Care Quality Evaluation

FROM EVALUATION TO ACTION:

Advancing Evidence-Based Decision-Making in Homelessness

Centre for Homelessness Research and Practice
Annual Conference 11June 2025

Dr Michela Tinelli,
Care Policy and Evaluation Centre,
The London School of Economics and Political Science

PROBLEM

1. **Care systems are disconnected**
2. **Inconsistent data collection**
3. **Lack of standardisation**
4. **Challenges in communicating insights**

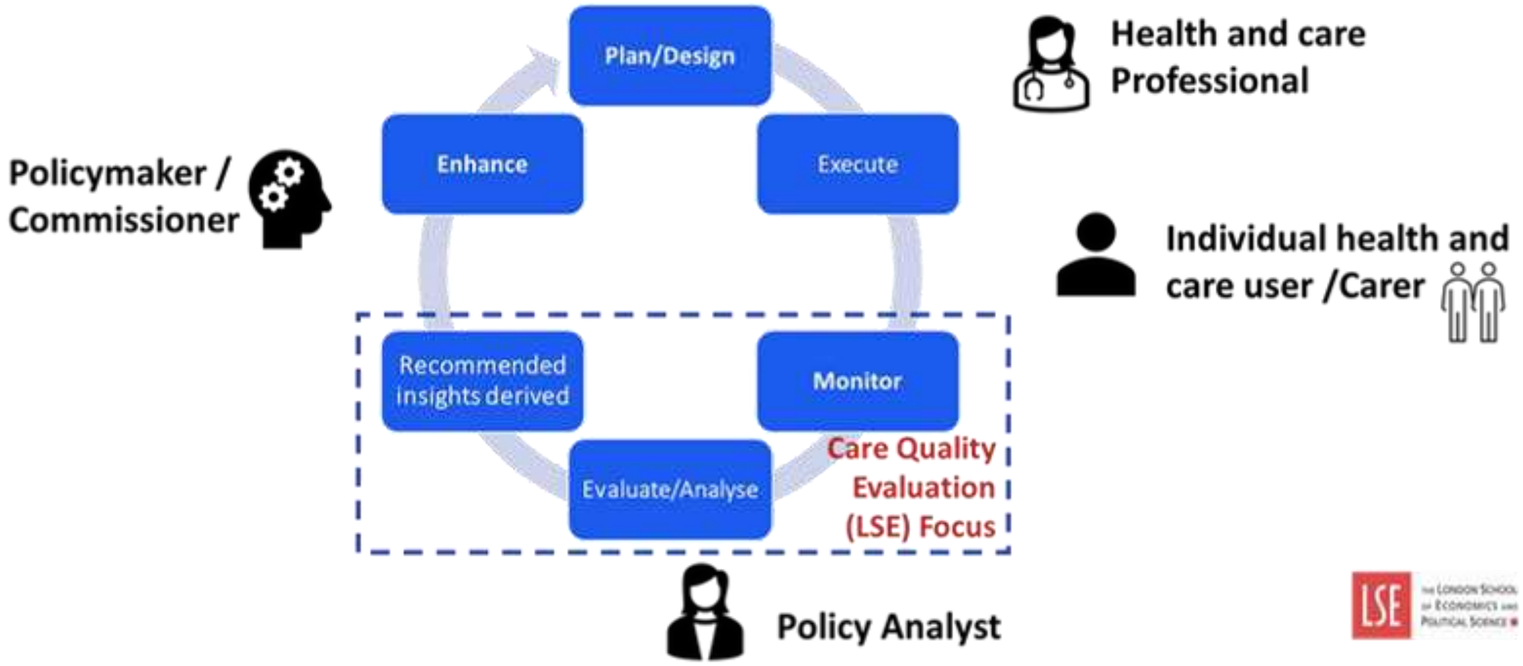
The results are poor person outcomes and waste of money

SOLUTION

Everybody is connected with a continuous flow of information that can be analysed real time to support daily operations and better decisions for everybody.

And individual patient-level data can be used to make population-level changes.

