BUILDING BRIDGES, BUILDING HEALTH

An evaluation of SPEAR's Homeless Health Link Service

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THE YOUNG FOUNDATION

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About SPEAR

SPEAR is a charity for people experiencing homelessness in South West London. We build communities in which everyone has a place to call home and provide the help needed to lead a fulfilling life. We recognise that homelessness is much more than just a housing issue, so we provide a range of accommodation and support services to help people reach their full potential.

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EXECUTIVE SUMMARY

About the Homeless Health Link Service

The Homeless Health Link Service (HHLS) was established by SPEAR to improve the health, wellbeing and social connectedness of homeless people. Since 2017 it has operated in the London boroughs of Richmond and Kingston. It provides one-to-one and group-based support and advocacy for homeless people, training and awareness raising to health and care professionals, and training and support to volunteers.

Why this service is needed

- In England there has been a sharp increase of +169% in homelessness between 2009/10-2016/17, and Richmond and Kingston boroughs are both in the top 50 'hot spots' for homelessness in England.[1]

- Homelessness has a significant impact on people's health and wellbeing: homeless people's life expectancy is 30 years lower than the general population and they are more likely to suffer poor physical and mental health and wellbeing, as well as social isolation.[2]

- Around 40% of homeless people say they would like more support with their physical and mental health than they are currently receiving.[3]

- There are a range of barriers that homeless people face when accessing health and social care, including practical (such as having no address), personal (such as low confidence) and systemic (such as complex services).

- These barriers, as well as the higher level of ill health suffered by homeless people, mean that homelessness places a high cost on the NHS, of around £85m each year. [4]

- HHLS aims to address these challenges by increasing homeless people's access to appropriate care, addressing the social determinants of their health, as well as by reducing homelessness itself.

Impact of HHLS

- Overall HHLS has a **positive impact upon clients' mental health and wellbeing, confidence and self-esteem, and access to appropriate health care, especially increasing accessing to primary and preventative care.** It has a further positive impact on people's social and community connections, and transition into settled accommodation. There is also evidence that HHLS has helped to directly prevent the death of some clients.

- HHLS also has a positive impact on the physical health of **some clients, and helps some clients to make less use of secondary care.** Overall, however, client physical health and access to secondary care appear to remain stable after engagement with HHLS. There is evidence to suggest that longer term engagement with HHLS may help to improve physical health and reduce secondary care use.

- **Looking to the future**, the majority of clients feel that **they would benefit from increased access to mental health care.**

- **HHLS boosts the confidence, experience and skills of the majority of volunteers**, helping to create a pathway for clients into volunteering, and for volunteers into professional roles.

- HHLS has **worked with around 270 health and care professionals** in Richmond and Kingston. The vast majority of those surveyed strongly agreed/agreed that HHLS has **improved their understanding of the health needs of homeless people and how to address those needs**, particularly awareness of suitable health pathways.

- **For some clients, HHLS is helping to reduce health care costs** by reducing inappropriate use of secondary care services, and instead increasing use of primary care services. However, overall, given that HHLS is helping people to access services that they may otherwise be unable to, there is a small increase in the cost of health care since clients engaged with HHLS. Qualitative evidence and evidence from elsewhere suggests that over longer period of time, HHLS may help to reduce overall health care costs among clients.

How the HHLS works

- **HHLS takes a relationship-based and human-centred approach** to working with clients, based on forming trusting, long-term and flexible relationships between staff/volunteers and clients. It recognises the strengths and assets of clients as well as their needs and challenges, and supports them to address a wide range of social, as well as medical, determinants of their health and wellbeing.

- **HHLS draws on the expertise of people who have experienced homelessness** and has recruited and supported 22 people (including eight accredited peer mentors) with lived experience of homelessness as volunteers. This has a mutually beneficial impact on both clients and volunteers and helps to break down barriers between 'professionals' and 'service users', as well as establishing a pathway for personal and professional development.

- **HHLS builds bridges between homeless people and health and social care services**, including primary and preventative health care, as well as community-based and specialist services. It does this by addressing the practical, personal and systemic barriers that homeless people face when accessing support.

- **HHLS works in partnership with other organisations and professionals** by: sharing information with them; attending multi-agency meetings about clients; advising other agencies how to support clients, as well as considering the advice of other agencies and professionals.

Recommendations

Our research has highlighted the following recommendations for increasing and amplifying the impact of HHLS:

- Ensure that the service is being as widely marketed as possible to potential clients and also professionals to ensure that those who could benefit are aware of and able to access the service.

- Continue to develop HHLS partnership work with mental health services and explore ways of ensuring that more clients have access to the mental health support that may benefit them.

- Continue to focus on the recruitment and retention of effective staff for HHLS as they are fundamental to the success of the service and even a relatively low level of staff turnover can be detrimental to the relationship-based approach of the service.

- Develop data collection mechanisms such that

  (a) WEMWEBS data is collected for all clients,

  (b) monitoring data is collected at consistent intervals e.g. every 3 or 6 months, and

  (c) HHLS has access to NHS administrative data on service use by clients.

- Explore further geographical areas where the service may be needed and seek funding to extend the service into these areas.

For policy-makers and commissioners

For policy makers and commissioners, our research highlights the following recommendations:

- Support a long-term evaluation of HHLS which has access to NHS data on HHLS clients. This will help to establish how far HHLS is achieving cost benefits for the health system.

- Continue to fund HHLS in Richmond and Kingston and identify locations where there is no equivalent provision and scope options for providing a health advocacy service for homeless people.

- In order to monitor the health of homeless people, Kingston London Borough Council should include the health needs of homeless people in its Joint Strategic Needs Assessment, as Richmond does.

- Health agencies should recognise the importance of sharing information and data with voluntary sector organisations which have shared goals. Health agencies, such as NHS foundation trusts, should explore ways of sharing data on service use and patient health, whilst respecting data protection regulations.

- Primary care providers should find ways of removing barriers to access among homeless people, for example by relaxing proof of address requirements or by providing Freephone telephone numbers. Indeed, there is no legal requirement for patients to provide proof of address to register with a GP but this is still a commonly reported barrier. [5]

- Review the extent to which mental health services are able to meet demand among homeless people and explore options for extending this provision.

- Health commissioners should ensure that they are aware of and follow the Healthy London Partnership commissioning guidance for the health and care of homeless people.

1. INTRODUCTION

Overview

The Young Foundation was commissioned by SPEAR, a charity working with people experiencing homelessness in South and West London, to evaluate their Big Lottery funded Homeless Health Link Service (HHLS). [6]

With levels of homelessness in London continuing to rise, by 121% between 2009/10 and 2016/17[7], it is more important than ever that homeless people can access health and social care in a timely, supported and appropriate way.

In this evaluation we sought to provide an independent review and report on how well the service achieved its aims and met its outcomes by:

- Seeking feedback from service users, volunteers and health and social care professionals[8] on their experience of interacting with the service

- Conducting a cost benefit assessment of the service.

We identify what worked well, what didn't work, and key learnings to make recommendations about the future of the SPEAR service and other similar services.

This report builds on a 2015 evaluation[9] - *Saving Money, Saving Lives* - of Homeless Health Peer Advocacy Service in Central London, run by the charity Groundswell.

About the Homeless Health Link Service

SPEAR's Homeless Health Link Service (HHLS) was first established in 2015 with the aim of improving the health and wellbeing of homeless people in South West London, thereby reducing health inequality. It was originally established and operated in five boroughs: Richmond, Kingston, Wandsworth, Merton and Sutton. From April 2017 to March 2019 the HHLS has been funded by the Big Lottery Fund (which is the time period this evaluation report applies to) and has operated in Richmond and Kingston only, as these were identified as areas with greatest need and also links to existing SPEAR outreach services. This is the only service specialising in homeless people's health in Richmond and Kingston.

In particular, the service aims are:

1 **HHLS clients** experience improved health and other outcomes as a result of using this service

    a physical and mental health will improve, reducing the risk of developing severe or long term health problems

    b increased confidence and self-esteem, enabling them to make informed choices and access appropriate health services

2   Health professionals in Richmond and Kingston will better understand homeless people, improving how they plan and deliver services to them

3   Volunteers will gain confidence, self esteem and improved social networks, improving their future life chances and health

In order to achieve its aims, the HHLS delivers the following key activities:

- One to one (professional and volunteer) support to homeless people in relation to their health and wellbeing, helping them to access preventative, primary and specialist health services, including through advocacy and accompaniment.

- Weekly group sessions for homeless people in relation to health and wellbeing knowledge, treatment and care.

- Presentations and reports on homeless people's health needs and experiences to local, regional and national professional audiences.

- Training, managing and supporting volunteers with lived experience of being homeless or at risk of homelessness to support currently homeless people to address their health and wellbeing needs. Five HHLS volunteers have also been supported to participate in an accredited peer mentoring training course, funded by the Monument Trust. All volunteers have been service users of SPEAR or similar services in the past.

Its centre of operations is the SPEAR hub in Twickenham, and the HHLS also offers drop-in sessions in the SPEAR Penny Wade house, the Vineyard Centre in Richmond, and Kingston Churches Action on Homelessness, as well as at SPEAR hostels.

Evaluation methodology

- We adopted a mixed-methods approach to deliver this evaluation:

- A review of HHLS documentation to assess the provisions and intended impact of the service

- Interviews and focus groups with clients, staff and external professionals to explore and understand their experiences and perceptions of the service

- A survey of external professionals to gain an external perspective of the effectiveness and impact of the HHLS

- Analysis of the HHLS client monitoring data to track and assess outcomes of using the service

In this report we identify where changes are statistically significant[10] and the photos used throughout are of HHLS service users, volunteers and staff.

The outcomes and evaluation framework can be seen in Appendix 1 and full details of the methodology are in Appendix 3.

2. WHY THIS SERVICE IS NEEDED

Key messages

- In England there has been a sharp increase of +169% in homelessness between 2009/10-2016/17, and Richmond and Kingston boroughs are both in the top 50 'hot spots' for homelessness in England.

- Homelessness has a significant impact on people's health and wellbeing: homeless people's life expectancy is 30 years lower than the general population and they are more likely to suffer poor physical and mental health and wellbeing, as well as social isolation.

- Around 40% of homeless people say they would like more support with their physical and mental health than they are currently receiving.

- There are a range of barriers that homeless people face when accessing health and social care, including practical (such as having no address), personal (such as low confidence) and systemic (such as complex services).

- These barriers, as well as the higher level of ill health suffered by homeless people, mean that homelessness places a high cost on the NHS, of around £85m each year.

- HHLS aims to address these challenges by increasing homeless people's access to appropriate care, addressing the social determinants of their health, as well as by reducing homelessness itself.

"Homelessness is not just about not having a house. HHLS client

Levels of homelessness have been on the rise in the UK. Between 2009/10 and 2016/17, rough sleeping in England increased by +169%, whilst the number of households formally assessed as 'unintentionally homeless and in priority need' was up by 48%. In London, this figure has risen by 121% from over the same period.[11]

The experience of homelessness is complex and has far-reaching implications for every aspect of a person's life. As one homeless client expressed, *"homelessness is not just about not having a house".*

The health inequalities associated with homelessness are stark; **people experiencing homelessness have a life expectancy 30 years lower than the general population**.[12] Health problems faced by the homeless population are often associated with tri-morbidity – the combination of physical and mental ill health with alcohol and drug misuse.[13] For homeless people living on the street, they are more susceptible to health problems such as hypothermia, infections, mental health problems, addiction, malnutrition and chronic pain.[14]

Homeless people also experience high rates of loneliness and isolation, low confidence and self-esteem, with relationship breakdown a common cause of homelessness.[15] Evidence from Crisis suggests that around 61% of homeless people classify as 'lonely', three times the proportion of over 52s generally.[16] This has a direct impact on people's health as we know that loneliness increases the likelihood of death by 26%[17] and people with strong relationships are 50% more likely to survive life-threatening illness than people with weaker ones.

