Health at home

A new health and wellbeing model
for social housing tenants

July 2018

Contents

Peabody is responsible for 55,000 homes, 110,000 residents and a wide range of care and support services across London and the South East.

Our mission is to help people make the most of their lives by providing good quality homes, working with communities and promoting wellbeing.

We strive to do things differently, in a way which adds the most value for our residents and for our communities. There are three key areas which distinguish us from other organisations:

We put the most vulnerable first
We develop and help create great places at scale – designing, building and maintaining homes and neighbourhoods which people are proud of living in.

We help grow resilience in people, households and communities, so that people are better able to respond to changes in their circumstances, sustain their tenancies and live independently for longer.

In 2017, we completed a successful merger between Family Mosaic and Peabody to create a stronger organisation with greater capacity to meet the demand for housing in London and the South East. This report references previous research conducted by Family Mosaic.

Summary

In 2016, Family Mosaic (now merged with Peabody) published a three-year health study, Health Begins at Home, that was subsequently peer reviewed and published by the British Medical Journal.[1] The study found that health and wellbeing interventions for older people resulted in reduced demand on the NHS and improved health outcomes, especially for the most vulnerable. It also identified that some of our residents became overly dependent on our staff and there was an opportunity to deliver the service more efficiently and effectively.

This new research was therefore designed to answer three interrelated questions that are key to the future of housing support services and all community-based health services:

How can we deliver effective services at lower cost?
How do we encourage self-care for our most vulnerable customers and reduce dependency on direct support?
How can we work with other agencies to ensure a coordinated response to our residents' complex and multiple health needs?

We wanted to test whether more focused, person-centred health and wellbeing interventions could address this potential dependency issue, by improving people's ability to manage their health more efficiently and effectively. To find out, we developed a service using health navigators and volunteers to coach and connect residents with the relevant health, housing and community services they need. We tested this service model using a randomised control trial of 261 general needs residents aged over 50.

To enable our residents to manage their health and wellbeing related problems, we had to understand their activation levels. The research used two tools: the Patient Activation Measure (PAM) and Coaching for Activation (CFA). Both are being piloted by the NHS, so we selected them to explore their potential in a housing context.

The Patient Activation Measure (PAM) assesses the knowledge, skills and confidence of each participant in managing their health, with their assessment scores placing them into one of four levels of activation. The higher the patient's activation level, the more willing and able they are to manage their own health. By grouping participants in this way we could target our resources at those who needed them most.

We used Coaching for Activation (CFA) as the framework for working with our residents to set realistic goals appropriate to their current level of activation. This involved developing simple support plans with them that identified and built upon their strengths and capacities.

Our key finding from this study was that three months of intervention with those who started in PAM Level 2 was sufficient to move them up, on average, an entire PAM level.

This increase in activation was sustained for at least nine months after the intervention ended. This suggests that recipients of our service gained the skills and confidence to effectively manage their health without our support after the initial intensive intervention. This is significant as one of the largest studies into cost reductions from PAM level changes in the United States found that

patients who moved from Level 2 to Level 3 reduced their annual healthcare costs by 12%.[2]

As the available evidence suggests that a PAM score is a strong predictor of health behaviours and dependence on health services, we believe our approach reduces avoidable demand on the NHS as well as benefitting our residents.

We have built on the learning from our first health research project to develop a more enabling service, that should deliver our health and wellbeing interventions more efficiently. PAM and CFA have allowed us to integrate the principles of self-management, co-production and personalised strength-based support into an effective health and wellbeing intervention. We also delivered this project for a shorter period, with fewer staff, and therefore a lower cost than the previous health intervention.

The research highlighted the importance of understanding our resident's confidence, skills and knowledge, and consequently, we have incorporated co-production into how we provide our wider floating support services. When we applied this approach to our Havering floating support service and delivered a tailored service dependent on need, we increased the number of people we support from 150-300 people a month to 2,000 a month, on the same commissioned service. This means our services are now more efficient, delivering better results at lower cost.

We will continue to develop our approach to building resilience in people and households through partnerships with the NHS and other providers.