The health and care Initiative lifecycle

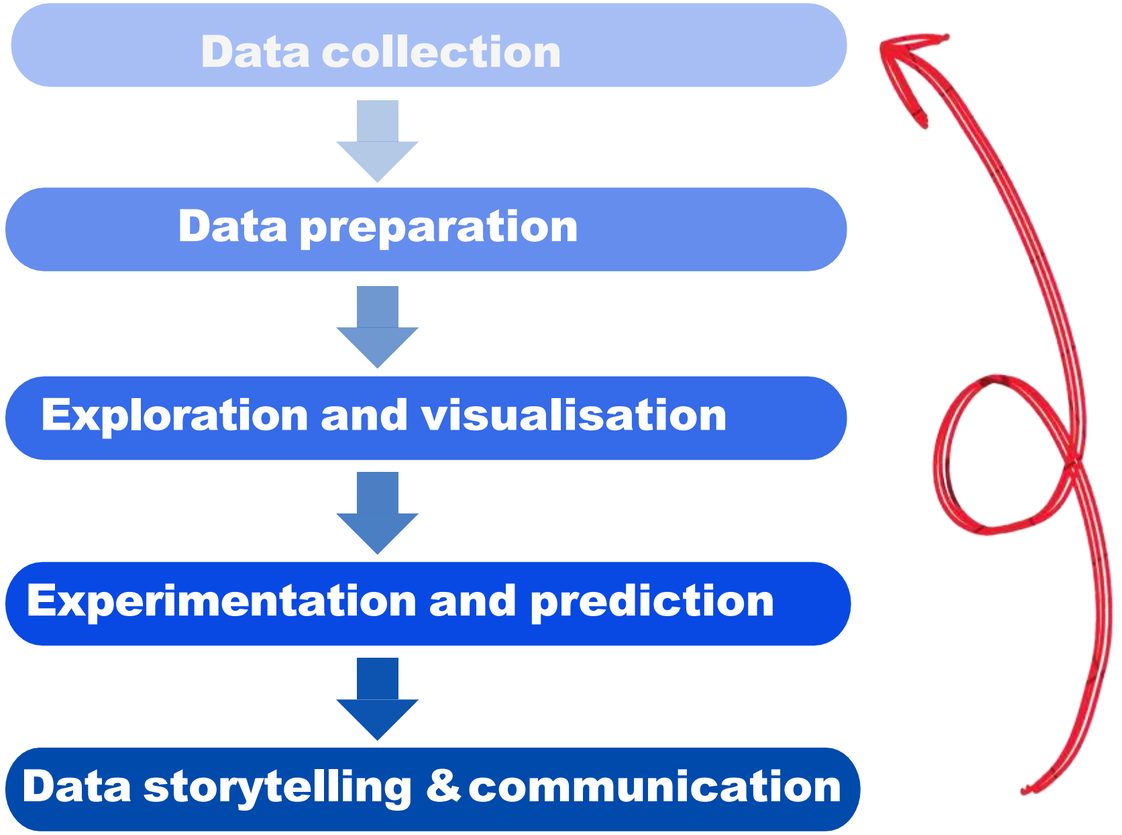


WHAT IS CQE?

Care Quality Evaluation

- A digital, decision-support platform.
- Integrates data across public budgets - housing, health, social care and more.
- Enhances understanding of care quality, outcomes, and costs.

The data science lifecycle



PLATFORM ORIGINS



Developed to support DHSC's Out-of-Hospital Care Programme



Now recognised by NHS England and DHSC as an innovation for planning and decision-making



WHAT CAN YOU DO WITH IT?

01 **Track outcomes over time**

02 **Identify trends and gaps**

03 **Benchmark performance:**

04 **Build an economic case**

05 **Inform service planning and commissioning**

06 **Improve transparency and accountability**

EXAMPLE: 10 INDIVIDUALS BEFORE AND AFTER RESIDENTIAL TREATMENT

The People's Recovery Project

Numbers + video story telling



The real cost of doing nothing (before treatment)

The UK government spends **£568,000 per year** to support them through fragmented and reactive services.

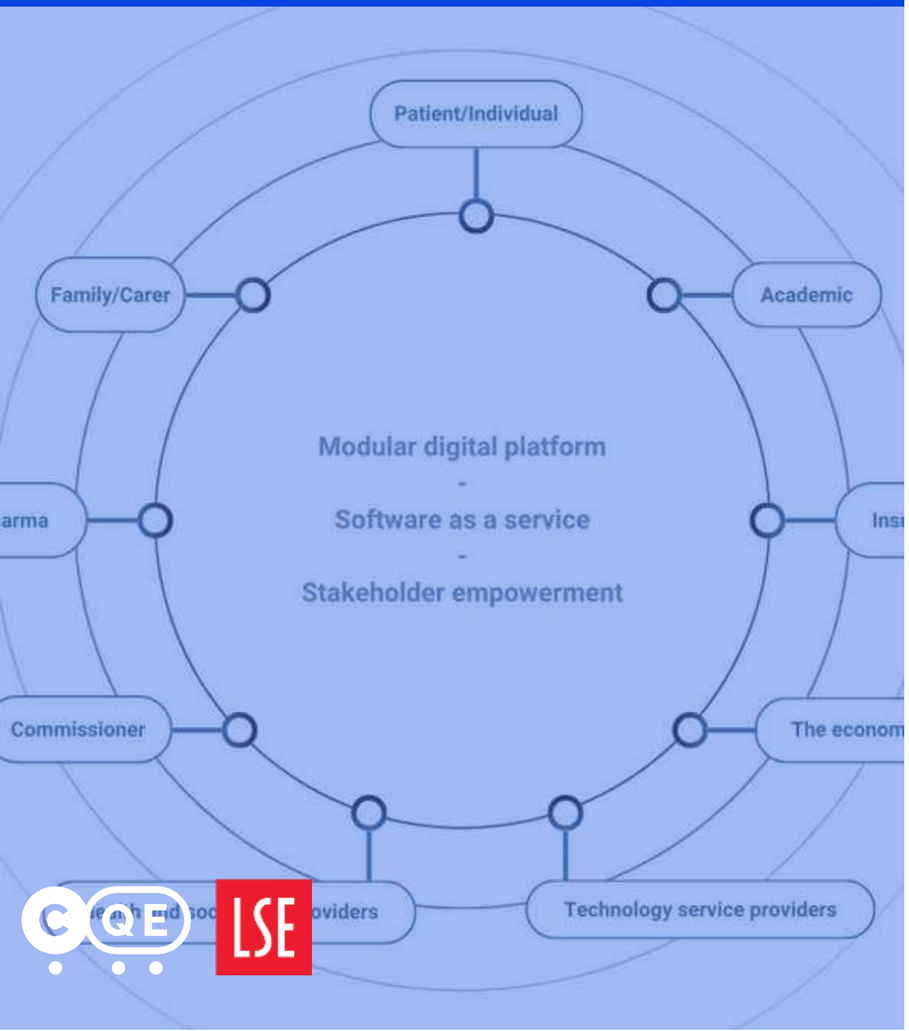
Broader societal costs —including lost productivity and the impact of crime— **£1.24 million per year**.

