family mosaic

HEALTH BEGINS AT HOME

Interim research report
November 2013

Family Mosaic: an introduction

Family Mosaic is one of the largest housing providers in London and the South East.

We provide affordable homes to rent and buy as well as care and support services to thousands of people who need extra support.

We provide our customers with a range of opportunities such as training, employment and access to learning.

We partner with local communities to make our neighbourhoods better places to live.

www.familymosaic.co.uk

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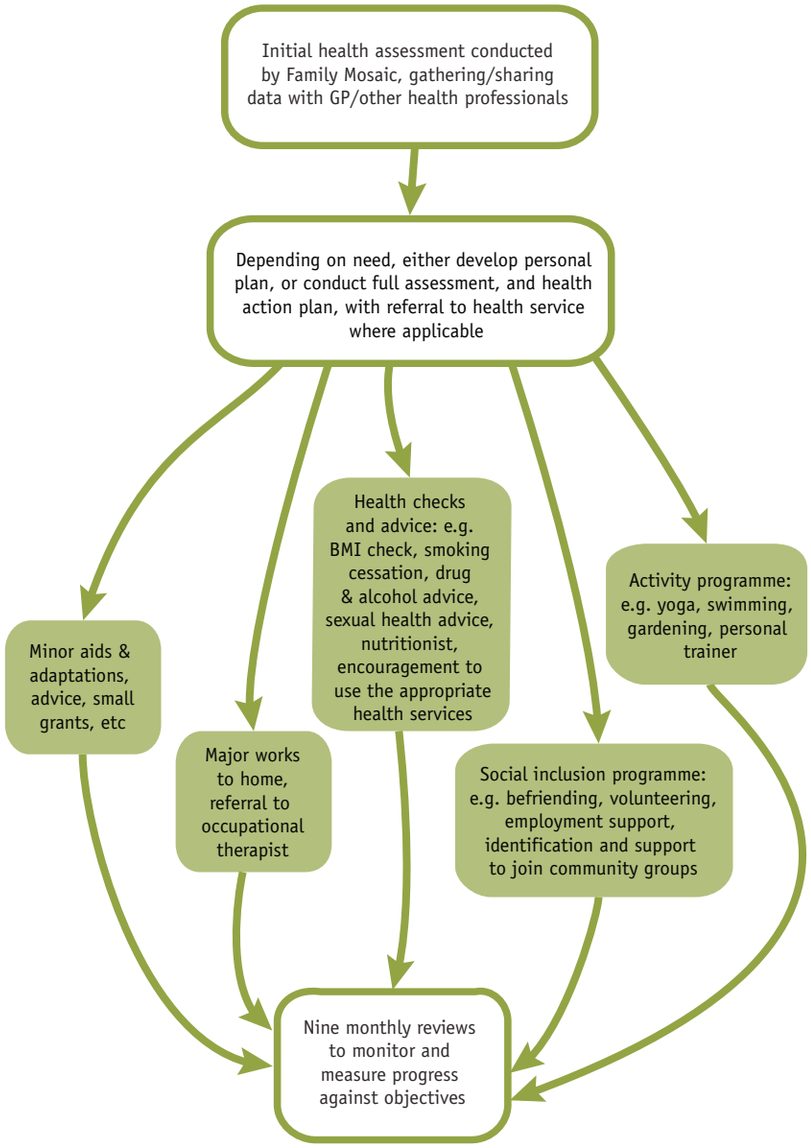
In 2012, we said we would save the NHS over £3m every year: so how are we doing?

In 2012, we launched *Health, Wealth and Wellbeing*, our manifesto for change through housing. Central to this was our belief that housing can help to reduce costs in the NHS. One way is to work with GPs and hospitals to provide home-based services that take the strain off expensive health facilities.

The other approach is preventative, promoting health and wellbeing initiatives among our tenants, so that their health improves and their NHS usage declines. In 2013, in partnership with the London School of Economics and local health care teams, we started a research project to measure and test the impact of our proposed new health service. This is focused on older tenants living in our social housing properties.

This report explains what we've discovered in the first six months of the study, and how this has begun to shape our thinking about what our eventual service offer might be.

Figure 1: Proposed service model, subject to findings from this study



SUMMARY

In 2012, we found that 71% of our tenants over the age of 50 had one or more long-term health conditions. So we developed a new service model to see if we could improve their health and wellbeing, and reduce NHS costs in the process.

We wanted, however, to test this model: can housing interventions effect a reduction in NHS usage by the tenants? Would it be enough to simply signpost our tenants towards health initiatives? Or would we need to proactively intervene to improve their health? And can we do it at all?

In 2013, we began a research study to test the model, in partnership with the London School of Economics, local public health departments and clinical commissioning groups. The research involves up to 600 of our tenants aged 50 and over from four London boroughs.

At the start of the study, each participant has an initial health assessment. These have shown that:

- 87% had visited a GP one or more times in the last six months;
- 92% had one or more long-term health conditions;
- 25% had suffered a fall in the last six months;
- 60% were overweight, and 52% wanted to lose weight;
- 49% felt lonely at least some of the time;
- 61% struggled to pay their fuel bills.

From their responses we are able to estimate the average annual cost to the NHS is a minimum of £1,437 per person. This equates to over £860,000 a year for all research participants.

Since their assessments, a high proportion of people have attended one or more health initiatives, ranging from weight management classes to advice on how to stop falls at home.

It is too early to draw any substantive conclusions from the pilot, but it's clear that there is a health need, that people want to improve their health, and that we are ideally placed to support them to take the first steps to healthier living, and to save the NHS substantial money in the future.

THE RESEARCH

The proposed service model might work in two ways: the first could be implemented relatively cheaply and quickly. The second would be more specialised. The aim of this research is to determine which is more effective in reducing NHS costs and improving people's health.

The 18 month research study was designed in partnership with the London School of Economics (LSE) as a randomised control trial. This involves the random allocation of a similar number of people into one of three research groups:

- the first group – the 'control' group – will receive no services;
- the second group will receive advice around health and signposting to services from our housing officers: this helps us to test whether we can have positive results by training existing staff to offer health advice;
- the third group will receive full support from a health worker, including being accompanied to local health and wellbeing services or activities: this helps us test whether we can get better results with dedicated staff.

