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Peer advocacy and access to health care for people who are homeless in London, United Kingdom: A mixed-method impact, economic, and process evaluation protocol.

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ABSTRACT

Introduction: People who are homeless experience higher morbidity and mortality than the general population. These outcomes are exacerbated by inequitable access to health care. Emerging evidence suggests a role for peer advocates – i.e. trained volunteers with lived experience - to support people who are homeless to access health care.

Methods and analysis: We plan to conduct a mixed-methods evaluation to assess the effects (qualitative, cohort, economic studies); processes and contexts (qualitative study); and fidelity; acceptability and reach (process study), of Peer Advocacy on people who are homeless and on peers themselves, in London, United Kingdom (UK). People with lived experience of homelessness are partners in the design, execution, analysis, and dissemination of the evaluation.

Ethics and dissemination: Ethics approval for all study designs has been granted by the National Health Service London – Dulwich Research Ethics Committee (UK) and the London School of Hygiene and Tropical Medicine's Ethics Committee (UK). We plan to disseminate study progress and outputs via a website, conference presentations, community meetings, and peer-reviewed journal articles.

ARTICLE SUMMARY: Strengths and limitations of this study

- We conducted a mixed methods evaluation, offering multiple perspectives on the effect and mechanisms.
- For cohort study outcomes we used the NHS Hospital Episode Statistics database, an objective source with direct applications for policy.
- The cohort study outcomes excludes care received at GP surgeries, an important site of health care.
- The cohort study findings are subject to bias from unmeasured confounders.

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1.1 INTRODUCTION

Homelessness has been increasing in England through since 2010;(1) it is estimated that over a quarter of a million people were homeless in England in 2019, mostly in temporary accommodation, but also in hostels and rough sleeping.(2) These numbers are likely to increase further following the economic impact of COVID 19.(3) People who are homeless are more likely to experience physical, mental, and substance use disorders,(4) often in combination (4,5) than people who are stably housed; these disorders may have precipitated or contributed to homelessness, or were instigated by or aggravated by it.(6) Frequent health challenges faced by people who are homeless in England and Wales are evidenced by the average age of death: 45 years for men, and 43 years for women.(7)

In addition to managing poorer mental and physical health, uptake and access to health services is often restricted for people experiencing homelessness. Structural challenges such as cost of transportation or services, navigating complicated booking systems and facing stigma from service providers can create significant barriers, combined with difficulties in reconciling daily demands of being homeless that can deter people from prioritising care.(8,9) As a result, people experiencing homelessness are disproportionately likely to use Accident & Emergency departments (37% in the past 6 months) and to be admitted to hospital (27% in past 6 months).(4) In the United Kingdom this pattern of service use results in per capita hospital costs which are four to eight times higher than the general population,(10) motivating policy focus on socially excluded groups.(11)

To improve equity of health outcomes for excluded groups such as people who are homeless, researchers and advocates have been developing the Inclusion Health agenda,(12) within which interventions developed and delivered by people with lived experience have been identified as a promising strategy. A 2017 systematic review of peer-delivered interventions for adults who were homeless (13) found consistent, though low-quality, evidence of improved outcomes in several different domains of wellbeing, including physical health, mental health, substance use, and housing. Of the four studies in the systematic review which measured the effect on health care use,(14–17) all had positive findings but only one (15) was judged to be of high quality. Alongside measurement of health care outcomes, there is also a need to elaborate on the mechanisms linked to peer-

delivered interventions. A realist synthesis of peer support models pointed to the role of peers in providing empathy, understanding and acceptance (13) and others hypothesize the effect through role-modelling health-seeking behaviours and providing social support,(18) but there is a paucity of evidence for these mechanisms.

There is need for high-quality evidence to measure the effects of peer interventions on a range of clinical and social outcomes and to elaborate on the mechanisms and context linked in order to improve health and well-being of this vulnerable and growing population. Here, we set out the protocol for an evaluation of a peer-delivered advocacy intervention on health care use for people who are experiencing homelessness in London, United Kingdom.

2 METHODS and ANALYSIS

The aim of the project is to evaluate the impact, cost-efficacy and process mechanisms through which a peer advocacy intervention improves health care attendance and health and social outcomes among people experiencing homelessness in London. Objectives will be achieved through the implementation of four linked studies: a qualitative study, a cohort study, a cost-consequence analysis, and a process evaluation.

The specific objectives and study designs are:

Objective	Design
1. To explore the mechanisms, contexts and outcomes for peer advocacy and how they interplay with broader social and structural factors that shape health and social welfare and affect access to services to develop a Theory of Change	Qualitative
2. To explore the range of social and health outcomes the peer support programme brings to the peers themselves, and the mechanisms and contexts for these outcomes	Qualitative
3. To estimate the effect of engagement with peer advocacy on health service use (i.e. outpatient appointments, use of emergency services and hospital admissions.)	Cohort
4. To estimate change in health service use before and after engagement with peer advocates	Cohort
5. To measure associations between (non)engagement with peer advocacy on health and social outcomes and access to health services, including the mediating effect of other macro-structural, community and individual factors	Cohort
6. To perform an economic evaluation of peer advocacy compared to no provision on attendance at health services and the health and social welfare of homeless populations	Cost-consequence
7. To assess the fidelity, acceptability and reach of the intervention	Process

2.1 Patient and Public Involvement

The studies are informed through a participatory approach,(19) which is increasingly used within social science and epidemiological research with excluded populations. People with lived experience of homelessness are included as co-researchers in all aspects of the study design, data collection and

analysis and are included as members of our study steering committee, which also includes clinicians, researchers, and local government officials. The committee will be consulted for reviewing study instruments; collecting, analysing and disseminating data for qualitative and quantitative designs; and for guidance across all designs and dissemination activities.

2.2 Setting & context

We will draw on the UK government legal definition of homelessness comprising: people sleeping rough, people sleeping in a hostel, and people in insecure or short-term accommodation, such as in a squat or on a friend's floor, or who cycle into rough sleeping and the hostel system.(20) It has been estimated that 170,000 people in London were homeless as of December 2019,(2) a figure which includes 10,726 people who sleep rough.(21) According a 2015 health needs audit of England, 71% of people experiencing homelessness are men, 78% report a physical health problem, and 44% have been diagnosed with a mental health condition.(4)

All legal residents of the UK are entitled to health care through the National Health Service (NHS), which is free at the point of care. Primary and emergency care is open and free to all, though undocumented persons are without recourse to public funds and required to pay for prescriptions, dental care, secondary care, and community care. In London, current efforts to improve health care accessibility for adults currently homeless include street outreach services, peripatetic nursing, mobile tuberculosis testing, hospital discharge team,(5) specialist hostels (e.g. for people affected by substance dependency or severe mental disorders) and five specialist primary care clinics.

This protocol describes the evaluation of a peer advocacy programme that has been commissioned by several local government councils within London, and which has been run by a third sector organisation, Groundswell, following its development in 2010.

Our working definition of peer advocacy is the provision of support by trained advocates with experience of homelessness to those currently homeless to help them overcome the practical, personal and systemic barriers to accessing health and social care and to increase their confidence and skills to independently access services. The Groundswell model of peer advocacy fits within a broader typology of peer involvement in health care processes.(22) Peer advocacy differs from informal support such that people might give each other within a hostel or street setting, or organised support groups and communities since it is unidirectional and intentional.(13) It is further distinguished by being service and professional led, rather than community led (23) as in other forms of community mobilisation and activism. Groundswell's peers are volunteers who have cleared a background check which enables them to volunteer in NHS settings, have two references including one from a key worker, and who have completed 22 days of training (supplementary material), with on-going training provided as necessary alongside monthly supervision meetings. Peers are provided with a smartphone and are reimbursed for travel costs. Some peers progress to paid positions, including within Groundswell or the NHS.

As of 2020, the Groundswell's peer advocacy programme had been commissioned by 10 of the 32 local government authorities in London, and, typically key workers (e.g. social workers, hostel staff, and day centre staff) in these areas refer clients who have problems managing their health and/or need help attending a GP, outpatient, or other medical appointment. Peers also periodically visit hostels and day centres in these 10 areas to raise awareness of health and care for people who are homeless, and to sign up individuals as clients, or occasionally as potential future Peer Advocates.

A core activity of peer advocacy is to accompany clients to a scheduled health care appointment. On first contact, a peer meets their client at a designated meeting point, usually at or near the client's

place of sleep, where the peer briefs the clients about their remit, and clients give oral consent to proceed. A peer advocacy engagement can include several components. Before the appointment, peers help clients understand the nature of their appointment, take inventory of concerns which must be discussed at the appointment, and manage transport. For clients with severe mobility impairment, advocates arrange a taxi. Clients can request accompaniment to appointments with the peer, who ensures that the clients' concerns are raised and adequately addressed. After the appointment, peers offer advice on managing follow-up appointments or preparing for inpatient admission. Peers are provided discretionary funds to meet at a café to discuss health care needs, and are encouraged to use a 4-item Planning and Debrief Tool to aid with planning and evaluation. Clients will typically have a different peer at each health appointment, though will be matched to a specific peer if they are fluent in the same language, or have a specialist appointment type. Ultimately, peers provide support for clients to increase their ability to independently manage their health care. Notably, peers do not provide medical advice, do not provide direct support or counselling for drug, alcohol or mental health problems, and are not a befriending service. While it is not in their remit to offer support for issues which are not directly linked to health care (e.g. housing, food, benefits), peers can signpost to other services. Information disclosed during peer advocacy meetings is kept confidential within the advocacy team. If a client makes a credible threat of harm to self or another person, a peer is obliged to report the incident to the volunteer manager, who in turn will disclose the concern to a relevant authority such as a key worker, police, or health provider.

There are no formal eligibility criteria to become a client. No one is excluded by residency status or language fluency. The most common route to a peer engagement is for a key worker at a hostel or day centre, or street outreach workers, to refer to Groundswell when someone needs support for an upcoming health appointment (e.g. hospital outpatient care, dentist, or GP). There is no minimum or maximum number of visits for which a client can request support.

2.3 Qualitative study

The qualitative study seeks to understand the context, mechanisms and outcomes associated with the peer advocacy programme to develop a theoretical model ('Theory of Change') to illustrate how peer advocacy works and for whom (objective 1) and explore and define the range of social and health outcomes the peer advocacy programme brings to the peers themselves (objective 2).

2.3.1 Sample size.

We aim to conduct 25-30 interviews with four different participant groups: people who are homeless (with and without experience of peer advocacy, n=50 each), peer advocates (n=20), and Groundswell staff and other stakeholders (n=10) (discussed below). Data collection will continue until we anticipate theoretical 'saturation'(24) – the point at which further data no longer offers novel analytical insights – has been achieved. When possible, we will supplement these interviews by shadowing health care appointments and following a cohort of peer advocates as they are recruited, trained and begin volunteering. We will also conduct ethnographic observation in the Groundswell offices in order to build rapport with staff and volunteers, and deepen our understanding of the environment within which peers are trained and engaged.

Interviews with Groundswell staff and stakeholders will compare experiences of peer advocacy among staff from a variety of professional contexts and explore their perspectives on how, why and for whom peer advocacy works. These interviews will also investigate the potential influence of the wider health system and politico-economic context. Meanwhile, interviews with clients will focus on

understanding experiences of peer advocacy, with a focus on health and social outcomes. These interviews will explore the configurations elaborated in an emergent theory of change as well as the acceptability, fidelity and reach of the peer advocacy programme. The sub-sample of interviews with people who are homeless and who are not peer advocacy clients will explore experiences of accessing healthcare, barriers to accessing peer advocacy, reasons for disengagement, and any possible network and diffusion effects of peer advocacy.

Interviews will be semi-structured and will aim to capture in-depth insight. However, as interview length and depth will ultimately respond to the external contingencies of the interview – principally the time available from interviewees – we expect interviews to vary in length from 20 minutes to an hour. Clients and non-clients will be offered £10 to thank them for their participation, along with the latest edition of The Pavement magazine(25), which contains an updated list of support services for people who are homeless in London.

2.3.2 Data collection and recruitment

Qualitative data collection will take the form of semi-structured interviews with the following four groups of people: 1) Clients (people who accessed peer advocacy at least once); 2) Non-clients: people who are homeless, age 25+ years, and who have never accessed peer advocacy; 3) Peers (including those in training, those currently volunteering, and those who have moved on to paid employment or other opportunities); 4) Groundswell staff, including those who are currently employed by Groundswell and involved in supporting or managing peers, and stakeholders who are working in service delivery, support or policy in relation to homelessness in London.

We will initially recruit participants purposively via Groundswell, day centres and hostels, seeking to engage a range of participants according to age, gender, ethnicity, health status, and contact with the peer advocates. Recruitment will subsequently extend to stakeholders from NHS primary and secondary care sites. Further sampling will be increasingly theoretical, following the initially purposive exploration and responding to emerging analyses and the experiences of sub-groups identified as having particular outcomes and experiences of peer advocacy.

2.3.3 Analysis

Analysis will principally follow a grounded and abductive strategy (26,27) to develop theory of peer advocacy, which draws upon extant empirical research and theoretical literature, whilst allowing for inductive insight. Specific analytical steps will follow a grounded theory approach (27), by coding data descriptively, before exploring links across the coded data to develop selective conceptual categories. We will subsequently draw on broader social science insight, as well as the insights from co-researchers with lived experience of homelessness, to develop and refine a theoretical model of peer advocacy. Supportive analytical strategies will include: 1) memo writing to explore concepts and theoretical links; 2) comparison between individuals and sub-groups through developing framework matrices linked to close attention to deviant cases, and 3) triangulation of data collected from different methods – including both interviews and observation – and different members of the research team – including those with and without lived experience of homelessness. Data collection and analysis will be iterative, with analysis beginning directly from the beginning of the study, to inform sampling and to allow emerging theoretical conclusions to be integrated into ongoing data collection and thereby fully developed.

2.4 Cohort study

We aim to estimate the effect of peer advocacy on the number of missed outpatient appointments, Accident & Emergency department visits, and inpatient admissions, over a 12-month period (objective 3). Objectives 4 and 5 are secondary analyses which we will detail in a future report.

2.4.1 Eligibility Criteria

All new peer advocacy clients are eligible to participate in the cohort study, provided they have not yet completed two health care appointments with a peer. We will recruit a comparison group of non-clients, who, like the peer advocacy clients, are: 1) currently homeless per UK legal definition (20); 2) facing ongoing physical, mental or substance use problems; and 3) facing challenges in meeting their health care needs. Across both arms, participants have to be fluent in English or Polish, and cognitively able to provide informed consent and complete a 30-minute questionnaire.

2.4.2 Sample size

Our primary outcome is the number of outpatient appointments classified as 'did not attend' (DNA) in 12 months, as documented in hospital records. Based on historic Groundswell data, we anticipate 150 people will become new clients of peer advocates over a 6-month period, of whom 80% will consent to participate in the research study, of which 70% will link to hospital records, resulting in 84 participants for analysis. Informed by hospital use figures from London (28) and by an earlier pilot evaluation of Groundswell's peer advocacy programme (18) we estimate that peer advocacy clients will have an average of 0.06 DNA appointments over 12 months, similar to that in the general population, compared to 0.42 DNA appointments for non-client participants. To detect this difference with 80% power and two-sided alpha of 0.05, we must analyse 270 in the comparison arm, and so will enrol a minimum of 386 participants, allowing for 70% linkage to hospital records.

2.4.3 Recruitment

The data manager at Groundswell will flag new clients who have an upcoming appointment, and will schedule a peer advocate to meet at the client's preferred location. The peer will ask the client for permission to be contacted for research, affirm that permission is voluntary and has no effect on provision of peer advocacy, and if given, share contact details with the research team.

For recruitment into the comparison arm we listed all hostels and day centres in London and identified a total of 120 venues where Groundswell are not active but would be if commissioned by the local government. We will request support from managers and key workers at these venues to identify potentially eligible individuals to the research study, and if interest is expressed, to share contact details with the research team.

The research team will recruit participants and collect questionnaire data remotely, though will consider in-person field work as originally envisaged, if local, national, and institutional Covid-related regulations allow.

2.4.4 Baseline data collection

A co-researcher will phone or video call the recruit to describe the study, discuss contents of the study information sheet and consent form and, if appropriate, proceed with informed consent. Recruits who consent can proceed to the baseline questionnaire. The co-researcher will administer a 120-item structured questionnaire in English or Polish on a tablet device with the Open Data Kit (ODK) Collect app. The questionnaire contains the following sections: sociodemographic characteristics; homelessness characteristics and multiple exclusion homelessness; presence of

physical, mental and substance use problems; barriers to health care; health-related self-efficacy; health-related social capital; help with health care appointments; depression and anxiety screening; substance use; experience of violence and of sex work; contact with police and justice system; smartphone use; willingness to use a Covid contact tracing app; and personally identifying information for linkage to outcome data. The full questionnaire – which includes the source of each item - is available on the project website www.lshtm.ac.uk/hhpa.

We will not actively follow up participants. We will collect primary outcome data via NHS Hospital Episode Statistics (HES) records (29). HES variables of interest include the date and attendance outcome of scheduled outpatient appointments; date of accident & emergency department visits; date of inpatient admissions; and any clinical information generated through these visits. We will collect other secondary outcome data via the Combined Homelessness and Information Network (CHAIN) database (30), which is supported by the Greater London Authority, and is used by government agencies and selected NGOs to record interactions with people who sleep on the street or in other areas not designed for habitation. CHAIN variables of interest include HIV prevention, testing and treatment services; Hepatitis C and tuberculosis testing and diagnoses; registration with a GP; use of dentist/podiatrist; substance use/harm reduction; support for mental health, housing, welfare, and immigration; and contact with police or any aspects of the criminal justice services.

2.4.5 Primary outcome data linkage

As part of the baseline questionnaire we will collect personally identifying information from all participants including name, aliases, date of birth, NHS number, and current and past personal and GP addresses, and store these separately from other questionnaire data, though linked with a study ID. After the cohort's 12 month follow up period is complete, the identifying dataset will be transmitted to NHS Digital, which will use the Personal Demographics Service to undertake a 'list clean' and to identify and complete missing NHS numbers. These NHS numbers are then used to locate relevant HES records and use a two-step deterministic linkage process to ensure the cohort groups are mutually exclusive. NHS Digital will upload a de-identified copy of the records to the University College London Institute of Health Informatics' Data Safe Haven, which is a robust infrastructure certified for processing and analysing identifiable data according to international and national information security standards (ISO/IEC 27001:2013 and NHS Information Governance Toolkit). Within the Save Haven, each participant's HES records are linked to their questionnaire data for analysis. The cohort study processes are presented in Figure 1.