_____

[1]http://jech.bmj.com/content/early/2018/03/08/jech-2017-209888
[2]Hibbard, J. H. (2015). Patient Activation: Improving Health Outcomes and Reducing Costs

Introduction

In 2016, Family Mosaic (now merged with Peabody) published the results of its three-year randomised control trial (RCT), Health Begins at Home, subsequently peer reviewed and published by the British Medical Journal (BMJ) in 2018. The study tested the effectiveness of an intervention-based service model in improving the health and wellbeing for older residents.

The research found that our health and wellbeing interventions resulted in reduced demand on the NHS and improved outcomes, particularly for our most vulnerable residents. The study also highlighted, however, that some residents became overly dependent on our staff.[3] We felt there was an opportunity to deliver the service more effectively and efficiently.

Our older population is projected to grow substantially over the next three decades. We estimate our general needs residents aged over 85 will double by 2035 and triple by 2045. In 2012, an estimated 71% of Family Mosaic's residents aged over 50 had a long-term health condition.[4] The Department of Health estimates that long-term health conditions account for 70% of total health spending.[5] Peabody now provides homes to over 110,000 residents, of whom almost 20,000 are over 55 years old.

Peabody is able to identify and access highly vulnerable citizens who might otherwise be forgotten. Many of the people identified in the 2016 study were not engaged with any existing health services or with their communities. We can use our proximity to our residents, our existing role as community anchors and the support services we deliver in our role as a landlord to deliver services that can have a positive impact on the health and wellbeing of our residents.

We know that as people become more active in managing their health, they reduce their use of acute health services.[6] We wanted to test whether we could use our role as their landlord and as one of the largest supported housing providers in London to encourage independent health management amongst our older residents, building on the lessons from Health Begins at Home.

Approach

We developed an approach based around health navigators and volunteers, delivering health and wellbeing signposting, coaching and advice to residents during a three-month intensive programme. The participants were general needs residents aged over 50, living in Lambeth, Southwark and Lewisham.

We licenced and used the Patient Activation Measure (PAM) to assess each resident's level of skill, knowledge and confidence in self-management of their health and wellbeing. We then used Coaching for Activation (CFA) to tailor the support and intervention element of the service according to the outcomes of the PAM assessments.

The Patient Activation Measure

PAM is an assessment tool developed by Insignia Health, that measures the knowledge, skills and confidence individuals have in managing their own health and care.

Table 1: Key areas assessed by PAM

Knowledge	The understanding a person already has, or is capable of processing, related to his or her health
Skills	The ability to perform tasks necessary for self-management of healthy living or condition management
Confidence	An individual's belief in his or her power or ability to impact his or her health

---

[3]Health Begins at Home, Family Mosaic, 2016.
[4]A picture of health: how housing and health can work together, Family Mosaic, 2012
[5]Improving the health and wellbeing of people with long-term health conditions, Department of Health, 2010
[6]Shively MJ, G. N. (2013). Effect of patient activation on self-management in patients with heart failure. Journal of Cardiovascular Nursing, vol 28, no 1, pp 20–34. Hibbard, G. a. (May 2012). Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. J Gen Intern Med, 520-526. Begum N, D. M. (2011). Hospital admissions, emergency department utilisation and patient activation for self-management among people with diabetes. Diabetes Research and Clinical Practice, vol 93, no 2, pp 260–7.

71%

of FM residents over 50 had a long-term health condition in 2012

70%

of total health spending are on long-term health conditions

20,000

of Peabody's residents are aged over 55

Table 2: PAM levels. © 2018 Insignia Health. Patient Activation Measure® (PAM®). All rights Reserved

PAM level 1	PAM level 2	PAM level 3	PAM level 4
Disengaged and overwhelmed	Becoming aware, but still struggle	Taking action	Maintaining behaviours, and pushing further
Individuals are passive and lack confidence. Knowledge is low, goal orientation is weak, and adherence is poor.	Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals.	Individuals have the key facts and are building self-management skills. They strive for best practice behaviours and are goal-orientated.	Individuals have adopted new behaviours, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus.
Their perspective: "My doctor is in charge of my health."	Their perspective: "I could be doing more"	Their perspective: "I'm part of my health care team."	Their perspective: "I'm my own advocate."

Patients are asked to reply to 13 statements. Their responses are scored between 0 and 100, and they are then placed in one of four levels depending on their level of activation. Each level provides an insight into a range of health-related characteristics, including behaviours and outcomes (see table 2).