There are significant unmet health needs within the homeless population at present, with many people receiving little or no support. A 2014 study by Homeless Link revealed that in terms of physical health problems, while 40% said they were receiving help, 26% said they would still like more help, and 16% said they were not receiving support but would like to.[18] For mental health needs, 28% said they were receiving help but would like more, and 18% weren't receiving help but thought they would benefit from it.[19]

2.3 Barriers to accessing care

Through this research and as highlighted in other previous studies, including Saving Money, Saving Lives, we found that homeless people face multiple and interrelated practical, personal and systematic barriers to accessing health and care including:

Figure 1: Key barriers that homeless people face when accessing health care

Type of barrier	Examples
Practical	**Competing priorities**, such as accessing housing, food and warm clothing means, and at times alcohol and/or drugs, means that addressing health issues is often not a priority. As one staff member reported, *"they tend to ignore health when they are thinking about dealing with life"*. **Having no permanent address and limited means of communication (such as email or phone)** means it can be difficult to register with services, to make, change or remember appointments, or to get test results. **Limited economic resources, mobility and time** can make traveling to appointments challenging, especially if somebody has limited physical mobility.
Personal	**Negative prior experiences** (including fear of hospital settings) and **low confidence**[20] can result in lack of ability and willingness to engage with and navigate the healthcare system.[21] **Fear and distrust of professionals and people in positions of authority** mean homeless people do not always seek out support. As one professional explained, *"these people traditionally don't trust positions of authority, they have mental health issues as well and they will naturally distrust medical professionals"*. **Feelings of neglect and a lack of self-worth mean homeless people do not always feel they deserve to be well**. A client of the HHLS explained that *"when you're homeless you neglect yourself."* A professional further added, many homeless people *"feel let down by society. They don't necessarily place much value on themselves."* **Some homeless people may not have the knowledge or skills to access support, often due to low levels of education**. As a professional told us: *"The cohort of people SPEAR work with historically have poor health, education and they will have a lot of unmet health needs which they don't know how to access [support for]."*

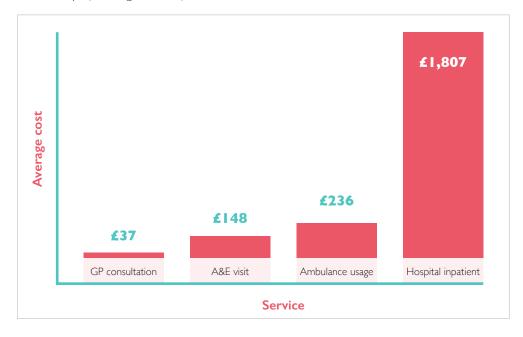| Type of barrier	Examples
Systemic	**Lack of understanding of the specific needs of homeless people amongst health and social care professionals.** A staff member of HHLS stressed that often hospital staff *"don't know how to deal with the needs"* of homeless people. HHLS clients spoke about how HHLS had supported her with her specific health needs which were unmet by other services. **A complex and often disconnected system.** Health and social care services can be inflexible and disconnected, requiring a great deal of work from service users, which makes it difficult for people with complex lives and needs to access.[22] **Poor attitudes to homelessness and stigma.** At times homeless people experience stigmatising attitudes or treatment from services. As one staff member said, *"this group is not a priority among hospitals or local authorities as they (homeless people) are seen as a problem"*.

2.4 Costs to the system

The barriers that homeless people face make it challenging to 'appropriately'[23] access health and social care services, increasing the risk of problems worsening to crisis point. As well as causing harm to homeless people, this can place increased and unnecessary costs on public services because secondary and unplanned services (such as A&E and hospital) can be more expensive than preventative and primary care, as shown in Figure 2.[24]

Figure 2: Summary of average costs of health services

Homeless people are more likely to use A&E, spend time in hospital and to be heavy users of mental health and substance misuse services.[25] [26] For example, in 2015 in the space of six months, 38% of the homeless population accessed A&E services, which is four times higher than for the general public.[27] This is partly because homeless people have poorer health than the general population, but also because of the barriers they face to accessing primary and preventative care. Rates of hospital readmission are also higher than the general population, as many homeless people are discharged from hospital onto the streets or hostels without appropriate care plans, worsening their chances of recovery.[28] In addition to a reliance on unplanned emergency care, missed appointments among homeless people are disproportionately higher the than the average population.[29] In total, treating homeless people costs the NHS at least £85m in total each year.[30]

2.5 Homelessness and health in Richmond and Kingston

In the boroughs of Richmond and Kingston, the number of people accepted as being homeless and in priority need per 1,000 households are 2.26 (Richmond) and 3.41 (Kingston) - below that of London overall (5.03), but still above the figure for the rest of England (2.09).[31] A report by Shelter (2016) estimates that both boroughs are in the top 50 'hot spots' for homelessness in England.

Regardless of the final figure, there is consensus from staff, clients and professionals that the HHLS is essential. One professional explained that:

"There is a huge need for it in the area. It appears to be a rich area but here the poverty is more invisible and there are fewer resources because the majority don't need it. We have a significant population of street homeless. Police keep moving them on."

This suggests that the relative affluence of the boroughs means that homeless people in these areas may face particular challenges, such as being less welcome in public spaces.

In terms of the health of homeless people in the boroughs, Richmond Borough's Joint Strategic Needs Assessment found that in Richmond, only 57 out of 134 rough sleepers during 2014/15 had a GP, and none were registered with a dentist.[32] [33] [34]

3. THE IMPACT OF THE HHLS

Key messages

- Overall HHLS has a positive impact upon clients' mental health and wellbeing, confidence and self-esteem, and access to appropriate health care, especially increasing accessing to primary and preventative care. It has a further positive impact on people's social and community connections, and transition into settled accommodation. There is also evidence that HHLS has helped to directly prevent the death of some clients.

- HHLS also has a positive impact on the physical health of some clients, and helps some clients to make less use of secondary care. Overall, however, client physical health and access to secondary care appear to remain stable after engagement with HHLS. There is evidence to suggest that longer term engagement with HHLS may help to improve physical health and reduce secondary care use.

- Looking to the future, the majority of clients feel that they would benefit from increased access to mental health care.

- HHLS boosts the confidence, experience and skills of the majority of volunteers, helping to create a pathway for clients into volunteering, and for volunteers into professional roles.

- HHLS has worked with around 270 health and care professionals in Richmond and Kingston. The vast majority of those surveyed strongly agreed/agreed that HHLS has improved their understanding of the health needs of homeless people and how to address those needs, particularly awareness of suitable health pathways.

- For some clients, HHLS is helping to reduce health care costs by reducing inappropriate use of secondary care services, and instead increasing use of primary care services. However, overall, given that HHLS is helping people to access services that they may otherwise be unable to, there is a small increase in the cost of health care since clients engaged with HHLS. Qualitative evidence and evidence from elsewhere suggests that over longer period of time, HHLS may help to reduce overall health care costs among clients.

3.1 Clients

Health and wellbeing

"The service is contributing to the improved health and wellbeing of clients in Kingston and Richmond. External professional

In this section we review the impact that HHLS has had on the mental and physical health of clients.

Clients mental wellbeing was measured[35] when they first started engaging with HHLS and then at a later point in time (on average 281 days later, with a wide range of between 35 and 955 days between Time 1 and Time 2 audits). Although 281 days is a relatively short time period to effect change in the lives of people who are likely to have suffered multiple and severe disadvantages, overall the mental wellbeing of clients improved or was stable during their engagement with HHLS.

At the start of their engagement with HHLS, only 20% of clients reported high or moderate wellbeing. At their most recent assessment, this had risen to 46% of clients, as shown in Figure 3. In addition, the overall average wellbeing score of clients increased from 33.5 to 39.8 (out of 100), compared with a national average wellbeing score of 49.9.[36][37]

Feedback from clients, staff and professionals reinforces the evidence that, overall, clients' health and wellbeing tended to improve over time. In many cases this is directly attributed to HHLS involvement. On several occasions clients told us that they would not be alive now if it were not for SPEAR and the HHLS team. When asked what would happen if this service did not exist, a participant in the focus group replied,

"I would be homeless for one thing and I would probably be dead."

Figure 3: Proportion of service users in each group - WEMWBS (n=60)

Another client told us; *"if it wasn't for them I wouldn't be alive now. I would have lost my legs. I now live in a bungalow which has everything. I love it."*

A staff member also described how the HHLS team helped to prevent a client from committing suicide:

"There was one client I worked with who was screaming to be sectioned; he was suicidal every day.

He told doctors he could act on it at any time. HHLS acted on it instantly, got him into a hospital, they got him into a care sheltered accommodation where he could reflect and have access to doctors and psychological support. As soon as he was discharged they've continued to provide support. He is being put forward for a council house now. It's been a huge journey."

External professionals also report that the HHLS has effectively improved the physical and/or mental health of mutual clients. A professional in the sector spoke about the positive impact she had witnessed working with HHLS who supported a client to access mobility aids to live independently:
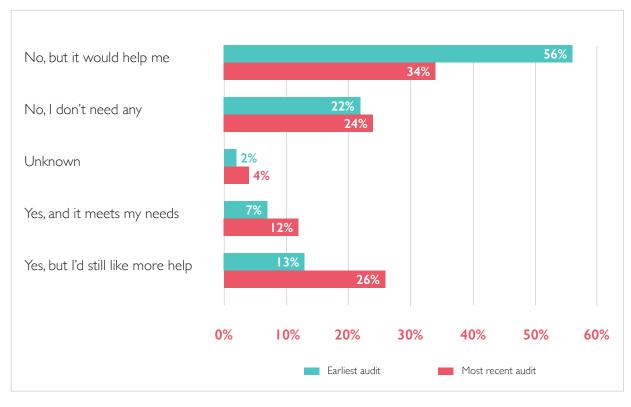
"This client was a 68 year old street homeless woman who had mental health problems and was partially sighted. She had developed a really good relationship with the SPEAR worker who went out of her way to help her. The HHLS staff member and this professional managed to support this client to be housed and helped to organise health aids such as sticks to help her mobility and dark glasses to help her sight."

However, although many clients reported improved mental wellbeing since they engaged with HHLS, many still feel that existing support is insufficient. Figure 4 shows that at their most recent assessment, 56% of clients would welcome receiving mental health support, who weren't currently. This was echoed by some clients. For example, one young man explained that,

"I've always said that I would find counselling helpful but it has never materialised. I don't know why I couldn't access counselling - something in the journey was broken."