2.4.6 Co-researchers

We recruited and trained separate sets of co-researchers to conduct baseline study procedures. For English-speaking peer advocacy clients, co-researchers were Groundswell non-peer volunteers who had lived experience of homelessness. For the comparison group and any Polish-speaking participants, co-researchers were research staff who had lived experience of homelessness or experience working with vulnerable groups.

2.4.7 Informed consent

For recruits in both arms the co-researcher describes the study and its procedures, and gives the recruit an opportunity to ask questions. The co-researcher reads a series of statements off the informed consent form - including a statement that researchers will extract participants' HES records – and are required to agree with each statement as a condition of participation. Recruits are asked but not required to agree with one statement about researcher use of de-identified CHAIN records. The co-researcher documents informed consent or the reason for declining consent on the tablet

device. For recruits with uncertain level of cognitive ability, the co-researcher can request witnessing of the informed consent process by a key worker. On completion of the questionnaire, as a token of appreciation the co-researcher will send a £10 grocery voucher via email or text message to the participant or a key worker of the participant's choosing, with a copy of The Pavement magazine.(25) In the case of face-to-face interviews, participants will be offered a cash reimbursement. Participants in the comparison arm will be referred to key workers in case urgent health or welfare needs are identified during the course of the interview.

2.4.8 Intervention

The Peer Advocacy programme has been described above. Participants in the client arm of the study receive the same type and level of peer advocacy as clients who decline to participate, and are not compelled to remain clients. Participants in the comparison arm of the study are not prohibited from becoming a Peer Advocacy client if they have the opportunity to do so, e.g. by moving to a hostel in an area where Groundswell has been commissioned.

2.4.9 Analysis

We will estimate the difference in the number of missed outpatient appointment over 12 months for peer advocacy clients versus comparison participants using Poisson regression, with the number of missed appointments as the dependent variable and study arm as independent variable. To balance the arms for differences in baseline characteristics we will use inverse probability of treatment weights in the regression model. The treatment weights (also known as propensity scores) are calculated from a logistic regression model with arm as the dependent variable (0/1), and as independent variables we will consider measures thought to be predictive of joining peer advocacy which were collected from the questionnaire (e.g. age, gender, national origin, health problems, depression/anxiety screening score, last sleeping location, barriers to health care, substance use, and history of incarceration), and from historic HES data (e.g. number of missed outpatient visits, diagnoses) subject to linkage. After calculating the treatment weights, we will assess the weight-adjusted standardized differences for participants' characteristics, and revise the propensity score model as needed to achieve better balance across arms (e.g. by adding quadratic and interaction terms, and trimming/truncating weights).

If more than 5% of outcome data are missing, which will occur if we are unable to link a participant to HES, we will use multiple imputation with chained outcomes and will include all variables from the main regression and propensity score models. When there is sufficient variation in the data, we will consider exploratory sub-group analysis, for example estimating whether the effect of peer advocacy on missed appointment differs by gender, by nationality, or by morbidity. We will follow the steps as described above and will stratify propensity score estimates within each sub-group.

We will use similar approaches for analyses of the other primary outcomes (i.e. number of A&E visits, number of inpatient admissions), though may use logistic regression with a binary outcome instead of Poisson regression when the zero counts are inflated. We will detail analyses for objectives 4 and 5, and for secondary outcomes from the CHAIN dataset, in future reports.

2.5 Economic evaluation

For the economic evaluation we aim to estimate the costs and cost-effectiveness of peer advocacy on attendance at health services and the health and social welfare of homeless populations (objective 6).

2.5.1 Data Collection

We will assess the cost-effectiveness of the peer advocacy drawing on the impact estimates from the quantitative study. Both health and non-health care costs will be included in addition to the costs of the intervention. We will interview staff and review project documents and programme data to define the range of activities to be costed in order to cost the intervention. Costs will include those that are fixed (training, overheads) and variable (salaries to cover time spent peer training and with clients). We will follow standard methods for costing, including all costs regardless of payer and estimate a shadow cost where the price does not represent the values of resources.(31) NHS resource use will be estimated using the linked HES data and NHS reference costs will be used to value them. Resource items to be included will be planned and unplanned hospital visits. Self-reported non-NHS resource use, such as contacts with drug/alcohol services, will also be costed using information available from the Personal Social Services Research Unit.

2.5.2 Analysis

The results will be presented as the costs and outcomes for the peer and comparison arms separately rather than aggregate them into a single statistic (i.e. incremental cost per quality adjusted life year). We will therefore perform a cost-consequence analysis, which follows NICE Public Health Programme Guidance,(32) and is an appropriate form of evaluation to use when it is thought that quality adjusted life years are unlikely to capture all of intervention benefits of interest. We do not intend to supplement the analysis with decision modelling. The robustness of the results will be assessed using appropriate forms of sensitivity analysis.

2.6 Programmatic study

We will collate programmatic data collected by Groundswell including: i) nature and frequency of contact with peer advocate; ii) location of recruitment; iii) demographic characteristics of clients and peer advocates; iv) type of health condition (using ICD-10 chapter headings); v) location of health appointment, whether the appointments took place and the reason for cancellation (objective 7). These data will also enable us to define our exposure to peer advocacy as well as inform our quantitative sampling strategy.

Data will analysed descriptively to assess i) the fidelity (the extent to which the intervention is delivering what it set out to); (ii) dose (the intensity in which the intervention is delivered), (iii) and reach (what proportion of the population are in contact with the intervention) in line with published recommendations on utilising routine data for process evaluations.(33) We will link to the quantitative questionnaire data for descriptive analysis of clients, e.g. characteristics of once-off versus recurrent clients.

3 ETHICS AND DISSEMINATION

Study-wide ethics approval has been granted by the Dulwich Research Ethics Committee (IRAS 271312) and the London School of Hygiene and Tropical Medicine's Ethics Committee (Ref: 18021), both in the United Kingdom.

The main ethical and safety considerations for the study were concerned loss of confidentiality and feelings of distress. To minimize feelings of distress (e.g. for the section on personal violence, substance dependency) we pilot tested our questionnaire extensively, including with people with lived experience. In response to feedback, we added prompts with reminders about the ability to refuse questions, the rationale for including those questions, and that data would only be used for

analysis by the research team. Participants in any study component were told during the informed consent process that any threats to harm themselves or another person would be taken seriously; research staff would contact a key worker or emergency services as appropriate, and emphasise they would prefer to do so with the assent of the participant.

3.1 Quantitative and Economic study - Confidentiality protections

The ODK app used to administer the questionnaire encrypts data upon completion. Data are transmitted to a secure server at LSHTM, with decryption ability limited to SDR and LP. Personally identifying information are stored separately from other questionnaire responses, linked with a study ID. The personally identifying dataset will be uploaded to the University College London Institute of Health Informatics' Data Safe Haven. Once HES data are linked, personal identifiers are removed, the study ID is maintained, and the dataset is sent back to the Safe Haven for linkage to questionnaire data and analysis. No data are handed over to the NHS other than personal identifiers necessary for linkage.

A similar process will be used for CHAIN dataset linkage: we will send a dataset of only personal identifiers and study ID to CHAIN administrators. The administrators will link this dataset with requested outcome data, remove the personal identifiers, keep the study ID, and send the resulting dataset to LSHTM for re-linkage with the other questionnaire data. These processes are summarised in Figure 1.

3.2 Qualitative study – Confidentiality protections

Interviews will be recorded on an encrypted device and uploaded to an encrypted container accessible only to AG and PA. Recordings will be transcribed and stored using identification numbers rather than referring to participants' names, and any potentially-identifying information will be removed from the transcript content itself.

3.3 Dissemination plan

We will post updates on the project website at www.lshtm.ac.uk/hhpa, where we will make available data collection instruments, standard operating procedures, training manuals, and a data sharing policy. We have contributed to a feature about this project in The Pavement magazine (34), which is distributed freely in hostels and day centres across London. We plan to submit four manuscripts for peer-review: impact evaluation, qualitative study, economic study, and integrated analyses including programmatic data. As it is not practicable to re-contact our individual participants, we plan two dissemination workshops specifically for people who are homeless to report on preliminary and end-of-project findings. At these workshops we aim to get feedback, reflect on findings, and solicit proposals for changes to policy and practice. We will carry forward these proposals with our findings at two more dissemination events: one with policy makers and general service providers, another with homeless-specialist service providers. Throughout the duration of the project, we will approach our study steering committee for further advice and support for dissemination.

Figure 1. No legend.

4 Acknowledgments

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5 AUTHORS CONTRIBUTIONS

SDR drafted the manuscript. AG, AM, RWA, AS, ACH conceived the study with LP, the principal investigator. All authors edited the draft manuscript and approved the manuscript for submission.

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7 COMPETING INTERESTS STATEMENT

None declared.

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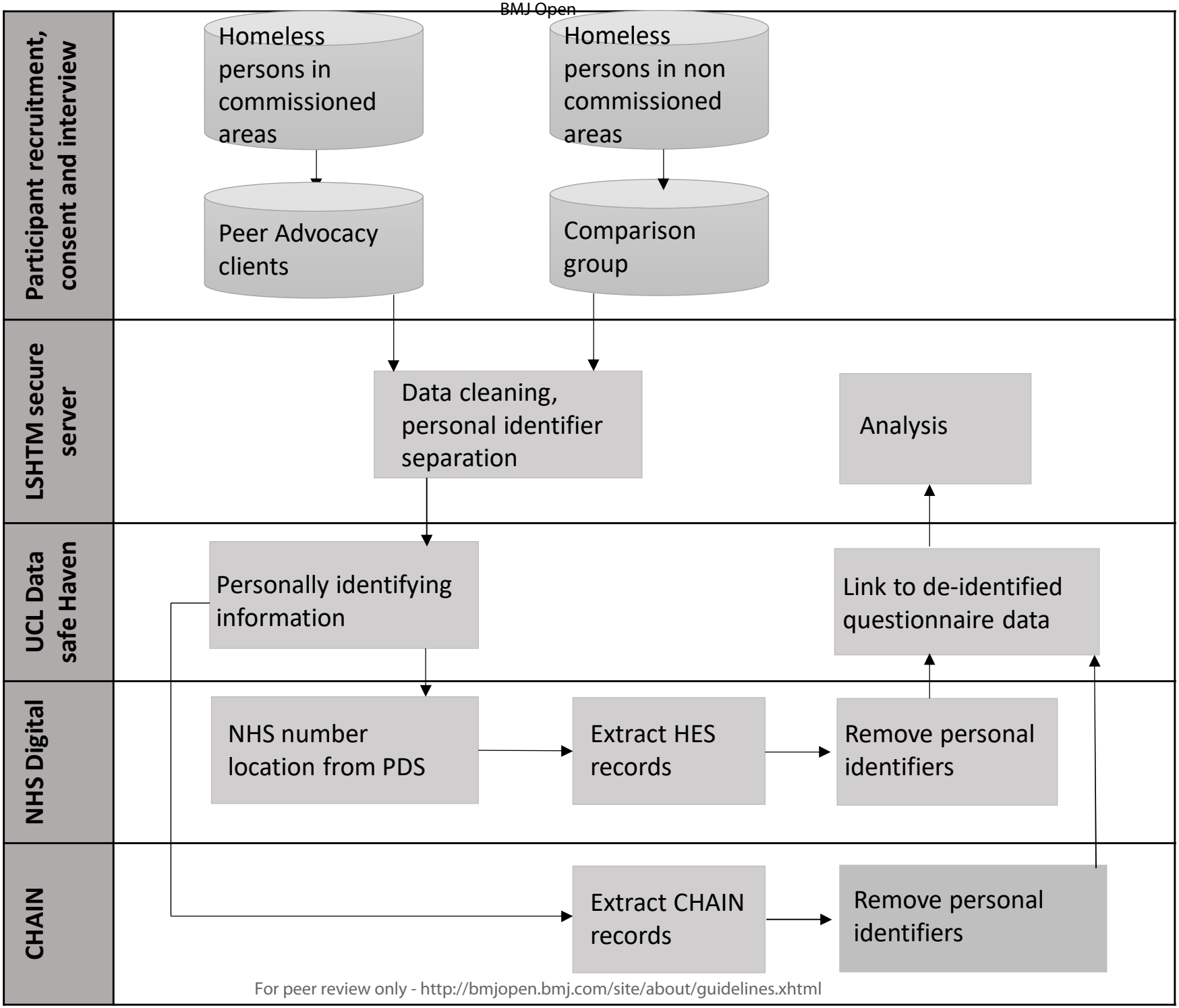

Groundswell

Out of homelessness

Volunteer Handbook

Groundswell's Mission

Groundswell exists to enable homeless and vulnerable people to take more control of their lives, have a greater influence on services and play a fuller role in the community.

Our Vision

Groundswell is working towards a world where homeless and vulnerable people are able to make their full contribution to our society for the benefit of all.

Our Core Beliefs

Inclusive solutions! The only way to genuinely tackle homelessness and social exclusion is by utilising the knowledge and expertise of people affected by these issues.

There is no Them & Us – only Us! Groundswell brings everyone together to create effective solutions

Involvement works! When everyone is involved, the process creates more effective services and enables people to regain their independence.

We believe in people! People are society's most valuable resource, and everyone has the capacity to make a contribution.

The whole community benefits when we effectively tackle homelessness and social exclusion.

Introduction

Welcome to Groundswell! This handbook will tell you a little bit about the organisation, who we are, and what we do. It will cover some of our key policies and procedures and explain what you can expect from us and what we expect from you in return.

Volunteers have always been vital to Groundswell and are key to our success as an organisation. The huge range of skills and experience they bring to the organisation mean we can offer the best possible service and can constantly develop and adapt what we do to meet the needs of the people we work with.

We hope that you enjoy your time with us, this Handbook should give you all the information you need to get going, but if there's ever anything you are confused about or want to know more about please just ask!

1) About Groundswell

1.1 Groundwell's People Policy

We Believe in People! Groundswell is an organisation that operates from a set of core beliefs, and one of Groundswell's core beliefs is:

'*We believe in people - People are society's most valuable resource, and everyone has the capacity to make a contribution.'*

Groundswell is People- Powered! Since our creation in 1996 Groundswell has consistently delivered a large amount of high-quality work – with a relatively small team. We are greater than the sum of our parts. We punch above our weight. This is due to the commitment and passion from our staff, volunteers and beneficiaries. The aim of this policy is enshrine our successful working practices to ensure our continued high levels of team collaboration and keep alive our 'give a lot – get a lot' ethos.

'Give a lot - Get a lot'. This policy lays down a clear and consistent framework that enables people to make their contribution to Groundswell, as staff, volunteers or clients, in a way that maximises the benefits to both the individual and the organisation.

An 'Asset Based' Approach. Groundswell values the experience and skills people gain through their lives. We acknowledge that lived experience of homelessness and using services brings with it a unique insight that is essential if we are to tackle homelessness effectively as a society. When looking at someone's suitability for a role –we take an asset-based approach, this means starting with the skills, experiences and knowledge that someone already has gained.

1.2 A Bit of History

Beginning: Groundswell's journey started as a campaigning project inside a larger homelessness agency the National Homeless Alliance in the mid-1990s. Our aim being to support homeless people themselves to be at the heart of creating and delivering solutions to homelessness. A series of networking events such as the legendary Forums in Sheffield, were held to bring together homeless people from all around the UK who were using their experiences of homelessness to make positive social change.

Speakouts: We were instrumental in developing the Speakout technique. These events brought homeless people in direct dialogue with policy makers to use their experiences to inform and influence policy at local, regional and national level. The Speakouts evolved into the Homeless People's Commission, using new techniques to enable homeless people to use their experiences to meaningfully engage with policy makers and service providers.

Grants and Research: We also ran a Grant Award Scheme for twelve years – giving over £250,000 to more than 500 homeless led self-help groups. Giving people the resources and support to "do it yourself" and create their own solutions to homelessness. In 2003 we began developing our own peer research work involving homeless people in all aspects of the research process, going on to involve hundreds of homeless people in their Local Authority Homelessness Strategies across England.

Thames Reach: In April 2012 we formed a partnership with Thames Reach - a provider of high quality services to homeless and vulnerable people. Groundswell remain an independent charity, but the formal partnership means that we now get support with governance and back office functions and are coordinating on business development – helping both organisations achieve our missions more effectively.

Health Peer Advocacy: A key finding of our research was uncovering that physical health was a bigger priority for homeless people than many services acknowledged. In 2010 this led to us developing our current Health Peer Advocacy project. The Project started in 2010 and in the first year we worked just in Westminster, recruiting 6 volunteers who supported people to attend 100 appointments. Since then the project has grown and grown. Last year 22 Peer Advocates worked across 6 boroughs to over 1000 appointments

1.3 What do we do?

Homeless Health Peer Advocacy: Groundswell's Homeless Health Peer Advocacy service works to address the health inequalities faced by homeless people by improving their access to healthcare - primarily through volunteers accompanying people to their health appointments.

Engagements: one-to-one support service for homeless people to enable them to make and attend health appointments. In addition to providing practical support, such as travel fares, reminders and accompaniment to appointments, peer advocates also focus on building the skills, confidence and knowledge to enable clients to continue to independently access health services.

Health Promotion In-Reach*:* Peer Advocates facilitate regular events at homelessness services – building relationships with clients, putting health issues on the agenda doing the preliminary work

that is ultimately aimed at supporting people to access and attend mainstream health provision. These would range from informal discussions on broader health and well-being issues, including substance misuse, hygiene, sports and physical activities to more formal sessions bringing health professionals into hostels and day centres.

Insight and Action: through their work our Peers gain an enormous amount of knowledge around the barriers that homeless people face to accessing healthcare and what health service could do to make their services more accessible. The project actively seeks ways of feeding this knowledge back to health services so that they can improve what they do.

2) Volunteering at Groundswell

2.1 What is volunteering?

Volunteering is when you choose to give your time and energy to benefit other people without being paid for it. It is important that volunteering is something that you freely choose to do. We hope that you want to keep volunteering for us, but if you are not enjoying it, or have other things you need to do, you can choose to stop at any time.

