#HealthNow

Evaluation Report

November 2023

#HealthNow

Groundswell

Out of homelessness

Contents

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Acknowledgements

We would like to thank everyone who took the time to share their considered feedback as part of this evaluation. This evaluation was carried out by a team of #HealthNow peer volunteers and Groundswell staff who worked collaboratively to ensure that the findings authentically represented the insights we heard. Thank you to all the peer evaluation volunteers who gave a significant amount of time, knowledge and consideration to make this evaluation possible.

This evaluation marks the end of a 4-year journey for the #HealthNow programme. We would like to take this opportunity to thank the National Lottery Community Fund for enabling us to deliver this programme. We would also like to thank everyone who has been involved in #HealthNow – the peers, staff teams, local and national partners and supporters of the #HealthNow campaign.

COMMUNITY FUND

Crisis Together we will end homelessness

SHELTER

#HealthNow

This report is dedicated to Kev, who was central to the #HealthNow journey

Key Terms

Homeless Health Peer Advocacy (HHPA)

A service delivered by Peer Advocates that supports people experiencing homelessness to address physical and mental health issues.

Peer Advocate

A volunteer with experience of homelessness who provides support to clients to address their health needs through information, practical and informal support to attend healthcare appointments.

Local #HealthNow Alliances

Local alliances of homelessness and health stakeholders and peers in Birmingham, Greater Manchester and Newcastle.

National #HealthNow Alliance (Homeless Health Partners)

A national alliance of homelessness and health stakeholders, co-delivered by Groundswell.

National #HealthNow partnership board

A board of national representatives from all three #HealthNow partner organisations.

Peer Researcher

A volunteer with experience of homelessness who designs and conducts research with people currently experiencing homelessness to better understand their experiences.

Peer Evaluator

Much like a Peer Researcher, a volunteer with experience of homelessness who conducts evaluation activities. For the purpose of this report, Peer Evaluators were #HealthNow volunteers who were trained to support the design and delivery of this evaluation.

Peer volunteer

A catch-all term used throughout this report referring to any #HealthNow volunteer with personal experience of homelessness. Peer volunteers may have been Peer Advocates, Peer Researchers or both.

1. Introduction

#HealthNow was a UK wide campaign, working towards an inclusive health system where everyone has access to the healthcare they need, ultimately moving people out of homelessness. #HealthNow was funded by a National Lottery Community Fund partnerships grant of more than £1.5m over four years, based on developmental work funded by the Tudor Trust and Stavros Niarchos Foundation, and with some overheads (such as IT support) provided by Crisis and Shelter. It began in October 2019 and was delivered in Birmingham, Greater Manchester and Newcastle, in partnership between Groundswell, Crisis and Shelter. This report is the culmination of monitoring and evaluation activity throughout the lifetime of the grant, including a focused period of data collection during 2023.

1.1. #HealthNow partners

1.1.1. Groundswell

Groundswell works with people with experience of homelessness, offering opportunities to contribute to society and create solutions to homelessness. Participation is at our core because the experience of homelessness is crucial in making decisions that affect lives and ultimately help people to move out of homelessness.

Groundswell exists to tackle:

- Homelessness - everyone has the right to a safe home and to contribute to society.
- Health inequalities - everyone has the right to good health and a right to access healthcare.
- A lack of participation - people with experience of homelessness should inform the solution.
- A society that doesn't work for everyone - the system has been designed in a way that restricts opportunity, it needs to change to work for everyone.

We achieve this through:

- Good health - We believe good health creates a foundation to move out of homelessness. Groundswell's people focused health work and innovative services enable people who are homeless to access the health care they need – because everyone has a right to good health.
- Progression - We are committed to developing and supporting a workforce of people with experience of homelessness to participate in designing and delivering solutions to homelessness whilst progressing in their own lives.
- Creating Change - Groundswell brings together insight from people with experience of homelessness, we use this insight to tackle issues through changing practice and challenging policy. We believe that the experience of homelessness brings insight that can help tackle the issues of homelessness and create change.

1.1.2. Crisis

Crisis is the national charity for homeless people. We are committed to ending homelessness. Every day we see the devastating impact homelessness has on people's lives. Every year we work side by side with thousands of homeless people, to help them rebuild their lives and leave homelessness behind for good. Through our pioneering research into the causes and consequences of homelessness and the solutions to it, we know what it will take to end it. Together with others who share our resolve, we bring our knowledge, experience and determination to campaign for the changes that will solve the homelessness crisis once and for all. We bring together a unique volunteer effort each Christmas, to bring warmth, companionship and vital services to people at one of the hardest times of the year, and offer a starting point out of homelessness. We know that homelessness is not inevitable. We know that together we can end it.

1.1.3. Shelter

Shelter was founded in 1966, not by the wealthy or powerful, but as a community organisation whose purpose was to change society. Shelter helps people in need with expert advice and support:

- Face-to-face services- advice and support services across the UK give people one-to-one, personalised help with all of their housing issues.
- National helpline- free emergency helpline is open 365 days a year and is often the first port of call for people facing a housing crisis.
- Online advice- Online resources or webchat helping people to access expert information about everything from reclaiming deposits to applying as homeless
- Legal support- solicitors provide free legal advice and attend court to help people who've lost their homes or are facing eviction.

Shelter gives people a voice:

- Research and policy- Shelter carry out ground-breaking research to understand more about the Uks housing crisis and develop reports and policies that capture the experiences of people across the country affected by bad housing, offering realistic yet ambitious solutions.
- Campaigning- with the support of campaigners, Shelter calls on the government and others to tackle the causes and consequences of the housing crisis.
- Press- Shelter works with the media to ensure that the voices of those affected by the housing crisis are always heard.

1.2. #HealthNow areas

1.2.1. Birmingham

#HealthNow Birmingham has been delivered by Crisis. Birmingham has a population of around 1.45 million. The city has a single local authority, Birmingham City council, making it one of the largest in the UK. There were an estimated 14,267 people experiencing homelessness in 2022, including people sleeping rough, living in temporary accommodation or staying in hostels and other forms of supported housing, but excluding many people who are sofa surfing.

1.2.2. Greater Manchester

#HealthNow Greater Manchester has been delivered by Shelter. Greater Manchester covers 10 local authorities – Tameside, Bolton, Bury, the city of Manchester, Oldham, Rochdale, Salford, Stockport, Trafford and Wigan – and is the second largest urban area in the UK, with a population of 2.8 million. An estimated 7,450 people in Manchester experienced homelessness in 2022.

1.2.3. Newcastle

#HealthNow Newcastle has been delivered by Crisis. Newcastle has a population of around 300,000. Northeast England, an area that includes Newcastle as well as Gateshead and Durham, is the region of England with the lowest proportion of people experiencing homelessness in England, with an estimated 2,118 people who were homeless in 2022. Newcastle, however, has the highest number of people sleeping rough in the area as well as the highest number of people whose homelessness was assessed by their local authority.

1.3. Aims and activities

The ambitious #HealthNow partnership set out to achieve an inclusive health system where everyone has access to the healthcare they need, though building a national #HealthNow alliance, led by and built upon lived experience of homelessness, and by:

1. Raising awareness and understanding of the barriers to accessing health services for people experiencing homelessness.

2. Identifying barriers to accessing care and treatment when homeless, at a local level in three key partner areas and develop action plans to eradicate those barriers.

3. Supporting people who are homeless to access the healthcare they need through locally tailored Homeless Health Peer Advocacy (HHPA) services.

4. Harnessing insights from peer-led research and learning from HHPA to create “national actions”, which the alliance can mobilise to create long lasting change.

5. Facilitating participation of people who are or who have been homeless who would, in return, receive support for their own wellbeing and to achieve their goals.

1.3.1. Homeless Health Peer Advocacy (HHPA)

A central component of the #HealthNow programme was the establishment of Homeless Health Peer Advocacy (HHPA) services in each of the three areas. Groundswell has delivered HHPA across London since 2010. Building on the success of the award-winning London service, new HHPA services in Newcastle, Birmingham and Manchester have been established over the past four years. During this time, they have supported a significant number of people to access appropriate healthcare. This is the main way in which #HealthNow has worked directly with individuals experiencing homelessness to reduce the health inequalities they face.

HHPA supports people experiencing homelessness to address physical and mental health issues by working to improve people's confidence in using health services, and to increase their ability to access healthcare independently. Volunteer Peer Advocates, all of whom have experienced homelessness themselves, deliver the service, supported in some areas by specialist Case Workers, many of whom began their role as volunteers. All volunteers attend a comprehensive training programme and receive ongoing support and supervision to enable them to carry out the role safely.

The HHPA service takes a broad view of health and healthcare, so that it can provide support in relation to more immediate health related issues that someone might be experiencing, as well as to support longer term behavioural change that can lead to sustained improvements in physical and mental wellbeing (and quality of life) for those who receive support. The Peer Advocates typically provide support to clients in one or more of the following areas:

- Registering with a GP and/or dentist, including help with paperwork and to find a practice that will register someone who may not have a permanent address.
- Support to attend appointments, including help with travel (such as support to obtain a bus ticket or pass) and reminders of appointments. This can sometimes also include attending appointments with the client, and putting in place things to help the person to be more self-sufficient in the future (such as by helping them remember the route, helping them to understand how best to behave and what to say during an appointment, and how to remember what they want to discuss with the health professional).
- Support to collect prescriptions.
- Emotional support and life coaching.
- Wider ad hoc activities that support improved health and wellbeing.

Peer Advocates can support someone for as long as it is needed, or until the person moves away from the area (which is often the case). In some cases, both paid staff and Volunteer Advocates provide direct support to individual clients.

HHPA in numbers

	Year one	Year two	Year three	Year four
Birmingham	6 volunteers trained to do HHPA health and wellbeing calls.	187 HHPA engagements, 29 clients supported. 28 in-reach sessions.	789 HHPA engagements, 65 clients supported. 45 in-reach sessions.	964 HHPA engagements, 72 clients supported. 27 in-reach sessions.
Manchester	9 volunteers trained to do HHPA health and wellbeing calls. 51 calls completed, supporting 15 clients.	37 HHPA engagements, 12 clients supported. 4 in-reach sessions.	222 HHPA engagements, 82 clients supported. 20 in-reach sessions.	635 HHPA engagements, 94 clients supported. 44 in-reach sessions.
Newcastle	4 volunteers trained to do HHPA health and wellbeing calls.	240 HHPA engagements, 67 clients supported.	899 HHPA engagements, 168 clients supported.	157 HHPA engagements, 46 clients supported. 16 health promotion sessions.

There is already some evidence from delivery across London that Groundswell's Homeless Health Peer Advocacy model delivers positive impacts for its clients and volunteers. An Oak Foundation-funded study by the Young Foundation, 'Saving Lives, Saving Money' (2016), found that HHPA led to between a 50% and 70% reduction in missed appointments, and that it 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."*

More recently, a team from the London School of Hygiene and Tropical Medicine has conducted an extensive study of London HHPA services. While the final report is not yet available at time of writing, a number of outputs have been published that outline the study and emergent findings.

1.3.1. #HealthNow literature reviews

Early in the life of #HealthNow, in 2020, Groundswell published a literature review of existing research into patient experiences of using healthcare, highlighting knowledge gaps for the campaign to address. The review found that:

- People experiencing homelessness often had poor experiences of accessing, interacting with, and discharge from healthcare services. People experienced this throughout the healthcare system but the evidence was particularly strong in primary care (including general practice and dental services).
- Key barriers to accessing healthcare included lack of phone credit, poor access to the internet, reduced ability to travel to healthcare centres, lack of accessible information, and assumptions by healthcare professionals that patients provide a fixed address to access services.
- People experiencing homelessness often felt dismissed by healthcare practitioners because of judgement about addiction, stigma, and discriminatory attitudes and behaviours.
- Healthcare plans for people experiencing homelessness were fragmented and paternalistic, often failing to consider the barriers to accessing appointments and long-term treatment.

The literature review also identified key gaps in the evidence around end-of-life care, eye care, inpatient and outpatient care, and the experiences of further marginalised groups such as sex workers or ex-military personnel.

In 2022 we published an update, tracking changes to patient experience since our first review. Since this period covered the COVID pandemic, some of these changes were substantial and consequential to people experiencing homelessness. Our report found that:

- Proof of address requirements still present a barrier to registering with GP services.
- Access to dentistry is severely limited for people experiencing homelessness.
- Digital exclusion continues to affect people who are homeless.
- The pandemic also led to positive changes. In drug and alcohol services especially, changes in how professionals and patients interacted resulted in improvements in trust.
- Continuity of care is extremely important for people experiencing homelessness.
- Dedicated 'inclusion health' and outreach services can promote engagement and reduce feelings of stigma.
- Powerful new evidence links homelessness to premature death.

1.3.2. Peer research; local health needs audits and thematic projects

Peer research is a method of enquiry that involves people with lived experience of the topic under investigation playing a full and active part in the research process. This involves making space for people to develop the confidence they need to participate fully then, as a team, undertaking a research process including:

- Attending training to develop skills in research principles, methods and ethics.
- Co-designing and piloting research tools to ensure questions are appropriate and tailored.
- Piloting and delivering research interviews and utilising personal experience to develop rapport.
- Supporting the data analysis by taking part in an interactive analysis workshop.
- Evaluating the process, sharing top tips, and suggesting ideas for future research approaches.
- Presenting the findings to the #HealthNow alliance and devising next steps.

Throughout the lifetime of #HealthNow Peer Researchers have undergone training and worked on research studies. These studies provided the evidence upon which the local #HealthNow Alliances have based local plans, and they have fed into national discussion and decision making through the national #HealthNow Alliance.

"I've spoken to so many inspirational people this week. This research is a powerful tool: the more we do, the louder we become because we have more voices behind us."

Peer Researcher, Birmingham

#HealthNow research in numbers				
	Year one	**Year two**	**Year three**	**Year four**
Birmingham	9 Peer Researchers recruited.	5 Peer Researchers conducted 64 research interviews.	2 Peer Researchers supported national thematic research.	1 Peer Researcher contributed to national evaluation.
Greater Manchester	6 Peer Researchers recruited.	8 Peer Researchers conducted 55 research interviews.	6 Peer Researchers supported national thematic research. 4 peers phoned 39 dentists to gather information about access	4 Peer Researchers contributed to national evaluation.
Newcastle	9 Peer Researchers recruited.	7 Peer Researchers conducted 68 research interviews.	4 Peer Researchers supported national thematic research. 29 research interviews for thematic research about leaving prison.	2 Peer Researchers contributed to national evaluation.
National	80 interviews for national thematic research for ''Knowing where to turn: access to mental health support whilst experiencing homelessness 138 interviews for national research for monitoring the impact of Covid-19 on people experiencing homelessness 62 interviews for national rapid research for 'COVID-19 testing and vaccines: Whats working for people facing homelessness? 75 interviews in Calderdale, Kirklees and Wakefield for #HealthNow West Yorkshire: Understanding homeless health inequality in Calderdale, Kirklees and Wakefield (2022)			

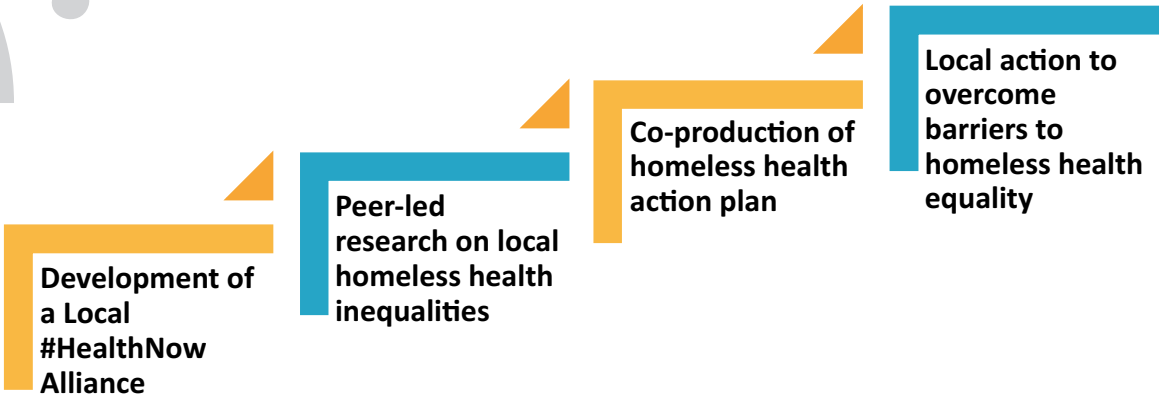
The local peer research reports mentioned in this evaluation are all available online:

- #HealthNow peer research report: Understanding homeless health inequality in Birmingham (2021)
- #HealthNow peer research report: Understanding homeless health inequality in Greater Manchester (2021)
- #HealthNow peer research report: Understanding homeless health inequality in Newcastle (2021)
- Healthcare inequality for people experiencing homelessness during and transitioning from prison (2023)

1.3.3. Local system change through alliance and action plans

In order to influence positive change to local systems, each area convened a local #HealthNow Alliance. The nature of this activity varied between areas, in line with the local structures and networks that were already in place. For example, because of the large number of local authorities, all already attending several homelessness and health forums, a new Manchester local alliance would have duplicated effort. Instead, #HealthNow Manchester focused on ensuring lived experience representation at existing meetings and conferences, such as by attending the Manchester Health and Homelessness Task Group.

