University of Brighton

Brighton and Hove Common Ambition Initial Evaluation Report
Executive Summary

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> **Important note:**
> *BHCA lived experience members, facilitators and partners are advocates of coproduction with people with lived experience of homelessness. However, collectively, they ask anyone reading this report who is considering coproduction with people with experience, to prioritise the emotional safety of participants at all times and use a trauma-informed approach.*

1. This executive summary provides an overview of the Brighton and Hove Common Ambition (BHCA) Initial Evaluation Report (November 2023). It sets out the aims of the programme, including the barriers to lived experience involvement in systems improvement that BHCA faced. It summarises the project's achievements and presents the risks that arise from coproduction activity with this group being discontinued.

2. People with experience of homelessness are at a profound disadvantage when it comes to being equal partners in health service improvement. Whilst a significant charitable sector exists who advocate on behalf of this group, unlike other areas of health advocacy, nationally, there are no longstanding, lived experience-led, patient groups for people with current experience of homelessness.

3. This has led to a deficit of peer-led, capability building and system level, expert knowledge of how people experiencing homelessness can: empower themselves and each other; develop a collective voice; participate in service improvement initiatives; and act as equal partners in health service quality improvement and research.

4. However, in the specific case of Public and Patient Involvement (PPI) activity and people with current experience of homelessness, important questions must be addressed concerning:

   1.) the **capacity** of people to engage in PPI activity given the daily challenges they face trying to remain safe, keep warm and meet basic needs
   2.) the **ethical implications** of asking people to engage in PPI activity given the system-induced trauma and routine discrimination they face from the general public and some service providers
   3.) the **ethical commitment** of local systems and service providers to listen to voices of people with lived experience and embed what is learned
   4.) the **safety and wellbeing** of participants given the trauma, distress and multiple health issues they routinely face

5. The time, effort and diligence required to address these questions are significant therefore they can be perceived as a barrier to engagement. Yet, evidence from health quality improvement and health inclusion research shows that there is very likely to be a clear connection between: a lack of lived experience voice, representation and PPI capability building for people who experience housing crisis and homelessness; and the fact that once homeless, this group experience the worst health inequalities and disparities of any other

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population, or group of people, in the UK. Addressing this deficit therefore offers a potential strategy for generating improvement in the quality and safety of services.

6. An additional barrier to improving health outcomes for this group that is frequently cited is: their needs are complex. People with experience agree with this statement but ask for closer examination of *what this complexity is and how it arises*. Whilst the needs of someone without a home are without doubt multiple and time critical (i.e. they need advice, shelter, safety, food and support with resolving immediate housing and financial crisis) they can be met; and effective, timely intervention in housing crisis and experience of homelessness prevents a potentially overwhelming cascade of negative effects, that if ignored, lead to an excessively high prevalence of lifelong health conditions, disabilities and infirmity.

7. Quality improvement, implementation science and design-led research advocate for the involvement of end users in service design and innovation, as a potential solution to intractable, system level problems. In addition, there are many important examples† of health, patient and carer-led advocacy which has resulted in social movements, and the development of organisations and networks, through which individual groups collectively: share and retain knowledge; campaign for service improvements; and achieve equal voice in defining and implementing those improvements.

   †For example, patient-led HIV advocacy has, since the shock and loss of life experienced in the 1980s, created capability building networks that support people living with HIV and the advocacy organisations they have formed, to be: research partners, policy makers and service coproducers, sharing capability internationally with countries where people are still dying from AIDS-related illness.

8. The question posed by the case of homelessness is: can lived experience-led involvement in health (and health critical) services for people with experience of homelessness catalyse the same levels of innovation and improvement that other patient-led movements have achieved?

9. These questions are significant because they address the clear possibility that there is a connection between: absence of empowerment, collective voice and PPI capability building for people experiencing homelessness; the health crisis-creating and worsening experiences they have; and the lack of access to support / social isolation that follows.

10. Brighton and Hove Common Ambition (BHCA) was funded by The Health Foundation to coproduce quality improvement in the city's local systems to improve the health disparity and inequality experienced by people with current or very recent experience† of homelessness.

    †*everyone with lived experience who became a member of BHCA was experiencing homelessness at the time of joining. Some members fortunately became housed over the time they participated*.

11. Given the depth of inequality, isolation and health challenges that this group faces, it was not ethical to anticipate in advance that the project would be successful. However, even if unsuccessful, it was assumed that vital learning about lived experience of health inequalities and disparities would occur.