While we know that HHLS is helping some clients to access mental health care, and the availability of provision of mental health services is largely outside of HHLS's sphere of influence, this is clearly an area of client need that could be further addressed.
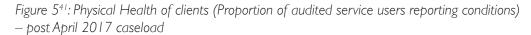
Figure 4: Client's response to question 'Do you receive mental health support?' (n=106) – post April 2017 caseload

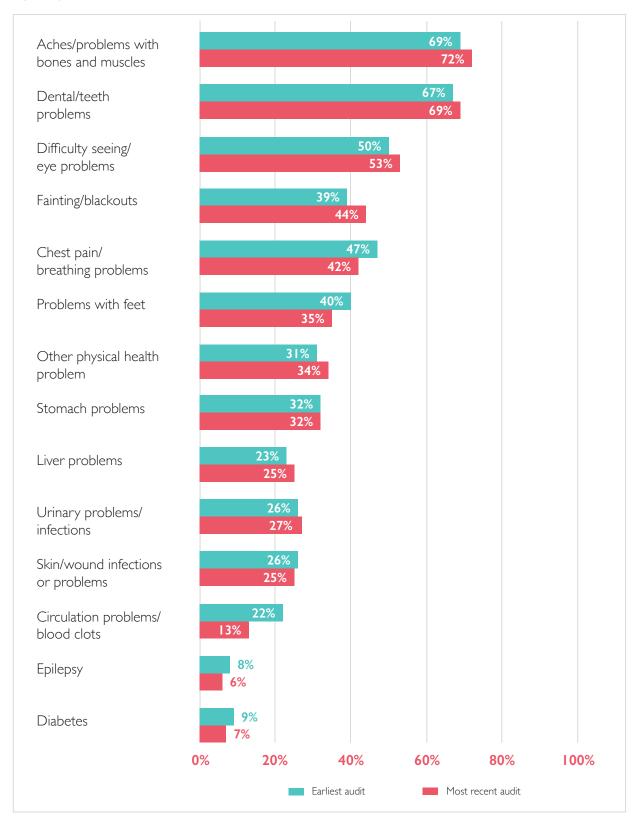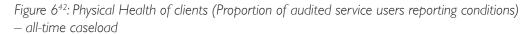|	Earliest audit	Most recent audit
No, but it would help me	56%	34%
No, I don't need any	22%	24%
Unknown	2%	4%
Yes, and it meets my needs	7%	12%
Yes, but I'd still like more help	13%	26%

SPEAR's monitoring data shows that for the vast majority of clients their physical health remained fairly stable between their first and last health audits, as shown in Figure 5[38] The slight fluctuations in the data may reflect increased levels of diagnosis, or a greater willingness and confidence in discussing health issues, rather than worsening health per se. Several clients told us that HHLS has helped them to get previously unrecognised health issues diagnosed, such as diabetes, dentistry problems and, in one case, female genital mutilation (FGM).
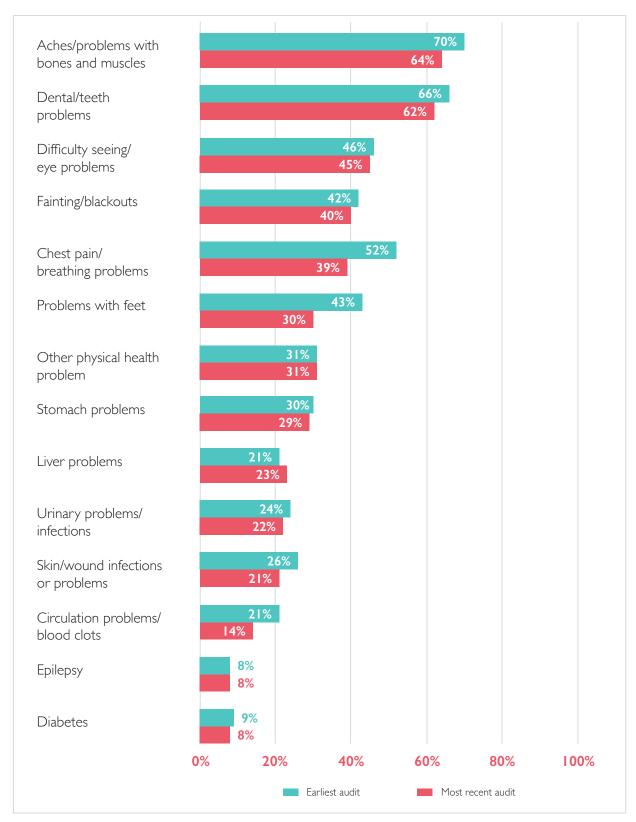
Over a longer period of time, earlier and increased diagnosis and access to appropriate care may result in improved physical health. Indeed, as shown in Figure 6, when we include clients who had been in the service for longer (since 2015, rather than since April 2017) in our analysis, the prevalence of chest pain/ breathing problems and circulation problems/ blood clots decreased significantly among HHLS clients over time.[39] The data for clients since 2015 also indicates a likely reduction in the overall number of self-reported health conditions over time.[40]

Figure 5[41]: Physical Health of clients (Proportion of audited service users reporting conditions) – post April 2017 caseload

	Earliest audit	Most recent audit
Aches/problems with bones and muscles	69%	72%
Dental/teeth problems	67%	69%
Difficulty seeing/eye problems	50%	53%
Fainting/blackouts	39%	44%
Chest pain/breathing problems	47%	42%
Problems with feet	40%	35%
Other physical health problem	31%	34%
Stomach problems	32%	32%
Liver problems	23%	25%
Urinary problems/infections	26%	27%
Skin/wound infections or problems	26%	25%
Circulation problems/blood clots	22%	13%
Epilepsy	8%	6%
Diabetes	9%	7%

Figure 6[42]: Physical Health of clients (Proportion of audited service users reporting conditions) – all-time caseload

Figure 6: Physical Health of clients

Condition	Earliest audit	Most recent audit
Aches/problems with bones and muscles	70%	64%
Dental/teeth problems	66%	62%
Difficulty seeing/eye problems	46%	45%
Fainting/blackouts	42%	40%
Chest pain/breathing problems	52%	39%
Problems with feet	43%	30%
Other physical health problem	31%	31%
Stomach problems	30%	29%
Liver problems	21%	23%
Urinary problems/infections	24%	22%
Skin/wound infections or problems	26%	21%
Circulation problems/blood clots	21%	14%
Epilepsy	8%	8%
Diabetes	9%	8%

However, while health has improved for many clients, the pathway is often complex and not necessarily linear. As one client highlighted:

"At the moment it's still early days and I am starting again. Due to my own doing you know. It's nothing that SPEAR have done, just me. It's my issues you know. They are still there for me, they still willing to help me, help to get back to the world and with the things I need to do."

This situation is reflective of the complicated and often chaotic lives that many homeless people have and the difficult paths towards securing a permanent residence and improving health and wellbeing.

Overall the data shows that HHLS is having a positive impact on client mental and physical health, helping clients to recognise and address health needs, and resulting in reduced or stabilised physical and mental health conditions.

Confidence and self-esteem

"It is all about confidence building. HHLS client

As well as improving the physical and mental health of clients, the HHLS also aims to improve client confidence and self-esteem. The intention of HHLS is not for staff to 'hand hold' but, as one professional explains, to *"encourage and empower clients to seek help themselves"*. By building confidence and self-esteem, HHLS aims to help clients more independently manage their health in the future.

"We work along the pathway of homelessness - connecting and leaving people empowered. The service connects to everything. Not just health but living with trauma, building relationships, building confidence, building trust in services."

Overall clients demonstrated slightly increased confidence since they started engaging with HHLS: as shown in Figure 7 the average confidence score increased from 2.2 to 2.9 (out of 5)[43]. Of all clients, 48% demonstrated increased confidence since they started engaging with HHLS.[44]

Feedback from clients, staff and external professionals also shows that HHLS helps to improve the confidence, self-esteem, optimism and empowerment of many clients. For example, a member of staff described how one client who was previously shy and timid is now performing on stage. Other staff and volunteers also commented on how they have seen transformations in clients, often from feeling hopeless to optimistic. Increased confidence has enabled some people to go back to work or to start volunteering as well as take charge of their health:

"I've seen people transform - change their face, their confidence, their behaviour. There was a particular girl at the refuge who was very quiet. Week by week she has become more open. She got CBT[45] from the hospital. I worked with her to help her access the doctor and yoga classes."

In the words of one client, *"it's helped me not give up on myself"*. For some people, part of this work has involved overcoming practical barriers to socialising, such as access to clean clothes: *"I have had a boost of confidence … it's clothes but it makes a huge difference … I bounced here this morning. I feel like I look good."*

Many staff and clients attribute the boost in confidence at least in part to the development of strong and trusting relationships between clients, workers and volunteers. *"It is basically knowing that they are there so you can build up your confidence…. it's just knowing someone is there"*.

"Our workers and volunteers play the role of a support network that other people would have in their friends or family".

The importance of the trusting relationship between clients and HHLS workers was also highlighted by clients. As one client told us:

"It wasn't until I came to SPEAR that my support worker actually picked up on the fact that I might have an undiagnosed learning disability. She was the one who helped me and pushed me into the direction of who I need to go to speak to find out

Figure 7: Mean client WEMWBS confidence score out of 1-5 scale (change in earliest vs. most recent score) (n=60)

what it is that I have … there has been times in the past when things have confused me but I never knew why. It is basically because of SPEAR I was pointed in the right direction."

Yet while the confidence of most clients had improved, for some this had been a slow process and others indicate they still have some way to go to feeling confident. As one client described,

"My confidence is better… it can still be improved. I won't argue with anyone. I'm getting better slowly."

Access to appropriate care

"We link clients to primary and secondary health care ….Advocate on clients' behalf - connect to all different sorts of services - physical and mental health. SPEAR staff

One of the main ways that HHLS seeks to improve the health and wellbeing of clients is by helping them to access appropriate health and care services. HHLS plays a bridging and advocacy role to enable this, supporting the relationship between clients and mainstream services. In particular, HHLS aims to support clients to make greater use of community and preventative care, such as GPs, and less inappropriate use of unplanned secondary care, such as A&E. This can help clients to access appropriate support before health needs escalate, and also to lessen overall costs to health and social care agencies. Our research shows that **during their engagement with HHLS, clients tend to make greater use of primary care and less use of unplanned secondary care.**

Clients are more likely to be registered with and accessing a GP after engaging with HHLS.[46] Figure 8 shows that in the most recent health audit, 97% of clients were registered with a

GP, versus 87% at the earliest health audit. Visits to the GP among HHLS clients also increased over time from 76% to 90%. Clients report that HHLS helped them access a GP, often for the first time:

"If it wasn't for HHLS I would be plodding along the way I was … It would be 8 years until I see a doctor."

Clients also highlight other preventative services that they were able to access with HHLS support: *"I wouldn't have booked a dentist or opticians without them".*

Professionals tend to agree that HHLS helps clients access appropriate care. For instance, one professional reported that: *"I would be horrified about what would happen without the service … nowhere near as many people would be able to access primary health care and some people would go under the radar."*
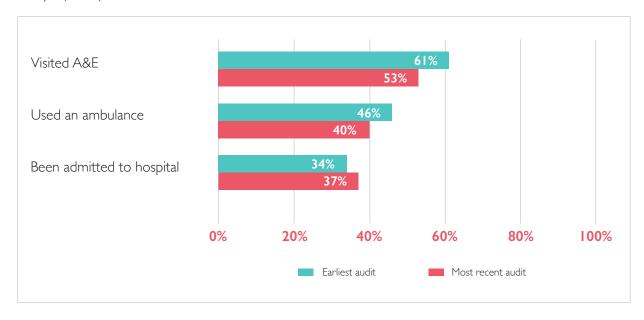
Figure 8: GP registration and use amongst HHLS clients 'in the last six months' (n=106) – post April 2017 caseload[47]

Visited a GP (last 6 months)
- Earliest audit: 76%
- Most recent audit: 90%

Registered with a GP
- Earliest audit: 87%
- Most recent audit: 97%

Earliest audit | Most recent audit

Although use of primary care has increased among clients, HHLS monitoring data suggests overall, during the time frame considered, there has not been a significant change in use of secondary care (see Figure 9). [48] However, as with physical and mental health, an analysis of all clients from 2015 (see Figure 10) shows a significant reduction in the proportion of clients using secondary care, particularly for use of A&E and ambulance services.[49] It is important to note that admission to hospital may include planned admissions arising from referrals from primary care to other services.