In each area, the aim of #HealthNow was to use locally collected data to inform action planning to drive change. The way that each area approached this varied, as the pre-existing networks and plans were at different stages. In Birmingham, for example, the local Alliance devised an action plan based on the peer research and additional insights garnered from HHPA delivery, which was then reviewed and decision makers held to account through the regular meetings. Representatives from health services or the local authority would often take on actions and report back to the alliance.



Local alliances in numbers

	Year one	Year two	Year three	Year four
Birmingham	9 local alliance meetings.	6 local alliance meetings.	6 local alliance meetings.	3 local alliance meetings.
Greater Manchester	9 local alliance meetings.	Attended 8 strategic mtgs across 10 local authorities, inc. Manchester Homeless Health Taskforce.	Continued to attend local strategic meetings across the 10 local authorities	Attended all 4 quarterly meetings of the Health and Homelessness Task Group
Newcastle	6 local alliance meetings.	4 local alliance meetings.	6 local alliance meetings.	

1.3.4. National change

#HealthNow set out to harness insights from peer-led research and robust HHPA data capture to create annual national actions, which the alliance could mobilise around to create long lasting change. The activity associated with this goal was, primarily, establishing a national #HealthNow Alliance and a national Peer Network. At the time the programme was designed, it was hoped there would be far more in-person work than was possible, including peer conferences and national #HealthNow Alliance planning meetings.

#HealthNow Peer Network

The national Peer Network was established early in the life of #HealthNow, to bring together peer volunteers from around the country. Open to Peer Advocates (including from HHPA services outside the #HealthNow areas), Peer Researchers and other peer volunteers, the group started to meet online because of national lockdowns. This format proved to be accessible to many. For example, for people who struggle with travel, who have mobility needs, or who have caring responsibilities at home, online meetings proved to be more accessible. Furthermore, through the lockdowns that took place during 2020 and 2021, and for people who were clinically more vulnerable to COVID-19 and had to shelter for extended periods, the online Peer Network provided a vital link to others, and a way to contribute remotely to an important programme of work. There were also many opportunities for peers to take part in national-level in-person events, including an in-person national Peer Network event, held in Birmingham in November 2022.

National #HealthNow Alliance

In light of the global COVID-19 pandemic, the national #HealthNow Alliance evolved into a monthly online community of practice, although during the height of the pandemic the group met fortnightly. Membership originally comprised voluntary sector organisations including Homeless Link, Pathway, Expert Citizens, Crisis, Shelter and St Mungo's. In response to the urgency of the COVID-19 pandemic this national #HealthNow Alliance became the 'Homeless Health Partners' meeting, which quickly evolved to include government officials alongside voluntary sector partners, including NHS England, Department of Levelling Up, Housing and Communities (DLUHC), Department of Health and Social Care (DHSC) and the Office for Health Improvements and Disparities (OHID). This national network now has a contact list numbering more than 60 people and the monthly meetings, now jointly organised by Groundswell and officials from DLUHC and DHSC, are regularly attended by more than 30 people.

Finally, the original plan for #HealthNow established the ambition to create national change through the compilation of national actions (identified through research and insights gathered through the Peer Network and National Alliance), and to pursue these actions through national campaigning. While actions have been identified and clearly articulated, and communicated through the national networks, there is no centralised repository. Such a resource is currently under development as part of another programme, the Comic Relief-funded Listen Up! project that developed from the COVID-19 monitoring project, which is described in more detail in section 1.4.2. below.

National #HealthNow in numbers

The monthly Homeless Health Partners meeting that serves as the National #HealthNow Alliance has over 60 people on the contact list and over 30 people consistently attend each month.

665 subscribers on the #HealthNow Newsletter mailing list, more than 40 e-newsletters sent.

More than 50 people have engaged with Peer Network activities over the four years.

1.3.5. Participation and coproduction

From the outset, #HealthNow was designed to be fully participatory, to be led by the experiences and insights of people who have faced homelessness and health inequalities.

Coproduction is a way of working that seeks to highlight the importance of ensuring that power and decision-making are meaningfully shared with people who are likely to benefit from positive change. This principle was central to #HealthNow; we were committed to uniting people with lived experience of homelessness and seeking their involvement at each stage, based on a conviction that this would add value to every aspect of the project.

Coproduction in the homelessness sector is not new. Manchester, for instance, already has a well-established coproduction network, The Manchester Homelessness Partnership was set up in 2016 and unites organisations from voluntary and charity organisations, statutory homeless services, healthcare services, businesses, and people with lived experience of homelessness.

The incorporation of the perspectives of people with lived experience of homelessness has also had positive impacts on service design. The approach has led to successful introductions of, for example, peer mentoring initiatives and accommodation design that integrates healthcare facilities. Evaluations of those projects, however, suggested that the true potential of coproduction was not fully realised. Without a wholesale cultural shift that includes the commissioning level, risk aversion and the need for efficiency to meet funding deadlines have meant that the voice and creativity of lived experienced is often restricted, leading to deadlock and disillusionment.

1.4. Getting underway

1.4.1. Timeline

2019

- #HealthNow project begins
- First national Alliance meeting

2020

- *#HealthNow Literature Review 2020: Trends in patient experience when experiencing homelessness* published
- First Peer Advocates trained to deliver health and wellbeing calls
- *COVID-19 monitoring project report* published

2021

- *Understanding homeless health inequality in Birmingham* peer research report published
- First #HealthNow Peer Network meeting
- *Understanding homeless health inequality in Newcastle* peer research report published
- #HealthNow newsletter subscribers reaches over 500
- HHPA delivery begins in full
- *Understanding homeless health inequality in Greater Manchester* published
- NICE guidelines published, incorporating feedback from #HealthNow's Peer Network

2022

- *Understanding homeless health inequality in West Yorkshire* published
- *#HealthNow literature review update* published
- An annual peak of 1910 HHPA interventions completed for 315 clients
- *Knowing where to turn: access to mental health support whilst experiencing homelessness* peer research report launched
- #HealthNow Peer Conference held in Birmingham, attended by volunteers and staff from all three #HealthNow areas

2023

- *Transfer of care from prison* peer research report published by Crisis in Newcastle
- Homeless Health Partners membership reaches a peak of 60 people

1.4.2. Overcoming challenges

COVID-19, lockdowns and additional funding

Probably the most significant obstacle the #HealthNow delivery faced was the global COVID-19 pandemic. National lockdowns across the UK in early 2020, just months into #HealthNow, meant plans for in-person work were put on hold and created significant delays as staff were needed to focus on crisis management. As the pandemic progressed, however, the #HealthNow partnership adapted extremely well, and identified valuable opportunities.

One significant challenge caused by lockdowns was that the planned peer research, fundamental to local areas' action planning, could not go ahead as designed. Pivoting to online and telephone-based training and data collection contributed to some volunteers dropping out, and meant that others needed additional equipment, data and training to be able to participate. However, once these obstacles were overcome, our capacity to conduct research, and our ability to shift focus onto the response to COVID-19, ensured that the experiences of people facing homelessness were heard throughout. For example, at local alliance meetings in Birmingham these insights helped address key issues arising due to the pandemic. A project amendment grant of £30,000 from the National Lottery Community Fund, coupled with £30,000 match funding from NHS England, allowed the #HealthNow partnership to conduct the "monitoring the impact of COVID-19 on people experiencing homelessness" project, which aimed to understand how COVID-19 and the response to it was affecting lives of people experiencing homelessness at the time, using this rapid insight to include the voice of lived experience in local and national decision making processes. The impact of this work is detailed in section 2.5.2. below.

Without this additional funding this work might not have been possible, but the pandemic response demanded greater flexibility from funders, and the #HealthNow partnership's appetite for change and creativity meant that extra funding could be well used.

In addition, the pandemic meant that face to face delivery of the HHPA model was not possible. Learning from the adaptations implemented for HHPA delivery in London, #HealthNow areas developed a remote welfare and health-related support for clients via telephone. This approach generated significant referrals to the HHPA service in each area, however, lesser amounts than conceived in the initial face to face model set up as often people referred to HHPA required help to physically attend appointments. The success of this model has enabled partners to expand the flexibility of the model and respond to needs more effectively. As lockdown restrictions eased, this approach was still offered to clients where appropriate.

Staff capacity and creative response to underspend

Local Coordinators were responsible for overseeing #HealthNow in each area. As the only paid staff members in each area, their duties included overseeing the HHPA service, managing volunteers and providing progression support and maintaining relationships with partners and stakeholders. They felt that the project would have benefited from an administrator in each location, as some administrative duties had been performed within partner organisations outside of #HealthNow's funding.

At the same time as dealing with the many challenges created by COVID-19, Local Coordinators were asked to juggle multiple priorities. Lockdowns and delays to setting up #HealthNow activities meant that strands of work that were intended to be staggered ended up happening simultaneously, including volunteer recruitment and support, setting up and/or adapting HHPA training and delivery, building local relationships and Alliances and supporting local peer research. In grant-funded projects, there exists a tension between allowing flexibility to respond to unexpected events, spending the restricted grant and delivering against key performance indicators as agreed with the funder.

During the first year of #HealthNow and the early months of the pandemic, managing the pressure on Local Coordinators and delays to activity led to underspend against the programme budget. The partnership responded by creating a new role of local Peer Coordinator in each area and a national #HealthNow Peer Coordinator. This was not in the original design but was later deemed by participants in the evaluation as crucial to the successful delivery of HHPA and the #HealthNow Peer network. Most local Peer Coordinators were significantly involved in the coordination of HHPA delivery at a local level, which alleviated some of the capacity issues faced by Local Coordinators.

> *"Because COVID-19 happened, we did have a bit of an underspend. We were able to implement and trial the Peer Coordinator roles, that then actually became so crucial to the delivery of the service that we've had to continue them. And we've had support from partners to be able to do that, which is really amazing."*
>
> *Groundswell staff member*

> *"I think being able to take on the Peer Coordinator role definitely helped a lot […]. And I can't see the project or peer advocacy at least working in the future without that role that's so key."*
>
> *Partner organisation staff member*

The introduction of local Peer Coordinators and a national Peer Coordinator, during the project's second year, was welcomed by all Local Coordinators, as well as by volunteers. This was a lived experience role that encompassed some of Local Coordinators' responsibilities for managing HHPA. Peer Coordinators increased the capacity and responsiveness of the team and provided a unique form of support for volunteers. That it was a lived experience position meant that trusting relationships with volunteers were built easily. It also created a valuable progression opportunity – in one case, the role was occupied by a former #HealthNow volunteer – acting as inspiration and as an exemplar of the project's values. The introduction of paid Peer Advocate roles was thought to be something that should be prioritised in future service design to bridge the gap in duties between Local Coordinator and Peer Advocate roles.

> *"I think one real success of the project for me is the creation of the Peer Coordinator role [...] Not only could the project not survive without that role, but I think it's a progression opportunity for somebody with lived experience of homelessness which is […] exactly what we should be doing. We should be creating these routes for our Peer Advocates to get work in this field, and with us ideally, wherever possible."*
>
> *Partner organisation staff member*

As a discrete campaign delivered within partner organisations, #HealthNow delivery depended on adequate staffing cover. In Newcastle, for example, despite strong support from volunteers, disruption to staffing caused reductions in delivery of some components. For example, the HHPA service had reduced delivery in Year 4 (October 2022 to September 2023). Despite this work being funded by a significant grant, the charity sector is vulnerable to capacity gaps when staffing is disrupted. Other staff may not have capacity to cover absence and, where they themselves are funded by restricted income, may not be able to reallocate their capacity. Recent increases in the cost of living in the UK may also have contributed to staff turnover and challenges in recruiting staff. However, due to the flexibility from National Lottery Community Fund, the partners were able to factor cost of living into all salaries during the grant amendment in year three.

Local Coordinators felt that, in general, the project would have benefited from an increased number of paid staff members. Since volunteers were unpaid, ensuring they were given freedom and flexibility over their working patterns was essential. Additional paid staff would have been able to work more consistently, enabling improved service reliance. It also would have provided more meaningful positions for volunteers and other people with lived experience. Local Coordinators felt that creating more paid positions would also have helped to define roles and responsibilities, and reduced ambiguity around the line between peers' and staff members' duties.

Coordinators were keen to see the incorporation of paid advocate roles (similar to the case workers established in London) because they believe these would give build in greater service reliance, knowing that advocates would always be available. Similarly, the funding for the Peer Coordinator role from the offset as this was seen as essential.

> *"I actually think there's what we should be looking at as well, is employing advocates, because then you get opportunities for people, but also to recognize people are getting paid for their work, but also you get guaranteed time as well, because if you're a volunteer, you volunteer in the time that you got spare, and not the time, if that makes sense. I would love to, if we'd have had the resource and if we'd have it again, that's what I would do."*
>
> *Partner organisation staff member*

Delays with the initial recruitment of Local Coordinators in some areas, and several changes of coordinators during the course of the project presented a challenge. Delays caused by recruitment, and lack of capacity elsewhere in local delivery structures, damaged capacity to deliver certain activities.

> *"When that one huge role goes, it's really big shoes to fill, and it's a big role for people. So then when we are trying to engage with other things, they just have really limited capacity and I think that has been a huge challenge for the project."*
>
> *Groundswell staff member*

This was also the case with national partnership board as staff changes in key leadership positions within the partnership meant the regular national #HealthNow partnership board meetings were much less frequent than expected and meant decision making did not work in the way which was initially envisaged.

> *"What hasn't really worked – and again how needed it was – the partnership board. I think it probably worked in the very early stages, but then all of those people left. And then finding the relationships to build it kind of worked through a difficult period."*
>
> *Groundswell staff member*

Data management system

A proportion of #HealthNow funding was allocated to design a new data management system (CRM) with each #HealthNow delivery partner. This would allow independent advocacy referrals and case notes to be stored securely and separately to other services delivered. The allocation of funding to design a bespoke platform meant that the partnership were able to consider the needs of their local client groups and what data was most important to collect. Two of the three #HealthNow areas were able to use the new CRM as an ongoing method of monitoring HHPA clients and interventions.

> *"I think we have had a benefit in building our own data management or CRM system. Because it helped us to really think about actually what are the different kind of interventions that we are doing"*
>
> *Groundswell staff member*
>
> *"The new CRM was really user friendly and intuitive and allowed our peer advocates to navigate it with ease, ensuring that all elements of service delivery could be peer-led by our Homeless Health Peer Advocates."*
>
> *Partner organisation staff member*

Situating #HealthNow within established local services, and sharing learning between different organisations, meant referral pathways were easier to establish and demand was often existing from the offset. There were also opportunities for shared learning and sharing of tools from the offset – coordinators worked together to navigate and design the process.

> *"Like thinking about setting up the CRM system, like when we talked about how we do risk management and identify safeguarding things that. We had tools from three organisations that we could use for our basis and build something that worked for us."*
>
> *Groundswell staff member*

1.5. Impact evaluation methodology

We wanted to understand the observed changes from the #HealthNow programme, exploring both positive and negative impacts through an impact evaluation. Due to the expansive nature of #HealthNow and its intended outcomes we adopted several methodological approaches. The evaluation design and delivery enabled participation of partners and peers throughout.

1.5.1. Data collection and analysis

This impact evaluation aimed to address seven questions about the process and impacts of #HealthNow:

1) How have HHPA clients benefited from #HealthNow? How much has #HealthNow improved the health and wellbeing of clients supported by HHPA services? Do clients have a stronger understanding of their right to healthcare, and do they feel more able to self-advocate?

2) What are the benefits for #HealthNow volunteers? How did volunteering with #HealthNow improve peers' confidence, wellbeing and progression?

3) Has #HealthNow increased the awareness and understanding of homeless health inequalities, both at a local level in Newcastle, Birmingham and Greater Manchester and nationally?

4) Has #HealthNow fostered collaborative working between health and homelessness sectors locally? How has this impacted experiences of healthcare for people who are homeless?

5) Has #HealthNow emphasised the role and importance of lived experience in both the homelessness and health sectors? How has this impacted services' ability to meet the health needs of people experiencing homelessness?

6) What additional learning is there from the #HealthNow programme? How did the programme influence delivery partners ways of working?

7) How can the #HealthNow programme be sustainable in Newcastle, Birmingham and Greater Manchester, and be replicated successfully in other areas of England?

We addressed these questions through the following methods:

- **Stakeholder survey:** we circulated an online survey via partner organisations in each area, targeting professionals who had been involved at any stage of #HealthNow. They included alliance members, referral partners or anyone else who may have linked up with #HealthNow at a local level.
- **Professional interviews:** we carried out eight semi-structured interviews with key professionals working on, or closely with, #HealthNow. These included two Groundswell staff members and six staff members from our partner organisations.
- **Volunteer interviews:** in June and July 2023, four volunteer Peer Evaluators and two Groundswell staff researchers carried out 19 semi-structured interviews with #HealthNow volunteers. Most of these interview participants were past or present Peer Advocates. Others had been Peer Researchers or had volunteered in both roles.
- **Documentary and data review:** this included monitoring reports from local areas to the central coordination team, and to the funder, as well as feedback collected during events and activities, and a wide range of documents and records.
- **Client interviews and economic analysis:** as outlined below, we commissioned Apteligen to conduct interviews with HHPA clients, and to use interview and case management data to undertake an economic analysis of HHPA specifically.

Qualitative data from both professional and volunteer interviews and the stakeholder survey was transcribed and analysed thematically using Dedoose software.

1.5.2. Embedding lived experience

We took a peer-led approach to exploring the experiences and reflections of volunteers; the team for this element of the evaluation was a combination of #HealthNow volunteers and Groundswell staff members.