Recovery changes everything (after treatment)

Government expenditure drops to **£138,000 per year**—a 76% reduction. Drug and alcohol-related costs fall by 99% and criminal justice involvement disappears entirely.

£169,000 in productivity gains following treatment—through paid employment, volunteering, and peer support roles.

WHO IS IT FOR?



Commissioners and policy teams

For data-driven decisions and systemic change

Providers and service managers

To monitor and improve service quality

Frontline teams

To enhance collaboration across sectors

Analysts and researchers

To evaluate interventions and compare services

Benefits

- Better value for public money
- Service improvement through evidence
- Cross-sector integration
- Data-driven, preventative strategies
- Real-time insights and transparency

What Makes CQE Different?

- Co-developed with providers and users
- Visual, action-focused, sector-standardised
- System-level perspective (vs service silos)
- Individual storytelling + population estimates

CQE: PROGRESS UP TO DATE

- Application to social care (homelessness) but also health care.



- Multiple stakeholder engagement from the start, including the Department of Health and Social Care, Local Authorities, Local commissioners, charities and more.
- Automated prototype (in the LSE environment) under testing.
- Initial impact on policy (Gov frameworks) and practice (shaping service delivery models and informing business case) for OOHC.

AUTOMATED PROTOTYPE FOR TESTING

Stakeholder-led development is ensured through a series of individual demo workshops and follow-up discussions after the trial.

- **Setting**: Homeless services
- **Participants:** Local authority commissioners/ service providers and third sector (9 across England and Wales)
- **Focus**: Functionality, data entry, usability and automation
- **Methods**: Observation, user feedback, walkthroughs

- **SWOT analysis**: Strengths, Weaknesses, Opportunities, and Threats
- **The MoSCoW framework** (Must-have, Should-have, Could-have, Won't-have) guides prioritisation of functionalities

PRELIMINARY ANALYSIS (3 SITES)

Strengths

- ✔ Co-produced with users
- ✔ Integrates housing, health & social care data
- ✔ Supports real-time insights & automation
- ✔ Customisable to local pathways
- ✔ Supports economic evaluation/business cases

Weaknesses

- ✗ Initial data entry burden
- ✗ Manual uploads
- ✗ Varying digital maturity across providers
- ✗ Need for onboarding & training

Opportunities

- ➕ Scalable to other sectors & regions
- ➕ Supports integration & transformation efforts
- ➕ Save staff time
- ➕ Tailored views for commissioners, providers, and analysts
- ➕ Prepares data for future AI analysis

Threats

- ⚠️ Uncertain funding
- ⚠️ Resistance to new digital tools
- ⚠️ Staff turnover impacting continuity

NOTE ON PRIORITISATION

Must-have: Tailored data entry forms and visual dashboards aligned with specific service settings, automated outcome tracking, integration of qualitative data, and standardised metrics to enable comparability across services.

Should-have: Role-based access, individual case-based reporting as well as population-based data, integration with case management.

Could-have: Predictive analytics, cross-borough comparisons.

Won’t-have (for now): Advanced AI forecasting until full data standardisation is achieved.

DASHBOARDS VS CQE PLATFORM

Feature	Tactical dashboards*	CQE
Visualise data	YES	YES
Improve data quality &fill in data gaps	❌	YES
Automate tasks	❌	YES
Predict trends	❌	YES
Secure &standardise	❌	YES

*Track key performance indicators to ensure daily operations support overall strategic objectives.