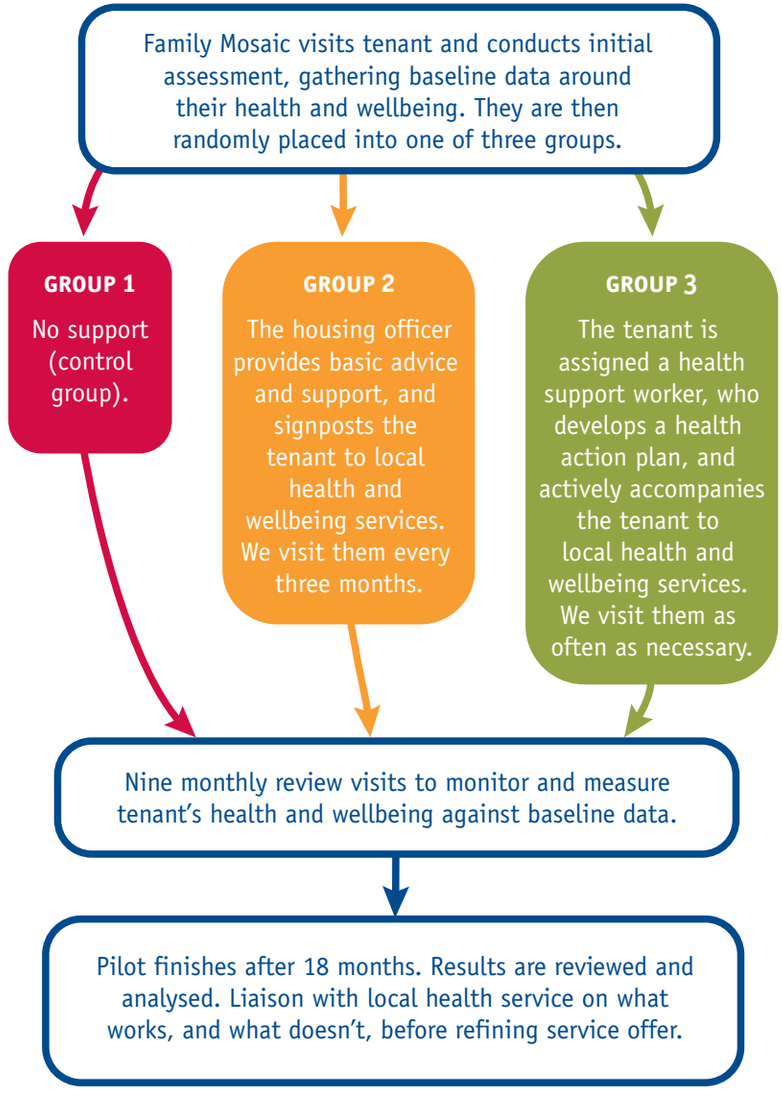
In April 2013, we began recruiting the research participants. Our target was 600 people, to ensure our results would have statistical significance. We invited tenants aged 50 and over living in our homes in Hackney, Islington, Hammersmith and Fulham, and Haringey.

By October, 580 people had signed up, and we had conducted an initial assessment with 445 of them. The assessments – devised with the help of the LSE – gather data around people's health needs and current use of health services. The responses given by participants provide the data used in this report. We recruited qualified nurses to lead on the assessment process.

Following the assessment, people were then randomly placed into one of the research groups. For those in Groups 2 and 3, we have created an evolving menu of interventions to standardise our approach for research purposes.

Fifteen people were deemed to be in very high need and were placed into Group 3 for immediate support: we could not risk them being randomised into Group 1. As they were not randomised, they are referred to as Group 3b. Some of their stories are included in this report, to highlight the situation facing some of our older tenants and the immediate impact that housing can have in improving people's health.

Figure 2: Research process



City and Hackney Clinical Commissioning Group was particularly interested to work with Family Mosaic on this project and be part of the project board. Housing associations are frequently in contact with the most vulnerable and often isolated residents.

This scheme facilitated an alternative approach to assessment of health and wellbeing and then providing support and social interventions that the NHS are often unable to deliver.

Being a member of the project board allowed us to influence the assessment process and ensure there was appropriate clinical governance structures in place as well as providing advice on access to NHS data in order to evaluate the impact of the scheme.

We look forward to seeing the impact of the scheme on usage of primary care and A&E services. In addition we felt this scheme aligned well with the CCG's social prescribing scheme, where primary care teams identify socially vulnerable patients and refer them on to a range of social interventions.

Frances Schmocker
Programme Director : Children & Maternity
NHS City and Hackney Clinical Commissioning Group

THE PARTICIPANTS

The 2,787 tenants we invited to participate in the survey were:

- aged 50 or over;
- living in Hackney, Islington, Haringey, or Hammersmith and Fulham;
- a social housing tenant with no assessed special needs.

We contacted them by a variety of methods, including phoning them, writing to them or visiting them in person. By October 2013, 580 people had chosen to take part. Their age, gender and ethnicity broadly mirrors those of all our tenants aged 50 or over.