2.2 Volunteering while you are on benefits

Volunteering will not affect your benefits as long as the only money you get from us is an exact reimbursement of your expenses (lunch, travel and phone). Sometimes your Benefits Advisor will want to know more about what you are doing so they can check it is a legitimate volunteer role. We can write to them and explain what you do for us, and answer any of their questions.

If you are on JSA you will be expected to be actively seeking work. Sometimes you might be called in for a meeting or interview at short notice. If these clashes with a time you are meant to be volunteering with us let us know as soon as possible and we can arrange for someone else to cover your work.

2.3 Why do we involve volunteers?

Volunteers are very important to Groundswell. Our research with people who have moved on from homelessness (*The Escape Plan*) showed that being able to volunteer and give something back is an important part of a lot of people's journey away from homelessness. All our volunteers (and a lot of our paid staff) have personal experience of homelessness and their knowledge and insight are key to us providing services that really work. Involving people as volunteers allows us to extend what we do and help more people, but we hope it also provides the people who volunteer for us with a way of developing skills, using their experience to help other people, and increasing their personal resilience.

2.4 Volunteer Agreement

This handbook is our Volunteer Agreement, outlining what we expect from you, and what you should expect from us. Some things in your Agreement will be specific to your role, but there are some things that are there for all volunteers:

What we expect from you:

1. Attend as arranged. If you are going to be late or cannot attend, you need to let us know
2. Stick to Groundswell policies and procedures
3. Be honest with us (and yourself) and let us know if you are stressed or struggling
4. Treat everyone – clients, volunteers, staff, and partners - everyone with respect.

What you can expect from us:

1. That we will provide you with the support you need to carry out your role
2. That we will provide you with the training you need to carry out your role
3. Reimbursement of expenses as outlined in the expenses policy
4. Opportunities to input into the development of the project and help shape how it is run
5. To be treated with respect
6. Materials/equipment necessary to perform the role.
7. That your work with us is covered by our insurance policy
8. Coaching to help you meet your personal goals
9. An up to date reference.

3) Key Policies and Procedures

3.1 Expenses

We think it's important that volunteering doesn't cost you anything, so we will reimburse what you spend on travel, phones and food while you are working for us. However we have to be very careful about how we pay expenses and keep records of what the money was spent on. It is important that everyone understands the importance of collecting receipts. These help prove that any money received is in fact 'reimbursement' and not 'payment'. This is for three main reasons:

- **Protect Benefits**. Ensure volunteers receive expenses safely – to ensure that welfare benefits are not threatened.
- **Legal.** Ensure expenses are paid in a way that does not imply someone is 'employed.' As this would open up complicated tax and employment legislation implications for the volunteer and the organisation
- **Value for money.** We need to be able to show the people who fund us that we are using the money they give us well. We have to be able to justify every single penny we spend and show that it is necessary.

You will have received a copy of our Volunteer Expenses Policy during your training. The policy outlines what we will reimburse for and how. Here are the key points:

- Each week you will be able to claim expenses for your weekly activities -Travel Expenses, Phone Expenses, Lunch Expenses and Advocate Meeting expenses.
- You will only be able to access cash for expenses on Monday's, Thursday's and Fridays, between 10-4. If you require cash expenses outside these times you must make arrangement with your line manager. Expenses cannot be claimed at any time when there is only one staff member in the office.
- If you have claimed for expenses in advance and do not end up doing the voluntary work – you may be required to pay back the expenses you have been allocated.
- Wherever possible your expenses money will be paid directly into your bank accounts as a bank transfer – known as 'BACS.' If you would like support in setting up a bank account then please arrange this with the Volunteer Progression Manager.
- Except in exceptional circumstance we will not pay out more than £20 in cash. If you need to purchase something that costs more than £20 and do not have a bank account then a staff member may have to buy it on your behalf
- Please be aware that receipts will be required to reclaim any expenses.

3.2 Equality and Diversity

Groundswell is committed to promoting equality and diversity and a culture that actively values difference and recognises that people with different experiences and from different backgrounds bring essential insights to the workplace and enhance the way we work. It is only with this diversity that we are able to develop and facilitate services that meet the needs of the diverse population we work with. You will have looked our Equality and Diversity policy in your training. These are some of the key points:

- As an employer and provider of services Groundswell has the responsibility to promote equal opportunities and challenge discrimination wherever it occurs.
- When we experience clients, trainees or staff saying or doing things that are incompatible with Groundswell's Equality and Diversity Policy we will do all we can to positively challenge such behaviour as well as acknowledge and attempt to address the beliefs that underpin it.
- Groundswell will not tolerate any behaviour from staff or volunteers which breaches our equality and diversity policy

Each employee and volunteer is responsible for:

- Implementing the policy in their day-to-day work and their dealings with colleagues, clients, health and homelessness service providers;
- Ensuring their behaviour is appropriate to the policy and that they treat people with respect and dignity;
- Not discriminating against colleagues or clients
- Notifying their line manager of any concerns with regard to the conduct of colleagues, clients, health and homelessness service providers.

3.3 Dealing with Problems

Problems are quite rare and we hope that you won't have to use these guidelines but it is important that you know what to do if you have a problem and what would happen if there was a problem with your work.

- Your Line Manager will deal with day to day problems with your work as part of your support and supervision. If you have any problems or if there is anything that you are worried about make sure that you talk to them.
- If a work problem is more serious the Line Manager will make a note of it on your file and work with you to try and sort it out
- If a serious problem happens over and over again and means we may need to ask you to leave. Your Line Manager will discuss this with Kate (if your Line Manager is Kate she will discuss it with Athol). You will be able to meet Kate and/or Athol and appeal against this if you think it is unfair
- If a volunteer is violent, abusive, breaks the law or does something that might harm someone then we might have to ask them to leave straight away. Again you can meet with Kate and/or Athol to appeal against this
- If you have a problem with someone else at Groundswell you can meet with the your Line Manager to discuss it and they will take your complaint to Kate and/or Athol
- If your problem is with your line Manager then a meeting can be arranged with Kate and/or Athol.

3.4 Drugs and Alcohol

Many people we work with have issues with drug and alcohol misuse. Over the years various Groundswell staff, volunteers and Trustees have been people who have tackled these issues or are still tackling them. We need to make sure that we work in a way that supports people's recovery. You will have looked at Groundswell's Drug and Alcohol Policy as part of your training. The main points are:

- That if you are under the influence of alcohol or non-prescribed drugs, you will be not be allowed to undertake work with Groundswell.
- That if you have drug and alcohol issues you will still be given the opportunity to contribute to Groundswell's work.
- That people who experience drug and alcohol issues deserve appropriate support to tackle these issues.
- Groundswell calls for honesty and encourages people who are experiencing drug and alcohol issues to be upfront with the organisation about these issues so that we can work with you to find the right way to support you.

If you are under the influence of drugs or alcohol at a time when you are meant to be working for Groundswell, in the first instance we sincerely ask you to contact the organisation at the earliest opportunity and explain that you are unavailable for work, and we request that you do not turn up.

If you turn up for work and it appears that you are under the influence of non-prescribed drugs or alcohol, you will be asked to leave the premises, and will no longer be able to continue working for the remainder of that day.

3.5 Confidentiality

You will have looked at the confidentiality policy we give to clients during your training. It is important that the people we work with understand that their information is safe and won't be shared without their permission. But it also important that they know that confidentiality is not between them and the person they are working with, but between them and the wider Groundswell team. We all need to be able to freely able to discuss issues with our team managers and line managers so that we can get support and feedback, and work together properly as a team.

The same principal applies to staff and volunteer's confidentiality. What you discuss with your Line Manager and during supervisions is confidential, but they may have to share information with their immediate team and their own Line Manager. If there are any serious concerns regarding the health, well-being or performance of a volunteer; or concerns that a volunteer may be about to cause harm to themselves or to others, then a staff member must report this formally to their line manager at the earliest opportunity. Serious concerns should be reported even if it breaks a previously held promise to withhold information. We will **not** share information about you with the wider team, other volunteers or people outside Groundswell unless you have asked them to.

3.7 Boundaries

We need to protect you and our clients and make sure that Groundswell is safely and professionally run

To do this we need to make sure that:

- You're not doing anything that you haven't been trained to do
- You're not doing anything that you are not happy or comfortable doing
- There is no risk of abuse or harm to you or to clients

Because of this we have clear boundaries around what people should and shouldn't do when they are volunteering for us. Each role has its own guidelines, and you will have looked at these during training, but there are some general boundaries that are common to all roles.

Volunteers Should Always

- Have a working, topped up, **phone** with them if they are working out of the office
- **Inform the office** (as soon as possible) if there is a problem or you are not going to be able to do something
- Take care not to infringe **the law** – remember technically if you witness illegal behaviour and don't report it to the police you are breaking the law
- Make sure you **put your own safety first** – if you feel a situation is unsafe leave as quickly as possible

Volunteers Should Never

- Never offer **medical advice**, give out medication, or carry out any kind of medical role (other than basic first aid in an emergency)
- **Never accept money** or presents from a client, give money or presents, or buy or sell anything to a client
- Never enter into a personal or sexual **relationship** with a client they are currently working with. Please inform your line manager if you already know a client
- **Never work after 6pm** or on a weekend without the knowledge of your Line Manager
- **Never wear Groundswell ID** unless they are specifically doing Groundswell work
- Never use drugs or drink alcohol with clients (or at all when working for Groundswell)

Boundaries are not always clear cut. In your role as a Peer Advocate you may find that your personal boundaries are tested. We encourage you to use your own common sense and judgment, but if there is ever anything you are unsure about please do speak to us. There is always someone at the other end of the phone for you to talk to.

3.8 Safeguarding

Groundswell's clients can be very vulnerable, it is important that we work in a way that is safe. These guidelines might look frightening but they are in place to protect everybody. Abuse is very rare but however unlikely it is to happen it is important that we create a service where people are as safe as possible and to do this we have to have guidelines and procedures. You will have covered Safeguarding in your training, and been given Groundswell's Safeguarding Policy but these are some of the key points:

When working with vulnerable people:

- Treat people with respect. Don't just dismiss someone's feelings because they have substance misuse issues or mental health problems
- When you are working one to one with people try to stay in public spaces where there are other people around. Do not go into someone's private flat. If you need to go into someone's room in a hostel keep the door open
- Never arrange to meet a client unless it has been booked as an appointment and is in the diary. Last minute appointments must be phoned in.

- Be careful with physical contact; be aware of people's boundaries
- Make sure you explain our confidentiality agreement. Never say that something someone tells you is private between them and you. Information is confidential within the Groundswell team, and we may have to break confidentiality if we think someone is at risk

What to do if you suspect someone is being abused:

Abuse can be sexual, physical, emotional or financial, or it could be that you suspect someone is being neglected. It is important that you know what to do if you suspect that someone is being abused.

If you suspect that abuse is taking place:

- Report it to your line manager as soon as possible
- Even if something seems quite small it is important to discuss it with your line manager it could be that other people have also noticed something wrong
- Do not try to investigate it further yourself, it is important that the situation is dealt with by trained professionals

Remember that until the police or social services investigate it is important that you do not discuss anything with anyone outside the Groundswell team. You may well need to talk to someone because you feel worried or stressed by the situation, we can arrange for you to speak to somebody who will be able to support you and talk to you

Because we are committed to safeguarding and promoting the welfare of vulnerable adults, we have to be careful that anyone (paid or unpaid) who works one to one with people is suitable to be in that role and doesn't have any convictions which suggest they might be a risk. This means that we carry out Enhanced Disclosure and Barring Service (DBS) checks for any role that involves unsupervised one to one work. It is possible that we may also require you to be re-checked by the DBS from time to time during your time with us.

We have a Rehabilitation of Offenders Policy which explains how we decide whether certain convictions suggest that there is a risk, which we will share with you if you would like to see it. We will look at how serious the offence was, how long ago it happened, what the circumstances around it were and what has changed in your life since it happened. Having a past conviction does not mean you can't volunteer and in most cases we will decide there is no risk.

You must immediately notify your Line Manager of any police investigations, cautions, bindovers or convictions that happen while you are working with us. We ask you to do this regardless of whether you think they are relevant to your role. Again, in most cases this will not affect your volunteering with us, but our first Duty of Care is to our service users, and it is very important that we are aware of anything that could but them at risk.

4) Some Practicalities

4.1 Coming into the office

The office is open 9.30 – 4.30 Monday to Friday (except bank holidays and the week between Christmas and New Year). You are welcome to drop in between these times and use the phones and

computers if there is one free. Please don't come in before 9.30 or after 4.30 unless you have arranged it with us first, there might not be anyone in! If you need to talk to someone make sure you phone and arrange to come in at a time when they are free to see you. People's diaries can get quite booked up, and if you just drop in you might find they are busy.

The office is split into two sections, when you come in through the door, to your left is the 'Office', and to the right is the 'Space'. We have some general ground-rules the whole team have agreed on for how we will all behave when we are in the Office and the Space

4.2 Groundswell Office - Space Ground rules

"The Office - Space is a healthy and productive Home for Groundswell, Where we deliver our best work imaginable."

1. There is a clear separation between The Office and The Space!

- The Office is a closed boundaried place for quiet working.
- The Space is open for interacting, thinking, eating, drinking, dreaming, doing.

2. We respect the place!

- We keep it tidy and hygienic.
- We clear up after eating and meeting.
- We put things away after use.
- We use the right door for entering and leaving.

3. We respect each other!

- We embrace diversity and difference – everyone is unique.
- Everyone can do their jobs and be themselves.
- Please don't swear (too much).
- We are generous when people need a hand.

4. We respect the roles!

- When someone is on duty – we leave them to work… and offer them drinks.
- When on reception we answer the door and the phone, when we are not – we don't!

5. We have good phone etiquette!

- When we are on the phone - we don't shout.
- When someone else is on the phone - we don't disturb them.

6. We have good meeting etiquette!

- We start meetings on time.
- We end meetings on time.
- We prepare in advance.

- We clear up afterwards.

7. We have good office etiquette!

- We reinforce good behavior – and affirm each other when we do things well.
- Any one of us can pull anyone else up if we don't follow the Ground rules.
- We don't take it personally if we get pulled up!
- We take responsibility for our own behaviour.
- We all contribute to creating a healthy and productive home for Groundswell.

4.3 Using the phones and computers

Phones

- Staff/volunteers should give their work phone number to clients and not their personal number
- Staff/volunteers should feel able to turn off/not answer their work phone when they are not working
- You can use the office phone to make important calls but please check with us first if you need to ring abroad or make a premium rate phone call
- There is a phone where you can make private calls in Everest.
- All staff/volunteers should take responsibility for making sure that their Line Manager has an up to date work mobile phone number for them

Computers

- There are usually a couple of computers free for volunteers to work on. The office gets quite busy before and after team meetings, so there is not always a computer available
- You are welcome to use the computer but please respect the fact the office is a workspace and all the computer screens are clearly visible to everyone who walks through the office.
    - Do not look at anything offensive or sexual – bear in mind other people may be more sensitive to certain things than you
    - If you want to view something with sound use headphones
    - If you want to show people something on the computer please do so in a way that doesn't disturb people working around you
- Do not attempt to download anything on to a Groundswell computer
- Staff and other volunteers are usually happy to help you if you get stuck, but do bear in mind that sometimes they will be busy and won't have time

4.4 The kitchen

The kitchen is a shared space for everyone who works at Groundswell. Groundswell provides tea, coffee, milk, sugar etc. and we will try and make sure there are snacks like biscuits and fruit. If food is left out on the side or on the table in the kitchen then it is for everybody, help yourself to it. Food in the fridge and cupboard has usually been brought in by people for their lunch, so don't eat it

without checking first. When you have finished with cups, plates and cutlery please put them in the dishwasher.

BMJ Open

Peer advocacy and access to health care for people who are homeless in London, United Kingdom: A mixed-method impact, economic, and process evaluation protocol

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Peer advocacy and access to health care for people who are homeless in London, United Kingdom: A mixed-method impact, economic, and process evaluation protocol.

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ABSTRACT

Introduction: People who are homeless experience higher morbidity and mortality than the general population. These outcomes are exacerbated by inequitable access to health care. Emerging evidence suggests a role for peer advocates – i.e. trained volunteers with lived experience - to support people who are homeless to access health care.

Methods and analysis: We plan to conduct a mixed-methods evaluation to assess the effects (qualitative, cohort, economic studies); processes and contexts (qualitative study); and fidelity; acceptability and reach (process study), of Peer Advocacy on people who are homeless and on peers themselves, in London, United Kingdom (UK). People with lived experience of homelessness are partners in the design, execution, analysis, and dissemination of the evaluation.

Ethics and dissemination: Ethics approval for all study designs has been granted by the National Health Service London – Dulwich Research Ethics Committee (UK) and the London School of Hygiene and Tropical Medicine's Ethics Committee (UK). We plan to disseminate study progress and outputs via a website, conference presentations, community meetings, and peer-reviewed journal articles.

ARTICLE SUMMARY: Strengths and limitations of this study

- We conducted a mixed methods evaluation, offering multiple perspectives on the effect and mechanisms.
- For cohort study outcomes we used the NHS Hospital Episode Statistics database, an objective source with direct applications for policy.
- The cohort study outcomes excludes care received at GP surgeries, an important site of health care.
- The cohort study findings are subject to bias from unmeasured confounders.