PAM has been used most extensively in the USA to support the management of patients with long-term health conditions. There is a strong body of evidence demonstrating that people with higher PAM scores engage in more preventative behaviour, are more likely to take their medication, manage their health conditions better, and seek more information about their health.

On average, people who increase their PAM score through health interventions have lower healthcare costs the following year.[7] One of the largest studies into cost reductions from PAM level changes in the United States found that patients who moved from Level 2 to Level 3 reduced their annual healthcare costs by 12%.[8]

In the UK, the NHS has only recently began to use this approach, particularly in primary care. Peabody has been one of the pioneers in the use of PAM within the housing sector. We used it in this study to help us address two of the key issues learned from our first health intervention: we needed to become better at helping residents manage their own health and wellbeing; and our service needed to be more effective in providing the right service at the right time.

Coaching for Activation

To achieve this, we adopted a second tool, called Coaching for Activation (CFA). This is a framework which helped us tailor health and wellbeing support based upon a person's self-management ability. It was used in conjunction with the results from each individual's PAM assessment, and enabled us to work with our residents to increase their level of health activation.

Health navigators, volunteers and residents co-created a tailored three-month plan using CFA for each resident in the intervention group. Instead of goals, each plan focused on increasing knowledge, skills and confidence with regard to a chosen medical condition depending on the individual's assessed level of activation. CFA enabled us to integrate the principles of self-management, co-production and personalised strength-based support into the way we delivered the health and wellbeing interventions.

According to the NHS, "understanding and responding appropriately to an individual's level activation is a key skill for clinicians and a key priority in realising the national aspiration for person-centred and personalised care".[9] The design of this service model would test whether PAM and CFA would work in a housing context.

[7]Greene J, H. J. (2015). When patient activation levels change, health outcomes and costs change, too.
Health Affairs (Millwood), Mar;34(3):431-7.
[8]Hibbard, J. H. (2015). Patient Activation: Improving Health Outcomes and Reducing Costs
[9]Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England, NHS England, 2016

Methodology

As with our previous health and housing research, this twelve-month research study was designed as a randomised control trial (RCT), to build a strong, credible evidence base.

Research sample

We started by recruiting 261 residents living in general needs housing. Prior to their participation, none of the residents were receiving floating support.

The ages of the participants ranged from 50 to 95, with a mean age of 65.

Over 86% had at least one long-term health condition, the most common of which were arthritis, back pain, anxiety and diabetes. Over 25% smoked, 40% had abnormal blood pressure (high or low), and 34% had high cholesterol.

PAM assessments

Following an initial PAM assessment, participants were placed into the four PAM levels:

PAM Level 1 – 22% of participants
PAM Level 2 – 16% of participants
PAM Level 3 – 42% of participants
PAM Level 4 – 20% of participants

The table below provides further information about the health conditions and NHS usage for each PAM Level from the baseline assessment.

Randomisation

Following this initial PAM assessment, participants were randomly allocated to either the intervention or control group. Those in the control group received no health and wellbeing support, signposting or advice, but did have further PAM assessments. Those in the intervention group received

a tailored package of interventions according to their PAM assessment that lasted for three months. Thereafter, they received no further support.

The intervention

PAM Level 1 and 2 residents in the intervention group were assigned a health navigator and a volunteer, who worked with them for three months on an intensive CFA programme.

These sessions focused on each resident improving their own understanding of how their current knowledge, skills and confidence may affect their health conditions, with a long-term view of how this may lead to an improvement in their ability to self-manage these conditions. The focus was on developing core areas of collaboration and discussion including:

condition knowledge;
medication adherence;
diet and nutrition;
guidance on stress and coping;
self-care and living skills;
guidance on how to communicate with providers to get the right medical support;
smoking cessation;
effective reduction of loneliness and isolation.

Participants were also signposted and supported to access appropriate departments within Peabody, for example, repairs or financial advice.

Over the three-month period, health navigators and volunteers delivered over 800 direct interventions, including support, coaching and advice, and over 260 signposting interventions, such as contacting another agency on the participant's behalf. Those in the intervention group received an average of 10.4 sessions each.

