

Public health: Housing workforce holds the key



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ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

FOREWORD

With only 40,000 people estimated to be part of the core public health workforce, and in light of the crisis in lifestyle health issues, it makes sense to explore the opportunity or ability of anyone to impact positively on health and wellbeing through their work, and to join the 'wider public health workforce'.

The potential of the wider workforce to impact on health was simultaneously recognised by the Royal Society for Public Health (RSPH), Public Health England (PHE), and signatories to the National Memorandum of Understanding (MOU) to support joint action on improving health through the home¹. The MOU agreed in 2014 that the housing workforce was in a good position to improve the health and wellbeing of their customers, but that further work was needed to explore this, and to develop learning resources to support broader action. The joint Centre for Workforce Intelligence (CfWI) and RSPH report, 'Understanding the Wider Public Health Workforce'² that was published in July 2015 alongside the RSPH companion report "Rethinking the Public Health Workforce"³ describes the housing sector as an 'early adopter' of the wider workforce concept.

Supported by PHE, Sitra's learning resources developed with housing staff and their customers provide an fantastic starting point for workforce development and integrated working between housing, health and care sectors locally.

Without a sea change in our approach to health improvement, our health and care services will be unable to cope. The difference in life expectancy between rich and poor will grow ever larger and our economy will pay the price. Changing this pattern can only take place by harnessing our communities' assets. RSPH and PHE will continue to call for greater investment in the wider public health workforce and do what we can to enable this through promotion of learning and development of capability.

¹ National Memorandum of Understanding to support joint action on improving health through the home
<http://www.cih.org/resources/PDF/Policy%20free%20download%20pdfs/MOU%20project%20final%20Dec%202014.pdf>

² <http://www.cfwi.org.uk/publications/understanding-the-wider-public-health-workforce-in-england>

³ <https://www.rsph.org.uk/en/policy-and-projects/areas-of-work/wider-public-health-workforce/index.cfm>

SECTION 1

Summary and Call to Action

8.6 million people rent their home from a social landlord in England, in 17% of households. In England almost half of social tenant households live in the most deprived 20% neighbourhoods. Despite being home to a large working age population, only 49% of tenants are economically active and 45% have an income in the lowest 20% of the population. Tenants' self-reported health and wellbeing and limiting long-term conditions are considerably worse compared to the general population.

The housing workforce has been estimated to employ 750,000 people, and at least one third of these are in a position to improve health and wellbeing through their customer contacts.

Although the mission and values of social landlords also vary across England, and even within local authority areas, many report a commitment to improving the health and wellbeing of their customers, and often the wider community. This may simply be because supporting customers to sustain their tenancies makes sense to the bottom line, or because the health and wellbeing of the workforce is important.

In response to identified health needs of customers e.g., mental health, most landlords responding to this study engaged in this study have trained their frontline staff to identify and respond to these. Social landlords have also invested their own resources in interventions that will deliver indirect health benefits e.g., employment and training. Whilst there is however little robust evidence of the effectiveness of trained housing workers, evidence of the effectiveness of health services and wider community interventions is more robust and developing⁴.

Whilst there is willingness to develop the housing workforce to contribute more to health improvement, limited staff capacity and resources to deliver the necessary training are barriers. This is likely to continue to be the case as the social housing sector implements plans to mitigate the impact of recent government proposals that are likely to reduce landlords' income. Overstretched statutory agencies and loss of local services are also challenges to the social landlord role in health and wellbeing.

However, there are opportunities. The local authority public health role is in a good position to bridge the gap between provision with health and care settings, and to harness the contribution of social landlords. The Care Act 2014 and devolution require local health, care and housing commissioners and providers to integrate their activities to achieve shared outcomes; engaging social landlords in local planning should be viewed as essential.

Call to action

Individual housing organisations

- Adapt tenant profiling to develop a better understanding of residents' health and wellbeing, and use this to inform workforce development.
- Recognise the potential impact of workforce development in this area as a means to improve the health of the workforce.
- Adopt the training and competencies developed through this study for all housing staff as part core induction programmes.
- Gather evidence of the impact of trained and competent staff on the health and wellbeing of tenants, and wider community.
- Work with other social landlords to identify opportunities in the locality, and deliver joint learning and development.
- Develop closer co-operation and joint working relationships with local health and social care agencies at strategic and operational levels, to strengthen and co-ordinate the workforce response

⁴ Public Health England, alongside five housing associations, is supporting the development of standards to generate robust evidence

Local health and social care commissioners

- Work with local housing organisations to help them to
 - Better understand the health and wellbeing needs of their customers and communities, and use this intelligence in commissioning for local services
 - Understand the contacts the housing workforce has with customers and the extent of the opportunities that exist to improve health and wellbeing
 - Gather evidence of the impact of trained and competent staff on the health and wellbeing of customers, and wider community
- Bring social landlords and other housing organisations together locally to enable them to share intelligence, identify gaps and opportunities to improve health and wellbeing through partnership working
- Understand what information housing organisations need about the local health and care system to enable their workforce to connect to this to benefit their customers
- Provide education and training on health topics that have been identified as important to improving customers' health and wellbeing

