SAVING LIVES, SAVING MONEY

How Homeless Health Peer Advocacy Reduces Health Inequalities

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inclusive solutions to homelessness

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SAVING LIVES, SAVING MONEY

How Homeless Health Peer Advocacy Reduces Health Inequalities

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Funded by

ABOUT THE YOUNG FOUNDATION

We are The Young Foundation and we are determined to make positive social change happen. We believe inequality undermines the economy and corrodes our wellbeing, leaving its mark on communities, relationships, aspirations and self-worth.

The Young Foundation is working to create a more equal and just society, where each individual can be fulfilled in their own terms. We work with the public and private sectors and civil society to empower people to lead happier and more meaningful lives.

We believe little about the future of society is inevitable. Bound by our shared humanity, we believe we collectively have the power to shape the societies and communities we want to live in. We work closely with individuals, communities and partners building relationships to ensure that our thinking does something, our actions matter and the changes we make together will continue to grow.

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CONTENTS

About the Young Foundation IV
Acknowledgements IV

Executive summary 2
Introduction 6
The barriers to accessing healthcare 9
The impact of the Homeless Health Peer Advocacy programme 12
Conclusion 23

Appendices 25
- Appendix I – Full evaluation Approach, methodology and framework 25
- Appendix II – HHPA project streams 29
- Appendix III – HHPA service use 30
- Appendix IV – Post-appointment classification for all appointments 32
- Appendix V – Cost saving calculations 33

References 34

EXECUTIVE SUMMARY

"As I said earlier, if it weren't for you guys [Groundswell] coming and taking the time out and getting myself sorted out, I reckon I would have been dead now. That's how much it made an impact in my life."
– HHPA Client

The experience of homelessness is complex and has far-reaching implications for every aspect of a person's life as they face the challenges of accessing services while having no place to live. The health inequalities associated with this are stark; people experiencing homelessness have a life expectancy 30 years lower than the general population.[i] Homelessness also creates barriers to employment and training, which can be further compounded by poor health, ultimately increasing the challenge of moving from homelessness to a stable life and independent livelihood.

Amongst the homeless population there is a disproportionately high reliance on unplanned health and care services and A&E, a high level of missed outpatient appointments and those experiencing homelessness often do not seek early stage or preventative healthcare support. With levels of homelessness rising, between 2010 and 2015 rough sleeping in the UK rose 37 per cent, it is increasingly urgent to enable those experiencing it to access healthcare in a timely, supported and appropriate way.[ii]

The cost to the state of a person experiencing homelessness is typically at least £24,000 per annum more than that of a person not experiencing homelessness, accounting for health, benefits and other costs.[iii]

The Homeless Health Peer Advocacy programme (HHPA) aims to address these challenges by training Peer Advocates, all of whom have previous experience of homelessness, to engage homeless people, build their trust, knowledge and motivation to keep well, and to access and use health and care services appropriately. In the process, the programme provides Peer Advocates the opportunity to develop skills relevant for employment, based on their unique and personal experience, in a supportive environment.

Peer support and advocacy models have the potential to make a profound improvement to individual health and life expectancy, have positive population health benefits and reduce inequalities, while reducing the overall cost burden on the National Health Service (NHS).

This report sets out the findings of an independent evaluation of the HPPA programme, conducted by The Young Foundation on behalf of Groundswell and funded by Oak Foundation. Utilising a mixed-methods, participatory approach, this assessment explored the following questions:

- Does HHPA improve clients' health?
- Are there associated cost savings?
- What is the impact of the programme for Peer Advocates?

The challenge

The complex nature of homelessness presents multiple inter-related, physical, personal and systemic barriers to accessing healthcare. There have been significant advances in the provision of targeted support, from the establishment of specialist GP practices in areas of high homeless population, to co-located nursing services. However, changes in the way services are supplied have not in themselves wholly addressed the barriers, many of which have persisted:

- **Practical barriers** such as the cost associated with appointment attendance or being refused GP registration due to having no fixed abode;
- Difficulty navigating the healthcare system and communicating effectively with medical professionals due to **previous negative experience and low confidence**;
- **Fear** of hospital settings and of discovering severe health problems;
- **Attitudes to homelessness and stigma**, both as an actual experience or as a fear based on prior experience.

These barriers combine to result in treatment of health issues only being sought when there is an acute need to do so, 38 per cent of the homeless population has accessed A&E in the past six months.[iv]

Improving the confidence, knowledge and skill of patients is often referred to as Patient Activation. An increase in which is known to result in improved health, increased preventative healthcare access and decreased future healthcare access as a result of better health.[v]

This suggests it would be fruitful to respond to the challenges homelessness presents, and to address the health needs of the homeless population, not just through smarter outreach, but by taking a co-ordinated approach to increase health-seeking behaviour. This entails drawing not only on clinical skills but on the tools of participation and peer support, identification, motivation and building trust. In this way, people experiencing homelessness can be empowered to overcome the barriers they face to improving their health.

The Homeless Health Peer Advocacy programme

Groundswell's Homeless Health Peer Advocacy (HHPA) programme seeks to empower people experiencing homelessness to overcome the barriers to accessing care through the provision of intensively trained Peer Advocates, all of whom have previous or continuing experience of homelessness themselves. Peer support models such as this are known to break down barriers to engagement with healthcare services amongst 'hard-to-reach' groups through the ability of peers to draw on their shared experience to develop trusting relationships.[vi] By taking this approach the programme aims to increase the confidence and knowledge of its clients to overcome barriers, seek appropriate and timely healthcare, and move towards independent access of healthcare services.

The impact of the HHPA programme

The Homeless Health Peer Advocacy programme has multiple benefits. It improves clients' health through:

- Increasing **confidence, knowledge and motivation** to access healthcare and to engage proactively with health management;
- **Decreasing reliance on unplanned secondary care services**; and
- **Decreasing missed outpatient appointments**.

Which result in:

- A **68 per cent reduction in missed outpatient appointments**;
- Bringing DNA rates for scheduled outpatient appointments in line with those of the general population;
- A reduction in DNA related costs;
- A **42 per cent reduction in unplanned care activity**;
- A saving of **£2.43 for every £1 spent due to a reduction in unplanned care activity costs** in the first six months following HHPA intervention;
- A probable **reduction in ongoing care costs** due to improved health; and
- Potential **efficiency savings** through better utilisation of health and care services which are already funded, available to and provided for this client group.

For many of the individuals participating in HHPA it appeared plausible that the need for such bridging support will decline as they gain confidence and adopt new behaviours suited to overcoming some of the barriers they once faced. For a smaller proportion, with the most complex needs, Peer Advocates will have a longer-term role to play in sustaining access to healthcare.

Alongside the impact for clients, and the associated cost reductions for the NHS, the HHPA programme has a positive impact for the Peer Advocates themselves. Within eighteen months of completing HHPA training Peer Advocates tend to transition from living in a hostel with relatively unstable lives to stable accommodation and employment or training. This improves the quality of life of the Peer Advocate, acts as a model for clients and results in financial savings for the state, alongside an increase in contributions to the state.

The HHPA programme achieves multiple benefits for individuals, for the NHS, other public services and for society more broadly. At a time when the NHS seeks ways to maintain or improve the quality of care and patient experience and reduce health inequalities, while reducing costs in the face of mounting financial pressure, HHPA meets both requirements and represents a model that merits mainstreaming and expansion. The search for health solutions for the homeless population has been a long one, and they continue to make some of the heaviest demands on the health system. Peer Advocates have demonstrated the capacity to act as an effective bridge between this community and public services, and to do so in a cash-positive way. HHPA illustrates the importance of funding access intermediaries as part of a well-functioning health and care system, without which high quality care being accessed by the most marginalised groups will remain an aspiration.

RECOMMENDATIONS

For health and care commissioners

As a result of the findings of this evaluation, health and care commissioners should consider:

- Mainstreaming Groundswell's Homeless Health Peer Advocacy programme to be a commissioned service, ensuring a stable future and expansion to major sites of urban homelessness around the UK where it is needed.
- Recognising the importance of longer-term funding for programmes such as this, making in-roads on population health among vulnerable groups requires great commitment in terms of time.
- Developing awareness and understanding of programmes, such as HHPA, that use peer models to create a bridge between members of 'hard-to-reach' communities facing multiple barriers and the health and care services they would otherwise not use. Much NHS reform currently sits with the supply-side, but there are as yet untapped gains to be made by exploring new models of access.
- Working collaboratively with organisations such as Groundswell to facilitate further testing and refining of such innovative models of working.
- Creating data sharing agreements to help measure the impact on health outcomes and evaluate the full cost savings to the NHS.
- Reviewing the knowledge and skills of clinical and care staff such that they are better able to understand the perspective of people experiencing homelessness and the flexibility they can exercise in providing services to them. Appropriate communication is a priority.

For Groundswell

Groundswell should consider a number of aspects related to the design and delivery of the programme, as well as how it can better measure and demonstrate impact in the future.

Service development and delivery:

- Enhance data collection for its clients. This will enable Groundswell to identify any emerging patterns in the demographics of its clients and target Peer Advocate recruitment to meet these changing needs.
- Consider segmenting clients to account for likeliness and appropriateness of transition to independence, for instance identifying those with mobility problems or those in end-of-life care for whom independent healthcare access is either not a desired outcome or practical.
- Consider approaches to working with clients to plan achievable, appropriate and realistic progression to independent management of health and access of health services.

Broadening the programme impact:

- Seek accreditation for its Peer Advocate training programme to support peer advocates further by providing them with a formal qualification.
- Consider how the Peer Advocacy model could support people experiencing homelessness more broadly, for instance with navigating the benefits or employment system.
- Identify opportunities for, and models of, replication and scaling to increase and spread the impact of the programme.

Demonstrating impact:

- Consider the introduction of a Patient Activation assessment to illustrate the progress made by clients even if they do not progress to totally independent healthcare access.
- Establish and maintain relationships which enable it to access anonymised data for all NHS service use for a sample of its clients with corresponding HHPA support data to provide a cohesive and comprehensive understanding of the impact of the programme.
- Improve data collection on the employability of Peer Advocates at the start and end of training and work experience, and prior to them progressing to other opportunities.
- Consider commissioning a full social return on investment study incorporating the impact for clients, the reduction in costs associated with changes in healthcare service use and the impact for Peer Advocates.