12. **The most significant evaluation outcome and contribution of this project has been its successful co-creation of a lived experience-led, coproduction group comprised of people with current experience of homelessness.** The group was active from its first meeting (at which point it had a membership of 3) and has been sustained to date (Jun 21 to Oct 23 and ongoing) with a current membership of 10.

13. A total of 19 lived experience members with current experience of homelessness have joined the BHCA steering group to date. It took 4 months to develop relevant policy and recruit lived experience members. The steering group began meeting in June 2021 with two facilitators and 3 lived experience members. Successive recruitment efforts saw the group build to 11 lived experience members (plus 4 facilitators). At the request of lived experience members, the group moved from bi-weekly to weekly meetings in Sept 2021. Following this, parallel weekly sessions were incorporated from Jan 2022, from which point members could attend up to 3, two-hour meetings per week.

14. Group members (supported by a project manager, specialist engagement lead and two university researchers) coproduced their own distinctive methods of group work practice, member support strategies and project goals[1]. They developed toolboxes[2] for disseminating these practices to other lived experience groups; resources for thinking strategically about the health and homelessness health care system for people with experience and professionals; engaged in 11 distinct service co-design sprints (a time-focused design-development effort) including a sprint to coproduce their own website[3]); and 3 consultations.

15. The trauma-informed approach to quality improvement the group have developed is unique within NHS quality improvement and is currently the subject of coproduced research. Locally their system level strategic resources, shared at 10 coproduced learning events, have attracted over 320 stakeholders. Since made available on the BHCA website (home page viewed 1.1k times Jan-Oct 2023), these strategic resources were the 2nd most viewed page (398 views) after the landing page and have been downloaded 372 times. Their highly successful model of place-based, systems analysis and service co-design methodology is currently the subject of academic research and dissemination.

16. Lived experience members built confidence, skills, and experience in service design and became experts in trauma-informed coproduction. This capability building was progressive: from members finding it difficult to speak in meetings; to members leading the delivery of training. Existing members were role models to new members (four waves of recruitment were conducted). Many members found pathways to work, education and successfully secured a stable home during their involvement. A small number of members experienced risks to recovery and wellbeing and were supported to leave the project.

17. Lived experience members have provided evidence and developed system resources that demonstrate the complexity of the housing pathway and the system of health service delivery with which it intersects. This complexity results in delay in accessing services, crisis, anxiety

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[1] https://www.bhcommonambition.org/about-us/#mission-and-goals
[2] https://www.bhcommonambition.org/wp-content/uploads/2023/02/Methods-Toolboxes_optimised.pdf
[3] https://www.bhcommonambition.org/

and distress, which in turn lead to hopelessness, and sadly, experience of trauma. They have proposed ways to address this complexity that have been recognised as valuable and actionable by professionals managing, delivering and commissioning services.

18. For the purposes of evaluation, BHCA project activities are divided into 6 areas:
    - i.) Group building
    - ii.) Groupwork methods
    - iii.) Strategic resource development
    - iv.) System learning events
    - v.) Design sprints and consultations
    - vi.) Sustainability/ending well

19. This initial evaluation report provides a summary of outcomes and impacts from iv.) system learning events and v.) selected design sprints and consultations. In addition, it provides a discussion of system level and local risks arising from the discontinuation of coproduction activity with this population group. These risks include:

    Risks of short termism
    - 7 months to start up and build capability; 3-6 months to 'end well'

    Financial risks
    - Repeated costs of 'start-up' and 'ending well'
    - Ongoing costs of system-induced trauma
    - Ongoing costs of complex care needs

    Management risks
    - Loss of management, service delivery and specialist participatory expertise
    - Risk of demands for 'cheaper' delivery models for trauma-informed interventions
    - Short termism repeatedly undermining what is attainable (outcomes/) impact for a vulnerable group
    - Risk of legacy mismanagement and loss post-project

    Ethical risks
    - Loss of trust with lived experience community
    - Measure of low ethical commitment of systems to listen to lived experience voice
    - Independent PPI infrastructure for vulnerable group not supported to build

    Health system risks
    - Continued worsening of health inequality and disparity
    - Continued high costs of homeless healthcare
    - Continued future need for urgent, pandemic-induced response
    - Continued pressure on NHS service

20. Given the risks of discontinuation identified and the cascade of positive outcomes this project has inspired and produced, it seems right to argue for the continuation of this work. However, at the time of writing, with 6 months funding remaining, a sustainability strategy has yet to been found for BHCA.