

Evaluation of Homeless Health Peer Advocacy service in Newcastle

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March 2022

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Contents

Part 1: Introduction.....	3
Background and context.....	3
Aim of this evaluation.....	4
Data sources.....	4
Part 2: Insights.....	5
What work are Homeless Health Peer Advocates doing?.....	5
What difference is the HHPA work having on clients?.....	5
What difference is the HHPA work having on peer advocates?.....	6
Part 3: How does peer advocacy address homeless health inequalities in Newcastle?.....	8
Registering with a GP practice.....	8
Accessing primary and secondary care.....	9
Difficulties with clear and consistent communication.....	9
Staff continuity affecting rapport.....	10
Financial barriers to accessing healthcare (travel costs, phone credit).....	10
Experiences of stigma and lack of awareness.....	10
Part 4: Challenges and recommendations.....	12
Adjustments to HHPA service delivery.....	12
Routine monitoring of activities and outcomes.....	12
Recording goals and outcomes.....	12
Categorising case notes.....	13
Integrating with other services.....	13
Appendices.....	19
Appendix 1: Case notes analysis methods and background.....	19
Appendix 2: Client survey methods and background.....	21
Appendix 3: Peer advocate survey methods and background.....	22

Tables and Figures

Table 1: Frequency of peer advocacy actions

Table 2: Improvement in health-related areas as a result of HHPA service (clients' perspective)

Figure 1: Outcomes from HHPA service (client survey)

Figure 2: Effectiveness of HHPA service (peer advocates' perspective)

Figure 3: Age groups of clients in case notes analysis

Figure 4: Frequency of number of actions per client

Part 1: Introduction

Background and context

The Homeless Health Peer Advocacy service in Newcastle is delivered by Crisis UK from the Crisis Skylight in Newcastle since June 2021.

People with lived experience of homelessness are trained up to be peer advocates around homeless health. Their role is to support and advocate on behalf of people whose own homelessness or precarious housing, and health issues exacerbated or brought on by their living situation, creates barriers to accessing health services.

The peer advocacy service is part of the local delivery of the UK-wide [#HealthNow initiative](#) coordinated by Groundswell, aiming to work towards an inclusive health system where everyone has access to the health care they need; ultimately moving people out of homelessness. [Peer research](#) by #HealthNow in early 2021 explored the issues surrounding homeless health inequalities in Newcastle: the extent of the problem locally; the services people experiencing homelessness find hardest to access; and the barriers preventing them from using the services they are entitled to. It is built upon a wide evidence base around homeless health inequalities and around the value of lived experience and peer support for people experiencing homelessness. The research concluded that people experiencing homelessness in Newcastle faced barriers to receiving a good quality healthcare service, which included: difficulties with registering for and accessing services; poor communication with/from services; healthcare staff (dis)continuity; stigma; and financial barriers to getting and preventing healthcare.

The Homeless Health Peer Advocacy (HHPA) service is designed to help alleviate the challenges these people face. In addition, the Homeless Health peer advocates (HHPAs) themselves may benefit from the role, by seeing the value of their own lived experience in supporting others, and by getting experience which helps them progress in their own lives and meet personal goals.

The #HealthNow Coordinator reports on the number of HHPA clients who receive interventions from peer advocates against targets to Groundswell. However, it is not clear how, and how far, the HHPA service addresses the local challenges identified in the peer research report. This evaluation aims to address these knowledge gaps.

Aim of this evaluation

A light-touch evaluation into the HHPA service was carried out by the Evaluation team at Crisis UK. The aim of this evaluation was to provide evidence-based insights into:

1. The type of work the peer advocates are carrying out
2. What barriers to health services are being covered by the HHPA work
3. What difference this service makes for the people accessing the peer support
4. What difference this service makes for peer advocates

The evaluation has explored in detail the HHPA work over a six-month period; and complementing this analysis with perceptions from the peer advocates and clients who were involved during this period.

To analyse the role peer advocacy can play in reducing homeless health inequality, the findings from this evaluation will be held up against the key issues drawn from the peer research in Newcastle.

Data sources

Outcome-level indicators of 'success' of the HHPA service are not currently being routinely collected and recorded. For the purposes of this evaluation, existing data on peer advocate interventions ('actions') was drawn on, alongside additional data collection activities to gather information about outcomes for clients and peer advocates.