Figure 9: Proportion of clients accessing secondary care 'in the last six months' (earliest vs most recent health audit) – post April 2017 caseload[50]

Visited A&E
- Earliest audit: 61%
- Most recent audit: 53%

Used an ambulance
- Earliest audit: 46%
- Most recent audit: 40%

Been admitted to hospital
- Earliest audit: 34%
- Most recent audit: 37%

Earliest audit | Most recent audit

Figure 10: Proportion of all clients since 2015 accessing secondary care 'in the last six months' (earliest Vs most recent audit) (n=209) – All-time caseload[51]

Case study: Hannah

Hannah and her partner were living in a caravan and did not consider themselves homeless. However, their living situation became more and more difficult and they decided to look for help.

Hannah found HHLS through the Vineyard where she was encouraged by her key worker to see a GP. She had fibroids and needed a hysterectomy but was putting it off because she didn't feel that the caravan was a suitable place to recover in. She previously relied upon A&E as she could not get an appointment at the GP:

"I was going to A&E frequently for pain relief. I was trying to manage with paracetamol. It was weird going to A&E for pain relief and it was probably weird for them too. I felt like I was abusing the service but it was a last resort for me as the doctor wouldn't see me. I am going to A&E less now. It's better that I can go to the doctors they know me and my history. I was going twice a month to A&E before and now not at all. I will only go to the hospital for my operation."

Hannah's HHLS key worker helped her to access the GP by accompanying her to register and by *"using her SPEAR name to persuade them"* to register her. Her key worker also made phone calls on her behalf as she often didn't have phone credit. Hannah feels that without this, she would have continued to seek pain relief from A&E, rather than going to the GP. As well as helping to address these practical and systemic barriers, Hannah also feels that HHLS took the worry and stress out of accessing appropriate health care. She explains, *"I feel like I can laugh and smile again... such a good moment when you realise that."*

This reflects evidence from other studies which also show that health advocacy services for homeless people can reduce the burden on existing services. Graham et al. found that homeless clients who were registered with a GP during outreach visits made significantly less use of health centre resources, meaning the additional costs of providing health advocacy were offset.[52] This finding was also reflected in the evaluation of Groundswell's homeless health peer advocacy service.[53]

In addition, HHLS clients reported increased access to specialist health and care services to meet their health needs, including treatment for substance misuse. Figure 11 shows that the proportion of clients getting support for alcohol use almost triple since the last health audit, from 13% to 36%.[54] The proportion of clients receiving support to address drug use also increased slightly, but not significantly, by +7%pts.[55] A large majority (92%) of clients said they know how to access sexual health advice, up by +7%pts since the earliest health audit.[56]

Figure 11: Clients access to specialist services (earliest vs most recent health audit)- post April 2017 caseload[57]

Overall, HHLS helps to increase client access to appropriate health and social care, including access to primary and preventative care, with a lower proportion of clients accessing secondary care over time. There is scope for HHLS to increase clients' access to mental health care, albeit this is only partially within the control of HHLS.

Social and community connections

"They make sure that I wasn't sat in a room 24/7 and never got out. That I went out and met people or went back home. HHLS client

The HHLS model recognises that social and community connections are a key driver of health and wellbeing, and that homeless people are more likely to suffer from loneliness and isolation (see Section 1). As such, a focus on enhancing the social and community connections of clients is a key aspect of HHLS.

Overall, **clients reported a slight increase in social connections since** they engaged with HHLS[58]. Figure 12 shows that average client scores for 'feeling closer to other people', 'getting to know new people', and 'feeling supported by people', all increased slightly over time.

Figure 12: Mean score out of 1-5 scale – change over time (first vs most recent) (n=60)

Bar chart showing mean scores:
- I've been feeling close to other people: 2.3 / 2.8
- I've been getting to know new people: 2.4 / 2.8
- I've been feeling supported by people: 3.1 / 3.2

Legend: Earliest audit / Most recent audit

Clients, staff and external professionals report that HHLS improves the social and community connections of many clients. For example a staff member spoke about the supportive and community environment created by HHLS and the wider organisation: *"It is working well - for individuals it is working well. We have a caring bunch of people, a familiar face that isn't statutory - almost a friend or family member"*

Another staff member elaborated on the success of the peer mentoring system and how it helps to build a "community network" by tapping into local groups and networks which in turn addresses social isolation, exclusion and loneliness.

The increased community involvement and improved social networks is also reiterated by clients. One of the clients described how she met people through the service that she had something in common with. Another client explained that she enjoys *"seeing people in my class regularly, otherwise I would have been sat at home on my own."*

Clients are also appreciative of the various different activities that the HHLS service referred them to such as gyms, yoga classes, gardening clubs, libraries and mental health groups. This illustrates how for some people HHLS helps to prevent and reduce loneliness.

A minority of clients also told us that HHLS helps them to maintain healthy intimate relationships. For example: *"My partner has mental health problems ... he don't want to burden me with his problems so he speaks to his key worker ... it really helps him and our relationships ... he respects and trusts his key worker."*

This is particularly valued by clients who explain that the importance of intimate relationships among homeless people is under-recognised. Many support services do not enable these relationships to be easily maintained, for example by only providing single-sex hostels.

As with the increase in confidence, volunteers and peer mentors also told us how their voluntary role has improved their social ties. For one volunteer coming to the peer mentor course was a reason to get out of the house, while another explained how volunteering *"gives me social connections. My friends are at SPEAR. I was very closed before".*

Evidently HHLS helps to boost client and volunteer social and community connections through a range of relationship building activities. It also helps to build client support networks beyond HHLS and SPEAR so that clients have multiple sources of support. In this way HHLS is helping to reduce loneliness and isolation which are key social determinants of poor health.
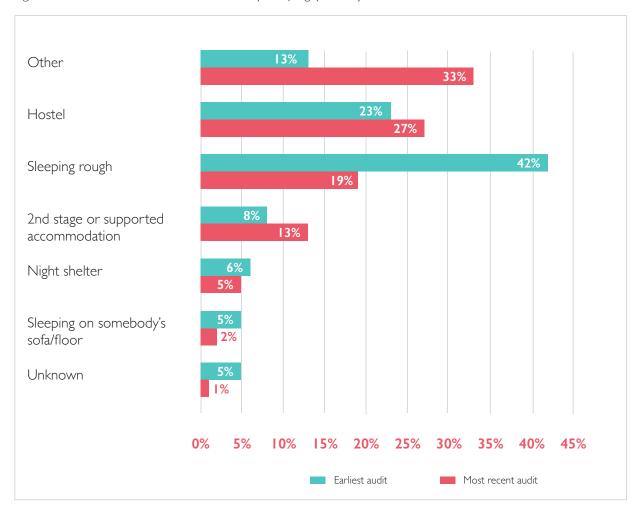
Settled accommodation

"I'm in a shared house now. Before I was on the street. I feel I am thinking clearly now, thinking about getting into work. When you're on the street you feel like you're at the bottom. HHLS client

As a housing association, SPEAR recognises that settled accommodation can help people to maintain good physical and mental health, and vice-versa. One of the aims of HHLS is to support clients to transition to more settled accommodation. HHLS staff work closely with the SPEAR resettlement team to achieve this and

Figure 13 shows that the proportion of HHLS clients sleeping on the streets more than halved during their engagement with the service.[59] In addition, the proportion of clients in 'other' accommodation, which includes non-supported independent housing options, such as the private rented sector, more than doubled.

Figure 13: Location where clients are currently sleeping (n=106)

One key advantage of increased settled accommodation is that clients who have been admitted to hospital can be discharged in a timelier manner, helping clients to become independent more quickly and reducing secondary care costs. HHLS data shows that while just 7% of clients had somewhere suitable to go upon discharge from their last visit to hospital at the first audit, this had increased to 18% at the most recent audit.

Settled accommodation also provides clients with somewhere suitable to recover following discharge, reducing the likelihood of complications and a need for readmission: *"we [HHLS] avoid relapsing and keep them in accommodation".*

Clients also recognise the reciprocal connection between health and housing. As one client told us, *"I have been referred to the wellbeing service and the GP … I feel like health care is a stepping stone for getting off the street."*

This is further supported by the example of a man who had drank heavily, lived on the streets and was previously unable to access alcohol support services. However, through the help of HHLS he is now sober and living in a training flat. We found that by linking health and housing, particularly through being housed in suitable accommodation for their health needs, clients are more likely to thrive. For example, participants explained that accommodation may need to vary depending on a client's mobility needs, where they are in their addiction recovery and what their mental health needs are,

3.2 Volunteers

As well as positively impacting on clients, our research clearly shows that HHLS has a positive impact on those who volunteer for the service, all of whom have lived experience of homelessness or being at risk of homelessness. As an HHLS staff member observed, volunteers *"tackle social isolation and help to build a community network around the client that is mutually beneficial to the volunteer and the client"*.

In particular, the experience of providing support to clients appears to have a positive impact on the confidence of volunteers. One volunteer said simply: *"It's made me want to achieve so much more"*.

Moreover, involvement with the service allows volunteers to develop experience and skills which can lead to employment and further opportunities. One current volunteer explained; *"We're able to get work experience, we're able to engage with people, we can build up the skills like computer skills, you know, hopefully lead to a paid job. That's what I'm trying to do."*

Some volunteers have gone on to become peer mentors, and 7 out of 8 peer mentors have gone onto gain paid employment or further volunteering work. As such, HHLS and SPEAR more broadly helps to create a pathway for personal and professional development for volunteers and peer mentors.

Case study: Barbara

Barbara is a peer mentor and supports HHLS staff at drop in sessions around Richmond and Kingston, as well as organising fundraisers and outings for clients.

Barbara explains that volunteering as a peer mentor has improved her confidence and her social connections – things she says she lost when she became homeless:

"I used to be somebody quiet in the corner. Volunteering is very helpful … I felt much better after I did the peer mentoring course ... I felt rubbish before and not useful. I couldn't do anything. I like to work. Volunteering is my work, it's my activity. It gives me social connections. My friends are at SPEAR. I was very closed before."

Over the last year, through the service user involvement group and with volunteer clients, Barbara has helped to organise outings to the zoo, summer picnics, fashion evenings, Christmas wrapping and craft sessions. Whilst Barbara supports clients, she also feels that HHLS is supportive and flexible around her own health.

3.3 Health and social care professionals

As well as working with homeless people to help them access mainstream health and social care services, HHLS also collaborates with health and care professionals to help them work more effectively with homeless clients. In particular it seeks to support health and social care professionals to better understand the health issues homeless people face and the health pathways available to them.