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HOMELESS HEALTH PEER ADVOCACY

285 clients supported per year

1000 appointments

IN FINANCIAL YEAR 14-15

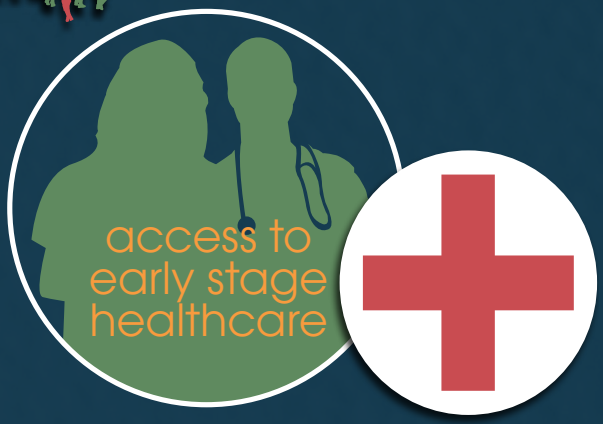
JUNE 2 · FEBRUARY 15 · JULY 1 · AUGUST 9 · NOVEMBER 25 · NOVEMBER 14

increased **KNOWLEDGE**

increased **CONFIDENCE**

increased **MOTIVATION**

INCREASED



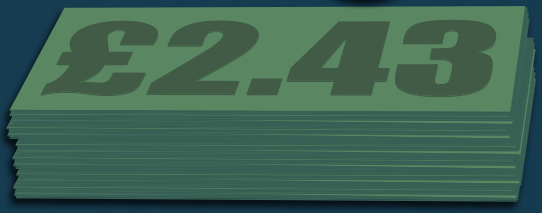
improved **HEALTH HEALTH HEALTH**

REDUCTION

68% in missed outpatients appointments

42% in unplanned care activity

every £1 spent could result in



REDUCTION

in unplanned care activity costs

INTRODUCTION

SUMMARY

- The level of homelessness is rising, rough sleeping in London rose 37 per cent between 2013 and 2014.
- People experiencing homelessness have worse health than the general population and:
  - Face multiple barriers to accessing healthcare;
  - Have low levels of confidence and knowledge to manage their health and healthcare;
  - Use A&E services up to four times more than the general population; and
  - Die, on average, 30 years earlier than the general population.
- Specialist services have been created to increase the provision and accessibility of healthcare, where and when it is most needed.
- However, there remains a disproportionately high level of secondary care use by the homeless population, and high Do Not Attend rates for planned appointments, which are costly to the NHS.
- The complex nature of homelessness requires participatory and co-ordinated approaches to increasing access if people experiencing homelessness are to overcome the barriers to healthcare and good health management.
- Through trained Peer Advocates, with experience of homelessness, Groundswell's HHPA programme supports people experiencing homelessness to access healthcare services and improve their health.

Homelessness is widespread in the UK. According to the recent Homelessness Monitor England from Crisis UK, in the year 2013/14 the number of people in the UK facing homeless rose to 280,000, up 9 per cent from the previous year. The number of rough sleepers in the UK has also risen by 37 per cent since 2010.[ii, 1] In London rough sleeping rose 37 per cent in just one year between 2013 and 2014.[vii]

People experiencing homelessness have disproportionately high rates of health and mental health conditions, compared to the general population (see box below).[iv] Visits to the A&E are disproportionately high among the homeless population – in fact, four times higher than for the general public – bringing with it associated higher costs for unplanned care to the NHS. In its Homelessness: a silent killer report Crisis found that people experiencing homelessness die, on average, 30 years younger than those who are not homeless, with an average life expectancy for homeless men of 47 and for women of 43.[i, viii]

The health needs of people experiencing homelessness

A recent health needs audit conducted by Homeless Link assessed the health needs of 3,355 homeless people across England found that:

- Over three-quarters reported physical health problems;
- 44 per cent of which were long-term problems, compared with just over 20 per cent for the general population;
- 86 per cent reported some form of problem of mental health issue;
- 41 per cent reported the use of drugs or recovering from a drug problem, and over a quarter reported current use or recovering from an alcohol problem; and
- 38 per cent reported visiting the A&E in the past six months.

Public health providers and those commissioning services on behalf of the NHS have a statutory duty to reduce health inequalities.[ix] They are required to work towards improved healthy life expectancy for all and reducing the differences in life expectancies between communities.[x, xi] As such, and given the low

1. In this instance 'people facing homelessness' refers to incidences which warranted a Local Authority Homelessness Case Action, including homelessness prevention, homelessness relief and statutory homelessness.

life expectancy and health inequalities associated with homelessness, there is a need for health service providers and commissioners to identify and support interventions which support people experiencing homelessness to overcome the barriers to accessing available healthcare, and ultimately improve their health.

The nature of homelessness creates many barriers to accessing healthcare, which will be discussed in more detail later in this report. These barriers combined result in low levels of knowledge and confidence to manage health amongst the homeless population. In recent years there has been a recognition of the need to adapt healthcare delivery models for people experiencing homelessness. There are now homelessness specialist GP surgeries and Health Centres, and nurses based in hostels and embedded in some outreach teams. Despite this progress in the supply of services we know that many barriers to access persist for people experiencing homelessness.

An individual's skill, confidence and knowledge to successfully manage their health forms the basis of Patient Activation. Low levels of which are associated with low confidence in ability to manage health, a passive approach to health management based on experience of failing to managing health successfully, and an attitude which would prefer not to consider health.[xii] Increased Patient Activation has been associated with improved health outcomes, reduced use of unplanned care and associated healthcare costs and better patient experience.[v] There is therefore a need to explore service models which enable people experiencing homelessness to increase their confidence and skills to manage their health.

The highly complex nature of homelessness, and the inextricable link between homelessness and poor health necessitates co-ordinated, multi-disciplinary, and inclusive and participatory approaches to improve the health and well-being and reduce the health inequalities of homeless people. This requires novel approaches to supporting people experiencing homelessness to overcome the barriers they face in accessing the services available to them.

The Young Foundation was commissioned by Groundswell, with funding from Oak Foundation, to conduct a mixed-methods evaluation of its Homeless Health Peer Advocacy programme. This evaluation seeks to understand the impact of the programme on the health, management of health and use of healthcare services of people experiencing homelessness, alongside any associated cost savings and impact for Peer Advocates. The evaluation aims to understand the impact of the programme as a whole, how and why it works and make recommendations for the future.

This evaluation draws on Groundswell's data on clients' service use, NHS appointment attendance and missed appointments levels, interviews with current and former Peer Advocates and, building on the participatory nature of HHPA, peer research interviews with clients of the programme. With these different sources of information, it seeks to answer the following questions to establish the impact of the programme:

- Does HHPA improve clients' health?
- Are there associated cost savings?
- What is the impact of the programme for Peer Advocates?

For the full evaluation approach and framework see Appendix I.

The Homeless Health Peer Advocacy Programme

Responding to these challenges, Groundswell developed the Homeless Health Peer Advocacy (HHPA) programme which trains people with experience of homelessness to support those who are currently homeless to access healthcare. The programme, which was developed through extensive research and in a participatory manner, has been delivered by Groundswell for five years. Peer Advocates are recruited based on having experience of homelessness and some volunteering experience. They undertake a rigorous six week training programme prior to supporting clients.[2]

The aims of the HHPA programme are to:

- Provide one-to-one support, through volunteer Peer Advocates, for homeless people to **make and attend health appointments**;
- Support people experiencing homelessness to overcome the **practical, personal and systemic barriers** which prevent them from accessing healthcare; and to
- Increase the **confidence and skills** of people experiencing homelessness to independently access healthcare services.

Many researchers and practitioners have underscored the importance and benefits of peer support services, in particular when used to engage 'hard-to-reach' groups. Peer support is premised on

2. The project is delivered across project streams, see Appendix II for full list of project streams.

an individual with a specific illness or experience supporting others facing the same, or similar, challenges to access services.[xiii] The success of peer support approaches comes from peers' ability to draw upon personal experiences and, as such, develop a shared understanding, decrease stigmatization, develop trust and empathy, provide role modelling, provide key support for navigating through complex and fragmented systems, increase engagement with healthcare services, reduce use of A&E and days spent as inpatient, and reduce substance use among persons with co-occurring substance use disorders.[xiv, xv, 3]

James first met a Peer Advocate after he had missed two appointments for a chest x-ray from the hospital. His key worker made the referral for him. He was apprehensive at first and didn't want to go the hospital in case the x-ray results were bad news. At his first Advocate Meeting he quickly realised the Advocate was like him and wasn't judging him but was there to support him. He went to his next appointment, with the Advocate, and needed some medication as a result. But the problem was caught early enough that with the medicine he quickly recovered. Had he not had the support he is unlikely to have gone for the x-ray until he was very ill, which would have meant a longer road to recovery.

Homeless Health Peer Advocacy service use

In the year to 31st March 2015:

- 285 individuals experiencing homelessness were supported.
- 1,400 HHPA appointments were made, 1,019 of which successfully took place.
- Accounting for outliers the average number of HHPA supported appointments per client per year is 2.9.
- The most frequent types of appointments to which clients were supported were outpatient appointments (for instance diagnostic imaging, gastroenterology and cardiology), GP services, dentistry and Advocate meetings (one-to-one problem solving and advisory meetings between a Peer Advocate and a client without attendance at a health appointment).

For full breakdown of HHPA service use and post appointment classification, see Appendices III & IV.

3. Throughout this report there are archetypes, generated from research with a range of clients, and case studies of interviews with individual clients and Advocates. All names have been changed.

THE BARRIERS TO ACCESSING HEALTHCARE

The complexities of homelessness are a barrier to accessing healthcare

KEY FINDINGS

The complexities of homelessness create many barriers to accessing healthcare. These include:

- **Practical**, for instance having competing priorities (like securing somewhere warm and safe to sleep), or lacking the funds to travel to appointments, or the disruption associated with having no fixed abode.
- **Personal**, for instance emotions relating to poor previous experiences and low confidence.
- **Systemic**, for instance encountering negative or misinformed perception of homelessness amongst health professionals, being prevented from registering for a GP if you have no fixed abode (although GPs are required not to bar registration on these grounds) or barriers to access presented by how the healthcare system communicates with people experiencing homelessness.

The barriers combine to prevent people experiencing homelessness from accessing available services, even those targeted specifically at this group.

Being homeless is not easy. There are many factors associated with homelessness which are interrelated and can combine to prevent people from maintaining good health and from accessing early medical care if, and when, they experience poor health. As a result, many seek healthcare only when a need is critical and do so through accessing unplanned and emergency care. A recent report from Homeless Link found that 38 per cent of people experiencing homelessness had accessed A&E services, and 27 per cent had been admitted to hospital, in the past six months.[iv]

HHPA is designed to support people experiencing homelessness to overcome many of these barriers in order that they can gain the confidence and skills to better manage their health independently and, ultimately, have improved health.

The complexities of homelessness present many barriers to accessing healthcare services. These can be categorised as practical, systemic and personal barriers – however they are inter-related, impact upon one another and do not exist in isolation.

Practical barriers are those which are a barrier to actually engaging with healthcare, these tend to be concrete aspects for instance the cost of travelling to an appointment. **Personal barriers** are those created through individuals' past experiences, beliefs and emotions, or knowledge and understanding. **Systemic barriers**, those created by the system in which people experiencing homelessness live, for instance attitudes towards homelessness, can impact upon personal factors such as confidence.