The data sources consisted of:

1. Case notes of HHPA clients (N=53) recorded between 1st June and 30th November 2021. Notes for each action was coded by HealthNow Coordinator into some action types (see Appendix 1).
2. Online survey for peer advocates (N=9) who were active during this six-month period
3. Online survey for HHPA clients who were receiving the service during this six-month period (N=14, six of which were closed cases). To address potential digital inclusion issues, the survey was completed over the phone by either the #HealthNow Coordinator, or the Peer Researchers working out of Crisis Skylight Newcastle.

For more information about the data collection methods, see Appendices.

Part 2: Insights

What work are Homeless Health Peer Advocates doing?

Table 1 in the appendix shows the types of activities peer advocates do to support people. For the analysis, these different sorts of peer advocate work are called 'actions'. The actions have been categorised under the following headings:

- Supporting attendance to appointments
- ~~Communicating with health services~~
- Primary care registration
- Information and referrals
- Practical and emotional support
- Supporting people to give feedback.

According to the analysis of the case notes:

- The most common type of support is 'check-in, confidence-building, emotional support' - 22% of all 'actions' were this sort of work.
- Also highly frequent are supporting clients to attend health-related appointments: attending a health-related appointment with the client; supporting the client to travel to them, and supporting the client to get them booked. 45 clients (83%) had support from peer advocates in one of these at least once.
- Peer advocates provide an average of 11 'actions' per clients within the date range, ranging from 1 (14 clients had one single action to their name) to 37 (one outlying client).¹

What difference is the HHPA work having on clients?

According to the responses in our client survey:

- 100% of clients who completed the survey stated they had had a 'very positive' experience of working with a peer advocate
- Clients reported a wide range of positive outcomes from the HHPA service (see Figure 1); in particular:
 - Receiving treatment the client couldn't access before (100% of clients)

¹The number of actions, or the frequency of a type of action, is not an indication of the amount of time spent resolving a task or request. Additionally, some single actions may take substantially more time than others.

- Moving closer to achieving health goals (86%)
- Being able to talk openly about health needs and concerns (79%)²
- 93% of clients believed their health had improved as a result of HHPA support
- 100% would 'definitely' recommend the HHPA service to friends or family
- Clients were asked their specific reasons for wanting a peer advocate. 100% of the time, clients reported that these specific barriers had improved for them (see Table 2). Also, some clients reported improvements in areas that had not been a main reason for wanting a peer advocate
- Peer advocates had helped clients most with:
 - Communicating with health services
 - Accessing a new health service or support organisation
 - Booking and preparing for health appointments (see Table 2)

What difference is the HHPA work having on peer advocates?

According to the responses in our peer advocate survey:

- The most frequently-cited reasons for **wanting to be a Peer Advocate** were for 'training and employment opportunities', and for 'improving advocacy skills'; eight of the nine responders (89%) selected these as a motivation.
- 100% of peer advocates reported having had a positive experience in the role (8 of 9 stated 'very positive')
- 100% of peer advocates believe the HHPA service is being run effectively by:
 - Being clear about their role as a peer advocate
 - Being clear about what steps they need to take to support their clients
 - Understanding the clients' health needs and barriers
 - Using own lived experience to help with peer advocacy work (see Figure 2)
- 100% of peer advocates believe:

² An anecdotal observation by the HealthNow Coordinator was that clients were responding more neutrally to the questions above because they were answering 'not yet', and we hypothesised that these clients might be new to the service and so there had not been much time to make a difference. Follow-up analysis revealed a faint relationship between agreement to the questions above and time spent on as a peer advocacy client: the longer ago a client's case had been opened, the more strongly they agreed with the above statements. Clients whose cases were open were no more strongly in agreement than those with closed cases – this suggests that a case can be closed for positive reasons (reaching health goals; self-sufficiency) or negative reasons (lost contact; terminating peer-mentee relationship).

- Their own training or employment prospects have improved
 - Their confidence has improved
 - They are making a difference to clients' health (see Figure 2)
 - Peer advocates suggested the following areas of improvement:
 - Text reminders to peer advocates for upcoming appointments with clients
 - A more diverse group of peer advocates in terms of language and culture
 - Increase GP awareness of HHPA through more conversations with GP practices
-

Part 3: How does peer advocacy address homeless health inequalities in Newcastle?

The Homeless Health Peer Advocacy service was set up to directly address, on a case-by-case basis, the barriers to healthcare faced by people experiencing homelessness in Newcastle.

The HHPA service is being offered as one of a suite of initiatives, and cannot address correct all the barriers of people experiencing homelessness face when accessing health services. However, the peer advocacy model (especially embedded in a wider homelessness service), has strengths and qualities that can go some way to reducing these barriers.