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1.1 INTRODUCTION

Homelessness has been increasing in England through since 2010;(1) it is estimated that over a quarter of a million people were homeless in England in 2019, mostly in temporary accommodation, but also in hostels and rough sleeping.(2) These numbers are likely to increase further following the economic impact of COVID 19.(3) People who are homeless are more likely to experience physical, mental, and substance use disorders,(4) often in combination (4,5) than people who are stably housed; these disorders may have precipitated or contributed to homelessness, or were instigated by or aggravated by it.(6) Frequent health challenges faced by people who are homeless in England and Wales are evidenced by the average age of death: 45 years for men, and 43 years for women.(7)

In addition to managing poorer mental and physical health, uptake and access to health services is often restricted for people experiencing homelessness. Structural challenges such as cost of transportation or services, navigating complicated booking systems and facing stigma from service providers can create significant barriers, combined with difficulties in reconciling daily demands of being homeless that can deter people from prioritising care.(8,9) As a result, people experiencing homelessness are disproportionately likely to use Accident & Emergency departments (37% in the past 6 months) and to be admitted to hospital (27% in past 6 months).(4) In the United Kingdom this pattern of service use results in per capita hospital costs which are four to eight times higher than the general population,(10) motivating policy focus on socially excluded groups.(11)

To improve equity of health outcomes for excluded groups such as people who are homeless, researchers and advocates have been developing the Inclusion Health agenda,(12) within which interventions developed and delivered by people with lived experience have been identified as a promising strategy. A 2017 systematic review of peer-delivered interventions for adults who were homeless (13) found consistent, though low-quality, evidence of improved outcomes in several different domains of wellbeing, including physical health, mental health, substance use, and housing. Of the four studies in the systematic review which measured the effect on health care use,(14–17) all had positive findings but only one (15) was judged to be of high quality. Alongside measurement of health care outcomes, there is also a need to elaborate on the mechanisms linked to peer-delivered

interventions. A realist synthesis of peer support models pointed to the role of peers in providing empathy, understanding and acceptance (13) and others hypothesize the effect through role-modelling health-seeking behaviours and providing social support,(18) but there is a paucity of evidence for these mechanisms.

There is need for high-quality evidence to measure the effects of peer interventions on a range of clinical and social outcomes and to elaborate on the mechanisms and context linked in order to improve health and well-being of this vulnerable and growing population. Here, we set out the protocol for an evaluation of a peer-delivered advocacy intervention on health care use for people who are experiencing homelessness in London, United Kingdom.

2 METHODS and ANALYSIS

The aim of the project is to evaluate the impact, cost-efficacy and process mechanisms through which a peer advocacy intervention improves health care attendance and health and social outcomes among people experiencing homelessness in London. Objectives will be achieved through the implementation of four linked studies: a qualitative study, a cohort study, a cost-consequence analysis, and a process evaluation.

The specific objectives and study designs are detailed in Table 1:

Objective	Design
1. To explore the mechanisms, contexts and outcomes for peer advocacy and how they interplay with broader social and structural factors that shape health and social welfare and affect access to services to develop a Theory of Change	Qualitative
2. To explore the range of social and health outcomes the peer support programme brings to the peers themselves, and the mechanisms and contexts for these outcomes	Qualitative
3. To estimate the effect of engagement with peer advocacy on health service use (i.e. outpatient appointments, use of emergency services and hospital admissions.)	Cohort
4. To estimate change in health service use before and after engagement with peer advocates	Cohort
5. To measure associations between (non)engagement with peer advocacy on health and social outcomes and access to health services, including the mediating effect of other macro-structural, community and individual factors	Cohort
6. To perform an economic evaluation of peer advocacy compared to no provision on attendance at health services and the health and social welfare of homeless populations	Cost-consequence
7. To assess the fidelity, acceptability and reach of the intervention	Process

Table 1. Objectives and study designs for Homeless Health Peer Advocacy evaluation, London, United Kingdom, 2020-2022.

2.1 Patient and Public Involvement

The studies are informed through a participatory approach,(19) which is increasingly used within social science and epidemiological research with excluded populations. People with lived experience

of homelessness are included as co-researchers in all aspects of the study design, data collection and analysis and are included as members of our study steering committee, which also includes clinicians, researchers, and local government officials. The committee will be consulted for reviewing study instruments; collecting, analysing and disseminating data for qualitative and quantitative designs; and for guidance across all designs and dissemination activities.

2.2 Setting & context

We will draw on the UK government legal definition of homelessness comprising: people sleeping rough, people sleeping in a hostel, and people in insecure or short-term accommodation, such as in a squat or on a friend's floor, or who cycle into rough sleeping and the hostel system.(20) It has been estimated that 170,000 people in London were homeless as of December 2019,(2) a figure which includes 10,726 people who sleep rough.(21) According a 2015 health needs audit of England, 71% of people experiencing homelessness are men, 78% report a physical health problem, and 44% have been diagnosed with a mental health condition.(4)

All legal residents of the UK are entitled to health care through the National Health Service (NHS), which is free at the point of care. Primary and emergency care is open and free to all, though undocumented persons are without recourse to public funds and required to pay for prescriptions, dental care, secondary care, and community care. In London, current efforts to improve health care accessibility for adults currently homeless include street outreach services, peripatetic nursing, mobile tuberculosis testing, hospital discharge team,(5) specialist hostels (e.g. for people affected by substance dependency or severe mental disorders) and five specialist primary care clinics.

This protocol describes the evaluation of a peer advocacy programme that has been commissioned by several local government councils within London, and which has been run by a third sector organisation, Groundswell, following its development in 2010.

Our working definition of peer advocacy is the provision of support by trained advocates with experience of homelessness to those currently homeless to help them overcome the practical, personal and systemic barriers to accessing health and social care and to increase their confidence and skills to independently access services. The Groundswell model of peer advocacy fits within a broader typology of peer involvement in health care processes.(22) Peer advocacy differs from informal support such that people might give each other within a hostel or street setting, or organised support groups and communities since it is unidirectional and intentional.(13) It is further distinguished by being service and professional led, rather than community led (23) as in other forms of community mobilisation and activism. Groundswell's peers are volunteers who have cleared a background check which enables them to volunteer in NHS settings, have two references including one from a key worker, and who have completed 22 days of training (supplementary file), with on-going training provided as necessary alongside monthly supervision meetings. Peers are provided with a smartphone and are reimbursed for travel costs. Some peers progress to paid positions, including within Groundswell or the NHS.

As of 2020, the Groundswell's peer advocacy programme had been commissioned by 10 of the 32 local government authorities in London, and, typically key workers (e.g. social workers, hostel staff, and day centre staff) in these areas refer clients who have problems managing their health and/or need help attending a GP, outpatient, or other medical appointment. Peers also periodically visit hostels and day centres in these 10 areas to raise awareness of health and care for people who are homeless, and to sign up individuals as clients, or occasionally as potential future Peer Advocates.

A core activity of peer advocacy is to accompany clients to a scheduled health care appointment. On first contact, a peer meets their client at a designated meeting point, usually at or near the client's place of sleep, where the peer briefs the clients about their remit, and clients give oral consent to proceed. A peer advocacy engagement can include several components. Before the appointment, peers help clients understand the nature of their appointment, take inventory of concerns which must be discussed at the appointment, and manage transport. For clients with severe mobility impairment, advocates arrange a taxi. Clients can request accompaniment to appointments with the peer, who ensures that the clients' concerns are raised and adequately addressed. After the appointment, peers offer advice on managing follow-up appointments or preparing for inpatient admission. Peers are provided discretionary funds to meet at a café to discuss health care needs, and are encouraged to use a 4-item Planning and Debrief Tool to aid with planning and evaluation. Clients will typically have a different peer at each health appointment, though will be matched to a specific peer if they are fluent in the same language, or have a specialist appointment type. Ultimately, peers provide support for clients to increase their ability to independently manage their health care. Notably, peers do not provide medical advice, do not provide direct support or counselling for drug, alcohol or mental health problems, and are not a befriending service. While it is not in their remit to offer support for issues which are not directly linked to health care (e.g. housing, food, benefits), peers can signpost to other services. Information disclosed during peer advocacy meetings is kept confidential within the advocacy team. If a client makes a credible threat of harm to self or another person, a peer is obliged to report the incident to the volunteer manager, who in turn will disclose the concern to a relevant authority such as a key worker, police, or health provider.

There are no formal eligibility criteria to become a client. No one is excluded by residency status or language fluency. The most common route to a peer engagement is for a key worker at a hostel or day centre, or street outreach workers, to refer to Groundswell when someone needs support for an upcoming health appointment (e.g. hospital outpatient care, dentist, or GP). There is no minimum or maximum number of visits for which a client can request support.

2.3 Qualitative study

The qualitative study seeks to understand the context, mechanisms and outcomes associated with the peer advocacy programme to develop a theoretical model ('Theory of Change') to illustrate how peer advocacy works and for whom (objective 1) and explore and define the range of social and health outcomes the peer advocacy programme brings to the peers themselves (objective 2).

2.3.1 Sample size.

We aim to conduct 25-30 interviews with four different participant groups: people who are homeless (with and without experience of peer advocacy, n=50 each), peer advocates (n=20), and Groundswell staff and other stakeholders (n=10) (discussed below). Data collection will continue until we anticipate theoretical 'saturation'(24) – the point at which further data no longer offers novel analytical insights – has been achieved. When possible, we will supplement these interviews by shadowing health care appointments and following a cohort of peer advocates as they are recruited, trained and begin volunteering. We will also conduct ethnographic observation in the Groundswell offices in order to build rapport with staff and volunteers, and deepen our understanding of the environment within which peers are trained and engaged.

Interviews with Groundswell staff and stakeholders (see Supplementary material) will compare experiences of peer advocacy among staff from a variety of professional contexts and explore their perspectives on how, why and for whom peer advocacy works. These interviews will also investigate

the potential influence of the wider health system and politico-economic context. Meanwhile, interviews with clients will focus on understanding experiences of peer advocacy, with a focus on health and social outcomes. These interviews will explore the configurations elaborated in an emergent theory of change as well as the acceptability, fidelity and reach of the peer advocacy programme. The sub-sample of interviews with people who are homeless and who are not peer advocacy clients will explore experiences of accessing healthcare, barriers to accessing peer advocacy, reasons for disengagement, and any possible network and diffusion effects of peer advocacy.

Interviews will be semi-structured and will aim to capture in-depth insight. However, as interview length and depth will ultimately respond to the external contingencies of the interview – principally the time available from interviewees – we expect interviews to vary in length from 20 minutes to an hour. Clients and non-clients will be offered £10 to thank them for their participation, along with the latest edition of The Pavement magazine(25), which contains an updated list of support services for people who are homeless in London.

2.3.2 Data collection and recruitment

Qualitative data collection will take the form of semi-structured interviews (supplementary file) with the following four groups of people: 1) Clients (people who accessed peer advocacy at least once); 2) Non-clients: people who are homeless, age 25+ years, and who have never accessed peer advocacy; 3) Peers (including those in training, those currently volunteering, and those who have moved on to paid employment or other opportunities); 4) Groundswell staff, including those who are currently employed by Groundswell and involved in supporting or managing peers, and stakeholders who are working in service delivery, support or policy in relation to homelessness in London.

We will initially recruit participants purposively via Groundswell, day centres and hostels, seeking to engage a range of participants according to age, gender, ethnicity, health status, and contact with the peer advocates. Recruitment will subsequently extend to stakeholders from NHS primary and secondary care sites. Further sampling will be increasingly theoretical, following the initially purposive exploration and responding to emerging analyses and the experiences of sub-groups identified as having particular outcomes and experiences of peer advocacy.

2.3.3 Analysis

Analysis will principally follow a grounded and abductive strategy (26,27) to develop theory of peer advocacy, which draws upon extant empirical research and theoretical literature, whilst allowing for inductive insight. Specific analytical steps will follow a grounded theory approach (27), by coding data descriptively, before exploring links across the coded data to develop selective conceptual categories. We will subsequently draw on broader social science insight, as well as the insights from co-researchers with lived experience of homelessness, to develop and refine a theoretical model of peer advocacy. Supportive analytical strategies will include: 1) memo writing to explore concepts and theoretical links; 2) comparison between individuals and sub-groups through developing framework matrices linked to close attention to deviant cases, and 3) triangulation of data collected from different methods – including both interviews and observation – and different members of the research team – including those with and without lived experience of homelessness. Data collection and analysis will be iterative, with analysis beginning directly from the beginning of the study, to inform sampling and to allow emerging theoretical conclusions to be integrated into ongoing data collection and thereby fully developed.

2.4 Cohort study

We aim to estimate the effect of peer advocacy on the number of missed outpatient appointments, Accident & Emergency department visits, and inpatient admissions, over a 12-month period (objective 3). Objectives 4 and 5 are secondary analyses which we will detail in a future report.

2.4.1 Eligibility Criteria

All new peer advocacy clients are eligible to participate in the cohort study, provided they have not yet completed two health care appointments with a peer. We will recruit a comparison group of non-clients, who, like the peer advocacy clients, are: 1) currently homeless per UK legal definition (20); 2) facing ongoing physical, mental or substance use problems; and 3) facing challenges in meeting their health care needs. Across both arms, participants have to be fluent in English or Polish, and cognitively able to provide informed consent and complete a 30-minute questionnaire.

2.4.2 Sample size

Our primary outcome is the number of outpatient appointments classified as 'did not attend' (DNA) in 12 months, as documented in hospital records. Based on historic Groundswell data, we anticipate 150 people will become new clients of peer advocates over a 6-month period, of whom 80% will consent to participate in the research study, of which 70% will link to hospital records, resulting in 84 participants for analysis. Informed by hospital use figures from London (28) and by an earlier pilot evaluation of Groundswell's peer advocacy programme (18) we estimate that peer advocacy clients will have an average of 0.06 DNA appointments over 12 months, similar to that in the general population, compared to 0.42 DNA appointments for non-client participants. To detect this difference with 80% power and two-sided alpha of 0.05, we must analyse 270 in the comparison arm, and so will enrol a minimum of 386 participants, allowing for 70% linkage to hospital records.

2.4.3 Recruitment

The data manager at Groundswell will flag new clients who have an upcoming appointment, and will schedule a peer advocate to meet at the client's preferred location. The peer will ask the client for permission to be contacted for research, affirm that permission is voluntary and has no effect on provision of peer advocacy, and if given, share contact details with the research team.

For recruitment into the comparison arm we listed all hostels and day centres in London and identified a total of 120 venues where Groundswell are not active but would be if commissioned by the local government. We will request support from managers and key workers at these venues to identify potentially eligible individuals to the research study, and if interest is expressed, to share contact details with the research team.

The research team will recruit participants and collect questionnaire data remotely, though will consider in-person field work as originally envisaged, if local, national, and institutional Covid-related regulations allow.

2.4.4 Baseline data collection

A co-researcher will phone or video call the recruit to describe the study, discuss contents of the study information sheet and consent form and, if appropriate, proceed with informed consent. Recruits who consent can proceed to the baseline questionnaire. The co-researcher will administer a 120-item structured questionnaire in English or Polish on a tablet device with the Open Data Kit (ODK) Collect app. The questionnaire (supplementary file) contains the following sections: sociodemographic characteristics; homelessness characteristics and multiple exclusion

homelessness; presence of physical, mental and substance use problems; barriers to health care; health-related self-efficacy; health-related social capital; help with health care appointments; depression and anxiety screening; substance use; experience of violence and of sex work; contact with police and justice system; smartphone use; willingness to use a Covid contact tracing app; and personally identifying information for linkage to outcome data. The full questionnaire – which includes the source of each item - is available on the project website www.lshtm.ac.uk/hhpa and as Supplementary material.

We will not actively follow up participants. We will collect primary outcome data via NHS Hospital Episode Statistics (HES) records (29). HES variables of interest include the date and attendance outcome of scheduled outpatient appointments; date of accident & emergency department visits; date of inpatient admissions; and any clinical information generated through these visits. We will collect other secondary outcome data via the Combined Homelessness and Information Network (CHAIN) database (30), which is supported by the Greater London Authority, and is used by government agencies and selected NGOs to record interactions with people who sleep on the street or in other areas not designed for habitation. CHAIN variables of interest include HIV prevention, testing and treatment services; Hepatitis C and tuberculosis testing and diagnoses; registration with a GP; use of dentist/podiatrist; substance use/harm reduction; support for mental health, housing, welfare, and immigration; and contact with police or any aspects of the criminal justice services.

2.4.5 Primary outcome data linkage

As part of the baseline questionnaire we will collect personally identifying information from all participants including name, aliases, date of birth, NHS number, and current and past personal and GP addresses, and store these separately from other questionnaire data, though linked with a study ID. After the cohort's 12 month follow up period is complete, the identifying dataset will be transmitted to NHS Digital, which will use the Personal Demographics Service to undertake a 'list clean' and to identify and complete missing NHS numbers. These NHS numbers are then used to locate relevant HES records and use a two-step deterministic linkage process to ensure the cohort groups are mutually exclusive. NHS Digital will upload a de-identified copy of the records to the University College London Institute of Health Informatics' Data Safe Haven, which is a robust infrastructure certified for processing and analysing identifiable data according to international and national information security standards (ISO/IEC 27001:2013 and NHS Information Governance Toolkit). Within the Save Haven, each participant's HES records are linked to their questionnaire data for analysis. The cohort study processes are presented in Figure 1.

2.4.6 Co-researchers

We recruited and trained separate sets of co-researchers to conduct baseline study procedures. For English-speaking peer advocacy clients, co-researchers were Groundswell non-peer volunteers who had lived experience of homelessness. For the comparison group and any Polish-speaking participants, co-researchers were research staff who had lived experience of homelessness or experience working with vulnerable groups.

2.4.7 Informed consent

For recruits in both arms the co-researcher describes the study and its procedures, and gives the recruit an opportunity to ask questions. The co-researcher reads a series of statements off the informed consent form - including a statement that researchers will extract participants' HES records – and are required to agree with each statement as a condition of participation. Recruits are asked but not required to agree with one statement about researcher use of de-identified CHAIN records.

The co-researcher documents informed consent or the reason for declining consent on the tablet device. For recruits with uncertain level of cognitive ability, the co-researcher can request witnessing of the informed consent process by a key worker. On completion of the questionnaire, as a token of appreciation the co-researcher will send a £10 grocery voucher via email or text message to the participant or a key worker of the participant's choosing, with a copy of The Pavement magazine.(25) In the case of face-to-face interviews, participants will be offered a cash reimbursement. Participants in the comparison arm will be referred to key workers in case urgent health or welfare needs are identified during the course of the interview.

2.4.8 Intervention

The Peer Advocacy programme has been described above. Participants in the client arm of the study receive the same type and level of peer advocacy as clients who decline to participate, and are not compelled to remain clients. Participants in the comparison arm of the study are not prohibited from becoming a Peer Advocacy client if they have the opportunity to do so, e.g. by moving to a hostel in an area where Groundswell has been commissioned.