Figure 3: Age range of research participants

Figure 4: Age range of all Family Mosaic tenants aged 50 or over

THE PARTICIPANTS: GENDER

Figure 5: Gender of research participants

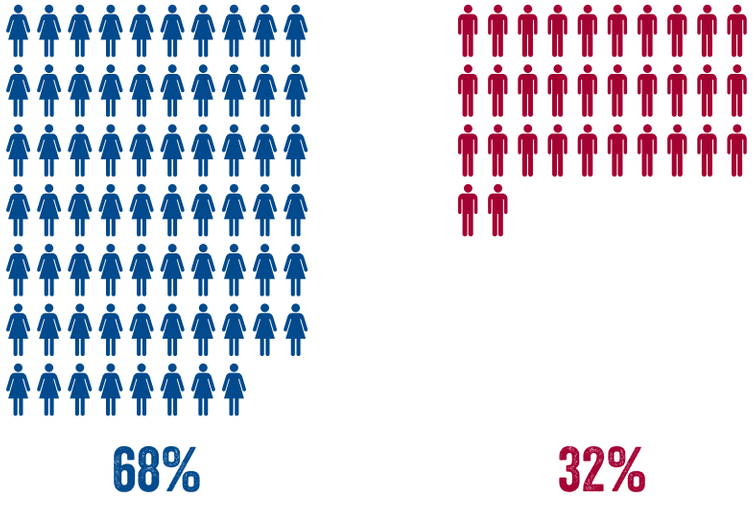
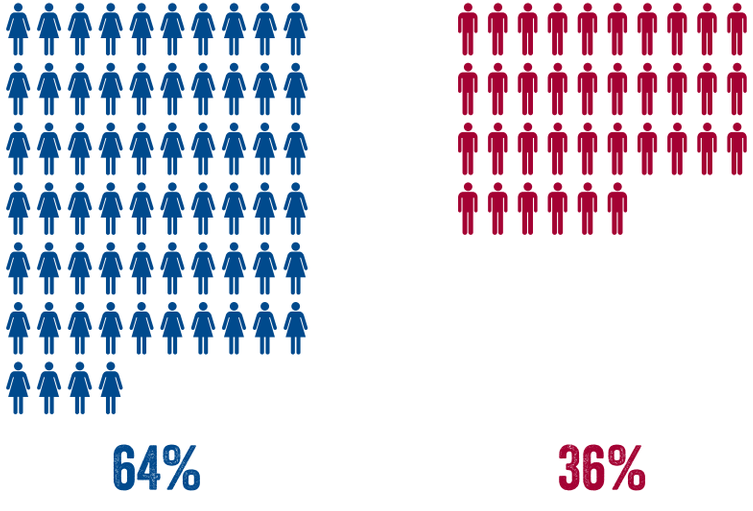


Figure 6: Gender of all Family Mosaic tenants aged 50 or over



THE PARTICIPANTS: ETHNICITY

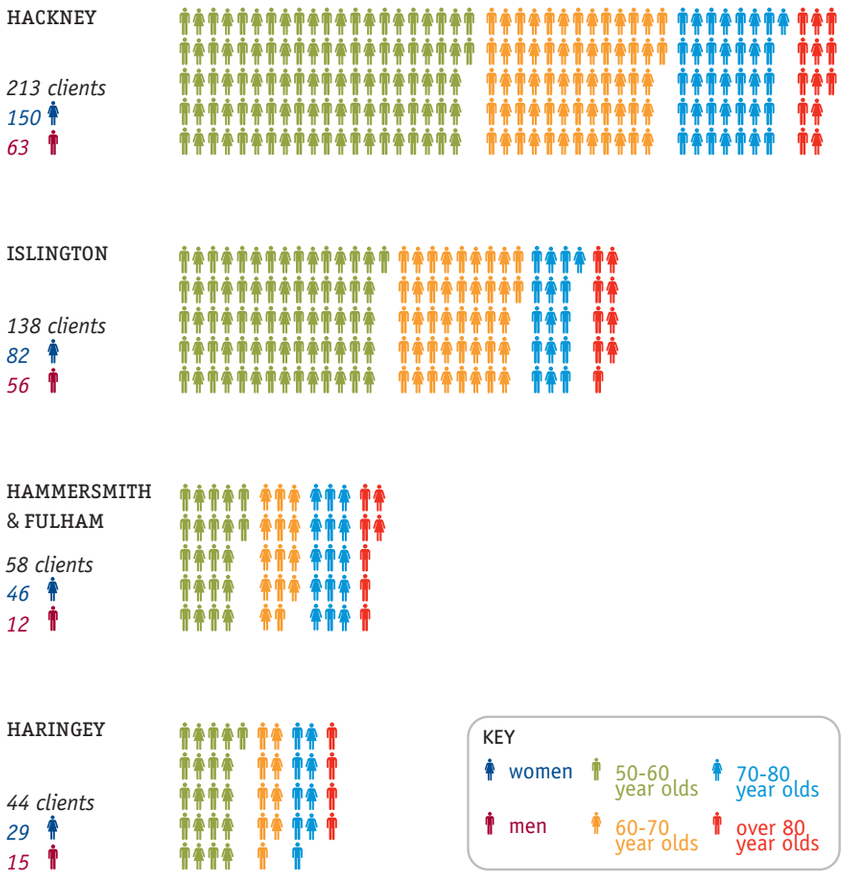
Figure 7: Ethnicity comparison

THE PARTICIPANTS: WHERE THEY LIVE

Initially, we invited older tenants living in our homes in Hackney and in homes owned by Old Oak HA (one of our subsidiaries) in Hammersmith and Fulham to participate in the research study.

After a positive take up on first contact, we extended the geographical scope of the research to include tenants in Islington, Haringey, and our other properties in Hammersmith and Fulham.

Figure 8: Participants by location



THE PARTICIPANTS: RESEARCH GROUPS

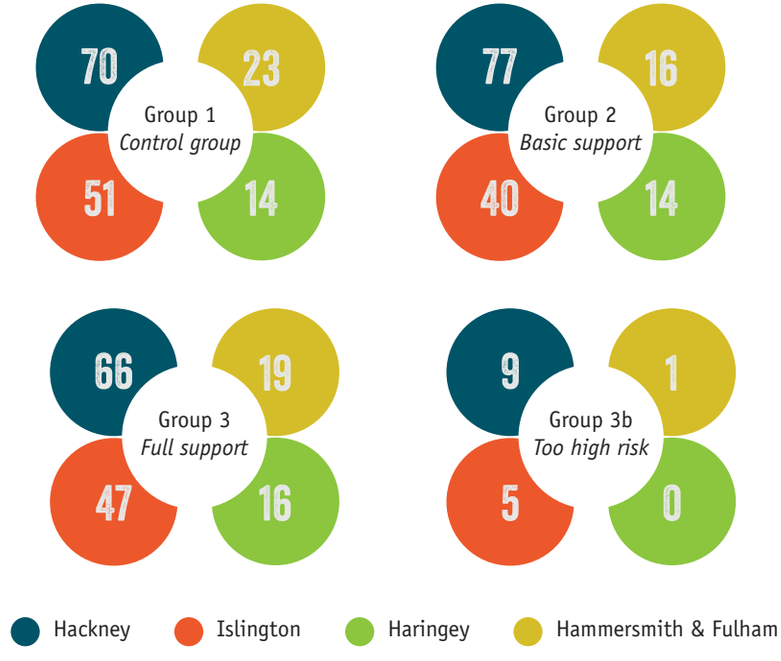
Once assessed, each person is randomly allocated into a research group. Group 1 receive no service: they are the 'control' group.