The report identified that the predominant challenges in Newcastle were:

- Registering with a GP practice
- Accessing primary/secondary care
- Accessing mental health services
- Difficulties with clear and consistent communication
- Staff continuity affecting rapport
- Financial barriers to accessing healthcare (travel costs, phone credit)
- Experiences of stigma and lack of awareness

Registering with a GP practice

According to the HHPA case notes, HHPAs supported with 12 registrations with a GP. This is in proportion to the peer research, which found that their participants were generally registered with a GP already (81% of participants, compared with 91% of the wider population). In addition, this may be low because the GP registrations are often a first intervention for HPPAs, so many clients may have been registered before the six-month sample this evaluation focused on.

"I was refused registration due to my immigration status but the advocate helped me to get registered and helped my wife too"

Accessing primary and secondary care

HHPA work involved a lot of activity supporting people experiencing homelessness to attend healthcare appointments, which had been identified as a common challenge through the peer research (for practical or emotional reasons). A large proportion of the HPPAs' work was around getting appointments booked, reminding clients of upcoming appointments, helping them travelling to them, and often accompanying the client, making the process for the client easier at each stage.

"The advocate has been really helpful in supporting me to get to appointments and speaking to medical professionals and to remind me about appointments which I sometimes forget. "

"I don't go to appointments if I have to go on my own as I [don't] feel safe going there myself... If I didn't have someone to help me then I wouldn't go. Even though I've still missed some appointments, my Advocate still comes to mine and doesn't put me under pressure if I'm having a bad day and reorganises it".

Difficulties with clear and consistent communication

The work that HHPAs do to address access issues includes supporting communication with health care services (particularly primary care and pharmacy – see Table 1). The content of this communication varies widely, but the HHPAs evidently function as a 'conduit' between client and healthcare provider in order for clients to get access to the support they need. This had been identified as a particularly pressing issue for the client group in the peer research.

They also have a role in helping clients understand the healthcare service they are receiving and their options regarding treatment. Their actions included providing information to the client about their options, and ensuring that a healthcare service provides interpreters for the client.

"Getting in touch with GP when things don't work out, for example when they get a prescription wrong the advocate usually manages to sort this out better than when I try."

"For me it was the ability to verbalise it and putting it down in writing so I knew what I wanted to tell the GP. And then getting an appointment and the letter the

advocate sent explained what I wanted. We then went through the checklist and answered each of the points I wanted to talk about”.

Staff (dis)continuity affecting rapport

HHPAs cannot themselves influence staff continuity in healthcare settings. However, the underlying consistency, trust and familiarity that healthcare staff changeover can undermine is something that the HHPA service itself provides.

HHPAs recording many actions of checking in and providing emotional support to clients – in fact, this element of the HHPA work was embedded in the rest of their remit, featuring in most of the work they did directly with clients. This was clearly the essence of peer advocacy.

Clients described the value of the relational and friendly quality of the advocate-client relationship, which itself will have a positive for clients, especially if their emotional health is suffering, and exacerbated by their housing situation and healthcare needs:

“The relationship with the advocate has been key, they have been there with me along the hospital journey, they are like family to me as I don't have any support, also they have been through similar things as me so I feel like I can trust them”

“When... I talk about my problems, [peer advocate] keeps offering help, I always feel like there is someone who cares about [me]”.

Financial barriers to accessing healthcare (travel costs, phone credit)

A less dominant part of the HHPA work is to alleviate the financial barriers that force clients to not receive the services they are entitled to. They provided basic items to clients who were at risk of not accessing healthcare, and covered the costs of travel to appointments.

“I have someone to take me to and from appointments as my mobility is poor and I can't afford taxis”

Experiences of stigma and lack of awareness

The lived experience of peer advocates may help them recognise where a client is facing stigma from healthcare providers. While the case notes coding categories did not capture this, it is reasonable to suspect that stigma and prejudice is being challenged by the HHPA

when communicating with healthcare staff and challenging registration refusals. The clients spoke of how their peer advocates had helped them in the face of discrimination:

"I was in a pretty bad place and my GP wasn't listening to me about my problems. My advocate came with me to appointments and helped me to explain things; the GP treated me differently because the advocate was in the room; they referred me to another service and for some tests, I'd been trying to make that happen for a while."

"I also really like that the advocate sticks up for you; I was in prison so sometimes the GP looks 'down' on me, but having everything put down in writing and having someone to back it up makes them change the way they treat me".

