Department of Health & Social Care

KING'S College LONDON

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LSE THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

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

Protocol Summary September 2021

Evaluation Team:

Michelle Cornes (co-PI) and Lizzie Biswell (King's College London)

Michela Tinelli (co-PI), Mike Clarke and Raphael Wittenburg (London School of Economics and Political Science)

Stan Burridge and Jo Coombes (Expert Focus)

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Out-of-Hospital Care Models Programme

- The overall aim of the OOHCM Programme is to scale successful homeless hospital discharge models that were shown to be effective and cost-effective in an earlier pilot programme - the 2013 Homeless Hospital Discharge Fund

- Successful models incorporated multi-disciplinary clinical in-reach and step-down intermediate care:
    - Shown to be more effective and cost effective than standard care
    - Reduced delayed transfers of care
    - Reduced A&E attendances by 18% (Cornes et al., 2019*)

- As part of the OOHCM programme, £16 million of shared outcomes funding allocated to 18 test sites across England to 'roll out' these successful models (December 2020)

- KCL, LSE and Expert Focus commissioned to undertake a 24 month evaluation (September 2021)

*https://doi.org/10.18742/pub01-007.

Evaluation Aims & Objectives

Aim

To capture the learning from the test sites and to evidence the outcomes that are being achieved.

Objectives

- Provide an understanding of the most effective way of implementing (scaling) out-of-hospital care across a wider range of areas – including how to shift to this position and the conditions needed to maximise the effectiveness and sustainability of the services.
- Describe how models are being integrated into the evolving health, housing and social care system, supporting D2A (the new NHS hospital discharge operating model), the NHS Long-Term Plan and Covid Care/Recovery.
- Identify the challenges that remain to systems and service delivery that require changes outside the direct control of organisations in the locality.
- Further test the key components of effective and cost-effective models especially where they have not previously been brought together into a single system.

OOHCM Programme Outcomes

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 patient experience J. Quicker recovery times K. QALY gains

Evaluation Timetable

1st September 2021 – 31st August 2023 (24 months)

Preliminary Phase: Ethical Permissions/Literature (Months 1-3)

Work Package 1 Programme Audit (Months 1-18).

Work Package 2 Implementation and Process Evaluation (Months 6-18)

Work Package 3 Economic Evaluation (Months 3-18)

Work Package 4 Choice Modelling (Months 3-18)

Regular reports/feedback for individual test sites (Months 3-24)

Analysis and writing for main evaluation report (Months 12-18)