Group 2 participants receive an enhanced service from their housing officer, with advice and signposting to available services, and visits every three months to encourage them to take these up.

People in Group 3 are provided with a health action plan delivered by a dedicated health and wellbeing team providing one-to-one support, including accompanying to groups, activities or health services.

Group 3b is a subset of Group 3. They receive the same service as Group 3. They were deemed to be at risk at their initial assessment, so we could not let them be randomly allocated to a group. We will account for these individuals differently when we publish our final findings.

Figure 9: Number of people in each research group, by location

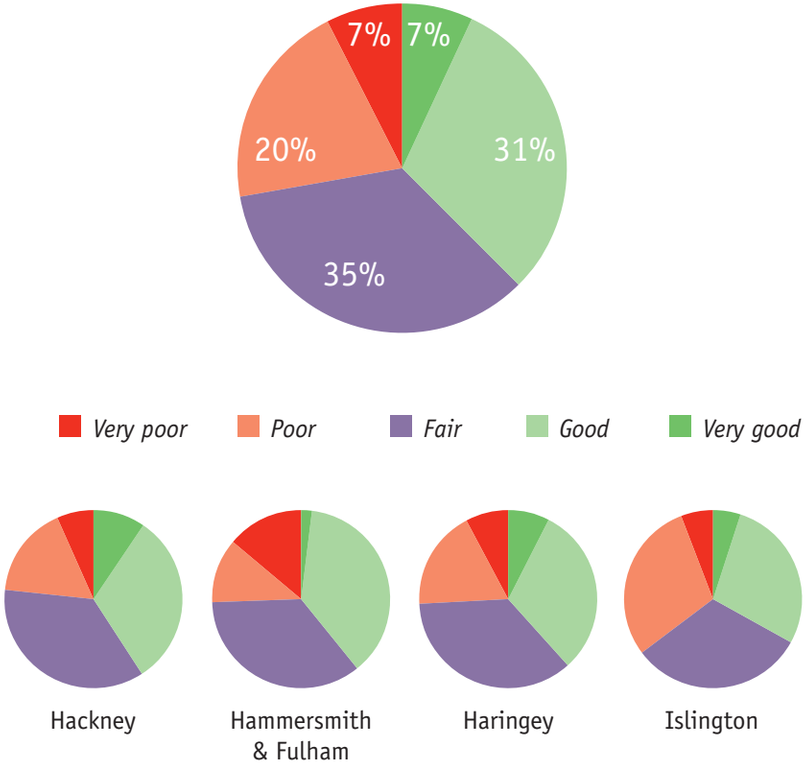


HEALTH ISSUES

As part of the initial assessment with each participant, we asked them how they would rate their health. Only 38% rated their health as good or very good. A third said their health was fair, while 27% said it was poor or very poor.

Older people living in Islington were most likely to feel that they were suffering from poor health: 35% said their health was poor or very poor, compared to 33% who said their health was good or very good.

Figure 10: Self-rated health of all participants, and by location



HEALTH ISSUES: CONDITIONS BY NAME

When we asked people about their health conditions, we found that almost half had arthritis and two in five had back pain. A third of the respondents reported suffering from depression, with a similar amount experiencing anxiety.

These figures were higher than those reported by respondents in our scoping report called *A Picture of Health*. This suggests those taking part in this research study may be more likely to have poorer health than our average tenant.

Figure 11: Long-term health conditions

HEALTH BEGINS AT HOME #1

Mr K has asthma and back problems. He's had two heart operations and a hernia operation. He is isolated and depressed, and lives in his bedroom, on his bed. The rest of his house is full of clutter.

He wanted his life to change. He wanted to learn how to use a computer. He was interested in losing weight, getting exercise and attending social events.

We've supported him to get his windows, doors and door handles fixed.

We've encouraged him to come on social excursions, including day trips.

We've supported him to attend a computer course.

Now he's planning to go to a weight management course, as well as a falls prevention session: and we're encouraging him to accept support so he can de-clutter his house.

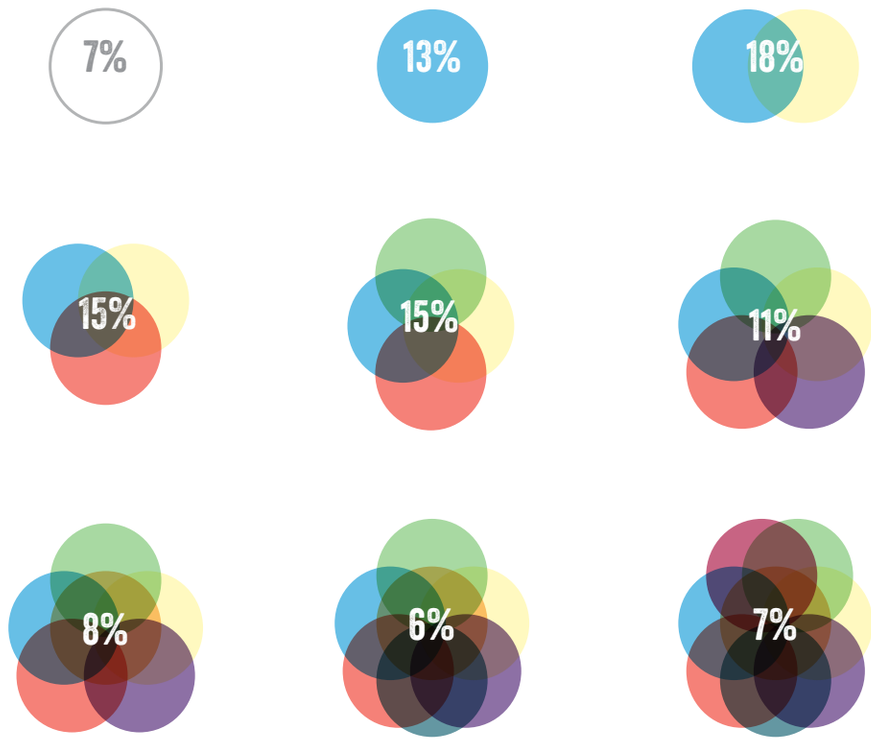
SMALL STEPS MAKE BIG CHANGES

HEALTH ISSUES: CONDITIONS BY NUMBER

The poor health of the research respondents is underlined when we look at the number of long-term health conditions they have. Over 92% said they had at least one health condition, with just 13% saying they only had one.

