the service (Q2). A validated 'Person Reported Experience Measure' (PREM)[21] (Questionnaire 3) for intermediate care was also included as part of the audit and was administered shortly after the person left the service by someone external to the service. In one test site, people with lived experience of homelessness who were members of a local service user forum were trained as 'peer researchers' to complete the PREM. In total, the audit collected over 630 questionnaires [272 Q1, 193 Q2, and 170 Q3]. Only 10 out of the 17 test sites collected questionnaire data. We shall return to discuss the reasons for this later.

Test sites were also provided with written guidance from the DHSC on how to access and collect secondary care usage data from their local hospital trust (Hospital Episode Statistics, HES). This was to enable the test sites to evidence the impact the services were having on outcomes such as reducing the number of hospital readmissions. Table 1.3 below lists the metrics that were captured as part of the '*OOHCM Programme Audit'* and the data sources for each of these.

[19] The audit questionnaires can be viewed in the study protocol at www.lse.ac.uk/cpec/research/OOHCM.

[20] Euroqol 5 Dimension 5 levels measure (EQ-5D-5L; accessible here) is a standardised measure assessing health related quality of life (HRQoL) on the dimensions of mobility, self-care, usual activities, pain/discomfort and anxiety and depression and according to five levels of severity (no problems; slight/moderate; severe; and extreme). In addition, a visual analogue scale records self-rated health on a scale of 0 ("worst imaginable health state" to "100 "best imaginable health state". The outcome measures used in the national audits of intermediate were the 'Sunderland Community Reablement Scheme Score' (for home based/reablement services) and the 'Modified Barthel Index' (MBI) (for bed based/care home services). However, both the Sunderland Score and MBI are designed mainly for use with frail older adults and are limited to understanding changes in physical functioning and dependency with regard to activities of daily living. EQ-5d was selected as it is more sensitive to the wider health and social wellbeing outcomes that may be linked to specialist out-of-hospital care.

[21] The measure used was the 'Intermediate Care (home-based)-Patient Reported Experience Measure' which was validated for use in the national intermediate care audits (Teale and Young, 2015) This measure also captures the NICE [QS173] quality standard for intermediate care and reablement.

1:6 First National Dashboard for Specialist Intermediate Care

Figure 1:1 presents the first ***'National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness 2021-2023'***. There were considerable challenges in collecting data for the audit and we discuss these in Section 5. As a result, data is derived from 10 test sites that collected outcomes (questionnaire) data, covering 907[22] people with experience of homelessness over the financial years 2021-22 and 2022-23. We have combined the two years, as there was limited data for 2021-22 due to slower than anticipated mobilisation of services.

The *National Dashboard* updates the earlier NAIC infographics for later national policy changes around the introduction of Discharge to Assess (D2A). It categorises costs and outcomes for *'home/reablement'* based intermediate care under the banner of Pathway 1 and *residential/bed based* intermediate care under the banner of Pathway 2. It also includes a new metric for the number of assessments completed.

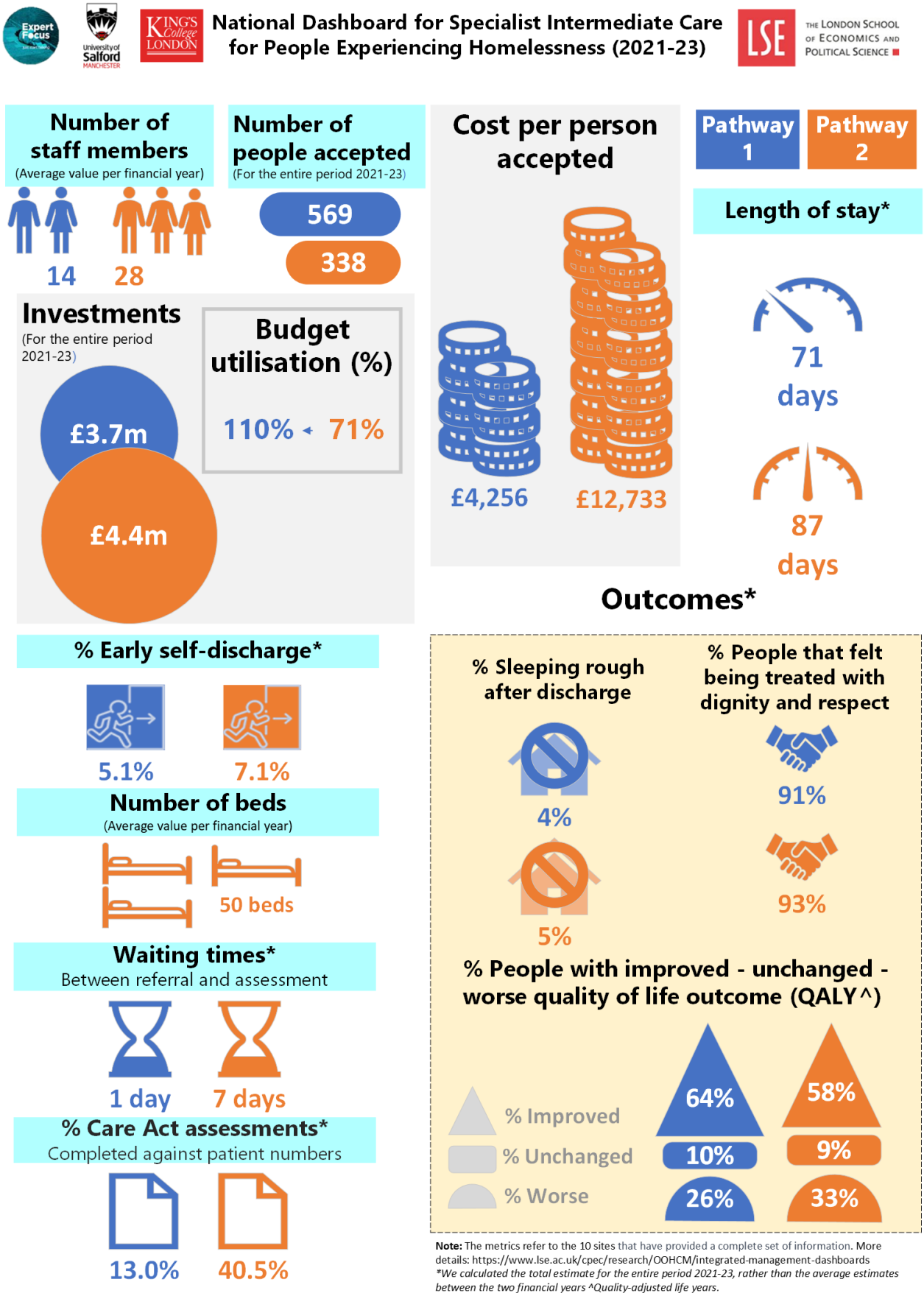
It is important to highlight that the *National Dashboard'* is one of the main outputs of this evaluation as it summarises the outcomes of the OOHCM Programme and was two years in development. We feel it is important to present the Dashboard here, at the beginning of this report, as it helps us to frame the discussion of implementation – for example, it enables us to understand the mobilisation and scaling of services in the individual test sites through reference to a set of *'national averages'.* In Sections 3-7, we draw on data from the qualitative work package to discuss how this ***'baseline'*** position was arrived at, and what it may mean for policy makers and commissioners going forward. In Section 9 we present a plan for continuing the audit so that this baseline picture builds into a longitudinal and interactive narrative.

[22] The Programme worked with a total of 11,030 patients. Of the 11,030 seen in hospital by an HHIRT, 1,954 were discharged to a specialist intermediate care service. Of those, outcomes data was available for 907 patients (569 of whom were seen on P1 and 331 seen on P2).

Table 1.3: Audit Data Collected for the Integrated Management Dashboards

	Metrics	**Data Source**
Investment costs for delivery of the service	Service delivery costs only for the two financial years (total and average per site)	Service delivery data collected by DHSC
People Demographics and Staffing	Sociodemographic data for the client	Quarterly monitoring form
	No. people accepted No. people referred	Quarterly monitoring form
	Acceptance rate	Quarterly monitoring form
	Number of staff	Quarterly monitoring form
	Average caseload per staff	Quarterly monitoring form
The flow of people in and out of services	Length of stay in OOHC	Quarterly monitoring form
	% Staying OOHC longer than 42 days	Quarterly monitoring form
	Waiting time between referral and assessment (average per person)	Questionnaire 1 – Baseline questionnaire (Q1)
	Waiting time between ready to transfer and actual transfer into OOHC – less than 2 days (% of people)	Questionnaire 2 – Exit questionnaire (Q2)
Health Care Utilisation	% A&E	HES
	% non-elective admission	HES
	% elective admission	HES
	% early self-discharge	Quarterly monitoring form
Access to Social Care	% of people receiving a Care Act (CA) 2014 Assessment	Quarterly monitoring form
Housing outcomes	% sleeping rough (before and after OOHC)	Quarterly monitoring form
	Destination after leaving services	Q2
Health outcomes	QALYs, based on EQ-5D-5L (see footnote 16)	Q1
Person-reported experience measure		Questionnaire 3 – self-reported PREM questionnaire (Q3)

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



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.*

.

PART 1: The Evaluation of the OOHCM Programme (2021-23)

2: Evaluation Methodology

To capture the learning from the 17 test sites, the DHSC commissioned a 24-month implementation evaluation. The target audience for the evaluation is Integrated Care Boards (commissioners and providers) policy makers and academics. The evaluation was led by King's College London (KCL), the London School of Economics and Political Science (LSE), and Expert Focus (a peer led research organisation). The objectives of the evaluation were coterminous with those of the wider Programme described earlier. The evaluation team was also commissioned to support the DHSC to carry out the Programme Audit. Ethical Approval for the evaluation was secured from the Health Research Authority Social Care Research Ethics Committee [22/IEC08/0016].

Implementation research seeks to understand the approaches that work best to translate research into the real world (Metz, 2022). That is, to identify barriers and facilitators to implementation and evaluate implementation success and strategies (Hull et al., 2019). Programmes such as the *OOHCM Programme* are themselves recognised as important '*improvement tools'* or levers for facilitating change in different contexts, that is moving beyond simplistic linear models that see research as simply transferred from producers to users.

The design of the evaluation of the OOHCM Programme was guided by the *'Implementation Science Research Development (ImpRes) Tool'*.[23] The ImpRes Tool contains 10 domains that cover the core principles and methods of implementation science that research teams need to address when planning and designing implementation research in health. Table 2:1 outlines each of these domains and how they are covered methodologically in this evaluation. The evaluation protocol can be viewed [here].

Table 2:1: Evaluation Design, Methods and Report Structure

ImpRes Tool Domain	PART 1: The evaluation of the OOHCM Programme (2021-23)
	Section 1: Background
Implementation Research Characteristics	The ImpRes tool encourages researchers to differentiate between studying the effectiveness of an evidence-based intervention (e.g., to improve a specific service or person outcome) and studying the implementation of an intervention in a real-world setting. This evaluation builds on the effectiveness studies that have previously been completed for specialist homeless OOHC (Cornes et al., 2021). Specifically, the aim is to explore the *'implementation efforts'* associated with the OOHCM Programme and if and how these supported the test sites to replicate (routinise) the positive results demonstrated in the original effectiveness studies.
Implementation Stages and Outcomes	Implementation is understood as a process that encompasses the following stages - it is acknowledged that this may not necessarily be a linear process: *1.* Exploration: identifying the need for change, learning about possible interventions that may provide solutions, learning about what it takes to implement the intervention effectively, working with stakeholders and champions, assessing and creating readiness for change, and deciding to proceed (or not). *2.* Installation: establishing the resources needed and putting in place the resources required to implement the service as intended. *3.* Initial Implementation: adoption and the first use of a new service by staff or service users and learning how to support the new ways of working.

[23] This tool was developed through NIHR Collaboration for Leadership in Applied Health Research and Care South London, a research organisation in London, UK. It is accessible here.

	4. Full Implementation: The implementation of a maturing service that is integrated into a routine offer and supported. *5.* Sustainment: Ongoing and longer-term delivery of a mature service integrated into a mainstream or routine offer. Implementation outcomes associated with each of these stages include acceptability, fidelity, adoption, penetration and sustainment. These stages and outcomes act as key reference points underpinning data collection (topic guides etc) and thematic analysis.
	Sections 3,4 & 6: Study of Positive Deviance and Discrete Choice Experiment (DCE); Evaluation Objectives 1,2,4
Implementation Strategies	Implementation strategies have been described as the active ingredient of the implementation process and the '*how to'* component of changing healthcare practice. In Section 1 we presented a description of the OOHCM Programme components (*financial resources; support via DHSC Programme Team; LGA Consultancy; Programme Audit [improve data quality*]). In Section 3 and 4 we consider the implementation strategies of each of the individual test sites as outlined in their bids to the DHSC).
Determinants of implementation (Contextual Factors)	Implementation success is, in part, a function of the context in which implementation efforts occur. Without a clear understanding of the contextual factors likely to impede or facilitate implementation efforts, implementation strategies to overcome barriers and maximize facilitators will not be optimized, thereby reducing the likelihood of implementation success. Context is discussed in Sections 3 and 4 of the report with a particular focus on how specialist homeless OOHC is being integrated within the wider D2A Hospital Discharge and Community Operating Model (Objective 2)
Implementation Theories	The use of theories and frameworks enhances the generalizability of implementation efforts and helps to build a cumulative understanding of the nature of change. For this evaluation we have adopted a ***'positive deviance'*** framework. This is a form of appreciative enquiry that seeks out positive practice, investigates the underlying factors contributing to the successful behaviours and strategies, and plans an appropriate means to replicate these with the aim to effect a change (Herington and Van de Fliert, 2018). This theoretical framework was selected as it has been used in other evaluations of intermediate care so allows for further testing and evidence building around *'what works'* in successful implementation (Hibbert and Trubacik, 2019). Resource constraints meant that it was not possible to study all 17 test sites in the same level of detail. Three test sites were selected for more in-depth qualitative fieldwork on the basis that they demonstrated aspects of positive deviance including mature levels of integrated/single system working (Objective 4). Audit data was used to identify positive deviance focussing on metrics such as length of stay in step-down and numbers of people sleeping rough after discharge. Following short-listing of possible sites, a discussion with the DHSC identified the three test sites for more in-depth study. Selection criteria ensured geographical spread and the potential to generate learning around different aspects of high performance. The three '*positive practice'* sites were: ● TS6 (out-of-London) – Enabled observations around how to integrate a wide range of specialist care services across the whole D2A system. This test site realised the most comprehensive model of OOHC. ● TS12 (out-of-London) – Enabled observations around rapid mobilisation, scaling and sustaining residential step-down services. This test site demonstrated how data quality improvements can underpin sustainability. ● TS13 (London) – Enabled observations around *'single system coordination'* (a key patient flow mechanism for preventing delays around housing and homelessness) and the importance of leadership in promoting positive multi-disciplinary working around transfers of care.

	A full economic evaluation was carried out in TS12 and TS13. However, TS6 was substituted with another test site as it was unable to produce the audit data needed for a full economic analysis. The substitute test site was TS14 which had developed a novel “settle-in” service (a service typology not previously studied in-depth).
Stakeholder Involvement and Engagement	The ImpRes tool explicitly urges researchers to view implementation research as a genuinely collaborative undertaking between researchers and stakeholders. The evaluation team built close relationships with test sites stakeholders at all stages of the research. Fieldwork in the three positive practice sites included observations of practices, interviews with key stakeholders [including commissioners, test site managers and front-line practitioners] (n=45). To contextualise the positive practice findings, additional interviews (n=14) were carried with test site managers in the other test sites. Three focus groups were also held with different groups of practitioners (hospital discharge staff; staff working in community step-down and staff working in residential step-down). Interviews were digitally recorded and transcribed. They were analysed thematically using the framework described above for implementation stages and outcomes.
Patient and Public Involvement and Engagement	Patient and public involvement (PPIE) is widely considered a marker of high-quality research. The evaluation team has supported PPIE events and activities in the test sites throughout the lifetime of the Programme. Peer Researchers were recruited onto the main evaluation team, informed the evaluation design and undertook interviews with 30 people using OOHC services (10 per positive practice study site). The interviews afforded an opportunity to take a more in-depth look at the PREM themes (for example, on issues such as ‘did you feel you were treated with dignity and respect?’ and ‘how involved were you in planning for your ongoing care and support?’). The interviews were recorded and transcribed. Choice modelling was also employed to gain further perspectives on the views of service users and to inform the future commissioning of services. This is a quantitative method increasingly used in health and social care to elicit preferences from participants (Tinelli, 2016). The aim of the choice exercise was to evidence people preferences for different models or types of OOHC. This tool quantifies preferences in both health and social care settings, while collecting data through a survey approach called a discrete choice experiment (DCE, Q5). Here individuals make choices between different scenarios or service options. Each scenario is described by several attributes, and the choices made help us understand how each attribute influences preferences, including their relative importance. A DCE survey was developed to measure people's preferences for what OOHC offers (the attributes) in terms of the location of care, the practitioner providing care, the frequency of care, the duration of care after hospital discharge, and the rules for behaviour in their living environment. Data analysis allowed us to model the probability of people choosing a particular service configuration. The attributes and their levels were based on our previous research, and we further validated and refined them through discussions with stakeholders during webinars. We also consulted with PPI stakeholders to develop the survey's presentation, wording, and format. To make the DCE questions efficient, we used experimental design techniques. Given the cognitive load associated with the survey, respondents received assistance from our peer research team to ensure we collected responses from more than 250 people experiencing homelessness. We used logit techniques to analyse the data. The DCE survey was well-received by study participants, and we collected 112 questionnaires for analysis. The response rate represented approximately 37% of the total cohort of 300 individuals enrolled from the 10

	sites participating in the DCE survey. Results are presented in a dedicated dashboard.
Unintended Consequences	The ImpRes tool prompts research teams to be mindful of and explore the potential unintended consequences of implementation efforts. We consider this in the analysis of the qualitative data.
	Section 5: Economic Evaluation (Objective 3)
Service and Patient Outcomes	The evaluation utilises data from the OOHCM Programme Audit (see Section 1) to establish the outcomes being achieved for patients (these include health, housing and care experience outcomes). Audit data was also used to evidence service (process) outcomes in the test sites (e.g., length of stay). This data is used in the economic evaluation and to evidence if (and how) the test sites were able to replicate the positive results demonstrated in the earlier effectiveness studies.
Economic Evaluation	**Deep Dive Economic Impact Case Studies:** The economic evaluation afforded a *'deep dive'* in to three of the test sites where there was good quality data and where models were thought to be mature about single system working (Objective 3). As noted above, two of these sites were coterminous with the positive practice sites selected for the in-depth qualitative fieldwork. The third positive practice site was replaced with another test site as it did not have sufficient quality data for a full economic analysis. ***Deep Dive Methodology****:* This aimed to rigorously examine the essential components of these models (according to change in outcomes) and their cost-effectiveness (cost consequence analysis based on various consequences of the intervention, which may include health-related outcomes, people experiences, resource utilisation, and more) considering NHS and also broader public perspectives. ***Economic Analysis: NHS Perspective***. A new integrated management dashboard was created to evaluate economic outcomes by comparing data from one year before and one year after OOHC admission, primarily focusing on the NHS perspective. Two positive practice test sites, one in London (TS13) and another outside London (TS6), received support from local hospital data analysts. These analysts used data from the HES to track admissions, including emergency and elective visits, accident and emergency cases, and outpatient visits from 2021 to 2023. We calculated total costs by multiplying the number of visits and admissions by unit costs derived from national tariffs, allowing us to combine the results. The economic analysis followed a before-and-after approach to assess the cost-effectiveness of discharge service delivery before and after OOHC implementation in the same study site(s), attributing observed differences to the intervention. Health and housing outcomes were determined from audit data collected before and after using audit questionnaires, with additional insights gathered from individual experiences upon service exit. ***Economic Analysis: Broader Public Budget Perspective***. An additional dashboard for the third test site (TS14) evaluates economic outcomes by comparing the period one year before admission to one year after admission, with a primary focus on the overall public budget perspective. With no access to HES data, we gathered data from a person self-reported resource use questionnaire (Q4) to track their interactions with healthcare (including hospital admissions, accident and emergency visits, and outpatient visits), adult social care, mental health services, substance abuse treatment, criminal justice, and housing support from 2021 to 2023. To determine total costs, we multiplied the number of interactions by unit costs derived from national tariffs (and other studies) and then combined the results. The number of individuals considered varies across sites, including those for whom we had complete datasets for analysis.

	Total broader public resource costs include all expenses related to resources required for public services to support individuals. The provided figures allow for a comparison of these costs between the year before and the year after individuals received OOHC. Analysing these figures helps assess the economic impact and efficiency of public support and care in response to changes in the OOHC model. It can reveal cost variations, potential budget savings, and the overall financial implications of shifts in patient care patterns as they transition from emergency care to planned community support. The economic analysis adopted a before-and-after approach, as explained above. **Developing economic evidence across other test sites:** The evaluation team also worked with other test sites not studied as part of the *'deep dive'* to support them to develop economic evidence for their business plans. Six test sites had sufficient data to enable the production of an integrated management dashboard. Where test sites did not have sufficient data for a dashboard, the evaluation team worked with them to produce an economic case story. Case stories were also included in some of the dashboards as they enabled a focus on impacts on wider public services (as well as the NHS). ***Individual case stories***: In seven test sites the evaluation team produced an economic case story. This involved the study of one patient's journey through the system. The case stories collected comprehensive data on interactions with various services, including housing, healthcare, mental health, social care, substance misuse treatment, and the criminal justice system for a selected client. Test sites carefully selected a case that they considered representative, although this choice might have biased towards positive outcomes. To ensure transparency, the key worker, who had a close relationship with the individual, obtained written consent and actively involved the person in the study. A template for counting and costing service and resource utilization was used, including healthcare and broader public services. The local and evaluation teams collaborated to collect and analyse data, focusing on areas with the highest costs influenced by the OOHC programme, making projections for the year following OOHC exit based on initial data. Adjustments were made when sites provided additional information about special circumstances affecting the individual. (One site opted not to proceed with publishing their data because their client passed away). **Outputs of the Economic and Quantitative Work**: The main outputs for the economic evaluation are a collection of integrated management dashboards that visualise implementation outcomes and investments. The aim was that the integrated management dashboards would seamlessly integrate the analysis of aggregate data (provided by test site managers) with the continuous collection, analysis, and comparison of ongoing population data, site by site. We have developed two types of dashboards, **Static** and **Interactive**: ● ***Static Dashboards*** – These are in the format of a PowerPoint presentation and have been prepared for test sites that have submitted questionnaire data in addition to quarterly monitoring data. They are primarily designed for local test sites to use in presentations to *Integrated Care Boards* (ICBs) and other potential funders. In Section 5 we showcase a full static dashboard that has been produced for one of the positive practice sites. ● We have also created one static dashboard (PowerPoint) for the whole national programme (see Figure 1:2). Economic evidence from multiple sources (HES data, audit/self-reported data on the use of public resources for either individual case stories or a larger cohort group (when possible) *PLUS* intervention cost data from the DHSC) has been collated to provide an overall view of the Programme. This is presented as the

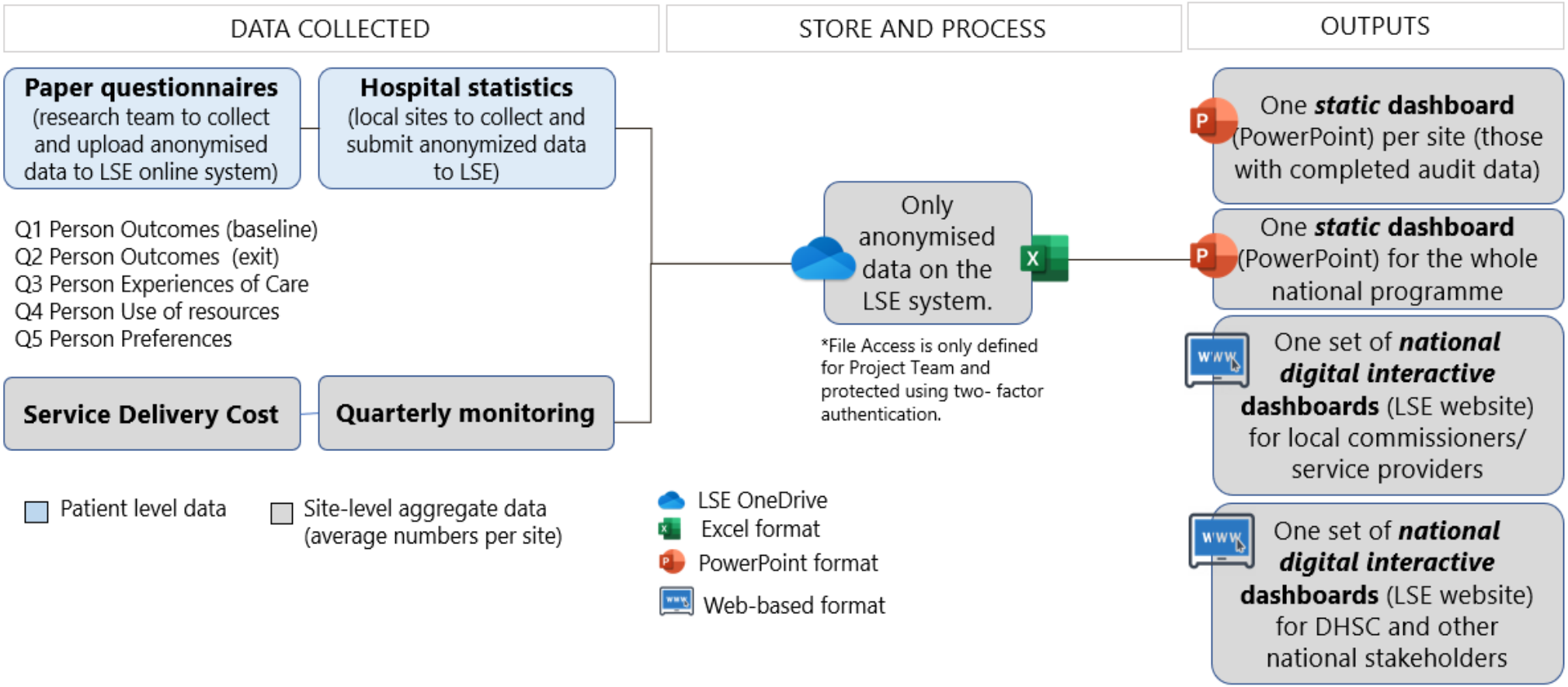
	first '*OOHCM Programme National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness'.* ● ***National Digital Interactive Dashboard*** – Economic evidence from multiple sources (HES data, audit/self-reported data on the use of public resources for either individual case stories or a larger cohort group (when possible) *PLUS* intervention cost data from the DHSC) has been collated to provide an overall view of the Programme. This is presented as the **first** '*OOHCM Programme National Dashboard for Specialist Intermediate Care for People Experiencing Homelessness'.* In addition to a static infographic, there is an online interactive dashboard that enables the performance of each test site to be compared**.** The interactive dashboard is accessible from the LSE website [link] – and discussed further below, in Section 8).This functionality is intended to allow for the routine monitoring and evaluation of trend data for individual service providers, Integrated Care Systems (ICSs), local government areas, and the nation at large, against established benchmarks. The intention is that the digital dashboards will serve as valuable management tools for monitoring progress and play a pivotal role in driving long-term service improvements.
	Section 7: Scaling and Sustaining
	We tackle the issues of keeping up and expanding specialist OOHC in today's economic conditions. The focus is on business planning and the strategies used by test site managers to secure long-term sustainable funding.
	Section 8: Conclusion
	We outline the comprehensive impact of the OOHCM Programme and summarize the primary findings of the implementation evaluation. Additionally, we highlight the main challenges for policymakers and commissioners regarding maintaining the Programme's impact over the long term.
	PART 2: A Data-Driven Strategy to Inform Future Service Implementation
	Section 9: Next Steps
	Integrated management dashboards roadmap: more work is planned by LSE to transition from current manually operated to automated dashboards. **Status of the project:** the creation of a collaborative initiative between local ICBs is underway to ensure ongoing evaluation of the services, while the automated version is ready for testing locally (*if interested in knowing more please contact the team: m.tinelli@lse.ac.uk)*. **Dissemination:** Workshops are planned by the evaluation team to showcase the study findings and full potential of the dashboards (*if interested in participating please contact the team: m.tinelli@lse.ac.uk*). In **section 5** of the report, we showcase three '**gold-standard' *static* dashboards** for service providers. More information on the uses and target audiences for the dashboards (with examples of the ***digital interactive*** **dashboards** for both local and national stakeholders) can be found in section 8 of this report and at www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards.

Overview of data collected: Building on the data collected for the Programme Audit (see Table 1:3 above) a summary of the additional data collected as part of the (PPI) *'Discrete Choice Experiment'* and the economic evaluation is presented in Table 2:2. Figure 2.1 below shows how both audit and evaluation data is linked to the various dashboards described above.

Table 2:2: *Additional* Economic and People Preferences Data Collected for the Integrated Management Dashboards

	Metrics	**Data Source**
Health Care Utilisation	Number of A&E visits	HES (or local audit / Questionnaire 4 - Self-reported use of resources data (Q4)
	Number of non-elective admissions	HES (or alternative local audit/ Q4)
	Number of elective admissions	HES (or alternative local audit/ Q4)
	Number of other admissions	HES (or alternative local audit/ Q4)
	Number of outpatient visits	HES (or alternative local audit/ Q4)
	Number of bed days	HES (or alternative local audit/ Q4)
Broader Use of Public Resources	Number of contacts with Housing services	Local audit/ Q4
	Number of contacts with Drug and alcohol services	Local audit/ Q4
	Number of contacts with Mental health services	Local audit/ Q4
	Number of contacts with Social Care	Local audit/ Q4
	Number of contacts with Criminal Justice	Local audit/ Q4
People Preference	What aspects of OOHC services are valued and their relative importance/ trade-off	DCE Questionnaire (Q5)
	Probability of uptake of different OOHC models	Q5

Figure 2.1: Data collection and integrated management dashboard development process



3: Mobilisation and Integration of Homeless Hospital In-reach Teams in D2A

3:1 Background

This section of the report provides an in-depth focus on the mobilisation and integration of HHIRTs in the post-Covid (D2A) hospital discharge operating arrangements. In the following section, we explore the mobilisation of step-down intermediate care and the wider implementation of the test plans as a whole system of care and support.

We begin with an overview of D2A and the policy expectations surrounding the integration of HHIRTs within these arrangements. We then draw on qualitative data to explore implementation from the perspective of staff working in the HHIRTs, highlighting key challenges and how they might be overcome. Finally, we present data from the Programme Audit to give an overview of progress to *'roll out'* HHIRTs and the outcomes that they are achieving, again supplementing this with qualitative insight.

Following the Covid-19 pandemic, the Health and Care Act, 2022 s91(1) repealed the previous statutory regulations surrounding hospital discharge and replaced them with a new Discharge to Assess (D2A) operating model (DHSC, 2022). D2A is where people who are clinically optimised and do not require an acute hospital bed (but may still require care services) are provided with short-term, funded support to enable them to be discharged to their own home (where appropriate) or to another community setting (NHSE et al., 2016). Fundamental to D2A is the idea that comprehensive assessment (including assessment under the CA 2014) will take place out-of-hospital, allowing people time for recovery before making choices about their longer-term care and support.

The *'single system'* (the mandated operating model) for D2A in England comprises '*transfer of care hubs'* that oversee the discharge of ***all patients*** from the acute sector[24] either home with no new care and support ***or*** onto one of three intermediate care pathways:

> **Pathway 0** - Simple discharge home; no new additional support required to get the person home, or such support constitutes only informal input from support agencies or a continuation of an existing health or social care support package that remained active while the person was in hospital. (Likely to be a minimum of 50% of patients discharged)
>
> **Pathway 1** - Able to return home with new, additional or restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home (Likely to be a minimum of 45% of patients discharged)
>
> **Pathway 2** – Recovery, rehabilitation, assessment, care planning or short-intensive support in a 24 hour bed-based setting, before returning home (Likely to be a maximum of 4% of patients discharged)
>
> **Pathway 3** - For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (Likely to be a maximum of 1% of patients discharged)

The *'Hospital Discharge and Community Support'* guidance is clear that the needs of people who are homeless need to be considered as part of D2A and that people who are homeless or at risk of homelessness should not be excluded from short-term post-discharge recovery and support because of their housing status (DHSC, 2022 p13).

When a patient is in hospital, the expectation is that where there are unmet care and support needs, ward staff will make a referral to the *'transfer of care hub'* as soon as possible. Every local health and social care system based around an acute hospital footprint should have a transfer of care hub whereby (physically and / or virtually) all relevant services across sectors

[24] Mental health inpatient services are not within the scope of the D2A operating model (DHSC, 2022).

(such as health, social care, housing and the voluntary and community sector) are linked together through multi-disciplinary team working (DHSC, 2022).

Decisions about what long-term support package is needed should not be taken on the hospital ward. Case managers in transfer of care hubs should link relevant services to coordinate care and support for the individual. The case manager can be from any discipline (such as social care, primary care or allied health professionals)[25] depending on the needs of the individual being supported. The LGA guidance (LGA, 2023) supporting the OOHCM Programme recommends that where there are complex health needs linked to homelessness, staff in specialist HHIRTs may be best placed to act as case manager.

A key recommendation of the NIHR research (Cornes et al., 2021) and D2A guidance (DHSC, 2022 p12) is that case managers acting on behalf of the transfer of care hub, should extend support beyond the discharge itself, working across both hospital and community settings to plan post discharge care, long-term care needs assessments and, where appropriate, end of life care. *Trusted assessment* means there is no expectation that people will be assessed by community service providers before leaving hospital.

3:2 Transfer of Care Hubs and Specialist Homeless In-reach Teams (HHIRTs)

HHIRTs were first developed in 2009 and have steadily been extended across the UK and internationally. NICE (NG214) recommends that a full 'clinically-led' multi-disciplinary HHIRT is developed in hospitals that see over 200+ homeless patients per year. HHIRTs are usually led by a GP or inclusion health nurse with a 'special interest' in homelessness. Additionally, they will usually employ housing link workers and peer navigators (people with lived experience of homelessness). Some teams also include social workers, occupational therapists and other clinical staff.

Where there are smaller numbers of homeless patients, housing workers will often in-reach into the hospital as a single worker or a small uniprofessional team. Housing workers are usually seconded into the hospital and employed by either the local housing authority (housing options team) or a local homeless voluntary and community sector service.

HHIRTs are usually co-located on the main acute hospital site and offer a range of services to homeless patients while they are in hospital, including clinical advocacy, discharge coordination, housing advice and (more recently) continuity of support into intermediate care. The primary goal of the HHIRT is to maximise the benefits of a hospital stay, using this as a window of opportunity for change. They play a key role in supporting patient flow through a *'homeless ward round'*. This enables the early identification of patients experiencing homelessness on the wards so that planning for discharge can begin at the earliest opportunity. They also work to prevent early self-discharge. Often self-discharge can be a result of substance use and the patient wanting to discharge themselves, against medical advice, due to the onset of unpleasant withdrawal symptoms. Withdrawal can also be at the root of much challenging behaviour on the wards, for example, where the patient feels that his or her withdrawal is not being appropriately managed and leaves the ward to use street drugs. In such circumstances, HHIRTs can intervene through clinical advocacy and more appropriate clinical management (e.g., the correct titration of opioid substitution medication such as methadone or buprenorphine).

Housing workers in the HHIRT can take on responsibility for sorting out a patient's 'personal administration' such as replacing lost ID, accessing benefits, setting-up a bank account and making an approach to the housing authority. They will also take on the responsibilities linked to the statutory *'duty to refer'* [26]under the Homeless Reduction Act, 2017 on behalf of ward staff. Because HHIRTs are often co-located (avoiding the need for ward staff to make external

[25] More recent guidance recommends that intermediate care should be 'therapy led' (NHSE 2023c). Therapy refers to occupational therapy and physiotherapy (mainly physical rehabilitation).

[26] Under the Homeless Reduction Act, (2017) staff in hospitals and other public services have a duty to refer people who are homeless to the relevant housing authority (accessible here).

referrals and wait for a response) they are often credited with playing a vital role in maintaining patient flow and reducing delays linked to housing and homelessness.

In the original NIHR OOHCM effectiveness study (Cornes et al., 2021), clinically-led HHIRTs were shown to increase access to planned follow-up care as compared to standard care (counted as higher numbers of elective readmissions). This is an especially important consideration given that many people who are homeless have complex health needs and die of common conditions that could potentially be avoided with more timely access to health care. It was also the case that HHIRTs with access to step-down intermediate care were more effective and cost-effective than those HHIRTs with no access.

3:3 Mobilising and expanding Homeless HHIRTs

As noted in the introduction, multi-disciplinary HHIRTs offering health and social care and housing expertise were conceptualised by the DHSC as key components of *'high fidelity'* OOHCMs. All the test sites except two planned to invest OOHCM funds in developing HHIRTs (see Appendix 2). The remaining two test sites already had established teams. OOHCM funding was used to develop new HHIRTs in 8 test sites (5 new clinical teams[27] and 3 housing-led teams). In the other test sites the funding was used to expand an existing team. Some areas focussed on developing a *'hub and spoke'* model, where new team members were recruited so that an existing HHIRT could extend its reach into smaller hospitals within the same Trust.

In TS13 (positive practice site) a longstanding HHIRT was redesigned as a *'Homeless Intermediate Care Team'* (HICT). Although continuing to offer in-reach into the hospital to build an initial relationship (rapport) with the patient, the primary focus was switched from supporting patients on the ward to seeing the intermediate care stay as the *window of opportunity*. Assessing and case managing patients out-of-hospital and in the community was thought to align better with the D2A operating model. In Section 5, we present a full economic case study of this novel intervention (Objective 3).

(Improvement Support)
Some of the test sites chose to use some of their OOHCM funding to commission the Pathway charity (www.pathway.org.uk) to support them to develop a new HHIRT under a franchise model agreement. Franchise support afforded the support of an experienced inclusion health nurse with extensive experience of setting-up and supporting new teams. It also afforded access to (off the shelf) policies and procedures and a quality framework to supporting monitoring and recording of activities. This support was described by some as being as invaluable, especially as it prevented much reinvention of the wheel. The network of homeless and inclusion health nurses hosted by the charity was also considered valuable in enabling nurses in the new HHIRTs to connect and learn from others in the more established teams. For the Pathway charity the wave of new OOHCM funding for HHIRTs dramatically increased their workload and created significant pressures in trying to support so many new teams simultaneously.

In one test site, a nurse was recruited to develop a new HHIRT from scratch. The nurse did not receive any support from the test site manager (who was not known to her) and became overwhelmed by the task. She faced opposition from the hospital who felt an HHIRT might cause delays. She was unable to gain access to the wards and was forced to spend most of her time working from home. The nurse left her post before the contract ended. This HHIRT did not become operational during the lifetime of the Programme.

There is important learning here about the importance of (*improvement)* Programmes affording access to both specialist and generic supports. In the OOHCM Programme the LGA support (funded directly by the DHSC and freely available to all test sites) was focussed on

[27] A new clinical team was also developed in TS17a. This was funded by the acute trust, but the service participated in the OOHCM reporting.

commissioning support (e.g., supporting test sites to develop business cases). Few of the LGA advisors had direct experience of working in homelessness. While generic support was considered helpful by commissioners with responsibilities for developing business cases, it did not meet the needs of all stakeholders in the Programme. For frontline clinical staff engaged in service development, having the support of someone with *'first hand'* experience of the service area was seen as vital to rapid mobilisation. London test sites had the additional benefit of support provided through the *Healthy London Partnership,* also commissioned by the DHSC to provide support to test sites free of charge. This provided a good mix of expertise and project support, but did not extend to out-of-London sites.

(Recruitment Challenges)

The most significant barrier to mobilising the HHIRTs was staff recruitment. Importantly, when considering risks and mitigations in their original bids to the DHSC, very few of the test sites anticipated just how acute this problem would be. In one out-of-London test site, there were ambitious plans for a high fidelity *'hub and spoke'* model encompassing a significantly expanded clinically-led HHIRT. The project plan envisaged a three-month timeframe from receipt of funding to a fully staffed model. However, recruitment challenges meant that the planned model was never fully realised. The plan was to recruit three inclusion health nurses and an occupational therapist. Despite enormous efforts to recruit, these posts were never filled. Across the sites, it was reported to be very difficult to recruit senior (Band 7) nurses into short-term posts. In this test site, secondments were not considered making the recruitment even more challenging. Such was the resulting pressure on the existing lead nurse that she left her post, leaving no clinical staff in post. This HHIRT continued as a housing-led service.

In London, the wave of new funding for OOHC meant that test sites were effectively competing against each other for a small number of appropriately trained and skilled workers. Workforce shortages coupled with lots of employment opportunities made for unstable teams where people voted with their feet if they felt unhappy about aspects of their employment or found a better opportunity.

> 'Recruitment has been a key issue - very specialised staff, small pool of people and there has been movement with people recruited and then moving on to better offers' (Test Site Manager, 5).[28]

Housing and *'settle in'* support workers were also in short supply. While the DHSC identified the destabilisation of existing services as a risk in its business case, the reality was that short-term contracts were not appealing to many potential candidates. As noted above, employment practices in some of the acute trusts also acted as a barrier where for example, secondments were not considered for interested candidates who were not willing to leave a permanent post.

(Starting-up pressures)

Staff in the new HHIRTs described the considerable pressure that was placed on them to get the service up and running quickly and to start accepting referrals. There were a multitude of complex practical matters to address in setting-up the new HHIRTs, such as securing honorary contracts, establishing effective data and outcome capture procedures and even finding office space and furniture. In one hospital, OOHCM funding was spent on a new reception desk for the accident and emergency department and not on the new office accommodation for the HHIRT as planned. Accepting referrals too soon led to many challenges, such as high volumes of inappropriate referrals and conflict with ward staff when these were returned or not actioned quickly enough.

[28] Numbers relate to interview transcript numbers not Test Sites. This is to protect the anonymity of interview participants.

Box 3:1 Positive Practice – Supporting New HHIRTs

Through their OOHCM consultancy work, Pathway suggest the following *'top tips'* for the mobilisation of a new HHIRT:

- **Provide new teams with general operational management support:** Like any new hospital team, HHIRTs will need induction support form general hospital managers to progress and develop as part of the wider hospital system.
- **Agree and protect the operational parameters of the role**. This is necessary to ensure that the HHIRT is not expected to 'take over' responsibility for the discharge of every homeless patient. Ideally, the HHIRT should focus on case managing the most complex cases. HHIRTs need protected time to raise awareness about their role and to train other hospital staff about homelessness and inclusion health.
- **Ensure adequate office space and equipment**: with easy access to office resources (e.g. scanner, photocopier, printer). A significant amount of advocacy and case resolution work takes place on the phone or via online case meetings, and teams need the right office equipment (e.g.to scan ID documents and print off leaflets in other languages or in large print / easy read versions)
- **Ensure honorary contract and system access is set up in timely fashion**. This is essential to getting the team established quickly and ensuring partnership working.
- **Ensure Teams have a Personalisation Fund** (e.g., money to purchase travel tickets, birth certificates, phones, clothing). Teams need their own personalisation funds to be able to resolve problems quickly. This also helps them to establish rapport with patients.

(Retention challenges)

Most staff working in HHIRTs report that the role is incredibly rewarding. Job satisfaction is linked to *'sorting people out'* and the feeling of making a real and important difference to people's lives. However, job satisfaction can be impacted where caseloads are too high, and staff start to feel that they cannot do their job properly.

In planning the new HHIRTs, team composition and staffing levels were largely determined by the available funding envelope. Test site commissioners and managers acknowledged that they struggled with capacity and demand modelling because the methodology was unclear and/or because data was not available.[29] The original proposals the test sites put to the DHSC often presented a wealth of information, but this was usually contextual (e.g. number of people rough sleeping in an area) and not directly relevant to understanding the flow of homeless patients through the hospital. Without robust understanding of the levels of need and implications for team composition, some of the new HHIRTs in London appointed too few staff and were quickly overwhelmed by the sheer volume of work.

> 'The number of people needing the service was so high… They also became victims of their own success being known [within the hospital] as the team that can really help people. They were getting so many referrals both from A&E and the wards… You can't have 50 patients for two members of staff…' (Test Site Manager, 7).

The mismatch between capacity and demand led to high levels of stress and burnout, leading to retention issues.

> 'Over July, August, September I had three chest infections… I just couldn't get better because I [was] holding my team up who were all going off sick all the time, I'm carrying on because I can't leave one Housing Worker to deal with everything, so I keep going,

[29] Some of the proposals to the DHSC requested OOHCM funding to undertake capacity and demand modelling. TS17 planned to conduct a homeless health baseline and needs audit to get full understanding of acute and mental health trust discharge activity, patient flow and hospital/OOHC needs for the population rough sleeping and at risk of rough sleeping. TS16 proposed commissioning an independent baseline study to identify areas of need and opportunity pertaining to discharge. No test sites reports were available to the evaluation team by the end of the Programme however, a modelling and audit was carried out through the Healthy London Partnership.

keep going, keep going. And then I was like, I can't live like this' because I've got my future to think of… So, I decided there and then I was going to leave…' (HHIRT Nurse FG2[30])

'Hub and spoke' models especially tended to underestimate the volume of work in the smaller outlying hospitals. Because workers in '*hub and spoke'* models often spent most of their time at the satellite hospital, isolated from the wider team, this seemed to exacerbate the feelings associated with stress and burnout. Lack of management support and appropriate supervision was also noted in some of the new teams.

Box 3:2 Positive Practice – Preventing stress and burnout among HHIRT staff

Through their OOHCM consultancy work, Pathway suggest the following *'tips'* for preventing stress and burnout among HHIRTs:

- **Effective workload management**: If teams are expected to work across multiple sites and have an impact on A&E frequent attendance, HHIRT staffing needs to reflect this additional workload.
- **Clinical supervision and group reflective practice** needs to be in place to help staff flourish in this situation and to help prevent burn out. Regular time is required as a team to reflect on effectiveness and the pressures of each other's role, responsibilities (Ideally with a senior hospital manager attending (but not leading).
- **Ensure staff are given adequate time for training / updating.** Inclusion health is a new specialism, that is continually developing. Effective working in this area is dependent on being up to date with the evidence base and in relevant health, housing, immigration and safeguarding law. Staff should be given time for upskilling and knowledge building and clinical networking as a core part of the working week.

3:4 Collaborative working and integration

Where HHIRTs focussed on delivering *practical support* to support patient flow and rapid discharge then relationships with other hospital staff were generally positive. Taking on responsibility for *'difficult cases'* and the *'duty to refer'* (liaison with the housing authority) were particularly appreciated because this was seen to reduce the burden on staff on the wards and in the discharge hubs.

'We've had mental health, safeguarding, domestic abuse, human trafficking, domestic servitude… It's not just a rough sleeper who needs a bed … If it's in the discharge hub's 'too difficult box' they'll send it to me…' (HHIRT Nurse, FG4)

'Having a healthy personalisation fund[31] has enabled [the HHIRT support worker] to be incredibly [proactive]: *"Yes, I'll put this person in a hotel. Yes, I'll go and buy them a whole new lot of clothes. Yes, I'll get them a train ticket and phone their mum and make sure their mum is going to pick them up."* For the [A&E and ward staff] seeing somebody coming in and going *"I'll deal with that, you've done your bit, they're healthy now, they're well enough to be discharged, I'll deal with the rest*…" I think that really helps with the relationships (Test Site Manager 2).

(Managing the tension between patient flow and person-centred care)
As touched upon above, the new D2A operating model significantly changed discharge practices across hospitals in England. In the early stages of implementation there was much uncertainty surrounding the policy guidance. For example, in many test sites D2A continued to be seen primarily as an 'elderly care model' and it was not uncommon for all homeless patients to be diverted away from the transfer of care hub and placed on Pathway 0. Pathway 0 is for

[30] FG refers to Focus Group and the number refers to the transcript number.

[31] Many test sites earmarked some OOHCM funding for staff to provide practical necessities for patients such as clothes, phones, travel cards etc, called 'personalisation finds'. TS12 also used funding to buy 'settle in' packs for patients that included practical items to support the move to temporary accommodation (bedding, towels etc,).

patients who have no care and support needs. Often the assumption was that housing would be the primary need of all *"homeless patients*" and that referral to the housing authority (if that happened at all) would suffice.

For homeless patients, discharge on Pathway 0 meant discharge back to the street or to temporary accommodation with no new assessment of their health or care and support needs. Among (non-specialist) hospital staff, this routine practice reflected that understanding of the levels of cognition issues, safeguarding issues, frailty and complexity experienced by people who were homeless was often poor.