In May 2023, we ran two day-long sessions with seven volunteers. In these sessions we delivered training on evaluation methods and interview techniques, and co-designed interview guides for volunteers and HHPA clients. This training prepared the Peer Evaluators to then conduct interviews with volunteers.

The nature of #HealthNow and its national Peer Network meant that, in many instances, interviewers were well known to the volunteers they interviewed. Although we minimised associated risk of bias by ensuring that Peer Researchers conducted interviews in areas other than where they had volunteered, participants were nevertheless less likely to give critical responses to interview questions. We reasoned, however, that the benefits of peer research methodology would outweigh this risk. Peer Researchers were able to use their own experiences of working on #Healthnow to co-create new understandings of the project during interviews. As these understandings developed throughout the fieldwork, we continued as a team to incorporate them into the interview guide to pursue emerging directions of enquiry. This was a way of ensuring that our evaluation was as coproduced as possible.

1.5.3. Economic analysis of Homeless Health Peer Advocacy (HHPA)

We commissioned Apteligen to conduct a discrete economic evaluation on the HHPA service in the three #HealthNow areas. This research focused on deepening our understanding of the different ways in which the HHPA service can lead to improvements in health and changes in health-related behaviour in clients, and which of these are most likely to lead to tangible monetary and social value across the wider system (including but not limited to the NHS).

The work involved one-to-one semi-structured telephone interviews with 15 people who have received support through HHPA; seven in Birmingham, two in Manchester and six from Newcastle, plus one Peer Advocate. Several of the clients interviewed had also volunteered for the service. Apteligen aimed to interview around 10 HHPA clients from each of the three areas (30 in total) but, despite repeated efforts, no other clients were able to be interviewed within the time available. Interviews were recorded and transcribed for the purpose of analysis. In addition to the interviews, researchers also reviewed the data held by the service about individual client interactions where consent to access this information was given.

The findings of this element of the evaluation are fully articulated in section 2.1.2. below.

Limitations of the economic analysis

A number of factors limited the breadth and depth of primary data collection and analysis that Apteligen could undertake, including:

- The limited data available on service activity and cost made it impossible to determine a meaningful unit cost (average cost per client) of the HHPA service in the three areas. In particular, activity data for previous years was not available due to the introduction of a new data collection system. It is also important to note that, to be person-centred and truly coproduced, peer advocacy support does not demand much by way of 'paperwork' or 'form-filling'. The implications of using this deliberately minimalist approach to data capture are considered in more depth in section 3.5 below.
- The difficulties that clients had recalling their use of health services both prior to HHPA involvement and since that time, due to their often complex health needs and unstable lives. Clients also found it difficult to separate the support they received from the Peer Advocate from other support they were currently receiving, or had received in the past.
- The long timeframe over which potential health benefits can lead to monetary value across the system means a much longer study would be needed in order to quantify these with any certainty.
- The lack of any reliable counterfactual (what would have happened without HHPA support) given the diversity of experiences and health status of the clients receiving support.

It is also important to note that the final sample size is relatively small, and there is likely some bias given that participants were self-selecting. From the data available, researchers are unable to determine how representative this sample might be for HHPA clients across the board. However, we were reassured by conversations with staff, and with one of the peers - and an anonymised extract of data showing interventions for other clients - that the findings set out below represent the wider benefits likely to be experienced by many of those supported by HHPA in Birmingham, Manchester and Newcastle.

2. The impact of #HealthNow

An aim of this evaluation was to explore how effective #HealthNow has been in emphasising the value of lived experience and what the impact of this emphasis has been on the homelessness and health sectors.

The remainder of this report explores the impact of the #HealthNow activities across two domains: 1) embedding lived experience and 2) reducing health inequalities. It outlines the impact for:

Section 2.1. Clients and other people experiencing homelessness.

Section 2.2. Peer Volunteers.

Section 2.3. Partner organisations (Crisis and Shelter).

Section 2.4. Local systems.

Section 2.5. National knowledge, policy and practice.

2.1 #HealthNow's impacts on local people experiencing homelessness

2.1.1. Embedding lived experience

The following section explores the impact on people experiencing homelessness who were supported by Peer Advocates. Since all Peer Advocates had themselves experienced homelessness, their role as volunteers offered inspiration for a potential route out of cycles of homelessness, both for their clients and for others in their social networks. In this way, #HealthNow was able to increase the profile of lived experience participation among local people who were homeless. Volunteers we interviewed spoke frequently about pride in being able to help others and make a difference, and some felt that people who were still homeless might be able to learn from this. One volunteer told us that fellow residents at his hostel had taken interest in the activities in which he was involved with #HealthNow and saw for the first time a way they would be able to influence change themselves. Another, herself recovering from a drug dependency, spoke about how visible and important her progression was to her clients.

> *"I found that because all the peer mentors [advocates] have shared experience, it's great when I see ones that have had difficulties and now they're trying to better themselves. They're trying – they've turned their lives around. It's not easy to change your life around when you've got an addiction. They've all lived it, they've all been on the streets, they've all lived the same life as the people they're trying to help. And it's great that, because of that, when we see clients […] they understand that they've been in the same place, and like it doesn't have to remain like that."*
>
> *Peer volunteer*

2.1.2. Reducing health inequalities for people experiencing homelessness

Direct health benefits of HHPA

In year three of delivery of HHPA services in Birmingham, Manchester and Newcastle (the last full year for which data were available for analysis at the time), 28 Peer Advocates delivered 1,910 HHPA interventions with people experiencing homelessness. Between October 2021 and September 2022, 315 clients were supported across all 3 sites; 65 in Birmingham, 82 in greater Manchester and 168 in Newcastle. The HHPA service was tailored in each local area. In Birmingham they adopted an approach where every client had a named Peer Advocate who they were matched and could work intensively with, whereas in other areas clients were often supported by multiple Peer Advocates.

This research has identified a number of different health benefits directly related to the HHPA service. These can be broadly categorised as:

- Improved access to healthcare, with clients more likely to attend appointments and more likely to have improved medication compliance, both of which can result in physical and mental health gains
- More efficient and effective use of healthcare resources, and
- Improved overall mental health and wellbeing.

However, many of these benefits are hard to quantify, both from a health improvement perspective and in terms of potential monetary value across the system. This is in part because of the longer-term nature of any measurable differences in use of health services, but also because of the considerable diversity of the medical conditions that they relate to.

Access to, and attendance at, healthcare services

Our interview data offered strong evidence that, as a direct result of their involvement with #HealthNow, HHPA clients are much more likely to access a range of different healthcare services, allowing them to be properly diagnosed and treated for existing health conditions. Many clients were not registered with a GP or in contact with other healthcare services at the point they first came into contact with a Peer Advocate. Some noted that not having a permanent address had been the main barrier to this. Others mentioned barriers such as difficulties completing the required forms or feeling anxious about dealing with formal health services. We found that a key first step in addressing existing health issues, and enabling access to other health services, was the support to be registered with a GP practice.

Furthermore, although some clients are already registered with a GP, the transient nature of their life meant that the GP surgery they were registered with was no longer in a convenient location. However, moving surgeries was not typically something they had either considered, or felt able to do. HHPA support enabled these clients to register with a GP closer to where they are now, in turn making visiting a doctor more manageable.

Support helping people to access dentists and opticians is also valuable. Clients have also received support to change which pharmacy their prescriptions are sent to, specifying a more convenient location. Given that many clients need to collect prescriptions regularly, sometimes daily, this helps to remove a large barrier to having the right medications. In turn, this has promoted improved compliance with medication.

Although the HHPA referral process means those referred often had an existing health condition, the characteristics and experiences of the clients means that they are often dealing with multiple health conditions. This has meant that new conditions are also dealt with at an earlier stage than they might otherwise have been. Both the interviews and data held about clients reveal some improvement in people being able to access support for new conditions or ones for which they had not yet sought help. For example, one client mentioned, at the point of contact with #HealthNow, that she had discovered a lump in her breast. This was overwhelming in the context of the other challenges that were going on in her life at that point, and the support she received enabled her to seek urgent support to receive the appropriate diagnostic tests.

A consistent theme across many of the clients we interviewed was that the financial cost of attending appointments was a significant barrier, given the trade-offs this might have involved. This was particularly true of hospital appointments where the journey was frequently longer, and sometimes across to the other side of the city. HHPA support removed this barrier by arranging bus passes or taxis. Where clients were getting buses, it was not simply the fares that were paid, but also support with route planning and timing in order to get their appointment on time. Similarly, the arrangement and funding of taxis helped avoid overly complex journeys to attend appointments which, again, might prevented individuals from attending.

Many clients reported that they have issues with their memory or other challenges that make it hard for them to remember they have appointments. Although not needed by all clients, HHPA reminder calls have been invaluable for many as a way of making sure they attended appointments.

A number of the clients we spoke to reported having had negative experiences in healthcare settings as a result of being homeless. For some clients, simply going to a GP can be a challenge. While the support and confidence boost of having someone with them, or advocating for them, was sufficient for some, the fact that there was a clinic specifically for people experiencing homelessness being run regularly at one of the sites, helped to remove a major barrier for some clients.

Appropriate and impactful spend

The HHPA service has undoubtedly resulted in fewer appointments being missed at GP and hospital services and, although it was not obvious what would have happened without the service in place, it is likely that some clients would have had to attend A&E at an average cost of £306 per attendance, called out an ambulance at £334 per call out or required a hospital stay at an average of £3,030. As such these have certainly resulted in less wasted healthcare services.

However, the more proactive approach individuals take to their health has also increased the number of appointments that are needed, mostly for primary care but also for secondary care services, particularly with respect to investigative appointments and tests. Although it is not possible to calculate the balance of this across the system, it is clear that by investing in more appropriate appointments, there is a longer-term value associated with avoiding future unplanned care and the spend is more impactful compared to the cost of missed appointments.

More efficient and effective use of healthcare resources

Another benefit associated with HHPA is the potential for more efficient and effective use of healthcare resources. The peer advocacy role, at the most intense level, involves attending appointments with clients. Evidence suggests that without this support many of these clients would not have attended appointments at all, and with the advocacy support not only did they attend, the appointments were considered more constructive, with clients better able to explain their situation, understand and follow the discussion, and be more likely to comply the agreed treatment plan.

For some clients this was about feeling more prepared for the discussion and therefore having more relevant and meaningful conversations. Clients talked about simple preparation techniques, such as making a list of key points or questions so that key information was not forgotten. This not only made the clients feel more confident attending the appointment, but also had the benefit of ensuring that the time was used effectively. It also became a longer-term technique to help in other situations.

HHPA helps clients better to understand how to use their appointment time and the behaviours that are expected or required within a health environment. There were, for example, cases where clients were at risk of being struck off from the GP because of anger issues. In cases like this the HHPA support involved advocating to the surgery to try and help ensure that the individual could remain registered.

Several clients explained how people experiencing homelessness are not always taken seriously at appointments, echoing previous #HealthNow peer research that has highlighted stigma as a significant fear amongst people experiencing homelessness, particularly around mental health.

"People do have this stigma of homeless people. And even if they're not aware that they have it, they have an idea of what they believe that homeless person is. And just the way you can interact and kind of meet these people and hear their stories and just try to support them somehow, it kind of breaks down that barrier. You realise these people have stories, you know, these, these people that like, I've had that thing that we're all a few bad decisions away from something."

HHPA client

One person we interviewed suggested that people experiencing homelessness can be 'fobbed off'. He felt that receptionists at GP surgeries are often playing a gatekeeper role and people can feel unable to stand up to them, as they are used to being dismissed. He felt that #HealthNow can not only advocate for people at the point of the appointment, but also in relation to getting appointments booked in the first place, with the right clinician and in the right location.

Whether support is delivered by paid staff or volunteer Peer Advocates, the value of having peers supporting individuals is pronounced. Many clients talked about how hard it was for them to trust people, and how being supported by someone who had been in a similar situation to them often led to a greater sense of trust.

> *"Because sometimes when people see me they don't realise that I've also been homeless, I've also been in a hospital. And like, the second you speak to someone and tell them your experience, you can see like a barrier come down straightaway."*
>
> *HHPA client*

Another client, who had also been a volunteer in the past, noted how she had been able to advocate for others despite finding it very different to advocate for herself. She described how the emotion associated with her own situation made it harder for her to say what she wanted to say, and to think clearly, at her own health appointments. Clients referred to HHPA support often don't have anyone else who can advocate for them.

HHPA advocacy extended to ensuring clients were supported to get an appointment at a time when they were best able to benefit from it, rather than just what was offered. For example, some clients struggle in the morning so an appointment later in the day is better. HHPA worked with the hospital to get appointment times that were more manageable and productive for the client. This ensured not only that clients were more likely to attend, but also made sure they were better able to absorb the information provided and adhere to the guidance and instructions given.

Case examples: Missed appointments

Research has shown that missed appointments cost the NHS £42 (for a GP appointment) and £187 (for a hospital outpatient appointment). One client interviewed as part of this evaluation estimated that in the year before she had been involved with #HealthNow, she had missed in excess of 12 appointments (mostly with a GP). This would have been a cost to the NHS of at least **£504.**

Another client reported often missing appointments for blood transfusions prior to HHPA support, which would normally happen once every three weeks. While it was difficult for the client to quantify exactly how many appointments were missed, a conservative estimate based on the discussion would be in the region of four appointments per annum, at a cost of at least **£748** to the NHS (excluding any costs related to the preparation of the blood products themselves which we understand were prepared specifically for each appointment).

Medication compliance

According to existing research the cost to the NHS in England of non-adherence to medication is around £1 billion for just 5 of the more common long-term conditions. The evidence reveals that HHPA supports patients to be better comply with their medication by:

- Ensuring medication goes to a pharmacy that it is practical to client to collect from, and supports transport to collect it
- Supporting clients to engage better with their GP services so they understand the medications they should be taking and when.
- Ensuring local service staff and volunteers are informed about, and understand, the medication clients are taking

Peer Advocates remind clients to make sure they are complying with the medication and can support clients to understand. They can also help support the health service in making sure that where there is a choice of medication options, those most appropriate for the client are chosen.

Improved mental health and wellbeing

One of the most common themes we identified across HHPA clients was experiences of poor mental health. Almost all clients involved in the research identified the wellbeing calls made by Peer Advocates as a key benefit of the service. The value of having someone to call in a crisis, as well as just knowing that someone would be there, made a considerable difference to their overall wellbeing.

Clients cited the fact that knowing there was someone they could call, even if they didn't need support at the time, was hugely reassuring. Many mentioned that this was not a support that they had received from other services. As well as improving their mental health, check-ins also had a positive impact on physical health, as clients felt that it gave them the responsibility and motivation to look after themselves better.

Clients also talked about how their wellbeing improved for other reasons:

- Access and support to attend mental health services and therapies such as talking therapies and making time for their own wellbeing.
- They were encouraged to feel more empowered about their own mental health and supported to undertake activities that improved their mental health such as eating more healthily, exercising, starting courses or pursuing other activities that helped them to keep their minds occupied and/or develop new skills.

Other wellbeing benefits and potential social value

The support provided by the Peer Advocates takes a holistic approach to heath, meaning that there is often consideration of the broader factors that impact on health (directly and / or indirectly), which can lead to both short term and long-term health improvements, and more sustained changes in health-related behaviour.

Adopting healthier lifestyles

The evidence gathered for this evaluation shows that HHPA often supports clients to move towards adopting healthier lifestyles. For example, one client described how their Peer Advocate had helped him to think more about his diet, how he can help to lower his cholesterol, and how to lose weight through physical activity. He reported that by adopting these behaviours his general wellbeing had improved and he was feeling more positive about himself.

Another client reported that as a result of encouragement from #HealthNow, he was receiving smoking cessation support. He reported that this was something that he wouldn't have embarked upon without that encouragement. Based on existing research, we estimate that the average value to the NHS of someone stopping smoking is in the region of £400 per annum.

Case examples: Avoiding prison

The cost of a person being in prison for a year was £49,858 in year 2020/21.

One client discussed their history of being imprisoned because they struggled with anger and aggression. They recalled a situation where something happened that historically would have resulted in them reacting in a way that would probably have resulted in return to prison. However, they felt they had learnt how to cope better with their anger because. as they had someone in the (HHPA) service that cared about them, they felt greater responsibility to make an effort to manage their behaviour, and they had avoided a return to prison.

Another client was on a life license from prison and, as such, without accommodation would have returned to prison. The references and support she received from #HealthNow, alongside other services, helped ensure she was able to maintain her accommodation. Without this she could have spent a number of years in prison. These were by no means the only examples of clients who felt that they may have ended up in prison without HHPA support.

Social value of the opportunities created

Many clients now engage in more meaningful activities as a result of the support they have received from #HealthNow. Whilst a number of these benefits have been achieved because of the individual has received from a combination of services working with them, it is clear that the benefits would not have been achieved without the part played by #HealthNow. Publicly available data provided by the HACT UK Social Value Bank show these activities create social value (or wellbeing value, i.e. the monetary value associated with uplifts in wellbeing they create), to the value of:

- Regular volunteering - £3,249 per year
- Employment training - £807 per year
- Full Time employment - £14,433 per year
- Part Time employment - £1,229 per year

Several clients reported that they were now regularly volunteering, and others were beginning to develop plans for this. Other clients now had sufficient stability in their life that they were able to undertake full time employment or had been able to undertake training to support them towards future employment. This is explored in more depth in section 2.2.1. below.