Almost half of the respondents had between two and four long-term health conditions. Of concern was the finding that almost a third of the research sample had five or more long-term health conditions.

Figure 12: Number of long-term health conditions per respondent



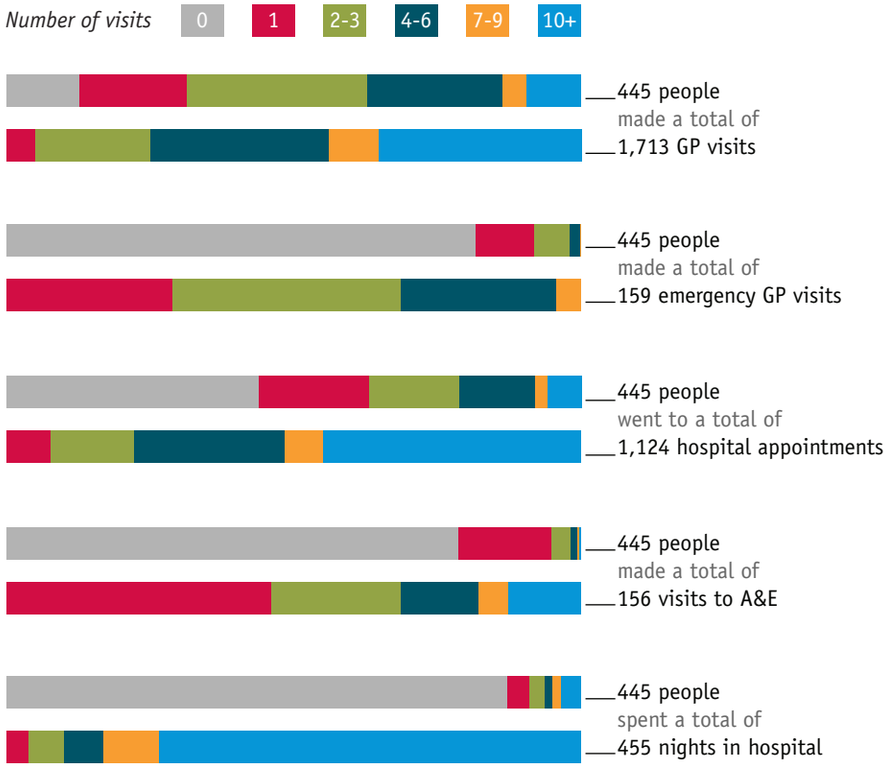
THE CURRENT COSTS

We asked people about their use of NHS services over the previous six months: 87% had visited a GP, and 56% had been to a planned hospital appointment. One in five had visited A&E, and 11% had spent a night in hospital.

There were 1,872 GP visits (this includes emergencies), 156 A&E visits, 1,124 hospital appointments and 455 nights in hospital.

Notably, the 16 people who had spent ten or more nights in hospital accounted for 74% of all overnight stays. This may be because their homes aren't suitable for immediate discharge or because it's difficult to get support in for them quickly.

Figure 13: NHS usage, by number of visits and total visits made

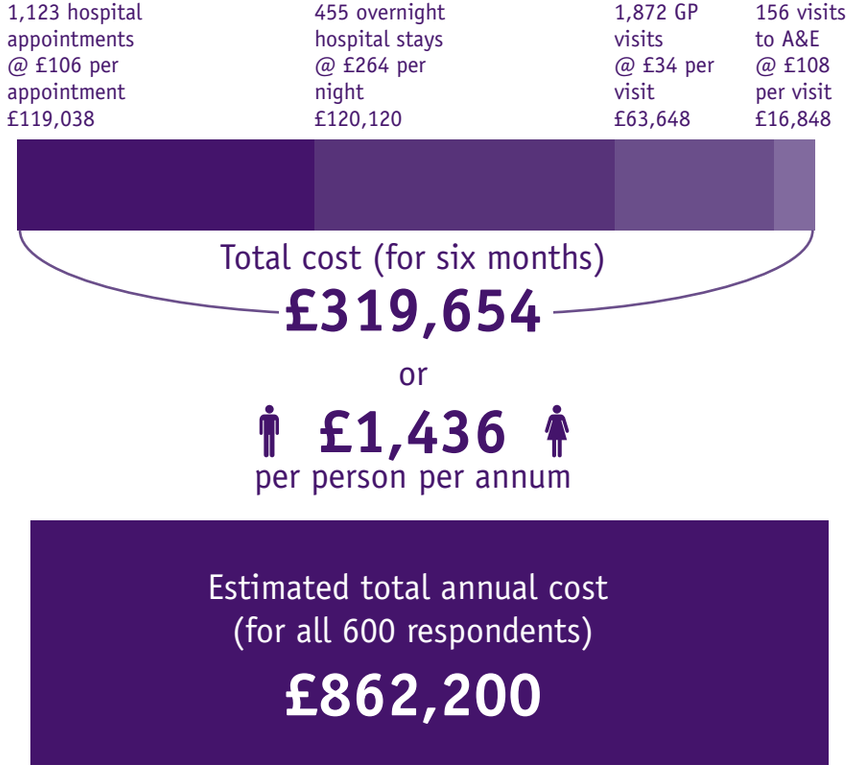


CURRENT COSTS: COSTS TO THE NHS

Using figures provided by the Department of Health, we are able to estimate that the cost to the NHS for treating the 445 people who had been assessed was £319,654 for six months. This equates to an annual cost of £1,437 per person.