In those hospitals where there already existed an HHIRT, discharge on Pathway 0 meant that they would be expected to take on full responsibility for the discharge and that they would not have the same ease of access to the wider multi-disciplinary team attached to the transfer of care hubs (social work, occupational therapy and physiotherapy). Lack of access to this wider team also meant other D2A Pathways, such as local authority reablement (Pathway 1) or a bed in a community hospital or nursing home (Pathway 2/3), would be closed off.

Undoubtedly, a key success of the OOHCM Programme has been to challenge this practice in the test sites, and to raise awareness that the policy guidance stipulates that D2A should be accessible to *all adults*, including those who experiencing homelessness.

> 'One of our [test site's] biggest successes is the progress we have made with hospital. They have a very distinct set-up there… Initially they wanted to hold on to that illusion and denied they had a problem with homelessness… Although it has taken almost the entire time of our project to make progress, the issue around homelessness is now being looked at from a more senior level…' (Step-down Service Manager, FG 2)

> 'If I go back [to the beginning of the Programme], you'd still have people with homelessness experiences on D2A Pathway Zero. I can't think of many cases where that would feel completely appropriate - where someone who is homeless is viewed as having no complexity and discharged with no support. I think that kind of holistic understanding of what Pathway someone should be discharged on is starting to develop and I think that is probably what we want to get to by the end of this… My concern now is the numbers discharged on Pathway 1, and the need for more use of Pathway 2' (Test Site Manager, 14)

However, this change in practice was hard won. Many of the clinical staff working in the new HHIRTs, reported bullying and poor collaborative cultures in hospitals, especially where they were seen to be *'blocking the discharge*". One nurse described her experience of the transfer of care hub as like entering a *'bear pit'*.[32] Leaving front line staff to advocate for change on a *case-by-case* basis led to very high levels of stress and staff burnout.

> '[The stress and anxiety] creeps up on you… You're just like fighting the system in every way and everyone's looking at you... You don't have any sort of power so you're just waiting for someone to respond… You've made a referral somewhere and you're chasing it and [ward staff] are being funny about you being so demanding… It just slowly, slowly, slowly burns at you. I have, for the first time in my life, just started anti-depressants because I was just like numb… I've been nursing 38 years this year and [this role] has just broken me, absolutely broken me.' (HHIRT Nurse, FG4)

> '[The HHIRT] enables a good discharge but they don't necessarily enable a quick discharge… I think that's at odds with what everyone else is trying to do in that department.' (Test Site Manager 7)

Nurses in the HHIRTs described how their lack of professional status inside the hospitals was a significant problem, and how their expertise was often not appreciated.

> '[Homeless and inclusion health nursing] is not sexy enough… We should be classed the same as other specialist nurses such as an HIV Nurse or a Coronary Care Nurse or an ITU Nurse. We should have the same respect as that… No matter how much I would

[32] Refers to TV show Game of Thrones which saw the hero thrown into a pit and expected to fight a grizzly bear.

> try to raise awareness of the [homeless and inclusion health nurse's role] they [ward staff] only see me as *'housing'*… I didn't want to wear my nurse's uniform as this puts up a bit of a barrier with our homeless patients, but it does give you more status with the staff' (HHIRT Nurse, FG4)

In London, staff shortages, high volumes of work and a hostile working environment fuelled a recruitment and retention crises. In one test site, the HHIRT was left with no staff leading to the service being suspended. In another test site, very high staff turnover meant that the footprint of the service was significantly reduced.

> 'All these pots of money and more positions being created… They are not going to get filled because [the hospitals] don't understand how to look after their staff properly and value them. [Inclusion health nurses are a] network, we all know each other. None of my friends are going to come into my job. I'm sorry, but they know the reality of it. No-one's going to do that. Especially, you know, after what's happened this year with all these London posts. We all know each other, and it will be someone fresh who's never done it before who will get burnt out' (London HHIRT Nurse).

Box 3:3 Positive Practice – Escalation Procedures

In TS13, where a new *Homeless Intermediate Care Team (HICT)* was being piloted, specialist clinical staff reported much more positive relationships with ward staff and the discharge hub. In this hospital, the operational manager of the transfer of care hub set the tone for collaborative working, making it clear to all staff that practices such as discharge to the street were not acceptable and would be treated as safeguarding concerns. Where disputes arose in relation to the discharge of individual patient, the test site manager implemented *escalation procedures*. The test site manager was a senior commissioning manager within the Integrated Care System (ICS) and could convene multiagency meetings and hold partners to account.

Key learning here is about achieving safe timely transfers of care through high level single system leadership rather than expecting front line staff to advocate on a case-by-case basis. This was one of the few test sites to have implemented the D2A guidance about the importance of every local health and social care system having a *single system coordinator* who can address any challenges that impact on patient flow and can hold all parts of the system to account (DHSC 2022p14). Other sites may have implemented this role, but it was only in TS13 that its reach appeared to extend to housing and homelessness.

3:5 Progress to 'roll out' HHIRTs – activities and outcomes[33]

By the end of the Programme, 12 test sites were each accepting over 200+ homeless patients a year. Of these, 10 had implemented a full clinically-led HHIRT, reflecting significant progress in *'rolling out'* this intervention in line with the recommendations of the NICE guideline and the earlier OOHCM research.

Acceptance rates and case load: Over the two-year lifetime of the Programme, HHIRTs accepted 11,030 homeless patients, with an average acceptance rate of 89%. Clinical HHIRTs had an average case load of 10 in test sites outside of London and 6 in London test sites. The caseloads for housing workers were higher, at 15 for out-of-London test sites, and 11 for London tests sites.

In terms of volume of work, some of the more well established HHIRTs also saw quite significant increases in the numbers of referrals/acceptance across the lifetime of the Programme, possibly reflecting the ending of the Covid-19 pandemic and policy of *'Everyone In'*. In TS6 referrals increased from 467 in 2021/22 to 841 in 2022/23. In TS1 the increase was more than threefold from 233 referrals to 942.

[33] This section draws on the audit tables that collated the Quarterly Monitoring data, so incorporates data for all 21 sites, not just the 10 sites that had complete data sets.

Activities inside the hospital: In Year 1, the HHIRTs in the out-of-London test sites reported an average of 2 face-to-face contacts per patient. For the London HHIRTs the figure was 0.4 (meaning not every patient accepted was seen in person on the ward). This raises the question as to whether the HHIRTs in London have sufficient capacity to fulfil a case management function on a routine basis (assuming that case management is conceptualised as a person-centred activity that necessarily involves some direct patient contact). In Year 2, we did not report quarterly monitoring data on the number of face-to-face contacts because many HHIRTs left this field blank. It was suggested by some staff that the number of face-to-face contacts was not a good measure of the work being carried out by HHIRTs, since it did not capture the activity that was taking place behind the scenes (such as making and following-up referrals to housing and other services). These administrative activities were perceived to have become increasingly more important since the advent of D2A and the significant pressures placed on HHIRTs to secure rapid discharge. Indeed, as time spent on activities associated with discharge and patient flow has increased significantly, some stakeholders questioned if the original Pathway model was still feasible, as this prioritised relational working (engaging and building trust) with homeless patients on the wards. As touched upon above, the *acceptability* of this model was often challenged by ward staff and discharge managers where it was seen to prevent the discharge.

Follow-up outside of hospital: A key recommendation of the earlier NIHR OOHCM research and D2A guidance, was about the need for HHIRTs to extend case management support to homeless patients for a short time after discharge. Among HHIRTs in London, 37% of patients were supported after discharge and 12% of patients were supported outside-of-London. The HHIRTs frequently reported that there was too much work inside the hospital to support patients after discharge. Where follow-up occurred, this often relied on some form of telephone contact. The average length of time that patients were supported by HHIRTs after discharge was 28 days in London test sites and 93 days in out-of-London test sites. In TS16a, a small team of specialist homeless nurses were commissioned to fulfil an intermediate care role (in addition to their specialist community nursing role) taking over responsibility from the HHIRT for follow-up after discharge. However, finding patients in the community without having first met them in hospital proved challenging. It was also felt that the 6 week intermediate care timeframe was too short, with patients requiring clinical case management for medical conditions such as wound care for much longer. This was due to difficulties handing over patients to other community nursing services. 66% of patients were supported longer than six weeks by this team, and the average time supported was 51 days.

> 'We are meant to see patients for six weeks, and I mean as an example, I've got two patients that have been on my case load for over a year. You might have a wound that is healed within let's say two months, and if they're continuing as before with injecting drugs - then just prior to them being discharged they may have got another wound … so it's a continuing process' (Specialist Nurse)

As noted above, TS13 (positive practice site) undertook the most significant redesign to ensure adequate follow-up after discharge, transforming the HHIRT into an intermediate care team. The team continued to provide some in-reach into the hospital but focussed efforts mainly outside of the hospital. This team aspired to follow up 100% of patients after discharge. However, as the team became established in the community it did start to feel increasingly pressurised by the hospital to provide more in-reach onto the wards. For both types of team, burning the *"in-reach/out-reach"* candle at both ends proved challenging.

Outcomes: Preventing early self-discharge and rough sleeping on discharge from hospital are key performance metrics for the HHIRTs.[34] 9% of patients seen by HHIRTs in the London test sites took early self-discharge. In out-of-London, test sites the figure was 8%. The lowest reported rate was 1%. This was reported for a housing-led HHIRT that also reported working with very low numbers of people sleeping rough on admission (7%). This may be indicative of a less complex caseload where self-discharge is not such an issue.

[34] We did not collect patient outcome (QALY) data for HIRTs – as, in line with D2A policy, recovery should be assessed and measured in the community following time spent in step-down intermediate care.

The highest figure for self-discharge was 14%. This figure was reported for one of the new clinical HHIRTs in London that also reported having one of the highest rates of people sleeping rough on admission (31%). This HHIRT was also experiencing severe staffing shortages.

24% of patients accepted by London HHIRTs were sleeping rough on admission to hospital and 20% of those accepted by the out-of-London teams were. On discharge from hospital, 7% of all patients seen by a London HHIRT slept rough on discharge and the figure for out-of-London teams was 9%. In TS13 (positive practice site), 3% of patients seen by the Homeless Intermediate Care Team (HICT) were sleeping rough on admission. 1% of all patients returned to rough sleeping.

In London, one of the longest established clinical HHIRTs had one of the lowest rates of rough sleeping on discharge (2%) and one of the new teams the highest (23%). This reflects the long lead-in time an HHIRT needs to build-up effective multi-agency relationships locally with housing and other providers to maximise the numbers receiving a safe, timely transfer of care.

> [In the first year] you are making all the right connections in the local area, knowing who to refer to, who does what… building all those more intimate connections where you can pick up the phone to someone in a certain team. It takes a few months to get that all going and then it's almost like as soon as it's going it might stop [due to lack of longer-term funding] (Test Manager 7)

Out-of-London rates for rough sleeping on discharge were between 0% to 15%. The HHIRT with highest percentage figure (15%) was housing-led and reported extreme housing shortages and a consequent silting-up in intermediate care. The HHIRT where no one slept rough after discharge was 'housing-led' and operated a '*bed every night'* scheme instigated by the local Mayor.

3:6 Summary

Through the OOHCM Programme, many more hospitals have benefited from the *'roll out'* of new HHIRTs or the expansion (scaling) of existing teams. Recruitment and retention issues were the main barrier to mobilisation. This was exacerbated by the injection of short-term funding which meant test sites were forced to compete with one another for a small number of highly skilled staff.

When the OOHCM Programme launched in 2021, D2A was seen primarily as an *'elderly care model'.* A key success of the OOHCM Programme has been to challenge this practice across the test sites, and to raise awareness that D2A should be accessible to <u>all adults</u> including those who are homeless. However, this change was hard won. HHIRTs were generally welcomed where they provided practical support for rapid discharge, but challenged where they took on a clinical advocacy role that was perceived to *'block the discharge'*. Poor collaborative cultures inside hospitals led to high levels of stress and burnout among specialist staff, and subsequent retention issues that threatened the viability of the newer teams. Key learning here was about the importance of achieving integration and practice change through high level leadership and *'single system coordination'* instead of expecting front line staff to advocate on a case-by-case basis.

Faster paced discharge coupled with capacity issues in teams, has meant less time for face-to-face relational working with homeless patients. There was also limited scope within HHIRTs to provide continuity of care, as people moved onto the D2A Pathways meaning that the policy vision for integration of HHIRTs into D2A was not fully realised.

Despite these limitations, the audit suggests that HHIRTs and the Homeless Intermediate Care Team (HICT) are playing an important role in preventing early self-discharge and improving housing outcomes (preventing rough sleeping on discharge). However, performance varies from area to area which is likely reflecting different local contexts and housing policies as well as the level of maturity of the teams themselves. Despite challenges in securing safe timely transfers for all patients, the figures reported here (7-9% rough sleeping after discharge) do represent a significant positive shift from the reported 70% of homeless patients being discharged to the street as was the case before the first hospital discharge fund.

4: Mobilisation and the Delivery of Step-down Intermediate Care

4:1 Background

For D2A to deliver its primary goals around safe timely transfers and improved patient outcomes, each of the discharge pathways (1-3) must encompass enough capacity across range of different step-down intermediate care services. This includes residential *'bedded'* facilities in care homes and community hospitals (Pathways 2/3), local authority reablement services and *'welfare checks'* by the community and voluntary sector (Pathway 1). A key objective is that discharge coordinators in the transfer of care hubs will develop strong links with care providers and will have a menu of readily accessible placements thus ensuring patients can leave hospital as soon as they are medically optimised with the right integrated support (NHSE 2023). The hospital discharge guidance is clear that,

> *'Health and social care professionals should follow an ongoing commitment to reducing health disparities and inequalities and consider the needs of groups that might need specialised support'* (DHSC, 2022 p29)

In Section 1 (Figure 1:1) we presented the first '*National Dashboard for Specialist Step-down Intermediate Care'* (2021-23). This section aims to provide an understanding of the most effective way of implementing step-down intermediate care – including how to shift to this ***'baseline'*** position and the conditions needed to maximise the effectiveness of the services (Objective 1). It describes the different service typologies that have been developed across the 17 test sites and how local contextual issues determined their development. It also describes how models are being integrated as part of Discharge to Assess (D2A) and common challenges such as why some services *'silt-up'* (Objective 2).

4:2 Typologies of specialist homeless intermediate care

As shown in Appendix 2, the OOHCM funding enabled plans for significant innovation and service development across D2A Pathways. Most test sites concentrated on developing a single service located on *either* Pathway 1 *or* Pathway 2. Potentially leaving gaps in provision. Fewer sites planned comprehensive models that aimed to integrate specialist care across the full range of D2A Pathways.

(Pathway 1)

Across Pathway 1, the main service development was the introduction of '*settle-in'* support. This is where teams of support workers offer floating (peripatetic) support to patients discharged to hotels and other temporary accommodation. The '*Hospital Discharge and Community Support Guidance' (*DHSC, 2022) states that anyone requiring formal care and support to help them recover following hospital discharge should receive an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles in their environment.

The specialist *'settle-in'* services developed as part of the OOHCM provide much additional support over and above basic welfare checks as they initiate the *'resettlement'* process. This involves liaising with housing authorities, organising benefits, setting-up the payment of bills and registration with a GP and other health services. Befriending is also important in terms of tackling social isolation and providing emotional support. In TS14, the HHIRT maintains oversight of the support plan and continues to act as case manager providing important back-up for the settle-in workers. In TS4 a team of specialist community nurses can be called upon to provide clinical support to people receiving settle-in support.

In TS5 and TS7 OOHCM funding was used to provide short-term support *plus* dispersed accommodation in the community. This included a small number of bungalows (provided through local housing associations) that were fully adapted and wheelchair accessible. In TS5, the local authority reablement team was commissioned to provide support into the adapted

accommodation. This was costed to enable up to four home visits a day thus enabling the service to address high levels of need. Reablement is a time-limited person-centred intervention that aims to restore self-care and daily living skills, and to support access to, or reconnection with, the local community and social and leisure activities. Support for 'physical reablement' and personal care (e.g. helping someone to wash and dress) requires services to be registered with the Care Quality Commission (CQC). In TS6, there had been issues with local authority reablement teams not wanting to work with patients who were homeless and who had drug and alcohol issues. Here, a specialist CQC registered reablement service was commissioned on a block contract basis to work alongside the *'settle in'* workers in the community and into the residential step-down services.

(Pathway 2)

Across Pathway 2, a range of residential (bed based) services were planned. These had the overall objective of offering short-term support in a safe environment avoiding the use of hotels and other unsuitable temporary accommodation:[35]

(i) In London, a *'pan London'* medical respite facility was commissioned centrally by DHSC (through the Healthy London Partnership) to offer 14 beds that were accessible to all the London HHIRTs. This facility was in a hospital environment and offered 24-hour clinical staffing on site. Currently, this is the only homeless 'medical respite' service in England. It is more expensive than other P2 services developed as beds are costed at palliative care rates, reflecting the ability to cater for end-of-life care and the most complex health conditions.

(ii) In TS1/TS6/TS9 step-down services were developed based on an independent living model. These services provided accommodation in ensuite rooms or studio flats on the same site. Independent living facilities differ from care homes in that they are staffed by support workers and are not CQC registered. The largest of these services offered 42 beds (with the OOHCM funding being used to increase the number of support workers able to support patients with move on and resettlement). This service worked mainly with older patients who had a housing issue (such as need for a 'deep clean' of their home following self-neglect).

(iii) In TS11 and TS12, residential 'step down' houses were delivered with a small number of beds (typically 3-5) usually with support workers on site during working hours.

(iv) In TS3 'step-down beds' were commissioned within a mainstream homeless hostel. Patients in these beds had a dedicated team of workers and received additional support to those in the mainstream hostel (such as provision of meals).

(Pathway 3)

No specialist Pathway 3 (care home) services were planned as part of the OOHCM Programme. However, commissioners in TS13 (positive practice site) put in place arrangements that ensured homeless patients could access non-specialist intermediate care services including nursing homes. Special arrangements were necessary in this test site (as elsewhere) to challenge the inequitable practices that often saw mainstream P2/P3 intermediate care services turning homeless patients away on the grounds that they did not have an address to discharge to. In TS13, it was agreed that the '*Homeless Intermediate Care Team'* (HICT)[36] would case manage homeless patients moving into non-specialist services, providing support to staff who had little experience of housing and homelessness issues. This integrated way of working ensured a complimentary and comprehensive approach that could address needs for *'physical/neurological rehabilitation'* in trauma informed ways, mindful of the interplay with mental health and/or drug and/or alcohol issues. The involvement of the specialist *'Homeless Intermediate Care Team'* (HICT) also gave intermediate care home managers the confidence to accept homeless patients, as they knew housing issues would be pro-actively addressed so were less likely to cause blockages.

[35] Typologies iii-iv sit on the boundaries of Pathway 1 and 2 as they cater for people who, if they were not homeless, could most likely be supported in their own homes through the provision of short-term reablement/resettlement support.

[36] As noted in the previous section, in TS13 a longstanding HIRT was redesigned as a *'Homeless Intermediate Care Team'* (comprising clinical staff and housing workers). Here the primary focus of the team was switched from *'hospital in-reach'* to assessing and case managing patients in the community.

(Comprehensive models)

As touched upon above, commissioners in TS13 (positive practice site) had a very clear strategic vision underpinning their approach to improving access to P3 services. Namely that they wanted to develop D2A as a *'single system'* that was accessible to *all adults* regardless of their housing status. We would identify this as '*mature'* integrated care commissioning.
In many of the other test sites, as we will explore further below, lack of integration with mainstream/non-specialist D2A services led to a siloed *'homeless pathway'.* This is arguably less effective because of difficulties securing access to the full range of intermediate care services (gaps). According to the audit carried out by the '*Healthy London Partnership'*,

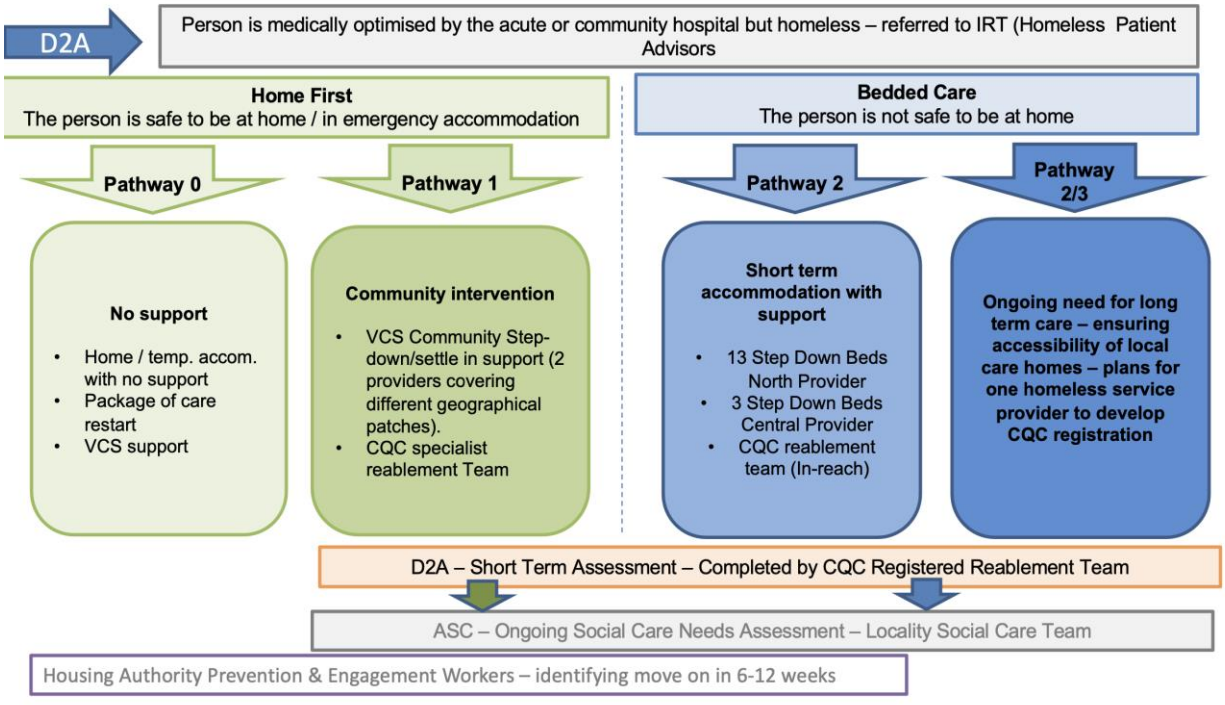
> '24% of patients were likely to be discharged to a destination unable to meet their needs… Most frequently, [this was linked to difficulties accessing] facilities that combine physical or neurological rehabilitation with substance misuse and /or mental health support' (Nguyen et al., 2022 p32)

Outside of London, an equally comprehensive and visionary model was planned for TS6 (positive practice site). This encompassed service developments across all D2A Pathways. See Box 4:1 and Figure 4:1 below.

Box 4:1 Positive Practice – Achieving Comprehensive Coverage Across All D2A Pathways

The out-of-hospital care model in TS6 encompassed hospital in-reach and support across Pathways 1 and 2. OOHCM funding was used to expand the HHIRT enabling it to work across two hospital sites (acute and mental health). Specialist intermediate care services included a '*settle-in'* (outreach) service in the community and three Pathway 2 residential 'step-down' units (including one fully accessible and one working mainly with people leaving the mental health hospital). Multiple providers were involved in delivering the model so services covered a wide geographical area (rather than a single town or city as was often the case in other test sites). As noted above, a specialist CQC registered reablement service was also commissioned (on a block contract basis) to work across all D2A pathways to support homeless patients leaving hospital who had drug and alcohol issues. This reablement team developed specialist expertise in addressing 'self-neglect' in relation to personal care. The provider of the accessible step-down facility was also working with commissioners to explore CQC registration to potentially offer a Pathway 3 level service in the future. The TS6 model is shown in Figure 4:1 below.

Figure 4:1 Comprehensive D2A Model in Test Site 6 (out-of-London)



In terms of the comprehensiveness of these models, there are important differences between TS13 and TS6. TS13 is a '*clinically led'* model and TS6 is *'housing- and care-led'*. In TS13 there was access to clinical case management across all D2A Pathways through the development of the *'Homeless Intermediate Care Team'* (HICT). In TS6 there was no specialist clinical support integrated into the model (the HHIRT was housing-led). However, there was access to the specialist CQC registered reablement team across the D2A pathways which was not available in TS13.

These two contrasting models illustrate how many different components can be factored into a *'single system'* for OOHC. Describing the early development of (generic) intermediate care in England, it was acknowledged that the range of possible combinations/schemes makes it very difficult to establish any strong link between scheme features and effectiveness (Kaambwa et al., 2008). This suggests that there is likely to be no single blueprint for an effective and cost effective OOHCM model, only important guiding principles such as those outlined in the LGA's *'High Impact Change Model'*.[37] We turn our attention now to what determines how models are configured locally.

4:3 Contextual factors impacting local configurations

As was the case with the HHIRTs, the size of the funding envelope largely determined what services were planned locally. A commonly expressed view by the test site managers / commissioners was that they were given insufficient time by the DHSC to plan their bids and to undertake any formal needs assessment or capacity and demand modelling.[38]

> 'My job as the lead commissioner was to work with existing healthcare partners and supported accommodation providers to try and pull together a bid… I was less of a commissioner and more of a bid writer... We put in a bid in a tearing hurry… We mobilised very, very quickly because that's the messaging that we were getting [from DHSC]. There wasn't enough of an opportunity I don't think for us to really think cautiously and carefully about what we were planning (Lead Commissioner 2).

Local contextual factors that determined how the bids were shaped included the availability of existing resources. For example, in TS8 there was a building that could be quickly repurposed as a Pathway 2 residential service, so the bid focussed on developing this. Also important were commissioners' views about local systems issues, including gap analyses. As noted above, in TS6 difficulties accessing mainstream reablement care packages led to the development of a new specialist CQC registered service. In another test site, the commissioner explained the rationale for the investment plan as follows,

> 'I think we've potentially got better relationships with adult social care and that's why we didn't invest [the OOHCM funding] in specific social work/reablement roles. We understood the gaps to be in other places within the system' (Lead Commissioner 1).

Another important factor in determining the focus of the bid, was the professional/disciplinary background and interests of the lead commissioner and/or commissioning group. In TS13, where a *'clinically led'* model was developed, the commissioning group was led by health commissioners. In TS6, where the model was '*housing and care-led'*, the commissioner's background was in housing related support and adult social care.

Some commissioners highlighted the difficulty of engaging the full range of commissioners across health, care and housing in bid development. For example, one commissioner with a

[37] The LGA's High Impact Change Model offers a practical approach to managing patient flow and hospital discharge. It identifies eight changes that will have the greatest impact on reducing delayed discharge including best practice in Home First D2A, link here.

[38] The HLA recognised the lack of capacity and demand modelling as an issue in their audit of London HIRTs. Scoping work was commissioned to quantify what is needed sub-regionally and regionally to address gaps in provision. Such is the complexity, this work was not completed before the HLP's OOHCM contract ended (2022 p42).

housing background commented that she could not get health commissioners to take an interest. However, another commissioner commented that in her experience *"There's nothing like a million pounds to get people round the table".*

In understanding the emergence of different local configurations of OOHC it is important to consider the impact of ***repeated*** injections of short-term funding. Such funding was perceived by some lead commissioners to limit what could be achieved locally.

> 'Well, I mean it was very short-term funding… So, there are drawbacks in that you can't look at anything particularly new or radical… It's going to have to be about bolstering existing provision… It was like Winter Pressure Funding… We thought it would be over by March" (Lead Commissioner 2)

This resulted in opportunism in some local systems to continue (and sometimes rebadge) existing services and roles where previous short-term funding was ending. In TS12 (positive practice site), OOHCM funding was used to continue posts established under a previous Trailblazer[39] Programme. The *'Embedded Mental Health Workers'* played an important role in the new OOHCM supporting some patients after they left the step-down houses. However, their inclusion in the model stretched the fidelity of intermediate care by offering long-term support in the community.

In TS4, in the interest of *'fairness'*, OOHCM funding was spread across a wide range of services locally. In this test site, it was some months into the delivery of the Programme before a test site manager was appointed and a meeting convened of all the different services and staff that had received OOHCM funding. Until this point, awareness of the OOHCM Programme and its objectives was reported to be low and the vision for an integrated D2A model not clearly articulated. At the first meeting that brought the different stakeholders together, there were two specialist social workers whose posts had been at risk and continued (at last minute) using the OOHCM funds. The two social workers reflected that until this meeting they had not known where their new funding had come from and, more worryingly, that they were not aware that they were now supposed to be dedicating most of their time to supporting homeless patients discharged from hospital.

In TS7, OOHCM funding was allocated to the Rough Sleepers Outreach Team to provide floating support to patients moving into dispersed step-down accommodation. No new staff were employed. Here, the test manager acknowledged that this was a pragmatic strategy for managing short-term injections of cash. The aim was not to waste too much time and effort setting-up new initiatives where there was perceived to be a low probability of continuation funding.

Overall, short-term funding was seen as something of a double-edge sword. On the one hand, it was associated with a certain weariness,

> 'A lot of people, even if they welcomed [the funding] thought "*it's only 12 months, I'm not going to engage too much because you'll be gone" …* Some of the people have been in the sector a long time and they've seen things like this before. They need convincing that it's worth any of their time' (Test Site Manager 1)

On the other hand, it could also lead to much excitement where the focus of the funding was perceived to align with local plans and priorities (see Box 4:2 below). Indeed, the more visionary models tended to stem from the passion and enthusiasm that came with this alignment and synergy of local and national objectives.

[39] The Trailblazer programme was launched by the Ministry of Housing, Communities and Local Government (MHCLG) in December 2016, with a budget of £20 million to establish a network of local authority areas across England to work with individuals and families to prevent homelessness. The funding was intended to support the enhancement of preventative services and, with appropriate local partners, develop innovative approaches to preventing homelessness.

Box 4:2 Positive Practice – Visionary models

In site TS6 (positive practice site) plans to implement a model of specialist out-of-hospital care were well underway prior to launch of the OOHCM Programme. The lead commissioner had worked in both adult social care and supported housing so had a clear vision about how D2A could work for homeless patients. TS6 had previously secured capital funding to convert a building into a fully accessible state-of-the-art Pathway 2 step-down facility. It had also identified another building that could be used for a second step-down house. The OOHCM funding was seen as *'heaven sent'* in allowing these plans to move forward at pace.

4:4 Mobilisation

The rate at which the test sites were able to mobilise their plans for specialist step-down intermediate care varied from area to area (see Appendix 2). Overall, mobilisation was much slower than anticipated. Many sites had large underspends at the end of the first year necessitating the extension of the Programme for a further 12 months.

There was an initial delay at the outset while test sites waited for the official confirmation of funding letters to come from the DHSC. Test sites reporting activity for all eight quarters mobilised before the official funding letters were received. However, most sites were reluctant to do this due the financial risks involved. The London test sites did not receive their official confirmation of funding letters from DHSC until a month after the out-of-London test sites were notified. As a result, most did not start reporting activity until the final quarter of the first year.

The main facilitators of rapid mobilisation were building on existing provision (rather than having to develop services from scratch) and finding a test site manager skilled in *'single system coordination.'* The main barriers to mobilisation were *'bricks and mortar'* issues and recruitment and retention. Allocating funding to *'Integrated Care Systems'* (ICSs) rather than to individual local authorities also led to slower mobilisation. We discuss each of these in turn.

4:4:1 Building on existing provision

Test sites mobilising quickly were usually where OOHCM funding was being used to expand or fill gaps in existing provision (see Box 4:3). Mobilisation was much slower in those test sites where key strategic and provider relationships needed to be built-up from scratch.

> *'*Colleagues in [name of town] have a pre-existing relationship with the hospital and their Community Nursing Team. There's the existing relationship there. Across the other [towns in the test site] it's been much more difficult because we were really starting from scratch in terms of those relationships… I suppose success is reflective of the maturity in the local systems' (Lead Commissioner 1)

Box 4:3 Positive Practice – Rapid mobilisation

TS6 reported activity for all eight quarters. Rapid mobilisation was enabled through long-standing and trusted purchaser-provider relationships. These collaborative relationships were highly relational. People had worked together for a long time and had shared values and understanding. There was a sense of the OOHCM Programme being a joint endeavour. Providers were invited to take part in governance meetings with the DHSC, to share-in success and to tackle challenging issues. As the Lead Commissioner explained,

'We were fortunate in that [when the OOHCM opportunity came along] we already had good relationships [with our providers] … We're all in it together and we're all here because we care, and we want to make a difference… I'm not hidden away somewhere just doing my own thing. I'm there with them as far as I possibly can... The providers were named in the bid, and they had submitted their costings to my procurement colleagues so we could directly award the contracts. There was a slight challenge `do we need to be doing out to tender?' and if I hadn't specifically named the providers - I think we would probably have been pushed down that tender route… The fact that we didn't have to go down the tender route - that's how we managed to get it up and running so quickly'.

No matter the degree of starting from scratch or building on existing arrangements, services always had to be thoughtfully organised around the local context. This was best exemplified by one test site, a county, which included two cities. City X started its service some months ahead of the second one, City Y. The commissioner's intention was to lift the model of service from X to build the service in Y, but they rapidly saw this wasn't possible because it was such a different environment to X, (e.g., in terms of relationships with the local hospital and access to housing – "just everything was different"). This underscores the evidence for there being no one, detailed blueprint for these services and of ensuring that integrated care commissioning [contracts, protocols, policies and procedures] support flexible practice, rather than being rigidly prescriptive.

4:4:2 The benefits of a skilled test site manager

Having a skilled test site manager was seen as key to rapid mobilisation and, indeed success more broadly.

> 'I think what we should have done was bid for a proper Project Lead rather than thinking that we could do it all between us [the commissioning team]. We underestimated how much time needed to be dedicated to this' (Lead Commissioner 13).

Finding a skilled test site manager was not easy and this delayed mobilisation in some sites. The role of the test site manager varied from area to area. In some areas, the role was limited to contract management (managing provider contracts and undertaking quarterly reporting to the DHSC). In other areas, the role was more developed. According to one Lead commissioner,

> 'Test site managers should be closely connected with frontline services - for real time intelligence scanning - have speedy access to senior colleagues in partner organisations to enable prompt improvements to help frontline staff and have access to system-wide groups who can help address boundary-crossing issues'.

In the positive practice sites and in some of the other sites, the test site manager role was developed to encompass many aspects of the '*single system coordinator'* role envisaged in the D2A guidance. In the guidance, it is envisaged that every local health and social care system will have a single system coordinator who acts on behalf of the system and patients to secure safe and timely discharge on the appropriate pathway for all individuals. This system leadership role can be employed by any partner in the system. Their primary function is to develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges (DHSC, 2022 p14). Where the test manager took on a 'single system coordinator' role instead of a more traditional project manager role, mature levels of integrated/single system working appeared to develop more quickly (See Box 4:4 and 4.5 overleaf).

Box 4:4 Positive Practice - Integration Mechanic

In TS13 the Lead Commissioner described the role of the test site manager as follows:

'We created the job title "***Head of System Co-ordination***" [for our test site manager]. That was our homeless brainwave! The role has been critical for the success of our model... [The person appointed] was very experienced in Urgent & Emergency Care and Discharge. She made the most of those connections and then started to look at things overall…

I don't think we've got a role like that anywhere else. We've got Directors of Integration who work in our boroughs around an integration agenda, but this is a much more hands on role. It's much more day by day. Where front line staff are struggling to get the support a patient needs - she's sort of fixing and connecting – escalating the issues upwards. She has dealt with some very complex escalations…

She has provided training for the Integrated Discharge Teams so that they really understand what the Homeless Intermediate Care Team (HICT) is doing. She has also made sure that the Homeless Intermediate Care Team (HICT) is developing relationships with the boroughs (the local housing authorities) because those are critical relationships in terms of us being able to safely 'hand off' that patient back into appropriate accommodation and care locally.

She also identifies where other pots of money are coming down and how we can support the extension of the modes [to boroughs that did not directly benefit from the OOHCM funding]. It is a sort of continuous process of building and connecting.

It feels to me that her role is like an **integration mechanic.** She is tuning the engine and connecting the parts. Sort of troubleshooting and bringing the whole thing together… It needs constant effort. People move on and so new things emerge.

TS3 – Here the Lead Commissioner/Test Site Manager role was combined:

'I was a Broker, so we'd come together, we'd talk about particular issues and then I would take the lead on taking those issues to the part of the system where those issues were… So I wasn't asking operational staff or project leads to kind of try and broker things at a strategic level…

We had a really significant barrier for a long time where Housing colleagues wouldn't prioritise people in step-down for access to supported accommodation which meant that our length of stay was much too long. I started negotiating with Housing colleagues, setting up meetings, pulling in support from senior leaders in other sectors to try and create very gentle pressure to shift the narrative which has finally worked. I did take two years, but we got there. My role was to try and facilitate conversations and create relationships and bring people together.'

TS12 – The Test Site Manager described his role as follows:

'I work with everyone across all the services. I don't feel particularly embedded in any of them and I sort of sit apart from them but act as a facilitator that opens-up communication… (Box 4:4 provides a case study illustrating how ***single system coordination*** worked to facilitate discharge in forensically complex case).

Box 4:5 Positive Practice – Single System Working in Action

John* was previously residing in supported accommodation (block of flats) due to long and enduring mental health issues. There was a fire at his property, putting John and other residents at risk of death. John was alleged to be the perpetrator of arson – police investigated but no charges were brought.

John's flat was severely damaged and uninhabitable. He was sectioned and admitted to Hospital. Forensics and other mental health professionals deemed that John was not suffering from an acute episode and was fit for discharge.

John's landlord served legal notice to vacate on grounds of probable arson. This put John at risk of homelessness. The Housing Officer from the HIRT advised medical professionals that John had a tenancy and that the landlord had to provide alternative accommodation (until tenancy ended in law). The landlord refused to accept John back due to perceived risk of arson. Complicating matters, the local Authority refused to pick up the homelessness duty to house on grounds of arson risk.

The Housing Officer obtained legal advice that demonstrated the local authority did have a duty to house. Conflict ensued between the hospital and local authority. The Test Site manager intervened and brokered a discussion between parties – it was agreed that if John could show that he could maintain a stay in the step-down house then the local authority would offer Temporary Accommodation.

Step-down accepted this referral, and the potential arson risk. John was supported by the step-down team – life skills, finances, social connections; Clinical Psychologist – mental health. He was also supported by the Health Home Treatment Team (HHTT) who took charge of medications management.

John did well in the step-down house – worked well with the team and was helpful with other guests. He seemed to grow in confidence and began to take his medication which had been a significant issue in the past.

On the basis of this good progress, the local authority identified a detached property (to minimise risk of fire to others) but insisted on John having a care package from adult social care before commencing the tenancy. Health brokerage had difficulty sourcing a care package (due to a lack of providers) and John became stuck in the step-down house. The Test Site manager intervened between parties and identified that the main concern of the local authority was that John would not be able to manage his medications. The test site manager brokered a solution - it was agreed that John could move into the property with HHTT support for meds with continued resettlement support from the Embedded Mental Health Workers.

"Step down flexed their boundaries (accepting risk); Health flexed their support (extending the length of time the HHTT could stay involved) leading to very positive outcome for someone who otherwise have remained in hospital indefinitely."
**Names and some details have been changed to protect anonymity.*

4:4:3 Integrated Care Systems (ICSs)

In most test sites, OOHCM funding was allocated to an individual local authority. In London and in one out-of-London test sites, OOHCM funding was allocated to the 'Integrated Care System' (ICS). ICSs covered much wider geographical footprints encompassing multiple local authority boroughs. Allocation to the ICSs led to slower mobilisation because of the necessity of building relationships with so many different partners. Only TS13 (positive practice site) achieved the objective of creating a *single* integrated care system for D2A across the whole geographical patch (see Box 4.3 and case study in Section 5). The main challenge here was the size of the funding envelope which meant that some boroughs benefited from the service developments more than others. This needed to be carefully managed to prevent conflict. In the other ICS areas, the money was allocated to groups of local authorities who then largely developed their own programmes of work. Effectively, creating multiple test sites within each ICS (see Appendix 2). For test site managers, managing multiple test sites was exceptionally challenging and they reported feeling spread very thinly. One commissioner reflected that in future it may have been better to have allocated the money directly to the boroughs and to cut out the *'middleman'.*

4:4:4 Bricks and mortar issues

Pathway 2 residential step-down services were particularly challenging to mobilise due to finding the right premises. Under pressure to mobilise quickly, many test sites compromised on the buildings they used, only to regret this later as the lack of disabled access proved problematic in terms of the ability to accommodate patients with mobility issues.

(Out-of-London context)

New or expanded P2 residential services were planned across seven of the twelve test sites (see Appendix 2). In TS8, it proved impossible to get the step-down up and running. A fully accessible building was available but there were issues around the transfer of the existing care workforce who had been delivering intermediate care to older people at the same site.

Use of existing hostel accommodation was also problematic as this was not usually conducive to convalescence and recovery, especially for people who had undergone a detox for alcohol or started on opioid replacement therapy while in hospital. In one test site, having separate staff and care arrangements for the step-down beds in a generic hostel caused problems between residents – residents in the main hostel could not understand why some people got what appeared to be '*better treatment'* (i.e. their meals cooked for them).

In TS9, spare capacity in a transitional mental health unit was used to quickly establish a Pathway 2 step-down service, without the need to source and adapt a new building. This provided high-quality (homely), self-contained accommodation and worked well, but there was always the threat hanging over the service that the step-down beds could be recalled for mental health use.

A homeless charity within TS6 (positive practice site) secured £96,000 grant funding[40] which was then match funded from charity reserves. This enabled a six-bed house that had been gifted to the charity to be refurbished into a fully accessible (award winning) step-down facility. This included stairlifts and wet rooms for every room. The OOHCM programme then provided funding for some of the running costs. Given the short timeframe of the OOHCM programme and the size of the funding envelope, it is important to note that this state-of-the-art development would not have been feasible had philanthropic funding not been in place.

In test sites that planned to offer dispersed step-down housing in the community (alongside a Pathway 1 reablement and/or floating service), finding the right accommodation was exceptionally challenging. As the lead commissioner explained in TS5,

> 'The Home First [reablement] offer worked in City A because they had the right accommodation provided through a social landlord. However, it did not work in City B because of the accommodation market… Private rentals were the only option here, and the reality is that ground floor, wheelchair accessible properties just aren't there… The

[40]Details about the funding source can be found here,

properties they ended up with in City B weren't suitable for patients needing (physical) reablement. We weren't able to modify the properties in the same way we could in City A because they were private landlords, and they didn't want their properties adapted' (Lead Commissioner).

TS7 piloting a similar model to TS5, aimed to provide eight properties (ideally ground floor fully accessible flats and bungalows) but too few properties became available quickly enough. By the end of Year 1, only four properties had been sourced. At this point the money for the Pathway 1 floating support service ran out so the scheme was suspended. The TS7 Pathway 1 service worked with a total of 11 patients meaning that it did not work as effectively as the other Pathway 1 services to support patient flow out-of-hospital. Across Pathway 1 (out-of-London) services, the average number of patients seen was 56 (Audit Data).

(London context)

In London, the '*Healthy London Partnership'* undertook a range of activities[41] over the lifetime of the Programme designed to explore ways of reducing the use of hotels and increasing capacity in Pathway 2 services. The main challenge was convincing health commissioners working in the Integrated Care Systems (ICSs) that residential step-down could be a viable model in London. The experience was that residential step-down services quickly became *'silted-up'* (blocked) due to a range of housing related issues that prevented people from *'moving on'*. An experienced housing consultant was appointed to engage housing authorities in the D2A agenda and to explore ways of overcoming the *'wicked issues'* that were identified. In many respects, the outcome of this work was to: *Identify the challenges that remain to systems and service delivery that require changes outside the direct control of organisations in the locality:*

- First, it was recognised that this was a critical time as all NHS metrics/targets were under review and that anticipated response times were now expected to be even faster (from 72 hours to 48 hours during Covid). While adult social care had received significant investment to speed up discharge through the *'Hospital Discharge Fund'*– concern remained that housing authorities had not received any financial support to speed-up their processes. Potentially, this could increase the use of hotel provision to get patients out of hospital while the necessary arrangements were being made.

- Second, there was an identified need for changes to housing and other legislation to ensure equitable access and timely flow through in 'step-down'. The issues were:

    - Where a patient has no local connection to any council borough - and they stay in a step-down facility - this can have financial implications for adult social care in the host borough should a long-term care package be required. As a result, step-down facilities sometimes limited access only to those with a local connection. This was not an effective use of step-down beds in terms of maximising capacity across the system.
    - How to arrange 'move on' for those who don't 'fit' any borough housing duty – no local connection, no ordinary residence.
    - How to arrange 'move on' for those who have no recourse to public funds but who have ongoing health, care and accommodation needs as they recover.

TS14 had recently commissioned a full feasibility study for a new step-down facility which did not proceed, due to local objections about what was seen as a *'homeless hostel'* in the vicinity. It was also the case that providers who owned buildings that might be used to house a new Pathway 2 service would not accept OOHCM funding because of past *"bad experiences"* with short-term funding not delivering sustainable services longer term.

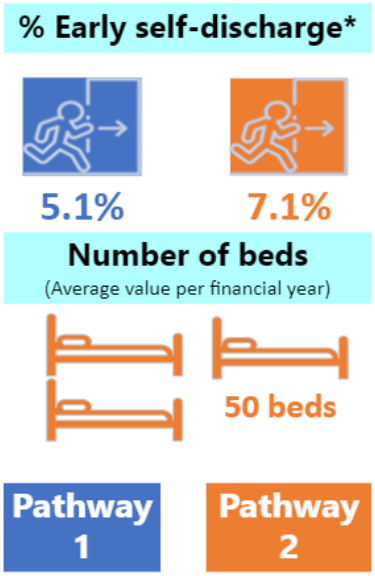
[41] Activities included: Regional learning groups for health and housing teams to come together and address local challenges and barriers to reduce discharge delays and prevent unsafe, inappropriate or unplanned discharges; Identifying gaps in access to housing expertise to advocate for more comprehensive access to housing advice for HIRTs; and shared learning and best practice (e.g., hosted a webinar on housing law, published podcasts, promoted no recourse to public funds webinars).

Only TS17 planned to develop new P2 step-down provision (three houses across three boroughs). Two out of the three proposed step-down houses became operational during the lifetime of the Programme offering 6 beds in total. Neither were suitable for people with mobility issues.

Across London this brought the total number of P2 beds to 40[42]. It is important to note that 35 step-down beds funded through the first hospital discharge were not sustained, so this represents a scaling-up of lost capacity (Gray, 2021).

Figure 4:2 below shows the total number of P2 beds funded across the 10 test sites (that had data) and also, waiting times between referral and assessment. The 9 days wait for a P2 service may indicate a lack of capacity in P2 services (we return to discuss this in the next Section).

Figure 4:2 Number of Beds and Waiting Times



→ Across the 17 test sites it was estimated that 130+ **Pathway 2** beds were being funded (of these full data sets* were held for 50 beds across 10 sites).

→ This number of beds is likely to represent insufficient capacity due to difficulties 'standing-up' **Pathway 2** services (e.g. in TS8 commissioners identified a need for P2 beds but were not able to open the service)

→ Longer waiting times to access a **Pathway 2** service (9 days)may also indicate a mismatch between capacity and demand with the potential for 'delayed discharge'. The wait time in generic P2 services is 1.5 days (NHSb, 2021).

4:4:5 Recruitment and retention

As was the case for the HHIRTs recruitment and retention was a significant barrier to mobilisation across most test sites. Use of agency workers to fill support workers roles was often key to rapid mobilisation.

> 'Key challenges were recruitment obviously, trying to find suitable people... We advertised a wellbeing support worker post as a temporary post, and we just didn't get any interest' (Lead Commissioner, 4).

In TS6 (positive practice site), it was the policy of the local provider organisation to offer permanent contracts to all staff despite the financial risks this posed to the organisation. However, even despite this progressive measure recruitment and retention remained challenging due to wider pressures in the labour market such as the availability of better paid alternatives. Skill shortages were also reported. Finding people with the right skills and could be difficult – but seeing how important this fit is to make the service run well, some localities delayed recruiting until they could find the right people. Recruitment challenges meant that many test sites did not fill all the posts they had planned to. Understaffing was commonplace.

[42] A consultancy report was commissioned by the GLA in 2021 to explore the potential for risk sharing arrangements for step down accommodation for homeless people on discharge from hospital. This identified 40 step-down beds in London (including the 14 medical respite beds) in 2021 (Gray, 2021).

> ‘When I first joined the service, it was meant to be a team of five of us. There was meant to be a manager, a co-ordinator, and three [project workers]. The Manager remains the same, the co-ordinator left. They didn’t recruit all the project workers. So now it's just the manager and me (Step-down Worker, FG2)

Short staffing coupled with the challenging nature of the work itself, led to stress and burnout. Key to staff retention was offering good quality training and supervision. Providers of services in the test sites varied as to the extent they offered this.