"Well you'll deal with something if it is causing pain or problems but once that is over you won't get help any more so you won't necessarily get treatment for the cause of the problem. It's like you just want to stop the problem, stop whatever is going to make you not be able to go to the off licence. And you put a lot of it down to just being on the streets, the cold and the drinking and drugs, so you don't think about it, and you don't want to know." – Peer Advocate

Practical barriers

Practical barriers are those which actually prevent an individual from engaging with healthcare services and can include:

- **Competing priorities** to address, for instance finding somewhere to sleep and money to get food, alcohol or drugs. So, for many people experiencing homelessness, health is not their number one priority.

- Having **no fixed address**, which can lead to GP surgeries refusing to register patients, despite guidelines being in place to ensure those of 'no fixed abode' are not prevented from accessing care at a GP surgery which has space to take new patients.
- **Navigating health services** both practically, for example, knowing which service to use, or how to locate a service within the complex environment of a hospital, and with regards to correspondence.
- **Other practical barriers** exist such as the cost of travel to appointments, potential mobility issues, waiting times and hostel or key worker staff not having sufficient time to provide dedicated one-to-one support to individuals to attend appointments.

"You don't know where you are from day to day, where you are from moment to moment, really. So you don't know when you're going to wake up in here, and when you've got appointments. … By the time you've sorted yourself out you might have missed that appointment." – HHPA Client (male, 38)

Personal barriers

Personal barriers are those which are particular to the individual; these are beliefs and emotions, often rooted in prior experience.

- **Negative prior experiences** for a number of reasons. People report poor **communication** from health service staff, a feeling of a lack of respect, or 'being looked down on', and a **stigma** associated with being homeless.
- **Low confidence** which can impact upon willingness to access healthcare with multiple causes including the stigma associated with homelessness, communication, previous experience and attitudes of healthcare staff.
- **Fear of hospital settings**, an emotion shared by much of the non-homeless population.
- **Ability to understand and retain information** about health needs and future treatments and appointments. Understanding what is being explained, the health issue and associated treatment can be challenging for people experiencing homelessness. Some have poor literacy, others have limited English. This can result in missed appointments and a lack of adherence to treatment regimes. It also creates a lack of confidence in, and ability to, engage with and navigate the healthcare system, and builds barriers to future interaction with health services.
- **Lack of knowledge** of health needs and available services. There are a number of homelessness specific surgeries in London, including The Great Chapel Street Medical Centre and The Dr Hickey Surgery in the Central London CCG. While these practices have a large number of patients registered, some are not aware of the surgeries and specialist services offered.

"I just feel that when I'm on my own, I'm not – I don't think they see me as a person. They just see me as a homeless person and, like, that I'm not worthy – I don't know if you can understand that. I've been homeless for eight years and people tend to look through you rather than at you." – HHPA Client (female, 53)

Systemic barriers

Systemic barriers are those created by the systems within which homeless people live and move around which can include:

- Staff are sometimes deemed to **not understand the needs of homeless people**. For instance, a homeless person with addiction being admitted to hospital might be in need of a methadone prescription. Clients and Peer Advocates report that this can be extremely challenging to secure resulting in the patient self-discharging from hospital to seek methadone or heroin or that they will not return to hospital next time they may need support.
- **Attitudes to homelessness and stigma**, both as an actual experience or as a fear based on prior experience.
- Having **no fixed abode** can, in some instances, prevent people experiencing homelessness from being registered at GP surgeries, although there are specialist homelessness health centres.
- Systemic **communication** barriers also exist, both in attitudes to homelessness and through the methods of communication employed by the healthcare system, for instance scheduling appointments by post two weeks in advance may often result in a person with a chaotic lifestyle not attending that appointment.

"If someone says to you, 'If you come to hospital, I guarantee before you leave the hospital, you will get your prescription,' that would make a massive difference. Their experience will have been fighting for their prescription." – HHPA Client (male, 43)

Whilst for some clients their health and health management is not a priority for other it is; confidence, skills and knowledge however remain barriers to accessing the appropriate services at the right time.

These multiple, interconnected, barriers culminate in an inflated reliance on emergency and unplanned care as people access help only at crisis point. Additionally, even when healthcare is sought, often only immediate symptoms are dealt with, rather than an underlying cause being treated. Once the immediate pain or illness is resolved individuals will not continue to seek care to address any underlying or chronic healthcare need. In effect, many homeless people are 'storing up problems for the future', potentially resulting in an increased need for unplanned services.

Given these barriers, and their impact on both health and health service use, a participatory and co-ordinated approach is required to supporting people experience homelessness to access the healthcare which is available, and which they need, at the appropriate time, and to increase their ability to overcome these barriers independently. This is precisely what HHPA aims to achieve.

> "… the language and communication barriers, not understanding what the doctors are saying but not really people they've been down a lot and they don't have the confidence to ask. It confidence. People don't have the confidence to even ask to see someone." – Peer Advocate

THE IMPACT OF THE HOMELESS HEALTH PEER ADVOCACY PROGRAMME

KEY FINDINGS

Through the support of HHPA Peer Advocates, the health of people experiencing homelessness improves because they:

- **Access healthcare to prevent problems arising or get help at an earlier stage to prevent problems worsening;**
- Have **increased knowledge, confidence and motivation** to manage health; and
- Change their attitudes to health resulting in engagement with proactive health management.

This results in:

- A **68 per cent reduction** in missed outpatient appointments (DNAs), bringing **DNA rates to a similar level as the general population**, meaning appropriate treatment is delivered when required;
- Resulting in up to £60,000 reduction in DNA related costs;[4]
- A **42 per cent reduction** in reliance on unplanned and secondary care in the 30 days following HHPA intervention;
- For every **£1 spent on HHPA, a potential £2.43 reduction in unplanned care costs**; and
- A reduction in related healthcare activity costs.

Improved health can lead to individuals having the confidence to address the wider challenges they face.

The **peer element of the HHPA model is crucial to its success.** The ability of the Peer Advocate to form trusting relationships based on shared experience is key to the impact of HHPA. Using a peer support model is effective in supporting clients to overcome the barriers they encounter to access available services.

- **Peer Advocates transition from homelessness and unemployment to a stable home and employment** or further training, contributing to the economy and society more widely within 18 months, **saving the state around £24,000 per year.**[5]

> "Well, I get a kick off of … [Peer Advocate] if I need my medication … As I said earlier, if it weren't for you guys [Groundswell] coming and taking the time out and getting myself sorted out, I reckon I would have been dead now. That's how much it made an impact in my life." – HHPA Client

Groundswell's Homeless Health Peer Advocacy service aims to support people experiencing homelessness to overcome the barriers that prevent them from accessing healthcare services at an early stage. This evaluation has found that HHPA has multiple benefits across groups. It has positive impact for clients, whose health improves as a result of the outcomes of the support; for Peer Advocates, who transition to more stable lives; for the NHS, in reduction in unplanned care and missed appointment costs and increased appropriate access to care; and for society as a whole as the health inequalities associated with homelessness have decreased impact as clients begin to overcome the barriers they face.

Early stage, preventative, targeted and specialist homelessness services provided by the NHS are available to people experiencing homelessness but are often not accessed, and scheduled appointments often missed, resulting in a disproportionate reliance on unplanned care amongst people experiencing homelessness. The HHPA programme acts as an intermediary, enabling access through supporting clients to overcome the multiple barriers they face and working closely with the providers of those services to support access. The shared experience of the Peer Advocates is integral to the success of the programme, as it enables the building of trusting relationships. Clients' health improves as a result and they become more actively engaged in their health management through increased confidence, knowledge and motivation to do so.

4. Based on data gathered for outpatient (OP) appointments for 24 known HHPA clients across GSST and King's shows that for the same group of clients when there is not HHPA support DNA rate for outpatient appointments is 45 per cent which decreases to 15 per cent when supported by a Peer Advocate.
5. Homelessness on average costs the state £24,000 additional to the cost of a non-homeless person. (See reference iii.)

HHPA improves health and reduces costs

Engaging with HHPA leads to an improvement in clients' health. A Peer Advocate's support helps clients to access healthcare when it is needed and to develop their **confidence, knowledge and motivation** to engage with and address their health problems. It reduces reliance on unplanned secondary care by supporting clients to overcome the multiple barriers to accessing healthcare and enables them to develop the 'soft' skills necessary to **engage proactively in their health management**.

> "I'm getting seen to by doctors, dieticians and that's through Groundswell coming with me and just giving me that bit of support." – HHPA Client

Rachel currently lives in a hostel, and has a number of health problems as a result of periods sleeping rough and of not going to the doctor. She has recently been through a drug rehabilitation programme and wants to start sorting out her health. She has known she has Hep-C for a while but had not got any treatment for it. Through her hostel key worker she was put in touch with a Peer Advocate who helps her get to her appointments and supports her while she is there. She is scared of hospitals and finds the having someone to ask questions and remember information invaluable. Rachel is starting to feel healthier, and feels more in control of her life. She is planning on asking a Peer Advocate to support her to go to the dentist soon to start getting her teeth sorted.

Clients describe taking more control of their health and developing an understanding of the importance of seeking more preventative support. In turn they identify their health is improving and so will often start to address other health issues or underlying problems.

Clients and Peer Advocates report an awareness that for many there will not be a return to full health. Nevertheless, improvements in health are seen as positive and, alongside an increase in confidence and a change in health attitudes, can act as a driver for clients to address additional challenges and issues they face (for instance alcohol or substance abuse) and to start the journey to more stable and less chaotic lifestyles.

> "My long-term goals for my health are, try to look after myself a bit better, cut down on the drink, stop missing appointments, because there are a lot of appointments that I miss. Say if I've got a doctor's appointment, I think, 'Oh, I don't want to go.' … That's what I want to get past." – HHPA client

> "I'll never get 100% health back, from memory losses and stuff like that, but I would definitely like to just be free of continuously having to go from one thing or another, one hospital here, one appointment there. Just being free of that." – HHPA client

Clients' knowledge, confidence and motivation increases

> "People feel empowered to look at their own health issues, you're not nagging but checking in, it encourages them to give healthier behaviour a try." – Peer Advocate

Groundswell's stated aim through HHPA is to increase clients' knowledge and confidence to access healthcare services *independently*. Peer Advocates and clients report that their **confidence and knowledge** to engage with the management and treatment of their healthcare increases as a result of the support of HHPA. Additionally, we found that the **motivation** of clients to proactively manage their health increases.

Low confidence and lack of knowledge are identified barriers to accessing healthcare for people experiencing homelessness. Increasing levels of confidence and knowledge leads to an increase in engagement with healthcare services and higher levels of proactive health management. Through engaging with health treatment and management health improves as both acute health problems, and their underlying causes, are addressed. Confidence and skill to engage with health services is often referred to as Patient Activation, increased levels of which are known to result in improved health, reduced reliance on unplanned and secondary care and a longer-term decrease in use of healthcare services due to improved health.[v] Providing a service which supports

clients to develop this results in both improved health and the confidence to address health issues and challenges more broadly.