National Housing and Health Memorandum Signatories

- Work with other national health and social care sector bodies to
 - Develop their member workforces to understand the impact of poor housing on health
 - Raise awareness of the potential role of the housing workforce as a means to improve health and wellbeing.
- Support the housing sector to develop capability in evidence generation, and particularly evidence of the impact of equipping the housing workforce to deliver public health messages.
- In supporting local areas to develop equivalent 'housing and health memorandums' (MOUs), encourage social landlords and other housing providers to develop their workforce to contribute to public health
- Promote take up of training and competencies within member organisations, through events, training and communications
- Develop further training to support
 - The development of strategic and systems leadership for health, housing and social care activities across the sector
 - Managers to enable them to translate the strategic direction through training
- Explore the potential for housing and health training to be accessed by:
 - Agencies delivering housing-related information and advice
 - Private landlords and lettings agencies, working with relevant industry bodies.

Public Health England

- Ensure that the competences and resources developed through this work are aligned with developments in Making Every Contact Count and the review of the Public Health Skills and Knowledge Framework
- Explore the potential to 'kitemark' training to enable organisations to demonstrate commitment to promoting public health and to housing's customers confidence in the services they are receiving (this will be dependent the conclusion of wider workforce development activity in PHE)

SECTION 2

Introduction

Almost 8.6 million people live in a home rented from a social landlords. Social housing is let at low rents, usually on a secure basis, to those who are most in need or struggling with their housing costs. It is allocated on the basis of need and as a consequence although it is warmer, safer than other tenures, the health and wellbeing of this population is poorer. In England, 11.5% social housing tenants reported bad or very bad health and 15.6% reported that their day-to-day activities were limited a lot by a long term health condition or disability, compared to population averages of 5.3% and 7.9% respectively^{5 6 7}.

The Chartered Institute of Housing estimates that more than 750,000⁸ people were employed in providing some form of housing services in 2013⁹. Much of this workforce is 'front line', with regular and sometimes sustained contact with customers. The RPSH identified 243,000 welfare and housing workers in their 2015 wider workforce study¹⁰. Public Health England commissioned this study to contribute to a more coherent understanding of the value of developing the housing workforce to contribute to improved health and wellbeing outcomes amongst their customers.

The primary research method was to work with staff and customers of three different types of social landlord (Family Mosaic, Bromford and Southdown – Annex A), to explore perceptions of the appropriateness of the workforce delivering health messages, to identify the key workforce competencies required to enable improved health outcomes, and to develop and test learning resources to enable those competencies to be achieved. This was preceded by a survey of social landlords and literature search. The detailed methodology can be found in Appendix 1 and the competencies in Appendix 2.



⁵ DCLG 2015 English Housing Survey Headline Report

⁶ Census 2011 LC3409EW – General health by tenure by age

⁷ Census 2011 LC3408EW – Long-term health problem or disability by tenure by age

⁸ CIH's research developed a new definition for the housing workforce which includes professions engaged in managing and maintaining social housing, commissioning or managing residential care, housing and/or care regulation, planning and enabling new homes

⁹ Rowell, A (2014) The UK Housing Workforce, TBR Skills and Labour Market Team

¹⁰ Kenth, K (2015) Rethinking the public health workforce, RSPH http://www.rsph.org.uk/filemanager/root/site_assets/our_work/wider_public_health_workforce/rsph_widerworkforce_report_final.pdf

SECTION 3

Context for the Study

Where we live is a wider determinant of our health, and drives health inequalities. The more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health. (Marmot, 2010)

Social housing shares its origins with public health: in response to the poor living conditions experienced in the mid-19th century, a number of philanthropists began to provide accommodation for their workers. Since that time legislation, house-building and regeneration programmes have sought to provide affordable, warm and safe homes for people on a low income. There are around 4 million homes in the social rented sector today, primarily owned and managed by not-for-profit housing associations and local authorities.

Developing and supporting communities has been a core feature of the social housing movement from the beginning, when model villages were developed for the workers. Housing associations, providing 60% of social rented homes, were reported to have invested £746.5 million in community activity in 2010/11, of which 71% was from their own money. This included £153m for education, employment and training, and £134m for health, wellbeing and independence¹¹. Much of this activity has adopted approaches recently recognised by Public Health England as 'community centred' and a means to improving health and wellbeing¹².

The current legislative and policy framework suggests that working with the housing sector is a means to improving health and wellbeing, particularly from within communities.

The return of public health responsibilities to local government (Health and Social Care Act 2012) presents an opportunity for local authorities not only to address the wider determinants of health such as poor condition housing but also to harness local resources to improve health outcomes and reduce inequalities.

The ambitions of the NHS Five Year Forward View require a 'radical upgrade in prevention and public health' and action to incentivise and support healthier behaviour. It is implicit that partnerships with local organisations working in the community e.g., social landlords, are part of the solution: making every contact count and enabling care closer to home¹³.

The Care Act 2014 recognises the importance of the home and housing services to improved health and wellbeing. Shifting to a population-health and preventive approach to delay and reduce the need for health and social care requires local authorities to consider the suitability of home to an individual's and their household's needs, and to integrate housing in commissioning and service delivery¹⁴.