> ‘I’m building up amazing relationships with the clients and I adore the clients. They come to me when they’re feeling distressed - telling me about stuff that’s happened in their childhood. It’s hard not to take that home. I’ve heard some horrendous things… I was promised supervision and reflective practice once a month… I’ve received it twice in the last 18 months… I’ve experienced four client deaths… I was meant to get debriefs and that hasn’t happened yet either’ (P2 Support Worker Female FG2)

> ‘I think [support workers] want to help people and I think what is clear with our industry is that there can be a cost… That cost can be marginalised through good support… you need to relieve yourself from stress… When you don’t get good support and you feel like you’re not achieving something that’s a recipe for disaster’ (P2 Support Worker, Male, FG2)

Retention of staff was another challenge for sites, made worse by uncertainty about securing sustainable funding. Colleagues in sites were clear about the impact of losing frontline staff on sustaining relationships across services/organisations and, ultimately, the negative impact this had on the quality of services.

Box 4:6 Positive Practice – Clinical Supervision

In TS12 (positive practice site) a psychologist was employed who delivered support to both staff and patients. Front line staff were included in *‘away days’* and meetings that engendered a sense of ownership in the programme. In TS12, there was very little turnover of staff in the step-down houses for the duration of the whole Programme.

4:4:6 Impact of staff shortages

Across both Pathway 1 and Pathway 2 services, test site managers reported that services were under considerable pressure due to high volumes of work and/or too few skilled staff. In two test sites, Pathway 1 services were mobilised for a short time only to be suspend due to staffing issues.

The impact of understaffing in Pathway 1 (settle in) services was exacerbated in the London test sites as travel times appeared not have been fully factored into the original delivery plans. Where people left hospital in London, they could be placed in locations far away from the hospital. This caused *‘logistical nightmares’* for many support workers.

> ‘Because of the housing crisis in London, most of our clients are placed way out of Borough so we end up travelling miles and miles… especially with the rail and bus strikes…. That doesn’t stop people needing help… I’ve spent two hours getting to a client before because they’re high priority, they need to be seen and they’re nowhere near our hospital. I think that’s a big struggle, especially with not having enough staff members’ (Pathway 1 Support Worker FG3).

Interestingly, the average number of face-to-face contacts (per patient) was reported to be much lower for the Pathway 1 services in London as compared to those services out-of-London (0.36 versus 19). This most likely reflects how practices established during the Covid-19 pandemic (such as the use of telephone contacts) may have continued as a way of managing demand in the face to staffing shortages and logistical challenges. As shown in Figure 4:3 below, caseloads are almost double for Pathway 1 services in London as compared to out-of-London (17 versus 10).

Staffing issues coupled with logistical challenges could often be seen (in the qualitative interviews) to impact on patient care. Frank was discharged to temporary accommodation that was a 50-minute bus journey from the hospital. The accommodation was a room with ensuite bathroom in a house of multiple occupation. It was nicely decorated but had no kettle or cooking facilities. There was no *wi-fi* or television, no towels or bedding and the mattress although new was of such cheap quality it was unusable. Frank needed help with a range of practical tasks such as organising a new bank account and applying for a Personal Independence Payment (PIP). He also reported that he was not regularly attending his weekly hospital appointments for kidney dialysis. He was also dressing a leg ulcer himself using cello tape and toilet roll. Frank was visited by a clinical case manager and a support worker shortly after discharge and reported being promised *"the world".* Six weeks later Frank reported having received no support. The case manager had left to take up a new job and the support worker had been off sick. Frank was still not attending his dialysis appointments and was still dressing his own legs with toilet roll. He was readmitted to hospital soon after being discharged from step-down.

Frank's case is a good example of where the Home First philosophy underpinning D2A may not always be appropriate in this context. Underpinning D2A is the idea that discharge on Pathway 1 (Home First) should be seen as the default pathway (DHSC, 2022). However, in this study, patients who were discharged on Pathway 1 were often sent to unsuitable temporary accommodation that was unlikely to support their recovery.

There is a case to be made then, that where there are housing and homeless issues, discharge on Pathway 2 to a ('*housing-led*') step-down house (such as that developed in TS12 and TS11) might be better considered as the default pathway. Such services usually offer the warm homely environment that is supportive of recovery, and in the current staffing crises, more consistent and economical support. Because workers are on site and are not having to spend the bulk of their time travelling, they can focus much more time providing direct support work. Social isolation for patients may also be lessened where workers are on site. In the TS11 step-down house, a worker was employed to cook for residents a few days a week. The aroma of home-cooked food and the love and kindness she showed to the residents created a sense of homeliness that was much appreciated by residents. We shall return to discuss this issue further in Section 6 in relation to service users' preferences for OOHC.

Figure 4:3 Staffing and Case Load

→ Average case load for **Pathway 1** services was 10 (out-of-London) and 17 (London)

→ Average case load for **Pathway 2** services was 6 (out-of-London) and 5 (in London)

→ Qualitative evidence points to the potential for increasing staff numbers across **Pathway** 1 services to improve quality and patient experience.

4:5 Integration and single system working

4:5:1 Access to assessment

At the heart of D2A is the belief that people should leave hospital as soon as they are medically optimised, and that assessments and decisions about future long-term care and support are made out-of-hospital and after a period of recovery. In the earlier D2A guidance, the assessment process was not set out. However, later guidance suggests that a *'rehabilitation assessment'* should sit at the heart of step-down intermediate care (NHSE, 2023). This involves

a holistic review of a person's needs and should identify the interventions needed to support them to recover and retain function. It should include a cognitive and psychological screening, a medication review and a review of physical functionality and communication needs. It should also consider,

> 'The home environment and issues relating to homelessness/risk of homelessness, including referral of people who are homeless or at risk of homelessness to a local housing authority' (p6).

It is recommended that assessment for longer-term/ongoing needs should be anticipated early in the pathway and fully completed towards the end of the intermediate care period. This may include assessment under the CA, 2014[43] or an NHS Continuing Health Care Assessment.[44] Where there is moderate to severe frailty a geriatric assessment[45] should also be considered.

Finally, in terms of who should lead the assessment, it is stipulated that the process should maximise the use of skilled support workers and other staff and volunteers with direction, advice and oversight from registered therapists - that the assessment process should be *'therapy led'.*

(Health and physical rehabilitation assessments)
Given that homeless patients have higher incidences of long-term conditions and are at risk of premature death from avoidable conditions (Aldridge, 2019) we would expect a comprehensive health assessment to be central to the delivery of specialist step-down care. As a result, the OOHCM audit asked test sites to report on the number of *'health assessments'* carried out (per patient) in hospital and in the community. This was broadly defined to include *'nursing, OT/physiotherapy (physical rehabilitation) and mental health assessments'.* Audit data for all 21 sites found that,

- 3/18 HIRTS reported that every patient received one or more health assessments.
- 3/8 Pathway 1 services reported that every patient received one or more health assessments.
- 2/6 Pathway 2 services reported that every patient received one or more health assessments.
- 2/2 (clinically led) Intermediate Care Teams (ICTs) reported that every patient received one or more health assessments.

These figures suggest that health assessment is not as central to the D2A process as might have been anticipated or hoped. Across most step-down services it appears that patients do not routinely receive a health assessment.[46]

A report by Healthwatch England (2020) on the early implementation of D2A found that 82% of patients leaving hospital did not receive a follow-up visit or an assessment, suggesting this may be indicative of a much wider problem.

> 'I didn't get much support from stepdown with regards to my cancer but that was probably too 'medical' for them. They were there to support me with my housing'. (Service User, 3)

In the qualitative interviews, test site managers and practitioners reported many challenges in accessing a range of professionals to deliver assessments. Access to occupational therapists

[43] Accessible here.
[44] Accessible here.
[45] Accessible here.
[46] Because '*health assessment'* was defined broadly in the OOHCM audit, the number of geriatric or NHS continuing care assessments undertaken in hospital and step-down is not clear. In TS13 (positive practice site) the hospital employed a consultant to undertake a comprehensive assessment (based on the geriatric assessment format) for their homeless and inclusion health patients. This post was not funded through the OOHCM.

and physiotherapists was said to be difficult in most sites. NHSE (2023) reports that a major barrier to delivering all types of step-down intermediate care is the lack of timely access to high-quality rehabilitation in the community, and that this is largely driven by therapy workforce challenges (p3).

> [One patient] was a new amputee from the pelvis down. We heard nothing [from the occupational therapy team] for weeks… We were ringing them up, chasing them up. Luckily, he's had the OT come out now but he's still waiting for a wheelchair assessment' (P2 Practitioner, FG2).

Most sites also reported significant problems in drawing in mental health expertise. According to one test site manager, this could sometimes lead to *'unmanageable levels of risk'* in step-down services.

> 'If I put a referral [into mental health services] and mention that [the patient takes substances] they don't want to know… That leaves me trying to deal with people going through psychosis. We haven't got that support from wider services and that's a big burden on me… I've got one client who became very aggressive towards me… He's been discharged from step-down now - but I've got to carry a personal safety device and have had to change my route home because of the threats he has made… You've got to be wary because his mental health is rubbish and at the moment, he hasn't got any support.' (P2 Frontline Practitioner FG2)

As part of the audit, data was collected on the percentage of patients accessing Accident and Emergency and having a non-elective admission to hospital while they were staying in step-down. This revealed wide variations across test sites suggesting some sites may be more challenged than others when it comes to accessing primary care and other health services. The numbers accessing planned (non-elective) care also varied between sites (see Table 4:1 and 4:2).

Table 4:1 Hospital Use while in Step-down Intermediate Care (Pathway 1)

(% of patients)	**Best Performing Test Site**	**Worse Performing Test Site**
Using Accident and Emergency while in step-down *National Average* 11%*	2%	64%
Accessing unplanned health care (non-elective admission to hospital) while in step-down. *National Average* 6%*	2%	46%
Accessing planned health care (elective admission to hospital) while in step-down *National Average*3%*	20%	0%

Table 4:2 Hospital Use while in Step-down Intermediate Care (Pathway 2)

(% of patients)	**Best Performing Test Site**	**Worse Performing Test Site**
Accessing unplanned health care (non-elective admission to hospital) while in step-down *National Average* 24%*	4%	53%
Using Accident and Emergency while in step-down *National Average*21%*	0%	53%
Accessing planned health care (elective admission to hospital) while in step-down *National Average& 7%*	23%	0%

**Audit Tables for 21 sites*

(Care Act (CA), 2014 assessment)
CA 2014 assessments should be carried out where there is an *appearance* of a need for care and support. The audit carried out by the *'Healthy London Partnership*' reported that only 1 homeless patient from a cohort of 104 needed '*just'* accommodation at the point of discharge from hospital (Nguyen et al., 2022). This suggests that most homeless patients leaving hospital will require a CA assessment in step-down. CA assessment covers a wide range of issues such as people's ability to meet outcomes linked to maintaining a habitable home environment and/or engage in activities such as education, training and employment (issues that have traditionally fallen under the remit if housing related support services). Indeed, a key conclusion of the earlier NIHR research was that given the morbidity and mortality profile of the homeless patient cohort, any benefits of an intermediate care stay would likely evaporate if they were not embedded as part of a fully integrated system that encompasses good access to longer-term support (Cornes et al, 2021).

Across the lifetime of the OOHCM Programme, 13% of patients receiving a Pathway 1 service received a CA assessment. On Pathway 2 the figure was 40%. Allowing for reablement and recovery (improved patient outcomes by the end of the IC episode) these figures suggest significant barriers to accessing CA assessment especially across Pathway 1 services.

The main barrier reported was difficulties engaging adult social care in the homelessness out of hospital pathways. In one test site, it was reported that P2 patients were waiting six months on average for a CA assessment. Poor legal literacy amongst key staff was also a problem in many sites hindering integrating care. Often the assumption by staff was that a CA assessment was only for patients needing help with washing and dressing (personal care) and/or very high levels of need so many patients with other needs for care and support or those in Pathway 1 where needs would be generally lower than in Pathway 2 were not being referred to adult social care.

In TS6 (positive practice site) a *'trusted assessment'*[47] scheme between services and organisations was introduced to overcome some of these barriers (see Box 4.7 below).

Box 4:7 Positive Practice – Trusted Assessment

In TS6 (positive practice site), the local authority had implemented arrangements for trusted assessment whereby the step-down service provider (a homeless charity) could request access to the specialist reablement/domiciliary care team without having to request a social worker to visit. This reduced pressure on adult social care and made for more timely discharges from hospital. As the Lead Commissioner explained,

'We have a Trusted Assessor's approach so that the [step-down provider] can assess individual needs and make a referral to the specialist reablement team to come in. They can do that assessment and actually put that care in place so it's not having to come to a social worker… We trust each other and I know that they wouldn't be saying the person needs care if the person doesn't need care… It's that kind of breaking down those silos within the system with regard to everybody being able to work together.'

The OOHCM audit (for all 21 sites) also showed wide variations between test sites in the percentages of patients accessing a CA assessment (i.e. a post code lottery). For example, across out-of-London Pathway 2 services, 47% of patients in TS1 received a CA assessment whereas in TS11 the figure was reported to be 0%. TS1 had the highest percentage of patients receiving a CA assessment of all the test sites and was an 'in-house' step-down provision run directly by the local authority.

There were also wide variations between the percentages of patients receiving a CA assessment in London, as compared to out-of-London. The percentage of patients accessing a CA assessment in Pathway 1 London services was 2% (only 1 service reporting), while out of London the figure was 28% (7 services reporting). In P2, the figure was 2% (one service reporting) while out-of-London 35% (6 services reporting).

[47] Trusted assessment is one of the LGA's High Impact Changes (accessible here).

In the London test sites, most CA assessments were still being carried out in hospital. The London HIRTs reporting that 4% patients received a CA assessment (8 services reporting). Practitioners in the HIRTs suggested that this was positive practice due to the difficulties of following-up homeless patients after they had left hospital. In other areas, it was suggested that the D2A policy had not really taken off and it was not just homeless patients who were still being assessed inside hospital.

> 'I don't think D2A has really taken off in [the acute hospital] … I think people are still assessed by the social work team on the ward… From what I've seen, the hospitals are barely coping and the idea of a big policy change at this time [may be unrealistic]? It maybe hasn't been pushed enough' (Test Site Manager 1).

In some sites, the lack of access to assessment and poor engagement on part of external agencies led to *'warehousing'* where people felt stuck in step-down facilities because they did not have any active rehabilitation or reablement plans. Here, some patients described feeling as if they were *'vegetating'.*

Figure 4:4 Percentage of Care Act Assessments

- → Likely to indicate significant barriers to accessing CA assessment, especially in **Pathway 1** services.
- → Post code lottery in evidence with wide variations across test sites in terms of the percentage number of patients accessing assessment.
- → In London most CA assessments still being carried out in hospital (4% of HIRT patient receiving a CA assessment)
- → 40% of Pathway 2 patients receiving a CA assessment many indicate some success on the part of the OOHCM in raising awareness of this issue. In Year 1, 24% of patients received a CA assessment, in Year 2 the figure was 42% [based on audit data for sites out-of-London].

4:5:2 Specialist and non-specialist services working in parallel

While many test sites reported significant challenges in drawing-in the expertise and support of ***non-specialist*** professionals and agencies, this gap was often filled by enhancing the support available through the wider homeless and inclusion health ecosystem.

Many test sites for example, used OOHCM funding to *'buy-in'* the expertise of ***specialist*** GPs and community nurses who were already employed in local homeless and inclusion health **primary care services.** This commissioning arrangement was perceived to have advantages over and above relying on continuity of care by the HIRTs who were generally too overstretched to provide much in the way of support post discharge. One lead commissioner reflected on the multiple benefits of this arrangement as follows,

> 'It's been really positive having the nurses visit [from the local inclusion health primary care service]. It gives the step-down housing support workers a professional net of support which makes them feel able to manage the level of risk that they're being asked to manage…. The nurses have also gained an enhanced level of respect for the housing workers and the housing workers feel heard and *'held'* in a way that they haven't done before' (Lead Commissioner 2)

This commissioner recognised however, that although the nursing component of the local OOHCM model was strengthened, there were still gaps:

> ‘The challenge now is to replicate that with mental health service provision and with social work provision - that’s a big one! Then you’d see much better outcomes for individuals because you’d have an MDT [multi-disciplinary team]. You’d have that real wraparound support, recognising the person as a whole person’ (Lead Commissioner 2).

Through the OOHCM funding, several test sites achieved the vision of having a fuller multi-disciplinary team wrapped around their step-down provision. In TS12 (positive practice site) the step-down houses had access to a specialist multi-disciplinary team comprising two social workers, an occupational therapist, a clinical psychologist and eight floating support workers. Although not called an intermediate care team, the MDT supported many D2A functions such as rapid access to assessment for those in the step-down houses. The specialist social workers in the team had direct links into adult social care which was reported to increase access to CA assessment. This MDT did, however, have expertise on working with patients leaving mental health hospitals. It did not have direct clinical nursing or GP input, though links were being forged with a local specialist homeless and inclusion health primary care practice. Interestingly this test site reported very low numbers of ‘health assessments’ reflecting how team composition may have impact on access to assessment and the outcomes being achieved.

TS9’s step-down beds also had access to a specialist *‘nurse-led’* multi-disciplinary team comprising nursing, social work and a range of support staff roles. Here, there were well-developed links into the much wider homeless and inclusion health ecosystem. Every patient was reported to receive one or more health assessments. Appendix 3 illustrates how the team worked together to deliver the comprehensive (rehabilitation) multi-disciplinary assessment envisaged in the D2A guidance:

- The multi-disciplinary team works together to identify needs across health, housing and social care, agrees a set of shared goals, then regularly monitors and reviews these (e.g., the support workers support the patient to address her health goals around healthy eating (malnutrition) by taking her shopping).
- The nurse acts as case manager (e.g., where a mental health assessment is carried out by an external agency, then the findings are integrated into the overarching plan creating a **single assessment process).**
- Assessment is seen as a longitudinal process (rather than a one-off event). It allows time for trust and rapport building and for the observation of executive capacity and activities of daily living in a homely environment (not a hospital ward).
- It allows patients to have some ‘breathing space’ and time to recover after illness and time on the street. CA assessment of needs for longer-term care and support takes place once the patient has reached their optimal recovery. The social worker employed by the team will have a good understanding of what support is needed and eligibility before approaching the local authority panel.

Indeed, Appendix 3 brings into sharp focus the recommendation that assessments should be *‘therapy led’* in intermediate care. Here, an inclusion health *‘nurse-led’* assessment appears fully justified given that the reablement or rehabilitation need is linked to the complex interplay between a complex long-term medical skin condition (Systemic Lupus Erythematosus) mental health (trauma/homelessness) and substance use. In the past, intermediate care has been criticised for taking a too narrow a focus on ‘physical rehabilitation’ (Pearson et al., 2015).

In summary, while specialist homeless OOHC services are generally well integrated as part of the local homeless and inclusion health ecosystem, they appear to be much less so with the wider mainstream D2A and longer-term care and support services.

> ‘Having a specialist team works really well. We’ve achieved some very positive outcomes with some individuals who’d been around the city a long time and you know nothing else had worked… However, we don’t really fit in with the mainstream. We were thinking that if we were more part of mainstream then we could get more support for our patients… That’s the challenge we’re on at the moment’ (Test Site Manager 5).

4:5:3 Silting-up (length of stay and service ethos)

In the D2A guidance, it is expected that step-down intermediate care will last for no longer than 6 weeks (42 days) and should ideally be provided for around 1-2 weeks. For settle-in support the timeframe can be as short as 72-hours (DHSC 2022). Earlier guidance stipulated that the goal of short-term reablement care is to help people return to the quality of life they had prior to their most recent hospital admission (DHSC, 2021).

The average length of stay in Pathway 1 services was 71 days and in Pathway 2 services 87 (National Dashboard). On Pathway 1, TS9 had the shortest length of stay at 29 days (with 28% of patients staying longer than 6 weeks) and TS7 the longest at 219 days (with 100% of patients staying longer than 6 weeks). On Pathway 2, TS12 has the shortest length of stay at 29 days (with 16% of patients staying longer than six weeks) and TS6 the longest at 163 days (with 100% of patients staying longer than six weeks).

In accounting for the differences in length of stay, the extent to which the test sites had aligned their model to the D2A policy guidance was significant. The step-down houses in TS12 (positive practice site) had the shortest length of stay of the Pathway 2 residential services (29 days). Here, the service ethos was very closely aligned with the D2A/intermediate care guidance. Supporting *'patient flow'* through the hospital was seen as one of the main goals of the service. The service was clearly communicated to staff and external stakeholders as a short-term emergency placement that saved hospital bed days by bridging the gap until the patient could be '*connected-in'* with mainstream housing and homelessness services. The manager of the service worked closely with the acute hospital often having weekly if not daily contact with the transfer of care hub manager. Planning for moving on from step-down commenced in hospital. Staff in step-down then worked tirelessly to action these plans and meet the target which was 14 days. There was strong oversight from the service manager and the test site manager who closely monitored length of stay, using escalation procedures to address any delays in the step-down beds. Asked to explain why TS12 had one of the shortest lengths of stay, the Test Site Manager explained,

> 'We do have very significant housing shortages… However, I would say [we meet our targets for length of stay] by being pragmatic - by not holding out for the perfect option is one thing. That doesn't mean discharging 'willy-nilly'. We've had 90 people through in a year or thereabouts, but only one discharged to rough sleeping and that was a self-discharge (they just walked out). We haven't had anyone else rough sleeping in that time, but we have made use of all options that are available whether that's going back to your family, whether that's temporary accommodation, whether that's supported housing. We've had a good record of getting people into supported housing where they need it, we've also looked at private rented. I would say having the Housing Options Officers, we've now got two of them in the [hospital in-reach team (HIRT)]. They are involved from day one on the wards identifying who's going to have housing issues and then considering what are their options… It's that kind of MDT approach has made it possible'. (Test Site Manager)

In test sites with longer lengths of stay, there was often a different service ethos that aligned more closely with traditional supported housing models. Indeed, D2A and intermediate care were new concepts to many stakeholders who had a primarily housing and homelessness background. In the newer step-down services, resettlement (including the achievement of independent living goals) and broader health improvement (including recovery from drug and alcohol use) were all seen as desired outcomes. The primary focus was not seen as *"assessment*". Indeed, staff described the fast paced nature of the work and the challenges that came in trying to achieve supported housing goals over such a short space of time. The usual time frame for a stay in supported housing is around two years. As the Test Site manager in TS9 explained,

> 'I think when we started this project there was this discussion that people would stay for two weeks. It was completely unrealistic. Many people stay here for six months and in those six months we really invest and really work with them to sustain their behaviour

> change…. We also don't want to set them up to fail. Because we've done all this work with these individuals, we don't want to put them back into [unsuitable] temporary accommodation…. So that's caused a problem with flow….' (Test Site Manager).

In TS9, the practice of keeping hold of patients contributed to the service *'silting-up'.* In Year 2 of the Programme, only 4 referrals were accepted (across 9 beds). In TS12, 72 patients were accepted (across 5 beds).[48] Longer lengths of stay also increased the costs per user. Yearly service delivery costs per user for TS12 were £2K compared to £9K for TS9 (in 2022/23).

The tension between managing patient flow and improving patient outcomes has long been recognised more generally in the hospital discharge literature (Glasby, 2003). In TS9, with longer lengths of stay, 89% of Pathway 2 patients had a better or unchanged QALY, whereas in TS12 the figure was 61% (still better than the national average 58%).

In many test sites the justification for longer lengths of stay was also linked to the complexity of homelessness. Practitioners pointed out that in addition to multi-morbidity and frailty, trauma (such as adverse childhood experiences) can lead to self-neglect and mistrust of services. Because of this, it was often argued that extended timeframes were necessary to enable the *'slow burn'* relationship and rapport building that is needed before any kind of assessment and case management can commence.

> 'I know that word is overused but [my patients] are so complex, it's the tri morbidities, it's their approach, it's their social network, it's the mood, it's just the devastation, trauma and it takes a little while to build up relationships' (Team Leader FG 3).

Discharges from mental health hospitals were also thought to warrant longer lengths of stay (which may reflect why they are not covered by the D2A operating model) and a much broader definition of rehabilitation. In TS12 (positive practice site), one of the new step-down houses focussed primarily on discharges from mental health wards.[49] The target length of stay here was 8 weeks (compared to 14 days in the other step-down house). As part of the model, a clinical psychologist supported the staff and patients in the step-down house and a team of *'Embedded Mental Health Workers'*[50] provided a further period of step-down in the community to ensure timely discharge from the step-down house.[51] This follow-on support was not time limited.

> 'I think if you've been on the mental health ward for years it can take a bit longer [before patients are ready to leave step-down]. It's not like coming from the [acute hospital] with a physical need and you just need to catch your breath while your home's been changed to make it possible for you to live there for example. It may be that you haven't had a bank account in years, or you haven't got a mobile phone and you've got no confidence... I see [step-down staff] supporting people into employment. We've had a great couple of results of recently but that's taken a bit of time (Test Site Manager).

4:5:4 Substituting for the lack of housing and mainstream services

Across the test sites, exceeding the recommended guidelines for length of stay was also symptomatic of a shortage of housing and longer-term care and support. Indeed, it is important to identify where delays in a system are systemic and not amendable to standard patient flow and escalation measures.[52] TS6 (positive practice site) had the longest length of stay for Pathway 2 services and second longest for Pathway 1. In TS6, the commissioner explained that

[48] The TS9 Pathway 1 service had the shortest length of stay (29 days). This service was a generic homeless hostel with a small number of health funded beds (pods). These had been commissioned prior to the OOHCM Programme. These were viewed as emergency accommodation rather than step-down and it was clearly stipulated by the local housing authority that the length of stay could not exceed 14 days. Through the OOHCM Programme, clinical support and case management began to be provided into these beds, moving them closer to a step-down model.

[49] This was something of a pragmatic decision as the house did not have disabled access.

[50] As noted earlier, this team was funded through the OOHCM so formed part of their model of Out-of-Hospital Care.

[51] See Section 5 for a full economic evaluation of this model.

[52] Standard patient flow and escalation measures are outlined in the LGA's High Impact Change Models. This encompasses mechanisms such as early discharge planning and trusted assessment, see here.

the challenges she faced required changes outside the direct control of organisations in the locality.

> 'The Housing Officers can't magic accommodation, it doesn't mean that there's necessarily housing there just because you've got a Housing Officer…We are now in a perfect storm… Covid hit and lots of people decided that they wanted to leave the city and move somewhere [rural/coastal]. So, we had people suddenly jamming up the private rented sector. That meant that all the supported accommodation providers couldn't access the private rented sector. Then we had people moving, just buying houses that meant that our average cost of housing in the last year has gone up by £100,000… Also, the rents have literally doubled and trebled, so it's like trying to find a needle in haystack to find somewhere that would be covered by Housing Benefit. [D2A] was working, we were doing [the six weeks] and now we are in an impossible situation because the flow has gone.' (Lead Commissioner, FG)

In TS6, difficulties discharging patients meant step-down was effectively substituting for long-term housing, care and support.

> 'The biggest problem for us is instead of it being a six-week service, it is now a six and a half month service... I mean it's wonderful because [reablement] has been in for the entire time for those people but if we can't move them onto their own accommodation and they're still in a room in the upstairs of a pub… It's not a home is it… it's a terribly long time.' (Service Manager, FG)

Many other commissioners and test site managers echoed very similar views about the challenges of trying to deliver intermediate care in the current economic and housing climate. The situation in London was thought to be particularly acute.

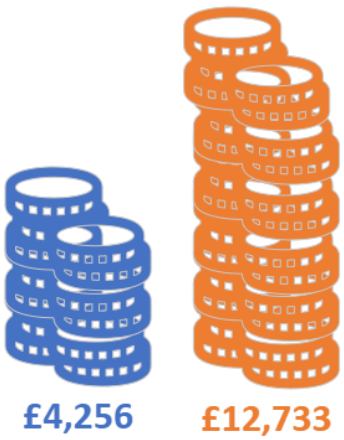
Figure 4:5 Length of stay and cost per person accepted

→ Length of stay across both **Pathway 1** and **Pathway 2** services are in well in excess of the national target which stipulates step-down intermediate care just last no longer than 42 days.

→ Variations in length of stay across the test site reflects differences in service ethos (how far services align with D2A/IC principles) and also the availability of housing and long-term care and support.

→ Lack of housing and long-term care and support lead to silting-up and increases costs per person accepted.

Cost per person accepted

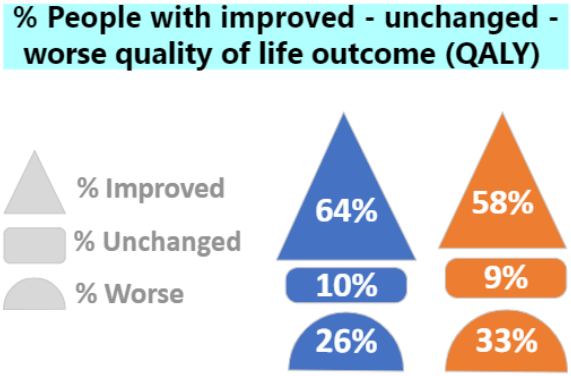


- → Costs per person accepted are very high compared to costs for generic/non-specialist services. Generic P1 costs £830 per person and P2 costs £6,648 (NHSB, 2021),
- → This difference is most likely linked to the long lengths of stay in specialist step-down services.
- → The higher costs are also potentially linked to the funding of the wider homeless and inclusion health ecosystem (i.e. funding for inclusion health GPs and community nurses who substitute for mainstream primary care).
- → Primary care costs for GPs and mainstream community nurses would not usually be attached to intermediate care budgets.
- → We discuss issues of cost-effectiveness of services in the next section.

4:6 Evidence of effectiveness

Step-down improved outcomes for most patients and led to very positive experiences of care and support. Very few people slept rough after leaving step-down. Overall, these findings add to the growing body of evidence about the importance of commissioning specialist out-of-care for people experiencing homelessness.

Figure 4:6 Health status (quality of life outcome, QALY) and % sleeping rough after discharge



→ By the end of the Programme, P1 step-down services had worked with a total of 1,364 patients and P2 services with a total of 580.

→ 10 test sites collected EQ-5D outcomes data. Services in these sites worked with 569 P1 patients and 338 P2 patients.

→ **The results show that step-down intermediate care improves quality of life outcomes for <u>most</u> patients.**

→ The figures reported here (4-5% rough sleeping after discharge) represent a significant positive shift from the reported 70% of homeless patients being discharged to the street as was the case before the first hospital discharge fund.

→ Delving into the wider audit data[1] it is also possible to quantify the reductions in rough sleeping which are substantial:

→ Across Pathway 1 - 320 patients were sleeping rough on admission to hospital. At the point of discharge from step-down, 37 returned to rough sleeping.

→ Across Pathway 2 - 143 patients were sleeping rough on admission to hospital. At the point of discharge from step-down, 20 returned to rough sleeping.

4:7 Summary

In Section 1 (Figure 1:1) we presented the first '*National Dashboard for Specialist Step-down Intermediate Care'* (2021-23). This shows that by the end of the Programme, step-down services were **improving** quality of life outcomes (QALYs) for most patients and reducing rough sleeping. Despite positive results across the Programme as a whole, there were wide variations in the performance of individual test sites. This section has provided an insight into this variable performance and how this 'baseline' position was arrived at - outlining the barriers and facilitators to mobilisation and effective service delivery. It has also explored progress to implement specialist step-down intermediate care as part of the D2A post-covid hospital discharge operating arrangements (Objectives 1 and 2) and has identified some of the challenges to systems and service delivery that require changes outside the direct control of organisations in the locality (Objective 4).

(How important was the funding in shifting to this position?)

The short-term funding that came with the Programme was perceived as a *'double-edge'* sword. Some sites used it conservatively to *rebadge* existing services and posts and to create as least *disruption* to the system as possible. Others used it to drive forward transformative change that was in the spirit of the new D2A operating model. The more ambitious and comprehensive 'high fidelity' models were implemented where there was close alignment between the objectives of the OOHCM Programme and local plans and priorities (that were already in train).

(Speed of mobilisation)
Across the test sites mobilisation was slower than anticipated. With the benefit of hindsight, the initial 15-month time frame for the Programme was not realistic. Many test sites did not become fully operational during this time.[53] Sites that were starting to build services from scratch were the slowest to mobilise. In some areas, engaging the full range of partner organisations was reported to be challenging. Continuing the improvement support (provided by the LGA) into the second year of the Programme and offering more targeted support to sites with less mature integrated care commissioning arrangements may have expediated progress.

Other barriers to mobilisation were:

- Recruitment and retention issues – services often had to rely on agency workers to mobilise.
- Bricks and mortar issues – leading to difficulties in *'standing-up'* enough accessible Pathway 2 services to reduce reliance on hotels and other unsuitable accommodation.

Both these barriers can be identified as *'challenges to systems and service delivery that require changes outside the direct control of organisations in the locality'* (DHSC, 2020).

- Where innovative approaches to addressing workforce challenges were tried and tested locally (such as offering permanent rather than short-term contracts) they were not successful in some local contexts.
- Housing shortages are acute nationally. To mobilise Pathway 2 services, many test sites relied on using sub-optimal properties that did not lend themselves to adaptation for use by people with disabilities. The fully accessible step-down house in TS6 was the '*jewel in the crown'* and was only made possible through philanthropic giving.

At the end of the OOHCM Programme, budget utilisation stood at 65%, equivalent to £15.89 million out of the allocated £24.44 million across the lifespan of the programme (2021-23). In large part, the underspend reflects the difficulties test sites faced in 'standing up' services and/or fully staffing them. A key conclusion here is that injecting tranches of short-term funding into local systems will not necessarily effect the desired transformational changes without being underpinned by more robust assessment of systemic risks and plans for their mitigation at national policy level.

(Facilitators of effective service delivery)

The main facilitators of rapid mobilisation and/or effective service delivery were:

- Lead commissioners with expert knowledge of integrated care commissioning (i.e. knowledge and links across health, housing and adult social care).
- Employing a skilled test site manager who acts as *'integration mechanic'* and offers single system coordination.
- Integrating 'standard' patient flow mechanisms such as those for 'escalation' and 'trusted assessment'.
- Integrating *specialist* step-down services within the wider homeless and inclusion health ecosystem in order secure access to comprehensive multi-disciplinary assessment and case management

[53] 12 test sites did not report any activity before the final quarter of Year 1.

- Pursuing single system working with non-specialist services - ensuring D2A (especially Pathway 3 care homes) are accessible to all adults and that a separate siloed *'homeless pathway'* does not evolve locally.

The main barriers to delivering effective step-down services were:

- Staff shortages – especially in Pathway 1 London services where patients are dispersed into unsuitable accommodation across wide geographical areas that make regular face to face contact difficult.
- Difficulties engaging mainstream services in assessment and care planning – particularly therapy services and adult social care – leading to *warehousing.*
- Lack of housing and longer-term care and support services leading to services *'silting-up.'*

Again, all three barriers can be identified as *'challenges to systems and service delivery that require changes outside the direct control of organisations in the locality'*. This was most clearly reflected in the experience of one test site manager who described how the step-down service had evolved from a 6-week to a 6-month service due to a *'perfect storm'* – the ongoing impact of Covid, the exodus of people to coastal and rural areas leading to an impossible housing market and the *'silting-up'* of their state-of-the-art step-down facility.

5: Economic Case Studies and Individualised Management Dashboards

5:1 Overview

In the previous section, we explored the challenges of integrating specialist intermediate care in the post-covid D2A hospital discharge operating arrangements. In this section we explore the economic impact and outcomes of mature levels of integrated/single system working (Objective 3).

TS6 (positive practice site) implemented one of the most comprehensive models of OOHC, offering hospital in-reach and integrating a wide range of services including specialist reablement across D2A Pathways 1 and 2. However, difficulties collecting questionnaire data for the audit meant that it was not possible to carry out a full economic evaluation for this test site. Across the Programme as a whole, collecting data for the audit proved exceptionally challenging. While it was planned that the evaluation team would work with each individual test site to produce an individualised dashboard of key indicators, only 6 test sites were able to generate the audit data that was needed to populate a dashboard. We begin this section by exploring these considerable challenges. In the following section, we explore the implications of poor data quality for business planning and the sustainability of the models.

The three case studies selected for full economic evaluation all demonstrate mature levels of integrated/single system working across different D2A Pathways. All represent newer service typologies that were not studied in the earlier NIHR research.

TS12 – Pathway 2 Residential step-down houses

TS14 – Pathway 1 Settle in Service

TS13 – Pathway 1/2/3 Homeless Intermediate Care Team.

In presenting each case study, we present a detailed description of the model and more background as to why it was selected for full economic evaluation. In reporting the findings, we showcase the static integrated management dashboards[54] that were produced for these three test sites. We also provide a narrative summary at the end of the case study, illustrating how the individualised dashboard can be benchmarked against the ***'National Dashboard for Specialist Intermediate Care 2021-2023'*** (shown in Figure 1:2).

We showcase the individualised dashboard for TS12 in full as this represents the *'gold standard'* in terms of having populated the complete data set (encompassing most of the 55-metric audit shown in Table 1:3). We present summary dashboards for TS13 and TS14 as both these have some data gaps.

Finally, we also showcase an individualised *'case story'* for TS6. Case stories focus on the journey of a single patient where it was possible to collect comprehensive data on interactions with various health, housing and care services (in the twelve months before and after step-down). These were produced for seven test sites that did not have sufficient quality data to populate a full individualised dashboard, but still wanted to include some economic evidence in their business cases for longer term funding.

[54] The national digital interactive dashboards can be viewed here: www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards.

5:2 The challenge of data collection for management and audit purposes

As outlined in Section 1, data for the audit and evaluation was collected from diverse sources and interconnected for the purposes of creating the integrated management dashboards. This included quarterly monitoring returns, questionnaires and secondary care usage data. We consider here the challenges of collecting data for each of these in turn.

(Quarterly Monitoring Returns)
Each test site manager completed a quarterly monitoring return to the DHSC. This gathered data related to caseload, service utilisation, and the demographics of individuals entering the OOHC service. Test sites reported that they found collecting data for the quarterly returns extremely challenging. It was the expectation of the DHSC that the test sites would take a *'whole system'* perspective with a view to nurturing and developing **all** specialist OOHC services in their area. However, several test sites chose to report only on those elements of their local provision that had been directly funded through the OOHCM programme. For example, in TS3 the step-down service made quarterly returns, but the hospital-based clinical In-reach Team (HIRT) did not, as they were not funded through the OOHCM Programme. As a result, quarterly monitoring does not necessarily provide a complete picture of the extent and scale of specialist OOHC in the test sites.

Where test site managers did see it as their role to develop a single integrated system (encompassing all specialist OOHC services in their area, not just those funded through the OOHCM Programme), a significant challenge was how to manage the disparate monitoring and reporting arrangements that were already in place. For example, in TS12 there were two step-down houses, one funded by the local council and one funded through the OOHCM Programme. The local council-funded step-down house was already using a patient experience measure and the test site manager had to negotiate with the service provider that they would agree to replace it with the one required by the OOHCM Programme. Different funders also had different key performance indicators and wanted a different set of metrics. In some areas, the OOHCM audit was seen to add to this already heavy data burden.

Aligning the different funder requirements into a single data architecture (a single database) took considerable skill and time on the part of test site managers. However, achieving this was key to integrating specialist care as part of the D2A operating model, as this required the alignment of services around the different discharge Pathways 0-3. It took one test site nearly two years to make a quarterly return. However, this reflected the enormous amount of work that was needed behind the scenes to engage and align different high-level stakeholders and homeless providers behind the D2A operating model.[55]

Indeed, data quality relied heavily on the development of close relationships between test managers and service providers. Where these relationships were weak, the quarterly returns were often based on 'guesstimates' of activity. Highlighting the problematic nature of self-reported data, organisational culture could be seen to impact data quality. Some test site managers appeared to be concerned with what Dixon-Woods (2013) terms 'external impression management' (public image and making things look better than they actually are). For example, one site reported exceptional performance in the number of CA assessments being completed, but the accuracy of this was questioned by the hospital discharge team.

(Financial forms)
Test sites also submitted financial forms detailing the sources and amounts of funding received, as well as the costs associated with service delivery, including expenses like hotel or accommodation costs, staff costs, overheads, office costs, and other related expenditures. Discrepancies were noted among sites in completing the DHSC financial forms; when reporting forms were unavailable, due to site discontinuation or other factors, the evaluation team referred to original funding application forms. The data for the financial year 2022-23 were collected before December 2022 and it represents the anticipated total expenditure, instead of being based on verified figures.

[55] Arguably it would have been helpful to have the LGA support available throughout the life-time of the Programme to help the sites that were struggling.

(Audit Questionnaires)

As part of the Programme audit, questionnaires were utilised to elicit responses from patients who were engaged with local OOHC services.[56]The questionnaires asked patients about their circumstances at the point of admission to hospital, including their housing situation and the primary source and reason for referral to intermediate care. Similar information was collected again upon their exit from the programme. The questionnaires also included the EQ-5D-5L questionnaire to assess changes in patient quality of life. To collect patients' experiences of using step-down services, a separate questionnaire (PREM) was administered before leaving step-down. As noted earlier, this was a validated measure used in the National Audits of Intermediate Care developed by NHS Benchmarking (Teale and Young, 2015).

While all the test sites contributed some quarterly monitoring data, not all were able to complete the questionnaires. As a result, only 10 out of 17 sites (59%) actively contributed and fed questionnaire data (on patient outcomes, use of health and care resources, care experiences and preferences) into the dashboards. The remaining 7 sites either never started (4), discontinued service provision (2), or found it too challenging to participate in the evaluation while setting up their services (1). There were a number of reasons for this low participation. First, it was anticipated that the questionnaires could be embedded as part of routine case management practices. However, while assessments were often carried out on entry to the services, a formal review was not consistently undertaken when the patient was ready to leave the service. Implementing the audit questionnaires (especially the exit questionnaire) thus required practice changes. In turn, this was not straightforward where providers were using computerised case management systems. Here, the OOHCM questionnaires had to be integrated into these electronic systems or be completed as a separate paperwork exercise, which was seen as adding to the workload. Where providers did undertake a review of patient outcomes, the tool being used (usually Outcomes Star) was not the one required by the OOHCM Programme, where a validated measure was needed to facilitate economic analysis.

However, the main reason why tests sites did not return questionnaire data (and indeed routinely undertake reviews of patient care) was pressure on services and staff. Practitioners reported that it was hard to prioritise what were often seen as bureaucratic tasks (paperwork) over direct patient care. Some also reported that their management structures did not encourage this. Indeed, test site managers varied in their views about the value of data. Some prioritised data collection and proactively ensured staff were completing the necessary tasks while others did not.

> *'Initially, there was some resistance to the OOHCM questionnaires in the step-down house. However, I explained why the questionnaires were important and that without this data we are just talking hot air... Staff* [in the step-down houses*] now talk positively about doing the questionnaires because it enables them to see just how much patients have improved because of what they do*' (Test Site Manager)

Contacting patients shortly after they left the service by telephone to carry out the PREM was also challenging.[57] In most sites this task was carried out by 'peer researchers' employed by the evaluation team. Often patients did not answer the calls or had changed their phone numbers. Where people could not be contacted by phone, a postal questionnaire was sent, but these were rarely returned.

In TS12 the local homeless service user forum completed the follow-up task, training peer researchers to complete the questionnaires over the telephone. PREM completion in the National Intermediate Care audits relied on patients or their families completing and posting returns (28% return rate) (Teale and Young, 2015). The strategy of engaging local peer

[56] Staff in the hospital based in-reach team (HIRTs) did not administer questionnaires, as their patients were picked up in step-down after they left hospital.

[57] To promote engagement in the audit, service users were given a £10 voucher for each questionnaire completed including the PREM. However, often patients would not answer the phone where the number was not recognised or may have lost their phone. Vouchers worked best then where face to face contact was possible.

researchers to carry out telephone contact was more successful (36% return rate). Importantly, engaging the local homeless user forum in supporting the audit, put in place the foundations for some genuine co-production. This was because forum members were able to develop extensive knowledge and understanding of what was going on in OOHC through the questionnaire administration. Thus, when they were invited to take part in local commissioning meetings, they had lots of useful lived experience insights to share.

(Accessing hospital data)
A further significant challenge for the test sites, was getting access to the data held by their local acute hospital trust. Often requests for data were simply turned down. This meant that most test sites could not provide their commissioners with evidence about reallocatable resources (or 'cashable savings' as defined by DHSC in their business case since they could not know if, for example, a person had used A&E less since leaving their service. Among test site managers it was frequently reflected upon that local commissioners "*Set the evidence bar higher for our services*" [as compared to older people's intermediate care]. Only two sites (TS12 and TS13) managed to obtain data on secondary care usage from their hospital trust and to present the complete picture of their performance, comparing data before and after contact with OOHC from the NHS perspective. Only TS12 was able to access data from the trust on discharge delays due to housing and homelessness.[58]

(Accessing data on access to services for the broader public budget perspective)
Data linkage with administrative data for the broader public budget perspective across sectors, including health, social care, housing, criminal justice, mental health, and drug and alcohol services, presents a multitude of challenges due to the complexity and diversity of these sectors. Different sectors often operate in silos, leading to fragmentation in data storage and management; each may have its own databases, systems, and data standards, making it challenging to integrate and analyse data seamlessly. Data sharing across sectors also raises privacy and confidentiality concerns. Sensitive information related to health, mental health, criminal justice, and substance use requires careful handling to comply with legal and ethical standards, leading to restrictions on data access. Collaboration between agencies in different sectors may face barriers related to differing priorities, organizational cultures, and operational structures. Establishing effective collaboration mechanisms for data sharing requires overcoming these institutional and systemic challenges.

An alternative to data linkage is to collect information directly from patients about the services they have used. For TS14 (which forms the third economic deep dive case study) the evaluation team collected data from a cohort of 20 patients (employing a resource use questionnaire, Q4) on their use of the NHS and other public services (such as criminal justice services). Taking a broader public budget perspective allowed for a cost consequences analysis beyond health. However, while self-reported questionnaires completed by patients with experience of homelessness can provide valuable insights into the impact of OOHC on individuals' lives, self-reported data is inherently subjective, and individuals may face challenges in accurately recalling details about their interactions with different services. There are also many logistical challenges involved in locating homeless patients for follow-up once they have left OOHC. Resource limitations meant the evaluation team could not support multiple sites to carry out follow-ups for Q4 completion. In an additional 7 test sites a similar public budget analysis was undertaken but this focussed on one individual's case story. An example of an individual case story is presented later in this section.

58 During Covid-19 the reporting of Delayed Transfers of Care (DTOCs) was suspended and the new methods of data collection were not available publicly at the time of this evaluation. Delayed discharged data showed relatively few patients who were homeless on admission having delayed discharges attributed to housing and homelessness. Also, the number of delays appears to have reduced since the implementation and scaling of the OOHCM (over 2022/23 period.

5:3 Economic Case Studies

Case Study 1: Out-of-London 'housing-led' step-down model (D2A Pathway 2) - Economic Impacts for NHS

Site Selection: TS12 is a 'housing-led' OOHCM. It was selected as a *'positive practice'* and economic evaluation site as it is a high fidelity model that demonstrates mature levels of single system working. It is one of only two sites that have significantly *'scaled-up'* its residential step-down provision. It has the shortest length of stay of all Pathway 2 services and performs well on many of the other audit measures. This test site prioritised data collection (designing a single architecture that captured data for both OOHCM and alternatively funded D2A services). It secured stakeholder engagement in data collection exercises including analysts in the acute sector and the discharge hub. As a result, this test site affords access to a comprehensive and high quality data set that is supportive of the most detailed and in-depth economic analysis.

Model Description: The step-down houses in TS12 can be conceptualised as sitting on the boundaries of D2A Pathways 1 and 2. While offering a residential option they work as a Home First service supporting people who might potentially have returned to their own homes had they not been homeless at the point of discharge from hospital.

The first step-down house was opened in 2018 with Winter Pressures monies from the NHS. Another house opened shortly after but closed due to lack of funding. A third house was then opened in 2021 with funding from the OOHCM programme. Further winter pressure monies for 22/23 enabled two more step-down houses to open and a step-up house. This ensured city and county wide coverage with an increase in bed provision from 5 to 27 beds. The OOHCM audit and evaluation reports on outcomes and activities for the two step-down houses that were operational 2021-23 (offering 10 beds).

