Study into the Impact of the Housing Workforce on Health Outcomes

EXAMPLES OF HEALTH AND WELLBEING INITIATIVES

expertise, training & consultancy in
housing with health, care & support

1. Introduction

In December 2015 Public Health England commissioned Sitra to identify how the social housing workforce in England is able to effectively contribute to public health outcomes. These examples demonstrate the existing range of initiatives across England and how these housing providers are contributing to public health outcomes. Sitra also carried out two surveys with partner housing organisations, Sitra members and associate networks using this evidence to produce a set of staff competencies and associated training resources to support the housing workforce in delivering public health messages and 'nudge' healthy behaviours in their customers and also in those who live in the communities they work in. These resources and the accompanying report can be found on the Sitra website.

2. Social Prescribing

Examples 1 and 2 describe how two housing providers have developed models for social prescribing in the North East of England.

Example 1: South Yorkshire Housing Association (North East)

South Yorkshire Housing Association (SYHA) is working with the Doncaster CVS (Community and Voluntary Services) to deliver a social prescribing service. The Doncaster Innovation Fund funds the project. This is a two-year project, ending in August 2015. The Project works with GP practices across the North West and central Doncaster. There are four staff (two from each organisation). The Project provides a single point of contact for GPs to refer patients who present at the practice with non-medical needs or have other needs, which have a negative impact on their health.

The Social Prescribing Advisors visit patients in their homes and conduct holistic assessments of their needs, mapping out a range of community, voluntary and statutory services which are available for them. The service provides signposting to these services as well as close working with patients to ensure they are able to make initial contact and continue to access the services. SYHA and Doncaster CVS are working in partnership with Sheffield Futures and Sheffield Hallam University to collect research data and evaluate the impact of the Project.

Example 2: Gentoo (North East)

Reducing fuel poverty, GP and hospital admissions: Gentoo is a large housing provider based in Sunderland, providing both general needs housing and supported housing services. As part of its overarching approach to health and wellbeing, their internally commissioned Green Deal Pilot Scheme was launched in 2011. This provided energy saving home improvements to 1200 homes. In a report published in December 2012[1], Gentoo stated that the scheme not only resulted in savings to energy bills and fuel poverty, but residents also reported an increase in their general wellbeing.

Gentoo used this evidence to make a business case to local health commissioners to pilot a Boiler on Prescription project. The first pilot was commissioned in 2014 by Sunderland CCG for people with a Chronic Obstructive Pulmonary Disease The Project resulted in the development of a framework where a GP can prescribe a suite of home improvements, free of charge, for patients who have medical conditions exacerbated by cold, damp homes. In the first six months results have shown a 28% reduction in the number of GP appointments and a 33% reduction in outpatient appointments. Gentoo are now in discussion with other potentially interested CCG's[2].

[1] The Energy Saving Bundle Report 2013: http://www.gentoogroup.com

[2] Full details can be found on Gentoo's website: www.gentoogroup.com

3. Asset Based Community Development

Example 3 gives an example Asset Based Community Development in a recently commissioned service delivered by a social housing provider which combines local authority housing support and adult social care funding.

Example 3: Community Connect (South West of England)

North Somerset Council commissions community Connect. The service provides community based preventative services for people aged 50 plus. There is a particular emphasis on targeting areas of rural of deprivation and health inequality. The focus is on prevention and the need to provide information on local services to help reduce or delay the need for higher forms of care.

In 2014 Curo, (a housing and support provider based in Bath) in partnership with the West Of England Rural Network, won a 4-year contract (value £1.2m) to deliver Community Connect. The service will provide, through a wide range of referral options and promotional activities:

- Advice, information and sign posting service
- Brief interventions service offering 2 to 3 sessions of support and the opportunity of a structured support service for up to 3 months.

The service begins with an initial assessment of needs, using an "Advantage Thinking" approach, focussing on the individual's assets (strengths, skills; what they can do for themselves), as opposed to their deficits (their problems and issues). The support service will be led by a Wellbeing Coordinator who will support co-design of person centred holistic 'Connect Plans' agreeing personal goals, actions and agencies to support the plan.