The client survey revealed the prospect of a sustainable, longer-term impact of the peer advocacy support on its clients, helping them go on to access healthcare independently, being more confident and more familiar with their entitlements and the standards they should expect:

"I felt like I had some control over what was happening; from this I built my confidence in dealing with my own support. I don't need help anymore as I feel confident now with health professionals"

"People who have difficulty don't have to worry about their health, they have support to help them, it gives the confidence to do stuff for themselves".

Part 4: Challenges and recommendations

Adjustments to HHPA service delivery

Feedback from clients and peer advocates were compiled and are summarised below:

1. Ensure that all Lead Workers in Crisis Skylight Newcastle are aware of the service and know how to and refer members into it
2. Revisit the communication and awareness-raising strategy for this service, and consider ways to widen the reach externally (with particular emphasis on GP practices)
3. Introduce text reminders to peer advocates for upcoming appointments
4. Recruit a peer advocates who are more diverse in terms of language and culture
5. Widen the 'outreach' offer of HHPA service

Routine monitoring of activities and outcomes

This evaluation has produced promising findings into Peer Advocacy's effectiveness in reducing the barriers to healthcare people experiencing homelessness face in Newcastle.

However, it required a substantial amount of time and resource on top of business-as-usual to produce the appropriate data, because the existing data was not fit for purpose.

Changes to the running of the data side of the project could allow for more routine and straightforward feedback on effectiveness going forward.

Recommendation: #HealthNow Coordinators work with Crisis' Evaluation team and the Corporate Planning, Governance & Assurance team to develop a monitoring plan that would integrate with current systems (e.g. MAPS) and result in evaluative data being quick and easy to access by #HealthNow Coordinators themselves.

Recording goals and outcomes

Case notes are recorded in a spreadsheet and managed by the #HealthNow Coordinator. The actual desired health-related outcome for each client is not routinely or formally recorded in these spreadsheets, which means that it is not possible to use routine records to identify whether the peer advocacy service has been 'successful'. As such, this evaluation made assumptions about case notes (e.g. a GP registration, or helping to raise a complaint) was something that the client wanted to achieve.

It was not possible to know how many clients were *not* attaining their goals from the case notes. It is not known whether, for example, the single case of a peer advocate supporting a client to raise a complaint was because only one client wanted to raise a complaint, or because many others had wanted to but had not been supported to by the peer advocate.

It would be valuable for specific health-related needs (a longer and more comprehensive list than that on the referral form) to be gathered at the start of the advocate-client relationship and revisited at the end (with mid-point revisits to see if the needs have changed), and this information to be integrated into client records on monitoring systems, so that it is simple to compare progress against baseline goals.

Recommendation: #HealthNow Coordinators work towards developing a procedure for recording clients' health-related goals and revisiting them.

Categorising case notes

Case notes were a series of open-ended text boxes that could not be used for quantitative analysis. The case notes were categorised by the #HealthNow Coordinator for the purposes of this evaluation, in order to generate this data, using pre-existing categories of peer advocate 'actions' from the specification for the HHPA database (currently in development).

Through interpretation consultations between the evaluator and the Coordinator, it became clear that the pre-existing 'actions' were not exhaustive, and did not accurately reflect the range of work the HPPAs had been doing. Post-hoc adjustments to the coding scheme were made, but due to time and capacity constraints the validity of the codes, and the findings in the final analysis, must be interpreted with caution.

Recommendation: #HealthNow Coordinators revisit their actions list and consider regular 'revalidation' of the action categories in their upcoming database, allowing for actions to be added, combined or divided so that they most accurately reflect the real work of the peer advocates.

Integrating with other services

It was not possible to assess how much the position of the HPPAs as *embedded* within a wider homelessness organisation made a difference to the effectiveness of the service they provided.

While the casenotes analysis provided some evidence of joint working with Crisis Skylight Newcastle (in the code 'referred to Crisis for support'), it did little justice to the anecdotal evidence of collaboration between peer advocates and Skylight lead workers, and the working towards shared aims.

Some additional analysis into HHPA clients who were also members of Crisis was run for this evaluation to address the issue of outcomes (see above), by exploring whether health-related member outcomes recorded routinely by Skylights could be associated with their participation in the HHPA service. However, this analysis yielded no meaningful results, due to gaps in data (particularly to too few prompt reviews of Outcomes Star scores).