To date, the service has delivered presentations and training to approximately 270 professionals from a range of professions, including GPs, hospital doctors, sexual health professionals, dentists, and substance misuse professionals, amongst others.

As shown in Figure 14, the majority of these professionals (94%) agree/strongly agree that HHLS has improved their understanding of the health needs of homeless people. A recovery

practitioner commented that, *"they have improved my knowledge. They have highlighted the difficulties that homeless people face and how they are locked out of GP surgeries".*

The vast majority of professionals (97%) also strongly agree/agree that their interaction with HHLS has improved their understanding of how to address the health needs of homeless people.

Many professionals remarked that their contact with HHLS has made them more aware of the health pathways available for homeless people. For example, a discharge officer said that they found out about, *"lots of services I did not previously know about, very helpful and approachable team."*

Professionals agreed that through contact with HHLS they were helping clients to access support services, especially community services that they otherwise wouldn't have. This suggests that HHLS helped to raise awareness of homeless health issues as well as ways of addressing them.

Figure 14: How far professionals agree with the question 'How far do you agree that your contact with the HHLS has improved your understanding of the health needs of homeless people?' (n=67)

Several mentioned their intention to make referrals to SPEAR after attending the training. One probation officer said that their *"knowledge of SPEAR service improved greatly. [I] will be using the service a lot"*.

The geographic reach of HHLS is the main priority for service development highlighted by professionals. Many would be able to make better use of the service if it reached beyond its current borough boundaries and/ or linked up with other services in adjacent areas. For example, a probation officer said that HHLS, *"improved my understanding however you do not cover Sutton!"* as well as a social worker who thought *"It would have been better if the service was linked with Wandsworth as Richmond and Wandsworth are shared staffing."*

A senior discharge coordinator also noted potential benefits of working in closer partnership within hospitals and other health and social care services *"ideally allocated workers to the hospital to proactively manage homelessness [issues]"*.

3.4 Impact on health care costs

Although the HHLS was set up initially and primarily to improve the health and wellbeing of homeless people, an allied benefit is its potential to achieve cost savings for health and social care services in the medium to long term. Most professionals agreed that *"the HHLS service is very cost effective as it supports people before their problems get too entrenched."*

Another professional in the local area adds, *"I do think that it's reducing use of hospital and A&E"*, referring in particular to admissions as a result of self-harm and suicide. This is further exemplified through the experience of another professional who knew of a homeless man who was suffering from substance misuse and regularly attempting suicide, requiring frequent support from the police, ambulance and A&E services. Since this client started to receive support from the HHLS team, there have been no further suicide attempts. In this case HHLS helped to reduce unplanned care costs as well as, and more importantly, potentially saving this man's life.

Our economic analysis of the HHLS is constrained by the available data but suggests that it is delivering cost savings for health services among some clients. It is difficult to draw robust conclusions for several reasons: first, health audit data collected at two points in time is not available for all clients; second, the length of time between health audits varies considerably, as does the time of year at which they were completed, which means it is prone to seasonal effects; and, third, service use data is self-reported by the client, rather than coming from administrative data, and is therefore vulnerable to recall and optimism bias.

Below we highlight economic analysis of service use for two clients, for the six months before they accessed HHLS, and then during six months during which they were being supported by HHLS.[60] We have selected an example showing cost avoidance, as well as an example showing of increased costs, to demonstrate the range of impact that HHLS can have on health care costs.

Figure 15 shows that for one client, their use of primary care increased, and their use of secondary care decreased, during their engagement with HHLS. Assuming that without the HHLS intervention this client would have continued to use health services in the same way as they did at Time 1, HHLS may have helped to avoid around £9,313 in costs to statutory health services. This is consistent with qualitative evidence of client journeys, many of whom have been supported to access primary and preventative care.
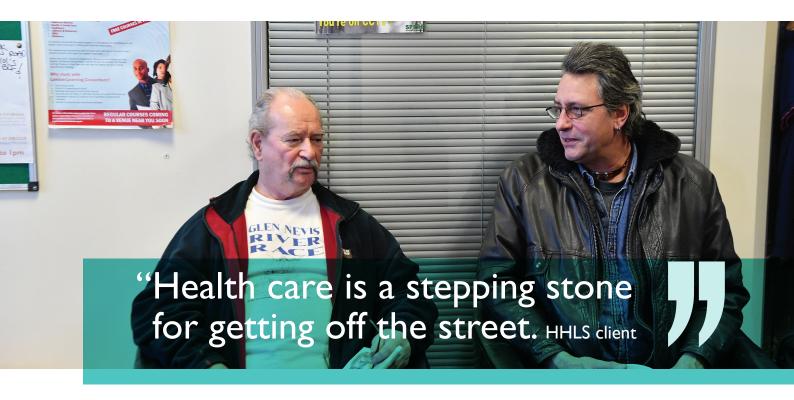
Figure 15: Estimated costs avoided for an HHLS client whose use of secondary care decreased over time

Time 1 Service use and cost (six month period)		
Service	**Number of times**	**Estimated cost**
Primary care		
GP appointment	1	£37
Nurse appointment	4	£180
Secondary care		
Outpatient appointment	4	£480
A&E attendance	4	£592
Ambulance use	4	£944
Hospital admission	4	£7,228
Total Time 1 health care costs		**£9,461**
Time 2 service use and cost (six month period, since engagement with HHLS)		
Primary care		
GP appointment	4	£148
Nurse appointment	0	£0
Secondary care		
Outpatient appointment	0	£0
A&E attendance	0	£0
Ambulance use	0	£0
Hospital admission	0	£0
Total Time 2 health care costs		**£148**
Estimated costs avoided		**£9,313**

Alternatively, Figure 16 shows that for another client, their use of secondary care remained stabled since they engaged with HHLS, while their use of primary care increased as they began to attend GP and nurse appointments. As such, the cost of their service use increased slightly over time, by around £164 compared to the six months before they started engaging with HHLS. This client explained that HHLS had helped him to register with a GP and access a wellbeing service and that for him, *"health care is a stepping stone for getting off the street".* At the time of interview

this client was about to embark on peer mentor training and expressed that they felt *"more needed and more connected"* than they had for a long time.

Therefore, while HHLS may have resulted in increased demand on health services (and therefore increased costs) in this case in the short to medium-term, qualitative evidence suggests that in the longer-term, HHLS may result in reduced overall health costs for this client, and that it is in any case helping to improve their outcomes more broadly.

> "Health care is a stepping stone for getting off the street. HHLS client

An overall analysis of health costs incurred by all clients since April 2017 who had at least six months between a Time 1 and Time 2 health audit, we find that on average there was a small increase of on average £112 in health care costs at Time 2 compared with Time 1. As our analysis has shown, one of the key ways that HHLS supports client's health is by helping them to access health and social care services.

As such it is unsurprising that in the short to medium term client use of services (and associated service costs) has increased, in many cases leading to improved health, wellbeing and avoided fatalities.

As one professional explained the economic impact of HHLS on health service costs: *"They edge about a percentage in the right direction every year but that is the difference of probably a couple of lives a year."*

In addition, this evaluation only applies to a relatively short time period (since April 2017) and qualitative evidence collected, as well as evidence on similar services[61] suggests that over time by increasing client access to primary and preventative care, HHLS is likely to improve client health and wellbeing and reduce overall health care costs. A longer term evaluation, including all HHLS clients and NHS data, will help to establish if this is the case.

Figure 16: Estimated costs avoided for an HHLS client whose use of secondary care remained stable

Time 1 Service use and cost (six month period)		
Service	**Number of times**	**Estimated cost**
Primary care		
GP appointment	0	£0
Nurse appointment	0	£0
Secondary care		
Outpatient appointment	0	£0
A&E attendance	4	£592
Ambulance use	2	£472
Hospital admission	2	£3,614
Total Time 1 health care costs		**£4,678**
Time 2 service use and cost (six month period, since engagement with HHLS)		
Primary care		
GP appointment	2	£74
Nurse appointment	2	£90
Secondary care		
Outpatient appointment	0	£0
A&E attendance	4	£592
Ambulance use	2	£472
Hospital admission	2	£3,614
Total Time 2 health care costs		**£4,842**
Difference between Time 1 and Time 2 costs		**-£164**

4. HOW THE HHLS WORKS

Key messages

The Homeless Health Link Service was established to ensure that the health needs of homeless people in Richmond and Kingston are not being overlooked. It provides one-to-one and group-based support and advocacy for homeless people; training and awareness raising to health and care professionals; and training and support to volunteers. It is based on a number of core principles which we explore in this section:

- **HHLS takes a relationship-based and human-centred approach** to working with clients, based on forming trusting, long-term and flexible relationships between staff/volunteers and clients. It recognises the strengths and assets of clients as well as their needs and challenges, and supports them to address a wide range of social, as well as medical, determinants of their health and wellbeing.

- **HHLS draws on the expertise of people who have experienced homelessness** and has recruited and supported 22 people (including eight accredited peer mentors) with lived experience of homelessness as volunteers. This has a mutually beneficial impact on both clients and volunteers and helps to break down barriers between 'professionals' and 'service users', as well as establishing a pathway for personal and professional development.

- **HHLS works in partnership with other organisations and professionals** by: sharing information with them; attending multi-agency meetings about clients; advising other agencies how to support clients, as well as considering the advice of other agencies and professionals.

- **HHLS builds bridges between homeless people and health and social care services**, including primary and preventative health care, as well as community-based and specialist services. It does this by addressing the practical, personal and systemic barriers that homeless people face when accessing support.

4.1 Relationship-based and human-centred

"I trust my worker with my life. It's the truth. HHLS client

HHLS takes a 'people first' not 'problem first' approach, recognising aspirations, abilities, interests and talents.'[62] This helps staff and volunteers to build meaningful relationships with clients which is key to enabling positive change for many clients. As one staff member described, HHLS *"treats individuals as human beings"*. One way that people feel that HHLS takes a human-centred approach is by working with clients on the many and often social issues that affect their health, rather than focusing narrowly on clinical needs and solutions. The interconnectedness of housing and health mean that, as one professional noted, *"a lot of people drop through the cracks if you don't have one holistic service."* Clients also reiterated this:

"The health link is very good - everyone is different and they do a huge brilliant job…The SPEAR and health link are like an umbrella for people in need….

I come here I had the issue with my house. But everything has surprised me - I get courses. I have a new way in my life. They do a perfect job."

Describing how the service is tailored and flexible to individuals a client expressed, *"they don't force themselves on you, you know. It stands with the individual if they want to go along with them, they go along with them and link up to other activities going to help with homeless people."* Another client added that they were also supported by HHLS even when their needs didn't fall into any 'typical' categories. This illustrates how HHLS is felt to adapt to the needs and abilities of clients, rather than expecting clients to be flexible to the way the service works. In turn this holistic and human-centred approach helps to build meaningful and trusting relationships between HHLS staff, volunteers and clients.

Case study: Gary

After coming out of a rehabilitation service, and going in and out of hostels, Gary became homeless and was sleeping on the streets. He first heard about SPEAR through people he knew on the street. At the Vineyard drop-in centre in Richmond he met an HHLS worker who was supporting homeless people with their diet, arranging medical appointments and screenings. Gary had been struggling with alcohol and drug abuse for years.