Localism and devolution in a time of austerity present a challenge for public bodies, and recent budget announcements are expected to reduce income generated by social landlords, and potentially reduce the 'added value' that these organisations bring to their customers and communities. In this environment partnerships between health and housing organisations locally will be essential to protect and improve health and wellbeing, and reduce health inequalities.

The wider workforce has an important contribution to make to the health improvement, wellbeing and prevention agenda; the time is right to encourage the social housing sector to have a role in improving the public's health. The view of many stakeholders is that the wider workforce should be considered as an integral part of the public health system, providing health and wellbeing services to the local communities they serve, and recognised for the public health contribution they make. The People in UK Public Health group is an advisory group providing independent, expert advice to the health departments of the four UK governments on an overarching strategy for the public health workforce. The vision of the group is to improve the public's health in the UK. This group recognises that improving the health of the public involves a broad range of people in a variety of professions, communities and settings, thereby placing the wider public health workforce at the heart of this change.

¹¹ University of Birmingham (2012) Building Futures: Neighbourhood Audit Summary and key findings, National Housing Federation, <http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/IASS/research/building-futures.pdf>

¹² South, J (2015) A guide to community centred approaches for health and wellbeing. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/402889/A_guide_to_community-centred_approaches_for_health_and_wellbeing_briefi_.pdf

¹³ NHS Five Year Forward View

¹⁴ Part 1, Chapter 23: 2014 Care Act

SECTION 4

Overview of the Findings

4.1 Who does the workforce work with?

Almost 8.6 million people live in a home rented from a social landlord.

Census data for England indicates that the social housing tenant population is younger and more diverse than the owner-occupied populations, although it is important to note that this profile varies within local areas and between social landlords.

Although living in homes that are more affordable, warmer and safer than other tenures, the health and wellbeing of this population is poorer. 11.5% social housing tenants reported bad or very bad health, and 15.6% reported that their day-to-day activities were limited a lot by a long term health condition or disability, compared to population averages of 5.3% and 7.9% respectively^{15 16 17}.

The health of this population is unsurprising given that this accommodation is prioritised for those with the highest housing need who are unable to meet this without assistance. The Census identified 49% of social tenants were economically active, compared to 69% homeowners and 79% private renters. Also, 46% of social renters live in the most deprived 20% of neighbourhoods, and 45% had an income in the lowest 20% of the population¹⁸.

The social landlord will have varying degrees of contact with their tenant and the tenant's household: if tenancy conditions are met and there is no other reason for contact by either party there may only be the annual gas safety check; if the tenant needs support to maintain their tenancy, for example because of ill-health, there may be regular contact over a period of time.

Neighbourhoods that were once wholly social rented are also likely to be home to homeowners and tenants renting from private landlords. Since the 1980s government policy has supported tenure diversification. In practice this means that social landlords are often in a position to influence the health and wellbeing of households who are not their tenants.

The three social landlords who participated in the study reflect the diversity found in the sector.

- Bromford provides almost 28,000 homes for rent, primarily in the West Midlands. 40% of their customers are over the age of 60, and 84% of these customers live in a 'general needs' home ie, it is not specialist accommodation.
- Family Mosaic provides over 25,000 homes for rent, serving more than 45,000 people. It is one of the largest social landlords in London, Essex and the South East. Around 20% of tenants living in their general needs housing are over 50.
- Southdown is a specialist provider of care, support and housing services for vulnerable people in Sussex, supporting over 8,500 people.

4.2 Why do we think the social housing workforce has something to offer?

4.2.1 The sector is already committed to improving health and wellbeing

In response to the needs of their customers and communities, social landlords have invested in and/or have experience of delivering services and initiatives intended to directly improve health and wellbeing, or that are known to improve health and wellbeing indirectly. This is typically in partnership with other local organisations.

The call for case studies to inform this study identified the following examples of social landlord activity intended to improve health and wellbeing (further detail is provided in Appendix 1):

- Services and initiatives intended to improve the warmth and safety of the home, and address fuel poverty eg, boiler on prescription (and other home improvements) service (Gentoo, working with Sunderland CCG¹⁹), a winter support service to older tenants (Viridian), a warm homes scheme intended to address fuel poverty (Oldham Housing Improvement Partnership (eight landlords), funded by Oldham Council, the Clinical Commissioning Group)

¹⁵ DCLG 2015 English Housing Survey Headline Report

¹⁶ Census 2011 LC3409EW – General health by tenure by age

¹⁷ Census 2011 LC3408EW - Long-term health problem or disability by tenure by age

¹⁸ English Housing Survey 2013-14 http://socialwelfare.bl.uk/subject-areas/services-activity/housing-homelessness/departmentforcommunities-sandlocalgovernment/175040EHS_Households_2013-14.pdf

¹⁹ Full details can be found on Gentoo's website: www.gentoo.org.uk

- Home from hospital services: Free short-term support for people on discharge from hospital including: emotional support; shopping; applying for benefits; dealing with correspondence; accessing other services (for example Dial-a-Ride, accessing care and repair services, community alarms, smoke alarms, domiciliary care etc. (Metropolitan, funded by the London Borough of Waltham Forest)
- Health promoting activities eg, the promotion of healthy eating and 'grow your own (Curo, Oldham Housing Improvement Partnership), physical activity, smoking cessation and mental health (Axioma, funded by the Big Lottery, Walsall Housing Group working with the local authority)
- Social prescribing to address non-medical needs that are known to have an impact on health and wellbeing (South Yorkshire Housing Association, working with the Doncaster CVS; Porchlight working with partners in the Kent Primary Care Community Link Service, Kent CCGs and Kent County Council)
- Services intended to tackle health inequalities eg, an integrated health, social care and housing model for homeless people who have been discharged from hospital (Horton Housing Association, in partnership with Bevan Healthcare, funded by Bradford City CCG and the local authority²⁰)