2.4.9 Analysis

We will estimate the difference in the number of missed outpatient appointment over 12 months for peer advocacy clients versus comparison participants using Poisson regression, with the number of missed appointments as the dependent variable and study arm as independent variable. To balance the arms for differences in baseline characteristics we will use inverse probability of treatment weights in the regression model. The treatment weights (also known as propensity scores) are calculated from a logistic regression model with arm as the dependent variable (0/1), and as independent variables we will consider measures thought to be predictive of joining peer advocacy which were collected from the questionnaire (e.g. age, gender, national origin, health problems, depression/anxiety screening score, last sleeping location, barriers to health care, substance use, and history of incarceration), and from historic HES data (e.g. number of missed outpatient visits, diagnoses) subject to linkage. After calculating the treatment weights, we will assess the weight-adjusted standardized differences for participants' characteristics, and revise the propensity score model as needed to achieve better balance across arms (e.g. by adding quadratic and interaction terms, and trimming/truncating weights).

If more than 5% of outcome data are missing, which will occur if we are unable to link a participant to HES, we will use multiple imputation with chained outcomes and will include all variables from the main regression and propensity score models. When there is sufficient variation in the data, we will consider exploratory sub-group analysis, for example estimating whether the effect of peer advocacy on missed appointment differs by gender, by nationality, or by morbidity. We will follow the steps as described above and will stratify propensity score estimates within each sub-group.

We will use similar approaches for analyses of the other primary outcomes (i.e. number of A&E visits, number of inpatient admissions), though may use logistic regression with a binary outcome instead of Poisson regression when the zero counts are inflated. We will detail analyses for objectives 4 and 5, and for secondary outcomes from the CHAIN dataset, in future reports.

2.5 Economic evaluation

For the economic evaluation we aim to estimate the costs and cost-effectiveness of peer advocacy on attendance at health services and the health and social welfare of homeless populations (objective 6).

2.5.1 Data Collection

We will assess the cost-effectiveness of the peer advocacy drawing on the impact estimates from the quantitative study. Both health and non-health care costs will be included in addition to the costs of the intervention. We will interview staff and review project documents and programme data to define the range of activities to be costed in order to cost the intervention. Costs will include those that are fixed (training, overheads) and variable (salaries to cover time spent peer training and with clients). We will follow standard methods for costing, including all costs regardless of payer and estimate a shadow cost where the price does not represent the values of resources.(31) NHS resource use will be estimated using the linked HES data and NHS reference costs will be used to value them. Resource items to be included will be planned and unplanned hospital visits. Self-reported non-NHS resource use, such as contacts with drug/alcohol services, will also be costed using information available from the Personal Social Services Research Unit.

2.5.2 Analysis

The results will be presented as the costs and outcomes for the peer and comparison arms separately rather than aggregate them into a single statistic (i.e. incremental cost per quality adjusted life year). We will therefore perform a cost-consequence analysis, which follows NICE Public Health Programme Guidance,(32) and is an appropriate form of evaluation to use when it is thought that quality adjusted life years are unlikely to capture all of intervention benefits of interest. We do not intend to supplement the analysis with decision modelling. The robustness of the results will be assessed using appropriate forms of sensitivity analysis.

2.6 Programmatic study

We will collate programmatic data collected by Groundswell including: i) nature and frequency of contact with peer advocate; ii) location of recruitment; iii) demographic characteristics of clients and peer advocates; iv) type of health condition (using ICD-10 chapter headings); v) location of health appointment, whether the appointments took place and the reason for cancellation (objective 7). These data will also enable us to define our exposure to peer advocacy as well as inform our quantitative sampling strategy.

Data will analysed descriptively to assess i) the fidelity (the extent to which the intervention is delivering what it set out to); (ii) dose (the intensity in which the intervention is delivered), (iii) and reach (what proportion of the population are in contact with the intervention) in line with published recommendations on utilising routine data for process evaluations.(33) We will link to the quantitative questionnaire data for descriptive analysis of clients, e.g. characteristics of once-off versus recurrent clients.

3 ETHICS AND DISSEMINATION

Study-wide ethics approval has been granted by the Dulwich Research Ethics Committee (IRAS 271312) and the London School of Hygiene and Tropical Medicine's Ethics Committee (Ref: 18021), both in the United Kingdom.

The main ethical and safety considerations for the study were concerned loss of confidentiality and feelings of distress. To minimize feelings of distress (e.g. for the section on personal violence, substance dependency) we pilot tested our questionnaire extensively, including with people with lived experience. In response to feedback, we added prompts with reminders about the ability to refuse questions, the rationale for including those questions, and that data would only be used for analysis

by the research team. Participants in any study component were told during the informed consent process that any threats to harm themselves or another person would be taken seriously; research staff would contact a key worker or emergency services as appropriate, and emphasise they would prefer to do so with the assent of the participant.

3.1 Quantitative and Economic study - Confidentiality protections

The ODK app used to administer the questionnaire encrypts data upon completion. Data are transmitted to a secure server at LSHTM, with decryption ability limited to SDR and LP. Personally identifying information are stored separately from other questionnaire responses, linked with a study ID. The personally identifying dataset will be uploaded to the University College London Institute of Health Informatics' Data Safe Haven. Once HES data are linked, personal identifiers are removed, the study ID is maintained, and the dataset is sent back to the Safe Haven for linkage to questionnaire data and analysis. No data are handed over to the NHS other than personal identifiers necessary for linkage.

A similar process will be used for CHAIN dataset linkage: we will send a dataset of only personal identifiers and study ID to CHAIN administrators. The administrators will link this dataset with requested outcome data, remove the personal identifiers, keep the study ID, and send the resulting dataset to LSHTM for re-linkage with the other questionnaire data. These processes are summarised in Figure 1.

3.2 Qualitative study – Confidentiality protections

Interviews will be recorded on an encrypted device and uploaded to an encrypted container accessible only to AG and PA. Recordings will be transcribed and stored using identification numbers rather than referring to participants' names, and any potentially-identifying information will be removed from the transcript content itself.

3.3 Dissemination plan

We will post updates on the project website at www.lshtm.ac.uk/hhpa, where we will make available data collection instruments, standard operating procedures, training manuals, and a data sharing policy. We have contributed to a feature about this project in The Pavement magazine (34), which is distributed freely in hostels and day centres across London. We plan to submit four manuscripts for peer-review: impact evaluation, qualitative study, economic study, and integrated analyses including programmatic data. As it is not practicable to re-contact our individual participants, we plan two dissemination workshops specifically for people who are homeless to report on preliminary and end-of-project findings. At these workshops we aim to get feedback, reflect on findings, and solicit proposals for changes to policy and practice. We will carry forward these proposals with our findings at two more dissemination events: one with policy makers and general service providers, another with homeless-specialist service providers. Throughout the duration of the project, we will approach our study steering committee for further advice and support for dissemination.

Figure 1. No legend.

4 Acknowledgments

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5 AUTHORS CONTRIBUTIONS

SDR drafted the manuscript. AG, AM, RWA, AS, ACH conceived the study with LP, the principal investigator. SDR, AG, PJA, PH, EW, AM, KB, MB, RWA, SL, DM, AS, ACH, and LP edited the draft manuscript and approved the manuscript for submission.

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7 COMPETING INTERESTS STATEMENT

None declared.

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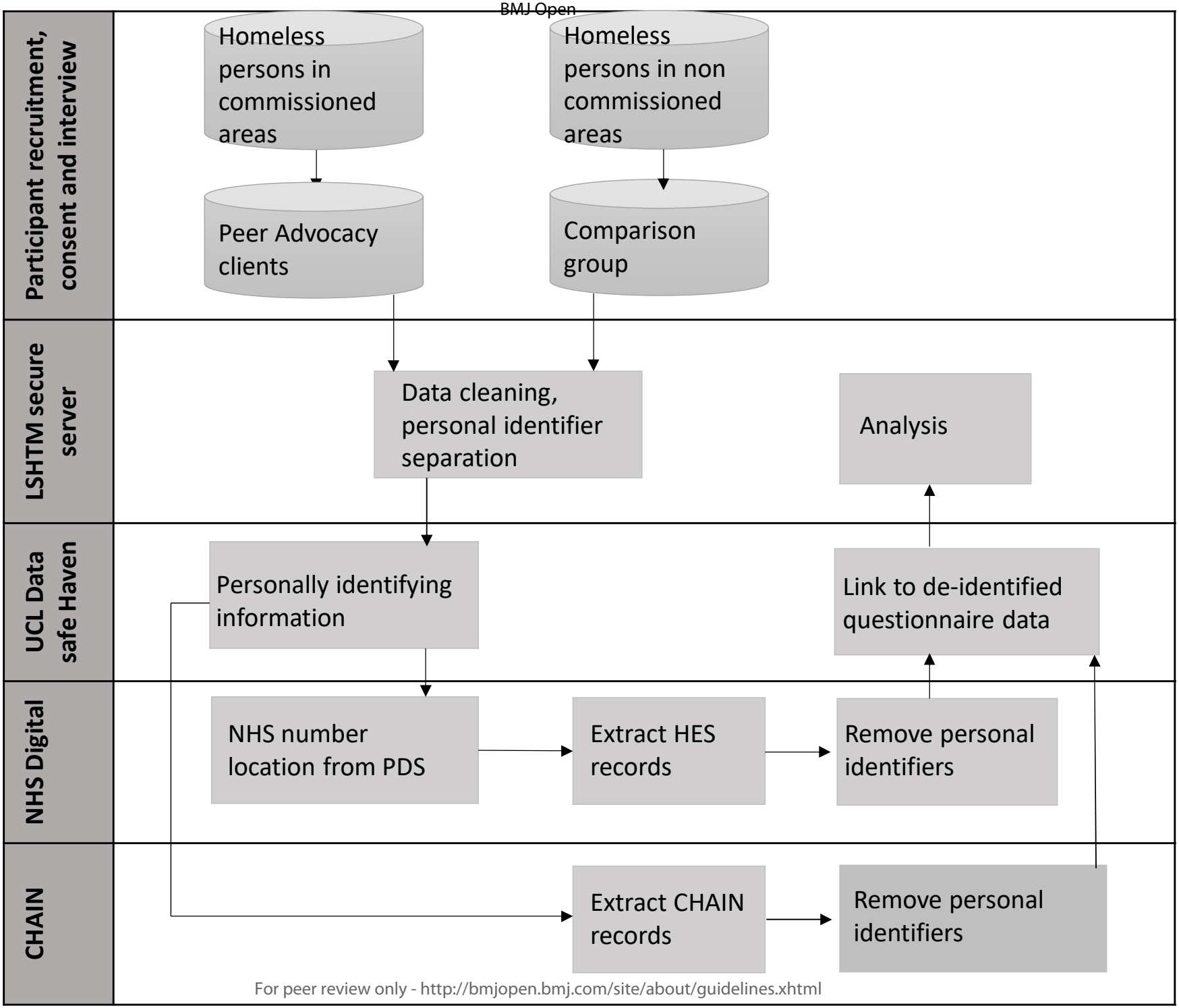

Groundswell

Out of homelessness

Volunteer Handbook

Groundswell's Mission

Groundswell exists to enable homeless and vulnerable people to take more control of their lives, have a greater influence on services and play a fuller role in the community.

Our Vision

Groundswell is working towards a world where homeless and vulnerable people are able to make their full contribution to our society for the benefit of all.

Our Core Beliefs

Inclusive solutions! The only way to genuinely tackle homelessness and social exclusion is by utilising the knowledge and expertise of people affected by these issues.

There is no Them & Us – only Us! Groundswell brings everyone together to create effective solutions

Involvement works! When everyone is involved, the process creates more effective services and enables people to regain their independence.

We believe in people! People are society's most valuable resource, and everyone has the capacity to make a contribution.

The whole community benefits when we effectively tackle homelessness and social exclusion.

Introduction

Welcome to Groundswell! This handbook will tell you a little bit about the organisation, who we are, and what we do. It will cover some of our key policies and procedures and explain what you can expect from us and what we expect from you in return.

Volunteers have always been vital to Groundswell and are key to our success as an organisation. The huge range of skills and experience they bring to the organisation mean we can offer the best possible service and can constantly develop and adapt what we do to meet the needs of the people we work with.

We hope that you enjoy your time with us, this Handbook should give you all the information you need to get going, but if there's ever anything you are confused about or want to know more about please just ask!

1) About Groundswell

1.1 Groundwell's People Policy

We Believe in People! Groundswell is an organisation that operates from a set of core beliefs, and one of Groundswell's core beliefs is:

'*We believe in people - People are society's most valuable resource, and everyone has the capacity to make a contribution.'*

Groundswell is People- Powered! Since our creation in 1996 Groundswell has consistently delivered a large amount of high-quality work – with a relatively small team. We are greater than the sum of our parts. We punch above our weight. This is due to the commitment and passion from our staff, volunteers and beneficiaries. The aim of this policy is enshrine our successful working practices to ensure our continued high levels of team collaboration and keep alive our 'give a lot – get a lot' ethos.

'Give a lot - Get a lot'. This policy lays down a clear and consistent framework that enables people to make their contribution to Groundswell, as staff, volunteers or clients, in a way that maximises the benefits to both the individual and the organisation.

An 'Asset Based' Approach. Groundswell values the experience and skills people gain through their lives. We acknowledge that lived experience of homelessness and using services brings with it a unique insight that is essential if we are to tackle homelessness effectively as a society. When looking at someone's suitability for a role –we take an asset-based approach, this means starting with the skills, experiences and knowledge that someone already has gained.

1.2 A Bit of History

Beginning: Groundswell's journey started as a campaigning project inside a larger homelessness agency the National Homeless Alliance in the mid-1990s. Our aim being to support homeless people themselves to be at the heart of creating and delivering solutions to homelessness. A series of networking events such as the legendary Forums in Sheffield, were held to bring together homeless people from all around the UK who were using their experiences of homelessness to make positive social change.

Speakouts: We were instrumental in developing the Speakout technique. These events brought homeless people in direct dialogue with policy makers to use their experiences to inform and influence policy at local, regional and national level. The Speakouts evolved into the Homeless People's Commission, using new techniques to enable homeless people to use their experiences to meaningfully engage with policy makers and service providers.

Grants and Research: We also ran a Grant Award Scheme for twelve years – giving over £250,000 to more than 500 homeless led self-help groups. Giving people the resources and support to "do it yourself" and create their own solutions to homelessness. In 2003 we began developing our own peer research work involving homeless people in all aspects of the research process, going on to involve hundreds of homeless people in their Local Authority Homelessness Strategies across England.

Thames Reach: In April 2012 we formed a partnership with Thames Reach - a provider of high quality services to homeless and vulnerable people. Groundswell remain an independent charity, but the formal partnership means that we now get support with governance and back office functions and are coordinating on business development – helping both organisations achieve our missions more effectively.

Health Peer Advocacy: A key finding of our research was uncovering that physical health was a bigger priority for homeless people than many services acknowledged. In 2010 this led to us developing our current Health Peer Advocacy project. The Project started in 2010 and in the first year we worked just in Westminster, recruiting 6 volunteers who supported people to attend 100 appointments. Since then the project has grown and grown. Last year 22 Peer Advocates worked across 6 boroughs to over 1000 appointments

1.3 What do we do?

Homeless Health Peer Advocacy: Groundswell's Homeless Health Peer Advocacy service works to address the health inequalities faced by homeless people by improving their access to healthcare - primarily through volunteers accompanying people to their health appointments.

Engagements: one-to-one support service for homeless people to enable them to make and attend health appointments. In addition to providing practical support, such as travel fares, reminders and accompaniment to appointments, peer advocates also focus on building the skills, confidence and knowledge to enable clients to continue to independently access health services.

Health Promotion In-Reach*:* Peer Advocates facilitate regular events at homelessness services – building relationships with clients, putting health issues on the agenda doing the preliminary work

that is ultimately aimed at supporting people to access and attend mainstream health provision. These would range from informal discussions on broader health and well-being issues, including substance misuse, hygiene, sports and physical activities to more formal sessions bringing health professionals into hostels and day centres.

Insight and Action: through their work our Peers gain an enormous amount of knowledge around the barriers that homeless people face to accessing healthcare and what health service could do to make their services more accessible. The project actively seeks ways of feeding this knowledge back to health services so that they can improve what they do.

2) Volunteering at Groundswell

2.1 What is volunteering?

Volunteering is when you choose to give your time and energy to benefit other people without being paid for it. It is important that volunteering is something that you freely choose to do. We hope that you want to keep volunteering for us, but if you are not enjoying it, or have other things you need to do, you can choose to stop at any time.

2.2 Volunteering while you are on benefits

Volunteering will not affect your benefits as long as the only money you get from us is an exact reimbursement of your expenses (lunch, travel and phone). Sometimes your Benefits Advisor will want to know more about what you are doing so they can check it is a legitimate volunteer role. We can write to them and explain what you do for us, and answer any of their questions.

If you are on JSA you will be expected to be actively seeking work. Sometimes you might be called in for a meeting or interview at short notice. If these clashes with a time you are meant to be volunteering with us let us know as soon as possible and we can arrange for someone else to cover your work.

2.3 Why do we involve volunteers?

Volunteers are very important to Groundswell. Our research with people who have moved on from homelessness (*The Escape Plan*) showed that being able to volunteer and give something back is an important part of a lot of people's journey away from homelessness. All our volunteers (and a lot of our paid staff) have personal experience of homelessness and their knowledge and insight are key to us providing services that really work. Involving people as volunteers allows us to extend what we do and help more people, but we hope it also provides the people who volunteer for us with a way of developing skills, using their experience to help other people, and increasing their personal resilience.

2.4 Volunteer Agreement

This handbook is our Volunteer Agreement, outlining what we expect from you, and what you should expect from us. Some things in your Agreement will be specific to your role, but there are some things that are there for all volunteers:

What we expect from you:

1. Attend as arranged. If you are going to be late or cannot attend, you need to let us know
2. Stick to Groundswell policies and procedures
3. Be honest with us (and yourself) and let us know if you are stressed or struggling
4. Treat everyone – clients, volunteers, staff, and partners - everyone with respect.

What you can expect from us:

1. That we will provide you with the support you need to carry out your role
2. That we will provide you with the training you need to carry out your role
3. Reimbursement of expenses as outlined in the expenses policy
4. Opportunities to input into the development of the project and help shape how it is run
5. To be treated with respect
6. Materials/equipment necessary to perform the role.
7. That your work with us is covered by our insurance policy
8. Coaching to help you meet your personal goals
9. An up to date reference.