Gary finds the HHLS staff very "welcoming" and feels that they haven't given up on him, even during challenging periods:

"If you want them to go with you, they go with you. They don't force themselves on you, you know…to a certain extent it may have appeared I have stuck two fingers up and I haven't and I am aware that they know that … a lot of people would have given up. Personally, they give me encouragement, words of wisdom, good counsel. I mean just like today. I didn't really come to see anyone per se, but they let me come in and sit in the waiting room and just chill out. Draw, read whatever, just so I feel well."

With the support of SPEAR Gary is now consistently accessing drug and alcohol support and going to college which has improved his wellbeing. Gary was accompanied to his medical appointments by his HHLS worker and, in his view, this has helped him to keep appointments and communicate with medical staff. Although he is still on the streets, he is, with the help of SPEAR and the HHLS team, *"not giving up on himself"* and becoming *"more stable one step at a time"*.

One factor which at times appears to limit the ability of HHLS to build and maintain strong relationships with clients is staff shortage and turnover. This view is reflected by some members of staff who feel that *"a lot of the work is firefighting."* It has also been noticed by a minority of clients, such as one who told us that HHLS *"could have contacted me more frequently"*. Perhaps inevitably, staffing challenges cause some *"negative impacts. Whether huge or very minor in terms of the relationships forming. Things have been lost between workers."*

As in any organisation, HHLS has had to manage staff turnover. Staff reported that this is a particular challenge in a front-line service of this kind, and especially given that SPEAR often recruits staff with lived experience of homelessness (see section 3.2) who may have faced or be facing complex challenges in their lives. Most staff and professionals feel that with more staff and peer mentors, HHLS could build on the support they are giving to clients and, importantly, would be able to reach more homeless people.

As with any service, it can be more difficult to build relationships with people who have more entrenched problems and who do not want to engage. As one client explained *"there are people who do not want to be in the system and who do not want help"*. It can be difficult for some people to ask for help and others may not consider themselves as 'homeless'. In recognition of the fact that many people do not come to the hub the team now travel to visit clients instead and hold more drop-in sessions at other locations. There are also practical challenges to building and maintaining relationships, for example with supporting clients who are moved outside the borough or whose first language is not English.

4.2 Experts by experience

> # "Clients also have someone else to listen to them, to hear their journey. Peer mentors have had a similar journey - trust is key and they have that rapport and consistency know that they're there. SPEAR staff

Core to the HHLS model is that it draws on the expertise and skills of people with lived experience of the health and wellbeing challenges facing homeless people. It does this by recruiting and training people with experience of homelessness as volunteers for HHLS, recognising their expertise through experience.

All HHLS volunteers are ex-clients of SPEAR or of other similar services. Each HHLS volunteer receives an induction and monthly supervision to review progress and development needs. In total 22 people have volunteered for HHLS, eight of whom have undertaken accredited training to become peer mentors. [63]

This aspect of the service was introduced in its second phase, since April 2017, and was based partly on the value of peer support highlighted in Saving Money, Saving Lives. MacLellan et al.'s (2015) systematic review also found that reciprocity of formed relations and a sense of responsibility of peer service workers allowed for a breaking down of traditional power structures within the health system.

Volunteers are as critical as paid staff to the success of HHLS. One volunteer explained:

"I think we are quite an asset really to the service … the staff does all the paperwork really and the volunteers go out to the appointments".

HHLS also agreed that volunteers are key to the success of the service because they help to challenge barriers between clients and professionals:

"volunteers are powerful because they are an example to others. They create a breakdown of 'them and us'".

Several volunteers explained how their own experience of homelessness allows them to empathise with the situations of clients. For example, one volunteer explained that:

"I used my own experience to calm down an aggressive service user… I remembered how I felt and I said words to calm her ' I know how hard it is', 'trust me it will get better' and it worked step by step."

"If you've experienced something yourself you can better come alongside someone else".

Comparing HHLS to another service in the area, a client told us that this other service does not understand the problems homeless people experience because, unlike HHLS, they do not have volunteers with lived experience.

HHLS also encourages all clients to get involved in volunteering and supporting the service and each other through its service user involvement network. Since April 2017 20 HHLS clients have engaged in this network, which has given them the opportunity to:

- Support others to attend health days and checks

- Organise and attend a wide range of social and seasonal events

- Support SPEAR fundraising efforts and explore training and employment opportunities

- Advise HHLS about how to develop the service

In this way HHLS helps to provide a pathway for clients to not only improve health and wellbeing, but also to develop broader skills for their future. Clients also recognise the opportunities for development and involvement which HHLS volunteering creates:

"And they have this other thing like, as you progress, you can become a peer mentor, go to college … you can do your GCSEs whilst in the hostel, they give you access."

Indeed, 7 out of 8 HHLS and SPEAR peer mentors have gone on to gain paid or voluntary work at SPEAR or elsewhere.

4.3 Building bridges

"We take a bridge building approach."
Staff member

Our research shows that HHLS helps to build bridges between homeless clients and health and social care services, especially primary and preventative care. There are a range of ways in which HHLS helps to build bridges between homeless people and mainstream services in order to achieve this:

- **Informing clients about available services.** Of the 239 clients included in the Healthlink audit, 72% said they had been given information about local health services. Out of this group, 76% said they found the information useful:

  "Basically it's all been information to be honest...it just keeps me informed of what I am entitled to and what I can or cannot do."

- **Helping clients to overcome practical barriers.** Clients report that HHLS helps them to overcome practical barriers to accessing support, such as travel costs for appointments, being reminded about appointments by their key worker, and being supported with form filling or making phone calls:

"Julia has phoned doctors for me to make appointments because I don't have phone credit. That's helped me immensely. No phone credit means no doctors, no prescriptions. It's been a god send that she's taken that on for me."

- **Giving clients the confidence to access mainstream support.** Some clients report that HHLS has made them more confident accessing mainstream support and in relating with professionals, often facilitated by the presence of a trusted HHLS worker:

  "They've helped me get set up with the doctor, opticians, wellbeing services and the dentist. I have schizophrenia. They don't pretend to be experts on this, which is to their credit. My key worker attended appointments with me. It was helpful as I was struggling to communicate; it was reassuring that she was there and it made me realise that what I was saying did make sense. She just listened."

- **Empowering clients to address health issues.** Many clients describe how engagement with the HHLS team encouraged them to seek medical help, often sooner than they would otherwise have done:

"I met Sandy when she found out about my medical issues, she said I had to get them sorted and go to the doctor. I wasn't dealing with it before."

"If it wasn't for HHLS I would be plodding along the way I was… It would be 8 years until I see a doctor. "

Professionals agreed, with one person stating that HHLS increases the *"health awareness amongst the homeless population".* In other cases, HHLS was able to recognise health issues that other services did not recognise:

"I found my health needs were not being met in my Borough - they dismissed my health needs … I accessed SPEAR through the drop in at the Vineyard. They recognised my health issues as well as homelessness."

HHLS also works directly with health and social practitioners to support them to better understand the health issues of homeless people and how to deal with them. As one staff member explained: *"It re-humanises the individual to services, rather than being seen as a service area or number".*

This is reflected in comments from professionals who also reflect that HHLS has helped them to better work with homeless clients in a range of ways. For instance, one professional from the council told us that:

"I've worked closely with HHLS since last October. HHLS have been key in linking us with other organisations, informing about what client's needs are and barriers to engagement and in bringing clients along to events/programs".

In section 2.3 we explore in more detail the impact that HHLS has had on health and care professionals, and how this has helped to build bridges between clients and health and social care support. However, from the client perspective, there is evidence that HHLS staff have helped to improve relationships and understanding between health care practitioners and clients. As one client described:

"I needed an address to actually allow me to register with a doctor, there was also the barrier of no ID. My worker advocated for me. I now have an understanding of the doctor. He deals with lots of residents, he understands me. Previously, doctors had been dismissive it makes you not want to engage. I need medical advice - I don't need judgement."

Case study: Jake

Jake was sleeping in his van when someone from Penny Wade hostel knocked on this door and told him about SPEAR and HHLS. HHLS staff have helped him to access the doctor, wellbeing services and the dentist. They have also helped him to get an appointment with an optician and a voucher for prescription glasses. He explained the difference this support made to him:

"It made it all much quicker and easier. It helped a lot. I didn't have to focus on this as they know how the doctor and dentists work. For me it would have been challenging without a phone or an address."

Jake has schizophrenia and was not sure if his medical practitioners understood his health needs. The HHLS team have been very supportive and have reassured him, and given him the confidence that what he was saying to professionals did make sense. This means he can access the help he needs more easily and independently. Jake is now enjoying living in the same SPEAR hostel as his girlfriend, along with his five guinea pigs who he looks after in the garden, and which he feels is also beneficial to his wellbeing.

4.4 Partnership working

"HHLS definitely work well in partnership with others in the sector. Professional

Close partnership working with wider SPEAR teams and external service providers is a key feature of how HHLS works.

In particular, HHLS facilitates collaborative working and information sharing to better meet client needs. As one staff member explained: *"For clients, we need to work as a system not as individual organisations, creating multiple networks."* A professional described how the HHLS team have a willingness to partner, connect with other organisations and are not competitive in this respect.

The success of their partnering is further exemplified by the fact that other services told us they feel they can trust referrals to HHLS. Relationships that HHLS have built with partners have, in turn, helped to improve those organisations' relationships with SPEAR more broadly. Furthermore, one professional specifically illustrated the contribution that the HHLS has made in improving his own organisation's ability to work with mental health services: *"mental health services were working in silos but HHLS chase them up and our relationship has improved so much with them."*

When asked, most clients felt unsure as to whether or not professionals work well together to support them. A minority of clients responded positively, for instance: *"As a group. Yes. Very impressive yes. Well basically A always speaks to B so then if I stop to speak to C, they will know what is going on."*

As well as sharing information with other services, HHLS also refer clients to and take referrals from other services as part of a wider network of support, depending on client needs and interests

As one professional explained, HHLS *'fill in the gaps within SPEAR itself and across other services'.* Reflecting this, clients spoke about how they were referred to the integrated recovery service (IRS), job centres, medical centres, libraries, other charities, drop-in centres and mental health services.

While our research shows that the partnerships and relationships developed at SPEAR are effective, some staff commented *"that 'there is always room for improvement'"* and *"for reaching others'",* for example, by partnering with other organisations to organise an event or share intelligence.

While most participants agree that HHLS is effective at communicating with clients and professionals, a minority of professional feel there could be better publicity and promotion of their services, for example at statutory service meetings, and that, at times, *"their main audience is their own organisation".*

Similarly, a minority of clients suggested that HHLS could be better promoted: *"I think that there should be more advertisement to let people know that there is places like SPEAR in Twickenham because a lot of people I have noticed from other areas who come to Richmond and Twickenham don't know about the hub as such".* This client suggested putting up posters in local libraries etc. Similarly, another spoke about how she would have sought help through HHLS sooner had she known that the service was open to any homeless person; she had initially thought the service was more suited to people with substance misuse problems. This suggests that HHLS may be able to reach more people by communicating externally more clearly about the service.

5. CONCLUSION AND RECOMMENDATIONS

Overall our research shows that HHLS is achieving its aims and objectives. In particular, HHLS is having a positive impact on: client experience; mental health and wellbeing; confidence and self-esteem; social and community connections; access to appropriate care; and settled accommodation. Client physical health appeared to remain stable, and our analysis suggests that over longer periods of engagement with HHLS, client physical health is likely to improve. There is also evidence that HHLS has directly helped to save lives through suicide prevention.