Alan has a leg ulcer and had not had treatment for a month. Last time he had treatment he didn't ask any questions about what he needed to do because he didn't understand what they were telling him. He eventually went to his GP as his ulcer had got worse and he was having trouble walking. He was put in touch with a Peer Advocate who went with him to the hospital and asked some questions on his behalf. He was pleased because he felt the doctors communicated more with him and because the Peer Advocate was able to explain his care to him once they got back to the hostel. He is now more confident to go to the GP to get his dressings changed on his own as he understands the treatment he needs.

Whilst confidence does increase, it remains closely linked to the presence and support of a Peer Advocate; few have reached the point of feeling confident to be fully independent in accessing all forms of healthcare. Nonetheless, many have taken steps along the road to greater independence and control of their health.

For example, clients report being confident to attend the GP or to collect prescriptions independently as a result of the support HHPA provided them, however they would continue to request support for attending outpatient appointments.

> "I am more comfortable now even to the point, and I have done this very recently, I actually phoned my own doctor from a hospital while chatting to their doctors, just to get a second opinion, just to make sure. That's come from Groundswell, having the confidence to say 'Actually, I'm not sure about that, I need to check that up'." – HHPA Client (Male, 43)

The reasons for continuing to value Peer Advocate support are many and varied. Given the multiple, structural, barriers facing homeless people it may take considerable time to develop the confidence and knowledge to wholly independently access healthcare. Moreover, the benefit of having HHPA support, including having another person present to ask questions on your behalf, may be of more importance to clients than achieving independence. Additionally, both the perceived improvement in attitude of healthcare providers when a Peer Advocate is present, and the Peer Advocates' ability to understand and recollect information given at appointments, mean support is welcomed over a long period. Furthermore, many report a major benefit of HHPA as having the cost of travel to appointments paid for; increased confidence alone may not result in independent appointment attendance without the necessary financial resources.

> "We try to help … the clients to do it for themselves. It used to be six appointments only but these guys they aren't able to organise their appointments after six with us. You know they just have so much, they're just chaotic lives and that and six isn't enough, they wouldn't go if we just stopped after six. But you can see changes, they will meet you half way to an appointment, or they will meet you at the appointment. You can't rush it." – Peer Advocate

For some clients, moving to full independence is neither the ultimate goal nor appropriate. For some, such as those receiving end-of-life care, the priority is support. For others with physical disabilities, they will always need support and the aim is to ensure that they are able to attend appointments.

> "As I said, it's made me more confident in myself and I'm dealing with things now that I never would have dealt with. If no one was there with me I wouldn't have dealt with it. So in the long run it's going to help. It really is." – HHPA client

Increasing access to preventative care

> "For twenty years being out on the street, this is the first time I've ever been in hospital, and engaging." – HHPA client

People experiencing homelessness access a disproportionately high level of secondary and unplanned care. Improving health and engagement

with health management through increased confidence, knowledge and motivation leads to a reduction in unplanned care activity.

This evaluation has found a **42 per cent decrease in unplanned care** in the 30 days following initial support from a Groundswell Peer Advocate, in comparison to the 30 days prior to support, based on NHS data for a sample of 35 HHPA clients.[6] For this sample, this equates to an **£870 reduction in costs associated with unplanned care activity per client** over the 180 days following initial HHPA intervention.

It was anticipated that the number, and cost, of planned care interventions would rise immediately following HHPA intervention, on the basis that clients would increase attendance at scheduled outpatient appointments, however the available data shows a decline. This is at odds with data from client and Peer Advocate interviews in which they state they are less likely to leave health issues until crisis point and seek emergency unplanned care but will now address health issues earlier as a result of HHPA. Clients refer to an increased awareness of their health, and willingness to engage with managing it as well as knowing and having the confidence to make appointments, seek HHPA support and go to the GP. It is therefore possible that following initial HHPA intervention clients increase access at primary care, the data for which was not available for this evaluation.

Cost savings

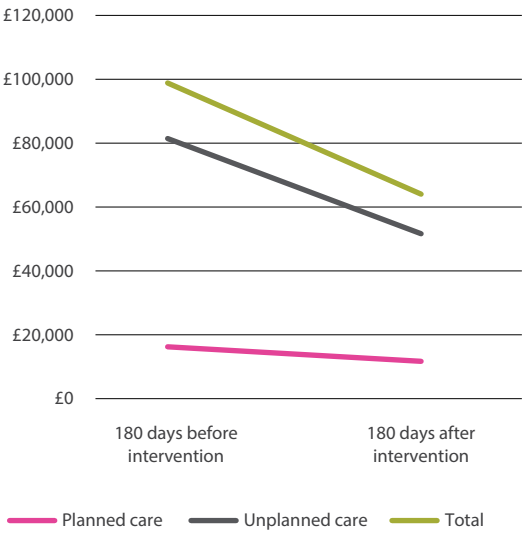
Changes in the types and frequency of healthcare service access based on HHPA support results in reduction in costs for NHS services.

- A **reduction in DNA** related costs including a **potential reduction of almost £60,000 in missed outpatient appointment costs**;[7]
- **For every £1 spent on providing HHPA, a potential £2.43 reduction in unplanned care activity costs** in the first six months following initial intervention;
- A £30,000 reduction in unplanned secondary care activity costs for 35 clients over six months;
- This is equivalent to a **saving of £870 per client in unplanned care costs over the first six months following HHPA support**;
- As clients' health, and confidence and motivation to manage their health, improves there may be **ongoing care savings for NHS services** resulting from decreasing future health service use;
- Potential **'efficiency savings'** associated with clients making more use of services which are available to them as opposed to a reliance on secondary and unplanned care.

Jason has had multiple physical and mental health problems and has relied on an ambulance to go to hospital seven times in the last year. On being discharged from hospital earlier in the year he was put in touch with Groundswell and given the support of a Peer Advocate who has helped him to attend his follow-up appointments and register with a GP. With Peer Advocate support he has progressed to having the confidence to attend GP appointments on his own, although he still needs support for his outpatient appointments as the travel is costly (which HHPA covers). It also helps him to remember when his next appointments are and what he needs to do to keep making progress. He is already feeling much healthier and now goes to the GP when he starts to feel unwell. He has only required an ambulance once since he started to receive HHPA support.

6. This information, and the figures in the cost savings box (above) are calculated from the actual numbers and costs of attendances, admittances and appointments of the sample of patients. This data was supplied by the SUS data warehouse. For more information on SUS data please see http://www.hscic.gov.uk/sus. Planned care includes OPFA, OPFU, OPROC, OP Tel contact, DC and EL. unplanned care consists of appointments classified as AE, UCC, WIC, NELEM, NELEMSS or NELEMXBD. The saving per client is based on an overall saving of £30,475 between 35 clients.
7. In a twelve month period across all homeless patients accessing services at the Guy's and St Thomas' NHS Foundation Trust and the King's NHS Foundation Trust.

Chart 1: Unplanned care costs for HHPA clients registered at The Dr Hickey Surgery and The Great Chapel Street Medical centre 180 days prior to and post intervention



Source: Anonymised NHS data for known HHPA clients' secondary care usage N=35

Cost savings

For a standard one year HHPA commission of £40,000 for 160 one-to-one and 100 in-reach sessions, there is an indicative **reduction in unplanned care activity costs of £48,000** over 180 days.[8] This calculation is based up on an £870 pound reduction in costs per client in the 180 days after first appointment with Groundswell however it does not account for wider costs savings associated with reductions in missed appointments, lower ongoing care costs including primary care and potential efficiency savings. While an evaluation of this nature and a intervention of this maturity cannot yet provide a basis for a full cost recovery assessment, nor long term savings to health or other services, it is very plausible further immediate savings are made as a result of the intervention and that there are also long term benefits.

This figure equates to an indicative **cost saving of £2.43 for every £1 spent** on the programme in relation to reductions in the cost of unplanned care activity alone.[9] This calculation does not account for potential wider cost savings and reductions. For calculation information see Appendix V.[10]

Decrease in missed outpatient appointments

> "… because you have built up trust you don't want to let the [Peer] Advocate down if they are turning up to collect you for an appointment. So when you probably without it you would have missed it you go because they've given that time to come and you have that trust with them."
> – Peer Advocate

For many of the same complex set of reasons that act as barriers to accessing healthcare at all, people experiencing homelessness miss a large proportion of scheduled health appointments. Engaging with HHPA and having a Peer Advocate's support to attend appointments decreases the level of missed appointments, classified as Did Not Attend (DNA) by the NHS. Missing appointments has implications for both the patient and the NHS. The patient's care is interrupted and reduces the effectiveness of care, the NHS incurs costs of approximately £111 for each missed outpatient appointment and waiting times increase.[xvi, 11]

Attending appointments to meet healthcare needs will result in improved health and can act to reinforce changing attitudes to health management, thereby increasing the likelihood of future early stage engagement with healthcare services.

8. This calculation cannot account for potential savings over the whole year as the data available does not allow us to model the longevity of any impact in quantitative terms, despite qualitative data suggesting the impact persists.
9. This calculation is based on a typical Groundswell HHPA commission of £40,000 to provide 160 one-to-one interventions and 100 in-reach sessions over a year, and assumes an average number of appointments per client per year of 2.9 as is the overall HHPA average number of appointments. This calculation is also based upon the £870 reduction in unplanned care costs per client for the Central London CCG sample of 35 HHPA clients in the 180 days following initial HHPA intervention. Additionally, this calculation is based on the assumption that a similar reduction in unplanned care costs will occur for a new sample as did for the Central London CCG sample and that this reduction was due to HHPA support. This does not account for any potential reductions in cost arising from reduced levels of missed appointments or future healthcare use resulting from improved health, nor does it account for the impact of the in-reach sessions.
10. HHPA in-reach are informal group sessions run by HHPA Advocates in hostels where health issues are discussed and relationships begin to form.
11. Figures obtained from Reference Cost Collection: National Schedule of Reference Costs – Year 2013–14 (NHS).