NEXT STEPS WITH OUR STAKEHOLDERS

Research & Development

- Refine Usability
- Prioritise Needs
- Expand applicability

Adoption & Market Readiness

- Sustainability
- Integration
- Efficiency

Care Quality Evaluation

THANK YOU

JOIN US AT THE LSE

LSE Research Festival
16 to 21 June (public)

In Person Discussion
26 June
(with our stakeholders)

FOR MORE INFORMATION AND A DEMONSTRATION

m.tinelli@lse.ac.uk
www.qualityevaluation.com

LSE CPEC
CARE POLICY AND EVALUATION CENTRE

Experiences of racism and homelessness:

Research report by Crisis UK

Georgia Leith

Senior Research & Evaluation Officer

Manoel Filho

Community Researcher



Background and aims

Existing data point to racialised system

Overcrowded; unaffordable housing
PRS evictions
Approaches to LA for support
Living in TA; housed outside local area
Rough sleeping

Aims of this research

- A duty to repair/compensate where we can
- Gather evidence on *intersection* to benefit the community
- Bringing to front stories from people who have experienced it

Together
we will end
homelessness

Research methodology

58 interviews

England *n*=40; Scotland *n*=11; Wales *n*=7
Black (African, Caribbean, other) *n*=28; Other, mixed/multiple ethnic groups *n*=30
Currently homeless *n*=40; previously experienced homelessness *n*=18
Co-produced with EbyE panel (17) and community researchers (13); supported by third party

Community research approach

- Learn about research, shape research at all stages, put forward ideas
- Co-wrote interview questions
- Conducted interviews; ‘going out into field’
- Powerful to sit with people affected by the same issues I have
- Strong emotions, difficult to hear stories, but needed to be brave

Findings and learning

From the research

A picture of racism throughout life course in various systems creating additional pressure for people, so harder to avoid homelessness

Concrete examples of racial discrimination from landlords preventing people accessing a home

Examples of practice within homelessness services not working effectively for people of colour, so harder to end homelessness

About approach

- Racism a difficult topic; we needed people to check in with us, credit to *Power With*
- Power sharing is complicated, needed to ensure supremacy doesn't lead
- Expensive process!
- Project length

Together we will end homelessness

Legacy of research project

Insights on **services** and **systems**, so we share with service delivery community and policy influencers

Leading by example: scrutinising our own services

Community researchers have been key in dissemination (news & media, conferences, webinars etc)



- Powerful to come together with community
- Bringing me close to power
- Community research showed my strength; other people can't get to the stage I'm at; want to open the space for others

Together we will end homelessness

Thank you for listening

Any questions?

Link to online report

Link to webinar series

georgialeith@crisis.org.uk

manoel.filho@livedexperienceproductions.co.uk

Right by You Wessex

Collaboration in Providing Personalised Cancer Support to People Experiencing Homelessness

Amanda Cummings & Beth Hawkins
RbY Project Manger & RbY Care Coordinator

11th June 2025

Background

- Community outreach model of care
- Pilot service across 2 sites
- Supported >700



In partnership with MACMILLAN CANCER SUPPORT

NHS Wessex Cancer Alliance

Right by You

Right by You is an NHS support service available to anyone with a diagnosis of cancer living in Southampton.

Good support is about more than medicine, it is about understanding the things that matter and are important to you. This will be different for everyone. The Right by You team will focus on the things you want to talk about, and you need support with. The team will help you to create a plan of support based around your needs and preferences.

The team includes a Cancer Nurse Specialist and Cancer Support Worker. They will work together with existing teams involved in your healthcare (this may include hospital-based cancer teams, GP practices and other community services). The aim is to ensure a joined up approach to cancer support that puts what matters to you first.

Talking about your diagnosis and the impact on you and your loved ones

Managing emotional and physical wellbeing

Balancing your commitments, e.g. work, family, finances

Support could include:

Helping you to access support services in your community

Community Information workshops for newly diagnosed

How to get in touch:

We can accept self-referrals, or a healthcare professional can refer you.

Service Working Hours:
Monday-Friday 9am-5pm

Contact our Right by You Team:
Jo Dowle, Cancer Nurse Specialist
Sally Condra, Cancer Support Worker
Marian Parfitt, Cancer Nurse Specialist
Lewis Foglia, Mental Health Practitioner
Catherine Scothmer-Clay,
Pathway Navigator/Administrator

Email: RBYteam@uhs.nhs.uk
Telephone: **07585 625461**
(Messages can be left out of hours)

Southampton City

- Pop^{N} 250,000
- Port & university city
- Wide ethnic diversity

RbY:

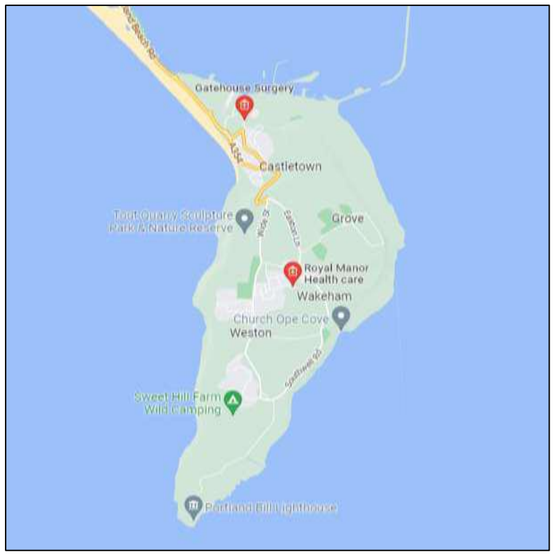
3 Cancer clinical nurse specia

Psycho-oncology CNS

Homeless care coordinator

Pathway navigator





Portland

- Pop^{N} 13,000
- Tied island
- High deprivation
- 1 GP practice
- 2 prisons

RbY:

Cancer clinical nurse specialist

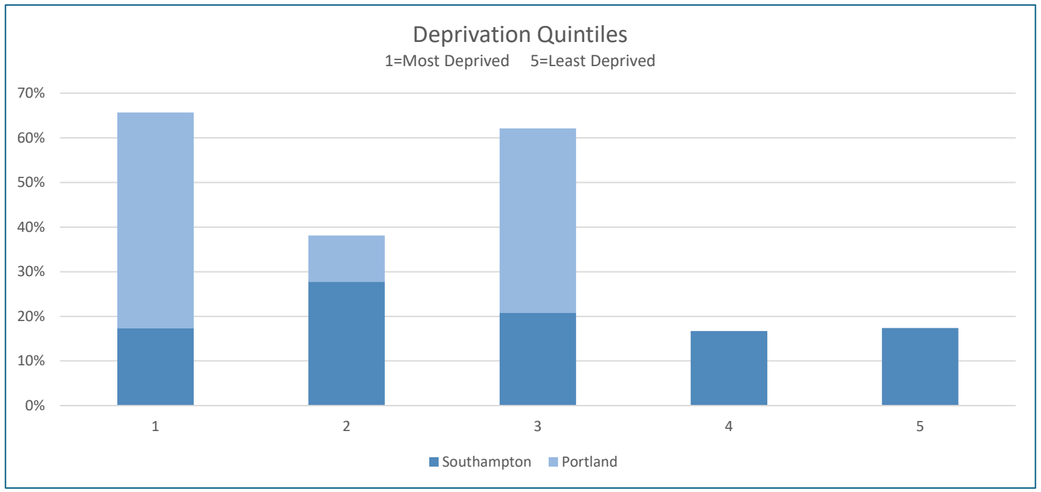
Cancer support worker

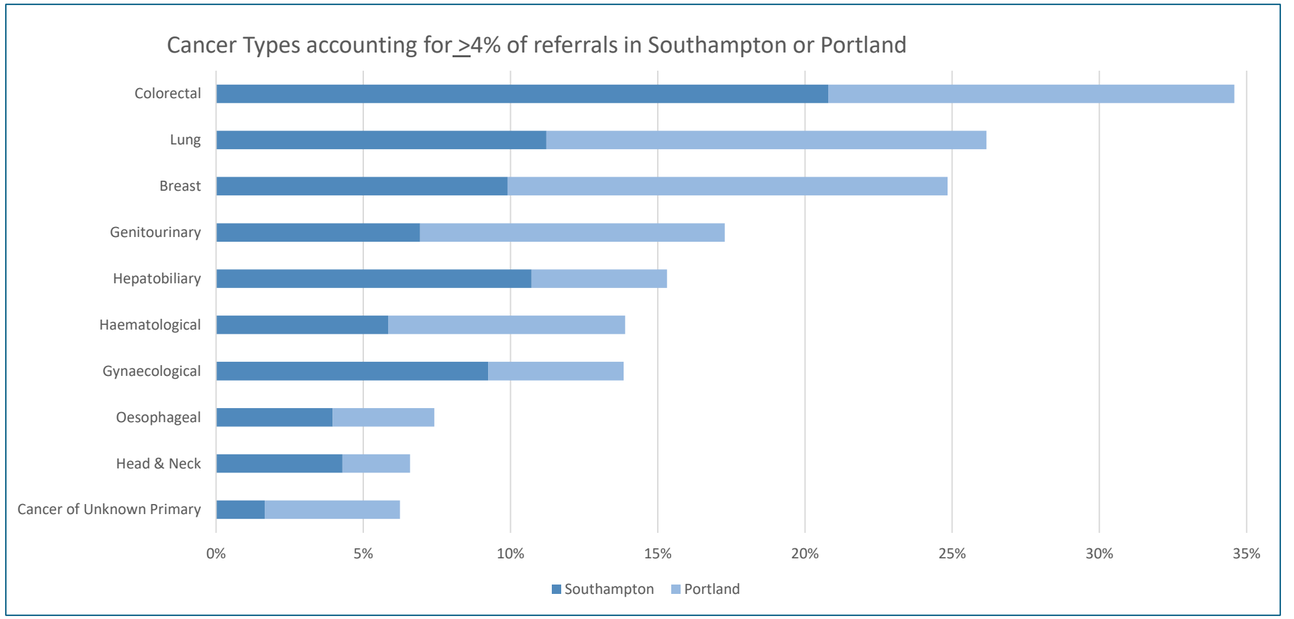
Cancer Matters Wessex

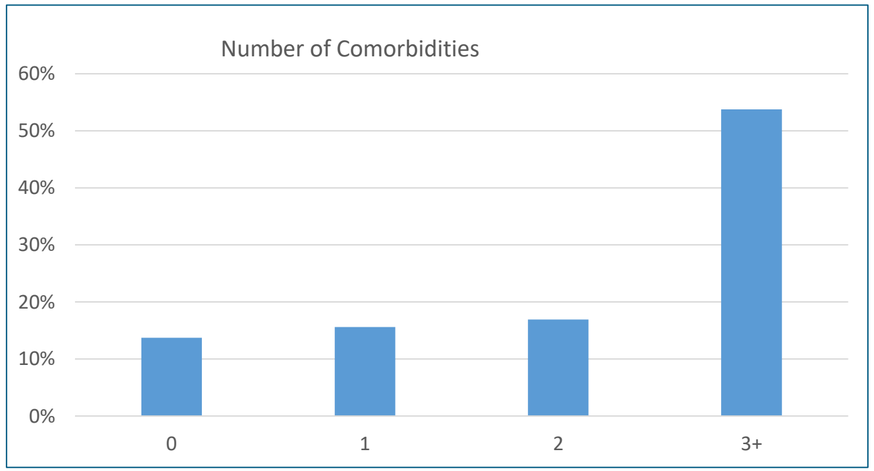
RbY Community Outreach Service Delivery Model

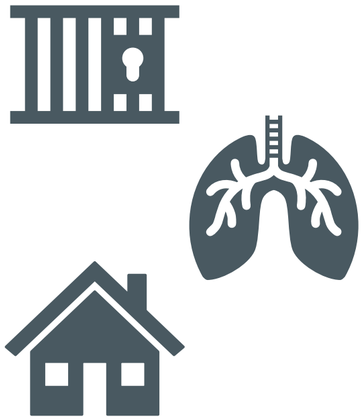
What is delivered?	· Longitudinal therapeutic health need assessments with highly skilled psychosocial intervention. · Complex support provision, including expert symptom and side-effect management, advocacy, and self-management support, tailored to the lived experience and needs of people with cancer. · Collaboration and shared knowledge across primary, secondary and community care services. · Includes comorbidity and frailty management.
Who delivers?	· Experienced cancer CNSs with enhanced psychological training (NICE level 2+). · Care coordinator, patient pathway navigator and cancer support worker. · Boundary spanning role across acute, primary care and community services settings.
To whom?	· People diagnosed with cancer, their family, friends, and carers. · People with complex needs (including psychological, social, and relating to multi-morbidity). · Specialist support to marginalised populations including homeless and prison communities.
How delivered?	· Service users are supported in their preferred location, typically their own home. · Support is also provided via telephone, text, and email (depending on preference and need).
When?	· At any stage in the cancer pathway from pre-diagnosis to post-treatment, including palliative care. · Continual, repeated needs assessments are undertaken at times appropriate for the service user.

Service User Characteristics







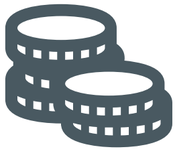


22	18
People Experiencing Homelessness	Prisoners HMP The Verne

Identify & Support
Wide Range of Concerns

- Emotional & psychological support
- Physical symptom & side effect management + comorbidities
- Practical support (e.g., financial, housing, medication management)
- Family support