The role of social landlords in health and wellbeing has been recognised by the government. The National Housing Federation, representing housing associations in England who own and manage more than 90% of the country's housing association properties, is one of 22 Strategic Partners working with the Department of Health (DH), NHS England and Public Health England (PHE). Through the Health and Care Strategic Partner Programme the Federation has generated a number of resources intended to support social landlords in working with health and care partners locally²¹. Many more examples of social landlords' health and wellbeing practice can be found on the Federation's website²².

Investment in community activities to achieve other outcomes has been shown to have health benefits. Building on the knowledge that housing associations invest considerably in communities HACT, working with the social landlord Affinity Sutton and employing expertise in social value and wellbeing, sought to understand the impact of seven outcomes from community investment that were felt likely to impact positively on health and wellbeing²³. These were: full time employment; relief from being heavily burdened with debt; feeling in control of life; access to internet; understanding society; worried about crime; talking to neighbours regularly. The research found that all of these outcomes have a significant impact on health.

Finally, two of the social landlords participating in the study provided examples of services they have developed to improve the health and wellbeing of their tenants.

Bromford "Enriching Lives"

- Bromford recognised that 40% of their customers are 'older' (60+) and 84% of those live in general needs housing.
- A reduction in local government spending on services intended to enable older people to sustain their accommodation was the catalyst for Bromford developing and delivering a new service model, funded through rent and service charges.
- Two members of staff deliver support to customers over 50 where it is identified they need to improve their financial circumstances, and a programme of activities is provided to enable people to keep active and involved, nurture relationships and friendships.
- The service was piloted initially, and launched as the Enriching Lives Programme in February 2015.
- The impact of the service will be formally evaluated in November 2015 including a customer wellbeing survey.

Family Mosaic Health Begins at Home Pilot

- Customer research in 2012 identified that 71% of customers aged over 50 had one or more long-term health conditions, with the most common being chronic back pain, arthritis and diabetes.
- Two new service models were designed to improve the health and wellbeing of these customers and subsequently reduce costs to the NHS.
 - A signposting intervention provided by in house general needs Neighbourhood Managers
 - A specialist health and wellbeing service, which brought together qualified nurses, mental health specialists, health trainers and support workers to deliver an intensive handholding support to customers.
- For those receiving support from the health and wellbeing team, these assessments formed the basis of a personalised support plan. A range of interventions were provided through the service, including: welfare

²⁰ <http://www.hortonhousing.co.uk>

²¹ Strategic partnership programme <http://www.voluntarysectorhealthcare.org.uk/strategic-partnership-programme/>

²² National Housing Federation health and housing resources <http://www.housing.org.uk/topics/health-care-and-housing/health-hub/housings-offer-to-health/>

²³ <http://www.hact.org.uk/sites/default/files/uploads/Archives/2015/6/HACT%20Investment%20Activities%20report%202015.pdf>

benefits advice, aids and adaptations, encouragement to participate in community activities, IT training, weight management courses, awareness of falls prevention at home and support to attend health appointments.

- Starting in 2012, a self-funded randomised control trial was run to test the effectiveness of these interventions. 532 participants were recruited to the study, and followed over a period of 18 months. Each participant went through a health assessment at the beginning and end of the study.
- In partnership with the London School of Economics, Family Mosaic is evaluating the impact of this new service. Their final report is due end of 2015. The analysis is showing some positive impacts and Family Mosaic is exploring how they can develop the service in light of the findings and lessons learnt.

4.2.2 The sector supports its workforce to develop in response to customer needs

In 2014 the Chartered Institute of Housing commissioned a major study to examine the challenges that housing organisations are facing, how frontline services are adapting to meet new demands and the impact of this on the role of the frontline housing worker²⁴.

This study identified the top external drivers of change. Welfare reform, lack of housing supply and the increasing gap between income and housing costs, and withdrawal of other public services were critical – tenants were reported by frontline workers to have more complex and multiple needs, and to be increasingly in crisis. The ageing population was also identified as a driver. The study found that many organisations were reviewing the frontline housing role, and supporting the workforce to develop. Examples of this included:

- ‘Channel shifting’ and enabling self-help. Most organisations were changing the ways in which customers interact with the organisation, with many establishing self-help routes for information and transactions filtered through customer contact centres or via the organisation’s website. Training staff to enable tenants and customers to help themselves rather than solving the problem for them was also a solution
- Reorganising services to enable the workforce to focus on building relationships with customers, for example in order to deal with more complex problems, or to better understand neighbourhoods and communities in order to sustain tenancies within these
- Operating a Psychologically Informed Environment (PIE²⁵), training staff to have difficult conversations with people who are often challenging and providing staff with the support of a psychologist and mental health trust
- Enabling the workforce to operate in local multi-disciplinary teams alongside other professionals including health, the police, education etc,

Going forward the study identified that partnership working with health and care sectors would be particularly important to the housing sector and its workforce.