Table 3: Baseline characteristics of participants, by PAM level

Baseline characteristics	PAM Level 1	PAM Level 2	PAM Level 3	PAM Level 4
Long term health condition	96%	98%	92%	83%
Smoking	31%	23%	26%	17%
Planned GP (median)	3	2	1	1
Planned hospital (median)	1	1	0	0
A&E trips (median)	0	0	0	0
Abnormal blood pressure	56%	38%	33%	39%
High cholesterol	26%	32%	27%	22%

PAM levels of all participants were assessed after three months and twelve months of the project. We also measured a number of outcomes using self-reporting measures, including planned GP and hospital appointments, and

A&E attendances in the previous three months. We collected self-reported cholesterol and blood pressure levels, and assessed health and happiness using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

86%

of participant had at least one long-term health condition.

10.4

average of support, coaching and advice sessions over 3 months received by those in the intervention group

Case study: Mr E

Mr E is 61 years old and lives alone. He suffers from anxiety, arthritis, high cholesterol, depression, liver disease and OCD (obsessive compulsive disorder). In addition to these listed medical conditions he also hoards and recognises this as one of his mental health challenges. He's taking medication and is one of the first to admit he is lonely with few friends and works many hours.

He has engaged with three separate services to help him with issues around hoarding, including one 12 session CBT (cognitive behavioural therapy) course, and three home visits to physically help remove belongings. Mr E said while some of these services were 'proactive and helpful' others were less so, describing it as 'tick box psychology' in which he was processed to meet outcome

measures. He began hoarding again after each of them.

Our health navigator ensured she was completely non-judgemental, friendly and neutral. The navigator focused on using techniques such as motivational interviewing to encourage Mr E to form solutions on his own. The approach also built upon on our knowledge of his activation so we knew where to pitch these questions. We made sure that we didn't make big goals around clearing rooms or areas, instead Mr E was

supported to look at why his hoarding was happening and why he thought he was doing it. Our Navigator said "it felt much more like a mentoring relationship, than a staff and patient relationship".

Mr E now says that "I have stopped visiting charity shops and this alone gives me the opportunity to see the light at the end of the tunnel... I still have a long way to go but your visits were the small kick I needed to start the process"

"I have stopped visiting charity shops and this alone gives me the opportunity to see the light at the end of the tunnel... I still have a long way to go but your visits were the small kick I needed to start the process"

Participants assessed as PAM Level 3 were offered three visits from a skilled volunteer over the three-month intervention period. The support involved completing person-centred, strength based support plans, signposting and encouragement to access the community health and wellbeing services they were interested in.

Those who scored PAM Level 4 were offered a phone service that they could call and ask for support, information or advice as and when required, although nobody used this service.

Volunteers

We recruited 30 volunteers to support health navigators deliver a more effective service to the participants. Most of the volunteers were final year degree students in public health and housing. They were required to complete a one-day training course covering topics like diversity, health and safety, confidentiality and safeguarding. Each volunteer then received further training in lone working, as well as in the role they were expected to play.

Volunteers were expected to have a variety of skills, including good listening, communication, motivational interviewing techniques and respect for others. It was essential that they understood the aims and culture of the project, in particular the commitment to co-production as a way of working.

The use of volunteers enabled us to deliver a more efficient service, and provided many volunteers with the opportunity to build on their existing skills and knowledge, and enhance their employment prospects. The vast majority of volunteers were recruited from universities and had little or no practical experience. Out of the thirty volunteers involved in the project, seven found work with us after the study. "I've grown up," one volunteer said afterwards. "I have more knowledge, skill and confidence and can figure out solutions, pinpoint where an issue is."

Removal from the trial

Following the first PAM assessment, six residents were taken out of the trial without being randomly assigned,

"I have more knowledge, skill and confidence and can figure out solutions, pinpoint where an issue is."

because their health needs demanded immediate or urgent attention. We couldn't risk them being assigned to the control group and not receiving the help they required.

Individuals were placed in this group for a number of reasons, including excessive hoarding, domestic abuse, and alcohol dependency. All six had long-term health conditions; five suffered from anxiety; five lived alone; four had arthritis; five had depression. On average, they each had just under eight long-term health conditions.

The situation was so serious for some in this group that we referred them on to safeguarding for adults.

Case study: Ms G

Ms G has a number of long-term health conditions, including depression, anxiety and persistent pain. As well as these issues, she told us she was being abused by family members who lived with her.

Following her initial assessment, she was placed in our planned treatment group.

We contacted her local social services to inform them of her situation: they had closed her case and were unaware of the severity of her situation. Her health navigator re-established this link with the local social services department, and then worked with them.