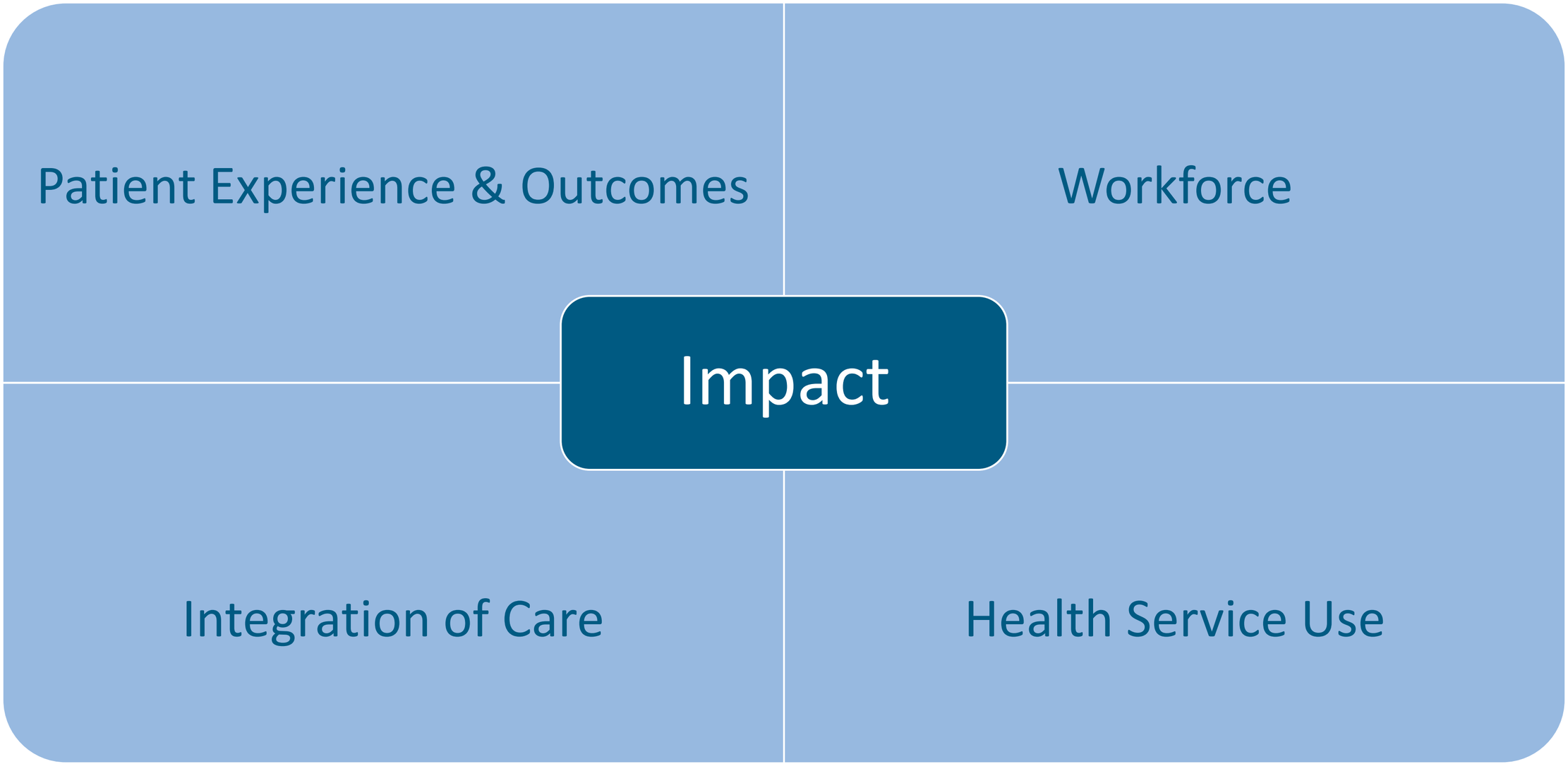
- Information provision to improve knowledge and understanding
- Liaison with primary, secondary & community services
- Complex decision-making support
- Advocacy during appointments
- Facilitate service user access and engagement with other clinical teams
- Signposting and referrals to other support services
- Anticipatory assessments / communication / care planning
- Avoid: Conflicting care or advice
  Unnecessary / unwanted cancer treatment
  Crisis escalation & unplanned care







Cancer Matters Wessex


Patient Experience & Outcomes
Workforce
Impact
Integration of Care
Health Service Use

People Experiencing Homelessness

RbY Outreach Support

- 'Right by Everyone'
- Oct 2021: Specialist advisor in homelessness and health inequalities
- Jan 2025: Homeless healthcare care coordinator



Southampton City

- Rates of homelessness 10.4 per 1,000 households
- High numbers of hidden homeless
- 1/3 Hampshire & IoW homeless population





Homelessness & Cancer

- Poorer physical and mental health
- Disproportionately impacted by social determinants of health

↓

- Cancer prevalence 2x higher

Cancer Matters Wessex

Challenges of Homelessness & Cancer Care

- Lack of stability → difficulty managing complex health conditions
- Access to ‘mainstream’ care obstructed
- Cancer management requires prolonged coordinated approach
- Discrimination & stigma



- Hinders effective cancer management
- Disjointed care
- Over-reliance on emergency healthcare services
- Comparatively poorer health and social care outcomes

Compared to the general population,

People experiencing homelessness attend A&E 6x as often, are admitted to hospital 4x as often and stay in hospital 3x as long

Cancer Matters Wessex

RbY Support for People Experiencing Homelessness

- **Need for integrated & coordinated care**
  → Personalised & intensive outreach support

- Person centered: addresses health, social and psychological needs
- Provide information and advocacy
- Support skill development and empowerment
- Collaboration within RbY
- Cross-sector health and social care collaboration
- Shared learning and upskilling

E.g., Enabled a patient to attend hospital for regular cancer treatment without compromising their access to a methadone medication regime

"If we didn't have the support of [RbY]… we wouldn't have been able to keep XXX with us, and XXX very much does not want to go to a hospice"
Hostel staff