Curo have begun to identify existing resources available. The objective is to build on these to develop a range of other community services such as peer support groups and befriending services. The organisation is currently

4. Public Health Domain:

IMPROVING THE WIDER DETERMINANTS OF HEALTH

Partnership Working With Health

The importance of stronger Partnerships with charitable and voluntary sector is acknowledged in the NHS Five Year Plan: "they provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff", and "are better able to reach underserved groups…a source of advice for commissioners on particular need"[3]. Examples 4 and 5 demonstrate how partnership working with Health and Adult Social Care has supported homeless people in Kent and Yorkshire.

Example 4: Porchlight

Porchlight is the lead organisation in the Kent Primary Care Community Link Service (PCCLS) which was jointly commissioned by Kent Clinical Commissioning Groups, Kent County Council Families and Social Care (Adults) and Public Health in 2013. It is a partnership between Porchlight (homelessness housing support provider), Kent County Council and local GPs, and aims to reduce pressure on GPs by helping people address low-level mental ill health caused by circumstances at home.

Porchlight staff provide support and advice in a range of areas including debt management, housing, health, drug and alcohol issues, education, training and volunteering, community involvement and building confidence. They work alongside GPs to access people whose needs are best addressed outside the surgery by dedicated support professionals. The aim is that provision of intervention and support will result in a reduction in repeat GP visits, thereby reducing NHS costs and helping people to move forward positively in their lives.

[3] page 14, NHS Five Year Forward Plan, published 23rd October 2014

Example 5: Horton Housing Association

The Bradford Respite and Intermediate Care Support Service is a 14-bed accommodation scheme for people who are homeless, inadequately housed and need support around health issues. The service opened in December 2013 and offers short term temporary accommodation for people on discharge from hospital. Developed and managed by Horton Housing Association and working in partnership with Bevan Healthcare, the service brings together clinical, social care and housing/homelessness practitioners who work alongside an established hospital-based in-reach 'Pathway' team to identify suitable clients, ensure continuity of clinical care and improve health outcomes. The service also signposts people to other appropriate services that can offer longer-term support to the individual.[4] It is currently being funded by Bradford City CCG and Public Health.

5. Public Health Domains:

HEALTHCARE, PUBLIC HEALTH & PREVENTING PREMATURE MORTALITY IMPROVING THE WIDER DETERMINANTS OF HEALTH

Health Projects

Examples 6 and 7 describe local housing provider initiatives targeted at keeping people warm in winter. The initiatives have impacted positively on health by reducing social isolation, addressing fuel poverty and working to reduce winter deaths.

Example 6: Viridian Winter Phone Calls

In 2013/14 Viridian offered this internally funded service to older residents in its general needs properties. A Winter Information Pack was provided for residents and a team of staff and volunteers donated their time to telephone vulnerable residents over 70. 178 residents were spoken to during the Project. This resulted in 20 people receiving help to maximise their benefits, 5 people receiving emergency fuel payments. In addition a number of unreported repairs and need for disabled aids and adaptations were acted on. A number of referrals were also made to voluntary sector organisations offering on-going support.

Example 7: Oldham Housing Improvement Partnership (OHIP)

In 2013 a Warm Homes Scheme was launched in Oldham, led by a group of 8 local social landlords. The £200,000 upfront investment for the project came from the Oldham partners- Oldham Council and OHIP have invested £77,500 each and the Clinical Commissioning Group (CCG) invested £45,000. It was delivered by Keepmoat, in partnership with the Citizens Advice Bureau (CAB). Oldham Council project managed the scheme. The service offers a range of support to help households out of fuel poverty. To be eligible for the service, at least one person in the household must be either: under 16 or over 50 years old, pregnant, suffering from a physical disability or mental illness, or presenting symptoms of an illness or disability exacerbated by cold.

During the first year the scheme worked with 586 households, the vast majority of whom were owner-occupiers. 439 of these households (properties) were brought out of fuel poverty, (in total 1074 people). A follow up survey demonstrated that 60% of respondents with a physical health problem said that their health had improved. 80% reported a positive impact on their general health and wellbeing. 96% agreed that their home was easier to heat and 84% now spent less on heating. The scheme also demonstrated wider health benefits: behaviour change in relation to energy use, improving health and wellbeing. The scheme has been continued for 2014/15[5].