At the beginning of her support package, she would often refer to herself negatively, saying that she was unable to do things, such as lift her right arm, because she "was stupid". By the end of the three months, her health navigator noticed a significant improvement in the way she spoke about herself.

30

volunteers were recruited to
help deliver the service

6

residents were removed from the trial
because their health needs required
immediate/urgent attention.

Three month and twelve-month assessments

As well as the baseline PAM assessment, all research participants received PAM assessments after three and twelve months. The number of participants who received the three-month assessment fell by 41% for those in the control group, and by 33% for those in the intervention group.

By the twelve-month assessment, the numbers had fallen further: just 18% of those in the control group completed their twelve-month assessment, compared to 19% for the intervention group.

Table 4: Number of PAM assessments at each research stage

Project stage	Control group	Intervention group	Planned treatment group
Baseline	131	124	6
Baseline and three months	78	83	6
Baseline, three months and twelve months	24	24	6

Such drop off rates are not unusual and were not unexpected. The difficulty in engaging people with their health and wellbeing has been well documented and experienced throughout the NHS.[10] With this research study, retention rates were exacerbated by the nine-month period without any contact for either intervention or control group between the three and twelve-month assessments.

When we compared the characteristics between the baseline, three-month and twelve-month sample groups, however, there were no statistically significant differences. Those who remained on the programme were representative of the overall sample group. Although the drop-out rate significantly reduced the numbers, it did not have observable bias on our final findings.

[10]Partners, M. (2015). How to engage people in their own health and care: a complete guide.

Findings

Baseline to three months

For those in the intervention group, the average increase in score for those on PAM Level 1 was 6.7 between the baseline and three- month assessment. For those on PAM Level 2, the average increase in score was 10.5. On average, this meant participants starting on Level 2 moved up to PAM Level 3 within three months. This demonstrates the value of the intensive three-month interventions for the majority of people on PAM Level 2.

Table 5: Change in scores, within PAM Levels, between baseline and three-month assessments, intervention group

	PAM Level 1	PAM Level 2	PEM Level 3	PAM Level 4
Mean PAM score (baseline)	43.7	51.4	61.4	82.9
Mean PAM score (three month assessment)	50.4	61.9	58.1	76.3
Change in mean score	+6.7	+10.5	-3.3	-6.6
% of participants with improved PAM score	80%	76.9%	30.2%	33.3%

Although participants in PAM Level 1 had a lower average increase than those in PAM Level 2, over 80% of them experienced an improvement in their PAM score.

Although participants in PAM Level 1 had a lower average increase than those in PAM Level 2, over 80% of them experienced an improvement in their PAM score.

For those who started at a higher level, however, there was a decline in their average scores. Only a third of them improved their PAM scores. This is unsurprising as they are already highly activated individuals. Other research using PAM and CFA shows that many highly activated individuals tend to see little to no change and often tend to fall back a few points, while remaining in the highest activation level.[11]

When we compare the increase in average scores of those in the PAM Level 2 intervention group (10.5) to those in the control group (0.45), there is an extremely high level of probability (p=<1%) that our interventions were responsible for this improvement.[12]

Although the average score of those in PAM Level 1 intervention group (6.5) is higher than the control group (2.6), we cannot be certain that this was because of our intervention (p=>5%). We think this may be partially explained by how it took longer to engage with these

residents at the beginning of their three months of assistance. This is because this group were the least engaged in managing their own health and wellbeing.

One of our health navigators described her experience of working with those on PAM Level 1: "Some were undecided as to whether they wanted to take part once they found out they were chosen for support. I felt that once I explained I wasn't there to tell them what to do, but just to listen initially, and explained that after the first visit if they felt it wasn't for them they didn't have to take part, then they engaged. They were worried that I was going to turn up and tell them to lose weight or stop smoking. Once they

realised that wasn't the structure of this intervention they quickly softened and were open to engaging."

While we can't say it influenced the results with any certainty, our observations and understanding of how people at PAM Level 1 engage with services may go some way to explaining this finding. We believe that for people on Level 1 to have an increase in PAM score similar to those on Level 2 requires a longer period of intervention.