Practical support and signposting

Many HHPA clients face a number of complex and interconnected issues, in relation both to their existing health status, and to those combined factors that determine their likely health and wellbeing over the medium to longer term. These factors (such as their financial situation, living environment, and a lack of a stable support network with friends and family) mean that crisis events are common, which can further undermine their capacity to make sustainable changes that will lead to improved health and wellbeing.

As a result, Peer Advocates provide a wide range of practical support, including:

- Referrals to food banks. This can help to ensure that clients have a healthy diet as well as removing at least one source of anxiety and stress. For some clients this has also included supporting clients to have cooking facilities. For example, one client had received items that could not be cooked in a microwave (the only cooking facility she had), so she was given an air-fryer.
- Financial support, by ensuring clients are aware of the benefits they could be entitled to. While the support does not extend to completing forms, it can involve reminding clients of appointments for related assessments. One client was also supported to obtain a replacement bank card.

Providing phones / SIM cards, or money to go towards phone credit. Not only did this allow people to be more independent in relation to their health (such as making appointments and being able to take calls from

- Part Time employment - £1,229 per year

- Healthcare providers and other support services), but it also helped to ensure they could be connected to others and to make contact with someone if they needed help.
- Support with transport. One client noted that he had been given a bus pass, which not only enabled him to attend medical appointments, it also gave him an opportunity to be somewhere warm during the winter, to charge his phone, and to feel less vulnerable as other travellers perceived him to be going somewhere with a purpose.

It should be noted that the broad support available from the local #HealthNow partner has not been limited to direct healthcare support, with clients identifying advocacy support that facilitated longer term health improvements. For example, for one client there was a letter of support written to courts to help support their housing situation and prevent further deterioration in mental health. For another client, it involved advocating with a college to help ensure their needs could be managed within a particular training course, which could help them with their mental health and support their longer-term wellbeing and self-sufficiency through to potential employment.

Helping to tackle loneliness and isolation

Clients often reported that as a result of the support they had received to engage in new activities, they had extended their network and made new friends. In some cases, these activities mainly provided an opportunity to keep busy and to rebuild confidence, while in other cases people had formed very close friendships with people they could start to rely on during difficult times.

Where clients had gone on to become volunteers with #HealthNow, they counted the staff and other volunteers as among their good friends. One client mentioned that prior to this they didn't have an emergency contact that they could give to health services. However, as a result of being an HHPA client and then going on to work as a Peer Researcher with #HealthNow, they had forged a friendship strong enough to have someone to name. Not only do these friendships support immediate wellbeing improvements, these networks also help build an individual's resilience against future crises.

Clients also talked about being happier with their life as a result of HHPA support. While we did not seek to quantify changes in life satisfaction as part of this evaluation (such as through the use of the ONS4 measures), existing research suggests that a 1-point increase in life satisfaction measured using the ONS4 question can have significant monetary value across the system (£14,170).

There were also several examples where people we interviewed described lower levels of anxiety and/or depression. These improvements can generate considerable social value (£36,766 per person per annum for relief from anxiety or depression).

The mechanisms of change

Building trust and positive relationships

One of the key factors, identified by a number of clients, is that they have been able to build trust and positive relationships with the people who have supported them. Many clients identified that they don't trust people easily, and the fact that the peers are able to relate directly to their experiences is important. However, beyond the peers, clients reported that others who have worked with them as part of #HealthNow have been consistently reliable and seem to go above and beyond for them.

As well as feeling supported by these relationships, clients also said that they felt a responsibility towards the person supporting them. It made them feel more inclined to stick to the commitments they had made because, if they didn't, they would be letting themselves down and the people supporting them. One client described it as:

> *"Keeping people on the straight and narrow for their health regardless of what they are struggling with."*
>
> *HHPA client*

The theme of keeping people on track was reinforced by many clients, albeit in different ways. The importance of feeling a responsibility towards the people who had given their time, energy and enthusiasm to provide support is a strong motivator for trying to overcome less positive patterns of behaviour, and to take care of themselves and look after their health.

All the clients involved in the research spoke highly of the passion and commitment of the people who worked with them. In many cases this had involved a significant commitment from paid staff, as well as the volunteer Peer Advocates, and it is clear that their role and being readily available was incredibly important to clients.

> *"Just, like really lovely and passionate about it, like really care about it, you know?"*
>
> *HHPA client*

Clients reported feeling supported by staff and volunteer Peer Advocates, who were passionate about them and didn't judge, either when the client first came into contact with the service or when they had a slip and were unable to meet the commitments they had made.

Sustaining the impact

Helping to create a sense of purpose

Given that some of the mechanisms of change relate strongly to relationships built between staff, volunteers and clients, and on the financial support clients receive, it naturally raises the question of whether the impact can be sustainable without the input of the service. The nature of the clients' situations means that they frequently encounter crisis events, even after periods of stability. Finances may become stretched or living situations may break down. However, this evaluation has shown that there are many aspects of HHPA support that may help to lead to more sustained changes and health improvements for clients.

Many of the clients who took part in this research reported that, as they were able to achieve a more stable living environment and improvements in their health, they had been able to begin to undertake other activities. While some had moved into employment or volunteering, including as part of #HealthNow or with other Crisis or Shelter services, others had got involved in other meaningful activities.

This included getting a dog, which helped with establishing a daily routine (taking the dog for a walk each day and generally caring for it), going on a woodwork course, and taking part in a training course. These activities helped to provide a purpose and focus for individuals and gave them a sense of purpose and a meaningful activity. There was some evidence that this led to feelings of greater resilience.

> *"Yeah, so I guess the … structure [and] purpose that was really good to gain from it. It sounded as well, like, the longer I was with Shelter, there was like a potential, like career progression in some way. Because they told me basically, as well, that a lot of the volunteers that started quite a few of them actually ended up working for them, which was quite promising."*
>
> *Peer volunteer*

Techniques for self-support

Another factor that supports longer term sustainability of the benefits from HHPA support relates to the coaching, and the associated tools and methods that clients learn and develop. For example, one client talked about how much she appreciated learning how to make better use of her appointments by writing down a bullet point list in advance. The client had found this approach particularly useful and talked extensively about how this had informed how she dealt with other things in her life. Similarly, clients reported techniques that meant that they were better placed to engage in positive health-related behaviours, such as asking a smart speaker (like 'Alexa' or 'Siri') to remind them about appointments, and texting themselves bus routes.

One client we spoke to, who had moved away from one of the HHPA areas and was therefore no longer receiving support, reported that despite his journey now being a lot more complicated and taking several hours, he had been able to maintain his three-weekly hospital appointments and had not missed any since moving. He had previously struggled to work out his route to hospital using public transport when living in the #HealthNow catchment area.

One client was also supported to be properly diagnosed and treated for a sleeping disorder, which had made a huge difference to their life, and which would last beyond their HPPA support.

> *"because I recently got the machine as well which was life changing because I'd slept for more than two hours in about two years."*
>
> *HHPA client*

Feeling more able to talk about past experiences also helped clients to be more resilient to future challenges. One client spoke about how they were now able to talk openly with others about their mental health issues, which helped with her anxiety and meant that she was more likely to reach out for support if things were becoming difficult for her. She is now also doing yoga on a regular basis, and is involved in other holistic therapies, and she has learnt to look after herself more and to be more compassionate towards others.

A holistic approach to health and wellbeing

There is some evidence from this research that the holistic approach to health and wellbeing offered by HHPA supports longer term stability. Many clients talked about how they had been considering what the future might hold for them.

> *"I'm thinking what I have to do…I might want to look at working for a charity myself in the future because of the great work that I can see they do… for many of us. I want to get back to doing my yoga on a regular basis which I hadn't been able to do for some time."*
>
> *HHPA client*
>
> *"We're looking at a forward plan. Obviously, the health issues [is getting more in control], so now need to think about what it is I would actually like to do as opposed to the firefighting that I've been doing."*
>
> *HHPA client*

They have also started to lead healthier lifestyles which support longer term health improvements. For example:

> *"I've got a smoking coach who rings me up every two weeks and I've cut down…. So I'm more positive."*
>
> *HHPA client*

Finally, as clients have been signposted to appropriate services that they were not aware of, or would not have felt able to approach, they have access to other support that is more tailored to their needs. This includes financial support which is a key driver of stability for this client group.

2.2. #HealthNow's impacts on peer volunteers

In total, across all three areas, #HealthNow trained 99 people with experience of homelessness as Peer Advocates. The Groundswell research team also trained 19 volunteers in research methods and interview techniques, and they went on to conduct the three local peer research studies and a thematic study about mental health. Seven volunteers were (re)trained in Year 4 and conducted aspects of this evaluation.

There are active HHPA and similar volunteers elsewhere in the UK (e.g. the London HHPA service, the Bevan Healthcare Smart Healthcare Inclusion Peers (SHIPs)), but these are not included in the scope of this evaluation.

2.2.1. Embedding lived experience

Belonging and purpose

Due to its central focus on participation, building positive working relationships between volunteers and paid staff was essential to all aspects of #HealthNow. Many volunteers spoke about feeling part of a team, fully integrated into the delivery of both HHPA and peer research.

> *"Even though I know that I am not a paid member of staff – I am only a volunteer – I feel like I am part of the team, and I genuinely do feel like I am part of the team. I don't feel like it's like separated, the volunteers and work staff. I think everyone works as a team."*
>
> *Peer volunteer*

This created a strong sense of belonging, in which volunteers spoke of a family feeling in their local Shelter or Crisis service. Volunteers often mentioned mutual support and celebration of each other's achievements.
Much of this feeling of connectedness depended on being present together in a physical space and was reduced when access to the office was restricted, such as during pandemic lockdowns. HHPA advocates, who in many cases worked in the same team for several years, volunteered in irregular patterns throughout the week and therefore rarely had the chance to see each other. A problem for some was a lack of structured opportunities to connect and cement team spirit under these circumstances.

Being part of the wider local and national #HealthNow community brought about yet greater feelings of belonging and purpose. Volunteers told us that even relationships with staff and other volunteers that were formed though online meetings felt vital, significant and familial. More than that though, this belonging transformed into a strong sense of meaning and purpose for some of the more active volunteers.

> *"I describe myself as a sort of a social campaigner – a social campaigner, to change the system, to make it more accessible for people who are experiencing homelessness […] so it sort of becomes like a vocation. So it's a whole lifestyle I think […] because you're always sort of answering people's tweets or tweeting to people to see what's going on around the country, or getting invited to different steering groups or training or to deliver training, or make films or just to go to conferences. So it becomes like a really big part. If somebody ask me what I do for a living, I don't say I'm on the sick, I say I work to try to help people who are experiencing homelessness."*
>
> *Peer volunteer*

Because most meetings were online, however, this benefit was not experienced by all volunteers; Peer Researchers were represented in the Peer Network far more than Peer Advocates, perhaps due to a difference in skills and interests between these groups. A 2022 in-person event for all national peers was extremely well attended and generated very positive feedback from attendees (see section 2.5.1).

Feeling trusted and valued

The sense of being part of a team depended on #HealthNow's approach to volunteer support; lived experience was essential to all aspects of the project, and this was frequently fully understood and appreciated by volunteers. Over time – and it often did take time – volunteers acknowledged that they were no less valuable team members than paid staff, a perception that translated to attitudes towards their place in society.

> *"They sort of treat you as an equal, and I think when you've been homeless or lived in a hostel or sofa surfing, you always feel like a second or third-class citizen, and you feel people just look down at you and nobody really cares what you say or what you do or if you live or die. And now you've got these sort of people who are obviously very well educated, good jobs, sort of going, 'well actually we are all equal'. And it takes a long time to get through your head like you're sort of like equal to everybody else in society, but when you do, it's like wow, you know what? Actually yeah, I am, right, I am."*
>
> *Peer volunteer*

This was talked about by volunteers working on HHPA and peer research, who both used lived experience to ask questions and find answers that staff with only learned experience would have been unable to. Often, the trust and responsibilities that were given to volunteers were what made them feel valued.

> *"After the last volunteer coordinator had left, I was like given the lead on drop ins and doing a bit of letting the other volunteers shadow me and I felt quite important."*
>
> *Peer volunteer*

In turn, this feeling of being trusted had a huge impact on volunteers' confidence. When they were invited by Local Coordinators to speak at conferences or to senior members of other organisations, this was often perceived as evidence of their worth.

> *"So I think one of the biggest successes is if I talk to volunteers and I ask them this question, 'what's #HealthNow given you?', they will talk about the development of confidence, competence, resilience, the ability to do things that they have never done before. You know … participating in an online meeting, give their thoughts and opinions about what's going on, to then talking to other people who have got experience of the health system and being able then to represent the views of not just themselves but other people as well. And I think that gives them confidence and quite a stable platform to work on."*
>
> *Partner organisation staff member*

Progression and personal development

Groundswell's model of flexible, person-led Progression support is designed to provide support to volunteers to address the barriers that get in the way of their volunteering activity and further progression towards their goals. An internal evaluation conducted for Groundswell by NEF (2022) has already provided good evidence that this support creates a range of positive impacts, including:

- Building confidence and trust
- Helping volunteers create realistic expectations for their lives
- Supported volunteers to attend medical appointments and to learn skills to manage their health and healthcare needs
- Improved volunteers' self-confidence, self-esteem and strengthened resilience
- Helped volunteers attain educational and vocational qualifications, as well as training in skills relating to job applications.
- Helped volunteers access legal support to resolve employment, citizenship and family issues.
- Helped volunteers build financial confidence.
- Supported volunteers with housing, including support with getting tenancies and resolving housing-related issues.

We spoke to a few former volunteers who are now in full-time employment, but most peers we spoke to were still volunteering with #HealthNow. While some didn't feel ready for paid work, others saw the programme as a positive route of progression towards employment.

> *"There is opportunities going forward with doing this because of the people that we work alongside and the people that we've connected with, like for example, the hospitals and stuff, they've decided that they wanted to – some of them have hired staff from the #HealthNow team to join their hospital and work there permanently. There's a lot of options for progression here, as well as for me. It's helping me to start my own business of being a child advocate. There's definitely chances for progression with this."*
>
> *Peer volunteer*

> *"I think, yeah, even with #HealthNow coming to an end, I think just all of the different avenues and different interconnectedness that I have been introduced to shows me that there are other options, and the world is wider than I could have imagined before."*
>
> *Peer volunteer*

> *"I think I have more understanding of what roles I am better defined for, and what I am not better defined for. And I think volunteering to #HealthNow, that's really helped with that because I've seen other examples of types of roles that I could, like, go for."*
>
> *Peer volunteer*

#HealthNow staff welcomed the uniqueness and flexibility of the volunteering roles available through #HealthNow, with some noting that they felt that the Peer Advocate role particularly helped ready volunteers for employment within the sector.

> *"The opportunity is so close to real life, realistic, professional support work experience I've said that over and over again. [It] is one of the biggest successes of the project – the model has a much healthier relationship with risk and volunteer responsibility, but it's that freedom that has made our volunteers really successful and then getting into paid work."*
>
> *Partner organisation staff member*

Several volunteers progressed into meaningful and relevant full and part-time employment positions as well as other paid roles; two volunteers in Newcastle, for instance, have worked as paid consultants with the NHS to support local and national inclusion health work. Many made other important advances towards their progression goals, which were often, but not necessarily career-focused. In Birmingham during #HealthNow's third year, for instance, 92% of volunteers had carried out actions towards their goals, with three attending college and several other completing various training courses around subjects from substance use to interpretation. Another had left #HealthNow to study for a PhD. Across all the areas, 20 volunteers per year were trained in encouraging vaccination uptake through the Royal Society for Public Health. There were a number of factors that limited the number of volunteers moving directly into employment during the course of the project; some were unable to work for health reasons or because they were ineligible to work in the UK.

> *"We haven't had many that have gone directly into employment in Birmingham but I think that is often because of immigration status. So actually like a really significant proportion of volunteers, like at the moment it's definitely more than 50 and it might be like 80% of our volunteers, are going through the asylum system or don't have the right to work in the UK. Some of them actually – just in the last few months – have got status so that's amazing and I'm sure they'll move into employment longer term, but I think one of the reasons why we haven't had that high turnover of volunteers either, we have got a core group that I recruited in the first HHPA recruitment that's still with us. All of the ones that are still with us had been going through the asylum or immigration application, so but they've done lots of other training – college courses and things like that."*
>
> *Partner organisation staff member*

In Greater Manchester, volunteer progression was closely tied to Shelter's GROW (Getting Real Opportunities of Work) traineeship programme. In #HealthNow's third year, three of Greater Manchester's six volunteers progressing directly into employment did so on this programme. Since the GROW scheme tailors paid work opportunities exclusively for people who have experienced homelessness, it provided inspiration and encouragement for #HealthNow volunteers and a clear progression pathway. When fewer placements were available in the later stages of #HealthNow, however, this resulted in a decrease in progression into employment. Nonetheless, over the course of the 4-year project, 22 volunteers from Greater Manchester were involved on the project for a period of 3 months or more. Of these 22, 14 gained paid employment, three entered into education or training programmes and two gained settled refugee status.

> *"One of the key components in moving forward whilst in recovery is a sense of structure and purpose, and during my time volunteering for Shelter I have most definitely been given that in abundance."*
>
> *Peer volunteer*

All of the respondents to a volunteer survey in Birmingham in early 2023 had said that their involvement with #HealthNow had improved their confidence. We were interested in whether this was universal across all areas and, if so, which aspects of #HealthNow had made the most difference. We heard most often that it was the interactive, social aspects of working on the project that made the most difference in boosting confidence. For many volunteers, this was what made the most difference in making them feel more ready for employment.