Applying this number to all 600 participants in the research, the total annual NHS bill is £862,200. This does not include costs from, for example, use of ambulances, any costs caused from long-term health care, nor the costs of adult social care services.

Figure 14: Estimated costs to the NHS



Rates for hospital appointments, A&E visits and overnight stays (excess day rates): Department of Health, Reference costs 2011-12, p8; rate for GP visit: PSSRY, Unit Costs of Health and Social Care 2012, p117.

HEALTH BEGINS AT HOME #2

Ms M has multiple health and mobility problems. She has had breast cancer, suffers from incontinence and recently had a bad fall while she was at home. When we met her, she had lost all her confidence in going out and meeting friends: instead, she stayed in her cold, poorly lit flat.

We supported her to attend her health appointments, and to liaise with her occupational therapist.

We helped her to apply for benefits and welfare funds, so she could buy a fridge / freezer, a cooker, a sofa and a mattress.

Ms M has been on two of the trips we've organised.

She's also attended some of our activities, including a falls prevention session and a Friends Who Do Lunch (a healthy cooking class funded by the Big Lottery Fund Activate Programme).

SMALL STEPS MAKE BIG CHANGES

THE INTERVENTIONS

By the end of October 2013, 186 people had received some support: of these, 84 were in Group 2, and 102 were in Group 3. In total, over 575 interventions had been recorded with tenants, as illustrated below.

Some points should be noted around these interventions. First, for people in Group 2, we ensured our housing staff had the skills and knowledge to provide advice on health and wellbeing issues, and to signpost them to other services.

Figure 15: Interventions, by type and group

INTERVENTIONS: EXPLAINED

Secondly, we recruited a dedicated health and wellbeing team to provide interventions for people in Group 3. The team includes qualified nurses, mental health specialists, health trainers and support workers.

An intervention – which is a fairly clinical term – will differ according to the Group the person is in, as well as their individual needs.

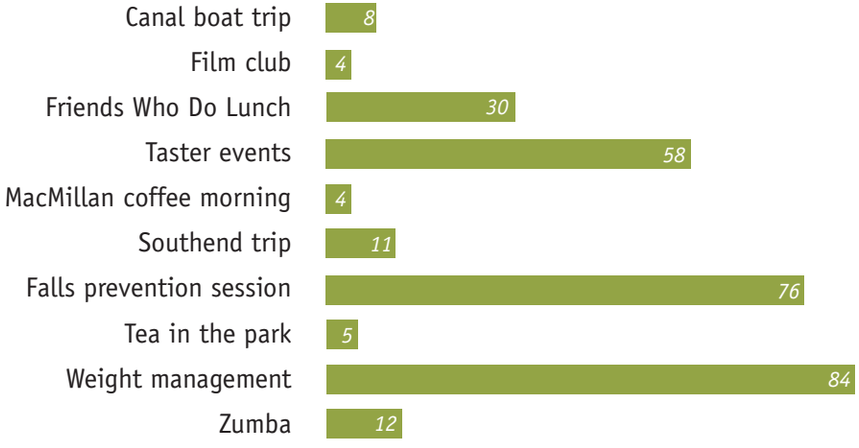
For someone in Group 2, we might simply tell them about, or signpost them to, our welfare rights or employment teams, local services and group activities.

For someone in Group 3, we would support them to access these services, whether going with them, helping them make a phone call or by actively encouraging them.

Advice and support given to people around areas of general health might include advice related to the individual's ill health, for example, information about diabetes. Advice about safety around the home might include information about falls hazards or winter warmth.

We also provided direct assistance to some participants: this tended to be for relatively small items, such as changing a light bulb.

Figure 16: Number of attendees at Family Mosaic-run activities



INTERVENTIONS: ACTIVITIES BY LOCATION

Figure 17: Activities by London borough

Family Mosaic or Old Oak activities shown in purple

HEALTH BEGINS AT HOME #3

Ms W was having trouble with her sons, and her daughter, who is an alcoholic. When we visited her, she was afraid to go out and meet people, and was obviously feeling very isolated.

After a lot of support and persuasion, Ms W is now attending IT classes at a local community centre.

She's also a regular at an exercise class that promotes strength and balance, which she thoroughly enjoys.

We made a referral to adult social care to ensure the safety of her grandson, and to provide support for her daughter.

Ms W has also attended a number of day events that we've organised, and is feeling less isolated as a result.