There were no statistically significant movements among participants in the PAM Level 3 or 4 intervention group. As noted previously, this is unsurprising, and is a trend confirmed by other research.[14]

Table 6: Changes in scores, within PAM Levels, between baseline and three-month assessments, control group

	PAM Level 1	PAM Level 2	PAM Level 3	PAM Level 4
Mean PAM score (baseline)	43.4	51.7	60.6	81.7
Mean PAM score (three month assessment)	46.0	51.9	58.2	69.8
Change in mean score	+2.6	+0.2	-2.4	-11.9
% of participants with improved PAM score	67%	41%	32%	17%

Three months to twelve months

Between the three-month and twelve-month assessments, the picture is more mixed. Based on previous research, at the start of the project we had predicted that increases in PAM scores would be maintained over time, once the Coaching for Activation finished.[15]

One issue, however, was the significant number of people who dropped out of the research. Only 24 people in the control group, and 24 in the intervention group completed the twelve-month assessment. This meant testing for statistical significance for any changes in scores between the three-month and twelve-month assessments was tenuous.

There were, however, some interesting trends. The average PAM Level 2 score for the intervention group increased by a further 4.55 points, while those in the PAM Level 2 control group decreased by 0.82. While this change is not statistically significant, because of the low sample size, it does indicate that improvements made in the first three months were sustained by those in PAM Level 2.

For those in PAM Level 1, however, the story was different. The average score for those in the intervention group fell by 6.58, compared to an increase of 3.84 for those in the control group. With only five cases in each category, however, we are unable to say whether these results were a consequence of random chance.

There were no significant differences between the intervention or control groups in either Level 3 or Level 4 at this stage.

It is, however, worth noting that while the change between the three-month and twelve-month assessments for those in the PAM Level 2 intervention group were not statistically significant, the overall change, from baseline to twelve month, was. Overall, those in the PAM Level 2 intervention group increased their PAM score by almost 14 points more than those in the control group. This provides strong evidence for the effectiveness of the service model for those in PAM Level 2.

What is more important is that it demonstrates that the skills and confidence that the intervention group gained during the three-month period can be maintained, sustained and perhaps even improved for nine months after the intervention ended.

NHS usage and wellbeing

Measuring NHS usage is always difficult in community-based interventions of this kind. We were unable to access NHS records to analyse reliable data about usage, such as the number of hospital visits, and had to rely on self-reporting, which can vary in quality.

The figures from those who completed the final assessment indicated that the intervention did not produce any substantial reductions in NHS usage after twelve months. Many other research studies have noted the difficulty in identifying significant changes in health or NHS usage through similar projects, because of the time it takes to establish the service, and for the impacts to happen.[16] Our focus was therefore on understanding the change in PAM scores.

A study conducted by the NHS Horsham and Mid Sussex Clinical Commissioning Group, for example, found that following coaching, patients improved by one PAM Level, on average. They also found that healthcare usage declined for these patients. Although they struggled to quantify the precise financial benefit due to the variability of tariffs and charges attached to different services, they estimated an average of £450 per head savings in the first year of the project.

As we noted in Health Begins at Home, reductions in demand for NHS services cannot be considered pure savings, as demand is so high that any vacated appointment times or bed spaces will still be used by another patient. The money will still be spent. What is more likely is a reduction in demand, over time.

When it comes to wellbeing, our results showed that an increase in PAM score is correlated with an increased wellbeing score ($p=<5\%$), with a 3.7 point increase in PAM score being associated with a one point increase in wellbeing score (measured from 0 to 4). This is a large improvement in wellbeing score – almost two standard deviations.

Taking all the available evidence into consideration, we are confident that a notable proportion of the recipients of our service gained the skills, confidence and knowledge to effectively manage their health after the initial intervention, without our support. It also underlines that when people become more active in self-care, they benefit from improved wellbeing, better health outcomes, and reduced avoidable demand on the NHS.

---

[13]The baseline mean scores are slightly different to those for participants in the intervention group, but these differences are not statistically significant.
[14]Amy Blakemore, M. H. (2016). Patient activation in older people with long-term conditions and multimorbidity: correlates and change in a cohort study in the United Kingdom. BMC Health.
[15]Hibbard JH, G. J. (2015). Taking the long view: how well do patient activation scores predict outcomes four years later? Medical Care Research and Review, Jun;72(3):324-37.
[16]Effectiveness of home based support for older people: systematic review and meta-analysis; Commentary: When, where, and why do preventive home visits work? 2001

Conclusions

This research was designed to answer three interrelated questions that are key to the future of housing support services and community-based health services:

How can we deliver effective services at lower cost?