The step-down houses were sourced through third sector providers and cater for people leaving both mental health and acute hospitals. They aim to provide short-term support for between 2-6 weeks. Residents have their own bedrooms and share kitchen, lounge and bathroom facilities. Case workers are on site at each house for part of the day and deal with a wide range of practical issues such as arranging ongoing accommodation, sorting benefits and registering people with a GP and other services. The step-down houses are not registered with the Care Quality Commission (CQC) so 'care packages' of reablement and personal care must be commissioned individually via the wider intermediate and adult social care networks.

In addition to the step-down houses, the TS12 model encompasses housing in-reach into the acute and mental health hospitals and a specialist homeless (community based) multi-disciplinary team. Although not called an intermediate care team, it supports D2A functions (such as rapid access to assessment for those in step-down) and admission avoidance. This team comprises two social workers, an occupational therapist, a clinical psychologist and eight floating support workers. The floating support workers fulfil a D2A Pathway 1 *"settle in"* function for those returning to the community or leaving step-down. The primary focus of the floating support is on continuity of care for patients with mental health issues, so the support is not restricted to six weeks. The multi-disciplinary team has close links with a local specialist GP practice, ensuring nursing and clinical support is brought into the housing-led model. The specialist social workers in the team have direct links into adult social care to ensure access to CA, 2014 assessments and packages of care.

The test site manager is '*hands on'* in terms of taking a keen and supportive interest in every aspect of the model's development and operation. He proactively coordinates the system through regular whole team meetings. These encompass front line practitioner input and people with lived experience. He has worked hard to raise the profile of the service with commissioners and was successful in sustaining the 'scaled-up' model going forward into 23/24. The economic evidence presented in the dashboard below is acknowledged as having been instrumental in securing this further funding. The hope is that if this performance can be maintained, the model will be included the ICB baseline and no longer be reliant on tranches of short-term funding.

While the economic evaluation focusses on the two step-down houses that were operational 2021-2023, it is important to stress that this impact and performance is reflective of the wider integrated care model in which the houses are embedded.

Figure 5:1: Static integrated management dashboard TS12 (key findings at a glance)

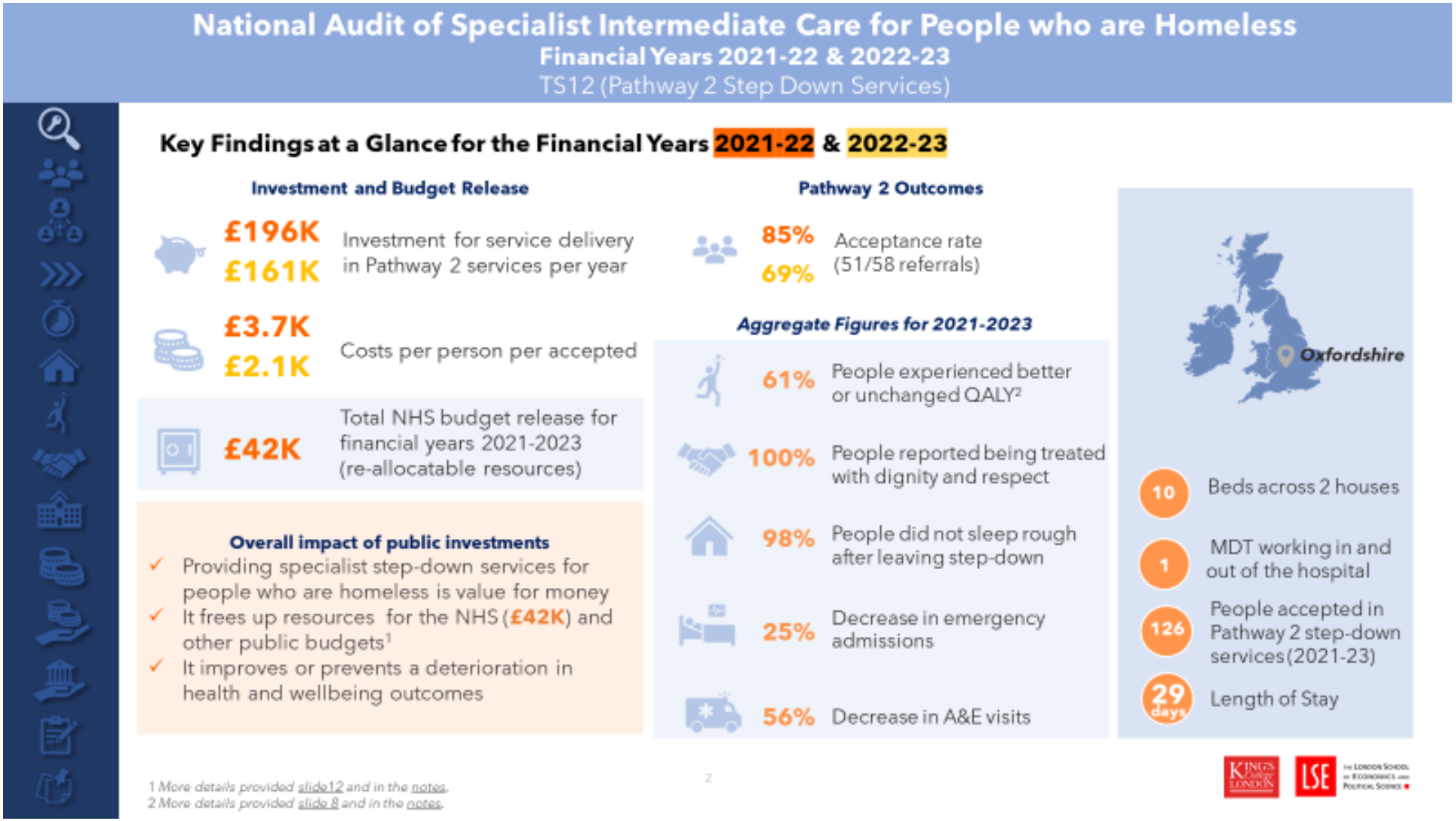


Figure 5.2: Static integrated management dashboard TS12 (Patient demographics and staffing)

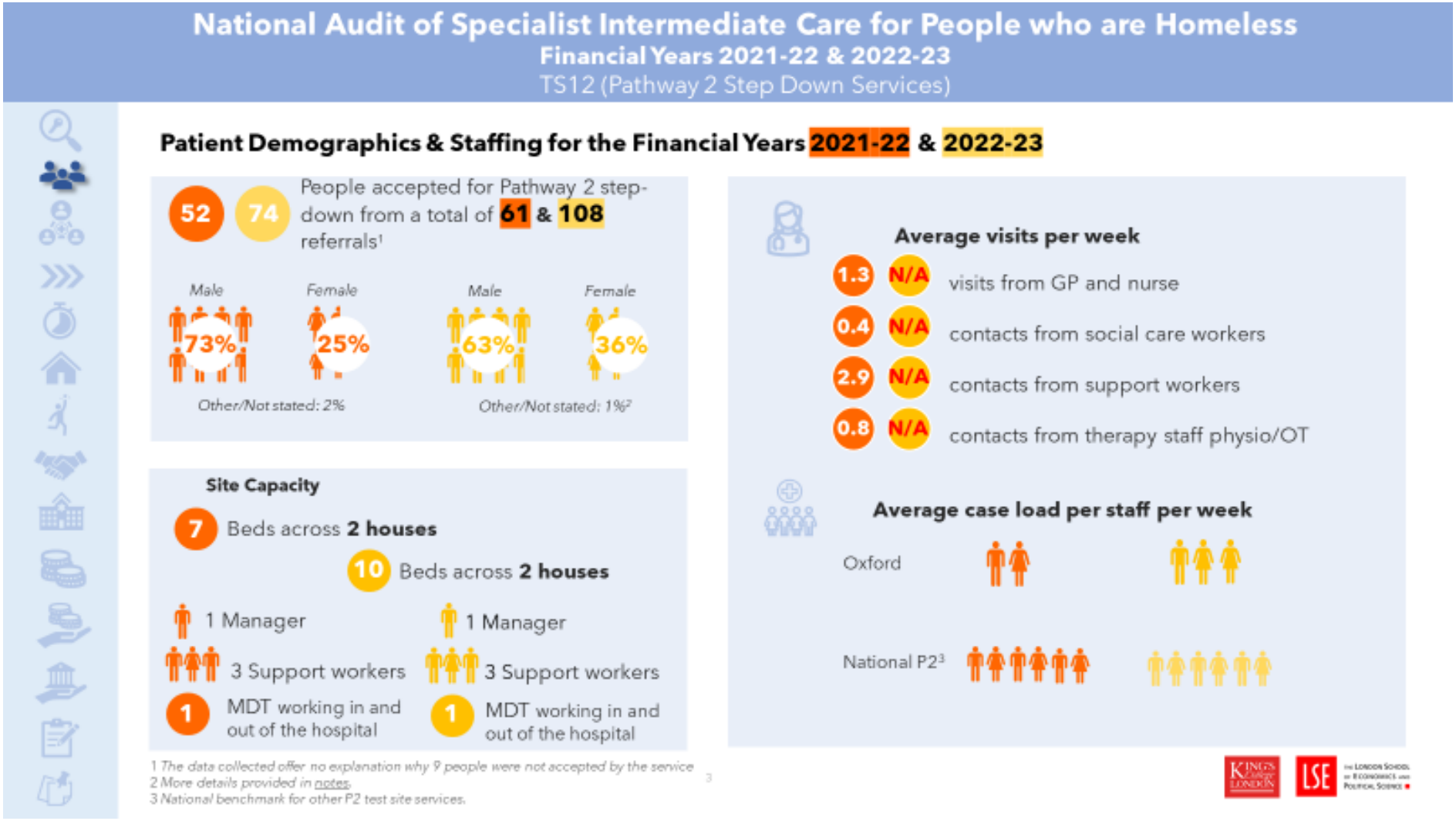


Figure 5.3 Static integrated management dashboard TS12 (Health and social care in step-down)

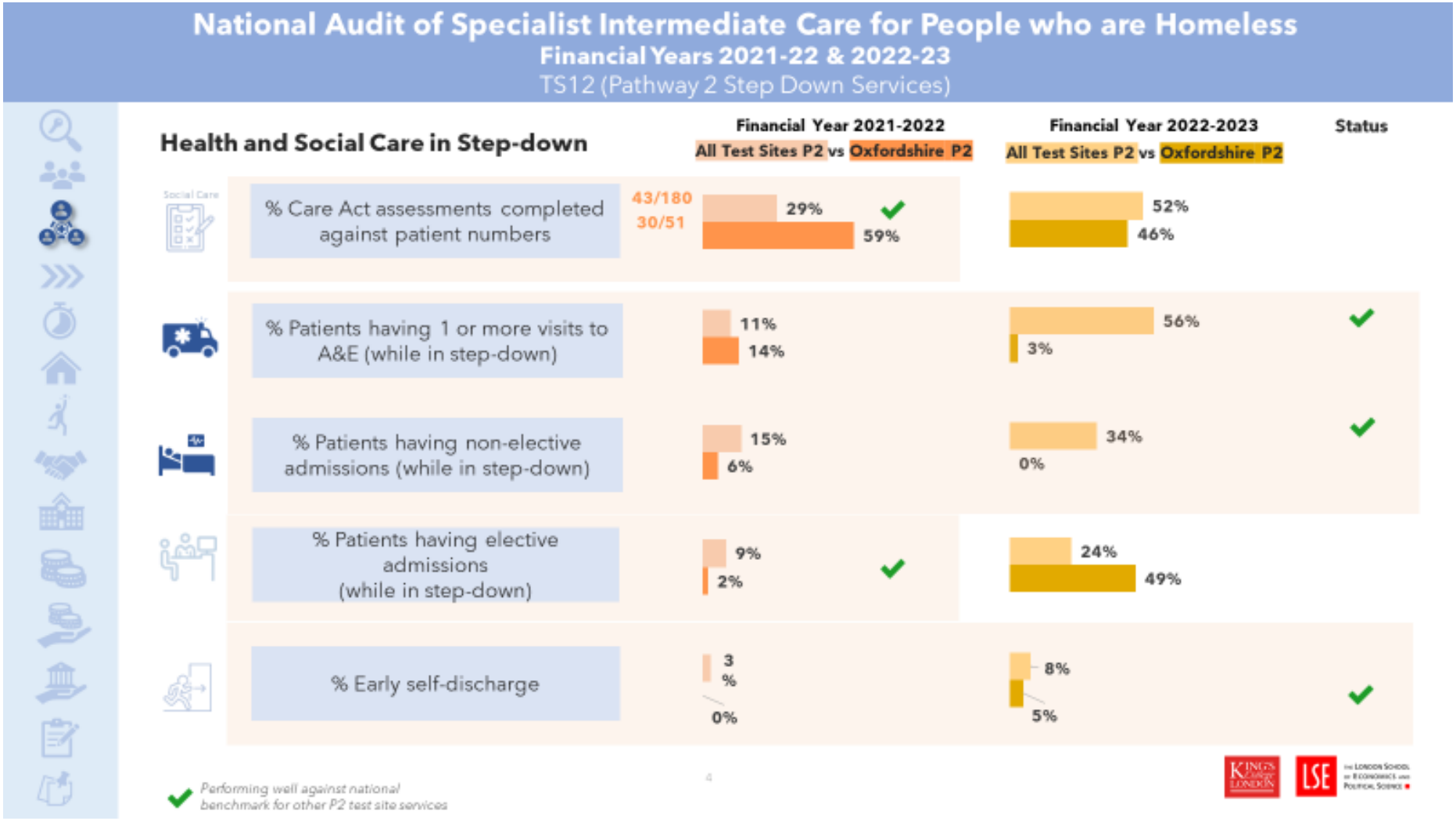


Figure 5.4: Static integrated management dashboard TS12 (Patient flow)

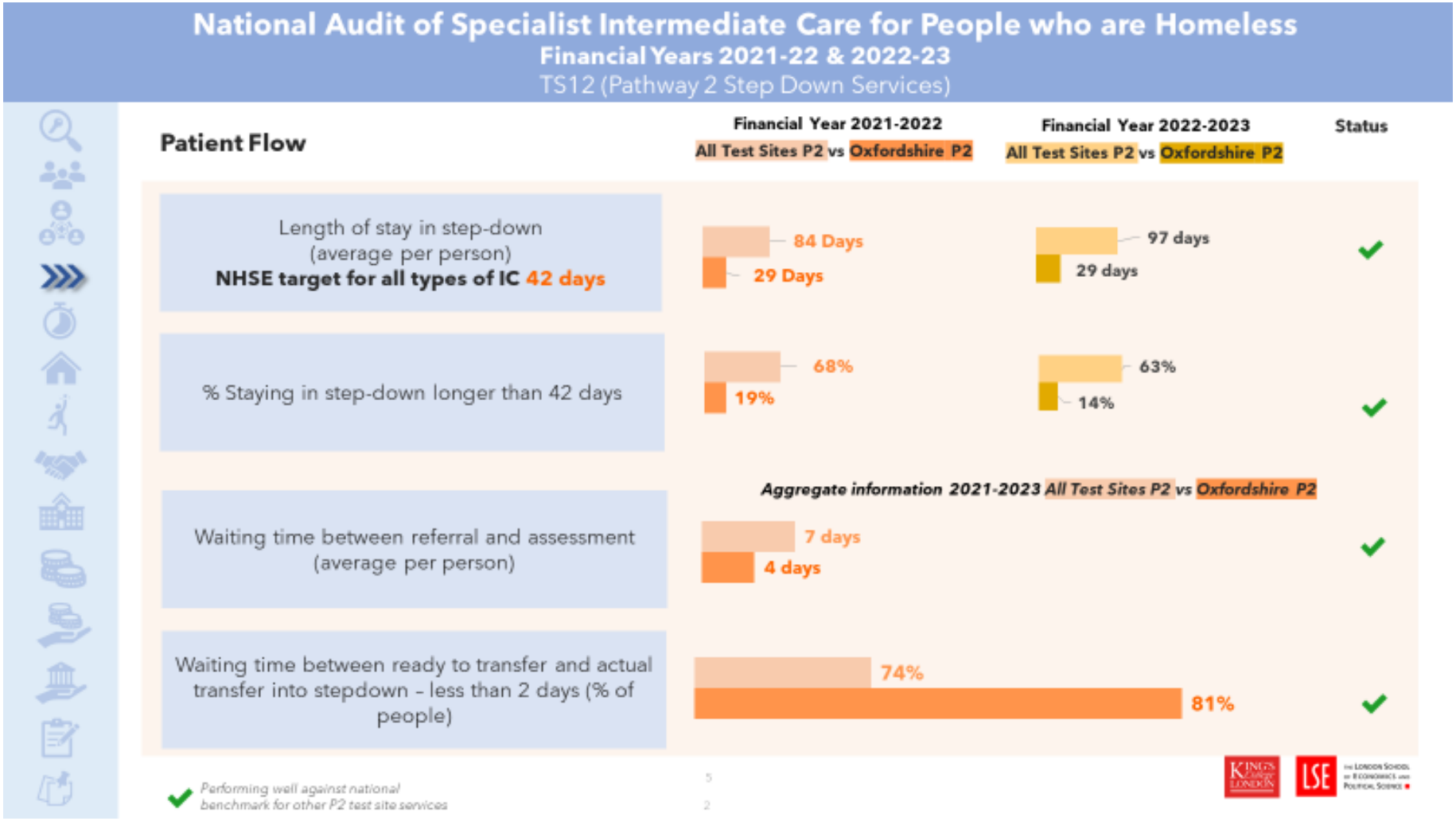


Figure 5.5 Static integrated management dashboard TS12 (Housing outcomes)

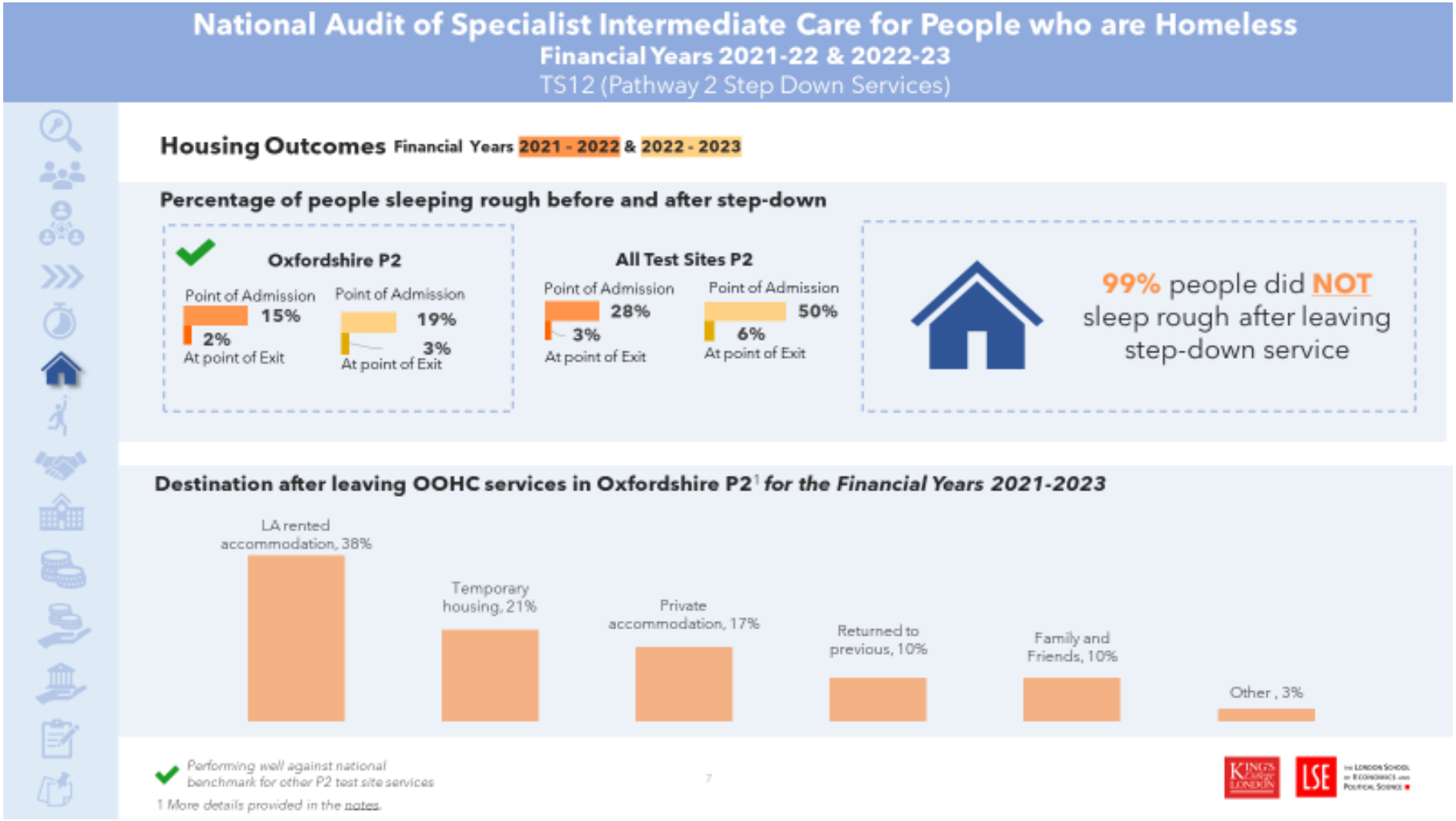


Figure 5.6: Static integrated management dashboard TS12 (Health Status Outcomes)

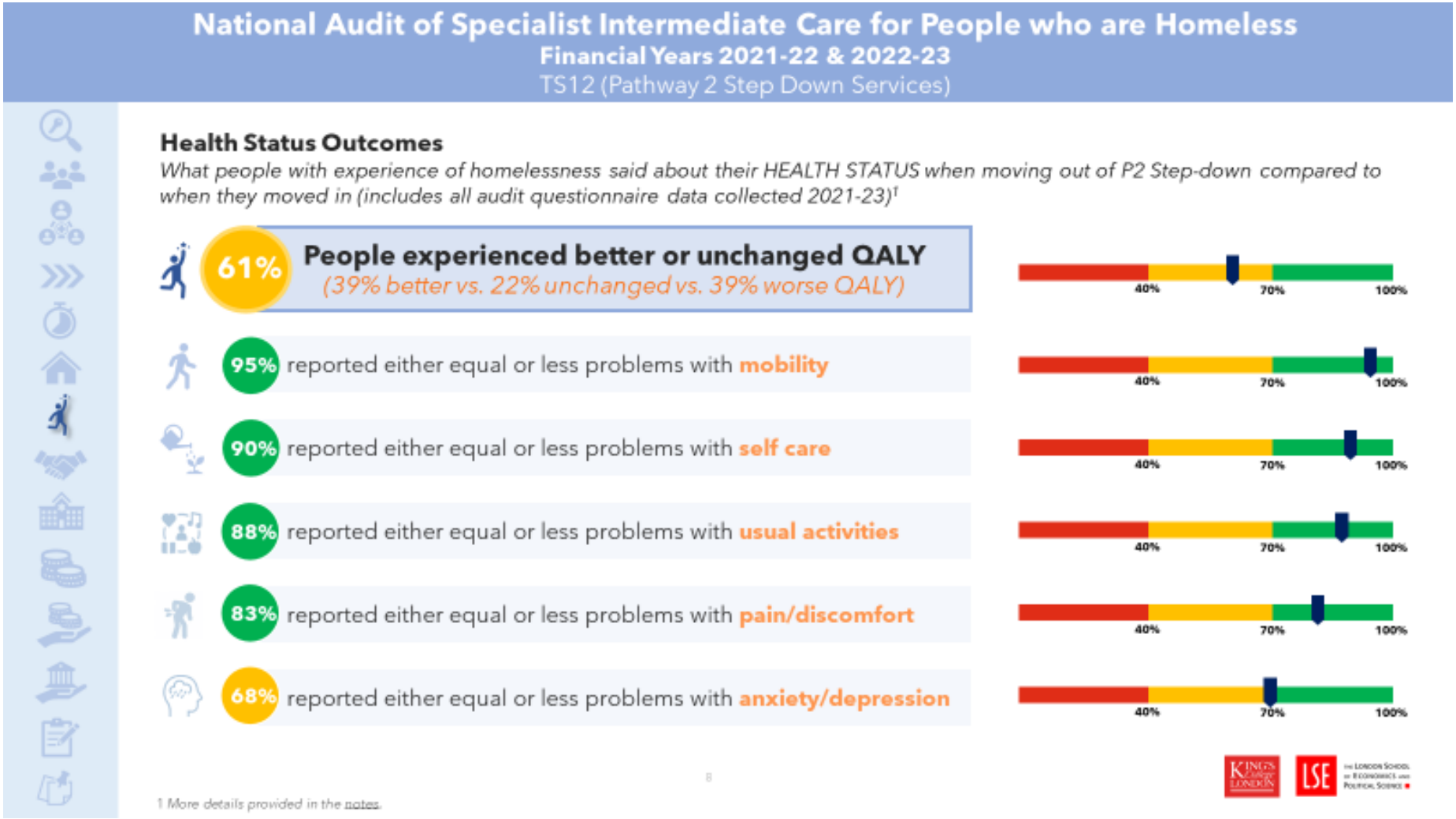


Figure 5.7: Static integrated management dashboard TS12 (Person Reported Experience Measure)

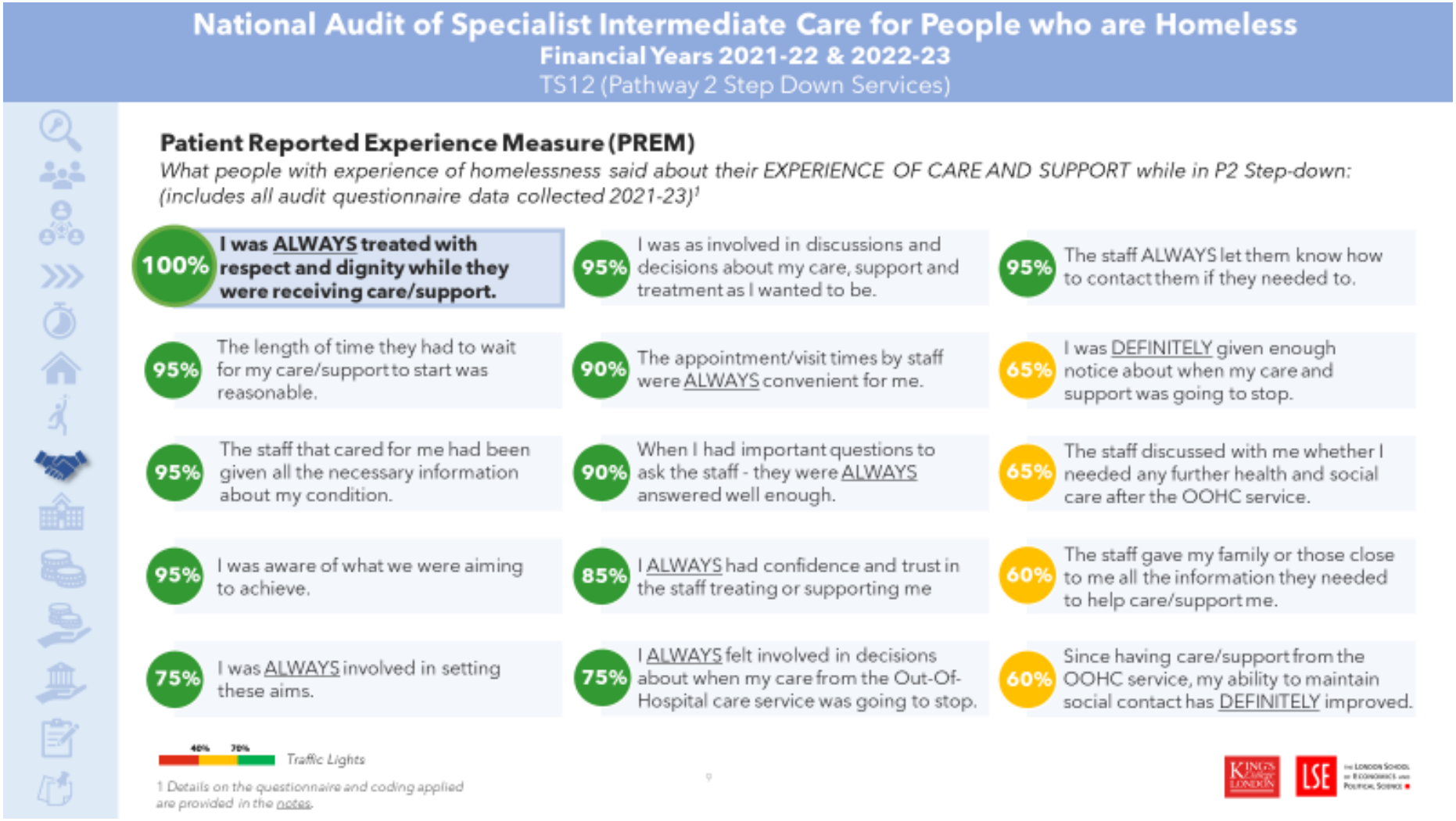


Figure 5.8: Static integrated management dashboard TS12 (Annual use of NHS resources)

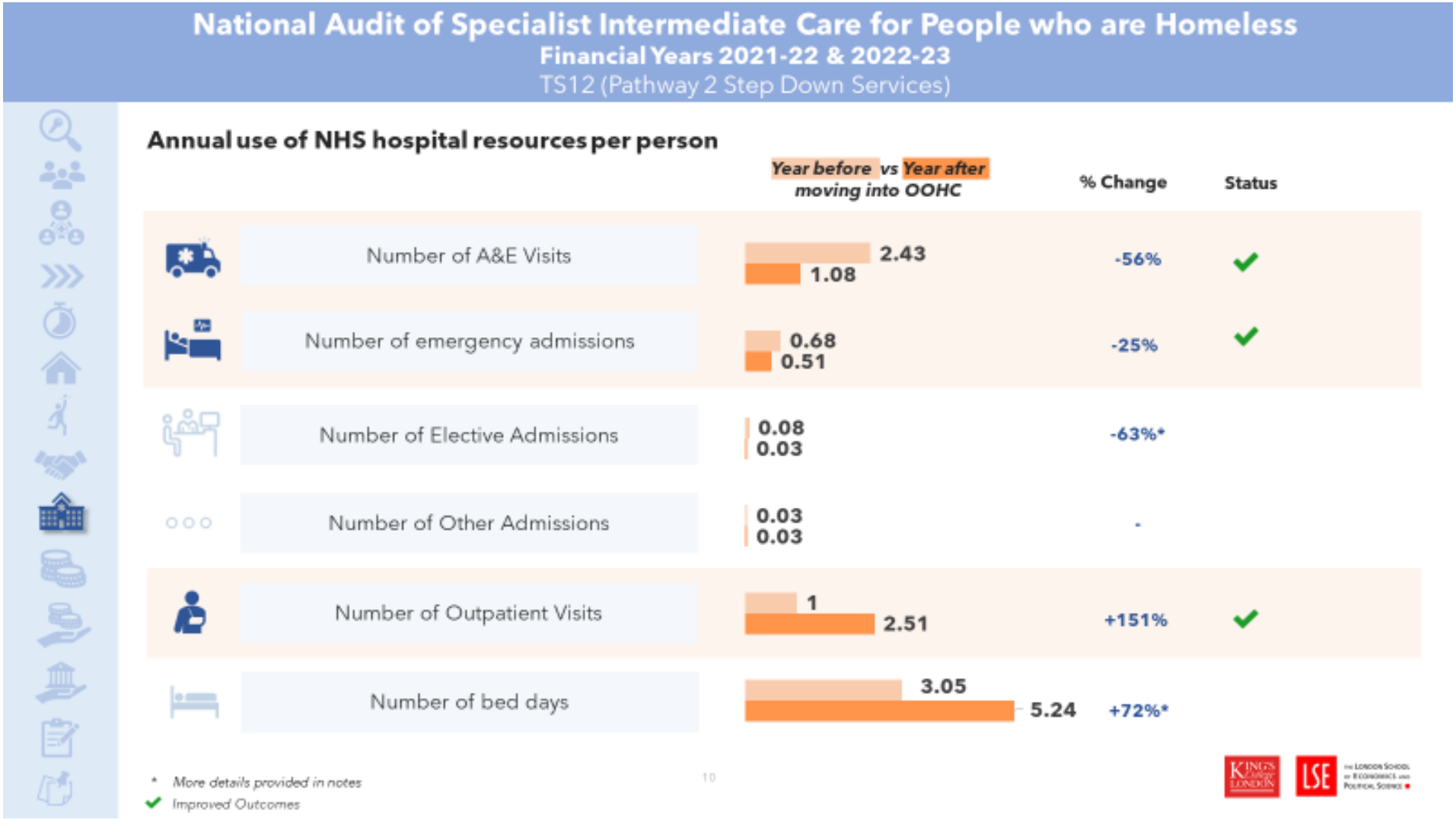


Figure 5.9: Static integrated management dashboard TS12 (Economic analysis considering the NHS perspective)

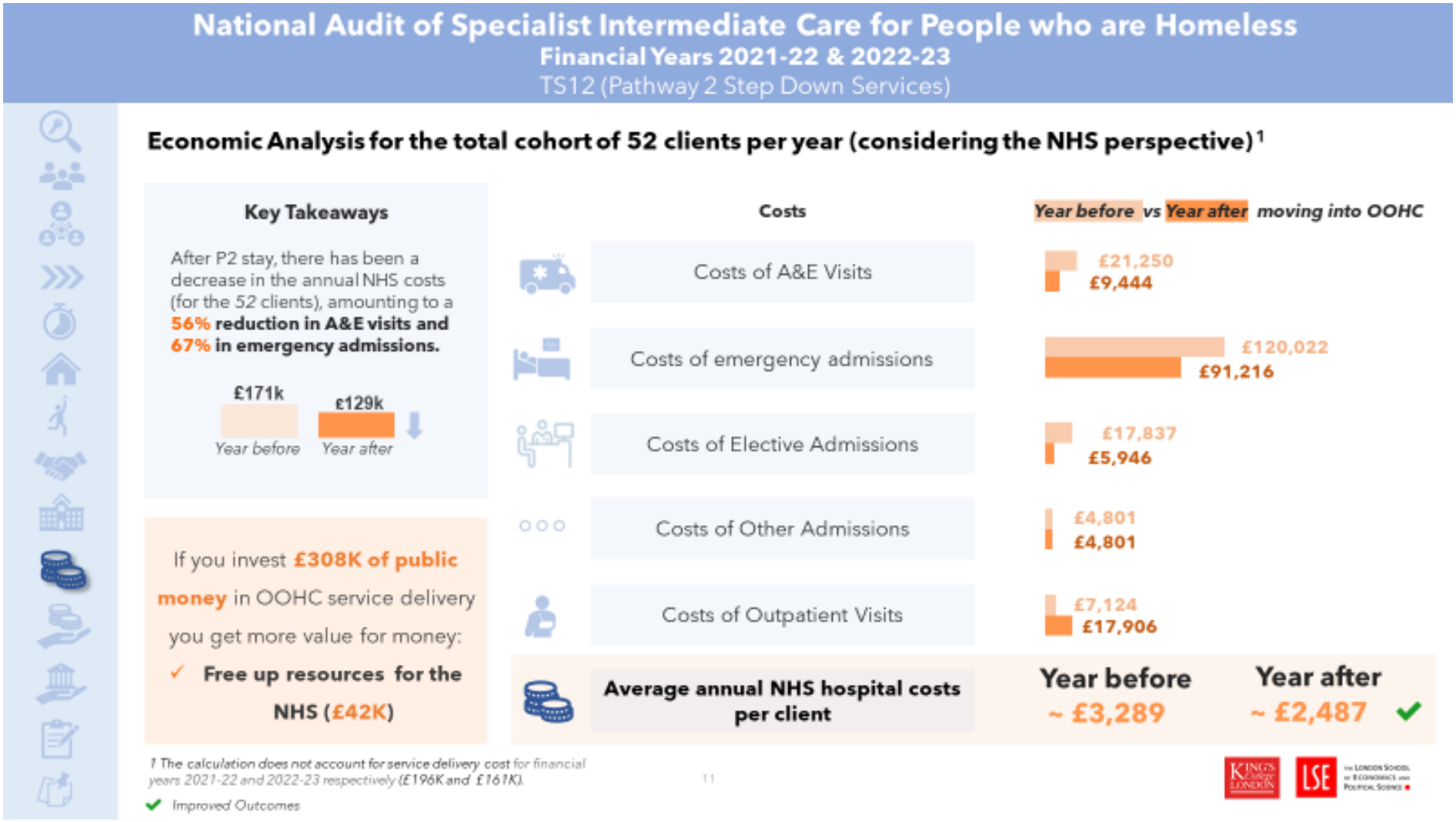


Figure 5.10: Static integrated management dashboard TS12 (Economic analysis of one case story considering the broader public perspective)

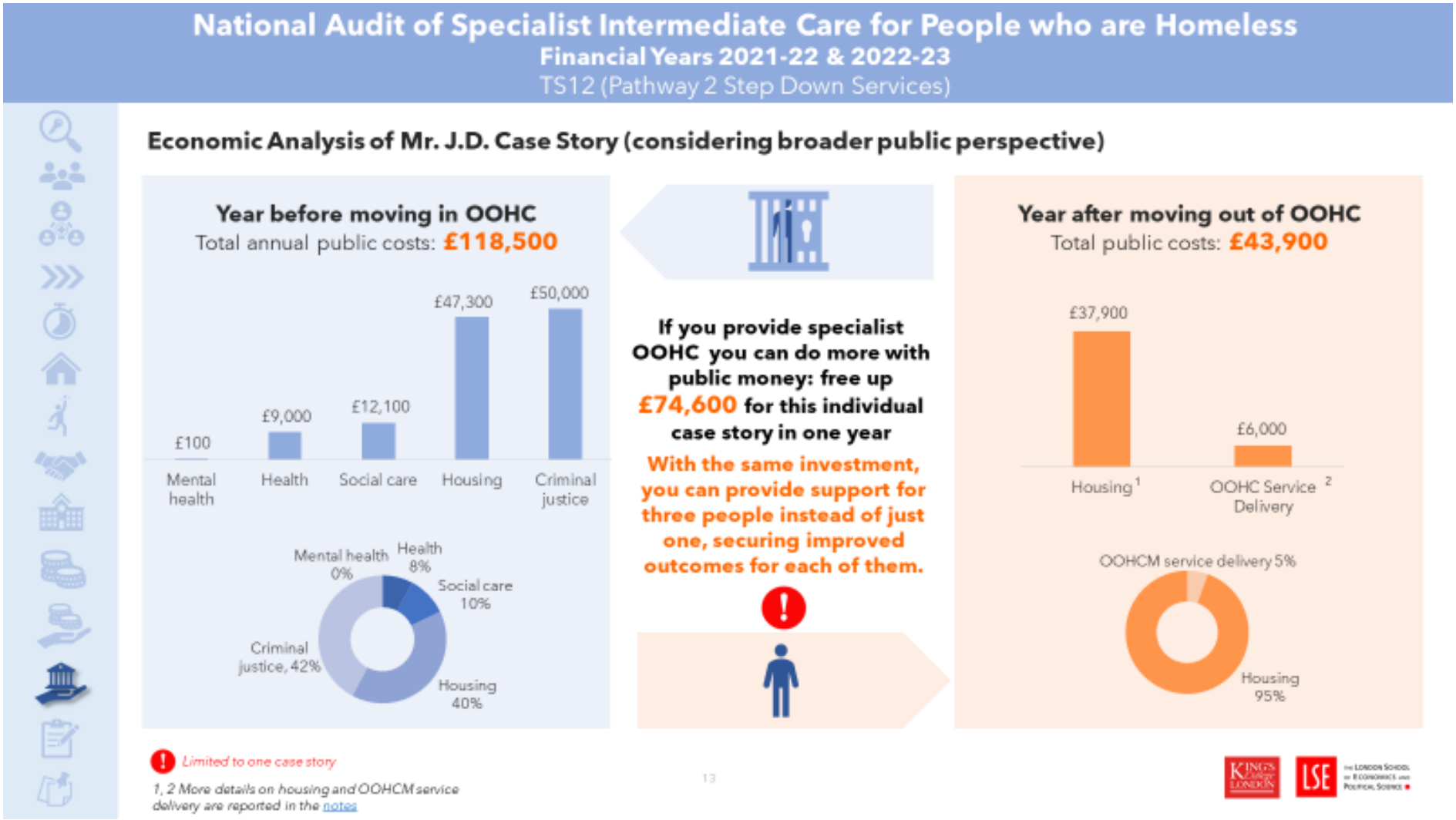


Figure 5.11: Static integrated management dashboard TS12 (Audit Summary)

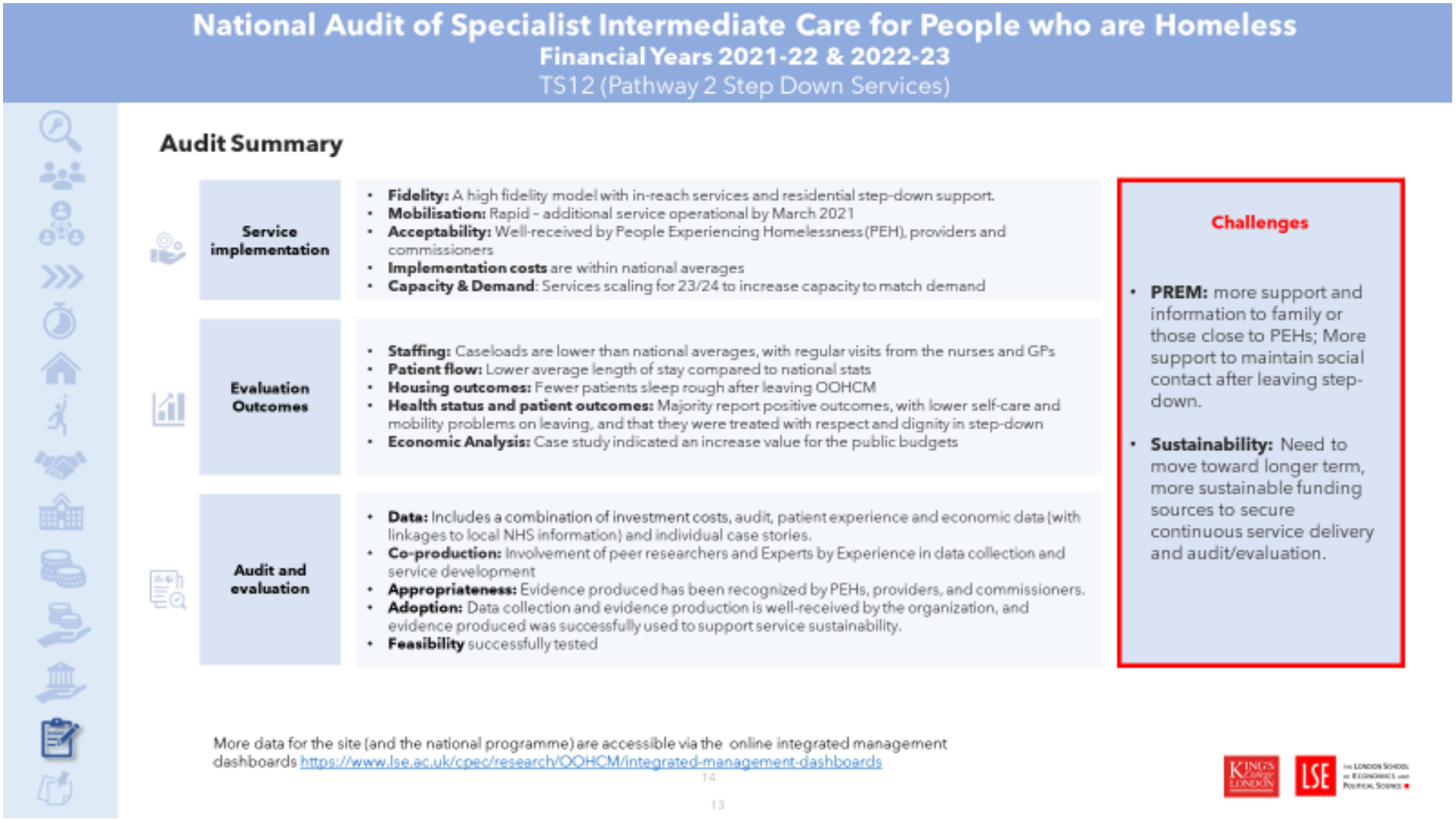
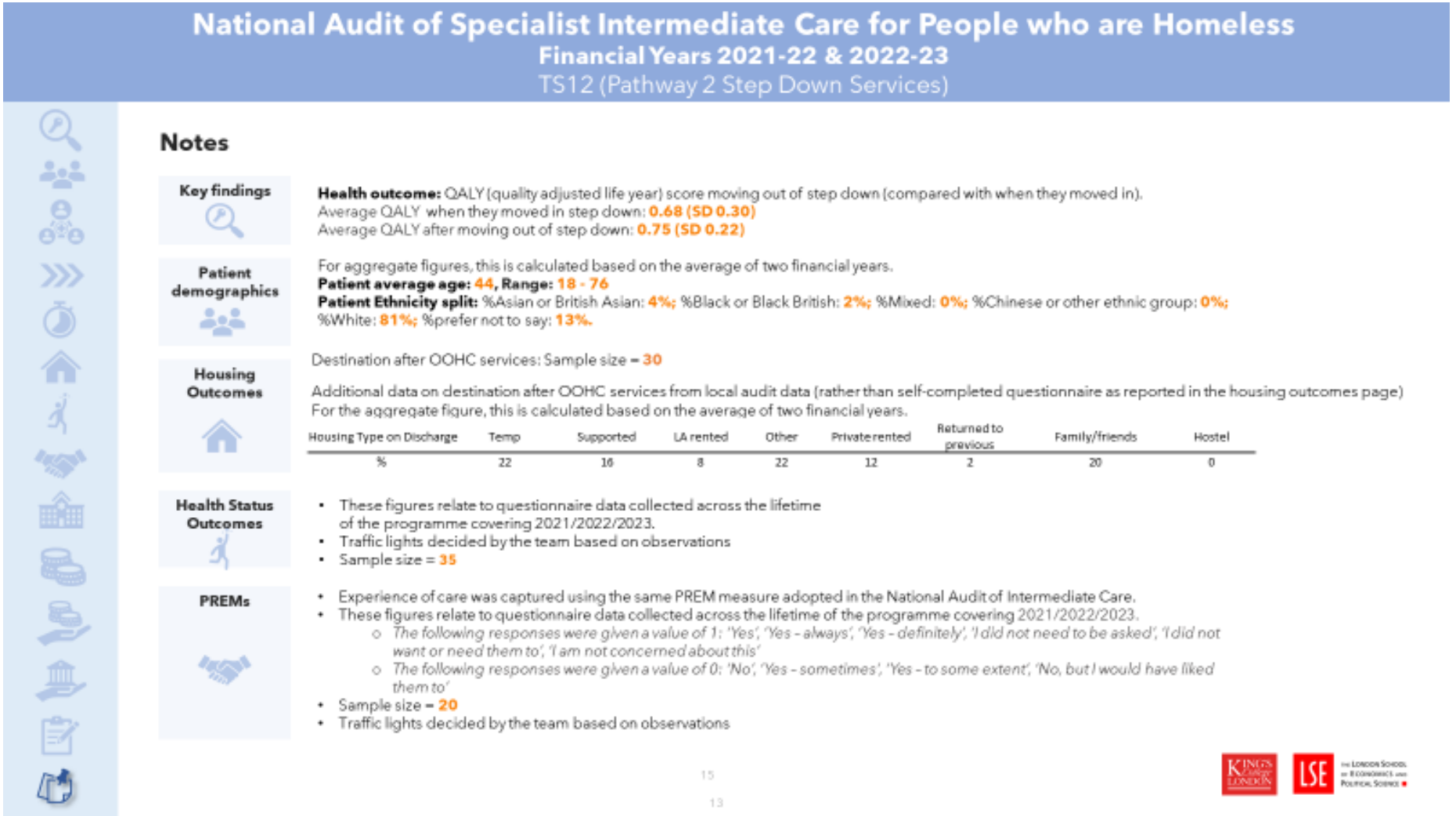


Figure 5.12: Static integrated management dashboard TS12 (Notes 1)



National Audit of Specialist Intermediate Care for People who are Homeless

Financial Years 2021-22 & 2022-23

TS12 (Pathway 2 Step Down Services)

Notes

Key findings

Health outcome: QALY (quality adjusted life year) score moving out of step down (compared with when they moved in).
Average QALY when they moved in step down: **0.68 (SD 0.30)**
Average QALY after moving out of step down: **0.75 (SD 0.22)**

Patient demographics

For aggregate figures, this is calculated based on the average of two financial years.
Patient average age: 44, Range: 18 - 76
Patient Ethnicity split: %Asian or British Asian: **4%;** %Black or Black British: **2%;** %Mixed: **0%;** %Chinese or other ethnic group: **0%;** %White: **81%;** %prefer not to say: **13%.**

Housing Outcomes

Destination after OOHC services: Sample size = **30**

Additional data on destination after OOHC services from local audit data (rather than self-completed questionnaire as reported in the housing outcomes page)
For the aggregate figure, this is calculated based on the average of two financial years.