The work of the peer advocates in drawing on, and linking up with, other homelessness service offers, is not being evidenced by existing monitoring processes. Given that Crisis' service model is one of holistic support to end people's homelessness sustainably, it is critical that consideration is given to how health-related peer advocacy can be evidenced as a step along the journey of ending homelessness

Recommendation: #HealthNow Coordinators work with relevant Skylight staff and 'Ways of Working' team to discuss making adaptations to existing (and future) monitoring practices and tools to ensure that the work of the HHPA does in collaboration with Crisis Skylight Newcastle can be recorded.

Table 1: Frequency of peer advocacy actions		
Supporting attendance at appointments		
Accompanied to appointment	98	
Appointment reminder	16	
Encouraged to attend appointment	1	
Appointment booked	86	
Support with travel to appointment	89	
Hospital visit	6	
Appointment reorganised	3	
Communication with health services		
Supported communication with primary care service	49	
Supported communication with hospital	1	
Supported communication with mental health team	7	
Supported communication with drug and alcohol service	2	
Updated contact details with health service	2	
Advocated for interpretation needs	4	
Support with pharmacy	21	
Support with HC2 certificate	0	
Primary care registration		
Registered with GP	12	
Registered with dentist	5	
Registered with an optician	3	
Admin support with GP registration	0	
Challenged registration refusal	2	
Information and referrals		
Referred to external service	3	
Provided information about options	16	
Referred into Crisis for support	8	
Other practical and emotional support		
Check-ins, confidence-building, emotional support	128	
Digital inclusion	0	
Support with benefits	1	
Form-filling	1	
Provided basic items	7	
Supported with wellbeing engagement	6	
Feedback and complaints		
Supported to give feedback	0	
Supported to raise complaint	1	
NB. Interquartile ranges:		
0-2 = 25 th percentile	3-16 = 50 th percentile	17-128 = 75 th percentile

Figure 1: Outcomes from HHPA service (client survey)