One such area where the housing workforce has developed ahead of other frontline services is dementia. The Alzheimer’s Society has acknowledged that the housing sector is ahead of both health and social care sectors in identifying the training needs of staff working in all housing settings with people with dementia, their families and carers. As an example, in 2013 Heantun HA in Wolverhampton, Racing Homes HA in Newmarket, Waltham Forest HA, Innisfree HA and Sutton Housing Society in London made a commitment towards becoming “dementia friendly organisations” and trained the workforce so they could better support customers. The Quality of Life Charitable Trust published an interim evaluation in 2014²⁶, stating that:

“Housing provider staff ...benefited from the training on dementia awareness and the opportunities this brought them to support tenants and service users (and their own relatives) better. Most importantly staff are committed and enthusiastic about taking the work further.”

Examples of workforce development from two of the social landlords participating in this study are:

- **Bromford** is developing bereavement training so that staff can help customers with their loss, and is also seeking to understand what would be needed for the organisation and staff to offer support for people at the end of their lives.
- **Southdown** has been commissioned by East Sussex County Council to deliver a housing-related support service to reduce health inequalities and support people to lead healthier lifestyles. The contract specified the provision of Making Every Contact Count (MECC) training for Southdown staff. Following this training the organisation has identified that staff feel much more able to discuss and tackle more difficult and challenging topics of obesity, healthy diets and substance misuse. Plans are in place to train all staff in Identification and Brief Advice (IBA) skills, to help staff become alcohol aware and develop the skills to have simple conversation about much people are drinking.

²⁴ Richardson, J, Barker, L, Furness, J, Simpson, M (2014) Frontline Futures: New era, changing role for housing officers, CIH

²⁵ For more information about psychologically informed environments (PIE) <http://pielink.ning.com/>

²⁶ Quality of Life Report Research Programme 2013: October 2014: quality-trust.org.uk

4.3 What does the qualitative research suggest the workforce is able to contribute to improved health and wellbeing?

4.3.1 What is currently understood about the health needs of tenants?

80% of respondents to Sitra's member and associate survey reported collecting data about the health needs of their customers, primarily through information provided on referral to their organisation and through customer profiling. This information is used in service planning and performance monitoring/reporting.

Despite the relatively high collection of health information just over 30% of respondents reported seeking to understand what impact health related support provided by staff had on their customers' health.

Surveys of customers and staff of the three social landlords participating in this study suggest that frontline workers are able to identify the health needs of their tenants. Almost three quarters of frontline workers identified over 50% of their customers affected by a public health priority issue²⁷. 72.9% of customers reported that they, or a member of their family, had experienced or been affected by a public health priority issue. Smoking and mental ill health were reported by 38% and 35% of customers respectively. 17% reported harmful drinking as an issue, and 13% reported obesity.

4.3.2 What do customers think about the role of the housing workforce in improving health and wellbeing?

Many customers are already receiving some form of health and wellbeing intervention from their housing officer, and welcome this:

- 84.1% of customers reported being happy to speak to their housing officer about health issues
- 71.4% said health and wellbeing issues came up either occasionally or frequently when they met with their housing officer
- 54.8% stated that their landlord had done something that had particularly improved their health: advice and support, and signposting to relevant services were the main interventions received
- One third of customers reported that housing officers were one of the main sources of health and wellbeing information, alongside GP practice nurses and friends and family
- When asked what the best ways to support their health and wellbeing would be, the most popular choice was for wellbeing support and advice from their housing officer (53%).

It is worth noting that provision of suitable accommodation alone was recognised by some customers as significant to improving their health and wellbeing (just over 20% noted this).

Almost half of the customers who would not want to speak to their housing officer cited that their health had nothing to do with their landlord. Other cited reasons were that the customer would be too embarrassed (23%), and that the officer would not have the required health knowledge (17%). Trust, confidentiality and workforce competency were also identified as concerns – these are explored in more detail in this report.

4.3.3 What do staff think about the role of the housing workforce in improving health and wellbeing?

Although it is evident that the housing workforce already plays a role in improving health and wellbeing of customers, there is a difference in opinion as to what this role should be:

- From the three social landlord organisations, many frontline staff reported that health and wellbeing issues frequently arise when they meet with customers, a view shared by their managers and their customers. 98% reported taking some action on health and wellbeing issues presented by their customers.
- Almost all respondents to the Sitra member and associate survey thought that health promotion and health support (93.9% and 88.5% respectively) are part of their organisation's role. However, 44.2% felt that health support should not be part of the frontline officers' role. This was not a consequence of resistance from staff – only 4.6% of respondents suggested this had been a barrier in previous work to improve the health of customers

²⁷ Public health priorities were drawn from PHE's 'From Evidence Into Action' and other locally identified priorities

The capacity of the workforce to deliver their core function is the primary reason cited by those who feel that delivering health and wellbeing interventions should not be part of the frontline role. Respondents clearly feel there is a difference between health promotion – something that can be done through the provision of information via leaflets for example - and health support. The implication of the latter is that officers are responding to the specific needs of their customer and taking a more active role e.g., referring to appropriate services.