Housing Type on Discharge	Temp	Supported	LA rented	Other	Private rented	Returned to previous	Family/friends	Hostel
%	22	16	8	22	12	2	20	0

Health Status Outcomes

- These figures relate to questionnaire data collected across the lifetime of the programme covering 2021/2022/2023.
- Traffic lights decided by the team based on observations
- Sample size = **35**

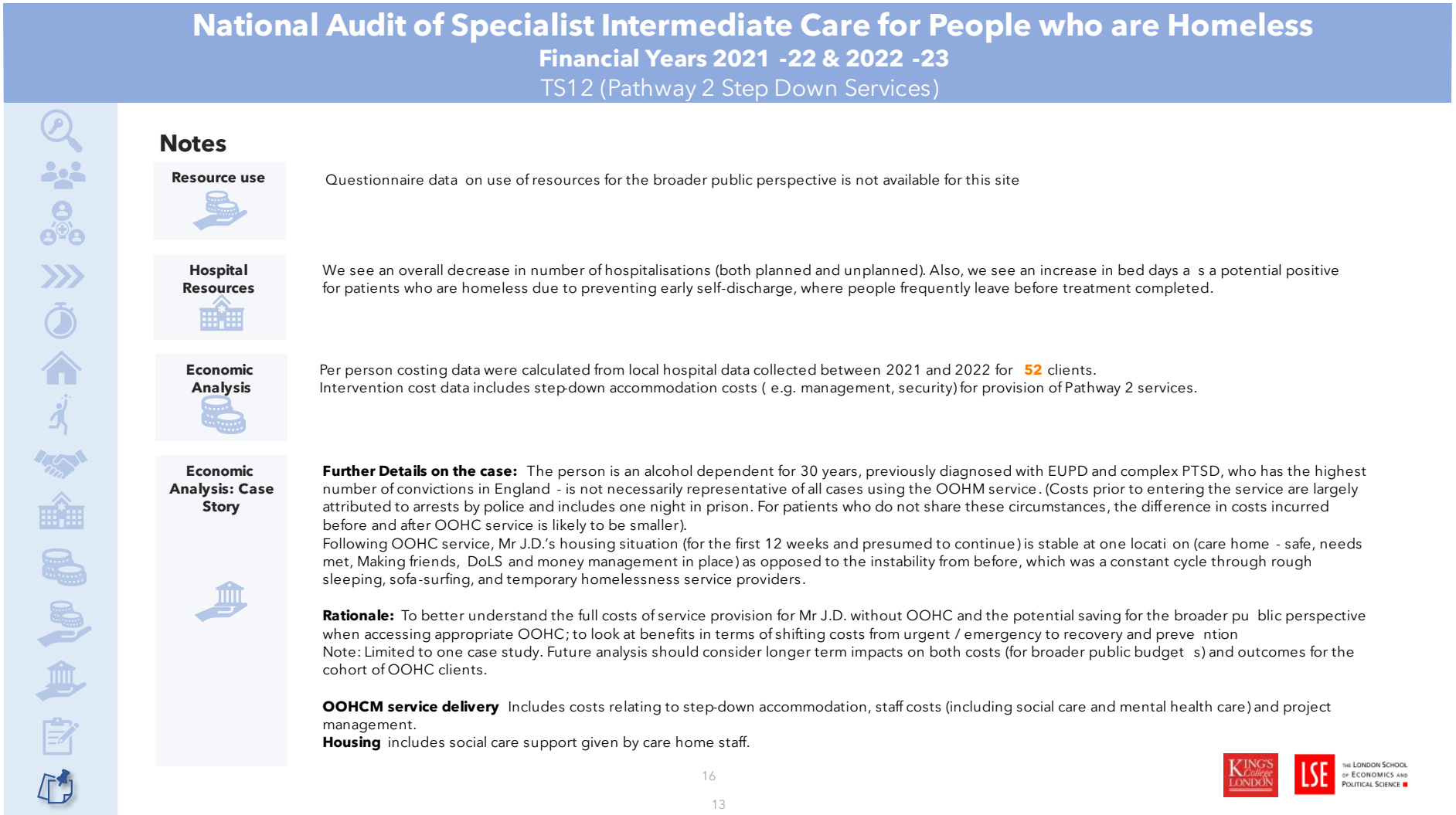
PREMs

- Experience of care was captured using the same PREM measure adopted in the National Audit of Intermediate Care.
- These figures relate to questionnaire data collected across the lifetime of the programme covering 2021/2022/2023.
  - *The following responses were given a value of 1: 'Yes', 'Yes - always', 'Yes - definitely', 'I did not need to be asked', 'I did not want or need them to', 'I am not concerned about this'*
  - *The following responses were given a value of 0: 'No', 'Yes - sometimes', 'Yes - to some extent', 'No, but I would have liked them to'*
- Sample size = **20**
- Traffic lights decided by the team based on observations

15

13

Figure 5.13: Static integrated management dashboard TS12 (Notes 2)



TS12 *Performance and Benchmarking Narrative:*

The static integrated management dashboard for TS12 can be viewed in Figures 5.1 to 5.13 above. The National Dashboard can be viewed in Figure 1:1.

- **Patient Demographics & Staffing (Figure 5:2):** for example, 52 people in 2021-22 (74 in 2022-23) were accepted in step-down from a total of 61 & 108 referrals, respectively. The average case load per staff per week was well under national average (2 people per staff in TS12 vs. 6 people per staff nationally in 2021-22).
- **Health and Social Care Use in Step-down (Figure 5.3):** for example, the percentage of early self-discharge cases remained consistently low for both financial years (0% and 5%, respectively in contrast to national average 3% and 5%. In the financial year 2021-22, 30 of 51 (59%) CA 2014 assessments were conducted in TS12, contrasting with the national average of only 19%. In the subsequent financial year, the % of CA 2014 assessments completed in TS12 dropped dramatically compared to the national average (only 4% vs. 64% respectively).
- **The flow of people in and out of OOHC (Figure 5.4):** Average length of stay in step-down care per person is notably below NHSE target of 42 days for all types of intermediate care. It stands at 29 days, compared to national average of 65 days for 2021-22 period. Similar results are observed the following year, 2022-23.
- **Housing Outcomes (Figure 5.5):** Percentage of individuals sleeping rough before and after step-down care is significantly below the national average. Also, in the 2021-22 period, there is a notable decrease in rough sleeping cases in TS12 when comparing the point of admission to the point of exit (15% vs 2%, respectively).
- **Health Status Outcomes (Figure 5.6):** Comparing what people experiencing homelessness said about their health status when moving out of Pathway 2 step-down, compared to when they moved in, 39% of people reported better vs. 22% unchanged vs. 39% worse QALY. TS 12 performs less well on this metric than national averages 58% better, 9% unchanged, 33% worse).
- **Person Reported Experience Measure (PREM, Figure 5.7):** 11 out of 15 indicators reported positive results for 75% or more of people. 100% of people reported that they were treated with respect and dignity while receiving care/support. This is higher than the national average (93%)
- **Annual use of NHS hospital resources per person (Figure 5.8):** Number of A&E visits decreased by 56% when comparing the year before moving into OOHC with the year after. Positive outcomes were also observed for emergency admissions (a 25% reduction, indicating less emergency care) and outpatient clinics (a 125% increase, indicating more planned care).
- **Economic Analysis of the entire cohort of 52 patients per year (considering the NHS perspective; Figure 5.9):** Shows that after Pathway 2 stay, there was a decrease in annual NHS costs for the 52 patients, dropping from £171K to £129K. The average annual NHS hospital costs per patient were £3,289 (year before) and £2,487 (year after). Investing £308K of public money in OOHC delivery brings value for money, freeing up resources for the NHS (£42K).
- **Economic Analysis of Mr J.D. Case Story (considering broader public perspective, including health, social care, drug and alcohol, mental health, housing and criminal justice, Figure 5.10):** The patient has been alcohol dependent for 30 years, previously diagnosed with emotionally unstable personality disorder and complex post-traumatic stress disorder; he presents the highest number of convictions in England. Costs prior to entering OOHC are largely attributed to Police arrests and one night in prison. Following OOHC, Mr J.D.'s housing situation (for first 12 weeks; presumed to continue) is stable at one location (care home; safe, needs met, making friends, Deprivation of Liberty Safeguards and money management in place) as opposed to prior instability: cycle through rough sleeping, sofa-surfing, and homelessness services. OOHC enabled the release of £74,600 per individual annually.
- **Audit Summary (Figure 5.11):** Outcomes of service implementation were positive. Implementation costs align with national averages and resources are freed-up for the NHS. There is some scope to improve QALY in line with national averages and this may be an area for the test site to explore. Overall, TS12 is not only replicating but improving on many results demonstrated in the earlier NIHR OOHCM effectiveness study (Cornes et al., 2021). For example, there was a 56% decrease in A&E visits in the year following a step-down house stay; in the original study the figure was 18%. The success of TS12 initiative is rooted in the delivery of a high-fidelity model with in-reach services and residential step-down support, rapid mobilisation strategies (the service was operational March 2021), broad acceptability in the community by people experiencing homelessness, providers and commissioners - and proactive services scaling for 23/24 to increase capacity to match demand.

Case Study 2: London 'Take Home Settle-in Service" (D2A Pathway 1) - Economic impacts for broader public budget.

Site Selection: In TS14, a Pathway 1 *'Take Home and Settle-In Service"* has been developed to support the discharge of homeless patients from five London acute hospitals. The *'Home from Hospital'* model delivered by the Voluntary and Community Sector is well established in many hospitals, providing vital support to older people. In TS14 the model has been extended to support homeless patients leaving hospital and is the first to do so in the UK. As noted earlier, TS14 was unable to access secondary care data from the hospital trust. To compensate for the lack of HES data, the evaluation team implemented an additional resource use questionnaire (Q4) following up a cohort of 20 'settle in' patients (examining resource use six months before and after step-down). This enabled the assessment of impacts for the broader public budget as well as NHS but has limitations linked to the use of self-reporting.

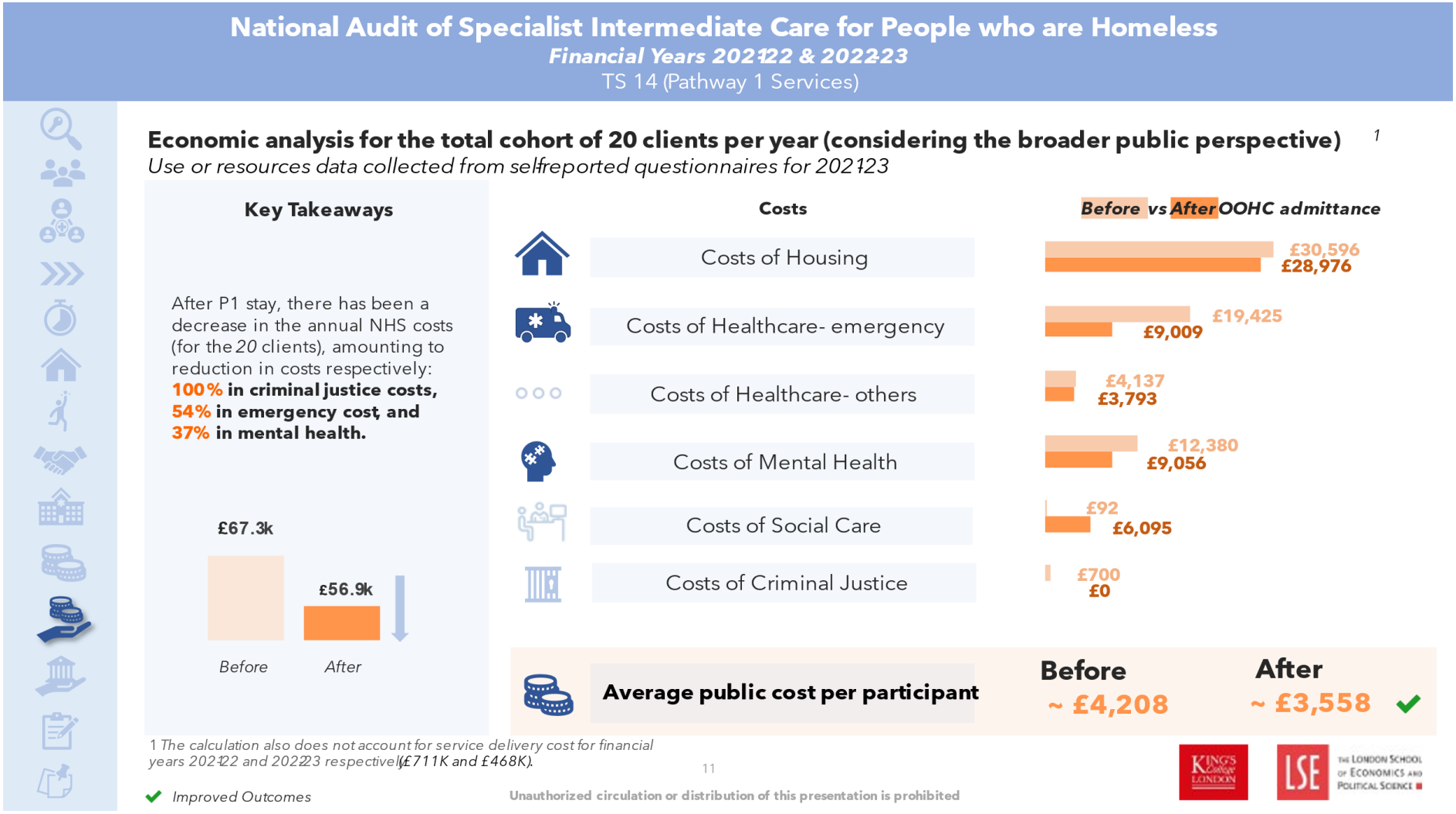
Model Description*:* The '*Take Home and Settle-in'* service includes a service manager, an administrator and 7 full time equivalent service coordinators. The service is operational 7 days a week between the hours of 9-5pm. The overall aim of the service is to ensure that patients settle into a safe environment by offering timely help and practical assistance, where people are moving into hotels or other forms of temporary accommodation (see Table 5:1). There is a high level of single system working in TS14. A well established and newly expanded HIRT provides clinical oversight (case management) of patients as they are discharged into hotels and temporary accommodation. This ensures the settle in service is well supported and not expected to take sole responsibility of patients with complex needs.

Table 5:1 Summary of Service Activities

Needs Assessment	Individual needs assessment for independent living services support. It does not include assessment for health or social care needs. Asset-based needs assessments inform activity, support planning and risk assessment.
Goal Setting + Support Planning	The co-production of person-centred goals help service users to identify what really matters to them in terms of maintaining their safety and confidence living at home. It does not include goals for health or social care support (e.g., rehabilitation).
Welfare Checks	Telephone or visit to check wellbeing and risks in terms of maintaining safety and confidence living independently at home.
Community Transport	Some taxi provision can be provided under the basic sustenance budget (£5000) however finite pot so other options to be explored e.g., Hospital transport.
Practical Support	Support with shopping, key cutting, arranging GP and outpatient appointments, collecting prescriptions and medical equipment, checking home safety (e.g., arranging pest control, water and gas, fire sensor working) prior to discharge.
Emotional Support	Listening and befriending (kindness) and potentially coaching (identifying triggers and coping strategies).
Navigation Support	Connecting service users to other voluntary or statutory agencies who can meet their needs and with community groups in line with social connection goals. Supporting service users to access other services and community groups. Escorting service users to appointments.

Figure 5.14: Static integrated management dashboard TS14 (key findings at a glance)

Figure 5.15: Static integrated management dashboard TS14 (economic analysis of broader public perspective)



TS14 Performance and Benchmarking Narrative*:*

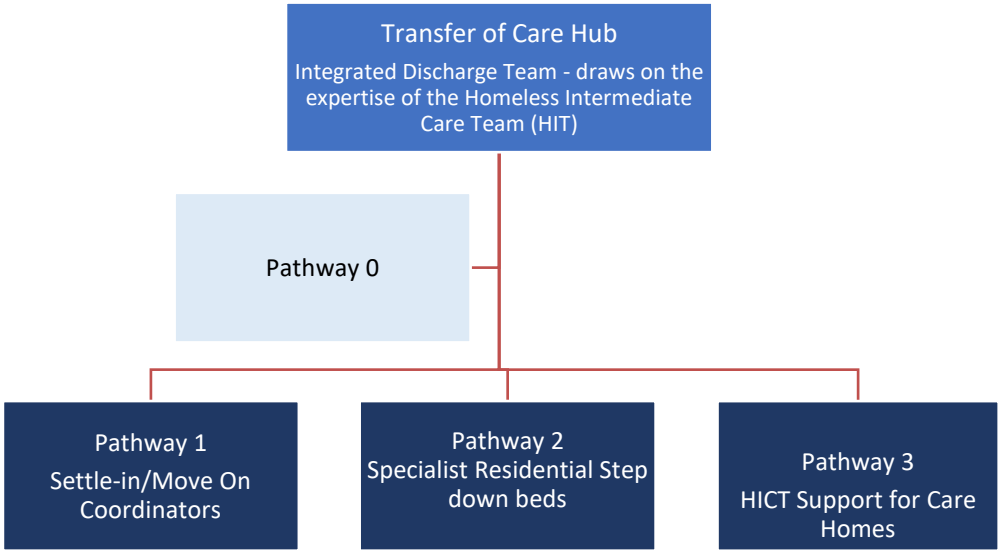
The static dashboard for TS12 can be viewed in Figures 5.14 – 5.15 above. The National Dashboard can be viewed in Figure 1:2.

- **Patient Demographics & Staffing:** for example, 74 people in 2021-22 and 304 in 2022-23 were accepted in step-down from a total of 75 & 305 referrals, respectively. The average case load per staff per week was comparable with the national average (10 people per staff in TS14 vs. 10 people per staff nationally in 2021-22).
- **Health and Social Care Use in Step-down:** for example, the percentage of early self-discharge cases remained consistently higher for both financial years (11% and 3%, respectively in contrast to the national average of 7% and 2%. In the financial year 2021-22, 0% CA assessments were conducted based on patient numbers, contrasting with the national average of 41%. In the subsequent financial year, the number of CA assessments completed was again 0%, compared to the national average of 28%).
- **The flow of people in and out of OOHC:** The average length of stay in step-down care per person is below the NHSE target of 42 days. It stands at 35 days, compared to the national average of 58 days for the 2021-22 period. In 2022-23 the opposite is reported, with 225 days (TS14) vs. 136 days (national average).
- **Housing Outcomes:** The percentage of individuals sleeping rough before and after step-down care is significantly below the national average. Also, in the 2021-22 period, there is a notable decrease in rough sleeping cases when comparing the point of admission to the point of exit (80% vs 16%, respectively).
- **Health Status Outcomes:** When comparing what people said about their health status when moving out of OOHC compared to when they moved in, 53% reported better vs. 12% unchanged vs. 35% worse QALY.
- **PREM:** 13 out of 15 indicators reported positive results for 75% or more of people. 95% of people reported that they were treated with respect and dignity while they were receiving care/support.
- **Economic Analysis for a total of 20 clients per year (considering broader public perspective, including health, social care, drug and alcohol services, mental health, housing and criminal justice)** shows that after OOHC stay, there has been a decrease in annual NHS costs for the 20 clients, dropping from £67K to £57K. The average annual public budget costs per client were £4,208 (the year before) and £3,558 (the year after).
- **Audit Summary:** The outcomes of service implementation were positive, featuring a high-fidelity model that includes a clinically-led hospital based in-reach team and a Pathway 1 settle in service (fully operational for 5 quarters). The approach was well-received by people experiencing homelessness, providers, and commissioners. Moreover, implementation costs align with national averages. Indeed, TS14 is replicating the results demonstrated in the earlier (pilot) effectiveness studies. Significant findings include a 54% reduction in emergency healthcare costs, a 37% decrease in emergency mental health costs, and a complete elimination of criminal justice costs. The economic analysis for the broader public budget perspective from TS14 in London indicated the potential for a public budget release of £1000 per year for 20 people. The total public resource costs per person the year before accessing OOHC are £4,208 (compared with £3,558 the year after; see Figure 5.16).

Case Study 3: London 'Homeless Intermediate Care Team' (working across D2A Pathways 1/2/3) – Economic Impacts for NHS

***Site Selection**:* TS13 was selected for the economic deep dive as it is piloting a '*Homeless Intermediate Care Team'* (HICT). This is *a* new service model not previously evaluated. This site was also selected as a positive practice site as it has achieved a high degree of integration between specialist and generic intermediate care to create a single D2A operating model (rather than a separate 'homeless pathway'). Here, there was a very clear strategic vision that D2A should be accessible to *all adults* and that patients who are homeless should not be excluded from the full range of available resources and expertise. There is also strong leadership in the discharge hub around preventing discharge to the street and *'system escalation'* of complex cases, which avoids individual practitioners having to advocate on a case-by-case basis. The OOHCM in TS13 was developed by commissioners working in the Integrated Care System (ICS) and encompasses five London boroughs. The full model is shown in Figure 5.16 below and each of the different components are described below.

Figure 5.16: TS13 London D2A Integrated Care System



Model Description: Prior to the OOHCM funding, the main acute hospital in TS13 had a long established clinically led Homeless In-reach Team (HIRT). However, with the advent of D2A this was remodelled into a 'Homeless Intermediate Care Team'. While this continues to provide some 'in-reach' onto the wards, the main focus is now on OOHC (assessing and supporting people in the community). The Homeless Intermediate Care Team comprises a clinical operations manager, a clinical specialist for outreach/prevention, two senior staff nurses, a podiatrist and a health care administrator. The team works across three acute hospital sites that all have high numbers of homeless patient admissions. All patients begin their D2A journey via a referral to the Transfer of Care Integrated Discharge Team. The Transfer of Care Hub / Integrated Discharge Team consults a wide range of professionals involved in OOHC and arranges for the person to be discharged on the most suitable D2A Pathway (0-3).

Strong effective leadership by the Integrated Discharge Team Managers across the ICS ensures safe practice for all patients in which *"discharge to the street*" is not an option. Where this occurs, it is recognised as a safeguarding concern. Patients will be delayed rather than discharged unsafely.

Once discharged, the HICT will then follow-up all homeless patients (regardless of any local connection issues) on the day they are discharged and will case manage their recovery, coordinating a comprehensive assessment of their health, care and support needs. The team undertakes a wide range of activities including assessment and care planning but does not provide direct clinical care. Support is provided until longer term services are in place and working well, ideally for around six weeks. The HICT provides support across all D2A Pathways:

> ***Pathway 1*** – In addition to local authority reablement teams, specialist support on Pathway 1 includes a linked team of "move on" coordinators who manage the housing dimension of the intermediate care plan, including following-up the 'duty to refer'. Each borough has its own co-ordinator who also provides some basic settle-in support. Co-ordinators have access to personalisation funding to provide for basic items such as toiletries and mobile phones.
>
> ***Pathway 2*** - Another use of the DHSC funding has been to provide resources for the spot purchase of specialist step-down beds to ensure patients have a place to recover. This includes bed spaces at two homeless facilities that offer respite type services. Funds have also been used to adapt temporary accommodation so that it is accessible to people with disabilities. The Homeless Intermediate Care Teams maintains case management responsibility for the patient in temporary accommodation and in the spot purchased beds.
>
> ***Pathway 3*** - Importantly, while the Homeless Intermediate Care Team holds its own case load, it also works to improve the accessibility of (generic) D2A services. For example, if a homeless patient requires placement in a Pathway 2 or 3 ('therapy led') rehabilitation bed (where staff are mainly working with older people), the team will support staff around any drug and alcohol issues and how to work in trauma informed ways to address any challenging behaviour.

Single System Coordination - A programme manager plays a key role in ensuring that these specialist and generic resources are fully integrated as part of the D2A operating model and with longer-term care and support services. Where any *'patient flow'* or safeguarding issues arise the programme manager intervenes to implement *'Single System Coordination'* (a negotiated solution to the problem based on principles of learn, develop, improve). This provides key intelligence for strategic planning and ensures that front-line staff do not get bogged down in day-to-day 'battles' which can damage working relationships and lead to high levels of stress and 'burn out'.

Figure 5.17: Static integrated management dashboard TS13 (key findings at a glance)

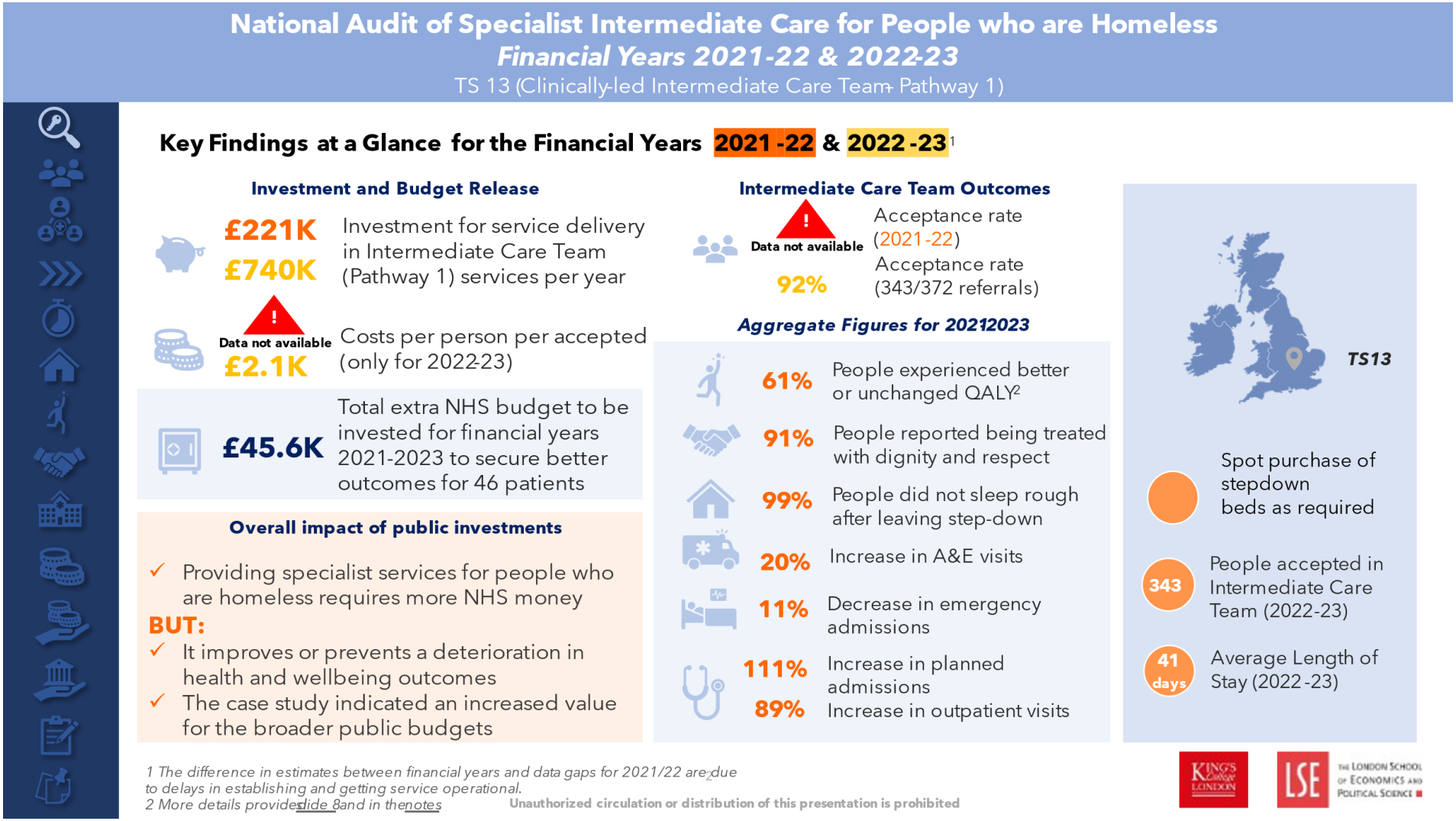
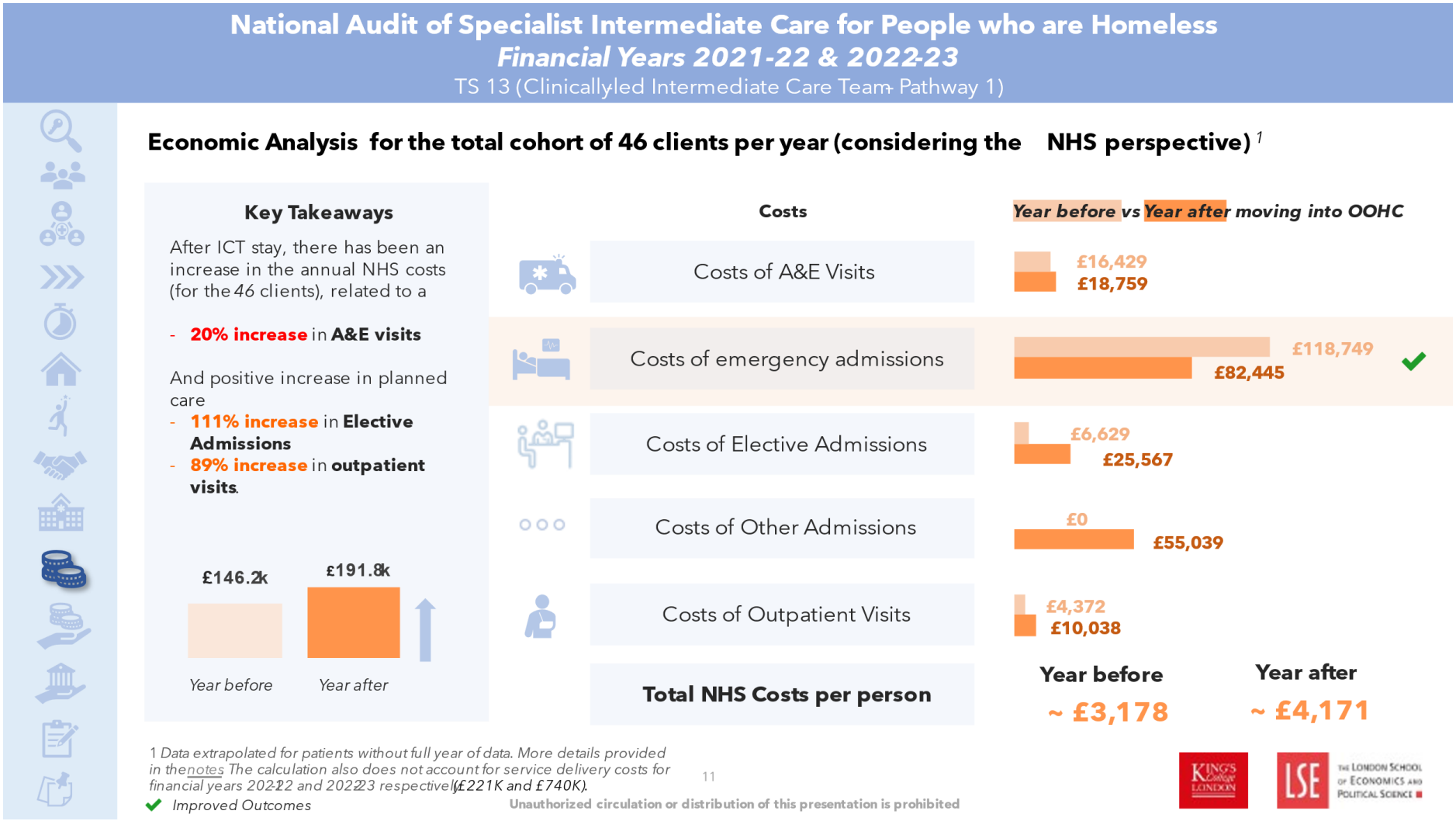


Figure 5.18: Static integrated management dashboard TS13 (Economic Analysis for the total cohort of 46 clients per year considering the NHS perspective)



***TS13 Performance and Benchmarking Narrative*:**

The summary dashboard is shown in Figure 5.18 above. Due to late mobilisation, no data are available for the financial year 2021-22. The HICT is unusual in that it works across all D2A Pathways, however for audit purposes it most closely aligns with a Pathway 1 non-residential service (due to inclusion of settle in support and peripatetic working).

- **Patient Demographics & Staffing:** for example, 343 people were accepted in step-down from a total of 372 referrals. Clinical staff have caseloads of around 8-9 and support staff have between 5-6.
- **Health and Social Care Use in Step-down:** for example, the percentage of early self-discharge cases was 2%. 30% of patients received a CA assessment (less than the national average of 34%)
- **The flow of people in and out of OOHC:** The average length of stay in step-down care per person is 41 days, slightly below the NHSE target of 42 days for all types of intermediate care, and much lower than the national average of 93 days)
- **Housing Outcomes:** The percentage of individuals sleeping rough after step-down care is below what was reported at point of admission (1% vs. 3%). The performance is better than the national Pathway 1 average 10%.
- **Health Status Outcomes:** When comparing what people with experience of homelessness said about their health status when moving out of OOHC compared to when they moved in, 48% of people reported better vs. 13% unchanged vs. 39% worse QALY. This performance is below the Pathway 1 national averages 46% vs 10% vs 26%
- **PREM:** 12 out of 15 indicators reported positive results for 75% or more of people. 91% of people reported they were treated with respect and dignity while they were receiving care/support. This is in line with the national average.
- **Annual use of NHS hospital resources per person:** The number of A&E visits increased by 20% when comparing the year before moving into OOHC with the year after. Positive outcomes were observed for emergency admissions (a 30% reduction, indicating less emergency care) and outpatient clinics (an 89% increase, indicating more planned care).
- **Economic Analysis of the entire cohort of 46 clients per year (considering the NHS perspective)** shows that after OOHC stay, there has been an increase in annual NHS costs for the 46 clients from £146K to £192K. The average annual NHS hospital costs per client were £3,178 (the year before) and £4,171 (the year after.
- **Economic Analysis of Mr John Case Story (considering broader public perspective, including health, social care, drug and alcohol services, mental health, housing and criminal justice):** The patient presents ischemic heart disease, he is heavy drinker, an ex-intravenous drug/cocaine user, and diagnosed with Crohn's and anxiety (costs before entering the service are largely attributed to hospital inpatient admissions). Following OOHC service, we assume two scenarios for Mr John's situation: (1) assume the use of health care services remains constant for the rest of the year (with 9 nights spent as inpatient), and (2) use of health care services decreases by 50% over the rest of the year (with 4 nights spent as inpatient).
- Mr John's housing situation (for the first 12 weeks and presumed to continue) after OOHC is stable at one location (living in own accommodation; receiving 12 visits with housing tenancy support) as opposed to the instability from before of living with family/friends for the entire year. Total annual public costs the year before moving in OOHC was £23,686 and dropped to £20,034 (scenario 1) or £12,068 (scenario 2). The provision of specialist OOHC can free up either £3,652 or £11,618 of public money per person in one year, respectively.
- **Audit Summary:** The outcomes of service implementation were mixed. Mobilisation was slow, with poor-quality data for 2021-22, but the approach was well-received by people experiencing homelessness, providers, and commissioners. Moreover, implementation costs align with national averages. Indeed, TS13 is replicating some of the positive results of the earlier pilot/effectiveness studies with regard to increasing the use of planned care and reducing the use of emergency care. TS13 can also be seen to enhance or prevent a deterioration in health and well-being outcomes. However, in this clinically-led model we can see that providing specialist services for people who are homeless requires additional funding from the NHS. There are no cashable savings.

5:4 Individual case stories

Where test sites struggled to access data for a full management dashboard, they were supported by the evaluation team to develop an economic case story, describing what happened to one patient the year before approaching the step-down service and in the year after leaving the service.

In TS6 (positive practice site – see Figure 4:18) a project team was formed and guided by a Local Government Association (LGA) advisor, including the test site project manager, hospital stakeholders, and community providers. The economist from the evaluation team joined to advise on the methodology and participated in a series of vHIRTual meetings. The team chose a representative case, Mr Adam (not his real name), acknowledging potential bias toward a 'good outcome.' Once selected, the key worker obtained written consent from Mr Adam that he was happy for his case to be discussed as part of the economic evaluation. Mr Adam also attended some of the meetings where his case story was being developed. The economist provided a template for counting and costing service and resource use, expanding the evaluation scope from the NHS to include other public services like criminal justice and community policing.

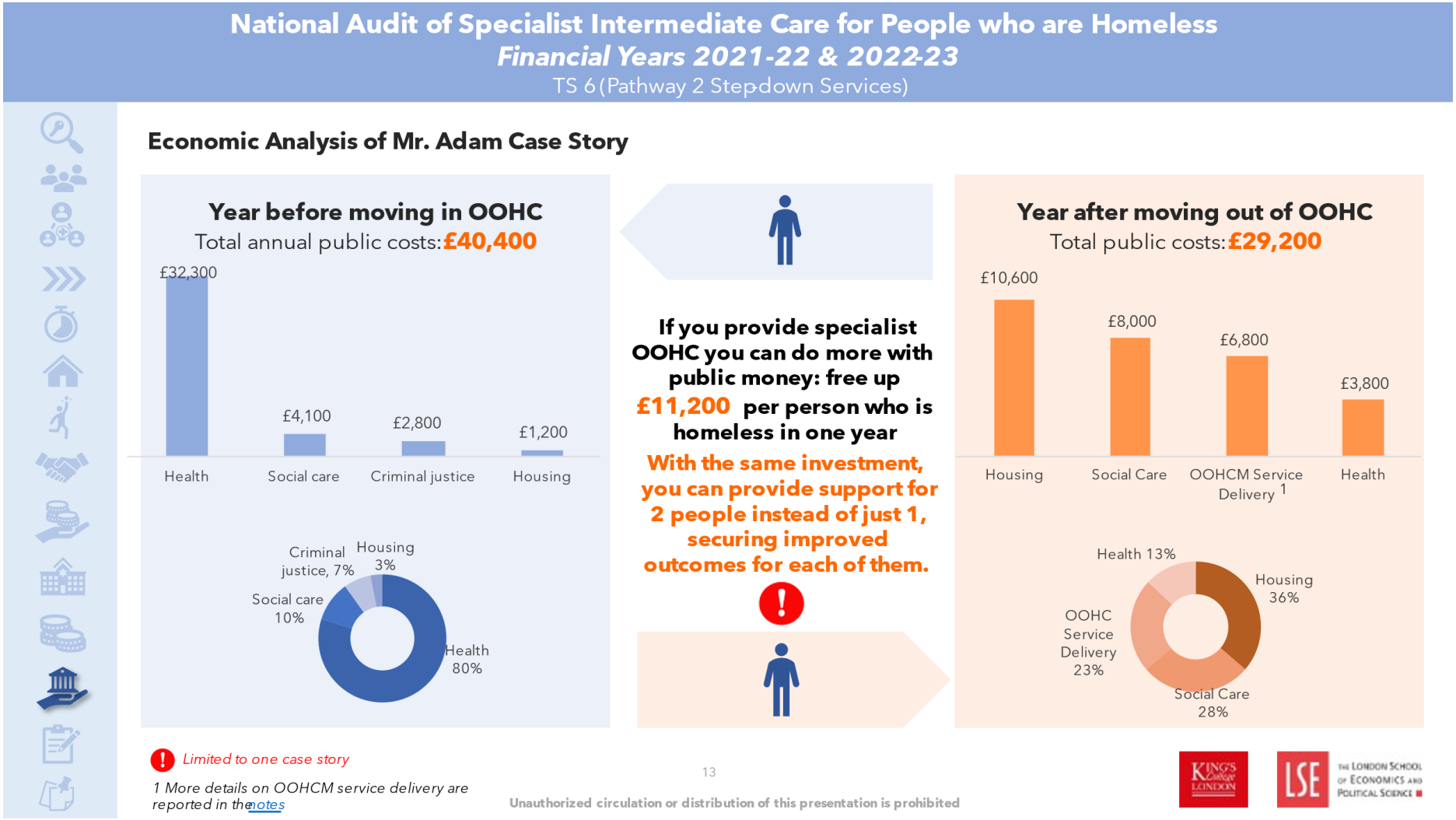
Data collection focused on Mr Adam's service and resource use 12 months before entering step-down and 12 months after leaving. The team collaborated to compile comprehensive notes, and Mr Adam's self-rated health information was gathered through OOHCM audit EQ-5D questionnaires. While this was not feasible for other case analyses, it enriched Mr Adam's story. After completing the template, the economist analysed the information, aiming to understand the costs without OOHC and potential savings and health improvements with appropriate OOHC. The analysis explored the benefits of shifting costs from urgent/emergency care to a recovery and prevention-focused system. Resource usage data were derived from stakeholder audit data and were costed using published tariffs and previous studies. In summary, the team compared Mr Adam's experience (1) without OOHC in the year before (2020/21) and (2) with OOHC in the following year (2021/22).

Prior to OOHC engagement, the total public costs incurred in the year before step-down were £40,400. Mr Adam faced frequent A&E admissions due to complex health conditions, rough sleeping, and self-neglect, resulting in a below-the-knee amputation and wheelchair use. In the year before entering step-down, he visited A&E seven times, spent 46 days in the hospital (across six different emergency hospitalizations), and had one outpatient visit. He had social care assessments and consultations, and the Homeless Outreach Team and community police had frequent interactions with him, mainly related to welfare and antisocial behaviour. Overall, he slept rough for 309 nights and stayed in a hotel for 10 nights just before moving into OOHC.

With OOHC in place, the total public costs incurred after one year were £29,200. The hospital in-reach service efficiently moved Mr Adam from the hospital to the step-down house, where his ongoing health, care, and housing needs could be properly assessed. He gained access to a key worker, a specialist domiciliary social care service, and community health and outpatient care to manage his health and cope with the impact of his amputation. Assumed to have three A&E visits, one planned hospital admission, and 24 outpatient visits in the first year after leaving step-down, Mr Adam had a care package, engaged with a daily paid carer, stopped contact with community police, stayed in supported accommodation full-time, and had a team of professionals working together to meet his needs. OOHC delivery included staff time, overheads, and other costs per client. Figure 5.20 (below) shows how the costs were shifted from urgent / emergency care to supporting a system that focuses on housing (ending homelessness), recovery and prevention.

In total, seven case stories were produced for the evaluation. To see the findings from the other case stories, see www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards.

Figure 5.19: Static integrated management dashboard TS14 (Example of an individual case story)



OOHCM service delivery includes costs relating to step-down accommodation, staff costs (including social care and mental health care) and project management. **Housing** includes social care support given by care home staff.

5:5 Summary

In this Section, we have sought to further test the key components of effective and cost-effective models, especially where they have not previously been brought together into a single system (Objective 3). We have focussed on three test sites demonstrating a high degree of maturity around integration and single system working across D2A pathways.

Table 5.2 below presents an overview of the evidence presented across the case study sites. In the case study analysis, performance has been assessed against a wide range of metrics, using national averages. This demonstrates considerable positive practice while also pinpointing any areas where future improvement efforts might be focussed. Results of the economic analysis suggest that services in the case study test sites are cost-effective, freeing up resources for the broader public perspective and aligning with the findings of earlier cost-effectiveness studies. In TS12 for example, the services were outperforming the original effectiveness studies on metrics such as reducing readmissions and A&E attendances. TS12 also demonstrates the ability to secure reallocatable resources. Although the evidence is not as robust, these conclusions are supported by the economic analysis of seven individual case stories and cohort data for 20 individuals in TS14. Both TS13 and TS14 are newer typologies of specialist care and not previously tested. They stand out from the other new services being piloted in the OOHCM Programme because they have collected data that enables some independent assessment of their implementation progress.

In presenting the *'gold standard'* dashboard for TS12 we hope to have illustrated the evidence standard that commissioners might aspire to when reviewing business cases and assessing issues of cost and quality. However, barriers to embedding the full audit and evaluation process were numerous and the completeness and quality of the data contributed by the test sites was variable. Only 10 of the 17 test sites had sufficient data to produce a dashboard and most of these had significant data gaps (particularly HES data).

It is clear from the discussions with test site managers and commissioners that improving data quality requires action on many fronts: collecting appropriate metrics in a standardised manner across services; tackling duplication and aligning multiple and fragmented reporting systems; ensuring ease of access to key data sets and the analytical support needed to make sense of them; ensuring data collection is sufficiently prioritised in management structures; partnering with external evaluators to secure impartial audit and evaluation and most important of all, ensuring that front line staff have the capacity and capability to deliver quality data. Addressing these issues locally are likely to require additional resources to enhance capacity for data collection, as well as training to improve capability around analysis and reporting. It is also likely that a smaller minimum data set may be helpful in reducing the data burden. In Section 8, we outline a 'road map' for securing continuous data collection and long-term monitoring evaluation, highlighting the potential for digital interactive versions of the individualised management dashboards. In conclusion,

- OOHCM services demonstrating high levels of maturity around data collection and integrated single system working are cost-effective, freeing up resources for the broader public perspective.
- Barriers to embedding the full audit and evaluation process were numerous and the fullness and quality of the data that was contributed by the test sites was variable.
- There is much scope for further development of the individualised management dashboards to ensure continuous data collection and long-term monitoring evaluation.

Table 5.2: Audit summary comparison between the three positive practice economic impact case studies.

	TS12 Outside London Pathway 2 Step down houses	TS13 London Clinically-led Intermediate Care Team	TS14 London Pathway 1 Settle in
Service implementation	✓ **Implementation costs** are within national averages. ✓ **Mobilisation:** Rapid – additional service operational by March 2021. ✓ **Acceptability:** Well-received by People Experiencing Homelessness, providers and commissioners. ✓ **Capacity & Demand**: Services scaling for 23/24 to increase capacity to match demand.	✓ **Implementation costs** are within national averages. ✗ **Mobilisation:** Slow, poor-quality data for 2021-22. ✓ **Acceptability:** Well-received by People Experiencing Homelessness. ✗ **Capacity & Demand**: no data.	✓ **Implementation costs** are within national averages**.** ✗ **Mobilisation:** Late mobilisation (fully operational for 5 quarters). ✓ **Acceptability:** Well-received by People Experiencing Homelessness, providers and commissioners. ✗ **Capacity & Demand**: data not available,
Evaluation Outcomes	✓ **Staffing:** Caseloads are lower than national averages, with regular visits from nurses and GPs. ✓ **Patient flow:** Lower average length of stay compared to national stats. ✓ **Housing outcomes:** Fewer patients sleep rough after leaving OOHCM. ✓ **Health status and patient outcomes:** Majority report positive outcomes, with lower self-care and mobility problems on leaving, and that they were treated with respect and dignity in step-down. ✓ **Economic Analysis:** Case study indicated an increase value for the public budgets with a drop in emergency health care and criminal justice costs.	✗ **Staffing:** Caseloads data not available. ✗ **Patient flow:** Longer than average length of stay (~10 times longer) compared to NHSE target for all types of IC. ✓ **Housing outcomes:** Fewer patients sleep rough after leaving OOHCM. ✓ **Health status and patient outcomes:** Only 61% report positive health outcomes, mainly with pain and discomfort. They were treated with respect and dignity. ✓ **Economic Analysis:** Case study indicated increased value for the broader public budgets. For NHS perspective, more money needed to secure better outcomes.	✗ **Staffing:** Caseloads are higher than national averages. ✓ **Patient flow:** Lower average length of stay compared to national stats. ✓ **Housing outcomes:** Fewer patients sleep rough after leaving OOHCM. ✓ **Health status and patient outcomes:** 65% report positive health outcomes and 95% were treated with respect and dignity. ✓ **Economic Analysis:** Economic analysis for the total cohort of clients per year indicated an increase in value for the public budgets.