For some individuals, HHLS is helping to reduce costs to the health system, by helping clients to address health issues before they escalate and by helping clients to access primary and preventative care, rather than resorting to unplanned secondary care. Our analysis suggests that over time, this may result in overall cost avoidance for health and social agencies. However as with many early intervention approaches, in order to improve the lives of clients, HHLS may be slightly increasing costs to health and social care agencies in the short to medium term.

HHLS is also having a positive impact on volunteers' confidence, self-esteem, personal and professional development, as well as on health and social care professionals and their ability to work effectively with homeless people.

They key characteristics of HHLS which are supporting this positive impact are:

- It takes a **relational and human-centred approach to working with clients** which is based on working flexibly with clients depending on their own unique strengths and needs, rather than expecting clients to adapt to the service. It builds meaningful relationships of trust with clients which becomes a platform for addressing health and other issues.

- It recognises the **expertise of those with lived experience of homelessness** by recruiting them as volunteers, drawing on their understanding and skills to engage and support people currently experiencing homelessness.

- It **works in partnership with a wide range of health and social care and voluntary sector agencies**, supporting coordinated and collaborative work around clients.

Recommendations

Our research has highlighted the following recommendations for increasing and amplifying the impact of HHLS:

- Ensure that the service is being as widely marketed as possible to potential clients and also professionals to ensure that those who could benefit are aware of and able to access the service.

- Continue to develop HHLS partnership work with mental health and explore ways of ensuring that more clients have access to the mental health support that may benefit them.

- Continue to focus on the recruitment and retention of effective staff for HHLS as they are fundamental to the success of the service and even a low level of staff turnover can be detrimental to the relationship-based approach of the service.

- Develop data collection mechanisms such that a) WEMWEBS data is collected for all clients, b) monitoring data is collected at consistent intervals e.g. every 3 or 6 months, and c) HHLS has access to NHS administrative data on service use by clients.

- Explore further geographical areas where the service may be needed and seek funding to extend the service into these areas.

For policy-makers and commissioners

For policy makers and commissioners, our research highlights the following recommendations:

- Support a long-term evaluation of HHLS which has access to NHS data on HHLS clients. This will help to establish how far HHLS is achieving cost benefits for the health system.

- Continue to fund HHLS in Richmond and Kingston and identify locations where there is no equivalent provision and scope options for providing a health advocacy service for homeless people.

- In order to monitor the health of homeless people, Kingston London Borough Council should include the health needs of homeless people in its Joint Strategic Needs Assessment, as Richmond does.

- Health agencies should recognise the importance of sharing information and data with voluntary sector organisations which have shared goals. Health agencies, such as NHS foundation trusts, should explore ways of sharing data on service use and patient health, whilst respecting data protection regulations.

- Primary care providers should find ways of removing barriers to access among homeless people, for example by relaxing proof of address requirements or by providing Freephone telephone numbers. Indeed, there is no legal requirement for patients to provide proof of address to register with a GP but this is still a commonly reported barrier.[64]

- Review the extent to which mental health services are able to meet demand among homeless people and explore options for extending this provision.

- Health commissioners should ensure that they are aware of and follow the Healthy London Partnership commissioning guidance for the health and care of homeless people.

APPENDICES

Appendix 1: Outcomes framework

The table below outlines the HHLS outcomes framework, including outcome targets and current delivery against these. It also indicates the evidence that this is based on.

Figure 17: Outcomes framework, targets and progress to date

Outcome	Indicator	End of Project Target	Proportional target (75%)[65]	Achieved August 2018
Outcome 1: Health professionals in Richmond and Kingston will better understand homeless people, improving how they plan and deliver services to them	The number of health and social care professionals who demonstrate an increased understanding of the health issues facing homeless people	160	100[66]	65
	The number of health and social care professionals who report improved knowledge of the health pathways for homeless people	160	120	65
	The number of homeless people with joint care plans	60	45	79
Outcome 2: Homeless people will have increased confidence and self-esteem, enabling them to make informed choices and access appropriate health services	The number of people who have demonstrated their confidence by choosing to access appropriate support before their conditions become critical	35	26	57
	The number of people who commit to and complete specialist treatments when they are needed	55	41	51
	The number who gain in confidence and as a result register with a GP	143	107	160
Outcome 3: Service users' physical and mental health will improve, reducing the risk of developing severe or long term health problems	The number of people who are able to successfully make the transition from homelessness to a settled way of life or maintain their accommodation	102	77	70
	The number of people participating in community based health and social activities	135	101	167
	The number of people who report the development of new friendships and support networks	113	85	26
Outcome 4: Volunteers will gain confidence, self-esteem and improved social networks, improving their future life choices and health	The numbers of people who can demonstrate their increased confidence by taking a lead role in volunteer and project steering group meetings	8	6	5
	Volunteers will report feelings of reduced isolation as a result of the new friendship groups and support networks they have developed	4	3	5
	The number of people who demonstrate increased confidence and self-esteem as a result of becoming project volunteers	10	8	5

Appendix 2: HHLS activities

Figure 18: Summary of HHLS activity targets

YEAR ONE	Assess, register and refer 75 beneficiaries to primary care services (GP, dentist) and specialist health care services (mental health, drug and alcohol services) Run weekly one to one and group sessions for 75 beneficiaries to help them understand their diagnosis, symptoms and treatment options Volunteers[67] and staff will provide weekly advocacy/ accompaniment to 75 beneficiaries to medical appointments, health, leisure and social activities in the community Deliver monthly presentations/ reports on homeless people's health needs and our service model to 12 local, pan-London and national health/ social care agencies
YEAR TWO	(Repeated activities) Assess, register and refer 75 beneficiaries to primary care services and specialist health care services (Repeated activities) Run weekly sessions for 75 beneficiaries to help them understand their diagnosis, symptoms and treatment options (Repeated activities) Volunteers and staff provide weekly advocacy and accompaniment to 75 beneficiaries to medical appointments and activities in the community Deliver monthly presentations/ reports on homeless health and disseminate project evaluation to 50 health/ social care agencies and statutory/ charitable funders

Appendix 3: Methodology and data

This evaluation sought to answer the following questions:

1. **To what extent does the HHLS achieve its aims and objectives**

   a. What are the aims and objectives of HHLS
   b. What outcomes are they seeking to achieve
   c. To what extent are HHLS meeting these outcomes

2. **What is the cost benefit of HHLS?**

3. **How effective has the HHLS been and what impact has it had?**

   a. What has worked well
   b. What could be improved

4. **What have been the experiences of those who come into contact with HHLS?**

   a. What are service users' perspectives of using the services?
   b. What are volunteers' perspectives of the service?
   c. What are health and social care professionals' perspectives of the service?

5. **What could be further improved and how?**

Taking into account the nature of these questions and the complexity of information and data it would involve in answering them, we devised a mixed methods approach to the research which can be seen in Figure 19.

While we have been able to assess change over time through time 1 and time 2 monitoring data for clients, as well as through interviews and focus groups, we have been unable to definitively attribute any changes observed to the HHLS as our evaluation design has not included a control or comparison group.

This means that observed changes could have been the result of other factors, especially given that HHLS clients are often involved in multiple services and interventions at any one time.

Figure 19: Summary of evaluation methodology

Data Source	Description	Sample size	Notes
Documentation and literature review	We conducted a review of strategic and operational documentation relating to HHLS, as well as a literature scan related to the health of homeless people and current provision for their needs.	N/A	N/A
Client interviews and focus groups	We conducted face-to-face interviews and focus groups with HHLS clients and volunteers	• Interviews with 13 clients • Focus groups with 8 clients	A member of SPEAR staff or volunteer was present in interviews and focus groups.
Volunteer interviews	We conducted face-to-face interviews with HHLS volunteers	• Interviews with 6 volunteers	A member of SPEAR staff or another volunteer was present during these interviews.
Staff interviews	We conducted interviews with SPEAR and HHLS staff	• Interviews with 8 members of staff	These were conducted in person at SPEAR offices.
External professional interviews	We conducted interviews with professionals who have worked in partnership with HHLS	• Interviews with 8 external professionals	These were conducted over the telephone and included a wide range of professionals such as social workers, nurses, substance misuse workers, housing advisors and staff in other charities.
SPEAR monitoring data	Current service usage data available through In-Form.	Variable	Includes: All time and current caseload numbers, registration with GP, visits to GP, attending and completing specialist treatment
Healthlink Audit	Audit of client physical and mental health needs, and use of services	106 service users completed at least two audits. The length of time between audits varied but was on average 281 days (with a range of 35 to 966 days). 239 completed at least one audit.	Accessed via In-Form
Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	Well-being scale developed to enable the monitoring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing.[68]	60 (completed at least two WEMWBS). These 60 people also completed a Healthlink Audit.	WEMWBS is a 14 item scale with 5 response categories [1= None of the time – 5=All of the time], summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing. [69] Accessed via In-Form
Practitioner Survey	Paper surveys between October 2017 – August 2018	67 external professionals who had attended HHLS training or worked with SPEAR	These surveys were completed independently and also over the phone.

Economic analysis

The table below shows the estimated unit costs for health care services, which we used for the economic analysis. It should be noted that these are all averages and that in reality these costs vary depending on a number of factors, such as location of service and duration and intensity of service.

Figure 20: Summary of estimated unit costs for healthcare services used in the economic analysis

Service	Estimated unit cost	Source
GP appointment	£37	Unit Costs of Health and Social Care 2017[70]
Nurse appointment	£45	NHS Reference costs 2016/17[71]
Outpatient appointment	£120	NHS Reference costs 2016/17[72]
A&E attendance	£148	NHS Reference costs 2016/17[73]
Ambulance use	£236	NHS Reference costs 2016/17[74]
Hospital admission	£1,807	New Economy Unit Cost Database 2013/14[75]

Warwick-Edinburgh Mental Well-Being Scale

The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is a robust and widely used measure of mental wellbeing which can be used to evaluate impact of projects on participants, when 'before' and 'after' measurements are compared.[76]

WEMWEBS is a 14 item scale of positively worded statements (Figure 21).

Figure 21: WEMWEBS statements. Source: Warwick University (2012) Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide.

1	I've been feeling optimistic about the future
2	I've been feeling useful
3	I've been feeling relaxed
4	I've been feeling interested in other people
5	I've had energy to spare
6	I've been dealing with problems well
7	I've been thinking clearly
8	I've been feeling good about myself
9	I've been feeling close to other people
10	I've been feeling confident
11	I've been able to make up my own mind about things
12	I've been feeling loved
13	I've been interested in new things
14	I've been feeling cheerful

For each statement participants are asked to tick the box that best describes their experience over the last 2 weeks. Responses are presented on a 5 point ascending scale: 1 – None of the time to 5 – All of the time.[77] These scores are summed to provide a single score ranging from 14-70. Figure 22 illustrates how the levels of wellbeing used in the report were ascertained.

Figure 22: WEMWEBS scoring table used in evaluation

≤ 42	Low well-being
43-57	Moderate well-being
≥ 58	High well-being

In addition to the standard WEMWEBS scale, for the purposes of this evaluation SPEAR added two additional questions to the scale (Figure 23), intended to measure the development of new friendships and support networks.

Figure 23: WEMWBS 'friendship score' questions

1	I've been feeling optimistic about the future
2	I've been feeling useful

These scores were added in order to produce a 'friendship' score for clients, scored out of 5 for each variable. They were not included in the overall wellbeing score for clients.