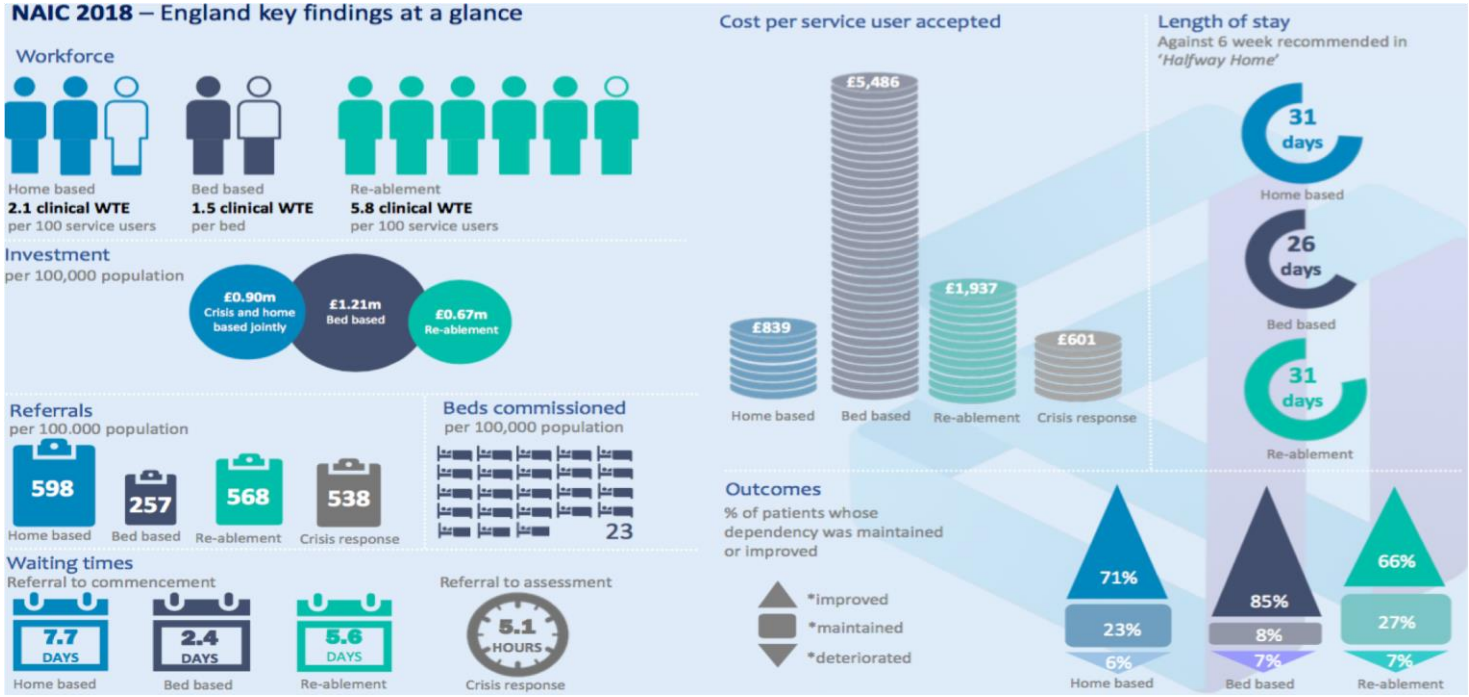
Final evaluation report due March 2023

National impact activity – sharing learning from test sites (Months 18-24)

Report of impact due August 2023

Work Package 1: Programme Audit

- Aims to generate a national picture of the costs and outcomes of OOHC for homeless patients – and to allow individual test sites to check their performance against this if they so wish.
- Collects the same information that it is used in national intermediate care/D2A audits (NAIC), plus additional information to sensitise for outcomes linked to homelessness (e.g. reduction in number of people returning to street)



Work Package 1: Programme Audit

To populate the Dashboard we will ask test sites:

1 To complete the quarterly monitoring forms used by DHSC
2 To provide us with information on service costs
3 Approach acute trusts for data (e.g A&E attendances)
4 To collect information on outcomes and patient experience for 40 service users

- ✓ Service user joins the service – project staff complete baseline EQ-5D questionnaire (Q1)
- ✓ Service user exists the service – staff complete a follow—up EQ-5D (Q2)
- ✓ With permission, a member of evaluation team (or local peer researcher) contacts service user and completes a questionnaire about the experience of using the service (Patient Reported Experience Measure Q3)

Service users will receive a £10 voucher for each questionnaire they complete

Each test site will receive an individualised infographic report to share with local commissioners

EQ-5D Gold Standard Outcome Measure

EQ-5D

Health Questionnaire

By placing a tick in one box in each group below, please indicate which statements best describe your own **health state TODAY**.

Mobility

I have no problems in walking about
I have slight problems in walking about
I have moderate problems in walking about
I have severe problems in walking about
I am unable to walk about

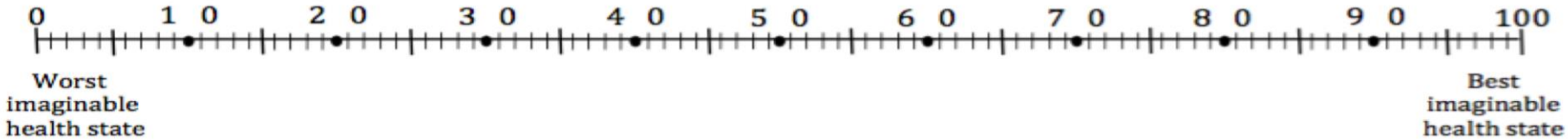
Self-Care

Usual Activities (*e.g. work, study, housework, family or leisure activities)*

Pain/Discomfort

Anxiety/Depression

Your Own Health State Today



Work Package 2: Implementation and Process

The overall aim of WP2 is to capture the learning from the test sites about 'what works' to successfully implement and scale out-of-hospital care in different contexts and in ways that maximise its effectiveness for homeless patients.