How do we encourage self-care for our must vulnerable customers and reduce dependency on direct support?

How can we work with other agencies to ensure a coordinated response to our residents' complex and multiple health needs?

Delivering more effective services at a lower cost

The research model demonstrated that it is possible to empower our residents to take control of their health and wellbeing.

After three months of intensive interventions, on average, those residents on PAM Level 2 moved up an entire PAM level. Moreover, this increase in activation was sustained for a further nine months after the intervention finished.

This suggests that, with a tailored and more economical approach based on co-production, people can gain the skills, confidence and knowledge to effectively manage their health without our ongoing support. Existing evidence also indicates that when people become more active in self-care, they benefit from better health outcomes, and fewer unplanned health admissions.

Coaching for Activation (CFA) required a different approach to providing

support. This new approach was welcomed by those working with residents:

"I could meet with someone and start them thinking about their health in a different way. Whilst they may not take any action as such that we could measure for a traditional support plan, typically we could start to see more confidence in making decisions or a greater understanding of their health condition." (Peabody Health Navigator)

CFA also required a different type of engagement from residents. Some found this easier than others. It necessitated a determination from both residents and our health navigators and volunteers not to fall back onto traditional dependency-orientated relationships.

"It gave me permission to dig a bit deeper. Building on strengths helped people open up and then you get the real feeling that as they have made their decisions about the way forward, you have more space to critique and challenge. It feels less like they are being judged or stereotyped. You are asking them to think about why they feel a certain way, and not just justify your perception of them." (Peabody Health Navigator)

Using CFA in combination with PAM helped us to target our resources more appropriately, and effectively. We were able to provide intensive assistance for those who needed the most support to build their skills and manage their health. The intervention was significantly shorter than the model used in Health Begins at Home, and required much less staff time, but still delivered benefits to our residents.

We have since incorporated the co-production approach into how we

provide other support services. One notable example of this is our Havering floating support service Here to Help (see box).

We believe this methodology could also be applied to services we provide to our general needs residents. Assessing people's activation, targeting resources more appropriately, and enabling people to help themselves are principles that could be applied across our community work.

Taking such an approach could help us to target resources towards those residents who would most benefit from building social networks and engaging with local community services. By using activation as our way of working, our staff will have the tools to co-produce our services with residents, raise their awareness of the services they might need, and help them develop the confidence to access them.

Encouraging self-care for our most vulnerable customers and reducing dependency

The PAM has not only been of use as an assessment tool. It has also provided us with a greater understanding about our residents' needs.

During the baseline assessments, 22% of our research participants were found to be PAM Level 1. If we apply this figure to our resident population over the age of 55, we estimate that 4,400 would feel disengaged and overwhelmed in relation to the self-management of their health conditions, and therefore more likely to have an increased use of the NHS particularly regarding unplanned visits.

On average, our participants in PAM Level 1 had made three planned visits to their local GP in the previous three

Here to Help: our floating support service in Havering

Here to Help covers a broad spectrum of needs, and takes referrals from a variety of sources. We have re-modelled the way we engage residents with their support plans, taking on board the key components of co-production and strength based support planning highlighted in this report.

Previously, staff carried out a paper-based assessment with each client, going through a long list of issues, including loneliness, isolation, engagement and tenancy related issues. Residents would get frustrated with this approach: often all they needed was help with managing a debt or dealing with the threat of eviction. Instead, they had to sit and respond to numerous questions about subjects of no relevance to them.

Our new approach delivers a more targeted service. Staff are equipped with tablets, with phone capabilities, that allow them access to a range of online sites and applications. We have refined the service so that residents are given the choice of one of three support services:

Stream 1:
providing individuals with help to self-help, addressing issues immediately on meeting with the resident, without the need for a formal assessment of their situation. These interactions take about half an hour.

Stream 2:
providing individuals with just enough targeted support, carrying out a basic assessment that focuses on the areas in which they asked for help. This would be followed up by one or two visits a week over a six to eight-week period.

Stream 3:
providing individuals with extended person-centred support to manage people with high risk needs, for example, mental health issues, domestic abuse or drug and alcohol-related issues. They receive a comprehensive assessment of their needs, with six to nine months of intensive support, including multi-agency collaboration.