"I just think it's been a really good experience and I think it's really prepared me for jobs in the future and helped me grow my confidence more than anything and allowed me to mingle."

Peer volunteer

"I feel like it's – I've grown from it. I feel like it's given me a lot more confidence, because I suffer with social anxiety and I feel like I'm coming out of that now. And it's quite easy for me to talk to people now."

Peer volunteer

Many volunteers had opportunities for public speaking, something most told us would have been prohibitively intimidating before their experience of volunteering.

"I always used to have false confidence. You put on the mask, you drink a can, and that's it; you can do anything, but now I've got real confidence. I stood up in front of a hundred people in the Methodist hall in town and presented our findings from the research, and my knees were going but I managed to do it."

Peer volunteer

Confidence also often came from gaining a sense of meaning and purpose, often for the first time in volunteers' lives. This sense of purpose was acquired in several ways. While numerous volunteers told us that wanting to "give something back" was the biggest motivation for beginning their journey with #HealthNow, most had previously felt unable to articulate what that would look like. Although they had often felt fully aware that their own lived experience meant that they could "pass on their knowledge to help people", it wasn't until they had gained more experience volunteering that the full effects of this began to become clear. One way in which volunteers were able to use their own experience to find purpose was in the outcomes that Peer Advocates were able to achieve for their clients. One told us about the pride she felt after supporting a client to have cataracts removed. The ability to view personal experiences not as a barrier but as an advantage was consistent for volunteers across each of the #HealthNow activities.

"For me, it was just a case of I wanted to meet new people and learn new things. I didn't know I was going to be so passionate about it and actually love doing it, and it's actually made me feel better about the situations that I've gone through and the experiences that I've had in my life whilst being homeless. It's – what's the word? It's given me a satisfactory type feeling of knowing that I can actually make a difference in this world and that's something I've always wanted to do. I just didn't know how. I didn't know how to find it, but it found me."

Peer volunteer

More than just a way to make a difference to individuals' lives though, volunteers who were involved in local alliances and the Peer Network had begun to find pride and confidence in being part of a wider movement fighting for positive change.

"The fact that I have met so many people like yourselves in Pathway, in Groundswell, in Crisis, and even people from Manchester Shelter […] has boosted both my self-esteem and also it's increased my trust to know that there is a community of people out there that want to make change and improve things."

Peer volunteer

It is also worth noting, as described in section 2.1.2. above, publicly available data provided by the HACT UK Social Value Bank show these activities create social value (or wellbeing value, i.e. the monetary value associated with uplifts in wellbeing they create), to the value of:

- Regular volunteering - £3,249 per year
- Employment training - £807 per year
- Full Time employment - £14,433 per year
- Part Time employment - £1,229 per year

While this evaluation did not set out to calculate the value generated by #HealthNow volunteers, across more than 100 individuals this is undoubtedly significant.

Challenges

While Local Coordinators all felt that volunteers had made exceptional progress over the course of the project, they had struggled to monitor any outcomes against progression goals. While this was partly due to a lack of tools for structuring measurement, it also reflected the intangibility of much of volunteers' progression. Some long-term volunteers, for example, had greatly developed in confidence and skills but were unable or not ready to progress into work for health reasons. How this progression had been supported had not been documented, often because it was the result of multiple informal conversations with coordinators. Supporting progression without existing dedicated management systems was also a challenge. Crisis had a volunteer management IT system developed for this purpose, bringing documents such as certificates of training into one place for each volunteer.

Finally, we acknowledge that, while a largely online, remote volunteering opportunity can increase accessibility for some, others will have been prevented from participating fully. Furthermore, lack of support for translation or real time interpreting will have prevented peers who cannot communicate fluently in English will not have been able to get involved. The high cost of language support services is a significant barrier to full participation, one that recurs across many homelessness services, research and evaluation.

2.2.2. Reducing health inequalities for people experiencing homelessness

Many Peer Advocates told us that their volunteering experiences had resulted in improvements to their mental and physical health. Partly, this was due to participating in meaningful, social activities. One volunteer told us that she had stopped getting migraines since being involved with #HealthNow and her vision had improved as a result. Wellbeing support was offered to all volunteers, varying slightly across areas, from coaching and psychological support to mindfulness sessions. Volunteers told us that they valued the way their wellbeing was supported and monitored. One, for example, said that learning yoga on these days had made her disability easier to manage.

Volunteers' health was also improved because of their increased knowledge of – and confidence in – accessing health services for themselves. This came about through increased confidence in accessing health services and through gaining a greater understanding of rights to healthcare and disability support.

> *"When I first heard about #HealthNow, it piqued my interest because I myself was going through homelessness and I was struggling to get help with all my medical stuff, for example, getting my diagnosis sorted and sorting out my kids at the same time, and I really struggled with it. And then once this came about, it opened up a whole new world of information that I could use to make things easier for myself and my kids."*
>
> *Peer volunteer*

We also heard how volunteer wellbeing was improved through a sense and belonging and through sharing purpose with volunteers and staff across #HealthNow's network. In some cases, this change was experienced as profound and life-changing.

> *"It's a family. It's a part of that family who wanted to grow bigger and have those and tell each other like you are not alone; you're doing the best and excellent job to make changes […] It's a feeling like you put in a dead body alive, like you resuscitated. You are dying. You just pump the heart; it comes back like your heart started working. Or in other way, you may say you made a candle and you join another candle […] and the flame become the most – illumination everywhere. The darkness has gone. I feel like that, and that's my true feeling."*
>
> *Peer volunteer*

2.3. #HealthNow's impacts on partner organisations

2.3.1. Embedding lived experience

Coordinators from both Crisis and Shelter felt that #HealthNow had enabled them to better value lived experience and to further integrate it into how they worked. One Local Coordinator told us that his organisation had already been transitioning towards a more coproduced model for various aspects of their work for some time, but that #HealthNow had demonstrated the extent to which coproducing requires adequate resourcing and planning; lived experience is only meaningful and useful when volunteers' participation and progression is adequately supported, through meeting pastoral needs, ensuring they have the equipment to do their jobs, and by providing the opportunity to work alongside staff as equals. Working in partnership on a project as large and diverse as #HealthNow has been an important learning experience for partners and will influence how they integrate participation into future work.

> *"Our new strategy - we're launching it in the new year - will be underwritten with a different level of confidence in what genuine peer-led approaches and coproduction are because of this. We've got somewhere to go now to tap into. When you're bold and you do things differently, what does it look like? […] I'm very confident that the fact that we've been part of [#HealthNow] means that we will change as an organisation in ways that will only improve us."*
>
> *Matt Downie, Crisis CEO*

Stakeholders from across all three areas told us that they had benefitted from working together as equals with people with experience of homelessness. Furthermore, they explained that they had come to appreciate that, in many circumstances, the expertise of people with lived experience can surpass that of professionals without lived experience.

One Local Coordinator reflected that embedding lived experience roles alongside more traditional support staff resulted in a much-welcomed reconsideration of power dynamics, and of what good support should look like. But this created challenges in how best to support the volunteers. While he found the external training he had received to do this enjoyable and useful, he felt that supporting people with skills that sometimes surpassed his own had brought challenges it had not prepared him for, perhaps reflecting a lack of consideration in professional training for work within a coproduction paradigm.

> *"I am very, very used to being the senior engagement worker or project coordinator, who knows more about support work and then I deliver that downwards, right? Which means it's more comfortable; you're able to support those individuals. But in #HealthNow it's the exact opposite, where the peers are way better at advocacy work than I am. Because they haven't had to unlearn anything, they take to it really naturally. They're like, "oh of course you'd never tell your client what to do", and so the fact that their dynamic is then that they know much more than me, it can sometimes be quite difficult to then support them."*
>
> *Partner organisation staff member*

#HealthNow's peer research was another opportunity to learn more about effective coproduction, and how peer involvement adds value to a project. The research was codesigned, co-delivered and collaboratively analysed and disseminated. One Local Coordinator was already familiar with coproduction methods but felt that this approach demonstrated, more than other participatory projects he had worked on, that people with lived experience of homelessness have more to give than their personal stories.

> *"The value of that research is […] not just the value to people who read that report. The fact that so much of that was conducted by peers I think is really empowering for staff members to see that actually volunteers can have a way bigger remit […] So I think having pieces where essentially we democratise research is a really important, but I also I think for the peers as well."*
>
> *Partner organisation staff member*

For organisations as large as Crisis and Shelter, the flexibility required to adapt policies to suit new ways of working came with challenges. Local Coordinators often found that their organisations' policies were at odds with the requirements of #HealthNow's peer-led model, especially in terms of managing risk. This could lead to being in an uneasy position of having to choose between compromising on the project's participatory ways of working and challenging organisation-wide policies. But, in some cases, this led to positive changes. Coordinators in all areas told us about changes in their attitudes towards risk and trust that could affect future ways of working throughout Crisis and Shelter's future work.

> *"One of the biggest successes of the project is that there is a really – and I think this comes from Groundswell more than it does from Shelter – is that the model has a much healthier relationship with risk and volunteer responsibility than what we have had traditionally at bigger organisations like Shelter. Don't know what it's like for Crisis. But it's that freedom that has made our volunteers really successful and then getting into paid work."*
>
> *Partner organisation staff member*

Sometimes this extension of trust meant adjustments to a volunteer expenses policy, but some examples were further reaching. Mindful of challenges faced by, for example, volunteers who are seeking asylum, one Local Coordinator trialled an alternative to the DBS system, involving references and risk assessments. People who would otherwise have been unable to volunteer became successful Peer Advocates.

#HealthNow volunteers from Greater Manchester consulted with Shelter's central volunteering team and advocated for changes to volunteering policies and processes. Three #HealthNow volunteers took part in a lived experience workshop aimed at breaking down barriers for volunteering within Shelter. As a result of this workshop, Shelter's volunteering policies governing petty cash usage and reimbursements were revised in line with the input from the group. Shelter have also developed a Volunteer Council, on which two #HealthNow Peers now sit, which will meet every quarter to discuss volunteering policy and systems change within Shelter.

2.3.2. Reducing health inequalities for people experiencing homelessness

For Crisis especially, #HealthNow has helped to reinforce perceptions across the organisation about the importance of focusing on addressing health inequalities. Coordinators at both organisations felt that the integration of lived experience was invaluable in getting this message across.

> *"I think that [#HealthNow has] really helped put health and homelessness on the map. I know that it's become more and more of a priority for Crisis, and having this project and having the research and also knowing that peer advocacy is evidence based – being able to evaluate that and show the outcomes – I think really helps show all levels across our organisations how important health and homelessness is, as well as the peer support side of things."*
>
> *Partner organisation staff member*

2.4. #HealthNow's local impacts in Birmingham, Greater Manchester and Newcastle

2.4.1. Embedding lived experience

Volunteers and stakeholders spoke often of the importance of embedding as much as possible of what they had learned about lived experience participation in multiple ways across their local areas. One former volunteer told us that she had taken the knowledge and experience gained through #HealthNow to introduce coproduction methods to the local homelessness charity she now works for.

> *"They didn't know what coproduction was, so my first part of my job was telling homeless workers what coproduction – how you coproduce […] And I've had free reign to build up the experts by experience group, and they believe in what I am saying. I've only got that through the learning that I got there."*
>
> *Peer volunteer*

Coproduction was already starting to gain traction in the three areas. For example, in Greater Manchester, the wider system had made good progress in this area. #HealthNow, however, responded to a gap in this work as it related specifically to health and homelessness, and helped embed lived experience into pre-existing networks.

> *"I suppose the alliance work is to feed into the forums that already existed. Thinking about the Manchester task and finish group. They had been meeting for a really long time, they have been really focussed on topics, there had been some sort of lived experience outside of those meetings. But one of the things that #HealthNow was able to support with was actually supporting people with lived experience to be involved in those meetings and networks. They have also had the opportunity to lead and codesign and co-deliver loads of workshops focussing on things like GP registration, out of hospital care. So I think that has been really useful. So I would say they are maybe not – not increasing awareness raising, but increasing lived experience involvement and elevating homelessness and health because of that."*
>
> *Groundswell staff member*

A top priority for using lived experience to work towards reducing health inequalities was to ensure that lived experience of homelessness was recognised and valued within the NHS. We heard in all the areas that health services were often surprised that this could sometimes be relatively straightforward.

> *"I have been working […] less than ten years and like eight of those years – 80% of my entire professional career – has been working alongside people with lived experience, and I forget that that's like a new concept for people. So you go to the NHS and you have a peer that's like with you in that meeting, contributing, that's got lived experience and people are like bowled over that the person can speak in coherent sentences. And I think there's a real lot of judgement and stigma. And they like have a voice of their own, and they're like actually, 'you are doing that wrong or I think that could be really helpful', or, 'can you just explain that in a way that a normal person can understand it, not like at a commissioners' level?' But that like blows people away how easy that level of involvement is, and you don't have to hold their hand and manage them through the door all the time, because I think people have that – they see the value of lived experience."*
>
> *Partner organisation staff member*

Despite the receptiveness of individuals to valuing lived experience, the complexity of the NHS was sometimes seen as a barrier to effectively and meaningfully embedding lived experience of homelessness into health services. Stakeholders saw a lack of established relationships between health services and third sector organisations as a problem that #HealthNow had made progress in overcoming, but they still viewed integrating the voices of people with experience of homelessness into whole NHS systems as a challenge. We were told of concerns that senior health professionals were sometimes unlikely to take volunteers with lived experience seriously in health alliance meetings, perhaps being more likely to "big them up in the meeting about their bravery", than to view them as partners of equal status, suggesting that there is still some way to go in changing NHS culture.

Ground-up approaches were seen as having significant initial successes in promoting lived experience as a means of overcoming these challenges. In Birmingham, #HealthNow volunteers devised and coproduced a 'Health Champions' initiative to deliver training for local NHS staff on working with patients experiencing homelessness. As this training developed, hospital staff learned to adapt to working alongside trainers with lived experience of homelessness, doing so in an increasingly trauma-informed way.

> *"I have learned a lot about – because it's actually quite a big deal for peers to talk about their experiences. It can mean reliving trauma […] The psychologist here has been incredible support from that point of view, and so we've now got a really firm system of preparation. We put everything in writing; we discuss the issues. We're going to talk about what's likely to come up. We've a prep session beforehand where we discuss what we're comfortable with coming up, and we've actually taken much more control of what we're going to do in the sessions. It's no longer freeform; it's very controlled. And then I always follow up afterwards to make sure if there are any issues, because initially it had a slightly sort of misgiving at the heart of it, in that people will just – sometimes quite raw. So that was a big thing to understand I think, and make sure that were controlling the agenda. And I feel like we're much more in control of that now. So that's a big thing."*
>
> *#HealthNow volunteer*

2.4.2. Reducing health inequalities for people experiencing homelessness

Creating quality evidence

One of the clearest ways in which #HealthNow has influenced the process of reducing health inequalities in each of the areas has been to demonstrate the simplicity of the barriers that people experiencing homelessness face in accessing healthcare. Our peer research found that barriers such as transport costs, digital exclusion and challenges with prioritising healthcare above more immediate needs were common reasons why people experiencing homelessness were unable to attend appointments. HHPA has shown to health services that the adjustments needed to help remove those barriers can in some cases be small ones.

> *"The reason why they can't go is it's either too much effort to get there, it's too expensive, or they just can't get there altogether. If you actually give it to them on a platter as it were, remove that barrier, they will engage with your health services, which is think is amazing […] We're not kind of sitting down with each of our clients spending one hour 45 doing an in-depth behavioural psychotherapy session on [what] health needs they want addressed […] I think that's been quite shocking for some health care practitioners that the bar is really low to help those individuals."*
>
> *Partner organisation staff member*
>
> *"I was at the NHS conference yesterday. And the chief exec Mark Fisher for NHS Greater Manchester […] said that he feels that sometimes the NHS has a tendency to over-medicalise problems which it sees at its front door, in its GPs and primary care services. And I thought that was exactly what we've been saying over the past two or three years. Loads of the problems that our clients are facing are not clinical problems at all […] and the way to solve those is not through a medical or a clinical approach. Its practical, its emotional, its motivational, its access. It's not the fact that you – they aren't having enough doctors' appointments and therefore you need to get more doctors, it's the fact that they're not [attending] doctors' appointments so you need to make more inclusive services. And I think that's been a huge change in Manchester. I like to think #HealthNow has contributed to that."*
>
> *Partner organisation staff member*

In each area, Groundswell convened and trained a team of Peer Researchers who conducted a local study into health inequalities for people experiencing homelessness. A fourth report was later produced in another area: West Yorkshire. The Groundswell team also conducted two extensive literature reviews, and a thematic research study about mental health and homelessness.

> *"I've spoken to so many inspirational people this week. This research is a powerful tool: the more we do, the louder we become because we have more voices behind us".*
>
> *Peer Researcher in Birmingham*

Across the three #HealthNow area studied Peer Researchers interviewed 164 people with experience of homelessness about their experiences of accessing healthcare (51 in Greater Manchester, 49 in Newcastle and 64

in Birmingham). These interviews formed the basis for area-specific reports on understanding homeless health inequality locally, all published in 2021. These reports have been cited widely in local publications.