[4] http://www.hortonhousing.co.uk

[5] http://www.oldham.gov.uk/warm_homes_oldham

Care and Repair and Home From Hospital Services

These services offer practical assistance for vulnerable, older and disabled residents. Example 8 illustrates the health outcomes and social return on investment for a Care and Repair service in Scotland. Example 9 illustrates a Home from Hospital service in North London.

Example 8: West Lothian Evaluation (Scotland)

In 2013 West Lothian Council in Scotland undertook a Social Return on Investment evaluation of their Horizon Housing Care and Repair service[6]. This analysed the social added value delivered through the total investment of £489,463 in the West Lothian Care and Repair service between April and December 2011 £135,339 of which was revenue funding for the Care and Repair services provided by West Lothian Council through a service level agreement.

Based on the outcomes of stakeholder consultation the evaluation reported positive health impacts, including a considerable reduction in falls and accidents at home (a significant factor in preventing premature mortality), increased sense of security and safety, ability to remain living at home and reduced bed blocking in hospitals. The main cost saving identified were reduced cost of housing elderly and disabled people and reduced cost of provision of domiciliary care services. The evaluation concluded (in 2013) that the value of Care and Repair West Lothian was £7,356,818. This gave a social return of £4.53 for every £1 invested in the service.

Example 9: Metropolitan Home from Hospital Service (London)

The Home From Hospital service is commissioned by the London Borough of Waltham Forest. The provider is Metropolitan (a large national provider of general needs and supported housing) The service provides free short term support for older people or disabled people on discharge from hospital. The support includes: emotional support, shopping, applying for benefits, dealing with correspondence and accessing other services (for example Dial-a-Ride, accessing care and repair services, community alarms, smoke alarms, domiciliary care etc. The service is available to Waltham Forest residents with a Waltham Forest GP and who have been inpatients at London and local hospitals.

7. Public Health Domains:

HEALTH IMPROVEMENT
HEALTH PROTECTION

Healthy Conversations

Healthy Conversations was a Foyer Federation & Big Lottery £3.6 million funded programme designed to create different conversations with young people about health issues. The project works with young people supporting them to develop understanding, opportunities and networks to improve the health and wellbeing of themselves, their peers and their communities.

Each organisation engaged with project and receiving a contribution from the lottery grant funding, was required to develop health action plans to achieve health goals and in collaboration with them develop a range of health related activities and networks of support, to enable the activities to be self-sustaining and also deliver these health messages to their local communities.

In the first year of the programme, over 700 staff from 20 services were trained to deliver health activities and coaching, who in turn worked with more than 1300 young people. There were also 800 beneficiaries from the wider community who benefitted from the community action projects that the young people developed. In Year 2 there are an additional 56 services on board, to deliver an even bigger and better programme[7].

[6] http://www.careandrepairscotland.co.uk/docs/Care Repair West Lothian SROI Summary.pdf

[7] http://foyer.net

Examples 10 and 11 show how two organisations have used their "Healthy Conversations" funding to deliver health outcomes for young people:

Example 10: Curo's Three Square Project (South West England)

Curo is a not-for-profit housing and support organisation based in Bath. In conversations with residents at the Bath Foyer, young people identified a common problem of how to cook and eat healthily with little or no income. Together the staff and residents came up with creative ways to address this. During the three-month period of this project, several different activities were provided to promote healthy eating at five different supported housing sites, including the foyer. Activities included cooking lessons, learning how to make healthy food from scratch, a 'free food Tuesday' (delivery from a local store) a 'ready steady cook' competition and a 'breakfast bombing' campaign. The project has had lasting impact and healthy eating continues to be a key theme within CURO's services.

Example 11: Axiom Housing Association (East of England)

Axiom is a medium-sized housing association based in Peterborough. A service user case study from their Peterborough Foyer demonstrates the positive impact of this initiative. SB moved into the Foyer after family breakdown forced her to leave home. She was a regular cannabis user with low employment prospects. Through the "Healthy Conversations" project SB attended cookery groups, as one of her goals was to eat a more balanced diet. As well as developing cooking skills at the Group she also socialised with her peers, developing her confidence and becoming less withdrawn. SB identified another goal, to improve her fitness. Staff helped motivate her to walk to town and back to improve her fitness plus save money on bus fare. With her improved confidence SB began to attend weekly 'drug sense' drop in sessions to for advice, overcoming her initial reluctance to meet them. She now has greater self-confidence, her cannabis use has reduced, she is eating more healthily, and is now on a work placement with Axiom Academy.