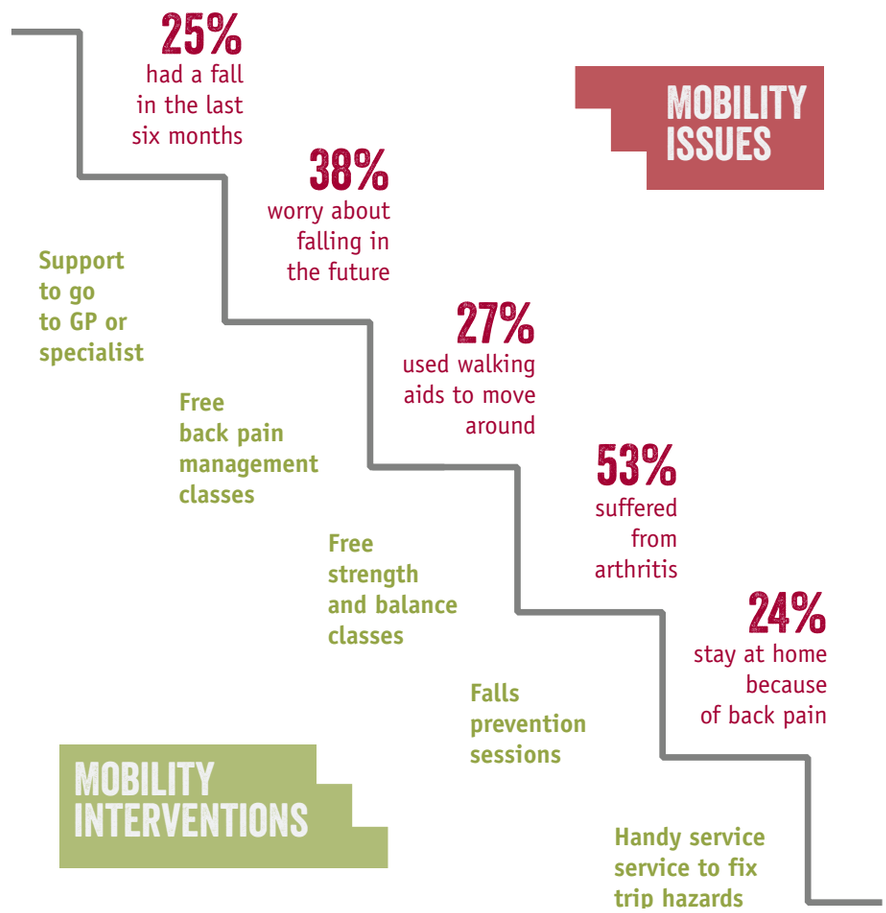
SMALL STEPS MAKE BIG CHANGES

INTERVENTIONS: FEAR OF FALLING

Back pain, mobility and fear of falling are some of the key issues that we're focusing on, because of the number of respondents who suffer from these health issues.

Almost 90% said they'd had no support from a fall prevention specialist. Our interventions are designed to improve people's mobility, and increase their independence around the home.

Figure 18: Mobility and back pain issues, and interventions

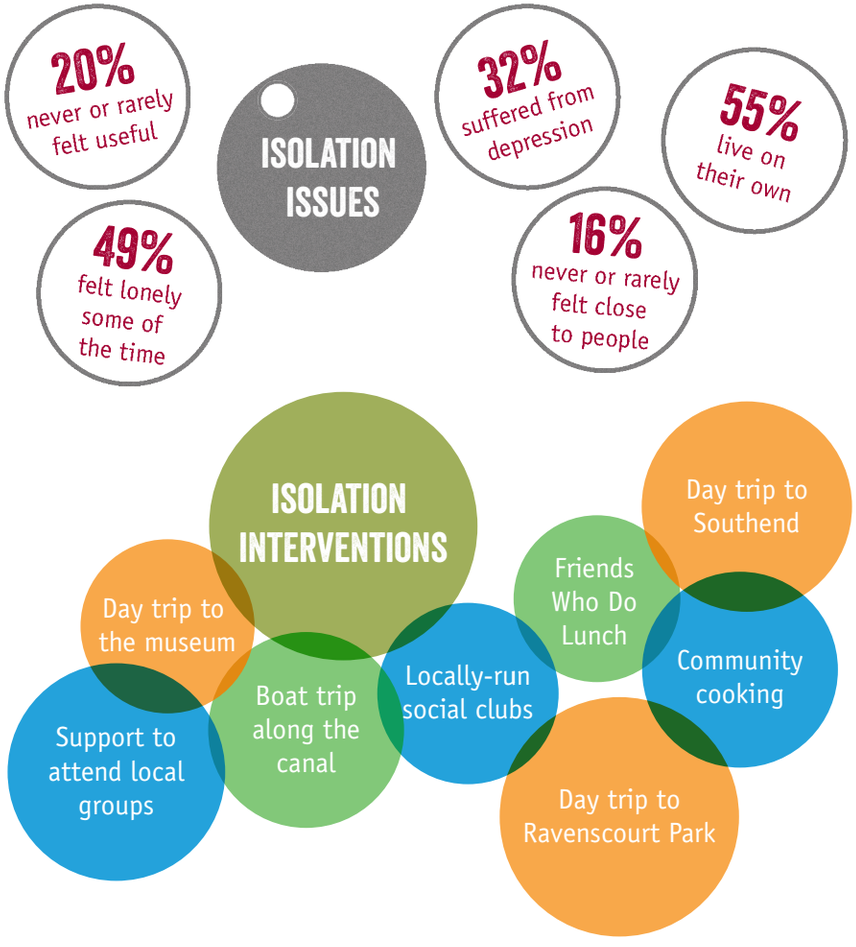


INTERVENTIONS: ISOLATION

Isolation and social exclusion is another issue for many of the participants in the research. Nearly half reported that they felt lonely at least some of the time.

Our interventions encourage and enable people to become more active, and to meet other people in neutral settings. We also run mini sessions in people's homes, if they are unable to get out.