E.g., Facilitating a patient's preferred place of death

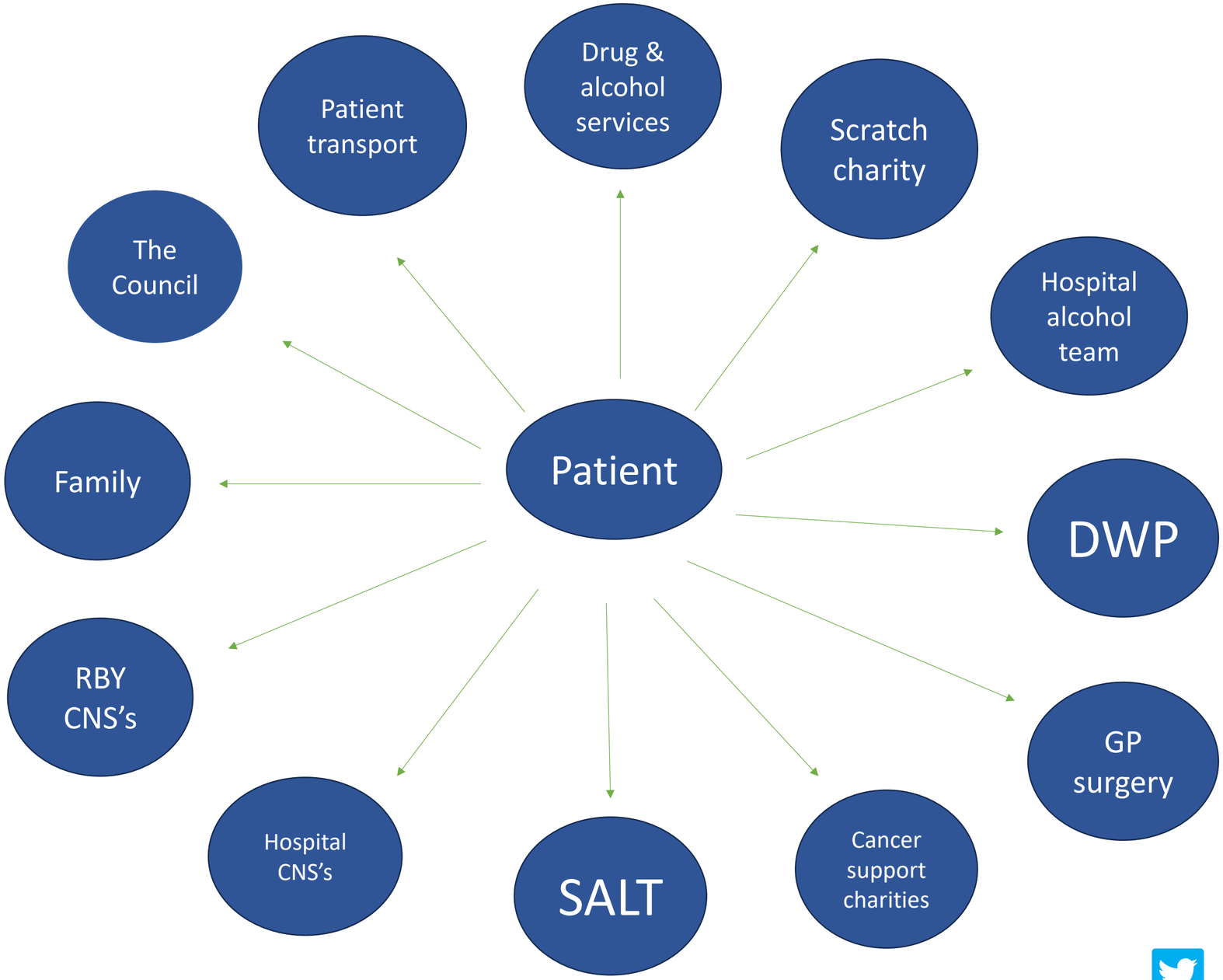
E.g., Supported patient in with informed decision to refuse chemotherapy

Cancer Matters Wessex

Case Study

Patient Background

- Patient has been sofa surfing with peers and family for 6 years after being cuckooed at previous self-contained accommodation.
- Historic intravenous drug user of crack and heroin. Has been on a substitute prescribing regime for 9 years. Still sporadically uses crack cocaine. Smokes cannabis daily and was drinking every few days up until recently.
- Patient struggles to read and write and struggles with communication overall due to a strained, hoarse voice that despite having medical investigations, has not yielded any answers.
- Patient has Oesophageal cancer and had an oesophagectomy in March 2025 to remove the cancer. Recent reconnection with half-brother who has been a support system. When asked what's important to him, patient responded to say, "watching his grandchildren and daughter grow up".


Patient transport
Drug & alcohol services
Scratch charity
The Council
Hospital alcohol team
Family
Patient
DWP
RBY CNS's
GP surgery
Hospital CNS's
SALT
Cancer support charities

Thank You
Any Questions?



They are the knotty issues that have prevented people in these situations from feeling they have any agency over their life or death. They are the difference between, ‘Can I pick up my methadone today and be alright?,’ or ‘Do I do I get to my chemo?’… I think this group of people in the situations I am describing were deemed to be difficult patients because they wouldn’t comply with the wishes. If we turn that on its head and say, ‘Actually the services are being far too rigid. How do we make it possible for individuals in these situations to get both their treatment and to know that, to get their treatment, they need to have had their methadone’” RbY Staff