The homeless population misses 34 per cent of scheduled consultant appointments in comparison with the general population which misses 12 per cent.[12] With HHPA support DNA rates dropped to 15 per cent for a sample of people 24 clients. This was a **68 per cent reduction in DNA rates at outpatient appointments** in comparison to when they did not receive support; and brings DNA rates to a similar level as the general population.[13]

DNA Rates for scheduled outpatient appointments:

General population: 12 per cent

Homeless population without HHPA support: 34 per cent

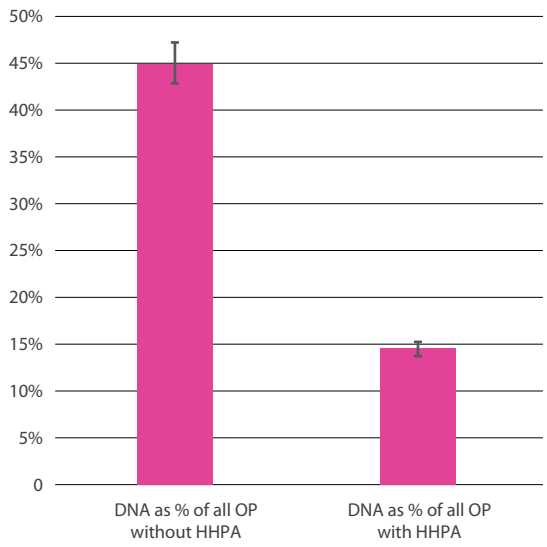
Homeless population with HHPA support: 15 per cent

The relationship between the client and the Peer Advocate, and the importance of the peer element of the model, is key to the programme achieving this outcome. As is described in more detail later in this report the ability of the peer to build a mutual trusting relationship with the client based on shared experience and understanding motivates clients to attend appointments. The importance of the peer model to HHPA is mirrored in a study of Peer Advocates' relationship building with clients in the HALT project. This found that through developing trusting relationships the Peer Advocate is able to increase the client's engagement with healthcare appointments.[xiii]

> "I need someone with me that I know that I can trust. I won't do things like that on my own." – HHPA client

While the numbers of clients in the samples for whom we could access data were modest, the scale of reductions was stark, and give grounds for having some confidence that the Peer Advocate model reliably achieves savings of this order. Furthermore, given the significant costs associated with individuals in the homeless population, the financial savings can be considerable, even if the numbers of clients benefitting from an advocacy model remain relatively low.

Chart 2: A comparison of DNA rates for known clients without HHPA support and with HHPA support



Source: NHS data for outpatient appointments for known HHPA clients at GSST and Kings.
N=24

Cost savings

- Up to **68 per cent reduction** in costs associated with missed appointments.
- A **possible reduction in cost of missed appointments of up to £58,363 in year** across all homeless appointments with consultants at GSST if HHPA support were available.

Based on HHPA support DNA rate of 15 per cent and GSST homeless population DNA rate of 34 per cent (without HHPA support). The approximate cost to the NHS of a missed outpatient appointment is £111.

The importance of the Peer Advocate

> "Well a lot of the [Peer] Advocates have been there and done it. So they understand us a little bit better, and you can talk to them on a level and you can be honest with them." – HHPA client

12. Data sourced from the Patient Information Management System and supplied with all identifiable information removed. This system covers all presentations of patients at GSST and King's for a year to October 2015. In the context of this data homelessness is classed as anyone who is registered as no fixed abode, anyone registered to a homeless hostel address in the London Boroughs of Lambeth, Southwark, Lewisham or Westminster, or anyone registered at The Dr Hickey Surgery or The Great Chapel Street Medical Centre.
13. Based on data gathered for outpatient (OP) appointments for 24 known HHPA clients across GSST and King's shows that for the same group of clients when there is not HHPA support DNA rate for outpatient appointments is 45 per cent which decreases to 15 per cent when supported by a Peer Advocate.

As is widely described in the literature, the use of peer support models can enable and empower members of 'hard-to-reach' groups to engage with healthcare services more effectively, and to better manage their health, leading to improved health outcomes.[vi] The role of the Peer Advocate, as opposed to a trained health professional without experience of homelessness, in HHPA is key to the health impact it achieves – and supports and enables the clients to access the wide range of services which are available to them but those which they may not access due to the multiple barriers they encounter.

Specifically, the relationship built between the client and the Peer Advocate is based on the Peer Advocates' **shared experience and ability to empathise and develop a mutual trust and understanding** with the client. Peer Advocates' experience of homelessness, and therefore understanding of the barriers, challenges and competing priorities facing clients, fosters a sense of shared understanding and respect which is crucial to the success of the programme.

Having shared experience with someone providing support is seen as an element of HHPA which is different, and more effective, than other support services. *"He's been through a similar sort of lifestyle, from the word go I felt safe, I trusted him."* For some this also has an impact on other areas of their lives; they see the Peer Advocate as having come from a situation resembling their own and having changed their life. This can act as motivational modelling behaviour for clients to explore what they could achieve in other aspects of their lives as well as health.

> "… people think that if he can do it anyone can do it." – Peer Advocate

Another important factor of the HHPA model is that Peer Advocates are not asking anything of the client in return for attending appointments. This helps to foster trust and respect between the Peer Advocate and client which in turn helps to ensure attendance at appointments and a desire to continue to engage with HHPA and therefore health more generally.

At the same time, many clients value that Peer Advocates are not "part of the system", reinforcing the belief that HHPA offers a service not otherwise available to connect clients to the health services which are accessible to them. Many people experiencing homelessness have had multiple interactions with numerous services which require something of them in return for a service or support, for instance the Job Centre, employment and housing services, homelessness support agencies and the criminal justice system. Peer Advocates are seen as being outside this system which enables some clients to build more trusting and honest relationships with them than with practitioners in other services they access.

> "I've been in the system all my life, it takes a lot for me to trust people, but [Peer Advocate], straight away from the word go he explained that he's had his troubles in the past and that really broke the ice, I felt quite comfortable." – HHPA Client

> "I guess as well the longer you're on the streets the more you feel separated form health professionals. So they don't feel comfortable and you don't want to go to them. They're part of the system and you're so far away from that." – Peer Advocate

For many clients the HHPA programme is successful for these reasons and also because it enables them to overcome other barriers to accessing healthcare:

> "He'd asked the doctor … Just to let me know what it's all about, you know what I mean? Half the time, I don't understand what they're saying. I don't know what they're saying, or what they're talking about, what's wrong with me." – HHPA client

- The Peer Advocate supports them to **navigate, understand and remember** information given to them during appointments so they can report it back to their key worker and ascertain what it means for them. This assists the client in taking care of their health and not missing future appointments.
- Having a Peer Advocate is perceived to alter communication with and from healthcare professionals so that they treat the client with more **respect**.
- Peer Advocates provide **company and support** to attend appointments, this not only improves communication and understanding but also provides companionship. The **social interaction** aspect associated with having some food or a drink with the Peer Advocate contributes to this.

> "Clients tell me they're treated differently when Groundswell are with them. They say they have more time spent with them, that doctors and nurses listen to them more rather than like brushing them off. It's a bit based on the individual though as well, some go to the GP drunk or you know have poor hygiene. Groundswell

gives a sort of witness and by supporting people it gives well it gives them credibility and then they get more confidence." – Peer Advocate

Peer Advocates transition from homelessness to employment or training

The personal cost of homelessness is considerable. A 2012 report from Crisis put the average age of morbidity for people experiencing homelessness at just 47 years old, 30 years lower than the general population.[xiii] The financial cost of homelessness is difficult to quantify. A review from the Department for Communities and Local Government puts the indicative cost to the state of homelessness at over £24,000 (gross) per year for per homeless person in addition to the cost of a non-homeless person.[iii, 14] Through the volunteering programme Peer Advocates transition from homelessness and chaotic lifestyles to employment or further training and contributing to the state and society more widely within eighteen months.

Groundswell has trained eight cohorts of Peer Advocates to date; a total of 52 Peer Advocates have completed training, 21 of whom have moved on to paid employment.[15]

In each cohort of Peer Advocates, one or two have dropped out within the first quarter. Anecdotally this tends to occur during the first few weeks of training as trainees begin to discern the reality of the role of a Peer Advocate and the level of commitment required. Some trainees struggle with the time management required and others are encouraged to apply by their key worker despite the HHPA programme not matching their interests and skills. One trainee did not complete the training programme due to pregnancy.[16]

Groundswell has clear policies around volunteer involvement. Expectations on boundaries and appropriate behaviour are clearly shared with volunteers via training, the Volunteer Handbook and monthly supervision sessions. Generally any issues with a volunteer's work are dealt with through supervision. On rare occasions where a volunteer continues to work in a way that might put themselves or someone else at risk or has fixed personal viewpoints which prevent them from carrying out their work (e.g. homophobia or racism) then the organisation has asked them to leave.

"[The] strength of the group pulls people along." – Groundswell staff member

Peer Advocates tend to remain in their role for between a year and 18 months before moving on to either training or employment and many go on to apprenticeships.

"That's the big bonus of being a volunteer, you're going to work through and people leave here to go off and do other jobs and that's what he's trying to get me to think exactly what it is that I want to do. It's all good like that, very good, very good opportunities." – Peer Advocate

Peer Advocate recruitment, training and support process

The process for Peer Advocate selection is rigorous. Prospective peers are required to have some volunteering experience, to have two references (including one from a recovery programme if relevant) and to go through an interview process. Once selected there is an intensive six-week training programme which gives both the Peer Advocates and Groundswell time to get to know each other and allows the Peer Advocates the opportunity to explore the role and learn if it is something they would like to do. Groundswell has a list of competencies for Peer Advocates to ensure that the right people are taking up the positions, and all Peer Advocates are subject to a Disclosure and Barring Service check, although the training is not accredited at this point.

Once training is completed a graduation ceremony is held for each wave of Peer Advocates, this acknowledges the progress made by Peer Advocates and through public celebration of their achievements helps to build self-esteem. Training as a group is seen as a beneficial part of the process as the group supports each member and they motivate each other.

There is a specific staff role at Groundswell to support the progression of Peer Advocates. Peer Advocates are also provided clinical supervision to support them, being a Peer Advocate can present challenges and this supervision is beneficial to Advocates to manage these challenges.

14. Including, though not exclusively, the cost to the Department for Work and Pensions through benefits payments, employment programmes and administration; cost to the Department of Health; costs to the Ministry of Justice as homeless and offending behaviour are shown to be linked; and costs to local authorities on homelessness prevention and temporary accommodation.
15. Obtained from Groundswell's internal records on Peer Advocate training and progression.
16. Anecdotal information about Peer Advocate training and progression gained through semi-structured interview with Groundswell staff and both interviews and informal conversations with Peer Advocates.

Aaron (mid 40s) – a former HHPA client and current Peer Advocate

In little over two years, Aaron has gone from street homelessness, addiction and acute illness to living in his own flat, stopping drug use, having treatment for Hepatitis-C, completing training as a Groundswell Peer Advocate, and volunteering to support other people. He has completed a computer training course and is applying for a college course. Aaron is more confident than he used to be, and takes more initiative and responsibility for the things that occur in his life.

Aaron attributes much of this progression to Groundswell and the HHPA programme. He found out about the programme through being a client and had been supported to seek treatment for Hep-C by a Peer Advocate who encouraged him to apply for the training. He completed his training as a Peer Advocate earlier this year and is using his experience of homelessness and addiction to support others to access healthcare. As with other Peer Advocates Aaron wanted to use his experience to give something back as he had been supported by the HHPA programme as a client.