3) Key Policies and Procedures

3.1 Expenses

We think it's important that volunteering doesn't cost you anything, so we will reimburse what you spend on travel, phones and food while you are working for us. However we have to be very careful about how we pay expenses and keep records of what the money was spent on. It is important that everyone understands the importance of collecting receipts. These help prove that any money received is in fact 'reimbursement' and not 'payment'. This is for three main reasons:

- **Protect Benefits**. Ensure volunteers receive expenses safely – to ensure that welfare benefits are not threatened.
- **Legal.** Ensure expenses are paid in a way that does not imply someone is 'employed.' As this would open up complicated tax and employment legislation implications for the volunteer and the organisation
- **Value for money.** We need to be able to show the people who fund us that we are using the money they give us well. We have to be able to justify every single penny we spend and show that it is necessary.

You will have received a copy of our Volunteer Expenses Policy during your training. The policy outlines what we will reimburse for and how. Here are the key points:

- Each week you will be able to claim expenses for your weekly activities -Travel Expenses, Phone Expenses, Lunch Expenses and Advocate Meeting expenses.
- You will only be able to access cash for expenses on Monday's, Thursday's and Fridays, between 10-4. If you require cash expenses outside these times you must make arrangement with your line manager. Expenses cannot be claimed at any time when there is only one staff member in the office.
- If you have claimed for expenses in advance and do not end up doing the voluntary work – you may be required to pay back the expenses you have been allocated.
- Wherever possible your expenses money will be paid directly into your bank accounts as a bank transfer – known as 'BACS.' If you would like support in setting up a bank account then please arrange this with the Volunteer Progression Manager.
- Except in exceptional circumstance we will not pay out more than £20 in cash. If you need to purchase something that costs more than £20 and do not have a bank account then a staff member may have to buy it on your behalf
- Please be aware that receipts will be required to reclaim any expenses.

3.2 Equality and Diversity

Groundswell is committed to promoting equality and diversity and a culture that actively values difference and recognises that people with different experiences and from different backgrounds bring essential insights to the workplace and enhance the way we work. It is only with this diversity that we are able to develop and facilitate services that meet the needs of the diverse population we work with. You will have looked our Equality and Diversity policy in your training. These are some of the key points:

- As an employer and provider of services Groundswell has the responsibility to promote equal opportunities and challenge discrimination wherever it occurs.
- When we experience clients, trainees or staff saying or doing things that are incompatible with Groundswell's Equality and Diversity Policy we will do all we can to positively challenge such behaviour as well as acknowledge and attempt to address the beliefs that underpin it.
- Groundswell will not tolerate any behaviour from staff or volunteers which breaches our equality and diversity policy

Each employee and volunteer is responsible for:

- Implementing the policy in their day-to-day work and their dealings with colleagues, clients, health and homelessness service providers;
- Ensuring their behaviour is appropriate to the policy and that they treat people with respect and dignity;
- Not discriminating against colleagues or clients
- Notifying their line manager of any concerns with regard to the conduct of colleagues, clients, health and homelessness service providers.

3.3 Dealing with Problems

Problems are quite rare and we hope that you won't have to use these guidelines but it is important that you know what to do if you have a problem and what would happen if there was a problem with your work.

- Your Line Manager will deal with day to day problems with your work as part of your support and supervision. If you have any problems or if there is anything that you are worried about make sure that you talk to them.
- If a work problem is more serious the Line Manager will make a note of it on your file and work with you to try and sort it out
- If a serious problem happens over and over again and means we may need to ask you to leave. Your Line Manager will discuss this with Kate (if your Line Manager is Kate she will discuss it with Athol). You will be able to meet Kate and/or Athol and appeal against this if you think it is unfair
- If a volunteer is violent, abusive, breaks the law or does something that might harm someone then we might have to ask them to leave straight away. Again you can meet with Kate and/or Athol to appeal against this
- If you have a problem with someone else at Groundswell you can meet with the your Line Manager to discuss it and they will take your complaint to Kate and/or Athol
- If your problem is with your line Manager then a meeting can be arranged with Kate and/or Athol.

3.4 Drugs and Alcohol

Many people we work with have issues with drug and alcohol misuse. Over the years various Groundswell staff, volunteers and Trustees have been people who have tackled these issues or are still tackling them. We need to make sure that we work in a way that supports people's recovery. You will have looked at Groundswell's Drug and Alcohol Policy as part of your training. The main points are:

- That if you are under the influence of alcohol or non-prescribed drugs, you will be not be allowed to undertake work with Groundswell.
- That if you have drug and alcohol issues you will still be given the opportunity to contribute to Groundswell's work.
- That people who experience drug and alcohol issues deserve appropriate support to tackle these issues.
- Groundswell calls for honesty and encourages people who are experiencing drug and alcohol issues to be upfront with the organisation about these issues so that we can work with you to find the right way to support you.

If you are under the influence of drugs or alcohol at a time when you are meant to be working for Groundswell, in the first instance we sincerely ask you to contact the organisation at the earliest opportunity and explain that you are unavailable for work, and we request that you do not turn up.

If you turn up for work and it appears that you are under the influence of non-prescribed drugs or alcohol, you will be asked to leave the premises, and will no longer be able to continue working for the remainder of that day.

3.5 Confidentiality

You will have looked at the confidentiality policy we give to clients during your training. It is important that the people we work with understand that their information is safe and won't be shared without their permission. But it also important that they know that confidentiality is not between them and the person they are working with, but between them and the wider Groundswell team. We all need to be able to freely able to discuss issues with our team managers and line managers so that we can get support and feedback, and work together properly as a team.

The same principal applies to staff and volunteer's confidentiality. What you discuss with your Line Manager and during supervisions is confidential, but they may have to share information with their immediate team and their own Line Manager. If there are any serious concerns regarding the health, well-being or performance of a volunteer; or concerns that a volunteer may be about to cause harm to themselves or to others, then a staff member must report this formally to their line manager at the earliest opportunity. Serious concerns should be reported even if it breaks a previously held promise to withhold information. We will **not** share information about you with the wider team, other volunteers or people outside Groundswell unless you have asked them to.

3.7 Boundaries

We need to protect you and our clients and make sure that Groundswell is safely and professionally run

To do this we need to make sure that:

- You're not doing anything that you haven't been trained to do
- You're not doing anything that you are not happy or comfortable doing
- There is no risk of abuse or harm to you or to clients

Because of this we have clear boundaries around what people should and shouldn't do when they are volunteering for us. Each role has its own guidelines, and you will have looked at these during training, but there are some general boundaries that are common to all roles.

Volunteers Should Always

- Have a working, topped up, **phone** with them if they are working out of the office
- **Inform the office** (as soon as possible) if there is a problem or you are not going to be able to do something
- Take care not to infringe **the law** – remember technically if you witness illegal behaviour and don't report it to the police you are breaking the law
- Make sure you **put your own safety first** – if you feel a situation is unsafe leave as quickly as possible

Volunteers Should Never

- Never offer **medical advice**, give out medication, or carry out any kind of medical role (other than basic first aid in an emergency)
- **Never accept money** or presents from a client, give money or presents, or buy or sell anything to a client
- Never enter into a personal or sexual **relationship** with a client they are currently working with. Please inform your line manager if you already know a client
- **Never work after 6pm** or on a weekend without the knowledge of your Line Manager
- **Never wear Groundswell ID** unless they are specifically doing Groundswell work
- Never use drugs or drink alcohol with clients (or at all when working for Groundswell)

Boundaries are not always clear cut. In your role as a Peer Advocate you may find that your personal boundaries are tested. We encourage you to use your own common sense and judgment, but if there is ever anything you are unsure about please do speak to us. There is always someone at the other end of the phone for you to talk to.

3.8 Safeguarding

Groundswell's clients can be very vulnerable, it is important that we work in a way that is safe. These guidelines might look frightening but they are in place to protect everybody. Abuse is very rare but however unlikely it is to happen it is important that we create a service where people are as safe as possible and to do this we have to have guidelines and procedures. You will have covered Safeguarding in your training, and been given Groundswell's Safeguarding Policy but these are some of the key points:

When working with vulnerable people:

- Treat people with respect. Don't just dismiss someone's feelings because they have substance misuse issues or mental health problems
- When you are working one to one with people try to stay in public spaces where there are other people around. Do not go into someone's private flat. If you need to go into someone's room in a hostel keep the door open
- Never arrange to meet a client unless it has been booked as an appointment and is in the diary. Last minute appointments must be phoned in.

- Be careful with physical contact; be aware of people's boundaries
- Make sure you explain our confidentiality agreement. Never say that something someone tells you is private between them and you. Information is confidential within the Groundswell team, and we may have to break confidentiality if we think someone is at risk

What to do if you suspect someone is being abused:

Abuse can be sexual, physical, emotional or financial, or it could be that you suspect someone is being neglected. It is important that you know what to do if you suspect that someone is being abused.

If you suspect that abuse is taking place:

- Report it to your line manager as soon as possible
- Even if something seems quite small it is important to discuss it with your line manager it could be that other people have also noticed something wrong
- Do not try to investigate it further yourself, it is important that the situation is dealt with by trained professionals

Remember that until the police or social services investigate it is important that you do not discuss anything with anyone outside the Groundswell team. You may well need to talk to someone because you feel worried or stressed by the situation, we can arrange for you to speak to somebody who will be able to support you and talk to you

Because we are committed to safeguarding and promoting the welfare of vulnerable adults, we have to be careful that anyone (paid or unpaid) who works one to one with people is suitable to be in that role and doesn't have any convictions which suggest they might be a risk. This means that we carry out Enhanced Disclosure and Barring Service (DBS) checks for any role that involves unsupervised one to one work. It is possible that we may also require you to be re-checked by the DBS from time to time during your time with us.

We have a Rehabilitation of Offenders Policy which explains how we decide whether certain convictions suggest that there is a risk, which we will share with you if you would like to see it. We will look at how serious the offence was, how long ago it happened, what the circumstances around it were and what has changed in your life since it happened. Having a past conviction does not mean you can't volunteer and in most cases we will decide there is no risk.

You must immediately notify your Line Manager of any police investigations, cautions, bindovers or convictions that happen while you are working with us. We ask you to do this regardless of whether you think they are relevant to your role. Again, in most cases this will not affect your volunteering with us, but our first Duty of Care is to our service users, and it is very important that we are aware of anything that could but them at risk.

4) Some Practicalities

4.1 Coming into the office

The office is open 9.30 – 4.30 Monday to Friday (except bank holidays and the week between Christmas and New Year). You are welcome to drop in between these times and use the phones and

computers if there is one free. Please don't come in before 9.30 or after 4.30 unless you have arranged it with us first, there might not be anyone in! If you need to talk to someone make sure you phone and arrange to come in at a time when they are free to see you. People's diaries can get quite booked up, and if you just drop in you might find they are busy.

The office is split into two sections, when you come in through the door, to your left is the 'Office', and to the right is the 'Space'. We have some general ground-rules the whole team have agreed on for how we will all behave when we are in the Office and the Space

4.2 Groundswell Office - Space Ground rules

"The Office - Space is a healthy and productive Home for Groundswell, Where we deliver our best work imaginable."

1. There is a clear separation between The Office and The Space!

- The Office is a closed boundaried place for quiet working.
- The Space is open for interacting, thinking, eating, drinking, dreaming, doing.

2. We respect the place!

- We keep it tidy and hygienic.
- We clear up after eating and meeting.
- We put things away after use.
- We use the right door for entering and leaving.

3. We respect each other!

- We embrace diversity and difference – everyone is unique.
- Everyone can do their jobs and be themselves.
- Please don't swear (too much).
- We are generous when people need a hand.

4. We respect the roles!

- When someone is on duty – we leave them to work… and offer them drinks.
- When on reception we answer the door and the phone, when we are not – we don't!

5. We have good phone etiquette!

- When we are on the phone - we don't shout.
- When someone else is on the phone - we don't disturb them.

6. We have good meeting etiquette!

- We start meetings on time.
- We end meetings on time.
- We prepare in advance.

- We clear up afterwards.

7. We have good office etiquette!

- We reinforce good behavior – and affirm each other when we do things well.
- Any one of us can pull anyone else up if we don't follow the Ground rules.
- We don't take it personally if we get pulled up!
- We take responsibility for our own behaviour.
- We all contribute to creating a healthy and productive home for Groundswell.

4.3 Using the phones and computers

Phones

- Staff/volunteers should give their work phone number to clients and not their personal number
- Staff/volunteers should feel able to turn off/not answer their work phone when they are not working
- You can use the office phone to make important calls but please check with us first if you need to ring abroad or make a premium rate phone call
- There is a phone where you can make private calls in Everest.
- All staff/volunteers should take responsibility for making sure that their Line Manager has an up to date work mobile phone number for them

Computers

- There are usually a couple of computers free for volunteers to work on. The office gets quite busy before and after team meetings, so there is not always a computer available
- You are welcome to use the computer but please respect the fact the office is a workspace and all the computer screens are clearly visible to everyone who walks through the office.
    - Do not look at anything offensive or sexual – bear in mind other people may be more sensitive to certain things than you
    - If you want to view something with sound use headphones
    - If you want to show people something on the computer please do so in a way that doesn't disturb people working around you
- Do not attempt to download anything on to a Groundswell computer
- Staff and other volunteers are usually happy to help you if you get stuck, but do bear in mind that sometimes they will be busy and won't have time

4.4 The kitchen

The kitchen is a shared space for everyone who works at Groundswell. Groundswell provides tea, coffee, milk, sugar etc. and we will try and make sure there are snacks like biscuits and fruit. If food is left out on the side or on the table in the kitchen then it is for everybody, help yourself to it. Food in the fridge and cupboard has usually been brought in by people for their lunch, so don't eat it

without checking first. When you have finished with cups, plates and cutlery please put them in the dishwasher.

Contents

Appendix 1 – Interview schedule for homeless clients engaged with HHPA

Introductions

Thank you for agreeing to be interviewed. I have some topics and questions I would like to explore around the HHPA programme and your experiences of it, but you should feel free to talk about any related issues or topics that are important for you.

To start, can you tell me how you are feeling today? explore current context

- How is your health? – explore current, recent and past health issues
- How is your current housing status?

HHPA process and context

Can you tell me what you think of the HHPA programme?

- Explore general experiences – what do you like? What don't you like?
- (explore for contextual influences – the hostel/day centre, the clinic site, life course)

It is helpful for us to understand the detail of your experience. Can you tell me about your experience today/most recent experience of working with a peer advocate? What happened?

- How was it organized?
- Talk me through the day – where you met? where you went? what did you talk about? what did the peer advocate do? What happened after?
- (explore for contextual influences – the hostel/day centre, the clinic site, life course)

How does that experience compare to past experiences of working with a peer advocate?

Tell me about your relationship with the peer advocate?

- Explore – communication style, communication content, length of relationship, expectations of it

Thinking back to past experiences of health care without a peer advocate, how do those experiences compare?

- Explore on interactions with care providers, ease of appointments, whether they attended appointments
- Relate this to the health issues raised at the start

HHPA outcomes and context

(following on from above, and referring back to points above if already raised)

In what ways, if any, do you think it has helped you? How?

- Explore specific health issues (referring back to health issues just described)
  - Physical health
  - Mental health
  - General well being / happiness
- (across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. your housing help, or welfare?)

- Explore on relationships, understandings and experiences of health care systems generally
  - How you are seen and spoken to by doctors, nurses and receptionists

Explore social impacts
Social support
Housing
(relate back to other issues as raised at the start of the interview)
(across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. your housing help, or welfare?)

(explore for contextual influences – the hostel/day centre, the clinic site, life course)

In what areas do you think it hasn't helped much?
Explore as above

Thinking about your general experience of homelessness, has peer advocacy helped that at all?
Explore – legal challenges, police, hardship

Broader HHPA impacts

Do you ever see the peer advocates in hostels or day centres?
Explore attending talks
Listening to people talk about it

What do other people say about peer advocates and HHPA?

Do you think peer advocates change anything in hostels or day centres?

Closing questions

Is there anything you think could be done to make HHPA better?

Is there anything else you think could be done to support the health of people who are homeless?

Is there anything you think we should keep in mind when interviewing other clients as part of this project?

I am at the end of my questions now, is there anything else you would like to tell me?

Do you have any questions for me?

Appendix 2 - Interview schedule for people who are homeless not engaged with HHPA

Introductions

Thank you for agreeing to be interviewed. I have some topics and questions I would like to explore around the HHPA programme and your experiences of it, but you should feel free to talk about any related issues or topics that are important for you.

To start, can you tell me how you are feeling today? Explore to understand current context

- How is your health? – Explore current, recent and past health issues
- How is your current housing status?

Health care access

Can you tell me about your access to health care?

- Explore in relation to health issues above
- Explore on appointments, attending, relationships with providers

Can you talk me through a recent experience of accessing care? How does that compare to other experiences?

How has this changed?

HHPA

Have you ever used the HHPA programme?

(no – go to 1, yes go to 2)

1 No HHPA experience

Have you heard of HHPA?

No – describe it, do you think that would help you? explore

Yes – what do you think of it? Why are you not using it? explore

2 Past HHPA experiences

what do you think of it?

It is helpful for us to understand the detail of your experience. Can you tell me about your most recent experience of working with a peer advocate? What happened?

- How was it organized?
- Talk me through the day – where you met? Where you went? What did you talk about?
- What did the peer advocate do? What happened after?

How does that experience compare to others' experiences of working with a peer advocate?

In what ways, if any, do you think it has helped you? How?

- Explore specific health issues (referring back to health issues just described)
  - Physical health
  - Mental health
  - General well being / happiness
- (across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. your housing help, or welfare?)

Explore on relationships, understandings and experiences of health care systems generally
How you are seen and spoken to by doctors, nurses and receptionists

Explore social impacts
Social support
Housing
(relate back to other issues as raised at the start of the interview)
(across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. your housing help, or welfare?)