- 2% surveyed frontline workers who reported not taking any health action cited lack of capacity
- Frontline workers with higher case loads were more likely to state they “did not think supporting customers with health and wellbeing issues should be part of their job”
- 91% of managers reported that additional resources would be required to enable their organisation to routinely provide support to help their customers improve their health and wellbeing
- Respondents to the Sitra member and Association survey cited lack of resources as the main barrier

One manager stated in their survey response that “while I feel it is important for staff to be aware of health issues and what is available locally, it should be remembered that they are not health professionals and there are other aspects to their role that need to be fulfilled on a daily basis”.

It is interesting to note that 45% of managers surveyed in the three social landlords felt that resistance from customers would be a barrier to delivering health messages going forward, yet only 16% of customers reported that they wouldn't be happy to talk to their officer about these matters.

4.3.4 How confident and capable is the workforce?

Social landlords have already taken some steps to develop their workforce to respond to particular health and wellbeing needs. 91.5% of social landlords responding to Sitra's member survey reported training their front line workers to deliver health messages. Almost one quarter of frontline staff in the three social landlords reported being confident to deliver health messages and did not require further training.

It is notable that the majority of landlords reported training staff in mental health issues (including anxiety and depression), and that for one third of landlords this training had been extended to their maintenance contractors (staff in this role will enter the customer's home to complete repairs).

The extent of training and awareness in other areas varies slightly between different types of organisations:

- Around three quarters of social landlords providing 'general needs' accommodation cited that workers were aware of the importance of improving physical health, improving health outcomes of older people and substance misuse.
- Social landlords providing supported housing reported higher levels of awareness in the same areas as for general needs, and also suggested that staff were aware of the importance of early diagnosis of long term conditions.
- Understandably, social landlords providing sheltered housing for older people reported that staff were familiar with improving health outcomes for older people, improving physical health, and the importance of early diagnosis of long term conditions.

Although most frontline staff and managers reported being aware of all, or some of, the national public health priorities, the extent to which training in these areas had been provided by social landlords varied. In order of the priority that social landlords have ascribed, training has been provided in:

- Substance misuse
- Dementia
- Obesity
- Smoking

Staff confidence in discussing health issues was perceived to be higher for officers working in a housing support or sheltered housing role, than for those providing a 'general needs' role, and significantly lower for general needs housing officers, ancillary staff and contractors.

4.3.5 What skills and knowledge does the housing workforce need?

In addition to maintaining confidentiality, the most important workforce attributes for customers were identified as (in order of priority): knowledge of, and a good working relationship with, relevant local services; ability to identify 'warning signs'; knowledge of their health issue; knowledge of the steps that could help improve (or prevent deterioration of) their health; ability to communicate sensitively about these personal issues. Managers and frontline workers from the three social landlords broadly agreed with the on the attributes, and these largely reflected the priority assigned by customers.

The survey of staff in the three social landlords identified different levels of awareness of relevant local services. All but one member of staff reported being aware of mental health services, and a significant majority reported awareness of services in relation to harmful drinking, child wellbeing and smoking cessation. At the opposite end of the spectrum only 24.8% of frontline staff reported being aware of TB services, but 45% managers expected frontline staff to have this knowledge. A difference of opinion was also reported for dementia: frontline staff reported a lower level of knowledge of local services than managers expected.

4.3.6 What will support the workforce to develop?

Frontline staff and managers from the three social landlords identified the action their organisations could take to increase their confidence in discussing health issues with their customers.

Given the importance assigned by customers and staff to knowledge of local services it is unsurprising that building relationships with these services was the top priority for frontline staff (65%), closely followed by making a 'library' of resources and information about local services available (50%). Managers identified joint working with local services as their second priority (81%) (their top priority was resources).

Almost 60% of frontline staff and managers suggested that training to improve technical knowledge of health issues would be beneficial.

The importance of these two aspects was highlighted during the development of the learning resources. In response to feedback from participants these resources were revised to have greater emphasis on local health and social bodies, and on the health issues that housing workers are likely to come across e.g. mental health (anxiety and depression), hoarding and dementia.



SECTION 6

Learning resources and training

In response to the findings of the study, and as a means to 'test' these, learning resources were developed to support social landlords and other housing organisations to develop their workforce. These were tested through five training sessions with five different organisations,

To begin with housing workforce competencies were developed (appendix 2). These describe the technical knowledge, skills and behavioural competencies necessary for the housing workforce to successfully contribute to public health outcomes. These were developed in consultation with customers, frontline staff and managers from the three social landlords, and a 'pilot' landlord, and incorporating feedback from the Skills for Care 'Housing and Workforce' Reference Group.

The competencies are broadly consistent with the Chartered Institute of Housing's Code of Personal and Professional Conduct²⁸ but include additional knowledge and skills that are not a general requirement in the social landlord. The behavioural competencies also have much in common with other, existing National Occupational Standards in the health and social care sector. In future it would be appropriate to map the competencies developed in this study against these standards to ensure consistency and avoid duplication.