> *"Some of the negative things in my life now could actually lead to being experience, so it's experience that not a lot of people would have ... and no one would actually go out to get it because you'd probably end up dead. But lucky enough I'm not dead and I've got all that experience, so if it can benefit someone, great. It's good for me, it's good for other people."*

Aaron is now applying for an Introduction to Counselling college course and wants to go on to get a job helping others, for instance working with young offenders to help them secure social housing. He is starting to see that he may not be held by a lack of formal qualifications and that his personal and work experience puts him in a strong position to get jobs in these fields. This has given him the confidence to pursue the training courses he does need to complete.

The journey of a Peer Advocate

In interviews with nine current and former Peer Advocates we found similarities along their journeys. The multiple reasons for which people become homeless have been well documented elsewhere and the Peer Advocates' experiences are no different.[17, 18]

When Peer Advocates join the programme the majority are in **unstable accommodation** such as hostels. There is a moment or incident which allows the **space and time to reflect on their ambitions for their future**. This can be hospitalisation, rehabilitation, illness or imprisonment and leads to, or enables, the Peer Advocate to identify, a desire for a more stable and less chaotic future.

Previous volunteer experience is a necessity for a prospective Peer Advocate. Many had begun helping out in their hostel or day centre, supporting others or on residents' boards. On finding out about the opportunity prospective Peer Advocates tend to feel **apprehensive** but consider it a good opportunity which will provide **structure and training**, and there is a clear desire to **'give something back'**. Peer Advocates all feel that others have helped them on their journey and that this is their opportunity to do something for other people.

Once accepted on to the programme the **training** is intensive but there is a sense of achievement on completion. Becoming a Peer Advocate helps to boost **confidence, ambition and belief in their ability** to achieve their ambitions. Groundswell also holds a **graduation ceremony** for each group of trainee Peer Advocates which formalises this and gives the Peer Advocates the opportunity to celebrate their achievement with others.

In addition, **building relationships** is important and can lead to Peer Advocates acting as role models for clients, *"if they can do it so can I"*. Peer Advocates' increased confidence and the nature of the shared experience between Peer Advocates and clients facilitates this.

There can be **challenges** whilst being a Peer Advocate. Some clients can be challenging to work with, however peers support each other with useful ideas on working with clients. There are also emotional challenges for peers as the nature of the role means they will often be supporting clients who are very ill, Groundswell provides clinical supervision to support Peer Advocates with this aspect of their work.

Being a Peer Advocate is demanding, there is a level of professionalism expected such as good time-keeping and completing the necessary paperwork. Groundswell supports the Peer Advocates to develop these employability skills and provides and identifies opportunities for **on-going training and support**. Becoming a Peer Advocate is not seen as an end point but a step on a journey to stability and independence. Peer Advocates are supported to develop more stable lives through, for instance; moving into an independent flat, reconnecting with family and children, opening a bank account, identifying opportunities for the future, and applying for training opportunities or jobs.

17. See for example http://www.homeless.org.uk/facts/understanding-homelessness/causes-of-homelessness
18. See journey map P23.

Peer Advocates move on to a range of different opportunities, typically **within a year to 18 months**. These roles are predominantly in health and social care or housing and homelessness as apprenticeships or jobs at either Groundswell or other agencies or organisations.

Without the opportunity to volunteer many of the Peer Advocates feel their journey to employment would be much more challenging, that they may not have been given opportunities to learn and train. A number of Peer Advocates have previously been arrested and spent time in jail, many have few formal qualifications and have often not been in work for many years, if ever. This life experience is essential to their role as a Peer Advocate, to use their familiarity with the clients' situation to provide support, and HHPA provides a unique opportunity for aspects of their experiences which could be deemed a hindrance elsewhere to become an advantage.

"It's quite empowering, I feel like a specialist elite force." – Peer Advocate

Tim (30) – a former Peer Advocate

Tim had been homeless for around a year before he found out about the HHPA programme, he had slept rough and been in and out of hostels. He wanted to start volunteering as route back into employment and as a way to maintain his motivation.

"I said to myself, you know what, it's time ... to start looking for volunteering and it's time to start improving myself as a person."

Tim completed his training as a Peer Advocate a few years ago and moved on to an apprenticeship, which he completed over a year ago, at another homelessness organisation where he now has a job doing outreach work with people experiencing homelessness. He left Groundswell as he felt he had gained sufficient experience and skills to move into employment, and he wanted to have a paid job. Looking back he thinks the professionalism required of the Peer Advocates is of importance to development and ultimately progression into work.

"It's kind of improved me as a professional person, it's changed me, in a good way, it has changed me."

Tim feels like he would have ended up getting a job even if he hadn't had the opportunity to become a Peer Advocate, although he thinks it would have taken a lot longer and he may not have ended up doing what he is now. Tim praises the support provided by Groundswell, in particular the specific support to progress onto training and employment. He was supported to complete his apprenticeship application and without that support is not convinced he would be working where he is now. He enjoys his job, and having a stable income, and has achieved his ambition of working with other homeless people but he wants to keep learning more.

"For me, Groundswell is like a landmark … dealing with humanity, with humanity." – Peer Advocate


building skills & professionalism
job application
CV
APPRENTICESHIPS
EMPLOYMENT
FURTHER TRAINING
JOB OFFER
CERTIFICATE
INTENSIVE TRAINING
developing trusting relationships with clients
clinical supervision
CV
progression support
peer support
GRADUATION
becoming a peer advocate
groundswell
"No one would actually go out to get this experience [of homelessness] because you'd probably end up dead. But lucky enough I'm not and I've got all that experience so if it can benefit someone, great. It's good for me, it's good for other people."
cost of homelessness
£24,000
per person per year
I WANT TO MOVE FORWARD
volunteering
I WANT TO GIVE SOMETHING BACK
find out about

CONCLUSION

Increasing access to healthcare for people experiencing homelessness must be a priority – it has huge benefits for individuals, can lead to cost savings for the NHS, and it is incumbent upon commissioners to reduce health inequalities.

Although the increase in provision of specialist services is to be welcomed, there remain significant barriers to accessing both them and mainstream services. The HPPA programme is an effective bridge to increased access of these services and is an effective form of increasing Patient Activation, which helps overcome many of the barriers to healthcare faced by those experiencing homelessness.

This evaluation shows that HPPA **improves client health** through:

- Increasing access to preventative and early stage health services through the support of a peer to overcome the multiple, and interconnected, barriers they face;
- Increasing the **confidence, knowledge and motivation** of clients to both seek appropriate healthcare and manage their health proactively in the future; and
- **Decreasing the numbers of scheduled appointments that are missed by clients**, thereby ensuring treatment is received.

Improved client health and changes in health related behaviour lead to cost savings for the NHS including:

- An indicative **saving of £2.43 for every £1 spent due to a reduction** in unplanned care costs;[19]
- A **42 per cent reduction in unplanned care activity costs**;
- Between **50 and 70 per cent reduction** in missed appointments;
- Potential future lifetime savings through better health leading to reduction in service use; and
- Possible efficiency savings of supporting clients to access those services which are already available to them.

The peer component of the HHPA model is essential as it develops trusting relationships with clients through the **shared experience** of the Peer Advocate. This relationship and trust would not be developed without the mutual understanding of the peer, and therefore it is necessary to utilise Peer Advocates to act as a bridge between clients and the services available.

HHPA has a significant impact for Peer Advocates. In the eighteen months from commencing volunteering, through developing employability and 'soft' skills whilst delivering support to clients, Peer Advocates transition from unstable accommodation and chaotic lifestyles to employment or training and more stable lives.

Whilst HHPA delivers clear positive impact for clients, Peer Advocates and the NHS there is potential for it to be improved. An aim of the programme is for clients to move to independent access of healthcare, it is not appropriate or practical for this to be achieved for all clients. More nuanced categorisation of clients should be introduced, and delivery should be adapted based on the needs of the client groups. Additionally, an approach should be introduced to planning for transition to independence with those clients for whom it is appropriate and practical.

In order to scale the impact of HHPA Groundswell should explore its data collection and management processes and should ensure access to NHS data for its clients. Additionally

19. In the 180 days following initial HHPA intervention, see Appendix V for calculations and notes.

through seeking accreditation for its Peer Advocate training programme, and measuring progress for Peer Advocates, it could successfully scale this component of the programme.

Groundswell's HHPA programme addresses many of the major health inequalities associated with homelessness. It supports improved health and increased confidence for those experiencing homelessness and, through its training and support for Peer Advocates, enables people experiencing homelessness to transform their lives. Through this it creates cost savings for the NHS and the state more widely. HHPA is a programme that improves the lives of many and one that should be scaled to ensure more people benefit from its participatory approach to tackling many of the challenges of homelessness.

APPENDICES

APPENDIX I – FULL EVALUATION APPROACH, METHODOLOGY AND FRAMEWORK

The Groundswell Homeless Health Peer Advocacy programme is highly complex with intended outcomes which range from changes in use of healthcare services, to improvements in individuals' knowledge, confidence and other personal advocacy and 'soft' skills.

At the outset of the evaluation, an outcomes framework was established against which the programme would be considered. The framework is centred on a series of questions with selected indicators, exploring the barriers homelessness presents to accessing healthcare and proxy measures for improved health for clients, such as increasing earlier stage healthcare access and clients' knowledge and confidence to seek healthcare support. The evaluation also explores the importance of the peer element to the HHPA model and the impact of the role for Peer Advocates themselves. Where possible this evaluation has also included an exploration of cost savings associated with changes in healthcare access.

To reflect its complexity and ensure that a holistic view of the programme outcomes was obtained, this evaluation employed a mixed-methods approach. NHS Data on service use has been combined with data on HPPA service use. These quantitative findings have been supplemented with further insights obtained through qualitative interviews with both HPPA clients and Peer Advocates.

Evaluation questions

This evaluation sought to understand the impact of the HHPA programme through using mixed-methods research to answer the following questions.

- Does homelessness create barriers to accessing healthcare?
- Does HHPA support people experiencing homelessness to have improved health?
- Does HHPA help increase access to earlier stage or preventative healthcare services by people who experience homelessness as measured by fewer unplanned care incidences, and increased planned care?
- How do Peer Advocates support people experiencing homelessness? And does this differ from not having peer advocates?
- Does becoming a Peer Advocate have an impact for Peer Advocates?
- Do the outcomes associated with HHPA mean that the programme makes cost savings for health services?

In line with the peer support model of the HPPA programme, a participatory approach was adopted for the qualitative phase. Four homeless peer researchers were recruited, trained and supported to conduct interviews with the HPPA clients. Interviews with

20. Data sourced from the Patient Information Management System and supplied with all identifiable information removed. This system covers all presentations of patients at Guy's and St Thomas' NHS Foundation Trust (GSST) and The King's College NHS Foundation Trust (Kings). In the context of this data homelessness is classed as anyone who is registered as no fixed abode, anyone registered to a homeless hostel address in the London Boroughs of Lambeth, Southwark, Lewisham or Westminster, or anyone registered at The Dr Hickey Surgery or The Great Chapel Street Medical Centre.

the Peer Advocates were conducted by The Young Foundation team.