Methods

- **Reflective interview with test site lead/project manager** in each of the 18 sites covering: project bidding, mobilisation, governance and sustainability.
- **Brining together key frontline staff** working in OOHCM from across the 18 test sites– with separate reflective practice focus groups for: (i) clinicians, (ii) social workers and therapy staff (iii) and support staff. We will also host a special focus group for (iv) practitioners working in admission avoidance and (v) people with lived experience.
- **More in-depth study of 3 positive practice* test sites**: involving local fieldwork (shadowing) and semi-structured interviews with a wide range of local stakeholders (commissioners, managers, practitioners and service users) (n=10+ interviews per site).
- **Final round of reflective interviews** with (i) test site lead/project manager in each of the 18 sites and (ii) stakeholder focus groups to capture overall reflections on participation in the programme and to discuss triangulate emerging learning.

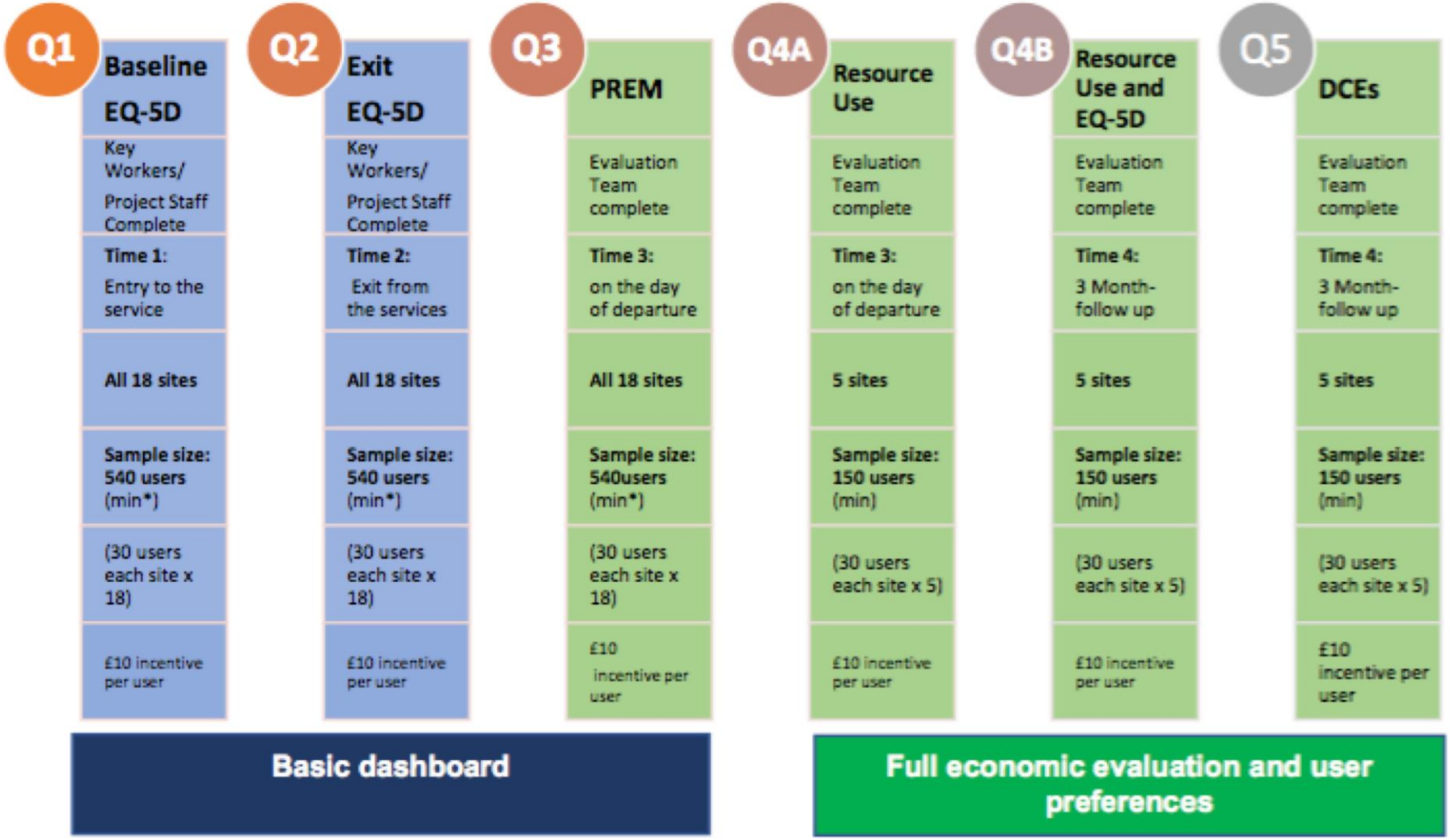
*'Positive practice' will be determined on basis of audit data and consensus agreement with all sites/DHSC)