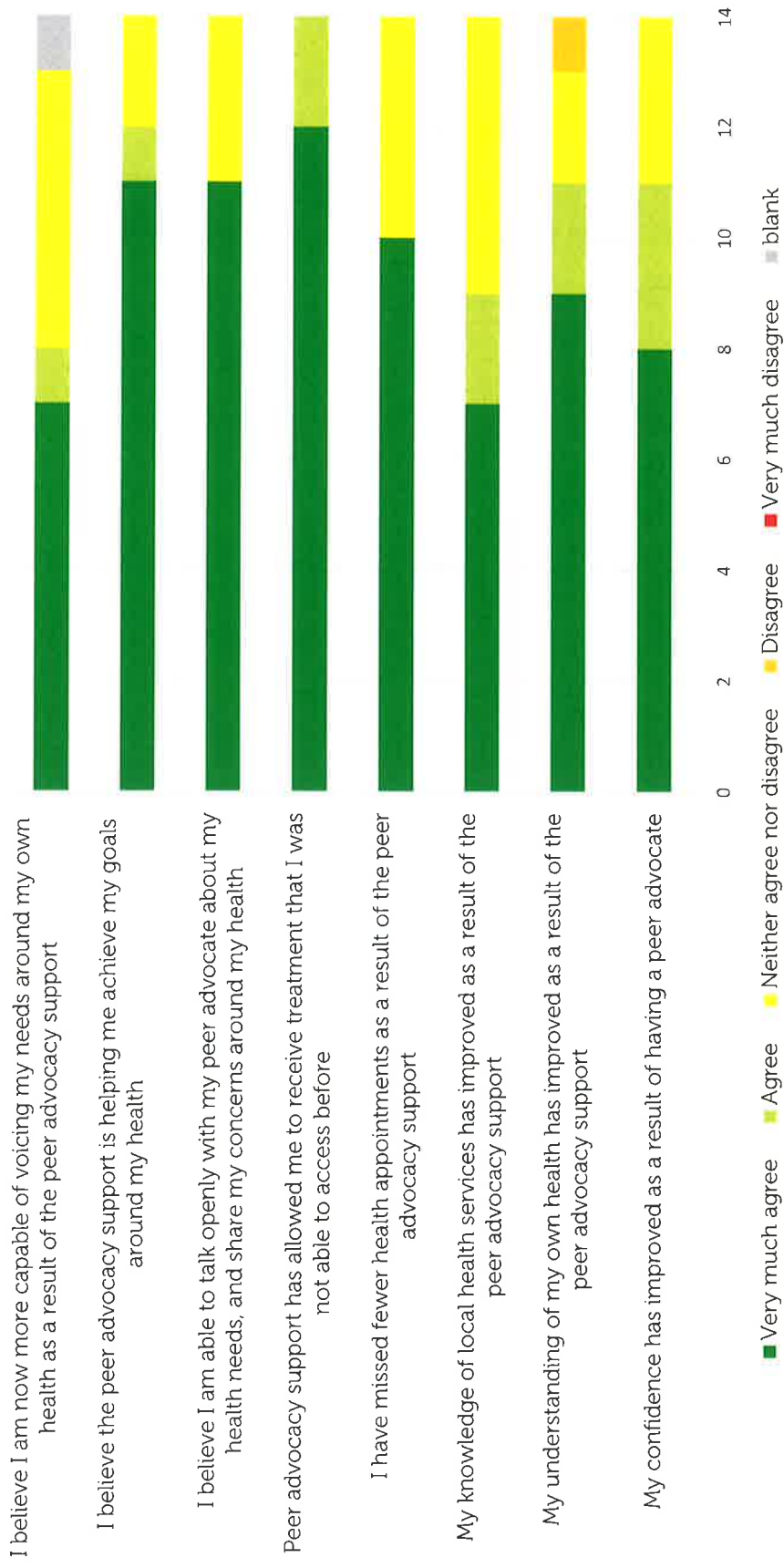
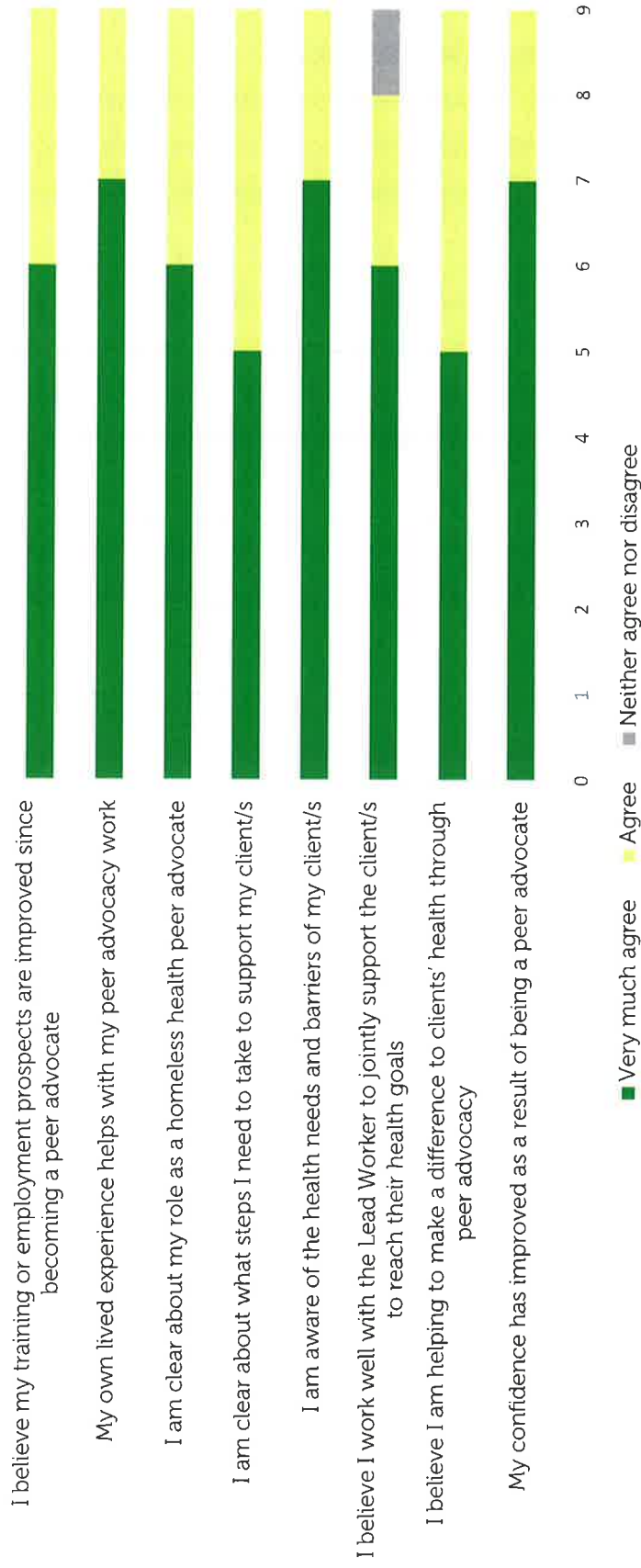