Partnership Working

Examples 12 and 13 describe partnership initiatives with housing providers working together with statutory and voluntary partners to capture and facilitate a range of health improvement activities within their communities.

Example 12: Oldham Housing Investment Partnership (North West England)

In their 2014-15 document, "Oldham's Co-operative offer[8], Oldham Housing Investment Partnership (OHIP) and Oldham Council state that their role has broadened beyond development of homes, to focus on 'investment' in the wider sense. This includes investment in neighbourhoods, communities and services.

One of Oldham's 2013/14 priorities was to improve the health and wellbeing of the community. This resulted in a number of projects, initiated and facilitated by the 8 social housing provider members. Projects included: facilitating sports activities, "grow your own" and healthy eating activities for schools and local community groups. For 2014/15 the health and wellbeing work stream continues with similar projects. OHIP will continue to capture and monitor impact of projects through the development of their own activities matrix.

Example 13: Walsall Partnership (West Midlands)

In 2013 Walsall Housing Group in partnership with Public Health Walsall and Caldamore Accord facilitated a health programme targeting men over 40, particularly South Asian men living in Caldamore and Palfrey. The aim was to encourage men to sign up to a free health and fitness programme in a bid to reduce rates of diabetes and heart disease.

The Project ran from April to June 2013. It focussed on ways to lead a healthy lifestyle, with information and advice ranging from healthy eating and exercise to alcohol and drug awareness. The programme was part of Walsall Housing Group's "Active M8" initiative, to promote healthy lifestyle choices, physical activity and health awareness and was shaped around the needs of the people who attended, covering topics from diabetes to drug awareness

[8] http://www.oldham.gov.uk/coop_hs

Housing Management Case Studies

Many housing providers are already picking up on issues presented by tenants who are falling under the radar of social services or other preventative services. These activities could be defined within the public health outcomes framework, but currently they are largely unmeasured or reported and are absorbed within the broad "housing management" service. The following case studies provide excellent examples of how many housing providers are helping to reduce hospital admissions and improve the health and wellbeing of children.

Example 14: BECHA (Kent) Case Studies of Vulnerable Residents

These case studies are from BECHA, a housing provider based in Bexley, Kent.

Case Study 1: Reducing Hospital Admissions/Maintaining Good Mental Health
Mr H suffers from paranoid schizophrenia and has been sectioned under the Mental Health Act on a number of occasions. The necessity for a section arose generally from Mr H lapsing in his medication. BECHA staff noticed a regular pattern with Mr H's calls and identified that when calls became more frequent and abusive this indicated that he had stopped taking his medication. Another sign identified by staff was Mr H's language. When well, he rarely swore, but when he had lapsed in his medication, his language became more offensive. BECHA staff began responding to these two indicators, by contacting either Mr H's son or Community Psychiatric Nurse, who were able to intervene and support Mr H to re-start his medication. This intervention by BECHA prevented potential hospital admissions on a number of occasions.

Case Study 2: Improving Health And Hygiene Of Children
Mrs Y was a lone parent with five children under the age of 12. She smoked large amounts of marijuana and was diagnosed with clinical depression. Her property was filthy and neglected, partly due to the large number of pets. Following a report from a contractor that there was cat excrement on the children's' pillows and in the knowledge of the deteriorating living standards, BECHA made an initial referral to social services. Social Services advised that the children were not at risk of serious harm. Following this, further reports were received from a contractor of cat excrement on the children's' beds and that the children were sleeping on bare mattresses. This prompted a second referral by BECHA to social services. A support package was subsequently put in place for the family. Following this, there have now been improvements to the family's living conditions, food in the fridge and bedding on the beds. BECHA have cleared the garden of hazardous and unhygienic waste, including several bags of animal excrement and rotting food.

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