Work Package 3: Full Economic Evaluation

Aims

- To undertake a cost utility and cost consequence analysis for each of the 18 test sites (using EQ-5D data and feeding into programme audit)
- To undertake a series of economic modelling exercises 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 4).
    - We will produce 4-5 in-depth economic case studies focussing on novel approaches and configurations not previously studied focussing on
        - cost-utility of services before and after their introduction in the same study site(s).
        - wider public sector perspective (including not only NHS but also criminal justice, social care, etc.). The measure of effectiveness will be QALY gain.

Data Collection for Economic Evaluation



BLUE = Questionnaires completed by OOHC staff GREEN= Questionnaires completed by the evaluation Team

See Appendix 7 for participant flow chart.

Work Package 4: Choice Modelling

Aim

To explore service user preferences for different types (components) of specialist out of hospital care (i.e. If resources are limited which components of service delivery should be prioritised?)

- Older people for example, prefer to have intermediate care at home (not hospital/care home), do not want ‘frequent contacts’ and if they are very sick prefer ‘nurse-led’ care*

Method

- Choice modelling is a quantitative statistical modelling exercise that uses data collected using a discrete choice experiments (DCEs) questionnaire
- Will be used to measure the strength of preferences among homeless patients for various models or types of out-of-hospital care
- From the utility derived, we will calculate the probability of uptake for different models or types of out-of-hospital care will be calculated

*Dixon et al. 2013 doi: 10.1111/hex.12096

Example of a DCE Question

Attribute	Service A	Service B	The service where I received care
Location of care	Care in a hotel	Care in a hospital type step-down facility	
Frequency of care	Contact once a week	Staff on site 24/7	
Principal carer	A support worker delivering most of your care and support	A nurse delivering most of your care and support	
Which option would you choose? ***[Tick [V] only one box]***	**I would choose Service A** ☐	**I would choose Service B** ☐	**I would choose to stick with the service were I received care** ☐

Out of Hospital Care Models for People Experiencing Homelessness Evaluation Team

Dr. Michelle Cornes

Joint Chief Investigator (CI)

Responsible for delivery of the project and final report; liaison with DHSC and project partners; management of fieldwork; knowledge exchange and impact. Has led several large-scale research projects, including in homelessness. Very experienced in research-policy-practice engagement in homeless support. Methodological expert in homeless evaluation, realist methods and qualitative methods.

Ms. Elizabeth Biswell

Co-applicant and Project Manager

Responsibility for securing ethical permissions and monitoring fieldwork progress across the 18 sites (e.g. that targets for questionnaire completions are being met). Responsibility for data collection in 9 sites. Providing clinical expertise to the project (including data analysis of clinical themes). Report writing. Experience of working on many complex research projects, including in homelessness

Dr. Michael Clark

Co-applicant

Responsible for WP2 interviews and focus groups, contributing to fieldwork in positive practice sites. Analysis and report writing. Experienced researcher of complex interventions, implementation, scaling up, including in homelessness.

Dr. Michela Tinelli

Joint Chief Investigator

Responsible for design and delivery of economic/quantitative work (WP3/4); managing a staff team; providing support to data analysts in sites. Highly experienced researcher particularly in economics and quantitative research.

Mr. Stan Burridge

Co-applicant

Patient and Public Involvement (PPIE) Lead coordinating the involvement of people with lived experience, setting-up and running the special advisory group and data collection across 9 sites. Experienced in organising PPI in research.

Dr. Raphael Wittenberg

Co-applicant

Responsible for supporting the delivery of WP3/4. Highly experienced researcher with extensive knowledge of researching complex care situations. Extensive experience of quantitative and economic evaluations.