Table 2: Improvement in health-related areas as a result of HHPA service (clients' perspective)		Respondents reporting improvement as a result of the peer advocacy support		Respondents <u>needing</u> support in this area who reported an improvement		Respondents <u>not</u> needing support in this area who reported an improvement	
Area of health-related support	N	%	N	%	N	%	
GP / dentist / optician registration	10 of 14	71%	7 of 7	100%	3 of 7	43%	
Booking or preparing for appointments	11 of 14	79%	10 of 10	100%	1 of 4	45%	
Communicating with health services	13 of 14	93%	9 of 9	100%	4 of 5	75%	
Accessing a new health service or support organisation	11 of 14	79%	6 of 6	100%	5 of 8	63%	
Using the phone or internet to access health services	5 of 14	36%	0 of 0	-	5 of 14	36%	
Giving feedback or making complaints about services	3 of 14	21%	0 of 0	-	3 of 14	21%	

Figure 2: Effectiveness of HHPA service (peer advocates' perspective)



Appendices

Appendix 1: Case notes analysis methods and background

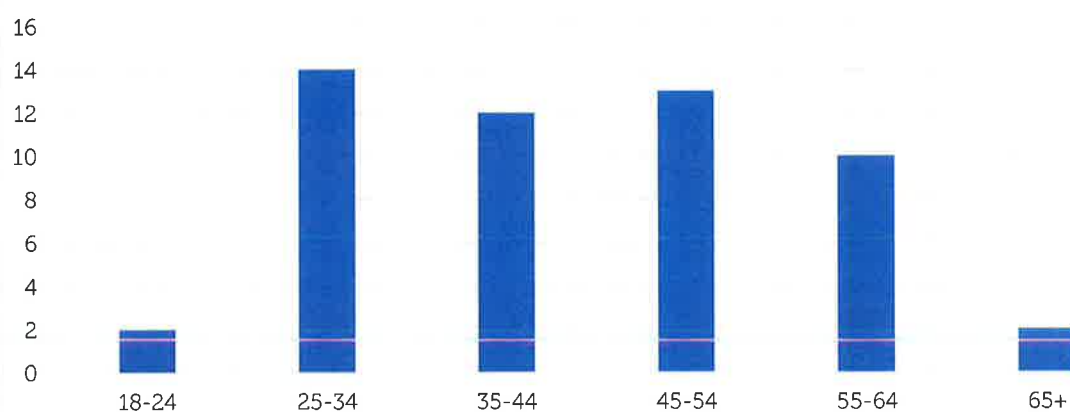
Clients whose cases were both open or closed were included in this analysis. Records between 1st June 2021 and 30th November 2021 were included in the analysis, to generate a 'snapshot' in time; thus, some cases were pre-existing since before June and some cases only opened in November.

Each client's case notes were codified by the #HealthNow Coordinator in Newcastle, so that every discrete action by the peer advocate was categorised as an 'action type'. These action types were agreed by the #HealthNow Coordinators in both Birmingham and Newcastle prior to the analysis, and the HCs communicated between them and with the evaluator when an action did not fit a 'type'.

Following data cleaning, 53 clients remained for analysis, with a total of 576 actions by peer advocates between them. 24 clients (44%) were closed cases, and 29 (56%) were ongoing cases.

8 (15%) of the peer advocacy clients were female, 45 were male (85%). By 30th November 2021, the oldest client was 70 years old; the youngest was 23, though the clients were well spread across all age groups in between (please see Figure 3).