Figure 19: Isolation and social exclusion issues, and interventions

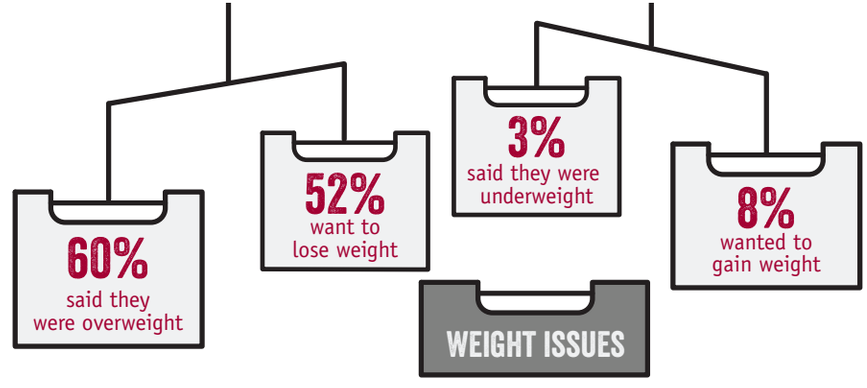


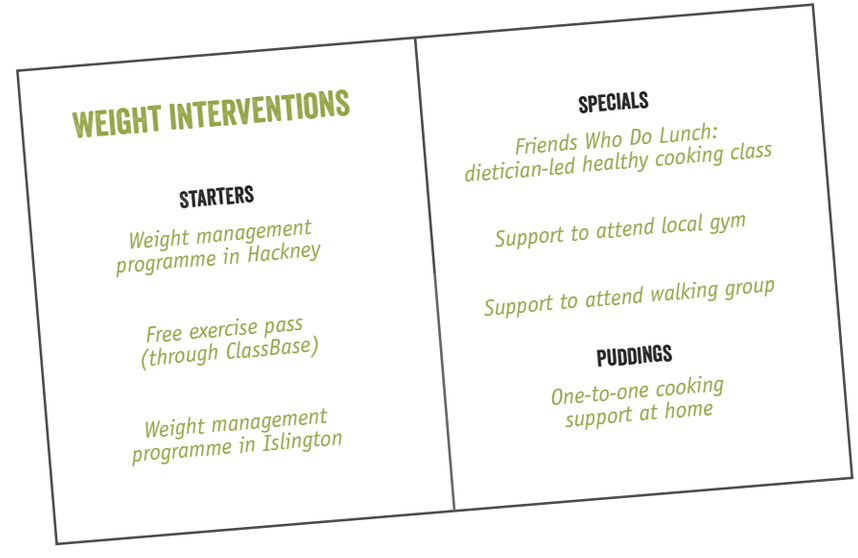
INTERVENTIONS: WEIGHT MANAGEMENT

Weight management is an issue for many respondents: 60% said they were overweight or obese. In addition, 3% said that they were underweight.

Respondents wanted to change: over half said they would like to lose weight, and 8% wanted to gain weight. Our interventions are helping people to manage their weight, and lead healthier lives.

Figure 20: Weight management issues, and interventions





HEALTH BEGINS AT HOME #4

Mr D is 51 years old, and has sickle cell anaemia, an illness that can cause extreme pain without regular monitoring and medication. When we first met him, he wasn't registered with a GP and would regularly go to A&E when he was in crisis because of his illness. In addition, his flat was cold and poorly furnished: he wasn't working, and was often short of money.

We supported him to get a passport, so he can register with his GP.

We've helped him to understand information about sickle cell anaemia, so now he's able to manage his illness better.

The windows in his flat have been draught-proofed, and we've told him about local groups who can help him with grants and recycled furniture.

With budgeting support, Mr D is now managing his money better, and has started saving for a new carpet.

SMALL STEPS MAKE BIG CHANGES

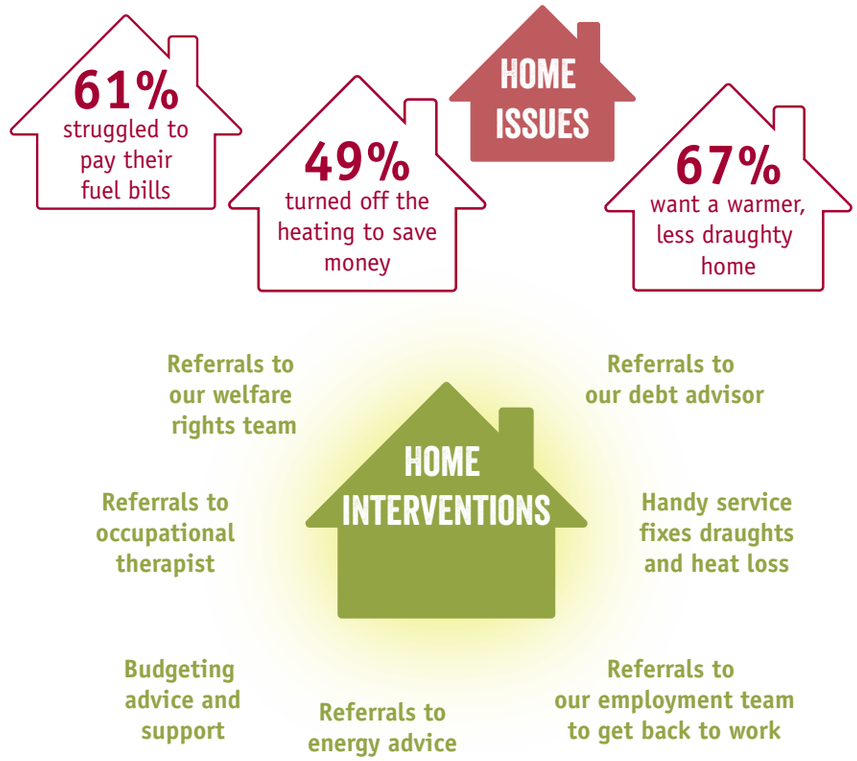
INTERVENTIONS: A HEALTHY HOME

Our final area of focus is on the home itself: over 60% said they struggled to pay their fuel bills. Almost 70% would like their homes to be warmer.

We support people to better manage their money, whether through advice about budgeting or their eligibility to benefits.

Everyone in Group 2 and 3 is eligible for a visit from our handy service. The handy service will arrange basic draught proofing, and repair any doors or windows, or refer on for other energy advice programmes. They will also help with small jobs, for example, changing lightbulbs or lifting and moving heavy objects.

Figure 21: Issues around the home, and interventions



NEXT STEPS

We are now six months into the research project, which is too early to begin making assumptions about the outcomes. What is clear, though, is that there is a health need amongst those taking part in the research, and that people want to improve their health. And this is likely to be the case across social housing as a whole.

We are ideally placed to make a difference. Thanks to our existing community initiatives, and our links with local community health projects, we can support people to make an active choice to lead a healthier lifestyle.

At this early stage in the research, one in five people has already attended one or more health initiatives. We have made over 570 interventions to help improve people's health at home.

It is clear there are huge potential benefits of the housing and health sectors working together. We estimate the average annual costs to the NHS is £1,437 per tenant aged 50 and over. We have around 6,500 tenants who are 50 and over: if they were all using the NHS at the same level, it would be costing over £9.3 million per year.

We have only just begun to test how we might best reduce these costs. The first six months of the project have focused on recruiting research participants and conducting their initial assessments. We now have 580 participants, and have conducted 445 assessments.

Over the next six months, we aim to reach 600 participants, and conclude the initial assessments. We will then have 200 participants in each of the three research groups, and will be able to monitor the impact of each approach.

We know the service will cost money to administer. We believe, though, that the research will show us the most efficient way of working, so we can realise the benefits of housing and health working together.

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"JOINING IN THIS PROJECT HAS MADE ME HAPPIER. YOU BECOME MORE ACTIVE. YOU MAKE MORE FRIENDS. GOING DANCING MADE ME REMEMBER MY YOUTH."

CYNTHIA, RESEARCH PARTICIPANT