In what areas do you think it hasn't helped much?
Explore as above

Thinking about your general experience of homelessness, has peer advocacy helped that at all?
Explore – legal challenges, police, hardship

Why do you no longer work with a peer advocate?
Explore – communication style, communication content, length of relationship, expectations of it

Thinking back to past experiences of health care without a peer advocate, how do those experiences vary?
Explore on interactions with care providers, ease of appointments, whether they attended appointments
Relate this to the health issues raised at the start

Broader HHPA impacts

Do you ever see the peer advocates in hostels or day centres?
Explore attending talks
Listening to people talk about it

What do other people say about peer advocates and HHPA?

Do you think peer advocates change anything in hostels or day centres?

Closing questions

Is there anything else you think could be done to support the health of people who are homeless?

I am at the end of my questions now, is there anything else you would like to tell me?

Do you have any questions for me?

Appendix 3 – Interview schedule for peer advocates

Introductions

Thank you for agreeing to be interviewed. I have some topics and questions I would like to explore around the HHPA programme and your experiences of it, but you should feel free to talk about any related issues or topics that are important for you.

To start, can you tell me a little bit about your role with Groundswell and how long you have been linked with them?

Our study is focused on understanding the HHPA programme – can you tell me about how you have been involved in the programme?

- As peer, and as client?

HHPA

Can you tell me what you think of the HHPA programme?

- Explore general experiences – what do you like? What don't you like?

It is helpful for us to understand the detail of your experience. Can you tell me about your experience today/most recent experience of working as a peer advocate? What happened?

- How was it organized?
- Talk me through the day – where you met? Where you went? What did you talk about?
  - What happened before the consultation? During? After?
- What did the client do?

How does that experience today compare to past experiences of working as a peer advocate?

Tell me about your relationship with the clients?

- Explore – communication, length of relationship, expectations of it

Tell me about your relationships and interactions with health care providers?

HHPA outcomes

(following on from above, and referring back to points above if already raised)

In what ways, if any, do you think it has helped clients? How?

- Explore specific health issues
  - Physical health
  - Mental health
  - General well being / happiness
- (across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. housing help, or welfare?)

- Explore on relationships, understandings and experiences of health care systems generally
  - How people are spoken to by doctors, nurses and receptionists
  - Possible impacts on understandings of people who are homeless

- Explore social impacts

Social support
Housing
(across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. housing help, or welfare?)

In what areas do you think it hasn't helped much?
Explore as above

Broader HHPA impacts
Do you ever see the peer advocates in hostels or day centres?
Explore attending talks
Listening to people talk about it

What do other people say about peer advocates and HHPA?

Do you think peer advocates change anything in hostels or day centres?

Impact on peers
How has HHPA impacted on you?

What has changed since becoming a peer advocate? What hasn't really changed?
Explore – health, social connections, employment, housing

In what ways has being an advocate met your expectations? In what ways hasn't it?

What are the benefits of being a peer advocate? What are the challenges?

HHPA management and support
What support do you get as a peer?

What training do you get? How was your original training?

Closing questions
Is there anything you think could be done to make HHPA better?

Is there anything else you think could be done to support the health of people who are homeless?

I am at the end of my questions now, is there anything else you would like to tell me?

Do you have any questions for me?

Appendix 4 – Interview schedule for Groundswell staff and stakeholders

Introductions

Thank you for agreeing to be interviewed. I have some topics and questions I would like to explore around the HHPA programme and your views of it, but you should feel free to talk about any related issues or topics that you think are important.

To start, can you tell me a little bit about your role?

Our study is focused on understanding the HHPA programme – can you tell me about how your role links to the programme?

HHPA

Can you tell me what you think of the HHPA programme?

- Explore general experiences – what do you like? What don't you like?

Based on your knowledge of clients and peer experiences, can you describe a recent experience of HHPA?

- How was it organized?
- What did the client do?
- Explore – relationships, trust, interactions in clinics

Is there anything specific that makes somebody a good peer advocate?

HHPA outcomes

(following on from above, and referring back to points above if already raised)

In what ways, if any, do you think it has helped people? How?

- Explore specific health issues
  - Physical health
  - Mental health
  - General well being / happiness
- (across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. housing help, or welfare?)

- Explore on relationships, understandings and experiences of health care systems generally
  - How people are spoken to by doctors, nurses and receptionists
  - Possible impacts on understandings of people who are homeless

- Explore social impacts
  - Social support
  - Housing
  - (across these – is it just the peer advocacy that helped? Or did other things or people also help? E.g. housing help, or welfare?)

In what areas do you think it hasn't helped much?

- Explore as above

Broader HHPA impacts

Do you ever see the peer advocates in hostels or day centres?

Explore attending talks

Listening to people talk about it

What do other people say about peer advocates and HHPA?

Do you think peer advocates change anything in hostels or day centres?

HHPA support and management

Can you tell me about how peers are trained, managed and supported?

What works well about these?

What doesn't?

Why do some peers volunteer/work for longer than others?

Health system context

How does HHPA fit within the broader health and social care system?

Are things specific to London or the UK that makes the HHPA programme particularly necessary?

Do you think the need for the HHPA programme will become bigger or smaller or different in future?

Closing questions

Is there anything you think could be done to make HHPA better?

Is there anything else you think could be done to support the health of people who are homeless?

I am at the end of my questions now, is there anything else you would like to tell me?

Do you have any questions for me?

Appendix 5 – interview schedules for new peer advocates in training

Introductions

Thank you for agreeing to be interviewed. I have some topics and questions I would like to explore around the HHPA programme and your views of it, but you should feel free to talk about any related issues or topics that you think are important.

For First interview

Can you tell me about why you wanted to be a peer advocate?

- What was going on your life at that time – explore life course: housing, health, social connections

Can you tell me about the process of applying and recruitment to be a peer?

How has the training gone so far? What is going well?

For second and follow-up interviews

Can you tell me about your recent training?

How are you feeling about the work?

- Anything excited about?
- Anything worried about?

Is anything different to what you expected? Anything exactly as you expected?

Has the training and work had any impact on you do you think?

For interviews when beginning work as a peer advocate

How are you feeling about the work?

- Anything excited about?
- Anything worried about?

Has the training and work had any impact on you do you think?

What successes and challenges have there been so far?

Questionnaire sections

Section/Question	Label	Value	Codebook variable	Source
Part 1 – Field Work Admin				
Welcome to the HHPA Evaluation				
What is your name?		1	cor	
		2		
		3		
		4		
		5		
		6		
		7		
		8		
		9		
		10		
		11		
		12		
		13		
		14		
		15		
		16		
		17		
		18		
How are you conducting the interview?	In person	2	mode	
	Remotely (phone, video chat)	1		
[For remote] Before calling the recruit confirm that you have the following	Contact details for recruit		remote	
	Contact details for venue staff			
	Link to The Pavement website			
	Communication device (phone/internet+headset)			
	Cash advance for e-vouchers (or to post voucher)			

Section/Question	Label	Value	Codebook variable	Source
[For in person] Before departing for the venue, confirm that you have the following:	Participant pack (info sheet, consent form, The Pavement, business card)		checklist	
	Face Mask			
	Hand sanitizer			
	Incentive (in envelope) or e-voucher codes			
	Contact details for host at venue			
	LSHTM badge			
	LSHTM introduction letter			
	Mobile phone			
[For in person] Before departing for the venue, consider whether you – or anyone in your household - have any of the following:	A new, dry cough [→ prompt to cancel]		covidsx	
	High temperature [→ prompt to cancel]			
	Loss / change of sense of smell / taste [→ prompt to cancel]			
[Cancel prompt] If you feel breathless: Use NHS 111 online https://111.nhs.uk/covid-19/ If you are struggling to breathe: Call 999 Otherwise, order a Coronavirus test: https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/get-a-test-to-check-if-you-have-coronavirus/ and stay at home until you get your result Call to re-schedule. [→ skip to end]				
Do you plan to interview a Groundswell HHPA (peer advocacy) client?	No	0	arm	
	Yes	1		
Recruit is based in what borough?	Brent	1	borough	

Section/Question	Label	Value	Codebook variable	Source
	Camden	2		
	City of London	3		
	Croydon	4		
	Ealing	5		
	Hammersmith & Fulham	6		
	Hackney	7		
	Haringey	8		
	Hillingdon	9		
	Islington	10		
	Kensington & Chelsea	11		
	Lambeth	12		
	Lewisham	13		
	Newham	14		
	Redbridge	15		
	Richmond	16		
	Southwark	17		
	Tower Hamlets	18		
	Waltham Forest	19		
	Wandsworth	20		
	Westminster	21		
[Controls only] Location of participants			venue	
[In person only] AT THE VENUE, confirm that you have done the following:	Identified a contact person (e.g. hostel staff)			
	Located the nearest fire exit			
	Located the venue's evacuation meeting point			
	Found a handwashing facility			
	Called/texted to confirm your arrival			
Now you can speak to a recruit for the study				
Is the recruit fluent in English?	No		english	
	Yes			
Is the recruit fluent in Polish?	No		polish	

Section/Question	Label	Value	Codebook variable	Source
	Yes			
[If English=No AND Polish=No] The participant is ineligible. Go back and revise answers if appropriate, or swipe left to end the interview.				
Pre-eligibility sociodems				
I'm going to ask you a few questions to see if you are eligible for this study.				
What is your date of birth?	dd-mm-yyyy		dob	
To confirm, you are ${age} years old	No [→ go back]		ageconf	
	Yes			
What best describes your gender	Male	0	gender	https://www.stonewall.org.uk/sites/default/files/do_ask_do_tell_guide_2016.pdf removed 'self-describe' option and added more terms with non-binary Adapted National LGBT survey 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf
	Female	1		
	Non-binary / genderqueer / agender / gender fluid	4		
	Prefer not to say	99		
	Other	77		
What is your ethnic group? [Choose all that apply.]	White		ethnic	

Section/Question	Label	Value	Codebook variable	Source
	Asian / British-Asian			Homeless Health Needs Audit (HHNA) #9, adapted by allowing multiple choices. Added Hispanic/Latino
	Black / Black British			
	Arab			
	Hispanic / Latino			
	Other			
Are you a citizen of…	United Kingdom		citizen	
	European Union country			
	Another country			
Where did you slept last night?	Sleeping rough on streets/parks		sleepnow	HHNA #4
	In a hostel or supported accommodation			
	Squatting			
	Sleeping on somebody's sofa/floor			
	In emergency accommodation, e.g. night shelter, refuge			
	In B&B or other temporary accommodation			
	Housed – in own tenancy [→ ineligible]			
	Other [→ ineligible]			
Without going into detail, do you have any ongoing health issues? Prompt: including mental health, substance use, and physical health	No [→ineligible]		ongoing	
	Yes			
How easy is it for you to make and attend health appointments? Prompt: Would you say it's easy, a bit challenging, or almost impossible?	Easy [→ ineligible]	1	easy	
	Challenging	2		
	(Almost) Impossible	3		
[Is the recruit cognitively able to give informed consent?]	No [→ reschedule prompt]		cognitive	
	Unsure [→ Prompt for witness]			

Section/Question	Label	Value	Codebook variable	Source
	Yes			
Prompt for witness: Before we continue can I ask you to find a key worker who can be a witness for the next section?	No [→ deferral prompt]		witness	
	Yes			
Deferral prompt: Let's schedule a time to speak when a key worker can observe the informed consent process, and we will be able to continue.	[→ end]			
[If ineligible] For this study, we are looking for people who are homeless and who are struggling to meet their health care needs. It seems that I can't recruit you for this study. Thank you for making the time to speak to me today.				
You are eligible for the study, let me tell you more about it.				

[Information sheet script] I'm part of a research team which is interested in people who are homeless in London. We want to know if health care use differs for people who have met a peer advocate, compared to people who haven't. In London, peer advocates are trained and supported by Groundswell, a third sector organisation based in South London. The research team includes people from the London School of Hygiene and Tropical Medicine, King's College London and University College London. Findings from this research will be useful for local commissioners in London, as they make decisions about what services to offer for people who are homeless. Study participants complete a questionnaire. The questionnaire takes about 25 minutes to complete, and has questions about your health status, drug and alcohol use, and health care use. You can refuse to answer any question I ask you. I will need your permission for the research team to access your NHS records for the past and future 12 months, to find out more about how often you use outpatient care, how often you use A&E, and how often you are admitted for inpatient care. To access your NHS records, I will ask for your name and date of birth, and, if possible, your NHS number. The research team is also interested in services offered for people who sleep rough. If you give us permission, we want to see if you have any records stored in the CHAIN database. It's up to you whether you give us this permission. Your data will be handled in confidence, stored on secure servers, and handled by a small number of researchers. We will store information about your name and date of birth separately from your responses to the rest of the questionnaire. We will not report your individual data to anyone. All our reports will be on a group level. There is one exception to confidentiality, and that is if you say something which makes me think you are going to harm yourself or another person. In that case, I'll stop the interview and we'll talk about how to get you help from a key worker. You can decline to participate in study. And if you do participate, you have the right to ask us to delete your data afterwards. This is possible up to the point of data analysis. I will give you our contact details when we're done with the questionnaire.			Information sheet

Section/Question	Label	Value	Codebook variable	Source
Do you have any questions? I will be happy to clarify anything I've said.				
[If witness required] Name of witness			witnessname	
I will read out a set of statements about this study. You need to agree with all the statements to be in the study. Say "yes" if you agree with the statement, or you can ask for clarification, or you can decline to participate in the study.	I understand the purpose of the study, what the study involves, and I understand why you would like to talk to me.		consent_	Consent form
	I have had the opportunity to ask any questions that I might have and am happy with the answers I have received.			
	I agree to complete the questionnaire.			
	I understand that I do not have to answer any question I do not want to, and that I can stop the interview at any time without giving a reason.			
	I understand that the information I give will be used in analysis and stored securely.			
	I understand that everything I say is confidential: researchers will not use my name when they write about this project.			
	I consent to giving my full name, date of birth, GP or home address and NHS number			
	I give permission for the team to obtain information from my health-related records and registers including from the National Health Service (NHS) (NHS registration,			

Section/Question	Label	Value	Codebook variable	Source
	health status, treatment and use of health services, GPs, other healthcare organisations); as well as via NHS Digital, NHS Central Register, NHS Personal Demographics* Service and the Department of Health and Social Care* (*or successor organisations if these change)			
	I understand that any personal information that I give will be kept separately from my questionnaire data and destroyed at the end of the project.			
	I understand that if I tell you something that makes you think I or another adult is in immediate danger, or that a child is being harmed, you may have to tell someone what I have said.			
	I understand that my participation in the study is voluntary and that I am free to withdraw from the study at any time, without giving a reason.			
	I understand that I can request that my data be removed from the study up to the point of analysis, but not withdrawn afterwards.			
	I agree to take part in this study.			
	OPTIONAL: I give permission for the team to obtain information about my accommodation status and alcohol, drugs or mental health			

Section/Question	Label	Value	Codebook variable	Source
	support needs, as well as my use of services relating to these needs, from the CHAIN database, if I have been recorded on it.			
[If decline any consent items 1-13] Thank you for answering these questions. Only people who agree with all of the statements can participate in the study. Is there anything I can clarify about the study? If not, I want to thank you for taking the time to speak with me. [→skip to end]				
Part 2 - Sociodemographic characteristics				
Thank you for agreeing to take part in this study. Your answers to the following questions will be used to help us learn more about the health status of homeless people in London. The only people who will see these answers will be members of the research team.				
You indicated an ethnic background which is white. Which of these best describes your background?	British / English / Scottish / Welsh / No. Irish		ethwh	
	Irish			
	Gypsy or Irish Traveller			
	Other White			
You indicated an ethnic background which is Asian. Which of these best describes your background?	Bangladeshi		ethas	
	Chinese			
	Indian			
	Pakistani			
	Other Asian			
You indicated an ethnic background which is African, Caribbean or Black British. Which of these best describes your background?	African		ethbl	
	Caribbean			
	Other Black			
Which of the following options best describes how you think of yourself?	Heterosexual / straight	1	sexorient	Adapted from Office for National
	Gay / lesbian	2		

Section/Question	Label	Value	Codebook variable	Source
	Bi	3		Statistics (ONS) Annual Population Survey
	Don't know	88		
	Refuse	99		
	Other	77		
Do you identify as trans?	No	0	trans	Stonewall 'Do ask, do tell' https://www.stonewall.org.uk/sites/default/files/do_ask_do_tell_guide_2016.pdf
	Yes	1		
	Refuse	2		
How good are you at reading English when you need to in daily life? For example: reading newspapers and magazines or instructions for medicine or recipes?	Very good	1	reading	2011 Skills for Life Survey, UK Dept for Business Innovation and skills Bqread,
	Fairly good	2		
	Below average	3		
	Poor	4		
	Cannot read English	5		
	Refuse	99		
How good are you at writing in English when you need to in daily life? For example: writing letters or notes or filling in official forms?	Very good	1	writing	2011 Skills for Life Survey, UK Dept for Business Innovation and skills Bqwrite
	Fairly good	2		
	Below average	3		
	Poor	4		
	Cannot write English	5		
	Refuse	99		
Which of these categories best describes you at present?	Going to school or college full-time	1	employ	HHNA #2, added 'unemployed and looking' and 'retired/ pensioner'
	In paid employment or self-employment	2		
	On a government scheme for employment training	3		
	Doing unpaid or voluntary work	4		
	Waiting to take up paid work already obtained	5		

Section/Question	Label	Value	Codebook variable	Source
	Intending to look for work but prevented by temporary sickness or injury	6		
	Permanently unable to work because of long-term sickness or disability	7		
	Unemployed and looking for work	8		
	Unemployed and not looking for work	9		
	Retired / pensioner			
	Other	77		
Are you at present receiving any state benefits where you are the named recipient?	No	0	benefits_named	East London Project (ELP) Q13.05
	Yes [→]	1		
	Refuse	99		
Are you eligible to receive state benefits?	No	0	benefits_elig	
	Yes	1		
	Refuse	99		
Have you ever been refused housing or state benefits??	No	0	benefits_refused	ELP Q13.05.01
	Yes	1		
	Refuse	99		
What is the highest level of education that you have completed?	Further education beyond secondary/high school	3	edu	
	Secondary/high school	2		
	Primary	1		
	Less than primary	0		
How many years have you lived in the United Kingdom?	__ years		inukyears	
How old were you when you first became homeless?	…. years old		first	
Homelessness characteristics				
In your life, have you ever…	Stayed with friends, relatives or other people because you had no home of your own		meh	Multiple Exclusion Homeless (MEH) #1, from https://doi.org/10.