Using this refined approach, we have increased the number of people we support in Here to Help from 150-300 people a month to 2,000 people a month.

The model is now being adopted across our floating support-type services.

months. If we apply this figure to the 4,400 people we would expect to be on PAM Level 1, this works out at 13,200 GP visits in three months. At a cost of £37 per GP visit , this equates to £488,400 every three months, or almost £2 million per year.

If we were able to identify those of our residents who were assessed as PAM Level 1, we would be able to target our services more effectively, with the aim of enabling them to improve their PAM scores, reduce their NHS usage and improve wellbeing. With improved information on our residents, we would also be able to provide geospatial data to health providers to enable them to plan their services more effectively, and efficiently.

Another key benefit from PAM is that it provides a mechanism for organisations who deliver health interventions to benchmark their performance, and share best practice about services that deliver more effective health interventions. The development and use of PAM, and CFA, will enable clinical commissioning services to have a more robust evidence base for effectively evaluating the impact of services in their local areas.

Working with the health service

Our approach through this study included connecting our residents with the relevant health, housing and community services they need. Looking ahead, as well as incorporating the principles of co-production and activation into our support services, we're also discussing with a number of clinical commissioning groups in London and the South East about the development of social prescribing services and linking them into appropriate local sources of support.

Recent research has highlighted that one in five patients visit their doctor because of an intense feeling of loneliness, rather than because they have a specific ailment. GPs say they see as many as ten lonely people every day, but don't have the necessary tools to help them. Our Positive Steps report outlines our success in implementing a programme enabling residents to access the support they need to address issues affecting their health. GPs at Lakeside Medical Practice (Thamesmead's main GP practice) refer patients to the volunteer-led support programme, thereby diverting them from using clinical time to address non-biomedical

needs. We think there is significant potential in adopting the PAM methodology in our approach to delivering similar prescribing services.

As well as using PAM ourselves, we have been supporting other organisations to employ PAM when they deliver interventions. This has included training clinicians and staff at Southwark CCG on the use of PAM as an assessment tool.

Other projects we have developed to try and reduce pressure on NHS services include discharge services. We've opened a six-bed hostel for the Royal London Hospital for people with delayed discharge of care because they are homeless.

We've also set up a hospital discharge service for people with long-term mental health issues at St Charles' Hospital in Ladbroke Grove. One ward is using our service, but the other isn't, so we have an in-built control group. This will help us to accurately measure the effectiveness of the service and any associated reduction in hospital stays.

Overall, we are continuing to enhance the approach we used in this study in order to build resilience in people and households, through partnerships with the NHS and other providers. We would encourage others to explore how they could also apply the principles of co-production and self-management to their delivery of support services.

There is a clear and compelling case for continuing to strengthen links between the health and housing agendas. Peabody will develop these links by exploring how we can continue to act as an enabler, anchor and connector to local community health and wellbeing services.

Case study: Ms D

Ms D has high blood pressure and was assessed as being at PAM level two. It was clear to her health navigator that it was her level of confidence and knowledge around health that was holding her back from being a PAM level three or even four.

We guided her through small changes she could make to reduce her blood pressure, such as diet and exercise.

Through setting small achievable goals, such as walking to work a few times a week and reducing her salt intake, her confidence increased and opened her up to other steps she could take to improve her situation.

Ms D came across as being proactive, however guidance and encouragement was the activating factor she needed.

Thanks

Peabody wishes to thank the residents who volunteered to participate in this study and who have enabled us to re-design and improve the way we are delivering services in many other areas of Peabody's Care and Communities Directorate.

We are grateful to the Health at Home staff team who developed and delivered the research services and for the invaluable assistance of our volunteers, East London University, Metropolitan University, as well as Havering Here to Help and Southend Floating Support Service.

We are also grateful to the staff from Insignia Health, the Clinical Commissioning Groups of Southwark and Lambeth and Cilla McGinn of the North Lambeth Care Network.

In particular we would like to thank Shade Adelaja, Natasha Bested, Megan Bown, Grace Dowswell, Moira Griffiths, Ade Opara, Ramone Senior, Helen Watson and Ben Webb at Peabody.

For further information
contact the Peabody research
and public policy team:
E research@peabody.org.uk