ENDNOTES

[1]Fitzpatrick S, Pawson H, Bramley G, Wilcox S, Watts B & Wood J, (2018) The homelessness monitor: England 2018. Crisis. Available at: https://www.crisis.org.uk/media/238701/homelessness_monitor_england_es_2018.pdf

[2]Fitzpatrick S, Pawson H, Bramley G, Wilcox S, Watts B & Wood J, (2018) The homelessness monitor: England 2018. Crisis. Available at: https://www.crisis.org.uk/media/238701/homelessness_monitor_england_es_2018.pdf

[3]Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. Perspectives on Psychological Science 10(2) 227-237. Available at: https://www.ahsw.org.uk/userfiles/Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf

[4]NHS North West London (2013) Rough sleepers: health and healthcare. Available at: https://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

[5]Cromerty, H. (2018) Rough sleepers: access to services and support (England). House of Commons Library. Available at: file://platinum/downloads$/amanda.hill-dixon/Downloads/CBP-7698.pdf

[6]Finlayson S, Boelman V, Young R, Kwan A (2015) Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities. The Young Foundation. Available at: http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

[7]Fitzpatrick S, Pawson H, Bramley G, Wilcox S, Watts B & Wood J, (2018) The homelessness monitor: England 2018. Crisis. Available at: https://www.crisis.org.uk/media/238701/homelessness_monitor_england_es_2018.pdf

[8]Throughout this report when using the term 'professional' we are referring to professionals working in organisations and services external to SPEAR or HHLS.

[9]Finlayson S, Boelman V, Young R, Kwan A (2015) Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities. The Young Foundation. Available at: http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

[10]Statistical significance testing is applied to assess the likelihood that the difference or variation occurred by chance. (I.e. if a result is identified as significant, we are 95% confident that the difference is not due to chance).

[11]Fitzpatrick S, Pawson H, Bramley G, Wilcox S, Watts B & Wood J, (2018) The homelessness monitor: England 2018. Crisis. Available at: https://www.crisis.org.uk/media/238701/homelessness_monitor_england_es_2018.pdf

[12]Public Health England (2016) Homelessness: applying All Our Health. Available at: https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

[13]Faculty for Homeless and Inclusion Health (2018) Homeless and Inclusion Health standards for commissioners and service providers. Available at: https://www.pathway.org.uk/wp-content/uploads/Inclusion-Health-Standards-for-Commissioners-and-Service-Providers.pdf

[14]Public Health England and Homeless Link (2014) Preventing homelessness to improve health and wellbeing. Available at: https://www.gov.uk/government/publications/preventing-homelessness-to-improve-health-and-wellbeing

[15]Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med 7(7)

[16]Sanders B, Brown B (2015) 'I was all on my own': experiences of loneliness and isolation amongst homeless people. Crisis. Available at: https://www.crisis.org.uk/media/20504/crisis_i_was_all_on_my_own_2016.pdf

[17]Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D (2015) *Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review.* Perspectives on Psychological Science 10(2) 227-237. Available at: https://www.ahsw.org.uk/userfiles/Research/Perspectives%20on%20Psychological%20Science-2015-Holt-Lunstad-227-37.pdf

[18]Homeless Link (2014) *The Unhealthy State of Homelessness.* Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

[19]Homeless Link (2014) *The Unhealthy State of Homelessness.* Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

[20]Tri-morbidity which characterises many homeless people often has its roots in histories of complex trauma, including high levels of child neglect, which has in many cases impacted mental health and self-esteem. See: Faculty for Homeless and Inclusion Health (2018) *Homeless and Inclusion Health standards for commissioners and service providers.*

[21]Finlayson S, Boelman V, Young R, Kwan A (2015) *Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities.* The Young Foundation. Available at: http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

[22]Faculty for Homeless and Inclusion Health (2018) Homeless and Inclusion Health standards for commissioners and service providers. Available at: https://www.pathway.org.uk/wp-content/uploads/Inclusion-Health-Standards-for-Commissioners-and-Service-Providers.pdf

[23]The right type and level of support for a person's particular health and social care needs.

[24]Sources for these average service costs are outlined in Appendix 3.

[25]Finlayson S, Boelman V, Young R, Kwan A (2015) *Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities.* The Young Foundation. Available at: http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

[26]Homeless Link (2014) *The Unhealthy State of Homelessness.* Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

[27]Homeless Link (2015) *Homelessness health needs audit.* Available at: http://www.homeless.org.uk/facts/homelessness-innumbers/health-needs-audit-explore-data

[28]Homeless Link and St Mungo's (2012) *Improving hospital admission and discharge for people who are homeless.* Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/HOSPITAL_ADMISSION_AND_DISCHARGE._REPORTdoc.pdf

[29]NHS North West London (2013) *Rough sleepers: health and healthcare.* Available at: https://www.jsna.info/sites/default/files/Rough%20Sleepers%20Health%20and%20Healthcare%20Summary.pdf

[30]Homeless Link (2014) *The Unhealthy State of Homelessness.* Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

[31]Ministry of Housing, Communities & Local Government (2016) *Homelessness Provision, Borough.* Available at: https://data.london.gov.uk/dataset/homelessness

[32]The Kingston JSNA does not assess or provide information about the specific needs of homeless people in the borough. See: https://data.kingston.gov.uk/jsna

[33]London Borough of Richmond Upon Thames (2016) *Joint Strategic Needs Assessment.* Available at: https://www.richmond.gov.uk/jsna

[35]The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) was used to measure client wellbeing. See appendix 3 for more details.

[36]Health Survey for England 2016 *Well-being and mental health* (2017) Available at: http://healthsurvey.hscic.gov.uk/media/63763/HSE2016-Adult-wel-bei.pdf

[37]The increase in wellbeing scores after participating in HHLS is statistically significant at the 0.05 level.

[38]None of these changes are statistically significant at the 0.05 level.

[39]Only the changes related to chest pain/breathing problems and circulation problems/blood clots are statistically at the 0.05 level.

[40]The distribution of missing data on health conditions means it is difficult to calculate a mean figure with confidence.

[41]Owing to missing data, sample sizes are different for each of the physical health outcomes listed; Diabetes (n=95), Epilepsy (n=97), Circulation problems/blood clots (n=97), Skin/wound infection or problems (n=106), Urinary problems/infections (n=96), Liver problems (n=93), Stomach problems (n=97), Other physical health problem (n=89), Problems with feet (n=99), Chest pain/breathing problems (n=102), Fainting/blackouts (n=99), Difficulty seeing/eye problems (n=53), Dental/teeth problems (n=99), Aches/problems with bones and muscles (n=100).

[42]Owing to missing data, sample sizes are different for each of the physical health outcomes listed; Diabetes (n=138), Epilepsy (n=140), Circulation problems/blood clots (n=140), Skin/wound infection or problems (n=141), Urinary problems/infections (n=139), Liver problems (n=137), Stomach problems (n=139), Other physical health problem (n=132), Problems with feet (n=141), Chest pain/breathing problems (n=139), Fainting/blackouts (n=141), Difficulty seeing/eye problems (n=139), Dental/teeth problems (n=141), Aches/problems with bones and muscles (n=141).

[43]The difference in confidence scores between Time 1 and Time 2 is statistically significant at the 0.05 level.

[44]The earliest and most recent scores for 'I've been feeling confident' (scored on ascending a scale of 1-None of the time to 5-All of the time) were compared for services users who had completed at least two WEMWBS assessments.

[45]CBT = Cognitive Behavioural Therapy

[46]Both of these changes are statistically significant at the 0.05 level.

[47]Owing to missing data, sample sizes are different for each of the criteria; Visited a GP (104), Registered with a GP (105)

[48]None of these changes are statistically significant at the 0.05 level.

[49]Of these three types of secondary care use, the difference between Time 1 and Time 2 service use is statistically significant at the 0.05 level for visits to A&E and use of an ambulance.

[50]Owing to missing data, sample sizes are different for each of the criteria; Visited A&E (n=96), Used ambulance n=(102), been admitted to hospital (n=98)

[51]Owing to missing data, sample sizes are different for each of the criteria; Visited A&E (n=141), Used ambulance (n=143), been admitted to hospital (n=142)

[52]Heer B (2004) Building Bridges for Health: Exploring the potential of advocacy in London King's Fund. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/building-bridges-health-exploring-potential-for-advocacy-london-baljinder-heer-kings-fund-1-december-2004.pdf

[53]Finlayson S, Boelman V, Young R, Kwan A (2015) Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities. The Young Foundation. Available at: http://groundswell.org.uk/wp-content/uploads/2017/10/Saving-Lives-Saving-Money-Full-Report-Web.pdf

[54]Statistically significant at the 0.05 level.

[55]Not statistically significant at the 0.05 level.

[56]Statistically significant at the 0.05 level.

[57]Owing to missing data, sample sizes are different for each of the physical health outcomes listed; Knows how to access sexual health advice (n=105), Getting support for alcohol use (n=77), Getting support to address drug use (n=83)

[58]The overall change in social connection score is statistically significant at the 0.05 level. This was calculated by combining the results from across the three variables in Figure 12 i.e. the overall average score at Time 1 was 7.8/15 compared with 8.8/15 at Time 2.

[59]Statistically significant at the 0.05 level.

[60]Full details of the estimated service unit costs for these calculations can be seen in Appendix 3, economic analysis.

[61]Heer B (2004) *Building Bridges for Health: Exploring the potential of advocacy in London.* King's Fund; Finlayson S, Boelman V, Young R, Kwan A (2015) *Saving Lives, Saving Money: How Homeless Health Peer Advocacy Reduces Health Inequalities.*

[62]Local Government Association (2017) *The Impact of Homelessness on Health: A Guide for Local Authorities.* Available at: https://www.local.gov.uk/impact-health-homelessness-guide-local-authorities

[63]The peer mentor training was funded by Monument Trust, not Big Lottery Fund, but the advocates supported clients involved in HHLS.

[64]Cromerty, H. (2018) *Rough sleepers: access to services and support (England).* House of Commons Library. Available at: file://platinum/downloads$/amanda.hill-dixon/Downloads/CBP-7698.pdf

[65]This reflects the fact that at the time of the evaluation the service has six months of a 24 months funding contract left.

[66]This target was weighted towards the second year, with a target of 40 in the first year and 120 in the second year. The proportional target for year 2 is therefore 100 rather than 120.

[67]Volunteers are former and current service users with experience of being homeless, or at risk of homelessness.

[68]Warwick University (2012) *Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide.* Available at: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/researchers/userguide/wemwbs_practice_based_user_guide.pdf

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[70]Curtis L, Burns A (2017) *Unit Costs of Health and Social Care.* Personal Social Services Research Unit, University of Kent. Available at: https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2017/

[71]NHS Improvement (2017) *Reference costs 2016/17: highlights, analysis and introduction to the data.* Available at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_publication_VSnAQ5x.pdf

[72]NHS Improvement (2017) *Reference costs 2016/17: highlights, analysis and introduction to the data.* Available at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_publication_VSnAQ5x.pdf

[73]NHS Improvement (2017) *Reference costs 2016/17: highlights, analysis and introduction to the data.* Available at: https://improvement.nhs.uk/documents/1972/1_-_Reference_costs_publication_VSnAQ5x.pdf

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[76]NHS England (2016) *Health Survey for England.* Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016

[77]Warwick University (2012) *Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide.* Available at: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/researchers/userguide/wemwbs_practice_based_user_guide.pdf

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