Having been trained and gained experience conducting research, the Newcastle #HealthNow Peer Researchers identified a gap in knowledge locally. They decided to undertake further research about healthcare inequality for people experiencing homelessness during and transitioning from prison. Subsequently, they attracted funding to host a launch event, attended by over 40 individuals from across local authority, probation, prisons and healthcare. Different participatory approaches were used during the event to engage people in change. The peers also created a short film, which is both witty and hard-hitting, to illustrate their findings.

Raising awareness of health inequalities

Our stakeholder survey asked *'One of #HealthNow's aims has been to increase awareness of health inequalities for people experiencing homelessness. How much impact do you think #HealthNow has had in doing this?'* All respondents answered positively, all but one answering that #HealthNow had made 'a significant impact'. Stakeholders were asked for examples to explain their answers. The excellence of volunteers and the insights gained by hearing from their perspectives were the most frequently cited in response to this. Social media campaigns and the peer research were also mentioned.

From our stakeholder interviews, we heard that the ongoing presence and perceived success of the HHPA programme had made a huge difference to raising the profile of #HealthNow. In Greater Manchester, the large number of services finding cause to refer into HHPA meant that its value was well-known; the breadth of work being done by advocates was highlighting the number of barriers faced by people experiencing homelessness.

> *"I think we've been quite successful […] in terms of awareness. I think that's a very different thing to influence, and then like systems change […] so much of the service delivery contributes to that. But like having kind of like open referral system for self-referrals, but also agency referrals […] lots of organisations in those key statutory health sectors. So Greater Manchester mental health trust, community mental health trust. Greater Manchester health and mental health and homelessness team, adult social workers, housing options officers: all of those people – and that doesn't even scratch like your NHS frontline practitioners – know that the #HealthNow project exists."*
>
> *Partner organisation staff member*

In Newcastle, #HealthNow raised awareness of health inequalities at the local authority.

> *"We have also been round the table with Collaborative Newcastle operational group, so for Newcastle Active Inclusion that was to include the underlying principles of #HealthNow about developing equity in health systems, getting people to engage in health and improving the health of homeless people, and do that with a range of different mechanisms but also recognising that financial and housing security can directly impact on people's health. So actually, those two things do have an impact on health. So the local authority listened to #HealthNow if they've not listened to Crisis, so for me that would be a particular success."*
>
> *Partner organisation staff member*

Perhaps even more importantly, #HealthNow has helped NHS staff to better understand health inequalities. One way in which this happened was by educating health practitioners about the prevalence of homelessness.

One NHS stakeholder in Birmingham told us that, through staff meeting volunteers in person, the peer-led training programme had helped to challenge assumptions and prejudices about people experiencing homelessness, demonstrating that more patients than they realised were homeless.

> *"Coming from my background in the NHS, I realise how little we know. And we should know but we don't. And one of the comments yesterday that was really interesting was that someone started the training saying, 'we're in a practice with no homeless people', and then when they saw the kind of iceberg, they – at the end they said, 'well, we're going to go and look,' and they went and looked on their system and there were loads of people in temporary accommodation, so it's a big message to get out there."*
>
> *#HealthNow volunteer*

That they had been successful in challenging assumptions was also noticed by the volunteers delivering the training. One told us that, "it makes them see things differently and see homeless people in a different light, not just by the stereotypical ways." It may not be possible to measure the eventual impact of this training on reducing health inequalities, but our findings suggest that the impact on local NHS culture has been substantial. Interviews with stakeholders and volunteers, as well as feedback from the training sessions, point to an increased awareness of the difficulties experienced by people who are homeless within the targeted health services. But the aspect of the training that perhaps made the greatest impression was that it was delivered by people who had themselves been homeless. Health workers were able to understand the barriers to accessing good quality healthcare through by firsthand from the people who experienced them.

In Birmingham, Peer Advocates delivered training on homelessness and hostels for care co-ordinators employed by GPs. The care co-ordinators subsequently contacted local hostels to better understand residents' needs.

In a feedback survey for training delivered in Birmingham between October 2021 and June 2023, 63 people responded to a question 'will the training change your practice?': 62 people said 'yes', and the other was already aware and practising what had been shared.

A training video made for NHS staff by volunteers in Birmingham had a similar impact.

> *"We made a video. When we were talking to some of the students or some of the workers within city hospital, you would see that there was a little bit of ignorance when it comes to homeless people or people with complex needs. There was this resentment that they're not part of the community – just dismissive – but we have actually changed that mindset even from the grassroots like the nurses. So we actually had a meeting with the new student nurses and we could see that, okay, these new students are picking up and all was positive but it was because of that video and that lectures like the team were involved with Dr [name removed] going around spreading that message so people actually took it on board."*
>
> *Peer volunteer*
>
> *"Actually there is loads of potential to use recorded experience, because it's still very powerful […] I've delivered training sessions but using the peer recording, and the feedback still is that it's the peers' voice that's made the difference. It's still very powerful […] and that's something I think is worth exploring."*
>
> *#HealthNow volunteer*

Working together (local alliances and action plans)

Evidence produced by the first-year peer research was used in many ways to raise awareness and to seek new ways of collaborating with local health services to enact change based on the barriers and issues the research had identified. Newcastle's research, combined with the fostering of a relationship with a local GP practice, led to the development of the GP and harm minimisation service – an inclusion health service.

"We get it because the relationship is – how much they thought of the Peer Advocates when they were working there, the discussion that led to with us. And then that idea of running something around inclusion health, bringing harm minimisation, testing doubt, evaluating and going to health to talk about it. Although it doesn't happen at Crisis anymore, it's now happening in Newcastle. But it isn't GP services, but it's all the other stuff that sits around it. So a lot of nursing, diagnostic, wound work, harm minimisation, referrals into a range of secondary services. So actually it's there, it's happening in different areas across Newcastle. Theres four different times that it happens in a week. And that's all come out of a discussion that happened because of peers going into a particular GP service."

Partner organisation staff member

The action plans that were developed from the peer research sometimes addressed issues that required further collaboration within the NHS.

"One of the things we noticed from the action plan was that it was raised that people who are experiencing homelessness don't feel like they can make complaints because they're worried it will affect their treatment […] And I was really upset to think this is the issue, so we decided it would be useful to train our peers in the complaints processes, and we got Healthwatch to come and we got PALS [Patient Advice and Liaison Service] to come from the local trust. And I did a little bit about our complaints process just to explain how it worked. And they talked to the peers and we have done that twice now, when we got new peers. And that has been really great actually, so we've tried to build a link Healthwatch. But the PALS person who came to talk to us is now moved to another trust. And he came back and said our trust is rubbish at dealing with this, we want to develop it and now – it's a big hospital he's working for in, which deals with a lot of homeless people. So he's come back and we've been and done some training for his ED nurses and now we are going to make a training package for them and he is really engaged, so we're getting people involved."

#HealthNow volunteer

In Newcastle, work with the local Alliance resulted in several positive changes, such as:

- Work with the local health Trust secured a trial of a harm minimisation service for people experiencing homelessness, situated within a homelessness service, to understand if it would lead to more referrals to substance use services (Appx 2 Oct 22). The Crisis HHPA service was integrated with the offer, providing support to access treatment and attend appointments.
- Regular Hepatitis C testing facilities and incentives were made available at Crisis Skylight.
- As a result of links made through the local Alliance, palliative care teams delivered training and a 'death cafe' for people who wished to develop an offer for people experiencing homelessness.
- Piloted GP drop in at Crisis Skylight to demonstrate patient engagement in familiar surroundings, and this informed the commissioning of an outreach GP service.
- A relationship with the Community Dental team allowed referrals for people experiencing homelessness to be made directly to the service, bypassing the usual expectation around GP or other medical service referral.

Birmingham's research found that paramedics were highly regarded by people experiencing homelessness. The Alliance used this finding to work with paramedic services and local accommodation providers to pilot a collaborative scheme to take advantage of this.

"I guess with the Alliance so – we've piloted a few things. There was a paramedic pilot – I think that was in year two – where it was basically built into our local action plan because, in the first year's piece of peer research, we found that paramedics were really highly rated by people experiencing homelessness. And so we took it to the Alliance and basically came up with this pilot that a couple of paramedics would go into a local hostel – it might have gone on for a couple of months, two or three months – and do a drop-in there. And Peer Advocates would go along with them and then support with any follow up that might be needed. And that worked really well. And it was something that we were exploring ongoing funding for, a few different kind of people and agencies were looking at getting funding for that. And it hasn't materialised but that's a good example of that joint working."

Partner organisation staff member

In Birmingham, work supporting a local dentistry working group resulted in several positive changes, including improved access to interpreters, an updated advice sheet for people on low incomes, work to widen access to mobile dental units, attendance at the inclusive dentistry steering group, and recommissioning of the dental weekend access scheme.

Collaborations were initiated at many other levels, with varying degrees of formal structure. Peer in-reach sessions were organised, for example, at a local homeless daycentre. Many of #HealthNow's achievements in creating local change were informal, brought about through discrete actions by individual volunteers. Several Peer Advocates gave examples of issues they had identified when supporting clients, which they either resolved directly with healthcare staff or fed back to the Alliance which, in turn, raised them with the health services.

> *"We managed to help one of our clients who was like – he had some leg sores and they had infection and used to go and treat it at City Hospital and they were neglecting him because of the smell. And we raised that issue with them and within a couple of weeks […] we raised it at […] the meetings at the alliance. We raised that issue and they took it onboard, and within a couple of weeks, they come and saw me with [the Peer Coordinator]. They had a sit down with us. They promised that they're going to solve it and went back there for a lecturer and everything was just changed and solved. So I can say that #HealthNow made a big impact, so I can't complain, man."*
>
> *Peer volunteer*

Through the links created by alliances with local authorities and other services, #HealthNow has also been able to influence initiatives that address health inequalities in creative and innovative ways outside of health services. Crucial to these initiatives were the Peer Advocates who were able to identify problems through their work that had not been clear to others.

> *"Some of the things that I suggested – for example, having a system where homeless women can get access to sanitary products – and then a few months after we spoke about it and they said that something was going to be done about it. I seen them pop up in public toilets in the train station, so if you go to Birmingham New Street, or any of the train stations here, you'll see in the toilets there's a little box on that machine on the wall that dispenses towels and tampons for free. You can take as many as you need and it gets replenished every day. That's good."*
>
> *Peer volunteer*

Throughout our interviews, we heard other examples of how building relationships with individuals working within health services and other agencies was often highly effective in bringing about positive change. A perceived overdependence on building these individual relationships, however, meant that barriers arose when well-placed, motivated people were not identified. Stakeholders in Birmingham, for instance, felt that they had been unable to find a contact in mental health services in a position to address the challenges highlighted in their action plan. Newcastle's Local Coordinator felt that, while the development of relationships with health services was an important success locally, #HealthNow's influence was still limited due to a lack of relationships between partner organisations and ICSs at a senior, strategic level.

More generally, a #HealthNow volunteer we spoke to suggested that the very structure of the NHS was one of the greatest challenges in influencing change across whole systems.

> *"The other challenge – and I understand it completely – is the NHS. Primary care particularly is a massive, fragmented organisation […] You have to be quite innovative to get in there, because you have got – practices actually function as individual units and not all of them are going to engage. It's easier in secondary care. And we're exploring some of that at the moment, because trusts tend to have much more managerial structure."*
>
> *#HealthNow volunteer*

2.5. #HealthNow's national impacts

#HealthNow began delivery in September 2019, six months before the first national COVID-19 related lockdowns were announced. When the pandemic began, the national #HealthNow Alliance was well placed to respond. In the years since, #HealthNow has established infrastructure that has promoted and enabled people with lived experience of homelessness to participate in national discussion and decision making about inclusion health.

2.5.1. Embedding lived experience

National Peer Network

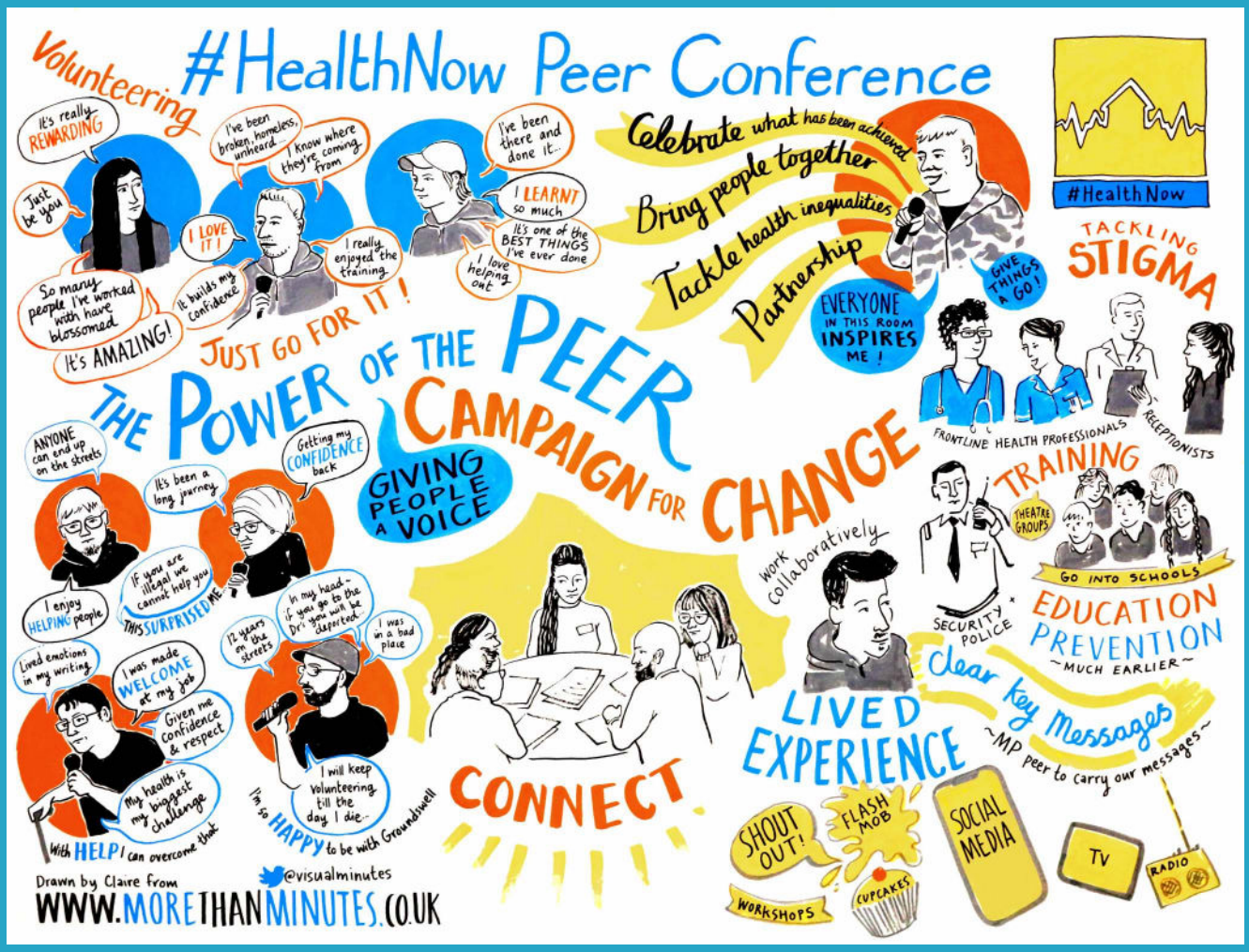
The national Peer Network was fundamental to the impact that #HealthNow achieved on a national scale. Established early in the life of #HealthNow, the Peer Network brough together peer volunteers from the three #HealthNow areas and beyond, with a wide range of perspectives gained through lived experience and their volunteering role. The Network allowed the group to learn about, explore and contribute to policy discussion on a wide range of topics, and to communicate directly with national decision makers. Our Peer Network continues to meet each month to discuss and input into topics of relevance or interest to peers.

As well as meeting regularly online, once the disruption caused by COVID-19 had lessened, it was possible to hold a national in-person event for peers from the #HealthNow areas and beyond. Around 33 peers travelled to the one-day event in Birmingham, along with staff from all three partner organisations and others. Feedback from attendees indicated that people had appreciated the chance to:

- hear about the positive impact of their involvement
- share knowledge between different areas of the country and projects
- shape the day itself, both by being part of the planning process and by leading sections of the agenda on the day.

A blog about the event by the Peer Network Coordinator, and the visual minutes recorded on the day (below), tell the story of a positive and supportive event that attendees enjoyed.

> *"I wasn't going to come, but I'm proud I'm here. I'm here, and I've done it, and it's been very good. Lovely day."*
>
> *Peer volunteer*



One of the most impactful activities the Peer Network undertook was contributing to the development of the NICE guideline 214: Integrated Healthcare for People Experiencing Homelessness (2022). This guideline provides the blueprint for all health and care services so that they are better able to meet people's health needs. Most significantly, the guideline contains a whole section on 'the role of peers', which extols the value of involving people with lived experience of homelessness in all aspects of health and social care design and delivery. While the guideline is still relatively new, and the success of its implementation is yet to be evaluated, the inclusion of so much detail about peer involvement is positive.

During the development of the guideline, the NICE advisory committee identified the need for a targeted engagement exercise with people experiencing homelessness, in addition to the routine stakeholder consultation. To achieve this, the committee commissioned Groundswell to use a group-based method in the form of a focus group. They engaged with the #HealthNow Peer Network to generate feedback on the draft guideline, based on ten questions relating to the relevance and acceptability of the proposed recommendations. This targeted consultation enabled the committee to test the relevance, feasibility, and acceptability of the draft guideline and selected recommendations at the stakeholder consultation stage.