	TS12 Outside London Pathway 2 Step down houses	TS13 London Clinically-led Intermediate Care Team	TS14 London Pathway 1 Settle in
Audit and evaluation	✓ **Data:** Includes a combination of investment costs, audit, patient experience and economic data (with linkages to local NHS information) and individual case stories. ✓ **Co-production:** Involvement of peer researchers and Experts by Experience in data collection and service development. ✓ **Appropriateness:** Evidence produced has been recognized by PEHs, providers, and commissioners. ✓ **Adoption:** Data collection and evidence production is well-received by the organization, and evidence produced was successfully used to support service sustainability. ✓ **Feasibility:** successfully tested.	✓ **Data:** Includes a combination of service implementation costs, audit, patient experience and economic data (linkages to local NHS information). ✓ **Co-production:** Involvement of peer researchers and Experts by Experience in data collection and service development ✓ **Appropriateness:** Evidence produced has been recognized by PEHs, providers, and commissioners. ✓ **Adoption:** Data collection and evidence production well-received by organization; evidence used to support service sustainability. ✓ **Feasibility:** successfully tested.	✓ **Data:** Includes a combination of audit, patient experience and economic data (with broader public perspective). ✓ **Co-production:** Involvement of peer researchers and Experts by Experience in data collection and service development. ✓ **Appropriateness:** Evidence produced has been recognized by PEHs, providers, and commissioners. ✓ **Adoption:** Data collection and evidence production is well-received by the organization, and the evidence produced was successfully used to support service sustainability. ✓ **Feasibility:** successfully tested.
Challenges	✗ **PREM:** more support and information to family or those close to PEHs; More support to maintain social contact after leaving step-down. ✗ **Sustainability:** Need to move toward longer-term, more sustainable funding sources to secure continuous service delivery and audit/evaluation.	✗ **PREM:** More to be involved in decisions about when OOHC service was going to stop; More given enough notice about when care and support was going to stop; More support to maintain social contact after leaving step-down. ✗ **Mobilisation:** delays impacted on the quality of the data for 2021-22. ✗ **Health outcome (QALY):** only 48% better vs. 13% unchanged vs. 39% worse health outcomes. ✗ **Sustainability:** as TS12	✗ **QALY and PREM:** already satisfactory but room for improvement. More support and information to family or those close to PEHs; More support to maintain social contact after leaving step-down. ✗ **Mobilisation:** was late. ✗ **Caseload:** higher than national averages. ✗ **Sustainability:** Same as per TS12

6: Patient Experiences and Preferences

Successful implementation of OOHC depends on the extent to which services meet the values and priorities of the people who use them. In this evaluation, we engaged with homeless patients in a variety of ways. In-depth qualitative interviews were carried out with 30 patients who were recruited from one of the three positive practice sites. These interviews were carried out shortly after the patient left step-down and provide insight into the overall experience of using the service and how they were supported through the transition out of step-down intermediate care. Across all the test sites, we embedded a (validated) PREM that had been used in earlier audits of generic intermediate care. Data on patient experience was subsequently returned for 9/21 test sites (total number of respondents n=170). Finally, we undertook a survey that explored patient's preferences for different types or configurations of intermediate care (total number of respondents n = 112). This was achieved using a flexible health economics tool for measuring choices in health and social care-related settings, namely **discrete choice experiments** (**DCEs**)[59].

We discuss the findings from each of these engagement methods in turn before drawing conclusions and discussing implications for further development of specialist OOHC services for people experiencing homelessness.

6:1 Patient experiences of OOHC

Overall, the qualitative feedback about the experience of using step-down services (in the three positive practice sites) highlighted that the service is greatly appreciated. People often began by highlighting the precarity and desperation of their previous health and life:

> 'My life was a total mess, in and out of A&E every other week, my health was so bad that I needed medication just to keep me alive, but it kept getting stolen because I was homeless and never had anywhere to keep it safe.'
>
> 'I have multiple health issues and to be honest I never knew how to manage my health condition properly, also I was constantly in pain all the time.'
>
> 'I was either in and out of hospital or in jail because of my addiction. I was always just waiting for that day where you never wake up.'
>
> 'I had three blood clots in my leg, and I ended up having the bottom half of my right leg amputated, so I lost my accommodation that I was living in.'

Individuals then talked about the significant improvements in their lives after entering step-down facilities, highlighting positive changes in health, substance use, mental well-being, and practical skills. Step-down is credited with saving lives, offering crucial support in health management, medication, addiction recovery, and improving essential life skills and overall well-being. Step-down was perceived to have played a vital role in helping residents transition from challenging situations to a more stable and fulfilling life.

> 'Step-down is fantastic, I never knew places like this existed. They have helped me not just understand but also deal with my health condition and they are getting me housed, how brilliant is that? I have never felt so happy as I do now.'
>
> 'Step-down saved me, I would be dead by now if it were not for them, they helped me get a doctor and got me on the right medication, because before I was on the wrong meds and I kept blacking out. I have woken up in a police cell before and I never knew how or even what I had done to get there.'

[59] Tinelli, Michela (2016) Applying discrete social experiments in social care research. Method Reviews, 19. NIHR, SSCR, London, UK (available here). An example of their application to measure care preferences for public HIV clinical services for people with experience of homeless or unstable housing during the COVID-19 pandemic is provided by Imbert E, et al (2022) Journal of Acquired Immune Deficiency Syndromes 90:40-145 available here.

> ‘Before I went into step-down, I was sleeping rough and then I started to feel unwell, so I went to A&E that is when I got diagnosed with cancer, and because English is my second language, I could not really understand what the doctors were telling me or even what meds they were giving me. Then I went into step-down and that all changed, they got someone who speaks my language who sat down and explained to me exactly what my condition was and what the meds I was put on were for and how they would work. They are also supporting me while I go through chemo, so if the step-down wasn't about I would have no one because I am in this country by myself and I don’t really know many people, and ironically the people that I do know now I have only met through step-down so they have not only helped me to understand my condition and manage it, they have also given me a social life, which I never had before.’
>
> ‘Step-down is amazing, it has helped me so much not just with my health but with my everyday life. I was using drugs daily before I came in here and because they helped me and got me the right support, I am now clean and loving life’.

Individuals, including those with language barriers, have benefitted from step-down's support in understanding medical conditions and medications and navigating healthcare systems. The facilities have provided a crucial bridge for individuals, ensuring they receive appropriate care and support. Practical support was especially appreciated, for example, help filling out forms and claiming benefits. Good support workers were seen as key to successful step-down. Being accessible and kind was considered to be very important.

> ‘You remember, just the little things… I’ve got this obsession with lemon tea and a few weeks later this lemon tea came up in conversation and I said to Clare [my support worker] `how did you remember that?’ sometimes the big things are quite easy to remember but it’s just the little personal things actually make you feel a person, an individual yeah’.

Step-down is also commended for providing holistic support beyond accommodation, including teaching practical skills, offering social activities, and fostering a sense of community. Residents appreciate the comprehensive assistance that goes beyond immediate housing needs and the positive impact on their wellbeing and confidence.

> ‘Step-down have really helped me; I didn’t even know how to boil an egg before I came in here, so they have taught me how to cook, and last week I cooked a roast for every resident in the house and they all really enjoyed it and even asked when was I going to cook for them again. Do you know how great that made me feel?’
>
> ‘I was not allowed to go back to my own flat and I really had nowhere to go, I 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.’
>
> ‘I never trusted anyone before I came in here, and the staff have helped me to trust again and have helped me to get the confidence that I never had. Before I was timid and even scared off my own shadow; now I make my shadow jump!’

A number of issues were raised with regard to how step-down could be improved. The first related to the lack of disabled access, including the need for accessible wet room facilities. Linked to this was the lack of access to occupational therapy and physiotherapy assessments and services. One patient was still using the wheelchair that the hospital had given him while in step-down. He was expected to collect his own medications from the chemist (as part of his promoting independence plan) and reported that he frequently fell out of his chair on the pavement especially in the wet.

A need for women only services was also identified.

> ‘When I got there, I was just like `this is amazing, I’ve got somewhere to live, I’ve got a roof over my head’ I was just yeah really grateful. My room was very simple, just a single

> bed, a wardrobe, set of drawers but it was nice. There was a shared bathroom, I didn't particularly like that to be honest, because I was sharing with two men and you know it's only silly things like you know you want them to flush the toilet after they've used it…'

The rules of Pathway 2 step-down services were sometimes queried. Some services did allow patients to have visitors, but most did not allow drinking or smoking on the premises. Communal spaces had purposively not been included in some services (to avoid anti-social behaviour) and this led to some patients feeling isolated. Adequate furniture was also reported as important, for example a table in the room especially if there was no kitchen area in which to eat meals. Where patients were receiving a Pathway 1 service finding themselves accommodated miles from the areas they were familiar with was viewed in a very negative light in most cases.

The most common area for improvement raised in the interviews was the need for better management of the transition out of step-down and relatedly the lack of follow-up care and support. Staying for prolonged periods in step-down (due to the silting-up of services) left many patients feeling depressed and 'in limbo.' Some patients reported not being involved in discussions about leaving step-down and it coming as a shock when they were told that they would be moving out. For others, the lack of support after leaving step-down and the feeling of being abandoned was a significant issue. Patients stressed the importance of ongoing support after leaving step-down, indicating that challenges persist even after securing independent housing. The need for continuous assistance and guidance is emphasised to prevent isolation, tenancy failures, mental health problems and drug and alcohol relapse, and to support long-term success.

> 'It's great getting all this practical support, but what happens when I leave here, who will support me then? There is still stuff that I need help with because I cannot do it by myself, what am I going to do?'

> 'All I do all day is sit in my room, I don't have a telly in my room and we are not allowed to have a communal area, so all I have are these four walls to look at, so go on you tell me, why I shouldn't give up?'

Some patients described how their step-down workers had kept them on a 'secret caseload' and how they had been told that in emergency they could always contact them. Others described the sadness when the relationship finally came to an end.

> 'They don't call me anymore. They don't answer my call and they don't return it… I don't have anyone who is helping me now'.

6:2 PREM Results

The PREM results are shown in Appendix 4a for Pathway 1 services and Appendix 4b for Pathway 2 services. Overall, these triangulate the findings of the qualitative interviews across a larger number of sites. They reflect very positive experiences of step-down overall, with slightly less positive scores relating to metrics concerned with the transition out of step-down. Across both Pathway 1 and 2, for example 90%+ reported being treated with dignity and respect. However, only 58% of people on Pathway 2 reported being given enough notice about when their care and support was going to stop. The PREM also appears to highlight that social isolation may be a significant issue for many patients after leaving step-down with 62% reporting that following the service their ability to maintain social contact has improved. For test sites that did not return PREM data it is not clear if and how they engaged with the people who used their services.

6:3 Choice modelling and DCE methodology

Choice modelling is a survey-based method that captures individual people's preferences regarding different services using DCE questionnaires. Each alternative service (e.g., specialist hospital discharge scheme) is described by several attributes (or characteristics). The choices made between two or more competing alternatives determine how preferences are influenced by each attribute.

DCE allows for the identification of which attributes are important within a decision-making context (e.g., location, main carer, duration of care, etc). Analysis can also establish a hierarchy of preferences, indicating which factors have a more significant impact on individuals' choices (e.g., whether provider of care is considered more important than location of service).

DCE provides information on the trade-off's individuals are willing to make between various attributes. By assessing choices made in different scenarios, we can understand the compromises individuals are willing to accept in one aspect to gain a benefit in another (e.g., individuals are willing to accept a delay in receiving care if it means it will be administered by a housing support worker in the comfort of their own flat, as opposed to receiving care from a nurse in a hospital, provided their health status permits such an arrangement).

The probabilities derived from DCE data can be used for predictive modelling of uptake rates or preferences for different models of care or services. Comparing different scenarios can provide insights into how preferences may vary between a baseline option (e.g., rough sleeping) and alternative services (each representing different specialist hospital discharge schemes). It can also identify optimal service provision that meets stakeholder requirements and has the best chance of sustainability in the long-term in preference to returning to rough sleeping.

(Selection of DCE items and DCE choice sets)

A DCE survey was developed to measure patients' preferences for OOHC, in terms of the following five characteristics compared with rough sleeping (see table 6.1):

- The location of care (hospital, own home/flat, shared flat/house, hostel, hotel or care home)
- The professional providing care (social worker, housing support worker, peer navigator, mental health support worker, or drug & alcohol support worker)
- The frequency of care per week (1 to 2 times, 3-4 times, 5 to 6 times, 7 or more)
- The duration of care after hospital discharge (4-5 weeks, 6-7 weeks, 8-9 weeks or 10-12 weeks)
- Rules for behaviour in their living environment (no rules, less strict rules, strict rules, very strict rules).

In this study, the initial choice of DCE attributes (characteristics) and their various levels were informed by our previous OOHC research. Efficient experimental design techniques were applied to create the DCE questions. Due to the cognitive load involved in completing the survey, respondents were assisted in the completion of the questionnaire by members of the research team. During the survey, each person was asked to respond to a series of five questions. In each of these questions, they were presented with a choice scenario that involved choosing between different options. These hypothetical options (Service A or Service B) represented different combinations of the five characteristics of care models (see Figure 6.1).

(Stakeholder involvement and engagement consultations)

Webinar discussions with the LGA network regarding what stakeholders' value about specialist services were used to validate and refine the attributes and levels. The PPI stakeholders were also consulted on the choice of the attributes and levels, development of the presentation, wording and format of the survey.

(Population and procedures)

The DCE was conducted with individuals with experience of homelessness who were asked to complete the DCE questions before they exited a Pathway 1 or Pathway 2 service. Individuals who, after receiving information about the study, provided consent, participated in the survey. The survey questionnaires were handed out in paper form by both researchers and frontline staff members from 10 sites enrolled in the OOHCM evaluation.

(Piloting)

An internal pilot study aimed to examine comprehension and understanding of the choice set tasks, attributes and their levels as well as the general functioning of the DCE survey. Results from the analysis of the pilot data were used to test the face validity of the survey instrument. The pilot study included responses from the first 88 participants (October 2022 to May 2023). We tested data collection and cleaning processes as well as the econometric model. The pilot revealed no procedural issues with the experimental design of the survey. Consequently, no revisions were deemed necessary, and the data collected during the pilot were utilised within the main analysis.

(Analysis of DCE data and uptake modelling)

The analysis employed regression modelling[60] to examine which attributes were valued by participants and their relative importance and whether higher or lower levels on the attributes (such as frequency of visits) were preferred.

- **The direction of preferences**: We looked at the coefficients for each variable. If a coefficient is positive, it suggests that as those variables increase, the likelihood of choosing the option also increases. For example, in terms of number of visits per week, respondents showed a preference for fewer visits per week (negative coefficient for 'How often you receive a visit from one of the professionals who provide your care'), whereas they preferred longer period of care (positive coefficient for 'How long for you receive care after hospital').
- **What characteristics of the specialist hospital discharge schemes are important:** All the attributes were statistically significant in the regression model indicating that the participants considered them all important. We examined the p-values associated with each coefficient. A low p-value, typically less than 0.10, suggests that the variable has a statistically significant impact on choices.
- **Their relative importance:** We considered the size of the coefficients. Larger coefficients indicate a stronger impact on choices compared to smaller ones. For example, 'main carer', 'no rules' and 'decreased frequency of visits' presented larger coefficients than other attributes.

Subgroup analyses were conducted to assess the potential impact of patient characteristics on preferences, with a particular focus on age, gender, health outcome and experience of care.

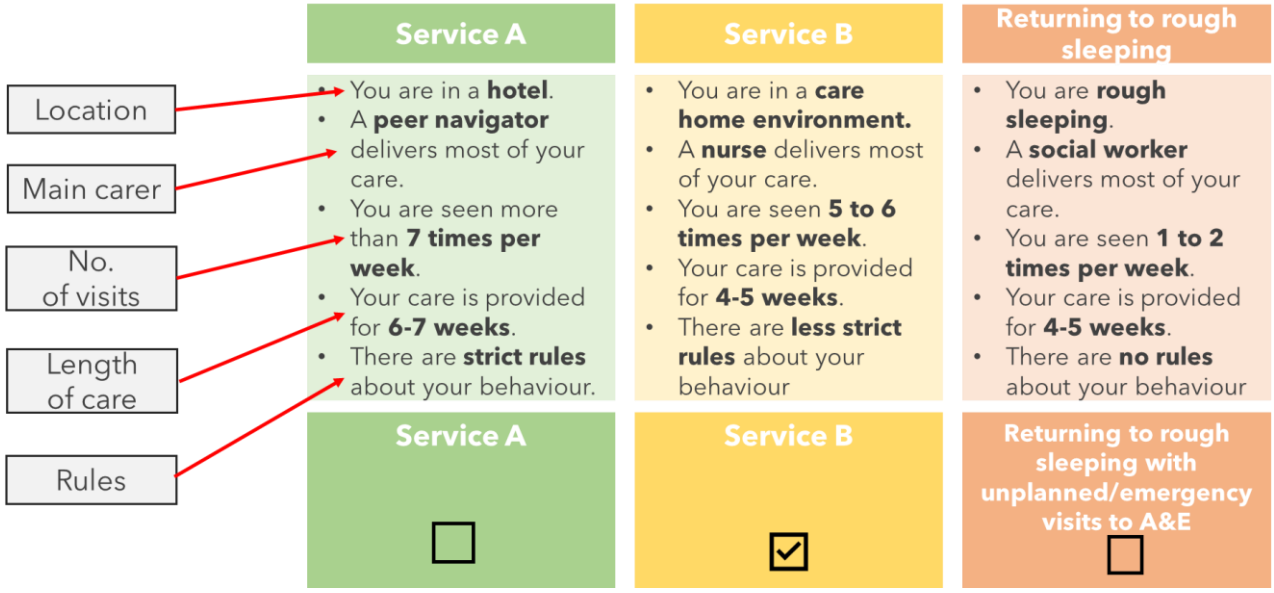
The regression outputs were used to compute probabilities linked to the selection of particular specialist hospital discharge schemes in contrast to returning to rough sleeping. Probability calculations assume that individuals are more likely to choose alternatives with higher utility values. These probabilities provide valuable information on the trade-off individuals are willing to make, shedding light on the factors they consider when making choices between models of care within a given set of alternatives. The computed probabilities were used to model the expected adoption rates of different specialist hospital discharge schemes. This modelling is relevant for extrapolating from the respondent preferences to the broader population, predicting the proportion of individuals likely to adopt each scheme.

[60] This report provides an overview of the fundamental aspects encompassing the methodology, results, and insights. Detailed information about the methodology, the regression model employed, and regression outputs pertaining to service users' preferences and adoption rates of various care models within specialist hospital discharge schemes are presented in a forthcoming paper by Tinelli et al. For information, contact Dr Michela Tinelli at m.tinelli@lse.ac.uk.

Table 6.1: Service characteristics and their levels

ALTERNATIVE specialist intermediate care	**Service 1 / Service 2**	**Returning to rough sleeping with visits to A&E**
ATTRIBUTES	**LEVELS**	**LEVELS**
Location of care	You are in a **care home environment.** You are in a **hospital environment.** You are in your **own flat/house.** You are in **shared flat/house.** You are in a **hotel** environment. You are in a **hostel** environment.	You are **rough sleeping.**
The professional who delivers most of your care (as part of a team with other professionals)	A **nurse** delivers most of your care. A **social worker** delivers most of your care. A **housing support worker** delivers most of your care. A **peer navigator** delivers most of your care. A **mental health support worker** delivers most of your care. A **drug and alcohol support worker** delivers most of your care.	A **nurse** delivers most of your care. A **social worker** delivers most of your care. A **housing support worker** delivers most of your care. A **peer navigator** delivers most of your care. A **mental health support worker** delivers most of your care. A **drug and alcohol support worker** delivers most of your care.
How often you receive a visit from one of the professionals who provide your care	You are seen **1 to 2 times per week.** You are seen **3 to 4 times per week.** You are seen **5 to 6 times per week.** You are seen more than **7 times per week.**	You are seen **1 to 2 times per week.** You are seen **3 to 4 times per week.** You are seen **5 to 6 times per week.** You are seen more than **7 times per week.**
How long for you receive care after hospital	Your care is provided for **4-5 weeks.** Your care is provided for **6-7 weeks.** Your care is provided for **8-9 weeks.** Your care is provided for **10-12 weeks.**	Your care is provided for **4-5 weeks.** Your care is provided for **6-7 weeks.** Your care is provided for **8-9 weeks.** Your care is provided for **10-12 weeks.**
Rules about behaviour where you live	There are **no rules** about your behaviour. There are **less strict rules** about your behaviour. There are **strict rules** about your behaviour. There are **very strict rules** about your behaviour.	There are **no rules** about your behaviour.

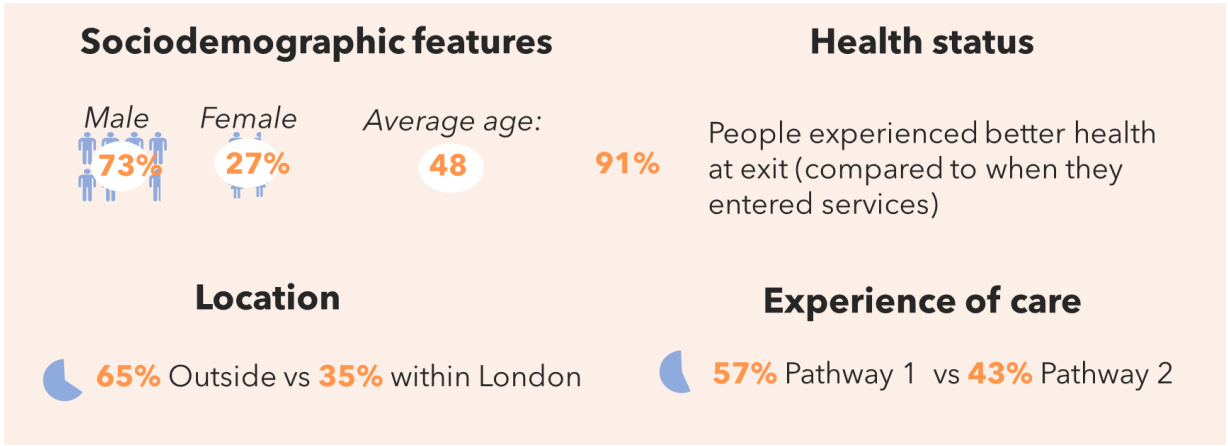
Figure 6.1: Example of Discrete Choice Experiment (DCE) choices



6:3:1 DCE survey responses

The DCE survey was well received by study participants. In total, we secured responses from 112 people (between October 2022 and July 2023). The response rate was 37% of the total cohort of 300 people enrolled from the 10 sites participating in the DCE survey. Respondents were mostly men (73%), had an average age of 48 years old and mostly experienced Pathway 1 care (57% compared with 43% Pathway 2; see figure 6.2).

Figure 6.2: Respondent's characteristics



6:3:2 Analysis of the DCE data

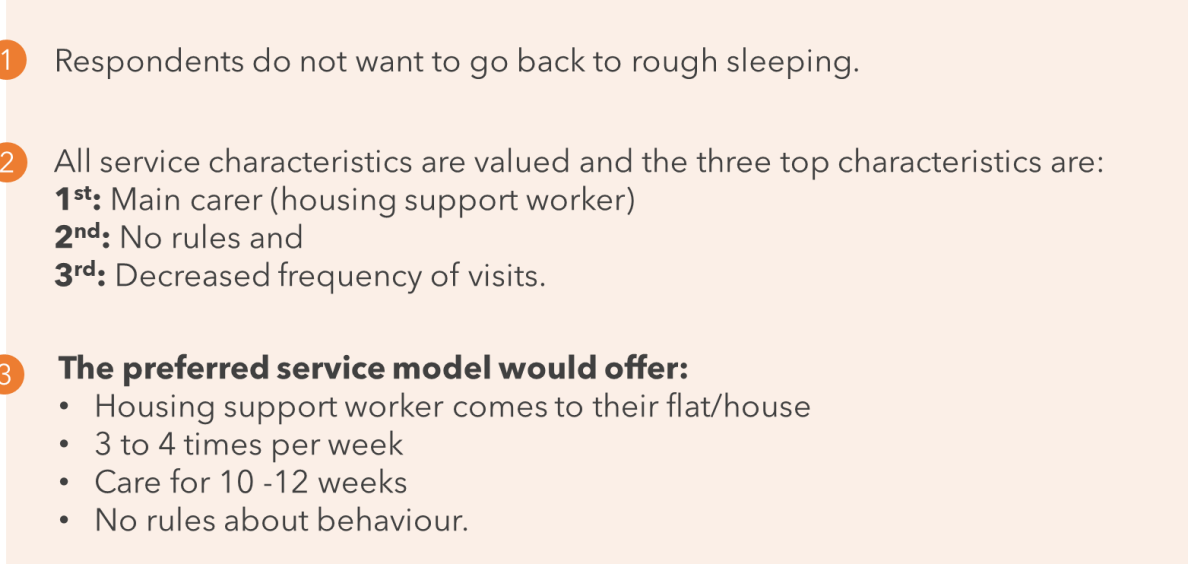
(Patients' preferences)
Key insights emerging from the analyses of the DCE data are outlined below.

Main analysis (figure 6.3): Firstly, respondents strongly expressed their reluctance to return to rough sleeping, aligning with sentiments expressed in the interviews about the high acceptability of step-down. All five aspects (location, professional providing care, frequency of care, duration of care, and rules for behaviour) play a significant role in individuals' choices regarding their specialist intermediate care.

The preferred characteristics were ranked (from the most to the least preferred) as follows: professional providing care (being a housing support worker), no rules about behaviour, location, duration of care (weeks), and number of visits per weeks. The preferred service model is described in figure 6.3.

Subgroup analysis: Data analysis revealed variations in attribute importance across different subgroups. For instance, individuals aged 65 and older are less likely to prioritise the location and duration of care, in contrast to those under 65 who deem all five aspects (location, professional providing care, frequency of care, duration of care, and rules for behaviour) important. Additionally, individuals accessing Pathway 2 support are less inclined to prioritise the location and duration of care compared to those with experience in pathway 1, where all five aspects are considered important.

Figure 6.3: Key messages emerging from the analysis of the DCE data



(Service uptake modelling)

Figure 6.4 illustrates three OOHCM examples. In each instance, we compare two alternative scenarios: the baseline scenario in orange (which remains constant, describing a rough sleeping situation) and a specific specialist hospital discharge scheme in yellow (each case representing a distinct OOHCM option). The attributes of the specialist hospital discharge schemes, such as the care provider, rules about behaviour, location, duration of care, and frequency of visits, are all considered in the modelling process. This allows for a comprehensive understanding of how these characteristics influence overall adoption rates of different models of care. The probabilities are indicative of how strongly respondents prefer specific attributes within the OOHCM schemes. Higher probabilities suggest a stronger preference for schemes with certain characteristics, as identified through the DCE.

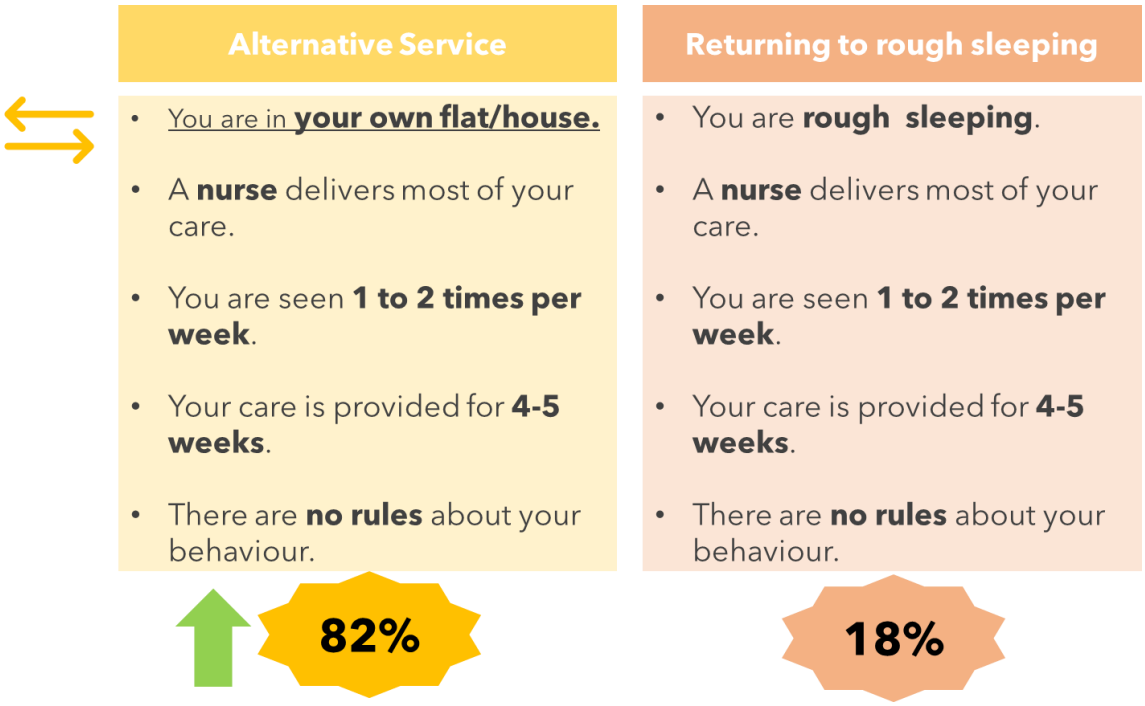
Example 1: the focus is on examining the probability of service uptake when modifying a single attribute compared to the rough sleeping option. The alternative service involves living in ‘your own flat/house’ rather than 'rough sleeping' while maintaining all other features consistent with the context of individuals returning to rough sleeping. The key finding is that the probability of service uptake is significantly higher for the 'alternative service' in contrast to the scenario of 'rough sleeping,' with findings indicating a likelihood of 82% for the 'alternative service' as opposed to 18% for 'rough sleeping'. This suggests that on offer of 'your own flat/house' positively influences the propensity of individuals to access services offered.

Example 2: the alternative service considered here involves changing a single attribute (rules about your behaviour) from ‘no rules’ to ‘some rules’, while keeping all other features consistent with 'Returning to rough sleeping.' The shift to the 'alternative service' results in a lower likelihood of individuals accessing the service compared to rough sleeping (31% vs. 69%). This suggests that the introduction of 'some rules' negatively impacts the willingness or ability of individuals to engage with the offered services.

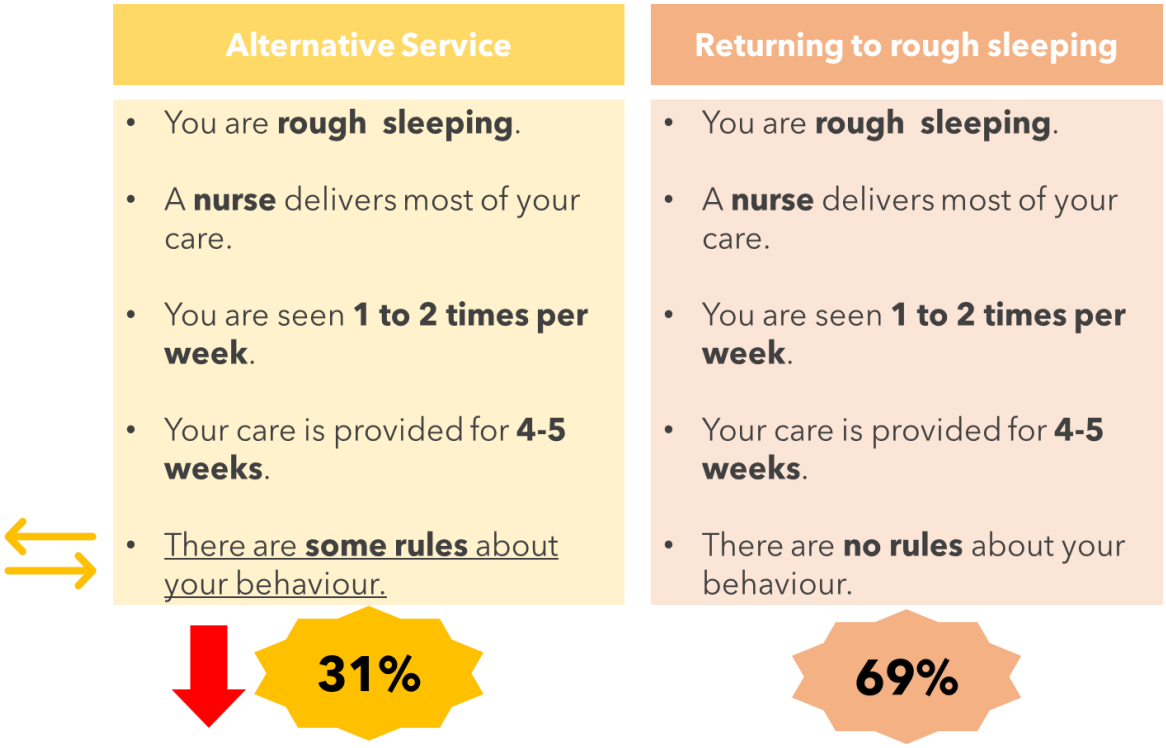
Example 3: the focus is on examining the probability of service uptake when the service offered differs from rough sleeping in multiple attributes. The alternative service with the highest probability of acceptance (100%) compared to rough sleeping involves securing longer-term accommodation (lasting a minimum of 10-12 weeks), preferably in one's own home. This specialist hospital discharge scheme includes multi-disciplinary teams providing consistent support (3-4 times per week) without imposing behavioural restrictions (see preferred care model described in figure 6.3).

Figure 6:4: Calculating the probability of service uptake for three separate examples, each comparing two options (alternative service vs. returning to rough sleeping)

(1) **Example 1:** In this case, the only change is in the location attribute, shifting from 'rough sleeping' to 'your own flat/house'; all other attributes remain the same.



(2) **Example 2:** In this case, the only change is in the 'rules about your behaviour' attribute, shifting from 'no rules' to 'some rules'; all other attributes remain the same.



(3) **Example 3:** In this case, we change multiple attributes to assess the impact of multiple changes on the probability of service uptake.

Note: Here we provide three separate comparisons, but more options can be modelled accessing the integrated management dashboards website (link here).

6:4 Summary

A DCE allowed us to quantify patients' preferences and decision-making by analysing their choices between hypothetical scenarios. The DCE survey worked successfully, achieving a response rate of 37% of the population with experience of homelessness who were approached to participate. This is considered a good response rate for a DCE in the social care setting.

All other factors being equal (such as the profession of the main carer, the number of visits by the carer, etc), participants in the DCE expressed a strong preference for entering step-down care rather than returning to rough sleeping. They expressed which features of a model of care were most important and the trade-offs they made in responding to the DCE questions enables the features to be placed in priority order. This provides a breakdown of respondents' preferences, emphasising the importance of the care provider, flexibility in behaviour rules, and specific aspects related to location, duration, and frequency of care in determining their overall preference for a given service model. The synthesis of these preferences delineates the participants' ideal service model, encompassing a housing support worker visiting their flat/house 3 to 4 times per week for a duration of 10 to 12 weeks, within an environment with no specified rules about behaviour.

The preferred approach maps most closely onto Home First principles about the importance people place on returning to their own home/or a homely environment rather than to more institutional environment such as care homes or hospital. The identification of housing workers as the main care giver may reflect the importance of receiving practical help and support such as help with maintaining a habitable home environment. The aversion to rules, likely relates to those that could potentially stigmatise people such as not being allowed visitors due to the association between being homeless and anti-social behaviour. The timescale also appears to triangulate with views about the value of having time to recovery, but not receiving support for too long so that one loses one's independence.

The analysis found differences between population subgroups in the importance attached to specific attributes. For example: individuals aged 65 and older gave less priority to the location and duration of care compared to their counterparts under 65. This highlights a divergence in preferences based on age. Preferences also vary based on the support pathway accessed. Those in pathway 2 were less likely to prioritise the location and duration of care, contrasting with individuals in pathway 1 who considered all five aspects crucial. It may be that as people age, they recognise the need for more accessible facilities and more support and so may be more accepting of care home and hospital type environments. This pathway-dependent preference highlights the need for tailored approaches based on the experiences and needs of individuals within different pathways.

A dedicated integrated management dashboard has been developed to visualize the preferences data of service users regarding specialist hospital discharge schemes and to offer insights from the DCE data on expected adoption rates of specific models of care. The three examples above, along with other models, are included in the online visualisations (link here). For further details regarding the integrated management dashboards see section 9.

Key implications for commissioners

Linking the DCE findings to the earlier chapters about roll out and commissioning challenges, the triangulated patient data would seem to support the ***housing led 'step-down house'*** model as the ideal model for those with lower level needs for reablement/resettlement. This offers some of the benefits of Home First, such as a homely environment but avoids the need for placement in unsuitable temporary accommodation and hotels. Step-down houses also allow for more face-to-face contacts with patients whereas settle-in workers can spend a lot of their time travelling between properties which limits what they can do for patients (especially where caseloads are high). While some test sites did source the ideal preference, by placing people in good quality accommodation that was fully adapted this was not a model that could be easily scaled due to finding enough suitable properties to accommodate the flow out of patients out-of-hospital. For older patients likely to have higher levels of need, an interesting finding of the DCE was that the location of care was less important to them than younger patients meaning that a stay in medical respite or care home type facility would be acceptable.

7: Scaling and Sustainability

7:1 Funding snapshot June 2023.

Appendix 2 presents a snapshot of the funding situation in each of the test sites on 30th June 2023 (some three months after the Programme end date). In summary:

(Hospital In-reach and intermediate care teams)
Most of the substantive posts in the HIRTs that were embedded before the OOHCM Programme started were sustained as funding was already in the baseline budgets of the acute hospital trusts and/or local authorities. However, many of the new posts that were recruited on short-terms contracts were *'at risk'* and had no confirmed funding by June 2023. Two of the new clinically led IRTs ceased to operate prior to the end of the Programme. One established team lost its clinical leader to become a housing led team. In TS16 the full model secured three years of funding from the Integrated Care Board (ICB) including funding for the community nurses to continue fulfilling an intermediate care role. The intermediate care team in TS13 had no funding in place by June 2023 but secured a further year's funding from the ICB shortly after this date. This included funding for the 'move on' coordinators.

(Step-down intermediate care)
There was a mixed picture among the step-down services. Five Pathway 1 services did not continue beyond March 2023. The block contract for the pan-London (Pathway 2) medical respite beds was not continued. Where step-down services did secure new funding through the ICBs, this was often short-term with the expectation was that a business case would be resubmitted the following year. Often the decision to fund was communicated late in the day, when plans to decommission services were already underway. This served to destabilise teams as staff left their posts due to the uncertain position around the continuity of employment, with significant impacts on operational efficacy, including relationships with other teams and, hence on patient care.

Often the level of (short-term) funding provided meant that some components of the model were not continued (posts and services). In addition, financial uncertainty meant there was little or no opportunity for scaling or increasing capacity within the services. Only one Pathway 2 service (TS12) was able to scale and increase capacity in the number of step-down beds available. This was made possible with monies from the Discharge Funding (that came to ICBs from central government to be spent during the winter of 22/23). By June 2023 these beds were *'at risk'* and the service had stopped taking referrals. Shortly after news came through that the full model in TS12 would be funded by the ICB for a further year with assurances of longer-term funding. The step-down in TS1 was funded in the 2021/22 and 22/23 period through the BCF with assurances of longer-term baseline funding.

Overall, the funding picture at the conclusion of the Programme reflects that significant challenges remain in scaling and sustaining specialist OOHC services for people experiencing homelessness. In this section, we unpick the factors that may have contributed to this situation and the persistence of what we have previously characterised as a '*light house'* effect where services are built-up for a for a time before being scaled back down or demobilised due to the lack of long-term sustainable funding (Cornes et al., 2012).

7:2 The Better Care Fund (BCF)

The BCF[61] is the main source of funding for OOHC services in England. Its primary goal is to support the integration of health, housing and social care through joint planning processes and the pooling of budgets. For 2022/23, the policy framework for the BCF set our four national conditions that all BCF plans must meet to be approved for funding (LGA & NHSE, 2022).

One of these conditions was that local systems must invest in NHS commissioned OOHC services. £1.28 billion was '*ring fenced'* for this purpose. As part of their plans, Health and Wellbeing Boards (HWBs) were asked to develop a '***single picture'*** that outlined the expected capacity and demand for intermediate care covering hospital discharge pathways 0–3 inclusive. This was to cover both BCF funded activity and *non BCF funded activity* and to include services delivered by the VCS.

There was a further requirement that plans should review local priorities for how BCF funded services were being delivered to address health inequalities. However, there was no specific reference to the new requirement contained within the NHS Hospital Discharge and Community Operating Model (DHSC, 2022) about the need to commission *specialist* intermediate care as a way of tackling health inequalities. Local areas have flexibility to spend BCF money on services most suitable to their local populations. BCF project managers are appointed locally to oversee BCF planning and delivery. Plans for the 22/23 financial year needed to be submitted to the national BCF team by 26th September 2022 for approval.

In the business case for the OOHCM Programme, it was reported that '*In many areas, existing funding mechanisms for intermediate care, such as the BCF prioritise support for older people rather than people sleeping rough'* (DHSC, 2021). The OOHCM Programme Team built relationships internally with the BCF Team to address this. The advice given to the test sites through the OOHCM Programme was that all possible local funding sources should be explored, including the BCF.

(BCF success rate)
Only one test site was approached by their local BCF team to submit data for the 2022/23 local capacity and demand modelling exercise. This site was also the only site to receive funding for the 2021/22 and 22/23 periods (i.e. to secure ongoing funding within the original 15 month timeframe for the Programme). The service funded was a 40 bed independent living unit (with step-down beds). It was established in 2020 prior to the OOHCM Programme. The service did not work exclusively with people who were homeless, and worked mainly with older people who could not return home after a stay in hospital due to housing issues (such as the need for a 'deep clean' of their property). The lead commissioner of this service was a BCF project manager.

The lack of engagement of the other test sites in the 2022/23 capacity and demand modelling exercise may reflect how specialist services for homeless patients were not at this time sufficiently on the BCF radar to warrant inclusion. By the time test site managers had built relationships with BCF commissioners and raised the profile of these new services, they had effectively missed the deadline for 2022/23 plans. Recognising that most test sites would potentially have a funding gap, the DHSC submitted a business case to the Treasury for a further year's funding. Sites were then invited to submit plans to the DHSC for match funding for the 22/23 period.

> 'There is money in the BCF pot now for next year, but I can't make that case until next year, so how do I manage between this year and next year? (Lead Commissioner, 10).

[61] The BCF requires Integrated Care Boards (ICBs) and local government to agree a joint plan and pool budgets to support integration (More information are accessible here).

The Treasury did not subsequently provide this additional funding, causing challenges for some of the test sites who were relying on it to release funding from elsewhere.

> 'We have funding which will take us to the end of March 2024. It hasn't quite landed yet as a large chunk of it is reliant on the match funding from the Treasury' (Lead Commissioner, 2).

The next BCF planning cycle was extended to a two-year programme (for 23/24 & 24/25), However, specialist intermediate care services for people experiencing homelessness were still not included in these plans.

In TS12 (positive practice site) this was especially disappointing as much work had been done to build relationships with the BCF team locally. The test site manager gave presentations at workshops and was subsequently invited to join the BCF committee. The BCF Team in TS12 mapped *'Things on the* Radar' for the 23/24 planning period*.* Specialist *'Homeless step-down pathway'* made it onto the radar but was pitted against many other improvement initiatives. These included: increasing interim nursing home capacity; non-weight bearing pathway; 7 day discharges; 7 day prevention; delirium pathway; complex dementia pathway; hoarding; connected communities, and trusted assessment.

The view among test site managers was that amid such fierce competition for limited pooled funding, services for older people were still the priority.

> 'I've worked in the NHS and the public sector for over 20 years… In all that time we've been talking about pooled budgets and integration… We have had 12 years of austerity and restricted budgets, and the bottom line is that if there's not enough money then we're never going to facilitate integration.... If we had proper pooled budgets, we wouldn't be doing the little pieces around the edges that we are doing now… (Lead Commissioner, 2).

Because test sites could not access the BCF pooled budgets (designed to facilitate integrated working across health, housing and social care) some were effectively forced to ***dis*-integrate** their models.

> 'The difficulty is where the pot of money is not in one place… I can't write one business case... We've got temporary short-term accommodation, the hospital in-reach workers, the community outreach workers and the reablement team…. It's trying to work out how to piece together the funding from different places and where to go. I've been all over the place talking to all sorts of different people… At the moment, we've got the Rough Sleeping Initiative (RSI). We looked at the numbers of people who were rough sleeping at the point where they'd come into the services, and it was about 50% of people. So, we've got half the money coming through the RSI… I'm talking to adult social care to look at funding the reablement. And then the mental health worker, I've been going to the Community Mental Health Transformation Board.... It's just feels very piecemeal – A bit of funding here, a bit of funding there. Can we pull it altogether to keep this model going as a whole? I am not sure…' (Lead Commissioner, 5).

Significantly, looking to other funding sources that did not prioritise the development of OOHC, also served to ***scale-back*** specialist intermediate care for people who were homeless. In TS4, the Rough Sleeping Initiative (RSI) picked up the funding for two of the '*settle in'* workers. While the workers continued to offer some support to patients leaving hospital, this was no longer the main purpose of their job.

> 'The settle-in function has been absorbed into the Rough Sleeping Floating Support Team' (Test Site Manager, 12).

This process was described as ‘watering down’ – dimming the Programme effects,

> ‘This isn’t necessarily ideal [for the hospitals] but that’s just what the public sector is. We just do what we’ve got to do to make things stack up financially… 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 models were trying to implement at the beginning’ (Lead Commissioner 1).

On reflection, there was a sense that more could have been done nationally to promote specialist care within the BCF, perhaps including a ‘ring fence’ within the ring fenced funding for OOHC.

> ‘If you leave everything down to the local level you will go back to that Postcode Lottery and much of the support dwindling away... I think there needs to be some kind of intervention higher up the system, quite where I don’t know but higher up the system and even funding to keep some of this going’ (Lead Commissioner, 2).

7:3 Other funding sources

Test sites had varying degrees of success with a range of other funding sources. Most looked to their ICB’s (and the various committees therein that coordinate a wide range of NHS/health/integrated care funding streams). TS16 had perhaps the most significant success with ICB funding, securing three years of funding for the full model. Health inequalities had been identified as a key priority for the ICB and TS16 was able to access the funding that was allocated for this purpose. TS6, TS9, TS12 and TS13 were also successful in securing funding for their full integrated models through the ICB but this was one year funding.

Between January- March 2021, £588m of additional discharge funding was made available by the government to tackle the rising number of delayed discharges. The funding guidance was clear that this could be used to fund hotel accommodation as an additional method to the usual discharge routes and that homeless patients and those who did not have recourse to public funds/no place to safely discharge to were eligible. None of the test sites accessed any of this funding. The process for accessing the money through the then Clinical Commissioning Groups (CCGs) was said to be opaque and there was little promotion of this fund locally to those involved in the test sites. The view among test managers was that *“homeless people*” would not be seen as a priority for discharge funding because they were a small cohort that did not create the same pressures for the system as *“older people”.*

Perhaps reflecting some success in raising the profile of specialist services, later tranches of discharge funding were accessed by some of the test sites. However, this was very short-term funding designed to boost capacity and had to be spent over the winter months. In TS12 the 22/23 discharge funding allowed for the scaling of the model with the opening of two new step-down houses and a step-up house.

The DLUHC launched a new Shared Outcomes Fund (Changing Futures Programme) in 2022. TS3 was successful in securing funding for part of their model through this new Programme. However, hospital discharge was subsumed under a much a wider change agenda. Only a small number of test sites went on to secure RSI funding. At national level, there was debate as to whether OOHC for people who are homeless was a DHSC or DLUHC responsibility. Local areas were left to decide how to allocate RSI funding. Charitable sources of funding were also sought by some providers and commissioners with varying success – sometimes the charities saw the merits of the services but were unable to fund them and thought that statutory organisations would be funding them.

7:4 Routinisation

One lead commissioner reminisced that previously if a new project had delivered good outcomes and had been in operation for three years it would automatically be treated as *'routine care'* and would secure a place in the ICB's baseline budget. Thus, avoiding the need to keep resubmitting a new business case every year. However, it was reported that in the ongoing difficult current economic climate of statutory service income, baseline budgets were increasing closed-off leading many new services to have to rely on short-term funding streams for much longer periods.

> 'We need more time to establish [the model] so it's not seen as an add on service or a special thing that needs special funding. It should be in the baseline budget and understood that this is as this how we care for our [homeless patients]. Once [the model] is routinised we wouldn't need to keep chasing the money every year' (Lead Commissioner, 10).

(Networking and building relationships with ICBs)

Flows of short-term funding come in and out of the ICBs and are earmarked for spending on different national and local priorities. Having a commissioner *'on the inside'* was key to accessing these flows. One lead commissioner described the importance of tuning in to the *'mood music'.* At one point having developed a business case she was told by the ICB not to submit it as there was *"nowhere to take it to".* Later when funding for mental health and health inequalities was prioritised, the ICB invited the business case. This test site was successful in securing one year's funding for the full model. The Lead Commissioner recounted,

> 'It started from the summer really and it was ongoing through the whole second half of the year, putting together the information that we had about the service and how well it was doing and what it was aiming to do. Trying to sniff out pots of money that might exist and going to various Boards. Sort of socialising it quite widely across the ICB and trying to get a lot of buy-in and endorsement from different programmes across Health and Social Care… Trying to find where the right funding source would be' (Lead Commissioner, 10).