Secondly, a one-day training course was developed to enable staff at all levels to deliver public health messages and to nudge people towards healthier behaviours. This was piloted with staff and customers from the three social landlords, followed by staff and customers from two landlords who had no previous involvement with this study. In response to feedback from the surveys and focus groups the training was developed to provide:

- A general overview of health and wellbeing
- An understanding of health and social care bodies, and knowledge of the role of other agencies
- An understanding of the relationship between health and housing
- An awareness of health issues: what to look for, what could prevent deterioration
- Skills to communicate health messages sensitively to nudge behaviours

Participants rated the effectiveness of training and training was refined each time. In addition to placing more emphasis on local partners and the health issues frontline workers would typically come across, the training was revised to provide greater emphasis on poor housing conditions and health impact. This is of interest: there is an assumption that housing workers understand the connection between the home environment, health and wellbeing but those participating in the training, including maintenance workers and other technical staff, reported that this was very beneficial.

Other learning from the training that informed the resources, and will be of interest to those thinking about using these in their own organisation:

- The organisation's attitude to health and wellbeing is felt likely to impact on the responsiveness of staff to training. However, even within an organisation that is committed to health and wellbeing, staff do not always agree that this is part of their role
- Improving health and wellbeing is a means to supporting tenants to sustain their tenancies. This knowledge is beneficial to staff (and the wider organisation) when they are considering what their role should be in this area
- The resources are relevant to staff in different roles
 - Most participants from the three social landlords were skilled in providing housing support and already had a reasonable level of knowledge and skills in relation to health, including how to 'nudge' behaviours. These staff still reported that the training had been of benefit to them
 - Resources were tested with frontline maintenance and customer care staff and their managers and felt 'fit for purpose'.
 - Managers were also able to identify additional training needs and areas for improvement in internal processes to support staff
 - Staff come into contact with a customer on an infrequent basis eg, repairs and maintenance, may still be in a position to use that contact to improve health and wellbeing, provided they are trained to communicate information appropriately

²⁸ CIH code of conduct 2015 <http://www.cih.org/resources/PDF/Marketing%20PDFs/Code%20of%20conduct%202015.pdf>

- Training helped staff to:
 - Think through the parameters of their role: what they are responsible for/ what they're not; what they can signpost people to; who they should speak to next and hand over cases to etc,
 - Learn more about the role of others in their organisation (where training is mixed)
 - Identify further training needs eg, learning about relevant legislation for example the Care Act 2014, and about local services
- Different staff roles require different levels of awareness and skills, and have different levels of capacity to attend training; the training resources were developed to respond to this (there is one standard introductory session and four key modules).
- Induction, and training sessions with contractors, have been identified as opportunities to make use of the learning resources
- Customer involvement in the training was felt by staff to be very valuable, particularly to develop understanding of the most effective ways to deliver health messages. The training was designed to be delivered with customer involvement.
- Staff reported that the training had encouraged them to examine their own lifestyle choices

The training resources comprise:

Full Course Outline: for Trainers who are delivering the training; detailed training notes, training outcomes and housing workforce competencies

Full Course Pack: including training agenda/timescales, handouts, exercises and suggested further reading

PowerPoint presentations with trainer notes on:

Introduction to Health and Housing – provides participants with a historical context for social housing and links to improving the health and wellbeing of tenants.

Module 1: Public Health Priorities and the Local Health and Wellbeing Landscape:

Provides the health and social care landscape the housing workforce operate alongside: Gives an overview of the public health landscape including national health priorities and key local bodies responsible for health and social care services. Provides knowledge to support service delivery and multi-agency co-operation.

Module 2: Health Issues:

Six brief presentations to introduce staff to the basic facts about some of the most common health issues your tenants and customers are likely to be exposed to. Makes the link between the condition and potential impact on housing.

Module 3: Communicating Health Messages:

Introduction for front line staff on how to approach discussion of health matters with customers.

Module 4: Impact of Poor Housing Conditions on Health:

A module specifically identifying the health impacts of poor housing conditions

Going forward a formal evaluation of the effectiveness of the training in improving health amongst customers and staff would be appropriate.

Appendix One

Methodology

This section describes the mixed methodology used to complete the study and develop competencies and training.

In summary it included:

- An internet search to understand the current state of play on the impact the housing sector is making on their customer's health and wellbeing, followed by
- Qualitative research with staff and customers on the impact of their housing services on customer's health and wellbeing and how the sector could be developed further to make a bigger impact and difference to people's lives
- Finally, the development of training resources and a set of skills and competencies to help make this a reality.

Stage 1 Dec/Jan 2015: Research into existing practice

Mixed methods were used:

- Researchers' drew on their existing knowledge of the sector, services and initiatives, and drew on existing contacts within the sector
- Existing knowledge was supplemented with an internet search and follow-up telephone calls with organisations to gather more specific information

The following criteria was used to undertake this research:

- Examples that were felt by organisations to demonstrate their commitment to health and wellbeing and/or that their workforce was competent and/or committed to health improvement
- Exploring services that are part of the 'housing offer' over and above the provision of housing e.g. employment opportunities, financial advice etc.
- Short term, jointly funded projects with the aim of improving specific aspects of health and wellbeing
- How organisations work together to deliver projects
- Impact of both small, medium and large organisations, in different geographical locations to show the diversity of the housing sector and what it can offer

Information on commissioned housing support services was not collated: there is already a wealth of research into the benefits of these types of services on health and wellbeing, and the health economy.