Fourteen peers with lived experience of homelessness participated in the focus group during the consultation period and a report was generated summarising their responses. The report was presented to the advisory committee and considered alongside other stakeholder comments that had been received during the consultation period. The advisory committee considered each point and provided a written response to each of the comments, outlining if any changes had been made to the guideline based on their feedback. The committee also provided a rationale for each of the comments that had not changed the guideline. The report and responses to the feedback formed part of the guideline documentation and were published on the NICE website.

Most of the Peer Network's feedback was acted upon, making changes to the recommendations. This included changes to the language and terminology used and the provision of services and their delivery. A NICE poster presentation to the 2022 Guidelines International Network conference in Toronto, credited the Peer Network's contribution with significant improvements to the final guideline, including:

- Changes to the language and terminology to ensure the guideline was appropriate and sensitive. For example, accepting the term 'complex needs' had negative connotations and reinforced the perception that a person is problematic, and changing it to 'severe and multiple disadvantage'
- Multiple recommendations were updated, including one that was changed to explicitly state that acronyms should be avoided, and adding one on sending reminders about appointments and following up if people do not attend.
- Adding a recommendation for future research into psychologically informed environments.
- Highlighting barriers to COVID-19 vaccine roll-out and potential barriers to this, such as difficulties registering with a GP, and signposting to resources to support roll-out to people experiencing homelessness.

Some months after the NICE guideline was released, NICE and the Centre for Homelessness Impact (CHI) published a step-by-step resource to support the implementation of the guideline aimed at commissioners and healthcare providers. That resource highlights several #HealthNow activities and wider Groundswell and partner projects as good practice and useful resources, including Homeless Health Peer Advocacy, Groundswell's extensive COVID-19 resources and Clarissa film (see section 2.5.2. below).

Furthermore, the NICE guideline is itself promoted in the government's 2022 Strategy to End Rough Sleeping, which particularly emphasises: "*People with lived experiences play a vital role in raising awareness, sharing first-hand knowledge and feedback on how the system works in practice and helps to bring human perspectives into policy-making; whilst also playing a role in building the confidence and skills of the individuals involved too.*" (p34)

While the development of the NICE guideline is the easiest impact to track, in terms of #HealthNow's national impact in embedding lived experience, other work is underway with this aim. For example, the Peer Network is currently working with UKHSA and UCLH to co design a national service model focussing on preventative healthcare and treatment of infectious diseases for people from inclusion health groups. In addition to participating in the project, members of the #HealthNow Peer Network have been recruited to form a steering group to support the design and delivery of a series of workshops to provide lived experience insight.

Other Peer Network activities have included (and are not limited to):

- Our mental health research led to an invitation to a Department of Health and Social Care (DHSC) workshop about the mental health plan for England.
- Feeding into a Department for Levelling Up, Housing and Communities (DLUHC) £28million 'protect and vaccinate' plan during the covid-19 vaccination roll out.
- Supporting the NHS to develop a new Inclusion Health Framework.
- Chairing sessions and sitting on panels at Pathway Homeless and Inclusion Health conference.
- Featuring in the film Less?, to raise awareness of issues faced by people experiencing homelessness.
- Development of Healthwatch England's strategy.
- Supporting the reference group for an NIHR-funded project with Newcastle University and Groundswell about the impact of 'Everyone In'.
- Developing resources on coping with a heatwave.

- Contributed to Improving the Health of People Living in Temporary Accommodation in London.
- Contributing to Amnesty's Health and Homelessness research, which is itself now developing into recommendations for the next government (ahead of an impending General Election). Following this, Groundswell has been commissioned by Amnesty to coproduce a lived experience homelessness manifesto that will be used to influence the major political parties in their approach to tackle homelessness as we approach the next general election. Insight from the #HealthNow research, alongside sessions with the national Peer Network, will shape this work.
- Contributing to "Bridging the Gap" – Access to primary care for people experiencing homelessness.
- Training Advisory Group and training development: Working with Groundswell's Learning and Development Manager to prioritise, codesign and support delivery of training for both internal and external professionals within the sector.
- Taking part in a number of consultations and workshops including:

  - NHS Digital, to consult on the use of accommodation codes.
  - The House of Lords Built Environment Commission, to give evidence on the impact of housing on health and how housing can impact your ability to engage with services.

National #HealthNow Alliance, Homeless Health Partners

The national #HealthNow Alliance, which came to be delivered through the network known as Homeless Health Partners, has achieved notable successes in creating opportunities for people with lived experience of homelessness to share their insight with key decision makers. For example, Homeless Health Partners provided a 'joint homelessness sector response to the call for evidence for the womens health strategy drawing on insight gathered through Groundswell and #HealthNow peer research. As a result, representatives from the alliance were invited to meet with the Rt Hon Nadine Dorries, then Minister for Patient Safety, Suicide Prevention and Mental Health, to discuss the particular issues faced by women accessing health care whilst homeless. The meeting is cited in the resulting strategy, which includes a section outlining government commitments to supporting women in Inclusion Health groups, which includes women experiencing homelessness.

> *"With a lot of [the volunteers], they have actually taken part of volunteering with Groundswell, and that's meant facilitating work with some high-level strategic thinkers in the NHS, NHS improvement etcetera, which means that then they have been able to influence at a national level. So one of the outputs from those inputs has been about the confidence and learning to do all those things and then being able to do them."*
>
> *Partner organisation staff member*

> *"We highly value Groundswell's leadership in convening the Homeless Health Partners meeting. It is an important forum for sharing information, particularly in ensuring that central Government is keeping the sector up to date, while offering the sector an opportunity to question and hold them to account. Groundswell have successfully cemented the Covid legacy of this group, while keeping it relevant and current."*
>
> Homeless Health Partners member
>
> *"The Homeless Health Partnership meetings have become an essential component of St Mungo's health approach. They have provided the opportunity to highlight emerging trends and issues whilst also allowing us to clarify and influence policy. This has been essential throughout the pandemic. No single agency or provider has been able to develop adequate responses to the multiple new priorities that have emerged over past 18 months, but in partnership we have been able to develop joint approaches that have kept people safe."*
>
> Homeless Health Partners member

In the early months of the COVID-19 pandemic, the Homeless Health Partners became a vital forum where officials could hear from VCSE service delivery colleagues, and people with lived experience, to guide their delivery of COVID-19 testing and vaccine rollout for staff and clients of homelessness services and other people experiencing homelessness. COVID-19-focussed work achieved significant impact. For example, attendees argued for the continuation of free lateral flow tests for homelessness settings to be included in the government's plan "Living with COVID-19". Discussions in the meeting on VCSE organisations' experience of working on the frontline were fed back to policy makers through DLUHC representatives, and the successful outcome will have helped ensure some of the most vulnerable people were protected. Furthermore, members of the national Peer Network had the opportunity to feed back about the use of incentives to promote vaccine uptake and their insights were shared with DLUHC, NHSE&I, DHSC and the Office for Health Improvement and Disparities (OHID).

On a more regular basis, the HHP meetings provided a conduit for insight gathered from the national Peer Network and other #HealthNow activities to feed directly into national policy consultation and development. The Homeless Health Partners monthly meetings involving the VCSE sector and government officials, have discussed an extremely diverse range of policy topics, including (but not limited to):

- GP contract reform and extension of the duty to refer relating to homelessness.
- Suicide prevention for people experiencing homelessness.
- Support to develop the Inclusion Health Framework for NHS England.
- Supporting the Office of Health Improvement and Disparities with (OHID) developing the plan to ensure implementation of the NICE guidelines.
- Recommendations for meeting the complex care needs of people experiencing homelessness based on research from St Mungo's and Transformation Partners in Health & Care.
- Supporting the launch of Homeless Link's 2022 Health Needs Audit.
- Supporting with the development of statutory guidance on the Duty to Cooperate.
- Consulting on the white paper on drug possession.
- Advising on the development of the Rough Sleeping Strategy.
- Ensuring covid tests available for all homelessness settings.
- Supporting the Office of Health Improvement and Disparities with (OHID) developing the plan to ensure implementation of the NICE guidelines.
- Contribution to creation of NHSE's Inclusion Health Strategy (2023).

The impact of #HealthNow's national activity went beyond the work delivered through the Homeless Health Partners and national Peer Network. For example, as a result of #HealthNow and connections established through the Homeless Health Partners meeting, Groundswell worked in partnership with The King's Fund and Pathway to support seven NHS Integrated Care Boards to develop their approach to supporting inclusion health populations. Groundswell championed involvement of people with lived experience in all aspects of developing and delivering services and input to inclusion health strategic activities based on the learning from #HealthNow on a local and national level. #HealthNow is included as a 'case study in excellence' in the 2023 report of the project. Furthermore, the project is cited in the new National Framework for NHS Action on Inclusion Health.

Homeless Health Consortium, Health and Wellbeing Alliance

Building on the success of the national #HealthNow activity, Groundswell, Pathway and Homeless Link established the Homeless Health Consortium (HHC), and successfully applied to join the Health and Wellbeing Alliance (HWA). This is a partnership between Voluntary, Community and Social Enterprise (VCSE) consortia and the health and care system, jointly managed and funded by DHSC, NHS England and the UK Health Security Agency (UKHSA). The HWA has provided an important conduit through which insights from #HealthNow peers, peer research, HHPA

activities and local #HealthNow alliances are represented at a national level, and contribute directly to the development of national policy. For example, the HWA has been extensively consulted by officials working on the new Major Conditions Strategy. Resources created by the HHC were recently acknowledged and promoted in the Department of Health and Social Care's recently published Suicide prevention in England: 5-year cross-sector strategy. Other activities conducted by the HHC involving #HealthNow insights include a recently published report about supporting people experiencing homelessness to access dental care.

2.5.2. Reducing health inequalities for people experiencing homelessness

It is more challenging to measure the impact achieved in terms of reducing health inequalities. Not only do these changes take longer to be realised than creating opportunities for people to participate in policy development, but it is also harder to attribute changes to specific interventions or activities. So many factors affect health inequalities, including changes to the cost of living, national government policy directions (economic and legislative), other allied interventions and developments and, of course, events like the global COVID-19 pandemic. Furthermore, there are no consistent national measures of health inequalities faced by people with experience of homelessness. We can, however, conclude that #HealthNow activities have directly contributed to activities and decisions that have improved healthcare provision for people experiencing homelessness.

Creating quality evidence

Between April and August 2020, additional funding from the National Lottery Community Fund and NHS England allowed us to amend the project so #HealthNow could conduct intensive real time insight gathering. This work produced 11 briefings containing information from 386 daily diaries, 138 telephone interviews and insights collated by 14 volunteer reporters. This COVID-19 monitoring project collected insights about health (including the impacts of COVID-19 prevention policies like social distancing, access to masks and testing and health services, and mental wellbeing), accommodation, communication and coordination, money and livelihoods, food security, and water, sanitation and hygiene. Through this work we established strong relationships with other organisations exploring the impact of COVID-19, often presenting and illustrating key findings in partnership. This research led to a joint statement of key actions in collaboration with Crisis, St Mungo's and The Strategy Unit.

From the outset of the pandemic, the #HealthNow national alliance – the Homeless Health Partners – used this live insight along with evidence from service delivery organisations to inform the national response to supporting people experiencing homelessness during the COVID-19 pandemic, with particular focus on vaccine uptake. #HealthNow peer researchers also played a key role in conducting national rapid research into people's experiences of COVID-19 vaccines and testing to better understand the barriers and enablers faced by people experiencing homelessness.

Beyond those first months of the pandemic, #HealthNow continued to generate research evidence that has had impact beyond the three areas of focus. The initial and follow up literature reviews, published in November 2020 and September 2022 have been read and used beyond the #HealthNow areas, including being cited in academic journal articles and resources aimed at clinical and administrative healthcare professionals.

The thematic research into mental health and homelessness, 'Knowing where to turn: access to mental health support whilst experiencing homelessness' has been particularly well received. It has been cited and shared widely, presented at the Pathway annual conference, and it informed the design of another charity's design for a new grant funding programme in 2023. An accompanying resource, a leaflet co-designed with national mental health charity Mind, called 'You have the right to feel OK' has been downloaded 512 times from Groundswell's website, becoming the third most downloaded resource.

Supporting the #HealthNow approach beyond Birmingham, Greater Manchester and Newcastle

In the #HealthNow areas, and in London, we have evidence that HHPA Peer Advocates and staff caseworkers help clients realise improvements in their health and access to healthcare. Our #HealthNow work has allowed us to support local organisations to develop HHPA services in Bradford and Leeds (Bevan Healthcare CIC), Cornwall (Cornwall Housing), Dublin (DePaul Ireland), Exeter (COLAB), Luton (Luton Homelessness Partnership) and Southampton (Solent NHS Trust). In 2022 Groundswell evaluated the Bevan Healthcare Smart Healthcare Inclusion Peer Advocates (SHIPs) project. The programme provided 125 mobile phones and 100 tablets to 77 patients and volunteers with experience of homelessness and/or the refugee and asylum-seeking process, in order to widen access to digital health resources. The evaluation concluded that the SHIPs programme had created positive impacts for Bevan patients, for the volunteers and for the local system. For example, interviews and focus groups with patients identified improvements in confidence, health and access to healthcare, English language skills and accommodation, and reduction in isolation. Bevan SHIPs volunteers have also been active members of the national #HealthNow Peer Network, contributing their insights to national evidence and policy development.

We have also supported other areas to adopt other aspects of the #HealthNow approach. For example, work in Wakefield has drawn on the development of local #HealthNow health inequality action plans. Groundswell supported six workshops with local stakeholders and people with lived experience of homelessness to identify and agree priority topics and to co-design solutions; an action plan has been created as a result. And in London, the London Participation Network, has been formed thanks to funding from Transformation Partners in Health and Care, based on the #HealthNow national Peer Network model. This network hosts regular meetings between stakeholders and people with lived experience from across London and is contributing insight to a range of planning and policy development. Groundswell is also supporting other Integrated Care Boards (ICBs) and NHS bodies, including in North East and Yorkshire and London, to establish inclusion health participation structures to ensure that people with lived experience of homelessness can feed into Inclusion Health Plans.

Creative and accessible communications

Throughout the four years of #HealthNow delivery, the partnership has created a wealth of creative communications outputs aimed at influencing improvements in healthcare delivery. At the time of writing, the #HealthNow newsletter has 665 subscribers, and will continue to be used to communicate recommendations and best practice guidance. Peers have also regularly contributed to blogs and other publications.

In October 2021 Groundswell launched a new film, 'Clarissa', funded by Wellcome Trust, which aims to create change through insights within the storyline of the main character, Clarissa and accompanying resources. Her story is one of trauma, the importance of trust, and how this impacts someone's experiences of healthcare. It was woven together from real experiences of people trying to access the healthcare system while facing homelessness in the UK, including through the #HealthNow areas of Newcastle, Birmingham and Greater Manchester. Clarissa was made by Chris Godwin from Inner Eye Productions in collaboration with Groundswell; screenwriter and producer Jimmy McGovern also served as a story consultant on the film. #HealthNow local areas were part of the initial research when the story was written, and local and national Alliance members were part of the panel discussions convened when the film launched. Over 650 people attended the virtual tour of the film, around a third of whom were healthcare professionals.

> *"Thank you for producing such a powerful, moving film that encapsulates the real-life stories of those individuals experiencing homelessness. It certainly gave me much food for thought and acts as further evidence of the health inequalities of this population which is something I am very passionate about and am striving to change in my Trust."*
>
> *Healthcare Practitioner, NHS Foundation Trust.*
>
> *"I am using the film in our new Pathway team's training. I think it's very useful to start conversations about engagement and what works... and helps us reflect on what we do."*
>
> *Medical professional*

Clarissa and the film's accompanying resource pack are also promoted in the November 2022 NICE/CHI step-by-step resource for implementing the joint guidance. Two years since release, the film's webpage has been viewed more than 4,500 times, and the online film has been watched more than 2,500 times.

> *"We have just launched a multi-agency training course on multiple exclusion homelessness and safeguarding – we are using the Clarissa video during the session and the feedback has been really positive."*
>
> *Local authority feedback*

Later, in 2023, the #HealthNow peers and the coordination team at Groundswell worked with GPs in London, in partnership with 'Westminster City Councils Changing Futures Programme', to create a new film, 'Top tips for GPs to support people with multiple disadvantage'. Featuring Dr Natalie Miller, a specialist homeless health GP from the Great Chapel Street Medical Centre, the nine minute-long film includes interviews with two #HealthNow peers, and outlines practical changes healthcare services can implement to become more inclusive, such as allowing people to wait outside or in a more private space than a waiting room, being flexible about the time or length or appointments, or storing medications for patients.

On a larger scale, #HealthNow's work at the beginning of the pandemic, particularly the COVID-monitoring project, helped to develop the proposal, funding application and project plan for the three-year Listen Up! project. Funded by a Comic Relief Changemakers grant, Listen Up! is a lived experience-led project, kickstarting major change towards better healthcare access and life expectancy for people facing homelessness. So far, 33 volunteer reporters have received training from our partner On Our Radar and produced 340 written reports, films and podcasts. These reports all feature on the Listen Up! Hub, which attracted over 11,500 views in 2022-23. The team has also conducted 115 research interviews and conducted webinars with 150 attendees nationally highlighting the health inequalities faced by people experiencing homelessness and codesigning solutions. Listen Up! has also designed a package of Rights Based Training to be delivered within homelessness services. The production of a podcast with Prince William and two of our volunteer reporters for Comic Relief's Red Nose Day television programme was a particular highlight, leading to significant media coverage for Listen Up! and Groundswell.