Section/Question	Label	Value	Codebook variable	Source
				1017/S147474641100025X
	Stayed in a hostel, foyer, refuge, night shelter or B&B hotel because you had no home of your own			MEH #2
	Slept rough			MEH #3
	Applied to the council as homeless or as threatened with homelessness?			MEH #4 + input from Suzanne Fitzpatrick
	Spent time in local authority care as a child			MEH #5
	Begged (that is, asked passers-by for money in the street or another public place)			MEH#12
	Shoplifted because you needed things like food, drugs, alcohol or money for somewhere to stay			MEH#14
In the last 12 months, were you ever hungry and didn't eat because you couldn't afford enough food?	No	0	food	CDC NHANES
	Yes	1		
	Don't know	88		
	Refuse	99		
Are you a caregiver for anyone?	No [→next section]	0	caregiver	Adapted from ELP Q13.02
	Yes	1		
Who do you care for? [Choose all that apply]	Children or dependents under 18 years		carefor	
	Children or dependents over 18 years			
	Parents or other adult family members			
	Friend(s)			
	Other			

Section/Question	Label	Value	Codebook variable	Source
## Health difficulties				
The next few questions are about your health status.				
Do you currently have any of the following health problems? Chose all that apply.	Asthma		health_ _asthma	Diseases from HHNA 13 & 16, combined some conditions, dropped others. Added autism, dyslexia, brain injury
	Autism		_autism	
	Brain injury		_brain	
	Cancer		_cancer	
	Chronic breathing problems (bronchitis, emphysema, obstructive airways disease)		_breathe	
	Depression or anxiety		_depress	
	Diabetes		_diabetes	
	Difficulty seeing / eye problems		_vision	
	Drug (addiction) problems		_drug	
	Dyslexia		_dyslexia	
	Epilepsy / seizures		_epilepsy	
	Foot problems		_foot	
	Heart problems (including heart attack, angina, murmur, abnormal rhythm)		_heart	
	Hepatitis C		_hepc	
	High blood pressure		_hyperten	
	HIV		_hiv	
	Joint, bone or muscle problems		_jointbone	
	Psychosis / bipolar disorder		_psychosis	
	Sexually transmitted infection (chlamydia, gonorrhoea or pelvic inflammatory disease)		_sti	
	Skin/wound infection		_skin	
	Teeth / dental problems		_dental	
	Tuberculosis			
	Other health problems		_other	

Section/Question	Label	Value	Codebook variable	Source
The next questions are about difficulties that people have when they are managing their health.				
Have you faced any of these difficulties when managing your health? Chose all that apply.	I was concerned about how much money it would cost.		barriers_	Composite International Diagnostic Interview (CIDI) Services module, SR116 / SR 126 Cut first several items e.g. 'insurance'. 'Transportation' is simplified.
	I was concerned about what people would think if they found out I was seeking treatment			
	I had problems with transportation			
	I was unsure about where to go or who to see			
	I thought it thought it would take too much time or be inconvenient			
	I could not get an appointment			
	I was scared about being put in a hospital against my will			
	I was dissatisfied with services I received in the past			
	I had experience with health workers who had not listened to my concerns			
	I had experience with healthcare workers who thought that I'm milking the system, e.g. trying to con them into giving me prescription medications to get high or sell.			from 10.1016/j.drugalcdep.2016.02.019, Items 4,5,6 "pill shopping" → "milking the system"
[Of the options selected in health_***] Which of these health problems do you have **most** difficulty managing? [Choose one]				
## Health-related Self-efficacy				Groundswell HHPA Planning and Debriefing Tool.
You have said that X is your most challenging health problem to manage.				

Section/Question	Label	Value	Codebook variable	Source
Do you feel you understand the X and what might have caused it?	Yes – very clear on it	2	pdt_understand	Simplified answers to the medication item.
	I have an OK grasp on it but have some questions	1		
	I don't know – need to ask in the next appointment	0		
Do you feel confident to talk to the medical staff about X?	Yes, totally confident	2	pdt_confident	
	Mostly confident	1		
	No – not very confident, I need help to explain to the doctor	0		
Do you know the different treatment options or medications that are available for X?	Yes – very clear on it	2	pdt_options	
	I have an OK grasp on it but have some questions	1		
	I don't know – need to ask in the next appointment	0		
Are you able to manage use any medication that you have been prescribed for X on an ongoing basis?	Yes	1	pdt_manage	
	No	0		
	Not applicable (no medications)	66		
Health-related social capital / HHPA exposure				
In the past year, has anyone helped you out when you had a medical appointment?	No [→next section]	0	helped	
	Yes	1		
	Don't know / don't remember [→next section]	88		
Did any of the following people help you? [chose all that apply]	Family		helper	
	Friends			
	Neighbours			
	Hostel staff			
	Day centre staff			
	Volunteers or Charity workers, including outreach workers			
	Religious leaders			

Section/Question	Label	Value	Codebook variable	Source
Did any of the people who helped you have lived experience with homelessness?	No [→]	0	livedexp	
	Yes	1		
	Don't know	88		
Were any of the people who helped you from Groundswell?	No	0	groundswell	
	Yes	1		
	Don't know	88		
In the past 12 months have you: [Chose all that apply]	Seen a GP		services	HHNA #27, turned into binary responses, removed 'homeless healthcare service', added 'dentist' and OST
	Been to A&E			
	Used an ambulance			
	Been admitted to hospital			
	Been to a dentist			
	Visited or been visited by someone working for a sex worker project?			
	Used drug or alcohol services?			
	Used substitute drug regime (e.g. methadone script)			
	Been visited by someone from Find and Treat			
	Been helped by a care navigator at Pathways			
## Covid vaccine uptake				
Has anyone offered you a Covid vaccine?	No	0	covaxoffer	
	Yes	1		
	Don't know	88		
	Refuse	99		
Who offered you the Covid vaccine?	Invited by GP to receive a vaccine at a health centre / hospital / pharmacy		covaxprovider	
	Approached by roving (mobile) team			
	Other			

Section/Question	Label	Value	Codebook variable	Source
	Don't know / don't remember			
Did you accept the vaccine?	No	0	covaxcaccept	
	Yes	1		
	Refuse	99		
## Depression & anxiety The next four questions are about your feelings over the past two weeks.				These are the 4 Qs used in ELP and Samvedana, day ranges adapted from Samvedana
Over the past two weeks, how often have you been bothered by having Little interest or pleasure in doing things	Not at all (0 days)	0	phq1	PHQ9 #1
	Several days (1 to 7 days)	1		
	More than half the days (8-11 days)	2		
	Nearly every day (12-14 days)	3		
Over the past two weeks, how often have you been Feeling down, depressed, or hopeless	Not at all (0 days)	0	phq2	PHQ9 #2
	Several days (1 to 7 days)	1		
	More than half the days (8-11 days)	2		
	Nearly every day (12-14 days)	3		
Over the past two weeks, how often have you been Feeling nervous, anxious or on edge	Not at all (0 days)	0	phq3	GAD7 #1
	Several days (1 to 7 days)	1		
	More than half the days (8-11 days)	2		
	Nearly every day (12-14 days)	3		
Over the past two weeks, how often have you been Not able to stop worrying	Not at all (0 days)	0	phq4	GAD7 #2
	Several days (1 to 7 days)	1		
	More than half the days (8-11 days)	2		
	Nearly every day (12-14 days)	3		
In your life, have you ever been admitted to hospital with a mental health issue? [This could be voluntarily or by being sectioned]	No [→]		admitted	MEH#7
	Yes			
	Refuse [→]			
Has this happened in the last 6 months?	No		admitted6	
	Yes			
	Refuse			

Section/Question	Label	Value	Codebook variable	Source
## Substance use				
The next questions are about alcohol and drug use. Remember that your answers are confidential and are only used by members of the research team.				ELP section Q12
Have you ever had a period in your life when you had six or more alcoholic drinks on a daily basis?	No		meh_binge	MEH#11
	Yes			
	Refuse			
In your life, have you ever been involved in street drinking? By street drinking we mean heavy and/or frequent drinking in outdoor public places such as street, parks and public squares.	No		meh_streetdrink	MEH#13, prompt from Ross et at (2005) doi:10.1093/her/cyg118 and here
	Yes			
	Refuse			
How often have you had an alcoholic drink during the past 12 months?	Seven days a week		drinkfreq	HHNA #22, CSEW (ALCOFT)
	Five or six days a week			
	Three or four days a week			
	Once or twice a week			
	Once or twice a month			
	Once every couple of months			
	Once or twice a year			
	Not at all in the last 12 months			
	Refuse			
In your life, have you ever used drugs not for medical purposes such as heroin, crack, weed?	No [→]		meh_drug	MEH #8
	Yes			
	Refuse [→]			
In your life, have you ever injected drugs not for medical purposes such as heroin or crack?	No [→]		meh_inject	MEH #9
	Yes			
	Refuse [→]			
[If ever inject is YES] In the past 12 months, have you injected any drugs?	No [→]		inject12	Adapted from ELP Q12.06.01
	Yes			
	Refuse [→]			
In the past 12 months, have you used needles/syringes that had been previously used by someone else?	No [→]		injectshare	ELP Q12.06.03
	Yes			
	Refuse [→]			

Section/Question	Label	Value	Codebook variable	Source
Have you taken any of these drugs in the past year? [Choose all that apply]	Did not take drugs in past 12 months		drug	HHNA 19 + ELP Q12.05.01 but with 12 month recall. Removed the combo drugs, ecstasy, lsd, opium, ketamine, poppers, barbituates/downers, steroids, methadone, legal highs, marijuana Added synthetic cannaboids (spice,)
	Heroin	1		
	Crack	2		
	Powder cocaine (coke)	3		
	Fentanyl	4		
	Marijuana / Cannabis / Weed	5		
	Synthetic cannabinoids such as Spice (or black mamba, noids, clockwork orange)	6		
	Tranquilisers such as benzodiazepines/benzos	7		
	Crystal Methamphetamine	8		
In the past 12 months, have you overdosed to the point where you lost consciousness?	No [→]	0	overdose	WHO drug use surveys
	Yes	1		
	Refuse [→]	99		
[If uses heroin] How often do you use heroin?	Nearly every day	1	dailyheroin	
	Less often	0		
[If uses crack/cocaine] How often do you use crack / cocaine?	Nearly every day	1	dailycrack	
	Less often	0		
[If uses spice] How often do you use spice?	Nearly every day	1	dailyspice	
	Less often	0		
[If uses weed] How often do you use marijuana / cannabis / weed	Nearly every day	1	dailyweed	
	Less often	0		
## Sex work				
In their lives, many people who are homeless find it difficult to engage in formal work and use different means to make money and go about their everyday life.				
Have you sold sex in the past 6 months? By selling sex, we mean exchanging sex for money, drugs or goods.	No	0	sexwork	ELP Eligibility Screener, with
	Yes	1		

Section/Question	Label	Value	Codebook variable	Source
	Refuse [→]	99		recall period of ever.
Have you ever sold sex? By selling sex, we mean exchanging sex for money, drugs or goods.	No	0	sexwork6	ELP Eligibility Screener, with recall period of 6 mo.
	Yes	1		
	Refuse	99		
Violence				
In their lives, many people who are homeless experience different forms of violence from relatives, people that they know and/or from strangers. I would like to ask you about some of these situations. This is important to know in order to understand all the issues people who are homeless experience that might affect their health and well-being. You do not have to answer any of these questions, but remember that if you do, all your answers are confidential.				Preface adapted from WHO Multi-country study on Women's Health and Life Events Version 9.9. Questions adapted from ELP Section 5. Change from 'a client' to 'another person'
In the past 6 months, has another person verbally, physically or sexually abused you?	No [→]	0	viosix	
	Yes	1		
	Don't know [→]	88		
	Refuse [→]	99		
Did you experience verbal abuse? Prompt: that is to say they belitted or humiliated you or used abusive or insulting language towards you such as calling you inappropriate names or making racist remark?	No [→]	0	viosix_verbal	
	Yes	1		
	Don't know [→]	88		
	Refuse [→]	99		
Did you experience physical abuse? [Prompt] That is to say you were pushed, shoved, slapped, kicked, punched, choked, dragged, burned you, or used a weapon against you, thrown something at you, or beaten you up?	No[→]	0	viosix_physical	
	Yes	1		
	Don't know[→]	88		
	Refuse[→]	99		
Did you experience sexual abuse? [Prompt] That is to say you were touched or grabbed you sexually against your will (grope) or attempted to get sex through force.	No[→]	0	viosix_sexual	
	Yes	1		
	Don't know[→]	88		
	Refuse[→]	99		
Has another person EVER verbally, physically or sexually abused you?	No [→]	0	vioev	
	Yes	1		
	Don't know [→]	88		

Section/Question	Label	Value	Codebook variable	Source
	Refuse [→]	99		
Did you experience verbal abuse? Prompt: that is to say they belitted or humiliated you or used abusive or insulting language towards you such as calling you inappropriate names or making racist remark?	No [→]	0	vioev_verbal	
	Yes	1		
	Don't know [→]	88		
	Refuse [→]	99		
Did you experience physical abuse? [Prompt] That is to say you were pushed, shoved, slapped, kicked, punched, choked, dragged, burned you, or used a weapon against you, thrown something at you, or beaten you up?	No[→]	0	vioev_physical	
	Yes	1		
	Don't know[→]	88		
	Refuse[→]	99		
Did you experience sexual abuse? [Prompt] That is to say you were touched or grabbed you sexually against your will (grope) or attempted to get sex through force.	No[→]	0	vioev_sexual	
	Yes	1		
	Don't know[→]	88		
	Refuse[→]	99		
## Policing				ELP Section 6
People who are homeless are often more vulnerable to being approached by the police or security guards and this can have negative affects on other aspects of their lives. We wanted to ask you about your contact with the police or criminal justice service. We won't ask you about the reasons for this contact, only if it happened. Remember that you don't have to answer any question, but if you do it will remain confidential.				
In the last six months, have you been arrested or detained or charged by police in the UK (for any reason)?	No	0	arrestsix	
	Yes	1		
	Refuse	99		
Have you EVER been arrested or detained or charged by police in the UK (for any reason)?	No [→]	0	arrestev	
	Yes	1		
	Refuse [→]	99		
In the last six months, have you spent time in prison or a young offenders institute?	No [→]	0	prisonsix	ELP Section 6
	Yes	1		
	Refuse [→]	99		

Section/Question	Label	Value	Codebook variable	Source
Have you EVER spent time in prison or a young offenders institute?	No [→]	0	prisonev	MEH #6
	Yes	1		
	Refuse [→]	99		
In the last six months, has a police officer (including community police officers) or security guards asked you to move on from a public space?	No [→]	0	movesix	
	Yes	1		
	Refuse [→]	99		
Has a police officer (including community police officers) or security guards EVER asked you to move on from a public space?	No [→]	0	moveev	
	Yes	1		
	Refuse [→]	99		
## Digital Literacy				
These next questions are about use of mobile phones, this information will be used to develop services for people who are homeless in London.				
Do you own a mobile phone?	No [→next section]	0	mobile_own	
	Yes	1		
Do you use this mobile to access the internet	No [→]	0	mobile_net	
	Yes	1		
Do you use this mobile to manage your health care?	No [→]	0	mobile_use	
	Yes	1		
Would you be willing to use your mobile to manage your health care?	No [→]	0	mobile_willing	
	Yes	1		
## Part 3 - HES linkage data				
The last few questions are so that the research team can locate your health records. Just to confirm, your answers are confidential, and are only used by people on the research team.				
What is your last name?			lname	
What is your first name?			fname	
What is your middle name?			mname	
Do medical providers know you by any other name(s)?	No	0	anyalias	

Section/Question	Label	Value	Codebook variable	Source
	Yes	1		
What other names are you known by? [Separate names with a comma e.g. "John, Jonathan, Johnny"]			aliases	
Do you know your NHS number? [do you have access to your NHS number at this facility? If you are able to get the letter, or from the staff here, I'll get your incentive ready while you get the letter/number]	No [→]	0	nhs	
	Yes	1		
What is your NHS number?			nhsnumber	
Do you have more NHS numbers?	No [→]	0	nhsmore	
	Yes	1		
	Refuse [→]	99		
What are the NHS numbers? Separate each number with a comma.			nhsnumbers	
Are you registered at a GP surgery?	No [→next section]	0	gpregister	
	Yes	1		
What is the name of the surgery where you are registered?			gpname	
Do you know the location of the surgery?	No [→]	0	gplocation	
	Yes	1		
What is the location of the surgery? PROMPT: If you can't remember the address, the name of the street and/or borough will be fine. Or any major landmark nearby.			gpaddress	
When you last used medical services, did you have a postal address?	No	0	postal	
	Yes	1		
Do you remember the address?	No [→]	0	remember	
	Yes	1		
What was the street, city and postcode? Type in as much as you remember.			address	
Part 4 – Postscript				
	No		qualpermission	

Section/Question	Label	Value	Codebook variable	Source
Our research team is interested in talking to a few people who have completed this questionnaire. We want to have an open-ended conversation experiences with accessing health care. We ask for about 45 minutes of your time, and we'd offer £10 as a token of appreciation. Can someone from King's College London get in touch to tell you more?	Yes			
[If yes] What is the best way to contact you? [enter email address, or phone number, or key worker contact details]			qualcontact	
We have come to the end of the questionnaire.				
Here is an envelope with £10. Thank you for participating in the study.				
Part 5 - Post-questionnaire documentation				
Were there any unexpected / unusual events to report?	No	0	anyevent	
	Yes	1		
What were the unexpected /unusual event(s)?	Harm to self	1	event	
	Harm to child	2		
	Participant needs to leave	3		
	Participant withdraws consent	4		
	Participant falls asleep	5		

Section/Question	Label	Value	Codebook variable	Source
	Other people interrupt / get too close	6		
	Participant has a medical issue	7		
	Participant starts to drink / use drugs	8		
	Participant experiences distress from the questionnaire	9		
	Participant gets distracted / disinterested	10		
	Confusing question	11		
	Harassment	12		
	Tablet fails	13		
	Bad internet/phone connection	14		
	Other	77		
Provide details about the event.			eventdetail	
The interview is complete. Swipe right, and click 'Save Form and Exit'.				