Data relating to a number of different samples of HHPA clients and comparator groups has been utilised for this evaluation due to the availability of anonymised data, this evaluation is therefore unable to explore total NHS and HHPA service use for any single sample.

Data used for analysis in this evaluation is:

- Unplanned service use and associated costs, prior to and post HHPA intervention, for a sample of 35 patients at the Dr Hickey Surgery and the Great Chapel Street Medical Centre.
- Proportion of scheduled outpatient appointments missed at both Guy's and St Thomas' NHS Foundation Trust (GSST) and The King's College NHS Foundation Trust (Kings) for a sample of 24 known HHPA clients, both when supported by HHPA and when not receiving support.
- A comparator sample for proportion of missed appointments at GSST of all general population consultant appointments and for all those classified as homeless.[20]
- Groundswell data for 1,400 scheduled appointments across 285 individual clients in the year to 31st March 2015.

Peer researchers

To understand clients' views of the HHPA programme four homeless peer researchers were recruited, trained and supported to conduct interviews with clients of the HHPA programme.

Peer researchers can provide a unique insight into the views and experiences of individuals and groups through the knowledge of shared experience facilitating relationship development and fostering trust between interviewee and interviewer.

Peer researchers were accompanied in the interviews they conducted by professional researcher to offer support and guidance if required. The peer researchers conducted 30 interviews across 13 different hostel and homelessness support sites.

Interviews explored clients' experiences and views of HHPA support, behaviours associated with utilising healthcare services, health needs and barriers to accessing healthcare. Interview guides were developed, and initial analysis conducted, with the peer researchers. Transcripts were thematically analysed using Nvivo.

Peer Advocates

This evaluation sought to understand the impact becoming a Peer Advocate has for volunteers. Semi-structured interviews were conducted with nine current or former Peer Advocates. Interviews explored the motivation for becoming a Peer Advocate, the journey for each Peer Advocate, current situations, ambitions for the future and views of the programme overall. Additionally the interviews explored Peer Advocates' views of the impact of the programme on clients. Interviews were analysed and thematically coded.

We have interrogated Groundswell's data on training and length of time for which peers are active Peer Advocates and gathered anecdotal information on reasons for leaving.

HHPA appointment data

Groundswell collects information about each client it works with and appointment it attends. The electronic data available only covers the period April 2014 to March 2015 and, often due to the nature of the client group, there are significant gaps in the data. For the purposes of this evaluation the available data on appointment type, project stream, date of birth, missed appointments and number of appointments per client in year were analysed.

NHS Data

Anonymised data for a cohort of 36 known Groundswell clients' outpatient appointments at Guy's and St Thomas' NHS Foundation Trust (GSST) and King's Hospital NHS Foundation Trust (King's) was utilised. This was cross-referenced with Groundswell appointment data for the same clients and analysed for differences in rates of did not attend (DNA) between when clients had HHPA support and when they did not. DNA is classed as when a patient fails to turn up to an appointment unexpectedly. DNA data was examined in relation to the cost of outpatient appointments, approximately £111.[21] The figure of £111 is based on NHS Tariff 2013–2014 data for outpatient appointments without procedure, for the purposes of this study it is used as an approximation of cost of missed outpatient appointments as details of specific appointment types are unavailable.

For the both The Dr Hickey Surgery and The Great Chapel Street Medical Centre anonymised unplanned and planned secondary care data across all sites at which care was accessed was available for a sample of

21. Figures obtained from the Reference Cost Collection: National Schedule of Reference Costs – Year 2013–14 (NHS).

35 known Groundswell clients and the date of their first appointment with a Peer Advocate. This data was analysed for change in appointment type relating to first HHPA appointment and associated costs attributed. Sixteen of the patients are registered at The Great Chapel Street Medical Centre, and 19 patients at The Dr Hickey Surgery. Six of the sample, 3 at each practice, had no secondary care data during the time period. The sample included 21 targeted clients and 14 HHPA one-to-one clients. Not included in the sample are six clients whose NHS number could not be matched.

There are some limitations in the NHS data. We are unable to analyse the GSST and Kings data set for changes related to first appointment with Groundswell as this information is not consistently available for the cohort. Due to data anonymization we are unable to link the Central London CCG data to specific Groundswell supported appointments and are therefore unable to analyse rates of DNA with and without HHPA support for this dataset. Additionally the data set for Central London CCG practices is a small sample.

Evaluation framework

Evaluation question	Indicators
1. Does homelessness create barriers to accessing healthcare services?	Peer research and Peer Advocate interviews exploring the nature of homelessness and any barriers this presents to accessing healthcare services.
2. Does the HHPA service help increase access to earlier stage or preventative healthcare services by people who experience homelessness?	Numbers of people supported to access healthcare Knowledge and confidence to access healthcare services
3. Can we see a change in patients' use of secondary care from reactive to proactive interventions, as measured by fewer unplanned care incidences, and increased planned care?	Activity and cost for: • A&E presentations (decrease) • NEL – Non-elective admission (decrease) • OPFA – Outpatient first appointment (increase) • OPFU – Outpatient follow-up appointment (increase) • OPPROC – Outpatient procedure (increase) • EL – Elective admission (increase) • DC – Day case (increase) • Rates of Did Not Attend (DNA) (decrease)
4. How do Peer Advocates support people experiencing homelessness? How does this differ from not having Peer Advocates?	People experiencing homelessness report that Peer Advocates' involvement supported them to access healthcare services in a more preventative manner or at an earlier stage. The complexities of homelessness impact individuals' ability to access healthcare services (health inequalities). Peer Advocates' ability to relate, provide empathy and develop meaningful and effective relationships is built on their having lived/first-hand experience of similar challenges.
5. Does becoming a Peer Advocate have a positive impact for Peer Advocates?	Peer Advocates develop skills and confidence to move onto further training or paid employment as a direct result of volunteering with the HHPA programme.
6. Do the outcomes associated with HHPA mean that the programme makes cost savings for health services which are greater than the cost incurred as a result of the programme?	Cost information associated with NHS appointment data for: • Unplanned secondary care • Missed appointments Groundswell unit cost for Peer Advocate appointment

STRENGTHS AND LIMITATIONS OF DATA

The data available for this evaluation provides a comprehensive overview of health service use among the homeless population which combines NHS service data with Groundswell service data, and is reinforced by the rich qualitative insights collected.

Quantitative data

Anonymised Groundswell service use data was utilised, including all clients who had accessed HHPA between April 2014 and March 2015. There were no exclusions to this data and so the sample is representative of Groundswell service use. Due to the nature of the client group some gaps in the data were

present including some demographic information, appointment information and historic data for clients using services prior to April 2014.

Due to NHS data governance restrictions data was not available for a single group of clients for all contacts with health services for a period before and after first HHPA intervention. We are therefore unable to compare both primary and secondary care instances under each condition. This evaluation has therefore drawn on different data samples which each provide robust information for different indicators, therefore the sample sizes vary.

NHS Data sample sizes limit the ability to conduct extensive statistical analyses however, when combined with the rich qualitative data gathered the conclusions drawn from the data provide a compelling narrative for the impact of the HHPA programme. The indicative cost reductions associated with changes in health care service use reported are based on findings from small data samples; the data available for this study has not allowed for comparison between groups to test the validity of the findings.

Three separate samples of NHS data were used for this evaluation.

- A sample of 36 GSST and King's patients was anonymously linked to Groundswell service use data through unique client identification numbers. This allowed a robust comparison between rates of DNA for scheduled outpatient appointments and HHPA support. Due to gaps in Groundswell's electronic data on service use we were unable to link this data to date of first HHPA intervention and so it was not possible to assess this data for change in health service use over time. This sample was therefore used to focus on comparing DNA rates between no HHPA support and HHPA support.
- A sample of 35 known Groundswell clients who are registered at either The Dr Hickey Surgery or The Great Chapel Street Medical Centre was used to explore changes in both planned and unplanned secondary care use in relation to first HHPA supported appointment. The data available covered a period of 180 days prior to intervention and 180 days post-intervention. This data included planned and unplanned secondary care use across all NHS sites and so provided a robust comparison between secondary care use pre- and post-HHPA intervention. This data, when linked with NHS Tariff information providing the cost of specific appointments, enabled this evaluation to establish the actual cost reduction for this sample with regards unplanned secondary care service use. This data does not include primary care use so it was not possible to compare primary care use prior to, and post, first HHPA intervention. Due to data anonymization we were unable to link this data to Groundswell's electronic data to identify which appointments were supported by a Peer Advocate, this prevented analysis of DNA rates based on HHPA support for this sample. Six individuals from this sample were excluded from comparison as they had no secondary care use during the time period.
- A comparator sample of all presentations of patients at GSST and King's for a year to October 2015 allows for comparison between general population DNA rates and overall homelessness DNA rates. This data was sourced from the Patient Information Management System and supplied with all identifiable information removed. In the context of this data, homelessness is classed as anyone who is registered as no fixed abode, anyone registered to a homeless hostel address in the London Boroughs of Lambeth, Southwark, Lewisham or Westminster, or anyone registered at The Dr Hickey Surgery or The Great Chapel Street Medical Centre. This data provided a robust, large sample, comparison for the data available for Groundswell clients.

Qualitative data

Employing a peer research approach for interviews with clients enabled rich and robust qualitative data to be collected. The peer researchers drew on their expertise to influence the design of the research. Additionally peer research approaches are known to enhance the data collected as clients have shared experience with the researcher, the power dynamic is changed from traditional research methods and peer researchers have a deep understanding of the experiences of those they are interviewing which can enhance data analysis. Peer researchers had a robust training and support system throughout the research. Peer research can have some draw backs, for instance researchers may ask leading questions or pursue a personal agenda. The training and ongoing support provided throughout aimed to mitigate this risk.

Interviews were conducted by The Young Foundation with current and former Peer Advocates. The data collected through these interviews covered a range of points in time, from Peer Advocates who had recently completed training to those who had moved on to employment. This provided robust and rich insight into the experiences of Peer Advocates, and their impressions of the experiences of clients.

APPENDIX II – HHPA PROJECT STREAMS

HHPA is delivered across four different project streams each with different target groups and aims but based on the same Peer Advocacy model.