Campaigning for change

Following the publication of the thematic research report, 'Knowing where to turn: access to mental health support whilst experiencing homelessness' in 2022, the Peer Network, both online and at the November in-person event in Birmingham, chose a priority topic for campaigning activity for 2023. The Network agreed that they would like to pursue the topic of stigma, mental health and homelessness.

On a national level, we have worked consistently to feed into government policy around mental health. When the Mental Health Plan for England was subsumed into the Major Conditions Strategy, we continued to call for consideration of people experiencing homelessness. We have also sought to highlight the role of stigma in the poor mental health experiences of people experiencing homelessness working closely with a team at King's College London on a long-term project about stigma and homelessness in health settings. Members of the Peer Network and colleagues and volunteers in HHPA roles have contributed both to research and sensemaking activities. This project will be presented at the Pathway conference in 2024.

We have also sought to communicate widely how it feels to experience stigma when you are already facing homelessness and mental health issues. Many Listen Up! reports have focussed on mental health and stigma and staff and peers have written blog posts to raise awareness of the campaign.

To deliver a more public facing element of the campaign, we have co-created a leaflet highlighting the challenges of stigma and homelessness, sharing practical solutions and resources for health professionals to change behaviours and end stigma, including a set of top tips for dismantling stigma. Importantly, we want these professionals to engage with, and learn from, the many resources we have collected including peer research reports, Clarissa, the film, a Listen Up! Insight and a leaflet co-designed with the charity Mind that explains people's rights when facing both homelessness and mental health issues.

To help disseminate this, and to provide a repository for evidence and resources about stigma, mental health and homelessness, we have designed two bespoke webpages; one aimed at new campaigners and the other aimed at targets. The page for targets (i.e., the people we hope to influence) summarises the evidence we have collected and directs to resources they can use in their work to address and challenge stigma. The page for campaigners describes the actions they can take to persuade and enable others to dismantle stigma. These resources were not launched early enough for their impact to be captured by this evaluation, but we will continue to promote and evaluate them.

Challenges

While #HealthNow achieved considerable national impacts in terms of embedding lived experience, and laid important groundwork for reducing health inequalities for people experiencing homelessness, challenges at local level meant that the core teams in each of the three areas were unable to get as involved in national-level influencing as they wanted. Owing to the varying obstacles described above, including, for example, the COVID-19 pandemic and gaps in staffing and capacity, on top of a high and varied workload, local teams did not have the time to attend national meetings regularly, or to focus on creating links between local and national Alliances. This is an area that could usefully be developed in future to support the sustainability of #HealthNow's impacts.

> *"Mechanisms to ensure dialogue between local and national alliance - e.g. structural issues raised at fortnightly meetings should be shared with national alliance and action fed back. Perhaps slots at local alliances for updates for input to & feedback from national alliance meetings"*
>
> *Local staff member*

> *"The national, I didn't particularity get involved with a lot of stuff. Partly because of time and just to go back to challenges, I think this role is... There is so many different bits to it, that you are balancing so many different plates at the same time. So I always feel like I am jack of all and master of none."*
>
> *Local staff member*

3. Looking to the future

While, as this report has outlined, there have been many significant achievements over the four years of #HealthNow delivery, there have also been aspirations that were not met, for a range of reasons. The most difficult aim to achieve and, indeed, to measure, is reducing health inequalities for people experiencing homelessness at national level. The last four years have seen a global health pandemic, a stark rise in the cost of living in the UK, and increasing pressures on both the NHS and the housing market. All of these have contributed to tipping people into homelessness and have made it harder for people to access timely healthcare support.

Against this backdrop, interventions like #HealthNow may not achieve the level of impact they might have otherwise, although arguably that makes this work all the more vital.

Measuring impact on this scale and attributing it to a particular programme of work, is also challenging because external factors and actors can have such a profound effect. Furthermore, achieving change at national level takes time. There are likely to be impacts of #HealthNow that are not yet visible or measurable and, therefore, are not captured by this evaluation. For example, we sought to influence the 10-year Mental Health Plan for England, and worked extensively on a submission to the call for evidence, before that plan was cancelled and subsumed into the major conditions strategy, pushing back the timeline and expanding the focus of the work. While evidence submissions have been moved over to the new strategy, the timeline for that is elongated, and with significant upheaval in government nationally, we do not yet know when that strategy will be published.

There have also been bumps in the road. For example, the COVID-19 lockdowns and gaps in staffing and capacity meant that some delivery activities were delayed or ceased before the end of the grant period. Nonetheless, #HealthNow has achieved considerable success; for individuals experiencing homelessness, for volunteers, for partner organisations, for local systems and nationally. The #HealthNow programme has demonstrated the crucial role that strong partnership working has on achieving real impact. #HealthNow would not work effectively without the structures of Crisis and Shelter and the good relationships developed across the sector at both a local and national level.

The impact on partner charities has been transformational. Open partnership-working with integrity helped build capacity, knowledge and buy-in for methods, as well as attracting support that might not otherwise have been available, especially to smaller charities. Each partner made a vital contribution. Crisis and Shelter's local knowledge and resources made it possible to build local alliances, while Groundswell's expertise in inclusion health and peer advocacy drove both strategy and delivery.

> *"For Crisis, I think it's had and will have a lasting and profound impact on who we are as an organisation. Our strategy going forward will be, where we have services, how do we not only help people out of homelessness who happen to be our service users, or our members, as we call them, but how do we help bring down homelessness in the local area? And this is the answer. Methodologically, this is the answer."*
>
> *Matt Downie, Crisis CEO*

#HealthNow has also demonstrated that local system change can be achieved, with the right staffing levels and skillsets, and with true involvement of people with lived experience. Partners in each #HealthNow area were struck by how, through this programme of work, they were able to reach institutions they had historically struggled to engage, and to improve knowledge and practice among those system actors. Meaningful and supportive involvement of people with lived experience (as peer volunteers and staff) was fundamental to this, and feedback from local stakeholders reflected this. And there is also evidence of significant national influencing. The national Peer Network and the Homeless Health Partners network rose to prominence nationally at the beginning of the pandemic, bringing real time insight to national conversations and policy responses to the COVID-19 pandemic.

In light of the achievements that have already been made, and the lessons learned, a number of recommendations and considerations for future delivery arise from this evaluation.

3.1. Adopting the #HealthNow approach in new areas will mean…

Ensuring adequate staffing

The evaluation findings suggest that:

- Staffing capacity should be sufficient to provide resilience to shocks, meaning that knowledge and expertise is shared across staff members, enabling staff members to cover absence.
- A paid Peer Coordinator or caseworker role to support volunteers allows senior local #HeathNow coordinators to focus on more strategic work, and provides a progression opportunity for volunteers and/or former clients.
- Including administrative support in the team capacity, to ensure that all #HealthNow activities are well-run, and also to provide a progression opportunity.

Allowing flexibility and capacity to allow it to be truly peer-led

High quality coproduction takes time, resource and flexibility. At the point of setting up a #HealthNow programme of work, consideration should be given to how flexible or rigid key performance indicators are. Rigidity of design prevents peers leading the work if they are not fully involved in the design, and could stifle innovation later in delivery. Greater flexibility with regard to targets, such as setting and revising these only once peers are integrated into teams, would align with the values of #HealthNow, as well as helping to realise the value of embedding lived experience.

It is also important to acknowledge that the various aspects of #HealthNow were not always adopted in each area for the full duration of the programme, arguably demonstrating that not all aspects need to be implemented in potential new areas. However, the integration of participatory and peer-led approaches was fundamental to the impact of #HealthNow and is crucial to the successful implementation of the approach.

3.2. Continuing the good work in the current areas will mean…

Ensuring the ongoing delivery of HHPA

Across two of the existing #HealthNow areas, plans are in place to ensure the ongoing delivery of HHPA. In Greater Manchester Shelter was commissioned to deliver a Salford based HHPA model. The project was originally planned to run for twelve months from February 2023 but, subject to a successful contract variation application, Salford HHPA delivery has been extended until April 2024. A former #HealthNow volunteer has been successful in securing full time employment to support the service set up and delivery. More recently, Shelter has secured a grant to fund a Manchester based HHPA project running from October 2023 to April 2025. Shelter plans to deliver both Manchester and Salford HHPA Projects until April 2024 and assess combining the projects thereafter into a single dual-borough Homeless Health Peer Advocacy Service.

In Birmingham, Crisis were successful in securing part of the funding required to continue HHPA for an additional 18 months through local Better Care funding, which started on 1st October 2023, ensuring no gap from when the original grant finished. At the time of writing, they are recruiting volunteers to boost capacity and a support role to help with administration and assessments.

HHPA developed a positive reputation in all areas, often perceived by health and support services as innovative and effective, and there was no shortage of referrals. The drawback to this was that some services were thought to be over-reliant on HHPA or to see it replacing their own responsibilities. In many cases, the parameters of peer advocacy were misunderstood, some health professionals believing that Peer Advocates' roles were to make clients 'fall in line' with treatment, rather than to advocate for clients. Organisations delivering HHPA in future should consider how to guarantee clarity amongst commissioners and referring agencies.

Building more direct links between local and national Alliances

Groundswell, Crisis and Shelter national teams should seek opportunities to create links between local #HealthNow Alliances or staff and volunteer teams and the ongoing work at national level. This might include finding ways to facilitate attendance at regular meetings or arranging specific agenda items at relevant meetings that promote learning in both directions.

Sharing and learning with all the other areas that have adopted the approach

Now that #HeathNow as an approach, as well as aspects of its delivery, is well established in many areas, any new area adopting the approach should factor in sufficient time and capacity to engage with existing #HealthNow areas. This may include building in resource to fund those areas and services to provide support to the new area.

All new and existing #HealthNow partners should factor into budgets and plans time and resource dedicated to sharing learning across the network.

3.3. Promoting and supporting volunteering

> *"I think all the volunteers who are involved, they make #HealthNow better. And #HealthNow makes us better."*
>
> *Peer volunteer*

Volunteering can play an important role in recovery and progression. For those who are eligible to work and who expect to be well enough to work, volunteering can play a key role in progression toward employment. In both existing and new #HealthNow areas, good support for volunteers should involve:

- Creating clear, interesting and meaningful volunteering activities that span all areas of the programme.
- Ensuring all staff are given sufficient training and support to deliver excellent volunteer management. This should include the provision of consistent, appropriate and – where possible – coproduced policies and procedures to govern processes like payment of expenses.
- Balancing 'giving a lot' with 'getting a lot'. Volunteers are unpaid but should derive value from their involvement. For involvement activities, a degree of remuneration is appropriate, in line with guidelines such as those provided within the NHS. In addition, Progression support should be available to all volunteers, including clear paths to paid opportunities in the host organisation where possible.
- Fostering collaboration and peer support between volunteers, by providing informal spaces as well as formal opportunities to come together to collaborate.
- Integrating volunteers into teams alongside staff and partners, recognising that everyone has a part to play and a valuable contribution to make. This means sharing power where possible and being clear where some decisions are retained by a particular group.
- At national level, the benefits system can make it hard to navigate volunteering and does not fully recognise its value. The government should review Universal Credit in particular, to ensure that it supports volunteering opportunities that promote wellbeing, deliver social value and support wellbeing.
- Appropriate support for all volunteers, including reflective practice where appropriate to the role, taking into account the potentially long-term impacts of experiencing homelessness.

3.4. Meaningful involvement of people with lived experience of homelessness/embedding lived experience

- Organisations delivering HHPA or other #HealthNow activities should provide training and support for staff aimed at preparing them to anticipate and navigate different power dynamics than they might have been used to.
- In partnership with people with lived experience, organisations adopting a #HealthNow approach should review internal policies and procedures that might place barriers in front of former clients or volunteers who would like to take on paid roles. This should include reviewing application and selection processes, policies around employing people with experience of the criminal justice system, other HR policies (such as sickness policies or policies around drug or alcohol relapse).
- On a national level, we call on government to put the NICE guideline 214: Integrated Healthcare for People Experiencing Homelessness (2022) onto a statutory footing, requiring that health and social care organisations implement it fully. Ahead of that, we call on health and social care institutions and systems to adhere to the guidance.
- Furthermore, Integrated Care Boards (ICBs), NHS trusts and foundation trusts should implement the Working in partnership with people and communities: Statutory guidance (2022) to support them to adhere to public involvement legal duties. Government departments, ICB's, Local Authorities and Voluntary sector organisations should utilise the –national framework for NHS action on inclusion health to plan, develop and improve health services to meet the needs of people in inclusion health groups.

3.5. Data and impact measurement

Calculating the cost benefit of HHPA

Local #HealthNow coordinators reflected that the traditional support tools to support HHPA clients, such the Outcomes Star, had felt inappropriate to those relationships. Similarly, risk assessments conducted by Peer Advocates with clients had exposed a power imbalance that felt at odds with the nature and intentions of peer support. A successful solution had been for Peer Advocates to coproduce them with clients using conversation rather than relying on restrictive forms. This elicited clients' feelings about their own challenges and made them feel included in findings solutions.

However, considerations should be made to balancing this risk of collecting monitoring and client data feeling inappropriate, and the burden of capturing and recording it, against the potential value of being able to conduct more detailed cost benefit analyses about the service. If this detailed economic modelling were desirable, service providers would need to establish more extensive data collection frameworks to capture:

1. Full direct and indirect delivery costs that can be averaged out across clients for comparability between services and to allow for analysis of overall cost benefit of a service. The data captured should include both:

- Overall service costs, which can also be averaged across clients and outcomes. These include:
  - Staffing costs (salaries, on-costs, benefits and other personnel-related expenses).
  - Material costs (equipment).
  - Overhead costs (office space, utilities).
  - Costs associated with training and supporting volunteers.
- Client-specific costs, both fixed costs (share of fixed overheads, share of staff time spent with each client) and expenditure related to each particular client (such as travel costs). This would allow a more granular analysis of costs per clients, and identification of patterns. It would also allow for modelling costs for a likely population in any new delivery area.

2. Activity and impact data, which should include:

- Client information, in a standardised format, to allow for larger scale analysis than has been possible for this evaluation. Ideally, this should include information about each individual's use of public services before their involvement with HHPA.
- Outcomes (both intended and unintended) and impact data, again in a standardised format. Ideally, there would be certain data items which were captured for all clients, if large scale economic evaluation is desirable. There are externally verified scales that allow for comparable information to be collected. Which scales to use, if any, is a choice for service providers based on which they perceive to be most useful and ethical.
- Various different types of measures should be considered, including complimentary measures which could be cocreated in collaboration with peers.

If detailed analysis is desirable, the quality and comprehensiveness of the data captured must be assured. This will require buy-in from everyone involved, including clients, volunteers and staff at all levels. Importantly, it will also mean that anyone charged with collecting or inputting data must be confident and capable of doing so, and must understand the reason for collecting it and the importance of accuracy.

All the data that is collected for use in analysis (above day-to-day case management) should also be recorded in such a way that authorised individuals who need to extract it, can, and can extract it in a useable format. For the most efficient large-scale analysis, especially across services, this should be collected in largely standardised formats across services, as well as across clients.

Finally, consideration should be given to the nature of consent that is captured from clients at the start and end of their involvement with the service. Service providers should consider whether it is possible to gain consent both

for analysis of aggregated data, and permission to recontact clients for research purposes once they are no longer working with the service.

Ongoing data needs

#HealthNow areas should capture data associated with other activities. In particular, the first four years of #HealthNow involved baseline data capture (through peer research) about the nature and extent of health inequalities for people experiencing homelessness.

When #HealthNow began, the areas where it operated did not have high quality baseline information about local health inequalities for people experiencing homelessness. Filling this gap is fundamental to directing activity that can start to reduce those health inequalities, and #HealthNow achieved that across all three areas. However, without repeating those studies, it is not possible to assess, in totality, whether health inequalities have been reduced across the whole population of people experiencing homelessness. It would be harder still to discern attribution for those changes and to what extent they were caused by the #HealthNow programme. #HealthNow areas should consider repeating this exercise in order to observe what changes have occurred, if any, and to respond to changes in need.

Statutory organisations in local systems adopting a #HealthNow approach should consider what data they might already have, or need to capture, in order to measure trends in health inequalities for people experiencing homelessness over time.

3.6. The nature of charitable funding

Changing systems at scale requires significant and adequate investment, but #HealthNow shows that long-term funding, particularly that which gives staff the time and space to develop extensive partnership networks, not only creates significant change but also helps to leverage further funding.

- Funders should consider the value of long-term, secure funding that is either unrestricted or allows for project evolution.

Furthermore, #HealthNow demonstrates the enormous value of involving people with lived experience of homelessness in identifying and pursuing the solutions to homelessness. This requires significant time and expertise, to ensure the relationship is reciprocal, and to provide the scaffolding that good quality involvement requires; expenses, progression opportunities and support staff time.

- Funders that wish to support lived experience involvement should move beyond short term funding only for innovative projects and consider providing more unrestricted, long-term funding that is flexible enough to allow peers to identify objectives and the project to evolve over time.

Ultimately, coproduced projects delivered in partnership with people with lived experience of homelessness achieve the greatest impact when there is enough flexibility built in to allow for creativity, testing, learning and adaptation.

This report was written by the Groundswell team with significant contributions from

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