Figure 3: Age groups of clients in case notes analysis



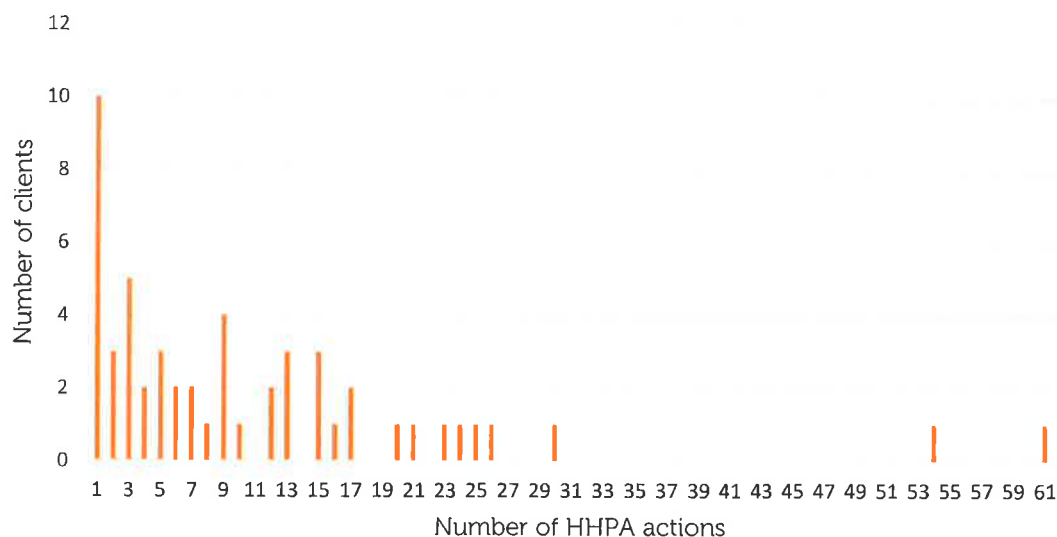
The predominant referral route for clients was through Crisis Skylight Newcastle (26; 49%); mainly through the Progression Team (20 clients), but also through the Learning team (4) and the Housing First team (2). Twenty clients (38%) became a HHPA client through self-referring. Referrals from housing associations accounted for 9 clients (17%).

Other, less used referral routes were other charities (3 clients, or 6%), and GP practices (2 clients, 4%).

The most common reason for a client needing a referral, according to their referral form, was support with travelling to, or accompanying to, medical and health-related appointments: 44 clients (83%) had this on their form. Support with booking or preparing for appointments was also common, with 39 (74%) forms selecting this option.

Across the 53 clients, 576 discrete actions by the peer advocates were recorded in case notes. These ranged from 1 to 61 actions per client, with a mean number of discrete actions per client of 10.9; however, more clients (14) had one action to their name than any other number of actions (see Figure 4). This may show that the vast majority of clients required very minimal work, and potentially quick solutions, by the peer advocate; however, in some cases, the low number of actions may be because the case has only recently opened.

Figure 4. Frequency of number of actions per client



Appendix 2: Client survey methods and background

Of the 53 clients used in the case notes analysis, 14 (26%) also completed a survey, via telephone, with the HealthNow Coordinator or a Peer Researcher. Eight of the clients were open cases; 6 were closed cases. This was not a representative sample of the client group (35% of respondents were female; ten were Crisis members); and while we do not have ethnicity records of all clients, the respondents were predominantly White British (13 clients), so is not representative of the general population, nor of the membership at Crisis Skylight Newcastle³. This was the subgroup of the client base who were contactable, willing to complete a survey, and in a stable enough position to do so; for these reasons, the respondent group cannot represent all clients.

In the survey, clients were asked about their living situation when they first started working with a peer advocate. The majority were at that point in stabilised housing situations: eight respondents (57%) were in supported housing at that point and two were renting from a Housing Association or Council, while another owned their own home. Some were in precarious living situations; one was rough sleeping, another sofa-surfing, and another in temporary accommodation renting from a landlord.

Clients were asked in the survey what their main health reasons were for wanting peer advocacy support. The most common response was for support booking or preparing for appointments (ten respondents selected this answer); and support communicating their health needs to professionals (nine selected this answer). Less common answers were for help registering with a GP or dentist (7 clients); for help with accessing a new health service or support organisation (6 clients); and to help increase confidence in using health services (4 clients).

³ At Crisis Skylight in Birmingham between 1st June and 30th November, White British members made up 31% of the active membership where ethnicity had been recorded. 18% of the active membership were female Source: Crisis 'Skylight Insights' Dashboard., 23/02/22.

Appendix 3: Peer advocate survey methods and background

Out of the ten peer advocates contacted, nine (90%) completed the online survey. Five were female, and four were male. Seven respondents were White British; two identified as belonging to mixed or multiple ethnic groups.

Seven of the respondents (78%) reported that they had experienced their own barriers to health care through their own lived experience of homelessness. These barriers included not knowing healthcare options; missing out on sustained healthcare because of not having a permanent residence; addiction; accessing mental health support.

The most frequently-cited reasons for **wanting to be a Peer Advocate** were for 'training and employment opportunities', and for 'improving advocacy skills'; eight of the nine responders (89%) selected these as a motivation. Six respondents (66%) also selected 'improving confidence' and 'learning more about health services' as a motivation. Three (33%) also selected 'developing interpersonal skills'. Four stated that they were also keen to help others and give something back (See figure 4).

Figure 4. Peer advocate responses to the question 'Why do you want to be a peer advocate?'