Many other test site managers and lead commissioners also spoke of the importance of networking and building relationships inside the ICBs. One local authority commissioner explained the benefits of co-location when the ICB moved into her offices,

> 'The floor where I have sat for many years is now being used by the ICB and the Mental Health Commissioners. There's a glass wall between us but being on the same floor makes a big difference… Everybody's working so fast… `*There's some funding here - quick what can we do, speak to that person, get that sorted'…* It's being able to have those quick conversations that makes the difference' (Lead Commissioner, 5).

She noted that the benefits of co-location were significantly enhanced when meetings were introduced to formally facilitate the process of integrated care commissioning,

> 'Integration is something that we always need to be working at… We'd pass each other in the corridors but having us all come together on a weekly basis is, it's just brilliant.'

In some test sites, simply getting access to the various ICB committees was challenging and required tenacity,

> 'We managed to get our pilot and the outcomes of the pilot onto the D2A Board. This was, to be honest, no mean feat. It took quite a few attempts to make sure that we were on the agenda, and we got bumped a few times. But being able to go and talk to that group was - well it was challenging because - we didn't like what they said

[about there being no money] but at least we were in a room with them for once' (Lead Commissioner, 12).

'There were occasions where I inappropriately raised the step-down service in meetings where it had no real right to be just to try to get somebody senior to listen to me' (Lead Commissioner, 2).

(The shark pool)

In addition to building relationships and networks inside the ICB, developing a robust business case was seen as key to securing further funding. One Lead Commissioner did, however, make the insightful comment that her job was more putting together funding bids, than developing a business plan as such.

Before the Programme was extended, test site managers were working on the understanding that the OOHCM funding had to be spent within the 15 month timeframe (by March 2022). As a result, they felt pressure to start working on a business case almost from day one of the Programme. It was assumed that in making a business case to the ICBs they would need a wide range of evidence especially economic evidence about cost-effectiveness and how the services were working to reduce pressure on the NHS (e.g. bed days saved). However, because most of the services were still mobilising at this time, they had very little evidence to feed into their business cases. Indeed, there was much frustration that the evaluation team was not poised to deliver results much more quickly.

Underpinning the engagement process between test site managers and ICB commissioners was the conceptualisation of specialist services as *'pilot projects'.* However, this tended to obscure the fact that specialist care was already approved by NICE as '*value for money'* and that there was a clear policy directive from DHSC (2022) about the importance of ICBs commissioning these services although with the caveat *"where budgets allow".* Thus, the primary task was not to gather more evidence about effectiveness and cost-effectiveness, but instead to instigate *audit* and *benchmarking* to ensure quality and fidelity to the evidence base (thereby increasing the likelihood that local services could replicate the results demonstrated in the original effectiveness studies).

This is a subtle distinction but one that might have helped shift conversations locally toward strategies for policy implementation and how best to nurture infant services through the different implementation stages from mobilisation, through to routinisation, sustainability and integration with the wider D2A system.

Instead, the test site services were expected to compete almost immediately in a highly competitive funding pool for very scarce resources. Had the OOHCM Programme not been extended by a further 12 months (and the tests sites allowed to use their underspend), most would probably have been axed even before they were properly *'stood-up'.*

(The postcode lottery)

As discussed in the previous section, difficulties collecting audit data meant that by the end of the Programme not all test sites were able to produce a robust business case. This was especially so for patient outcomes and experience (with only 10/21 test sites having data for an integrated management dashboard). Indeed, a key hypothesis underpinning the design of the OOHCM audit was that improving data quality would support the test sites to become more sustainable. However, in the final reckoning, this was a false logic as there remained something of a postcode lottery as to which services were funded or not.

For example, the test site securing three years of funding from the ICB had relatively weak evidence as compared to some of the other test sites. TS16 had relied on economic modelling based on one patient's case story, whereas TS12 and TS13 (securing only one year's funding) had linked patient data with HES and were able to provide very robust data on costs and outcomes.

The ICB commissioner that supported the funding case for TS12 (which had the most comprehensive dashboard of all the test sites) reported that while data were important, what had influenced him the most was a visit to the step-down house where he had been able to talk to one of the former residents about how the service had changed their lives.

The step-down house in TS12 had stopped taking referrals by March 2023 due to the uncertainty about its future funding. As a result, delayed discharges soon built-up at the hospital. The test site manager reflected that this 'negative impact' had also helped their case. The commissioner agreed, highlighting the importance of ensuring the hospital perceives your services as something they cannot live without.

Many other test site managers agreed about the value of softer intelligence over and above hard evidence,

> 'When you're dealing in the NHS more generally - with mortality in your late 70's and 80's- and you explain [homeless people are dying at 46] even the most hardened Commissioning Director said to me `I had no idea' and since then he has been very easy to work with' (Lead Commissioner, 10).

> 'Knowing commissioners there is always that desire to just know what is happening out there now – locally, in similar areas and nationally - even if it is just descriptive and sometimes the insight and intelligence gained from that knowledge can [influence their decisions to fund]' (Lead Commissioner, 3).

Another issue often raised was that the *'evidence bar'* for specialist care was often set to an impossibly high-level perhaps as a way of justifying budget short-falls and decisions not to fund.

> 'We went asking for money to continue the model… We told [the ICB Board] about the policy context - clearly setting the scene that [homeless] people are your responsibility, and that D2A Pathways need to work for them. We told them about the patient outcomes we were achieving. We told them a couple of patient stories to sort of bring it to life a little bit… I think one of the main things that I took away from [the meeting] was the [prioritisation of the] economic impact. People were challenging us: *"you need to be able to show us the evidence that this is money well spent in the long run"* and I can understand that. I think the other thing that threw me a little bit was the sort of feedback that "*You're bringing to us a very particular vulnerable population. There are lots of other vulnerable groups out there, why should we invest in this versus something else?"* That felt quite frustrating because you just think 'We've had a test site, we've got the evidence, we're gathering data and stats and experiences but you're still going to potentially choose to not do anything…' (Test Site Manager 14)

(The cliff edge)

Test sites reported that they were taken to the 'cliff edge' before finding out if their business case was successful. This exacerbated workforce challenges around recruitment and retention and was not supportive of collaborative working where services had to '*stop/start'* taking referrals.

> 'It just feels like that cliff edge is coming… To stop and then have to re-start again just feels like "aww man'' given everything we have achieved' (Test Site Manager, 8)

> ‘The DHSC was going to let us know mid-February at the earliest [about the second tranche of OOHCM funding]. Our staff contracts were ending at the end of March. This meant the provider was going to have to start giving notice to staff before we’ve been told the outcome … We could lose some really good staff… Do they jump ship, or do they wait to see whether the funding continues? It’s at a time when their own mortgages are going up and everything else, the cost of living too.’ (Test Site Manager, 11).
>
> ‘We lost provision when the OOHCM money ended, but we were ***lucky*** in that we managed to get local system funding for part of our model. So, there’s another gap again - the gap that we had before is back again… We are constantly lurching and always in crisis mode about where’s the money coming from’ (Lead Commissioner, 2)
>
> ‘I have literally left no stone unturned. I’ve been to charities, there is nothing that I haven’t tried to get funding for this model. It’s just been six months of hard work to get to this point [securing one year’s funding] … It’s craziness and it drives me to utter, utter frustration’ (Lead Commissioner, 10)

For those test site managers and providers who were ***‘unlucky’***, the process of demobilising services was demoralising and upsetting,

> ‘Unfortunately, we heard yesterday that we will not be funded, and are being given three months to wind the project down. This is devastating news for me, and I know my feelings will be replicated across the services and hospitals in [the area] … I am at a bit of a loss as to whether there is anything I can do to challenge this when I have been told there is no funding available?’ (Service Provider, by email).
>
> ‘A one year pot of money is a wonderful thing but it’s also quite a challenge… It takes a bit of time to be able to show what an amazing thing it is you’re doing and by that time you’ve got to close the thing down.’ (Test Site Manager, 5)
>
> ‘A year was tight. I don’t know how we achieved what we did in a year. We did well but it was tough. Right from the beginning you’re setting up your systems, you’re setting up relationships with Boroughs and other teams, agencies... It takes about a year to [get going] and then just to say `*bye-bye’*. It’s a waste of money in my opinion’ (Test Site Manager, 8).

7:5 Collaborative capability impacts

While there was a sense that many of the services would be scaled-back or not sustained longer term, there was among some test sites managers a sense that some of the other benefits of the Programme might be sustained longer term. These related to the collaborative capability impacts (where test site managers felt their own skills were being enhanced by having the opportunities to try out new ways of working in partnership with others) and integration impacts (where boundaries were broken down and new relationships forged). Overall, stakeholders reflected on the many positive advantages of being involved in the OOHCM Programme, and on balance this outweighed the negatives - possibly leading to the desired transformational changes but more iteratively and incrementally over time.

> ‘The way the funding streams come to us encourages us to work in quite a short-term way… All the documentation [the DHSC sends out] asks about sustainability, future planning and how are you going to embed [things] in your normal practice. Ultimately, they’re only funding you for a year, two years, three years… I’m not sure really what’s the right or wrong way… I think incrementally it probably does get you to

think in a different way and in a new way and to put things in place quickly and respond to things in probably a bit more of a dynamic way' (Lead Commissioner, 13)

'Grant funding lets you do things a little bit out there. It lets you do things that you've always wanted to do, and never been given the opportunity to do' (Lead Commissioner, 2)

'[The Programme] has acted as a focal point for understanding how we come together as partners to resolve issues that can only be resolved by us working together. it's acted as a catalyst for a lot of things' (Test Site Manager 6).

'You get bogged down with the challenges but when you look back on how far we've come...they're different conversations now… The fact that the external organisations are coming in and they understand what happens in the hospital up to the run up to someone being discharged really helps and vice versa, with what is happening in the community. I think we've got there now' (Lead Commissioner, 13)

7:6 Scaling-up

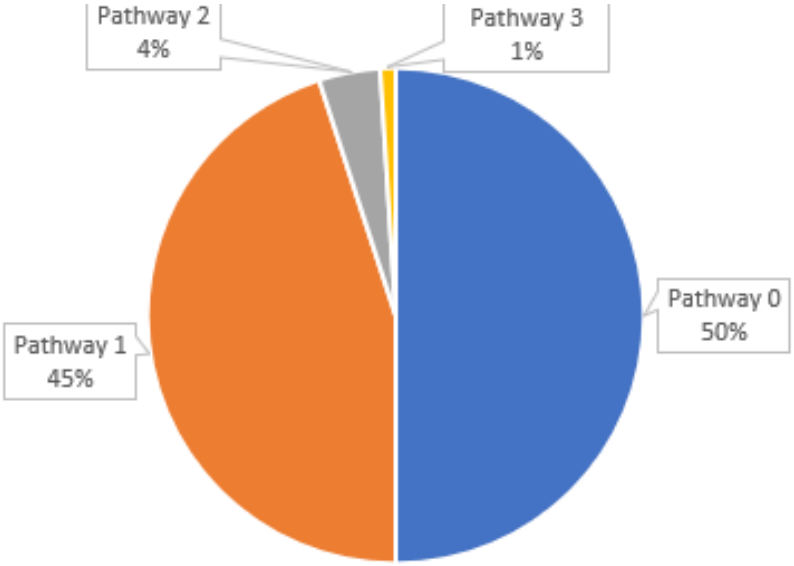
As noted above only TS12 was able to scale-up its step-down provision from 10 to 27 beds. Other test site services remained at the same level or were forced to scale-back provision as funding was lost (See Appendix 2). In this final section we explore issues around capacity and demand and if this level of scaling is appropriate. The qualitative data, suggests extra capacity is needed in some (but not all) areas and is needed to keep up with the expanding homelessness and rough sleeping problem.

'Referrals have tripled… [Before the OOHCM Programme started] I was probably getting about 20-30 referrals a month. Now it's nearer 80. We've got all these discharge beds now, but the problem has just got bigger and worse than it's ever been' (IRT Manager, FG4).

'We'd love to be able to grow the model, but I think [our commissioners are] happy to keep it on a small scale… The Council is facing significant pressure from Adult Social Care… As a result, I think we'll struggle to grow' (Test Site Manager, 4).

A key driver for the design of the D2A policy was the need to promote Home First as the default pathway for hospital discharge. Prior to the introduction of D2A there was a concern that too many older people were discharged to more expensive residential intermediate care services which likely over catered for the needs leading to a loss of independence and more expense. This was attributed to a lack of capacity in reablement services and risk averse practices in local authorities. To tackle this, NHSE drew on the capacity and demand modelling work carried out by John Bolton (2018). This approach defined the percentage of patients at any given hospital that should be discharged on each of the D2A Pathways 0-3 (see Figure 7:1 below).

Figure 7:1 Target Numbers of Patients to be Discharged on Each D2A Pathway



Across the lifetime of the OOHCM Programme, 11,030 homeless patients were seen at hospital by the IRTs. 1,374 (12%[62]) were discharged to a Pathway 1 specialist service and 580 (5%)[63] to a Pathway 2 specialist service. Use of (generic) [64] Pathway 3 services was reported to be low. In TS13 where access to P3 services was pro-actively supported and monitored the figure was around 3%. This means that approximately 79% of homeless patients may have been discharged on Pathway 0. [65]

Given that this 29% above the anticipated 50% target, the number of Pathway 0 discharges this is a potential *'red flag'* for policy makers and commissioners as it likely indicates unmet need and/or unsafe discharge. Indeed, we would argue that the situation is even more concerning than these figures suggest.

The percentages shown in Figure 7:1 encompass *all patients* discharged from hospital. As a result, there are questions as to how to shift the percentage dial to reflect the needs of the homeless patient cohort. As outlined in the introduction, the earlier NIHR research found that specialist intermediate care services were identifying and engaging with an excluded cohort of patients at extreme risk of death (Aldridge et al, 2019). In other words, homeless patients are more routinely complex than the general hospital population.

A useful indicator of the percentage allocations for each D2A Pathway can be found in the Healthy London Partnership (HLP) audit of 86 patients across 15 hospitals in London (Nguyen et al., 2022 & Nadicksbernd, et al., 2023). This asked the IRTs to outline (for each

[62] The figure for P1 in London was 19% and out-of-London 7%.
[63] The figure for P2 in London was 2% and out-of-London 8%.
[64] The quarterly monitoring forms asked test sites to report on numbers discharged to non-specialist (generic) intermediate care services. However, this was rarely reported with any accuracy. Qualitative data indicates the figures are low. The HLP audit faced a similar issue, noting that many of the HIRTs were not familiar with the D2A terminology/and or interpreted the definitions differently (Nguyen et al., 2022 p25).
[65] Some patients may have been discharged to a generic intermediate care service or to another specialist P2 service that sat outside of the OOHCM audit. However, we believe these figures to be very low. There were significant barriers to accessing generic intermediate care services and the number of specialist P2 beds outside of the programme monitoring were low and mostly in London and 'silted-up'. (e.g. medical respite facility and one other step-down house with some other health beds).

one of the 86 patients reviewed) what was needed for a safe appropriate discharge that would support improved outcomes.
The audit suggests:

- 1% (1/86) required a Pathway 0 type service (e.g., had a need for housing alone with no need for additional care and support).
- 55% (47/86) required a Pathway 1 type service (e.g., can manage with in-reach support/needs an assessment)
- 30% (26/86) required a Pathway 2 type service (e.g., rehabilitation with clinical staffing/accommodation with clinical in-reach)
- 14% (12/86) required a Pathway 3 type service (e.g., has specialist long-term care needs)

Using these adjusted figures, Table 7:1 suggests that the OOHCM Programme *'roll out'* has significantly under catered for homeless patients across D2A Pathways 1-3. Whereas older people have been over catered for, the reverse appears to be the case for homeless patients with around 8,653 potentially under-catered for on Pathway 0. This means that 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, these figures suggest the need for a threefold increase in capacity across Pathway 1 and a fourfold increase across Pathway 2 and Pathway 3 services.

Table 7:1 D2A Modelling Table

D2A Adjusted for Homeless Cohort Morbidity/Mortality Profile	**Projected Demand No. of Patients**	**Capacity Provided Through OOHCM Programme 21/22 & 22/23 No. of Patients**	**Extra Capacity Needed based on D2A modelling using HLP Audit Data No. of Patients**
Pathway 0 (1%)	110	8,753	-8,653
Pathway 1 (55%)	6,071	1,375	+4,696
Pathway 2 (30%)	3,312	580	+2,732
Pathway 3 (14%)	1,545	331	+1,214
	11,039	11,039	

This conclusion about the lack of capacity in step-down intermediate care is triangulated through some of the other audit data where for example waits for assessment for a Pathway 2 bed are 9 days, and out-of-London acceptance rates in Pathway 2 are 50%. In London test sites it was reported that there were so few Pathway 2 beds that the HIRTs had stopped referring (Nguyen, et al., 2022). In TS12, the only test site to have scaled, we see the fourfold increase in Pathway 2 beds and agreement locally between commissioners, hospital and providers locally that this is an appropriate level.

In terms of how to scale-up services, there is important learning from the history of intermediate care. Intermediate care services were first piloted in late 1990's. They were initially funded through short term Winter Pressures funding and the pattern was for services to come and go as funding allowed. What facilitated the shift to routinisation and scale was the National Service Framework for Older People (DHSC, 2001). This aimed to 'root out' age discrimination in the NHS and tackle the substandard care that was provided to older people in general hospital care and beyond. The NSF set targets - that by 2004 there should be 5,000 extra intermediate care beds. This served to mainstream intermediate care and drive increased provision. By 2006, targets had been met.

7:7 Summary

Difficult timelines, the need to build services, establishing and maintaining relationships with key stakeholders and organising the right mix of hard and softer data and narrative presented huge challenges to establishing the longer-term viability of services. These, and the demobilisation that variously affected sites made it hard to build and maintain a momentum to ensure high-quality patient service and outcomes – despite the huge efforts of frontline staff.

Managing building this network of support for sustainable services was made more challenging where it was not easy to identify who to speak to, such as which commissioners and/or directors. We were told in some sites that this was because the issue of homelessness, and specifically OOHC for this group of people, did not fit neatly into organisational structures. The ongoing reorganisation of local services around ICBs made this more difficult when it wasn't clear what organisational priorities were and/or who were the key people to communicate with.

Looking back, many test site managers and lead commissioners reflected that the OOHCM Programme had been a *'game changer'* when it came to addressing some of these challenges. They felt that housing was now much more likely to be viewed as the *'third pillar'* of D2A alongside health and social care services, and that across the system there was now much better understanding of health inequalities linked to homelessness. Relationships had started to be built-up with the BCF local teams and in some areas, specialist care for homeless patients had been put on the 'radar' for consideration in future funding rounds.

However, in the 2022/23 cycle, there was limited evidence from the test sites that the BCF was tackling health inequalities by identifying unmet needs relating to homelessness and that it was supporting financially the integration of specialist OOHC in D2A. All the evidence pointed to short-term funding mechanisms continuing to prioritise support for older people rather than people experiencing homelessness.

By the end of the Programme, the future of many of the step-down services remained uncertain because of the need to rely on short-term funding. While many test site services did secure further short-term (non-recurrent) funding that was enabling them to *"limp along*" – this was often allocated late in the day meaning decommissioning had already commenced and staff, expertise and partner relationships lost – with an adverse impact on service quality.

There was a strong sense that while relationships were stronger locally, and that there was a desire to support the integration of specialist care, changes were required that were outside the direct control of organisations in the locality. Namely, changes to BCF policy at national level (perhaps to 'ring fence' some funding for supporting integration in specialist care) and increased funding for ICB baseline budgets to enable the routinisation of services.

Any future investment also needs to be linked to more robust capacity and demand modelling, moving away from approaches where capacity is linked to the size of the funding envelope rather than demand. Using John Bolton's D2A methodology, the evaluation suggests too many homeless patients are currently being discharged on Pathway 0 and therefore unlikely to receive the right support in the right place to maximise their outcomes.

Lack of scope to routinise services and scale-up services, means the impacts evidenced in the first base-line picture of specialist OOHC are unlikely to be sustained.

8: Conclusion

During the lifetime of the OOHCM Programme, good progress was made to 'roll out' specialist OOHC for people experiencing homelessness. However, only a small number of test sites were able to fully evidence their work (especially for patient outcomes and experience). Table 8:1 below presents an overview of these evidence gaps and a summary of how far the Programme was able to meet the objectives set out in its business case. There are questions as to whether this progress will be sustained.

8:1 What underpinned effective implementation?

Effective implementation was linked to ambitious early-stage planning and visionary leadership that made best use of the OOHCM funding, expanding HIRTs and integrating specialist step-down services across the full range of D2A pathways. Progress with integration was clearest where test site managers and/or lead commissioners:

- Adopted the principles of *'single system coordination.'*
- Embedded standard *'patient flow'* measures such as trusted assessment, while balancing this against the needs of some homeless patients where extended stays in step-down may sometimes be warranted (e.g., where self-neglect is an issue and time needed for rapport building).
- Ensured the application of discharge pathways was consistent and inclusive of homeless patients.
- Challenged the *'under-prescription of care'* that saw all homeless patients discharged on Pathway 0.
- Adopted a data driven approach that combined integrated management dashboards, efficient use of resources with co-production (a focus patient outcomes, preferences and experience).

Progressive sites were mindful of staff exhaustion and the challenging nature of the work, embedding time for reflective practice and supervision to support frontline staff. Escalation of individual cases and *'integration mechanics'* were key to preventing the stress and burnout associated with advocating for change in ground-level practice.

Systems with mature levels of integrated single system working were able to demonstrate that step-down improved outcomes for most patients and led to very positive experiences of care and support. Very few people slept rough after leaving step-down.

The evaluation found newer service typologies (settle-in, step-down houses and Homeless Intermediate Care Team) to be effective and cost-effective,

Patients expressed strong preferences for the '*Home First'* ethos. There was good evidence that the smaller 'step-down' houses could offer this - offering an alternative route out-of-hospital for those patients who did not have a home to discharge to. Settle-in support was valued by patients, but hotels and poor-quality temporary accommodation (dispersed across large areas) proved challenging for staff to deliver the same intensity and quality of care that could be provided in step-down houses (where staff were on site). The Homeless Intermediate Care Team (HICT), offering continuity of multidisciplinary support from hospital to the community proved very effective on a range of measures, particularly in opening-up access to generic Pathway 2/3 care home services that had previously excluded homeless patients.

Overall, the evaluation findings add to the growing body of evidence about the importance of commissioning specialist out-of-care for people experiencing homelessness.

However, the most important finding of this evaluation is that not enough specialist step-down intermediate care has been rolled-out and that too many homeless patients are still being discharged to a location that is unlikely to maximise their outcomes. Our modelling suggests the need for three and fourfold increases across specialist Pathway 1 and Pathway 1/2 services respectively.

8:2 What were the main barriers to effective implementation?

Overcoming what were identified as the main barriers to effective implementation all require changes outside the direct control or organisations in the locality. Most of these are already acknowledged as priorities for action in NHSE's (2023a,b) intermediate care framework:

- Improving workforce planning at a national policy level to address the recruitment and retention crises in health and social care.
- Increasing capacity in mainstream health and social care services to ensure better access to assessment in step-down, particularly CA 2014 assessments and therapy-led assessments.
- Increasing capacity in longer-term care and support to prevent specialist services from 'silting-up'.
- Addressing the housing crises and complex underpinning legislation (e.g., local connection rules) that also contribute to services silting up.
- Recognising the significance of data quality data and coverage, and the role of embedding audit and evaluation into day-to-day operational practice.

8:3 Will this progress be sustained?

By the end of the Programme, progress had begun to stall and in many test sites things were starting to 'roll backwards'. In some sites, services had already ceased to operate. 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 the ICBs. This meant that test sites were forced to seek out further short-term funding. Where this was linked to new Programme funding such as the RSI or Changing Futures this usually came with caveats about adopting new objectives that meant that hospital discharge work would no longer be the primary focus.

Having to seek funding from many different sources also led to fragmentation of the models, with different funders for different services and posts, and was a barrier to integrated care. While many test sites did secure short-term funding to enable them to *'limp along'* this was often allocated late in the day meaning decommissioning may have already commenced with skilled staff having left their posts. The trend was toward to scaling back and there was very little scope for much needed scaling-up.

Difficulties accessing the baseline budgets of the ICBs is not limited to specialist care, but all types of intermediate care. The main source of funding for OOHC is the BCF. The BCF offers short-term 'pooled budget' funding designed specifically to support integration across health, housing and social care.

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. Specialist care for homeless patients was not included in the 2022/23 capacity and demand modelling exercise, which was a significant **missed opportunity** given the mismatch between capacity and demand, and only one test site service was supported financially in this funding cycle. This was an independent living service that worked mainly with older people.

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. Across all funding arenas, this reflected how specialist OOHC services for people experiencing homelessness were still considered a *"nice to have*" that commissioners would only fund once they had tackled what they perceived to be more pressing pressures on the NHS.

8:4 Was the Programme a gamechanger?

Despite these challenges, the OOHCM was considered by most test site stakeholders to have been a '*game changer'*. The launch of the programme by DHSC raised the profile of homelessness, gave people permission to think differently and was a call to arms. The funding was a catalyst to get people talking and planning together *("Nothing brings people to the table like million pounds")* and to shift some resources into different forms of action. The OOHCM Programme 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 was appreciated as much as more formally contracted improvement support. This helped enable the actions of 'integration mechanics' to reengineer local pathways, and support the huge motivation, commitment and innovation of many frontline staff.

Moving forward, key learning from the evaluation is about local systems being explicitly clear that tackling health inequalities needs to be seen as part of the routine transformation work to tackle delayed discharges. Otherwise, initiatives like the OOHCM will forever be left fragile and destabilised, and therefore not functioning fully, as they seek sustainable funding but rely on short-term funding.

Although there were strengths in the programme, arguably, it did not have enough of an understanding of the degree of innovation required in sites and understanding of the emergent nature of changing practice – and hence of the timelines needed to make these approaches 'business as normal' practices across partners. But to a high degree that is not surprising as this learning is an outcome of the evaluation. A future programme (whether national or local within individual ICSs) needs to fully understand this, give the time needed to make real change and support the reflexivity of integration mechanics to innovate, learn and continue to adapt. In some test sites, specialist care for homeless patients had been put on the BCF radar by the end of the Programme with good prospects of future funding. Had the Programme had a longer lifespan then much more could have been done to keep this kind of momentum going.

> 'It's been a real game changer… After a few glasses of wine, I may have said that I would never ever bid for this kind of short-term funding again… I'm lying. I'll bid for short term funding again. The positives far outweigh all the issues". (Lead Commissioner, 2),

8:5 Recommendations

The implementation challenges raised in this evaluation, around issues of scale and sustainability are echoed in the Hewett Review (Hewett, 2023). This review was commissioned by the Secretary of State for Health and sets out what ICSs can do to thrive and deliver. We summarise the key points here as they are coterminous with the recommendations that flow from this study.

- Funding should be largely 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 have been routinely and successfully used across systems for some time but they need to be more transparent and (we would add 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 and building capacity in data and evaluation alongside service delivery. Embedding continuous data collection *real-time data into day-to-day operational practices* empowers commissioners to make informed resource allocation decisions, monitor performance, and advocate for impactful policies. In the next section we present a road map for achieving this.

Table 8.1: OOHCM Programme Results Against Anticipated Outcomes

	Original target (DHSC 2020)	Results as per target	Data source	Sites with relevant data	Dashboard	Comments
Cash releasing outcomes	**[A]** Reduction in A&E costs and fewer emergency (non-elective) admissions.	**YES**	Evaluation, HES data	TS12, TS13	Economic analysis NHS perspective	• **TS12**: 25% decrease in emergency admissions (and 56% decrease in A&E visits) in year following stay in OOHC. • **TS13:** 30% decrease in emergency admission (but 20% increase A&E visits) in year following OOHC. • **Evidence limited to two sites.**
	[B] Reductions in operating costs (hospital bed versus out of hospital care)	**YES**	Evaluation, HES data	TS12, TS13	Economic analysis NHS perspective	• **TS12**: positive decrease of 25% in emergency admissions in year following OOHC, positive decrease of 63% in elective admissions [vs. 151% increase in outpatient visits (positive increase in planned care)]. • **TS13:** 30% decrease in emergency admission in year following OOHC (plus 111% planned admissions) [vs. increase of 89% in out of hospital visits]. • **Evidence limited to two sites.**
Other o	**[C]** Reduction in average length of stay in hospital (homeless people are more likely to be discharged	**NO**	Evaluation, HES data and	TS12 and TS6	Economic analysis NHS perspective	• **HES data (TS12):** increase of 72% in bed days in year following OOHC (as a potential positive for patients who are homeless due to

	Original target (DHSC 2020)	Results as per target	Data source	Sites with relevant data	Dashboard		Comments
Outcomes	sooner if their housing and next steps are adequately catered for)		case story				preventing early self-discharge, where people frequently leave before treatment completed). • **Case story (TS6):** increase of 4% in bed days in the year following OOHC. • **Evidence limited to two sites.**
	[C]cont.	**YES**	Individual case stories	TS9, TS10, TS12, TS13, TS16	Economic analysis NHS perspective		• **Case story (TS9, TS10, TS12, TS13, TS16**): decrease of 50 to 100% in bed days in year following OOHC. • **Evidence limited to *individual case stories from 5 sites.**
	[D] Lower rates of delayed transfers of care. Measured as reduction in numbers of people staying 14 days/21 days + without criteria to reside (for reason they are XII Homelessness/no right of recourse to public funds / no place to discharge to).	**Data not published**	**n/a**	**n/a**	**n/a**	**n/a**	
	[E] Improved collaboration between health and social care – including integration of housing authorities and homeless services.	**YES**	Qualitative Data	All 17 sites	Description of sites		• Qualitative data presents as mixed pictured across the test sites.
	[F] More efficient referrals to the correct D2A pathways/services	**YES**	Qualitative Data Audit/QM	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	The flow of people in and out of services		• The qualitative evidence highlights IRTs playing an increasingly important role in ensuring patients who are homeless can access D2A pathways. • However, D2A modelling suggests too few patients entering the right step-down pathway.

Original target (DHSC 2020)	Results as per target	Data source	Sites with relevant data	Dashboard	Comments
[G] Increased access to safe accommodation and community services – Reduction in patients discharged to street and/or unsuitable accommodation.		Audit, QM	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	Housing outcomes	• The percentage of people sleeping rough after OOHC is 5%, which is a significant reduction from the 77% before OOHC,
[H] Potential reduction in overall number of rough sleepers and associated costs to the health and care system, local authorities, the criminal justice system and probation system	**YES**	Evaluation, questionnaires (plus individual case story)	Questionnaires: one site (individual case story: for TS6, TS9, TS10, TS12, TS13, TS16)	Economic analysis broader public budget perspective (+ individual case story)	• **TS14:** The economic analysis for the broader public budget perspective showed a public budget release of £10.4K per year for 20 people. • **Collection of case stories for TS6, TS9, TS10, TS12, TS13, TS16**: free up an about £1,670 to £74,600 per person who is homeless in one year. • **Quantitative evidence limited to one site (plus six individual case stories).**
[I] Improved patient experience	**YES**	Audit, questionnaires	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	People Reported Experience Measure	• 92% of people reported being treated with dignity and respect (national average)
[J] Quicker recovery times	**NO** (national average for 10 sites)	Audit data, QM	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	Flow of people in / out of services	• **National average is 79 days** (NHSE target 42 days) • **% of people staying in OOH > 42 days: 69%** (national average)
	YES (6 of 10 sites)	Audit data, QM	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	Flow of people in / out of services	• Subgroup of sites with % of people staying in OOHC > 42 days that is lower than the national value of 69%: TS3, TS11, TS12, TS13, TS14, TS17
[K] Quality-adjusted Life Years	**YES**	Audit data, QM	TS2, TS3, TS4, TS6, TS9, TS11, TS12, TS13, TS14, TS17	Health outcomes (QALYs)	• 64/58% (Pathway 1/Pathway 2) improved health outcomes • 10%/9% (Pathway 1/Pathway 2) unchanged • 26/33% (Pathway 1/Pathway 2) worse

Key:

[A and B] Cash releasing outcomes (Objective met): *Two test sites, one outside London (TS12) and another in London (TS13), received assistance from local hospital data analysts. These analysts utilised data from the HES to extract data on admissions, encompassing emergency and elective visits, accident and emergency cases, and outpatient visits spanning 2021 to 2023. We computed total costs by multiplying the number of visits and admissions by unit costs derived from national tariffs, enabling the combination of results. The economic analysis employed a before-and-after approach to evaluate the costs and consequences of discharge service delivery pre and post OOHC implementation in the same study site(s), attributing observed differences to the intervention.*

- *In the year following their stay in OOHC, TS12 reported a 25% reduction in emergency admissions (and a 56% decrease in A&E visits). TS13 reported a 30% reduction in emergency admissions (but a 20% increase in A&E visits).*
- *TS12 reported a positive decrease of 25% in emergency admissions in the year following OOHC, along with a positive decrease of 63% in elective admissions [compared to a 151% increase in outpatient visits, indicating a positive increase in planned care]. TS13 reported a 30% decrease in emergency admissions in the year following OOHC (accompanied by a 111% increase in planned admissions) [in contrast to an 89% increase in out-of-hospital visits].*

[C] Reduction in average length of stay in hospital (mixed results): *From the economic analysis of HES data for TS12 we captured an increase of 72% in bed days in year following OOHC (as a potential positive for patients who are homeless due to preventing early self-discharge, where people frequently leave before treatment completed) (**Objective not met**).*

As part of the economic analyses the evaluation team looked at the economic impact of seven individual case stories. For each analysis we meticulously gathered comprehensive data on various service interactions for a selected client, focusing on areas like housing, healthcare, mental health, social care, substance misuse treatment, and the criminal justice system. The local test site teams employed a template to count and cost service and resource utilisation, collaborating to analyse data and project costs for the year following OOHC *exit, adjusting for special circumstances when necessary. The case story analysis conducted for TS6 showed an increase of 4% in bed days in the year following OOHC (**Objective not met**). However, in case stories (TS9, TS10, TS12, TS13, TS16), there was a reduction of 50% to 100% in bed days in the year following OOHC (**Objective met**).*

[D] Lower rates of delayed transfers of care: *During Covid-19 collection of DTOC data was suspended. New metrics are still under development and no data has been published by NHSE on delays linked to housing and homelessness. Waiting times for Pathway1 services of 1 day suggest they may be supporting timely discharge, but waits of 9 days for Pathway 2 suggests delayed discharge may still be a problem for those with more complex needs,*

[E] Improved collaboration between health and social care – including integration of housing authorities and homeless services: (mixed results) *Qualitive evidence points to difficulties engaging non-specialist professionals in assessment and case management of people with experience of homelessness out-of-hospital, but with a general sense among stakeholders that collaborative working has been greatly improved through the Programme.*

[F] More efficient referrals to the correct D2A pathways/services: Mixed results - *The qualitative evidence highlights IRTs playing an increasingly important role in ensuring individuals who are homeless can access D2A pathways. However, D2A modelling suggests too few individuals entering the right step-down pathway.*

[G] Increased access to safe accommodation and community services – Reduction in individuals discharged to street and/or unsuitable accommodation: Objective met. *Data gathered from the audit on housing outcomes across 10 sites reveals that the proportion of individuals sleeping rough after OOHC is 4% for Pathway 1 services and 5% for Pathway 2 demonstrating a significant decrease from the 77% recorded before OOHC.*

[H] Potential reduction in overall number of rough sleepers and associated costs to the health and care system, local authorities, the criminal justice system and probation system: Objective met. *The economic analysis included an additional set of analyses adopting a pre- and post-admission approach, specifically comparing the year before admission with the year following OOHCM admission, with a primary focus on the broader public budget perspective, including health, social care, drug and alcohol services, mental health, housing and criminal justice. Interactions with healthcare and social services were tracked using self-reported questionnaires, and total costs were calculated by multiplying interaction numbers by unit costs derived from national tariffs and other studies. For TS14, the economic analysis from a broader public budget perspective revealed a yearly release of £10.4K for 20 individuals. From gathering case stories for TS6, TS9, TS10, TS12, TS13, TS16 we can anticipate frees up approximately £1,670 to £74,600 per homeless person annually.*

[I] Improved person experience and [K] QALYs: Objectives met. *Person-relevant outcomes data were collected through a dedicated questionnaire. Frontline staff (key workers) administered a questionnaire upon the persons entry to the step-down service, capturing the baseline measurement of health-related quality of life using the EQ-5D validated outcome measure. This measurement was repeated at the service exit. Additionally, a validated PREM for intermediate care was part of the audit and administered shortly after the person's departure by an external party. Data from 10 sites showed positive outcomes in terms of experience of care (92% of people reported being treated with dignity and respect, national average) and health status (Pathway 1 64% improved health outcomes, 10% unchanged, 26% worse/ Pathway 2 58% improved health outcomes, 9% unchanged, 33% worse – national estimates).*

[J] Quicker recovery times: Mixed results. *Audit data regarding the flow of individuals in and out of step-down revealed a national average length of stay of 71 days for Pathway 1 and 87 days for Pathway 2, significantly exceeding the NHSE target of 42 days. Moreover, the percentage of individuals staying in* OOHC *for more than 42 days stands at 69% (**Objective not met**). However, a subset of sites demonstrated a percentage of people staying in OOHC for over 42 days that is lower than the national average of 69%: TS3, TS11, TS12, TS13, TS14, TS17 (**Objective met**). It should be notes that these figures reflect a combination of both recovery times and capacity issues (i.e., availability of move on accommodation).*

PART 2: A Data-Driven Strategy to Inform Future Service Implementation

Section 9: Integrated Management Dashboards – Next Steps

One of the main impacts of the OOHCM Programme has been to successfully pilot the use of integrated management dashboards. Workshops with DHSC, other national government stakeholders, and local service providers have gathered strong support for the use of the dashboards as operational and management tools. The OOHCM dashboards have been presented as a model of good practice in intermediate care and inclusion health frameworks (NHSE, 2023a; 2023b) and in the DHSC homeless discharge guidance (DHSC, 2024). The dashboards enhance evidence-based decision-making by offering quantitative data and storytelling, addressing gaps in data related to individual health outcomes, experiences and preferences, as well as economic outcomes for health and other public budgets. The dashboards have capacity to evaluate both historical and current events, provide long-term data, and connect live data and services. One commissioner emphasised their sense of urgency, stating, *"We can't afford to wait two years for data; the dashboards were needed yesterday!"*

In this final section of the report, we describe the current manual version of the integrated management dashboards (their aims and objectives, how they work, the insights they provide for which metrics), and outline plans led by LSE for the next steps: the transition towards automated dashboards. We conclude with the current status of the project and the plan for dissemination and impact workshops.

9:1 Where we are now - manual process

The first iteration of the integrated management dashboards require manual input through the LSE system to generate, update, or customise the displayed information (Figure 9.1). They offer actionable insights for stakeholders, aiding decision-making and optimising resource allocation, and have already been used extensively, in business planning, presentations to commissioners, and as multifaceted tools for performance monitoring, quality assessment, resource allocation, trend analysis, risk identification, benchmarking and reporting. Table 9.1 summarises target audiences, the content shared and the metrics visualised.

Access to these early dashboards is regulated through the project website at www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards via completion of an online form (see here). This structured approach ensures access to relevant, updated insights, while maintaining the confidentiality of individual person data. The project website serves as a platform for accessing the various content listed below.

Figure 9.1: Integrated management dashboard: roadmap

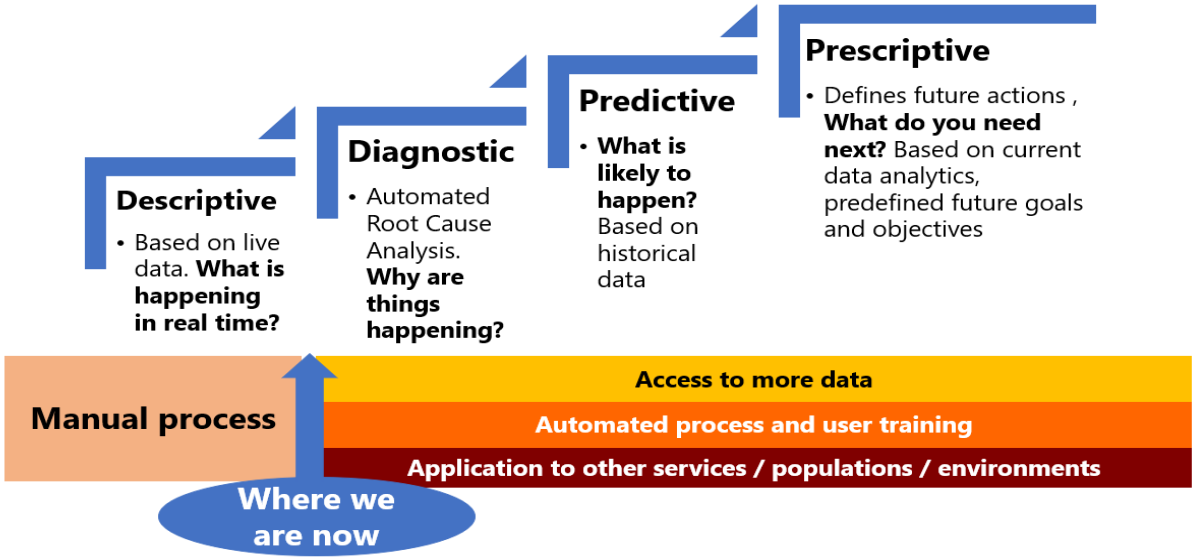


Table 9.1: Integrated management dashboards: target audiences from the OOHCM programme, content shared via the website and metrics visualised for financial years 2021/22 and 2022/23

	National dashboards for England accessible to OOHCM local users	**National dashboards for England accessible to national users**
Target audience	Local users include managers from the participating sites and representatives from the Intermediate Care Board (ICB) or Local Government Area (LGA) in England where the site is located.	Government agency representatives, civil servants and national commissioners for England involved in the oversight and management of homelessness services at national level. National Homelessness Charities in England.
Content shared	The content specific to each site includes:	The content shared with the national stakeholders includes:
	● Project report.	● Project report.
	● One **static dashboard** (PowerPoint) per site (those with completed audit data; see example in Section 4).	● Example of a **static dashboard** (PowerPoint; see Section 4).
	● A collection of 10 **digital interactive** dashboards (see below).	● A collection of 12 **digital interactive** dashboards (see below)'
	● One individual case story. It includes the economic analysis for an anonymised case, where applicable for the site (see example, Section 4).	● The full collection of individual case stories, with person and site information anonymised (see example, Section 4).
Metrics featured	● Summary Metrics ● People Demographics and staffing ● Health And Social Care While in Out Of Hospital Care ● The Flow of People in And Out of Services ● Housing Outcomes ● Person Reported Experience Measures ● Health Outcomes ● Economic Analysis NHS Perspective ● Economic Analysis Broader Public Budget Perspective ● People Preferences and Service Uptake Modelling	● Data Availability Map. ● Investments and service delivery costs. ● What is listed for the local users.
The OOHCM evaluation outputs are accessible by completing an online form <u>here</u>		

*Note: If you are a **guest user** (not falling within the stakeholder categories outlined above), you can contact the team and request samples of pertinent visualisations. This will enable wider learning about the framework of the evaluation applied, the outcome of the evaluation and consideration of transferability to other services / populations / environments.*

(The aims and objectives of the dashboards)

The integrated management dashboards are designed to serve as a management tool for both local and national stakeholders. Their primary objectives include:

- **Performance Monitoring**: Track and monitor the performance of out of hospital care provision throughout the national OOHCM Programme.
- **Quality Assessment**: Evaluate the quality of care provided to individuals with experience of homelessness receiving out of hospital care. Assessing care effectiveness, safety and outcomes is crucial to ensuring high-quality delivery.
- **Resource Allocation**: Optimise the allocation of resources, including staff, to meet the needs of individuals with experience of homelessness in out of hospital care settings. This involves identifying areas where resources may be underutilised or additional resources are required.
- **Trend Analysis**: Analyse trends in budget utilisation and person outcomes to identify patterns and make informed decisions about service improvements and resource allocation.
- **Risk Identification**: Identify potential risks and challenges associated with OOHC, such as gaps in care delivery, and develop strategies to mitigate these risks.
- **Benchmarking**: Compare OOHC performance metrics against national benchmarks to identify areas where improvements can be made.
- **Reporting and Transparency**: Provide a clear and transparent overview of OOHC performance to stakeholders, including local and national commissioners and providers. Effective reporting can drive accountability and facilitate data-driven decision-making.

(How they work)

- **Visual Data Presentation**: they employ interactive charts and graphs to visualise the data, making it simple to identify trends and patterns.
- **Filtering and customised Data Views**: You can customise data views by applying filters. For example, to focus on specific time periods (e.g., by financial year), type of service provision or specific locations (e.g., London / outside London) as well as individual service providers.
- **Comparative Analysis**: Users can compare performance metrics across different filters. This allows for meaningful benchmarking and trend analysis.
- **National Average**: Comparing metrics against the national average provides a broad perspective on performance. It helps organisations understand how they measure up on a national scale and identify areas where they may excel or need improvement.
- **Regional or Location Averages** (e.g., London vs. Outside London): Regional comparisons allow for more localised insights. Different regions may have unique healthcare needs, population demographics, and resource availability. By comparing against location-specific averages, organisations can tailor their strategies to meet the specific challenges and opportunities in their region.
- **Type of Service Provision** (e.g., Pathway 1 vs. Pathway 2): Different types of service provision have distinct goals, target populations, and care delivery models. Comparing metrics against benchmarks for specific service types helps organisations assess how well they align with their chosen care model and identify best practices within their category.
- **Benchmarking with Similar Organisations**: Organisations benefit from benchmarking against similar healthcare or service providers. This allows for a more direct comparison with organisations facing similar challenges and serving similar populations.

(What they provide)

The dashboards provide actionable insights for programme stakeholders, including service providers, local and national commissioners, policymakers, and third-sector organisations for the 10 TS that provided data. By utilising the data, they inform decision-making, optimise resource allocation, and enhance the effectiveness of out of hospital care for people who are homeless. Localities not enrolled in the OOHCM (plus those enrolled in the OOHCM who did not submit data) can contact the team (m.tinelli@lse.ac.uk) to inquire about receiving samples of relevant visualisations. This will facilitate broader understanding of the evaluation framework, the results of the OOHCM, and consideration of its applicability to other services, populations, or environments.

- ***Positive outcomes***: *Emphasise positive trends and improvements, increased access to care, improved health outcomes, improved experience, and more participants transitioning to stable housing.*
- ***Challenges***: *Indicate challenges and areas that require additional attention, such as allocated budget utilisation, accessibility issues or coordination concerns among service providers.*

(Collection of metrics covered)

The integrated management dashboards address the needs of various stakeholder groups, categorised into local users and national users. Specific sets of dashboards have been created for each group to provide access to their relevant data. They cover the following (see Table 9.1):

- **Data Availability Map:** A visual representation that conveys the accessibility status of different data sources utilised in gathering the information reported in various metrics (only for national stakeholders interested in quality of the data for national comparability).
- **Summary Metrics:** A concise summary of essential metrics related to OOHC. They include investment and budget utilisation plus a series of outcomes collected as part of the audit.
- **Investments and Service Delivery Costs:** Provides access to in depth data on investments and service delivery costs. We also provide additional information about sustainability of service provision. Because of the sensitive nature of the information, only national stakeholders have access (and aggregate data). Pertinent data are shared with individual test sites in the static dashboards).
- **People Demographics and Staffing**: Provides a snapshot of various demographic characteristics of the population of people with experience of homeless being served and the staffing levels within the service provider organisations.
- **Health and social care while in out of hospital care**: Provides information related to access to health and social care while in contact with OOHC services.
- **The Flow of People in and Out of Services:** Offers an overview of people access to services and waiting times during transitions in the OOHC context.
- **Housing Outcomes**: Provides a visual representation of key metrics and data related to the housing situations and outcomes of individuals receiving OOHC services.
- **Person Reported Experience Measures**: Presents what people who are homeless say about their experience of care and support while in OOHC. It includes all audit questionnaire data collected 2021-23 using the same questionnaire utilised by the National Audit of Intermediate Care to monitor intermediate care service post-discharge.
- **Health Outcomes**: Presents what individuals who have experienced homelessness said about their health when leaving OOHC compared to when they entered (includes all audit questionnaire data collected between 2021-23 using standardised questionnaire Euroqol 5D5L).
- **Economic Analysis NHS Perspective**: Evaluates economic outcomes by comparing the period one year before admission to one year after, with a focus on the NHS perspective.
- **Economic Analysis Broader Public Budget Perspective**. Assesses economic outcomes by comparing the period one year before admission to one year after, with a focus on the overall public budget perspective.
- **People Preferences and Service Uptake Modelling**. Presents preferences and choices of people who are homeless about OOHC options compared with rough sleeping.