- **HHPA one-to-one** is the main delivery model of the HHPA programme and delivers one-to-one support to attend appointments. Clients, or those who support them, will schedule an appointment with healthcare and request a Groundswell Peer Advocate to support them to attend.
- **HHPA targeted** is a proactive programme stream in which GP practices identify clients in need. In some instances patients have a high level of health need however fail to attend appointments; for the Targeted programme an HHPA Peer Advocate will be engaged to locate them and support them to attend much needed health appointments.
- **Hospital discharge** is support to leave hospital for homeless people who have had an inpatient stay. They will be supported to plan and make appointments for their follow-up care.
- **HALT** is a Hepatitis-C (Hep-C) specific programme that supports homeless people to access a minimum of three Hep-C treatment appointments.

APPENDIX III – HHPA SERVICE USE

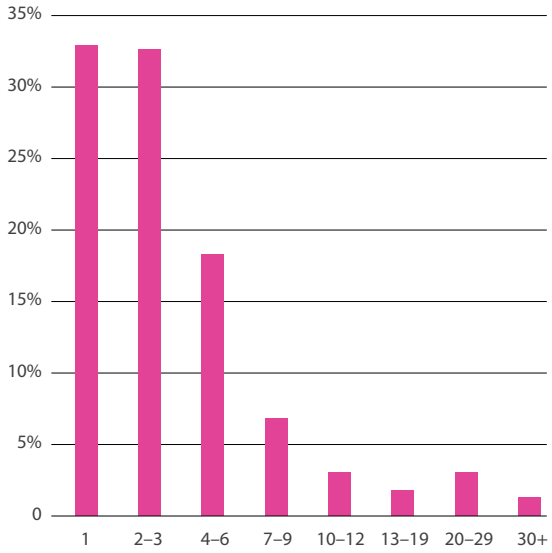
HHPA is currently delivered across eight London areas alongside a tuberculosis testing and treatment outreach service and the HALT programme. It receives funding from NHS Clinical Commissioning Groups (CCGs), Local Authorities the Greater London Authority (GLA).

In the year to 31st March 2015 there were 1,400 HHPA appointments made for 285 unique clients, and of these 1,019 appointments successfully took place. The majority of clients had fewer than ten HHPA appointments within the year. The mean number of appointments is 4.9 with a large proportion of clients having a small number of appointments. There are 22 clients who can be classified as high-frequency service users, with twelve or more appointments over the period. When this small sub-set of clients is excluded, the mean number of appointments is 2.9.

Table: The number of Peer Advocate appointments by client in year

Number of appointments in year	Number of clients
1	94
2-3	93
4-6	52
7-9	20
10-12	9
13-19	5
20-29	8
30+	4
Total	285

Chart: The number of Peer Advocate appointments in year by the proportion of all HHPA clients



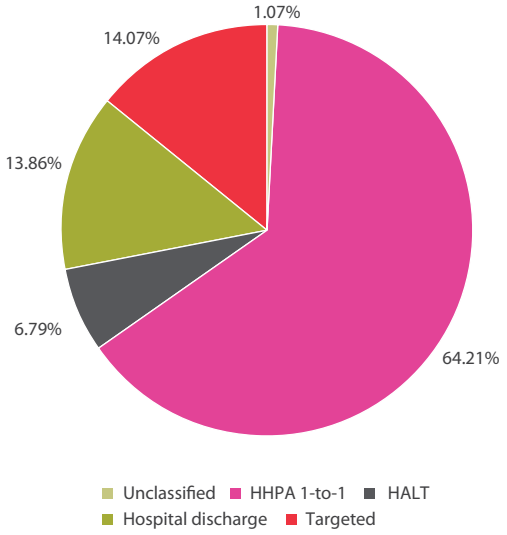
Souce: Groundswell data
N=285

Almost one third of those who engaged with Groundswell, 94 clients, were supported to only one appointment (32.9% of all clients). Of those 94 appointments one third were classified as Peer Advocate Meetings; these are meetings between a client and a Peer Advocate in order to build a relationship and better understand the needs of the client, they do not constitute a health appointment. Whilst it would be of interest to understand reasons why clients had not requested further appointments, given the nature of the group to whom HHPA services are available it is challenging to follow up with these individuals. By exploring the length of time since the appointment took place it is possible to rule out insufficient time to have scheduled additional appointments as a reason for many of clients in the group not having more than one appointment (i.e. it has been more than 4 months since the first appointment for the majority of clients).

Project stream and appointment type

HHPA supports clients to a range of appointments such as for dressing changes, to the optician, to register at the dentist and/or with a GP, and to leave hospital if they are admitted. It delivers this support through a range of project streams including the one-to-one programme, HALT which is for those receiving Hep-C treatment, a Targeted and a Hospital Discharge programme (see figure 1 below for breakdown of appointments by project stream). Over 60 per cent of appointments were made in the HHPA one-to-one project stream, with many fewer in each of the other project streams. This is to be expected as the target groups for the HALT programme are more specific than the one-to-one project stream.

Chart: Per cent split of all appointments by project stream



Source: Groundswell data
N=1400

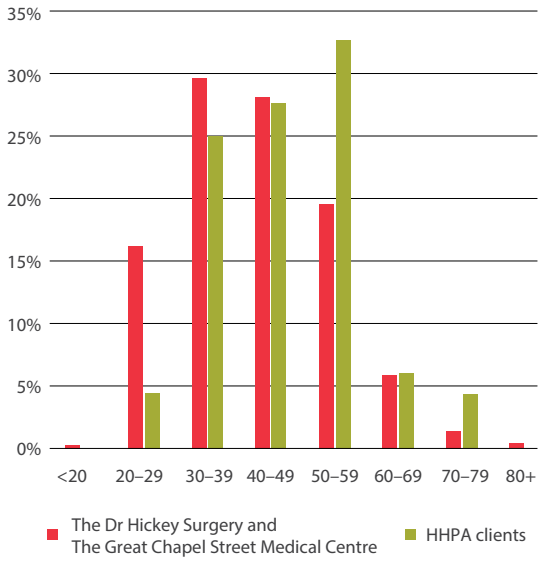
Post-appointment classification of all scheduled appointments shows that the most frequent use of HHPA is for outpatient appointments, dressing change appointments, followed by Peer Advocate Meeting, dentistry and GP appointments.[22] However, 89 of the 148 total dressing change appointments were with one individual, which accounts for this being the most frequent post-appointment classification and indicates a disproportionately high use of resource by an individual.[23]

Age and gender

Age data was available for 116 of the 285 HHPA in year clients.[24] In comparison to a broader sample of 2,228 people experiencing homelessness registered at The Dr Hickey Surgery and The Great Chapel Street Medical Centre the HHPA clients are older. Homelessness services for young people, under the age of 25, are delivered separately to adult homelessness service. Groundswell does not specifically target young people's services for client recruitment, although it does not exclude those under 25. This accounts, in part, for the older age range of HHPA clients than the comparator homelessness population data.

Groundswell does not routinely collect gender information for its clients. However, research shows that approximately 70 per cent of the homeless population is male and anecdotal evidence from Groundswell and the Peer Advocates indicates that this is broadly reflected in the HPPA client group.[iv]

Chart: A comparison of age range for homeless patients registered at two GP surgeries with age range of HHPA clients



Source: The Dr Hickey Surgery & The Great Chapel Street Medical Centre data.
N=2228
Source: Groundswell data. N=116

22. Excluding those appointments which are not classified.
23. Post-appointment classification data table in Appendix IV.
24. Data is not available for all clients as much of Groundswell's historic data has not been uploaded to its data management system, in some instances clients have not wanted to share date of birth information or it has not been requested.

APPENDIX IV – POST-APPOINTMENT CLASSIFICATION FOR ALL APPOINTMENTS

The below table shows the post-appointment classification for all HHPA appointments in year to 31st March 2015.

Post-appointment classification	Number of appointments scheduled
Renal and urology	1
A & E	9
Ear, nose and throat	9
Gynaecology/sexual health	10
Nephrology/renal/kidney	12
Pain Management	12
Physiotherapy	14
Diabetes & Endocrinology	15
Respiratory (including TB)	16
Oncology (cancer, radiotherapy, chemo)	17
Podiatry	19
Neurology (epilepsy & MS)	20
Urology	20
Hepatology (liver – apart from Hep C)	21
Cardiology (ECG, vascular)	24
Blood test	30
Hospital visit	33
Ophthalmology & Opticians	33
Gastroenterology (endo & colon)	36
Other	50
Diagnostic Imaging (x-ray, US, CT & MRI)	59
Blood borne viruses	83
Drugs and alcohol	98
GP	103
Dentistry	115
Advocate meeting	127
Dressings changes	148
Unclassified	266
Grand Total	1400

Note: 89 of the 148 dressing change appointments were with one individual client.

APPENDIX V – COST SAVING CALCULATIONS

Potential cost reductions and return on investment for a £40,000 commission to support 160 1:1 appointments in a year ***

	Number clients*	Cost per 365 days	Cost per 180 days	Potential reduction in unplanned care costs in 180 days post HHPA support**	Indicative cost saving in 180 days following initial HHPA intervention (£ saving per £1 spent)
Potential reduction in unplanned care costs based on an average of 2.9 HHPA supported appointments per client per year	55	£40,000.00	£19,726.03	£48,000.00	£2.43

* Calculated by number of engagements commissioned for year (160) divided by the average number of appointments per year (excluding high use outliers) of 2.9 appointments per client per year.

**180 day Reduction in unplanned care costs of £870 per client is based on Central London CCG data for a sample of 35 HHPA clients in a comparison of unplanned care activity costs in the 180 days prior to HHPA support and the 180 days post HHPA support.

*** This data is based on a series of assumptions including that the reduction in unplanned secondary care use seen for Central London CCG patients will persist across other clients and results from HHPA support. It is therefore an indicative return on investment related to unplanned care activity. The data used to calculate this does not take into account primary care activity, potential reduced costs associated with lower levels of missed outpatient appointments or future health service savings based on lower levels of service use due to improved health, nor does it account for the impact of 100 in-reach sessions delivered within the cost of this commission.

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About The Young Foundation

We are The Young Foundation and we are determined to make positive social change happen. We believe inequality undermines the economy and corrodes our wellbeing, leaving its mark on communities, relationships, aspirations and self-worth.

The Young Foundation is working to create a more equal and just society, where each individual can be fulfilled in their own terms. We work with the public and private sectors and civil society to empower people to lead happier and more meaningful lives.

We believe little about the future of society is inevitable. Bound by our shared humanity, we believe we collectively have the power to shape the societies and communities we want to live in. We work closely with individuals, communities and partners building relationships to ensure that our thinking does something, our actions matter and the changes we make together will continue to grow.

www.youngfoundation.org

About Groundswell

Groundswell is a charity enabling homeless people to take more control of their lives, have a greater influence on services and play a fuller role in the community. The HHPA service was created in 2010 and has since delivered over 6,000 engagements, won First Prize at the London Homelessness Award 2014 (Andy Ludlow), and is one of the winners of the 2016 Kings Fund GSK IMPACT Awards.

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THE YOUNG FOUNDATION

groundswell
inclusive solutions to homelessness

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