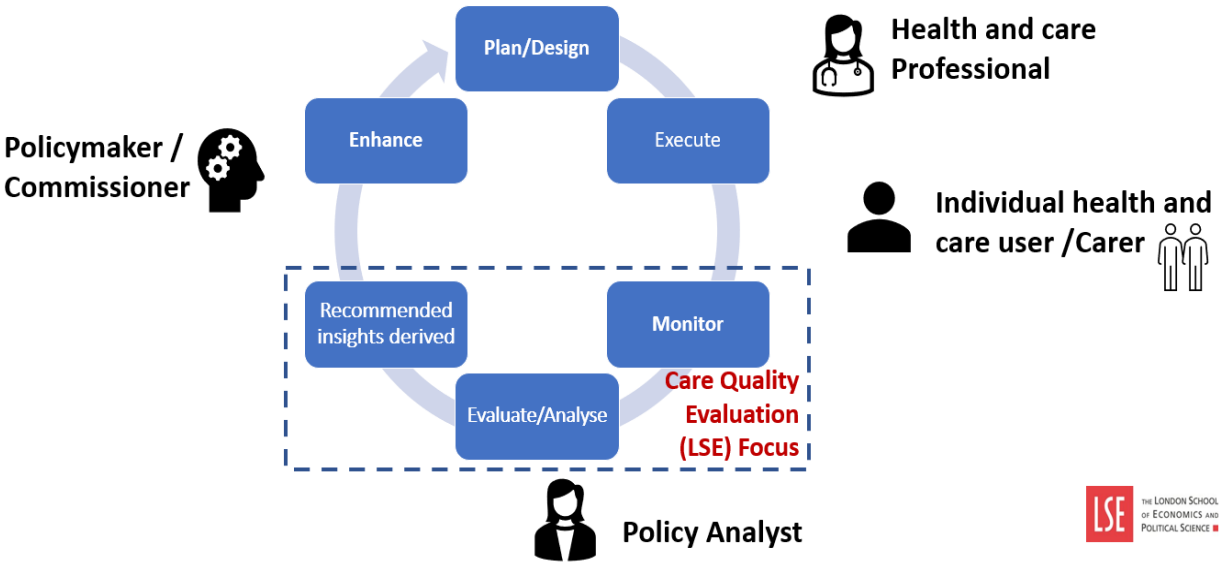
9:2 Next steps - automated dashboards

Moving forward, LSE already secured funding for a scoping project to build an automated version of the dashboard that can be dynamically updated, based on real-time data feeds or scheduled refreshes, without requiring ongoing manual intervention. The automated version will be made available to those OOHCM areas that are planning to continue, but also to other areas interested to adopt it (**see section 9:3 Current status of project, below**).

To support the dashboards, LSE as has developed the **'The Care Quality Evaluation (CQE) Platform'** (see Figure 9.2 below). This is a dynamic and responsive system that supports a cycle of continuous data collection, monitoring, and evaluation to drive insights for enhancements and quality improvements. By focusing on person-centred care, integrated services, data standardisation, organisational efficiency, and a commitment to continuous learning, the platform aims to contribute to the ongoing enhancement of care quality within the health and care ecosystem. The cyclical nature of the process allows for continuous improvement, ensuring that health and care remains responsive to evolving needs and challenges.

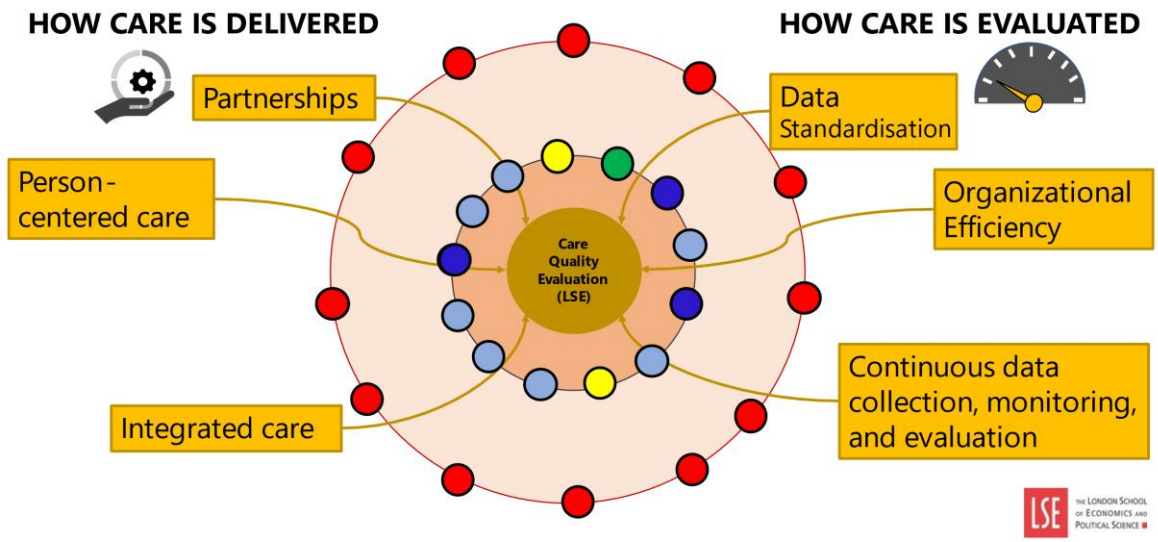
Figure 9:2: Care Quality Evaluation

(a) The focus of CQE within the life cycle of a homeless initiative



Note: The lifecycle of a homeless initiative (and other health and care initiatives) involves several stages, each crucial for its success and continuous improvement. Key stakeholders, including health and care professionals, individual users/carers, and policymakers/commissioners, play vital roles throughout the process. This is an overview of the lifecycle stages and the focus of the CQE platform. CQE is positioned as a transformative tool in addressing homelessness, aligning with evidence-based decision-making and continuous improvement in healthcare services.

(b) The role of Care Quality Evaluation (CQE) in the homeless care ecosystem



Who provides care: adult social care, drug and alcohol, housing, health care, criminal justice, mental health, voluntary sector.

Who experiences care: the individual user, their carer and family.

Who evaluates care: third party evaluator (academia)

Who plans and commissions care and evaluation: ICBs, local authorities, NHS trusts, Central gov dept, arm length bodies, other funders.

Data science and integrated platform

The Care Quality Evaluation electronic platform.

Outcomes

Note: In a comprehensive health and care ecosystem, delivery and evaluation of care for people experiencing homeless involves multiple stakeholders working collaboratively. This figure presents a breakdown of the key components and their interconnected roles. Serving as the backbone of the ecosystem, the CQE platform enables the flow of information among stakeholders, to facilitate standardised, secure, accessible data to support better outcomes.

Delivering the automated dashboards will involve the following steps (Figure 9.1):

1. **Access to More Data:**
    - *Objective:* Expand the scope of data collection to encompass a more comprehensive set of variables from a larger cohort and longer period of time.
    - *Rationale:* A broader range of data ensures a more nuanced understanding of homelessness factors, allowing for more informed decision-making.
2. **Automated Processes:**
    - *Objective:* Transition from manual to automated processes for data collection, analysis, and visualisation.
    - *Rationale:* Automation enhances efficiency, reduces errors, and enables real-time data updates, thereby improving the responsiveness of the system.
3. **Application to Other Services/Populations:**
    - *Objective:* Extend the integrated dashboard's functionality to address a wider array of homeless services and diverse population segments.
    - *Rationale:* A more inclusive approach ensures that the system caters to the specific needs and challenges of subgroups within the homeless population.
4. **Application to Other Environments:**
    - *Objective:* Explore the applicability of the integrated dashboard model to different geographical and environmental contexts.
    - *Rationale:* Adapting the system to varied environments ensures it is effective and relevant in diverse settings, allowing more widespread impact on homelessness management.

The planned evolution from the current status quo through descriptive, diagnostic, predictive, and prescriptive phases (Figure 9.1) are:

1. **Descriptive Phase:**
    - *Status Quo:* The current manual process provides a descriptive snapshot of homelessness, outlining key statistics and trends.
    - *Roadmap:* Enhance descriptive capabilities by accessing a more extensive dataset, offering a richer portrayal of the homelessness landscape.
2. **Diagnostic Phase:**
    - *Status Quo:* The existing system prescribes interventions based on descriptive data but lacks in-depth diagnostic insights.
    - *Roadmap:* Move towards a more diagnostic approach by leveraging automated processes to identify root causes and patterns contributing to homelessness.
3. **Predictive Phase:**
    - *Status Quo:* Limited capacity to predict future trends and challenges.
    - *Roadmap:* Implement predictive analytics to forecast potential shifts in homelessness patterns, enabling proactive and preventive measures.
4. **Prescriptive Phase:**
    - *Status Quo:* The current system provides prescriptive recommendations based on manual analysis.
    - *Roadmap:* Elevate prescriptive capabilities by incorporating advanced algorithms and automation, allowing for more sophisticated and timely interventions.

9:3 Current status of the integrated management dashboards project

The evaluation team is currently in discussions with a few local areas and their commissioners who are committed to establishing a partnership. This commitment involves either commencing the use of manually operated dashboards in non-OOHCM areas or continuing their use in OOHCM-covered areas. The Buckinghamshire, Oxfordshire & West Berkshire (BOB) ICB has agreed to lead the partnership and facilitate collective engagement with the LSE. BOB ICB will assist, with the support of the other partners, in finalising a data template and assessing the success of the dashboards, as well as providing data for a duration of 12 months starting in 2024. There are no financial costs for local test sites and their commissioners when committing to join the partnership. After the initial 12-month trial period, individual partners may choose to continue with the collaboration and cover running costs thereafter. This initiative aims to ensure the continuous evaluation of services as the automated version is under development. It is anticipated that these sites will be test sites for the automated version. It is critical for multiple sites to engage if we are to enable data comparability across sites, national estimates and reduce ongoing running costs.

The evaluation team is planning workshops to showcase the full potential of the dashboards and discuss the roadmap for adoption by local sites and commissioners, and national stakeholders. Events in 2024 will provide stakeholders the opportunity to explore the capabilities of integrated management dashboards, including DCE data visualisation. Updates and events will be posted on the website: www.lse.ac.uk/cpec/research/OOHCM/integrated-management-dashboards.

If you wish to participate in workshops or testing, please contact the dashboard leader, Dr Michela Tinelli, m.tinelli@lse.ac.uk.

References

Aldridge, R. W., Menezes, D., Lewer, D., Cornes, M., Evans, H., Blackburn, R. M., Byng, R., Clark, M., Denaxas, S., Fuller, J., Hewett, N., Kilmister, A., Luchenski, S., Manthorpe, J., McKee, M., Neale, J., Story, A., Tinelli, M., Whiteford, M., Wurie, F., … Hayward, A. (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. Wellcome open research, 4, 49.

Bolton, J (2018) *Reducing delays in hospital transfers of care for older people: Key Messages in planning and commissioning*. Oxford: Institute of Public Care. https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf [Accessed 20.02.24].

Cornes, M., Aldridge, R., Tinelli, M., Whiteford, M., Hewett, N., Clark, M., ... O'Shea, D. (2019). Transforming out-of-hospital care for people who are homeless. Support Tool & Briefing Notes: complementing the High Impact Change Model for transfers between hospital and home . London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London. https://doi.org/10.18742/pub01-007.
Cornes, M., Aldridge, R. W., Biswell, E., Byng, R., Clark, M., Foster, G., Fuller, J., Hayward, A., Hewett, N., Kilmister, A., Manthorpe, J., Neale, J., Tinelli, M., & Whiteford, M. (2021). Improving care transfers for homeless patients after hospital discharge: a realist evaluation. NIHR Journals Library. https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170/#/abstract [Accessed 20.02.24].

Department of Health (2001) *National Service Framework for Older People*. London. DH.

Department of Health and Social Care (2024) Guidance: Discharging people at risk of or experiencing homelessness/ https://www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness [Accessed 20.02.24].

Department of Health and Social Care (2020) *Out of Hospital Care Models for People Experiencing Homelessness: To Reduce Rough Sleeping and Health Inequalities*. *Outline Business Case.* (unpublished) London: HM Government.

Department of Health and Social Care /HM Government (2022) *Hospital Discharge and Community Support: Policy and Operating Model.* London: HM Government. https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model [Accessed 20.02.24].

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., & West, M. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ quality & safety, 23(2), 106–115. https://doi.org/10.1136/bmjqs-2013-001947.

Glasby, J. (2003) *Hospital Discharge. Integrating health and social care*. Oxford: Radcliffe Medical Press.

Gray. T. (2021) *Investigation of the potential for risk sharing arrangements for step down accommodation for homeless people on discharge from hospital*. London: Healthy London Partnership. (unpublished report).

Healthwatch England. (2020). *590 people's stories of leaving hospital during COVID-19*. Newcastle upon Tyne: Healthwatch England. https://www.healthwatch.co.uk/report/2020-10-27/590-peoples-stories-leaving- hospital-during-covid-19 [Accessed 20.02.24].

Herington, M. and Van de Fliert (2018) Positive Deviance in Theory and Practice: A Conceptual Review, Deviant behaviour 39:5 pp664-678 https://www.tandfonline.com/doi/abs/10.1080/01639625.2017.1286194?tab=permissions&scroll=top [Accessed 20.02.24].

Hewitt, P. (2023) An independent review of integrated care systems. London: DHSC https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems [Accessed 20.02.24].

Hibbert and Trubacik (2019) *Positive Deviance in Intermediate Care Services*. London. NHS Benchmarking Network.

House of Commons Health and Social Care Committee (2021) Workforce burnout and resilience in the NHS & social care.

https://committees.parliament.uk/publications/6158/documents/68766/default/ [Accessed 20.02.24].

Kaambwa, B., Bryan, S., Barton, P., Parker, H., Martin, G., Hewitt, G., Parker, S., & Wilson, A. (2008). Costs and health outcomes of intermediate care: results from five UK case study sites. Health & social care in the community, 16(6), 573–581.

Local Government Association LGA (2023) *Home First Discharge to Assess and Homelessness. Updated support tool and briefing note complementing the High Impact Change Model for managing transfers of care***.** LGA/ADASS and Partners in Care and Health: London. https://www.local.gov.uk/publications/home-first-discharge-assess-and-homelessness [Accessed 20.02.24].

Legislation.gov.uk. (2017) *Homelessness Reduction Act 2017*. http://www.legislation.gov.uk/ukpga/2017/13/pdfs/ukpga_20170013_en.pdf

[Accessed 20.02.24].

Local Government Association, Department of Health and Social Care, Association of Directors of Adult Social Care, NHS England and NHS Improvement (2019) *High Impact Change Model. Managing Transfers of Care between Hospital and Home. A self-assessment tool for local health and care systems.* London: Local Government Association. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model [Accessed 20.02.24]

Local Government Association and NHS England (2022) *Better Care Fund planning requirements 2022-23*

https://www.england.nhs.uk/wp-content/uploads/2022/07/B1296-Better-Care-Fund-planning-requirements-2022-23.pdf [Accessed 20.02.24]

Metz, A., Jensen, T., Farley, A. and Boaz, A. (2022) Is implementation research out of step with implementation practice? Pathways to effective implementation support over the last decade. *Implementation Research and Practice,* 3 (Jan-Dec) 1-11.

National Institute for Health and Social Care Excellence (2022) Integrated Health and Social Care for People Experiencing Homelessness. NICE Guideline NG214 https://www.nice.org.uk/guidance/ng214 [Accessed 20.02.24].

Newton Europe. (2019). People first, manage what matters. Abingdon: Newton Europe. Retrieved from https://reducingdtoc.com/People-first-manage-what-matters.pdf [Accessed 20.02.24].

Newton Europe. (2017). Why not at home? Why not today? Abingdon: Newton Europe. https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf [Accessed 20.02.24]

NHS England and NHS Improvement, Department of Health and Social Care, Association of Directors of Adult Social Services, Local Government Association, Housing LIN and Care Sector Alliance (2016) *Quick Guide: Discharge to Assess*. *Transforming Urgent and Emergency Care Services in England.* London: NHSE Publications Gateway Reference 05871. www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/discharge-to-assess/ [Accessed 20.02.24]

NHS England (2023a) Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge. Good Practice guidance for integrated care boards (commissioners and providers). London: NHSE

https://www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/ [Accessed 20.02.24]

NHS England (2023b) A national framework for NHS – action on inclusion health. London: NHSE https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/ [Accessed 20.02.24]

NHS England (2023c) A new community rehabilitation and reablement model. Good Practice guidance for integrated care boards (commissioners and providers). London: NHSE https://www.england.nhs.uk/publication/a-community-rehabilitation-and-reablement-model/ [Accessed 20.02.24]

NHS (2021) *Hospital Discharge and Community Support: Finance Support and Funding Flows*. London: NHS. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/05/C1281-hospital-discharge-policy-finance-support-may-21.pdf [Accessed 20.02.24]

Nguyen, T., JJ., Nadicksbernd, JJ., Jackson, T., and Shulman, C. (2022) *Health, housing and social care integration for people experiencing homelessness: needs identified in an inpatient audit.* London: Health London Partnership. https://www.transformationpartners.nhs.uk/programmes/homeless-health/health-housing-and-social-care-integration-for-people-experiencing-homelessness-needs-identified-in-an-inpatient-audit/ [Accessed 20.02.24]

Nadicksbernd, JJ Nguyen, T., Jackson, T., and Shulman, C. (2023) Health and care needs of hospitalised people experiencing homelessness: an inpatients audit*. Clinical Medicine, Vol 23, No4 395-402.*

Pearson, M., Hunt, H., Cooper, C., Shepperd, S., Pawson, R., & Anderson, R. (2015). Providing effective and preferred care closer to home: A realist review of intermediate care. *Health and Social Care in the Community*, *23*, 577–593.

St Mungo's and Homeless Link (2012) *Improving Hospital Admission and Discharge for People who are Homeless*. London: Homeless Link.

https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Improving_hospital_admission_and_discharge_for_people_who_are_homeless.PDF [Accessed 20.02.24].

Hull, L. et al., 2019 Designing high-quality implementation research: development, application, feasibility and preliminary evaluation of the implementation science research development (ImpRes) tool and guide. *Implementation Science* 15:80.

King's Health Partners (2018) Implementation science research development tool. A practical guide to using the Impress Tool. (version 1) https://arc-nenc.nihr.ac.uk/virtual-college/implementation-science-research-development-impres-tool/ [Accessed 20.02.24].

NICE (2018) Intermediate care including reablement. Quality Standard [QS173] https://www.nice.org.uk/guidance/qs173 [Accessed 20.02.24].

NICE (2022) *Integrated health and social care for people experiencing homelessness.* NG214. London: NICE https://www.nice.org.uk/guidance/ng214 [Accessed 20.02.24].

Teale, A. and Young, J (2015) A patient reported experience measure (PREM) for use by older people in community services. Age Ageing 44(4): 667-72.

Tinelli, Michela (2016) Applying discrete social experiments in social care research. Method Reviews, 19. NIHR, SSCR, London, UK. https://eprints.lse.ac.uk/73723/ [Accessed 20.02.24].

Young, J and Stevenson, J (2006) Intermediate Care in England: where next? *Age and Ageing* 35 339-342.

Appendices

Appendix 1: Resource Allocation, Planned Service Development and Mobilisation

Note about Programme Duration: Quarterly Monitoring by the DHSC was implemented from April 1, 2021 – March 31, 2023 (covering 8 quarters). There was some activity in test sites prior to this, but this is excluded from this evaluation as it was mainly focussed on Covid-19 support.

Table S1: Out-of-London Test Sites

Test Site *OOHCM Investment*	**Hospital In-reach** *& Management Costs for Test Site*	**Pathway 1**	**Pathway 2**
TS1 £600,000	Expansion of a clinical in-reach team covering four main acute sites. *New Staffing:* 3 specialist nurses, 1 occupational therapist, 1 substance misuse hospital link worker, 2 housing advice coordinators, 4 floating support workers, 1 administrator £440,000. Personalisation Fund £9,000 *Data Analyst £50,000* *Contingency/Learning £6,000* **Established service - Activity Reported from October 2021 for 6 Quarters.**		Established 40 bed independent living/step-down unit. OOHCM funding was planned to enable the expansion of the staff team to include a 0.5 FTE specialist occupational therapist and 2 resettlement posts to support people after leaving step-down £85,000. Personalisation Funding £10,000 **Established service - Activity Reported from January 2022 for 5 Quarters.**
TS2 £379,600	Expansion of clinical in-reach team to cover a second acute site and community and mental health hospitals. *New Staffing*: 2 nurses, 1 social worker, £166,745 *Data Analyst £44,200* *Project Manager (D2A Service Lead) £36,155* **Mobilised April 2021 - Activity Reported for 8 Quarters.**	6 Units of dispersed step-down (reablement) accommodation (council funded). OOHCM funding used to continue to 2 social worker posts and 1.5 reablement workers £132,500. **Mobilised April 2021 - Activity Reported for 8 Quarters.**	
TS3 £580,218	There is an established clinical reach team (not OOHCM Funded). OOHCM funding used for an A&E prevention worker £62,275. **Established service – Activity reported for 1 Quarter.**	Step-Away Team providing mainly step-up and some further support after stay in residential beds (sits with homeless outreach team) 1 nurse, I occupational therapists and assistants £230,317. **Activity reported for step-up**	5 Step-down beds in existing hostel facility. Support staff and clinical in-reach sessions delivered through local specialist primary care service £247,626. Personalisation fund £40,000 **Mobilised January 2021 - Activity reported for 8 Quarters**
TS4 £548,910	Expansion of existing clinical in-reach team to include team leader, 1 nurse and 2 social workers £191,438 **Established service - Activity reported for 6 Quarters**	Establishment of new settle-in floating support service. 4 support workers £112,000 Expansion of outreach nurse team - 2 nurses £215,472 Personal budget £30,000 **Mobilised January 2022 - Activity Reported for 5 Quarters.**	

TS5 £332,001	Expansion of a housing-led in-reach team aligned to hospital safeguarding team. 3 Senior Housing Solutions Officers £131,768 *Project Manager £30,360* **Mobilised April 2021 - Activity Reported for 7 Quarters.**	5 Units of dispersed self-contained accommodation. £50,373 plus funding for local authority reablement team to deliver 4 visits per day. £119,500 **Mobilised April 2021 - Activity Reported for 6 Quarters [ended September 2022]**	
TS6 £478,736	Expansion of long established housing-led in-reach team. Covers 1 acute and 1 mental health hospital. Additional housing advisor post funded £42,000. *Project officer £40,000* **Established service – Activity Reported 8 Quarters**	2 FTE outreach workers covering different parts of the county, providing 75 hours of settle-in and key work support. £78,000 A CQC registered specialist drug and alcohol domiciliary care service (block contract providing 70 hours per week) £74,764 £4000 personal budget. **Mobilised April 2021 - Activity Reported for 8 Quarters**	13 beds commissioned across 2 step-down units, £157,248 for onsite 24/7 support plus £120,324 to cover rental voids where housing benefit cannot be claimed. In-reach provided by CQC specialist domiciliary care service for those requiring personal care/reablement. Area has access 2 additional step-down beds funded through RSI. Personal budget £2,400 **Mobilised April 2021 - Activity Reported for 8 Quarters**
TS7 £303,330	Housing in-reach post already established. OOHCM funding used to commission a specialist primary care team to undertake in-reach sessions into 1 acute site (mainly A&E). £89,905. Plus 1 dual diagnosis worker £47,085 *Evaluation £5,000* **Established service – Activity Reported 4 Quarters**	8 Units of self-contained dispersed accommodation with intensive tenancy management £75,840. 2 workers to provide floating settle in support as part of their role in the Rough Sleepers Team. £85,500 **Mobilised July 2021 - Activity Reported for 5 Quarters [ended July 2022]**	
TS8 £546,344	Clinical In-reach team (not OOHCM funded). **No Activity Reported**		20 bed step-down unit plus staffing. Plan to repurpose a former local authority older people's reablement/sheltered housing facility £546,344. **Did not mobilise - No Activity Reported**
TS9 £487,000	Clinical In-reach team (not OOHCM funded). *Workforce development £4,000* *Consultancy from Pathway Charity £6,000* *Data analysis £15,000* **Established Service – Activity Reported 7 Quarters**	3 step-down health beds in a homeless hostel (not OOHCM funded).	9 Step-down beds (self-contained studios) located across 3 Units. OOHCM funding used to develop a multi-disciplinary support team – In-reaching into hospital, step-down units and the community. Staffing: GP, Nurse Navigator, Practitioner Post, Nurse, Social Worker, 4 Care Navigators,2x Housing Officers, 2 Wellbeing workers, Peer navigators £457,000 Personalisation Fund £5,000 **Mobilised April 2021 - Activity Reported for 8 Quarters**
TS10 £553,050	Development of a new clinically-led in-reach team. 3 GP sessions per week, 2 nurses and 1 navigator to coordinate social care assessments and continuity of care £226,355. *Programme manager/Analyst £50,222*	Reablement Team and minor refurbishment work to improve accessibility of 3 units within an existing temporary accommodation facility £73,000. Staffing 2x personal care workers and 3x housing-led reablement staff £203,473	

	Mobilised July 2021 - Activity Reported for 7 Quarters.	**Mobilised January 2021 - Activity Reported for 7 Quarters**	
TS11 £415,000	Development of housing in-reach across two acute sites. 2x Navigators for accommodation £60,00 *£30,000 system insight* **Activity reported from October 2022 (2 Quarters)**		15 Units of dispersed accommodation £225,000 2 outreach nurses £100,000. Delivery plan changed to establish a step-down house. **Mobilised October 2022 - Activity Reported for 2 Quarters**
TS12 £700,779	Expansion of housing in-reach across multiple acute and mental health sites. 1 embedded housing worker £67,500 to work alongside a third sector navigator (not OOHCM funded). *Programme Manager £81,374* **Mobilised April 2021 - Activity Reported for 8 Quarters**		New 5 step-down house (5 beds already funded locally through the homeless pathway bringing total to 10 beds). £308,072 for 15 months includes costs of support workers covering both houses. Funding for a multi-disciplinary team working mainly across step-up but with some in-put into step-down. This includes a clinical psychologist, a mental health social worker and 2 Mental Health Support Workers £243,833 **Mobilised April 2021 - Activity Reported for 8 Quarters**

Table S2: London Test Sites

Test Site	Hospital In-reach *& Management Costs for Test Site*	Pathway 1	Pathway 2
TS13 £1,000,000	Housing-led in-reach (with some workers offering settle in support): *Staffing*: 5 'Move On' coordinators aligned to 5 council boroughs. £255,000 Personalisation Funds £20,000 **Mobilised October 2021 - Activity Reported for 6 Quarters**	Clinically-led Intermediate Care Team offering in-reach and working across three acute sites and **works across all D2A Pathways**. Staffing: 4 specialist nurses and 5 reablement/settle-in workers. £455,000 *System Coordination £80,000* **Mobilised April 2022 - Activity Reported for 4 Quarters** Funding for mobility standard step-down flats £140,000	Funding for 4 beds in an existing intermediate care facility £50,000 Share of 14 beds in a Pan London Medical Respite Facility
TS14 £678,020	Expansion of an existing clinical in-reach team to cover three additional acute sites and two mental health sites. 1 extra GP session per week; Project lead and 2 homeless clinical specialists. £248,020 *Increased programme management capacity* £10,000 **Established Service – New Posts mobilised January 2022 – Activity Reported for 5 Quarters**	Development of a new voluntary sector led "settle-in" service. 5 'settle in' workers £350,000. Peer Advocacy £10,000. Funding for 100 nights hotel accommodation £55,000 Personal Budget £5,000 **Mobilised January 2022 - Activity Reported for 5 Quarters**	Share of 14 beds in a Pan London Medical Respite Facility
TS15a £385,539	Development of a clinical in-reach team. 5 GP sessions, mental health nurse, nurse, housing officer, navigator/settle-in worker £316,538 Personalisation Fund £10,000 *Consultancy to Pathway Charity £10,000* **Mobilised October 2021 - Activity Reported for 3 Quarters [Service suspended due to staffing issues]**	Spot purchase beds £50,000 **No Activity Reported**	Share of 14 beds in a Pan London Medical Respite Facility
TS15b £361,393	Development of a clinical in-reach team. GP led, Social Worker, Specialist Nurse, Housing Officer, Expert by Experience £248,393 Personalisation Fund £10,000 *Consultancy to Pathway Charity £20,000* *Building works for new office space £43,000* **Mobilised October 2021 - Activity Reported for 6 Quarters**	Spot purchase beds £40,000 **No Activity Reported**	Share of 14 beds in a Pan London Medical Respite Facility
TS16a £674,547	Development of a new clinical in-reach team, GP, nurse, coordinator, housing liaison and care navigator. Working across eight acute sites (some of which sit in TS16b) £298,000	Intermediate care team (2.5 nurses) in the community with some acute presence £155,000 **Mobilised October 2021 Activity Reported 6 Quarters.**	Share of 14 beds in a Pan London Medical Respite Facility

	Consultancy from Pathway Charity £20,000 *Project Management and Research* *Including development of a discharge protocol £81,547* **Mobilised October 2021 - Activity Reported for 6 Quarters**	Step down placements (1 beds No Recourse to Public Funds). £14,000. Various other funded community roles GP Sessional £10,000, Community navigator/wellbeing worker £48.000, 1 reablement/resettlement worker £48,000 **Activity not reported.**	
TS16b £537,529	Stated aims is to link Rough Sleeping Workers with discharge hubs: 5 link workers/resettlement workers £250,000 Various other funded community roles: Specialist GP/primary care £40,000, Community navigator/wellbeing worker £48.000, 2 Peer advocate care navigators £70,192. *Project Management and Research £81,547* **Mobilised April 2022 - Activity Reported for 4 Quarters**	Step down placements (7 beds No Recourse to Public Funds) £47,790 **No Activity Reported**	Share of 14 beds in a Pan London Medical Respite Facility
TS17a £268,913	Newly established clinical in-reach team (not OOHCM funded). 1 Out-of-are Reconnection worker and 2 link workers £92,021, *Management costs £14,228* *Project support £66,666* **Mobilised October 2021 - Activity Reported for 5 Quarters**		6 Step down beds plus some staffing £95,998 **Mobilised January 2022 - Activity Reported for 5 Quarters** Share of 14 beds in a Pan London Medical Respite Facility
TS17b £347,652	Clinical in-reach team already established at one acute site. New team for second acute site comprising GP, Nurse, OT £210,640. Resources for in-reach from mental health facility social worker and dual registered nurses £87,228. *Project support £66,666* **Established Team – Activity Reported 1 Quarter.** **New Team Not Mobilised – No Activity Reported.**		6 step-down beds £152,052 **Mobilised April 2022 - Activity Reported for 4 Quarters** Share of 14 beds in a Pan London Medical Respite Facility
TS17c £516,586	New housing-led in-reach team. 2 hospital in-reach/step down workers £83,042 plus 1 reconnection worker to help with out of area discharges £43,390. *Project support £66,666* **Mobilised April 2022 - Activity Reported for 4 Quarters**		6 step-down beds plus staffing £154,554 **Mobilised October 2022 – No Activity Reported.** Share of 14 beds in a Pan London Medical Respite Facility

Appendix 2: Sustainment and Scaling of Test Site Models (Snapshot June 2023)

Table S3: Out-of-London Test Sites

Test Site	Hospital In-reach & Management Costs	Pathway 1	Pathway 2
TS1	Difficulties with recruitment and retention. Clinical/therapy posts not recruited. Existing clinical lead left, so no clinical in-reach team. Housing coordinator posts recurrently funded through city council.		Existing 40 bed independent living/step-down unit. Better Care Funding confirmed for 23/24 with prospect of baseline 7 year funding.
TS2		Only 1 reablement worker recruited. Periods of absence meant service delivery reduced to telephone contact at times. No substantial funding identified beyond March 2023. Some RSI5 funding was secured but job descriptions changed so hospital discharge no longer main focus of job role.	
TS3	Existing clinical in-reach team (not OOHCM funded) baseline funded	Step-away team was not funded at end of programme.	Step-down beds funded through NHS Integrated Care System (ICS) Transformation Fund (to June 2023) and RS15 (to March 2025). Money in both ICB and Adult Social Care is reported extremely tight for next year and if test site can secure funding for rest of the year it is likely to be a remodelled or smaller service at a lower cost.
TS4	Existing clinical in-reach team (not OOHCM funded) baseline funded	In May 2023, Settle-in floating support team was given three months to wind down.	
TS5	Only 1 housing advisor in post for most of funding period due to recruitment and retention difficulties. No one in post from Jan 2023	Difficulties sourcing properties only 4 out of 5 available. Leases not renewed on 2 properties from July 22. No beds from October 22. Service ended prematurely.	
TS6	Funding secured for 23/24 (Integrated Commissioning Partnerships Group).	January 2023 funding was uncertain with plans to start demobilisation. February 2023 site notified that BCF funding was secured for 23/24 with commitment to scale service going forward subject to evaluation.	January 2023 funding was uncertain with plans to start demobilisation. February 2023 site notified BCF funding secured for 23/24 with commitment to scale service going forward subject to evaluation.
TS7	Specialist primary care in-reach was not continued.	Only 3 of 8 units provided. Service was not recommissioned.	
TS8			Service did not open.
TS9	Funding secured via hospital trust for 23/24.		Funding secured for 23/24 - £120K from the ICB and a further £85K from the hospital discharge fund.

TS10	ICS temporarily funding service to Summer 2023. Funded in principle 23/24. Sources TBC, likely to include BCF. Funding is for wider enhanced primary care model (OOHC forms part).	Temporarily funded as described	
TS11			No funding secured beyond April 2023
TS12	BCF funding secured for the whole model in June 2023 (until April 2024) with a further sum set aside for 24/25 pending system discussions and evaluation of need. Funding notified late in the day so decommissioning had commenced.	BCF funding secured for the whole model in June 2023 (until April 2024) with a further sum set aside for 24/25 pending system discussions and evaluation of need.	NHS Winter Pressures funding enabled scaling from 10 to 27 beds (plus 7 step-up beds) across 5 residential properties. Funding secured as described. As funding was notified late beds had begun to be emptied; confirmed service need as delayed discharges mounted.

Table S4: London Test Sites

Test Site	Hospital In-reach	Pathway 1	Pathway 2
TS13	£1.5 million funding secured for 23/24 from ICB for whole model.	Funded from £1.5 million	Funded from £1.5 million. Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS14	Clinical in-reach (part funded through OOHCM funded) recurrently funded through hospital trust with homeless workers covering all acute trust sites.	ICB committed £768K funding for 23/24 which aligns to the overall cost of the pilot in 22/23. The service provider will receive the required uplift to maintain staffing. There will be a reduction in the number of hotel beds to the match the necessary uplift.	Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS15a	Service was paused due to staffing challenges (staff left at end of their short-term contracts in November 2022). Some ICB funding was secured until March 2023 but no time to recruit. There are plans to relaunch the model but not until Spring 2024		Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS15b	Further short-term funding was secured until March 2024. High turnover of staff, currently only 1 nurse in place.		Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS16a	3 years funding was secured from the ICB. Very high staff turnover and the plan is to relaunch the model on a smaller foot print to make the work more manageable.	Intermediate care team experienced staffing issues with 1 nurse in post at 31 March 2023. 3 years funding secured from ICB to ensure step-down roles continues in this specialist community nursing team.	Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS16b	3 years funding secured from ICB for model as a whole. Team fully operational and reported to be working well.	Intermediate care team experienced staffing issues with 1 nurse in post at 31t March 2023. 3 years funding secured from ICB to ensure step-down roles continues in this specialist community nursing team.	Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS17a	New clinical in-reach team (not OOHCM funded) awarded funding to continue via hospital trust funding until end of March 2023. No confirmation of funding for OOHCM funded link workers. One reconnections link worker post was never recruited, one link worker funded util end of January.		6 Step-down beds still open, but future funding not confirmed. Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS17b	New clinical in-reach team never fully operational. Only 1 nurse recruited but in-reach not accepted by the hospital.		5 beds funded through OOHCM, plus additional 6 beds for No Recourse to Public Funds at a second facility. Future funding uncertain. Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.
TS17c	Funding not confirmed for housing-led hospital in-reach workers.		No confirmed funding. Block funding of Pan London Medical Respite Facility ended – services to spot purchase if required.

Appendix 3: Positive Practice – Specialist Comprehensive Multi-Disciplinary Assessment (Nurse-led).

Person Background: R is a 38-year-old woman. Long history of homelessness, long history of short-term placements in emergency or temporary accommodation. Prison history has been in and out of custody since adolescence. Longest time out of prison has been 4 months. History of sex working. R was referred to TS9 Pathway 2 Step down service following a hospital admission.

Table S5: Positive Practice – Specialist Comprehensive Multi-Disciplinary Assessment (Nurse-led)

Assessments Completed	**Care and Support Plan (Step-down Team Acts as Case Manager coordinating a single care/support plan)**	**Review (step-down team undertakes continuous monitoring and review of care and support plan).**
Nursing Assessment		**Outcomes Achieved**
Systemic Lupus Erythematosus (SLE) - R had significant skin lesions caused by her Lupus but exacerbated by her drug use. She was experiencing joint pain and inflammation and was not engaging in any health service to manage her Lupus.	*Goal: To improve management of long-term health conditions (physical health)* *Plan:* Referral to Rheumatology. Support staff facilitate engagement with GP and accompany to appointments.	R's skin is clear Fully immunised against Covid.
Malnourished BMI 16	*Goal: To manage and maintain nutrition.* *Plan:* Not eating due to loss of dentures – make appointment at dentist. Support worker to offer R support with shopping and cooking.	Has new dentures, was not bothered how she looked on admission, now very careful of her appearance, takes pride.
Mental Health Assessment		**Outcomes Achieved**
Coexisting mental health and substance use (Paranoid Schizophrenia, Dissocial personality disorder, Heroin, Crack, Amphetamines, Pregabalin, Spice, Diazepam).	*Goal: To improve management of long-term health conditions (mental health/addictions)* *Plan:* Step-down staff coordinated, accompanied and advocated for R to engage with mental health services. A mental health assessment was carried out and R was stabilised on a depot injection. Step-down staff referred and accompanied R to drug and alcohol service	R's mental health and presentation have been far more stable since being at the step-down. R has stabilized on methadone script, drug testing has shown she is testing negative for heroin, crack, amphetamines and diazepam.
Anxiety and Depression/Low Mood/Self-harm - R lacked hope, could not identify anything in her life that she enjoyed or looked forward to.	*Goal:* to improve mental well-being *Plan:* Support workers to provide emotional support	Wounds healing to arms. Much less reported self-harming, 2 incidents in 6 months.
Assessment of Care and Support Needs	**An initial assessment of care and support needs is undertaken by the specialist step-down team social worker.**	**Outcomes Achieved** NB Assessment under the CA 2014, takes place toward the end of the stay in step-down if still required following period of reablement.
Unable to maintain personal hygiene Not appropriately clothed R - was unkempt and self-neglecting.	Support worker to prompt R to maintain personal hygiene/be appropriately clothed.	Good self-care, always clean and smartly dressed, wears make up, takes pleasure in her appearance.

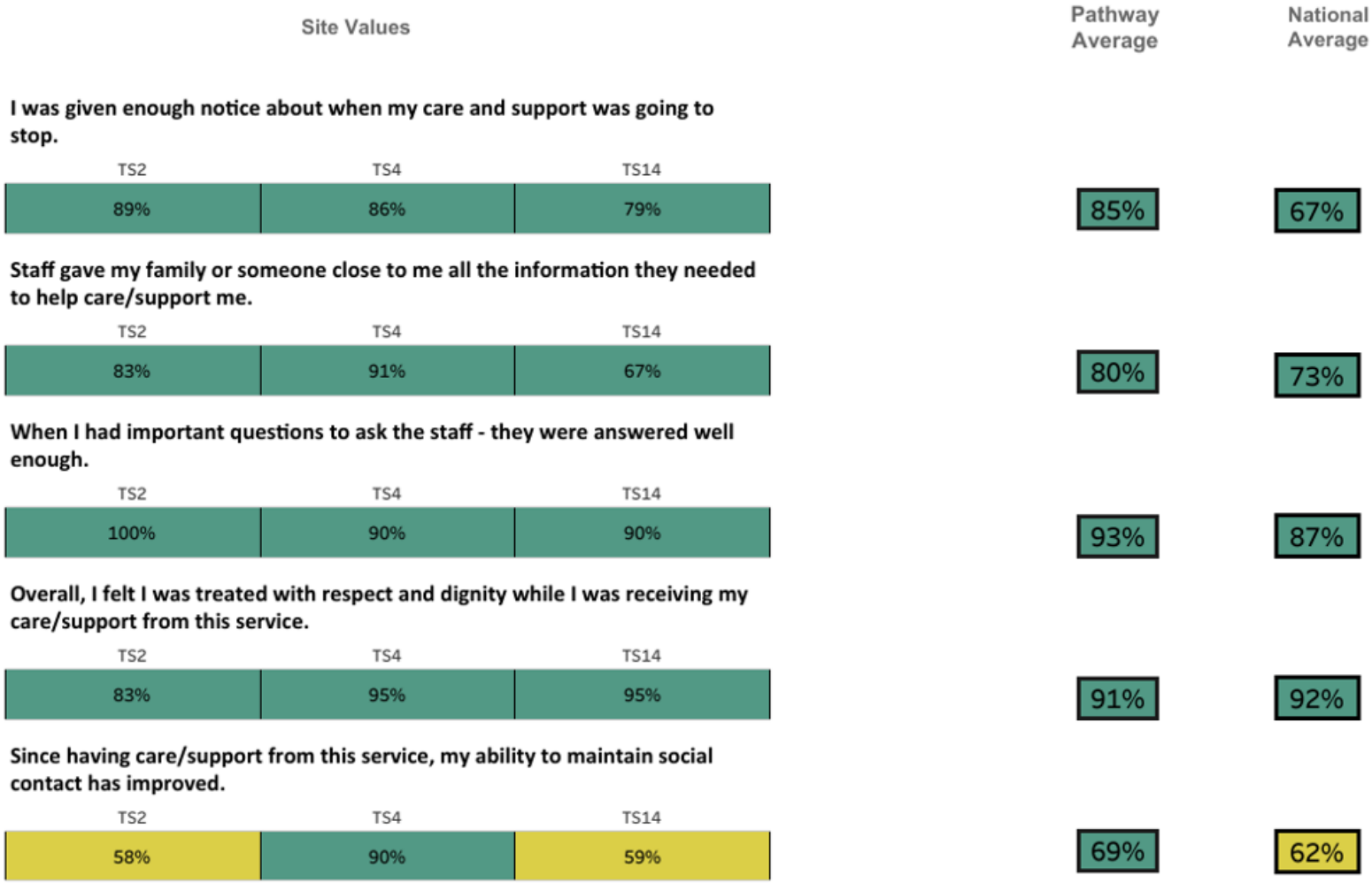
Assessments Completed	Care and Support Plan (Step-down Team Acts as Case Manager coordinating a single care/support plan)	Review (step-down team undertakes continuous monitoring and review of care and support plan).
Unable to secure/maintain habitable/safe home environment - R has a history of exploiting others for money for drug use – As a result R was being bypassed by housing due to risks to other tenants.	Risk management plan put in place to ensure other residents were protected from any potential harm from R. Step-down Team housing officers to engage with local housing providers to establish offers for R Support worker to assist R to collect benefits, prescriptions, budgeting, managing appointments, cleaning, shopping, and cooking.	Engaging very well with housing, ongoing work with housing to find the right home in the right area for R. Flat is clean and tidy. R very proud of this and motivated to complete tasks in the flat, self-esteem higher.
Unable to make use of necessary facilities or services in the community including recreational facilities /Unable to access and engaging in work/meaningful activities.	Support worker to encourage and coach R to pursue her interests - craft activities and poetry. Materials provided. Referral to third sector organisation working with women who are sex working.	Being at the step-down has developed her confidence and communication skills & meaningful occupation of time. R can identify things that interest her, and she enjoys such as poetry and crafts. This is the longest R has not been in prison since her adolescence.
Unable to develop/maintain family relationships - had lost contact with her family and had no relationships with any friends of family.	Step-down Support Worker to encourage more positive associations.	Has started to see her family, her mum, daughter and granddaughter. Has hope for her future, has entered a safe relationship. Can see a future for herself.
Housing Assessment		**Outcomes Achieved**
Long history of homelessness, long history of short-term placements in emergency or temporary accommodation	Referral to local council housing options service.	R is ready to move on to her own tenancy. There is a shortage of council property, a delay in repairs in any available council property, and not all properties are suitable for R. Due to the progress, we have made with R, there would be no benefit in moving her to temporary accommodation while she awaits a more permanent solution, this would not be trauma informed, there would likely be a deterioration in her health and wellbeing. R's discharge from step-down is delayed.

Appendix 4a: Results of PREM for Pathway 1

Figure S1: PREM, Items 1-5

Figure S2: PREM, Items 6-10

Figure S3: PREM, Items 11-15



Appendix 4b: Results of PREM for Pathway 2

Figure S4: PREM, Items 1-5

Figure S5: PREM, Items 6-10

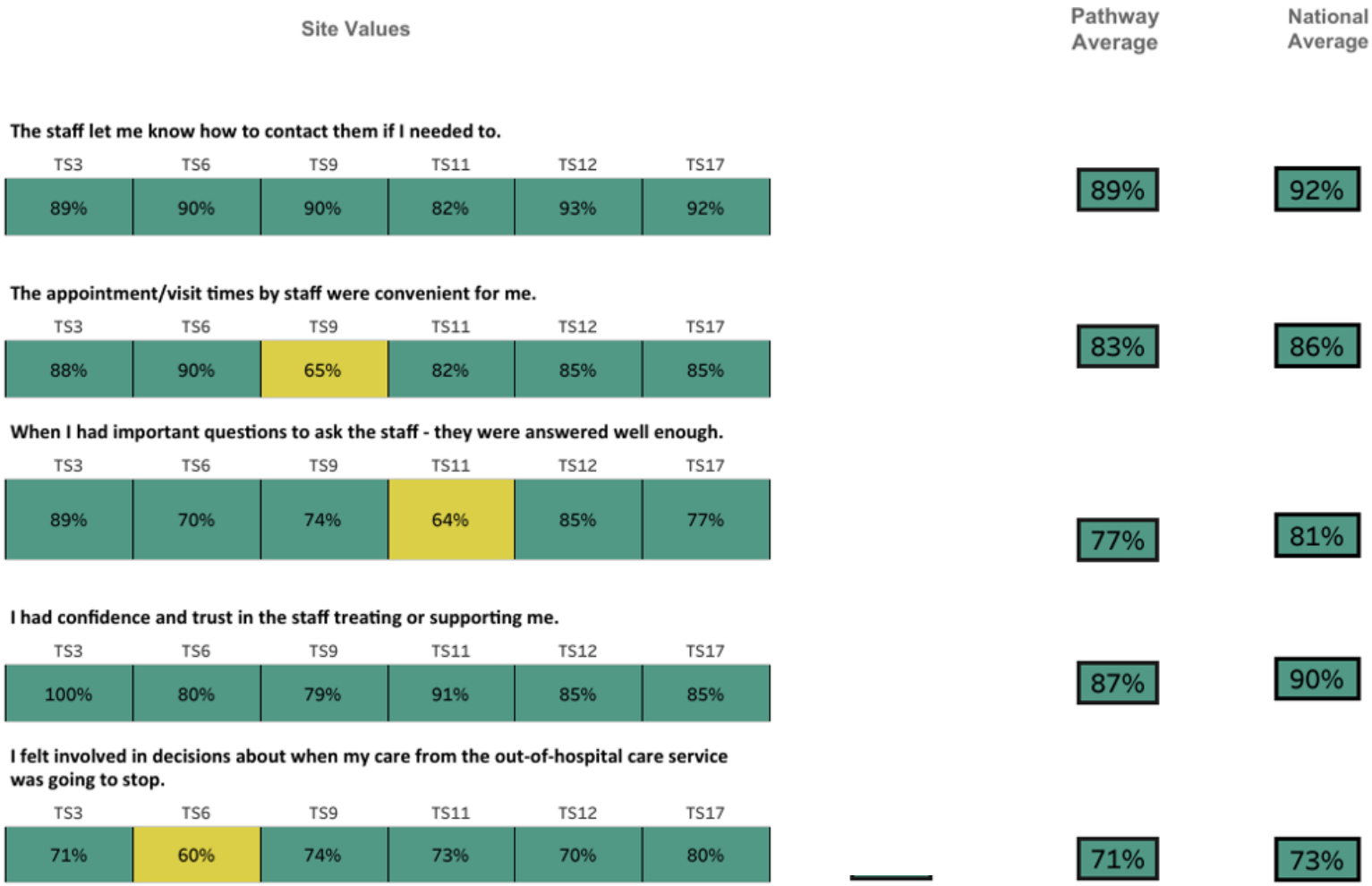


Figure S6: PREM, Items 11-15