This stage of the research was not intended to be an audit of provision [this is currently underway by the National Housing Federation].

Stage 2 February 2015: Developing the competencies required to deliver health messages

A review of a range of job descriptions/person specifications from across the housing and care sector was completed.

An initial draft was established and discussed in workshops undertaken in Stage 3 of the study. Further refinements were made and a final consultation took place at the Skills for Care Housing and Workforce Reference Group in June 2015.

Stage 3 March – June 2015: Consultation with the housing workforce and customers

Surveys, staff and customer focus groups were undertaken with three social landlords, selected primarily for their willingness and ability to participate in the study because their organisation was already committed to improving health and wellbeing. Each organisation was provided with a small bursary to participate in the study.

In addition the partners were chosen because they provided:

- Housing support services
- General needs housing (non supported)
- They covered three geographical locations around the country
- They had the resources to deliver on this project at relatively short notice, necessary to ensure a good level of engagement and delivery of outcomes

The above criteria restricted selection to medium to large providers, however we did focus on both small, medium sized and larger organisations within Stage 1 of our survey and found many examples of how smaller organisation on their own or working together can positively impact on the health of their customers.

Partner social landlords

Bromford is a large locally based provider located in Wolverhampton. It provides a mix of housing, including general needs and housing with support. Over the past two years Bromford has developed a number of health and wellbeing pilots and services, including developing social capital to combat health inequality and delivering complex case management for individuals with chronic long term conditions. The organisation has been working closely with health commissioners across Clinical Commissioning Groups (CCG) and Public Health, to tailor some of their existing services and create new ones to help alleviate the demand on NHS services, whilst building thriving and resilient neighbourhoods.

Family Mosaic is a large London and Essex based provider, providing both general needs housing and housing with support. In 2012 Family Mosaic launched a manifesto for change through housing called 'Health, Wealth and Wellbeing'. This included commitment to:

- Invest in care and support services
- Help people into employment
- Save the NHS £3 million every year.

The organisation has led and facilitated a range of activities to improve customers' wellbeing. Examples include investing over £2million in community projects, creating a range of opportunities for people to get involved in their local communities including, through gardening projects, and health, wealth and wellbeing.

Southdown (a medium-sized provider based in Sussex) operates a short-term floating housing support service for working age adults in East Sussex. East Sussex County Council commissioned the service identifying supporting people to better manage their physical health and emotional wellbeing is a core part of the services aims. The provider and commissioner work together on how the service can reduce health inequalities and support people to lead healthier lifestyles.

Surveys: Exploring the Impact of provider activity on people's health and wellbeing.

Two surveys were implemented to explore the views and experience of customers, frontline staff and managers in relation to health and wellbeing activities.

The first survey was completed by staff and customers in the three partner associations.

The second survey was a wider poll of Sitra's member and associate networks seeking further input regarding services and workforce development currently offered, and challenges the housing workforce might face in supporting the delivery of key public health outcomes. The surveys were completed by 374 customers and 376 housing association staff (including frontline staff and managers).

This information provided us with qualitative data on the impact of the housing workforce in relation to health outcomes and the challenges and barriers to delivering health messages. These have helped inform the content of the training resources (Stage 4) and refinement of the housing competencies (Stage 2).

Focus Groups: Exploring the potential for the housing workforce to deliver health interventions

The surveys were followed up with six local focus groups for customers and front line staff of the three social landlords (three groups for customers, three for staff). The following questions were asked:

- What was working well?
- Were customers happy for non-support staff to explore questions about health with them?
- What were the key competencies staff required from the customer's perspective?
- What should training focus on?

This helped focus on specific areas when developing the training resources (Stage 4) and further refine the draft competencies required for the housing workforce to be effective in this area (Stage 2). Focus Group outcomes are included in Appendix X.

Surveys and focus groups sought feedback in particular on opinions and capacity to address Public Health England's seven main health priorities²⁹:

1. Tackling obesity
2. Reducing smoking
3. Reducing harmful drinking
4. Ensuring every child has the best start in life
5. Reducing dementia risk
6. Tackling antimicrobial resistance
7. Reducing tuberculosis

Stage 4 June 2015: Developing the training resources "Delivering public health messages for tenancy sustainment".

Staff and customer's views from stage 3 informed a one day training course to enable staff at all levels to deliver public health messages to nudge people in to healthier behaviours.

The training was delivered to:

1. Frontline staff, managers and customers from the three partner social landlords: in total 27 staff, and two customers attended these sessions.
2. Staff and customers who had not been engaged in the survey work or focus groups: Cambridge Housing Society (seven staff mainly from supported housing or sheltered housing roles, one customer and one commissioner attended); Home Group (15 front line maintenance and customer service staff and two managers)

Efforts were made to encourage staff in different roles to attend the training. In practice most staff had a housing support role and thus health knowledge and skills to nudge healthy behaviours. However, the small number of technical (two) and general needs housing staff (five) and customers (three) made extremely valuable contributions, which have been taken into consideration. The housing support staff provided a valuable contribution towards the format, design and feedback on the resources used.

Participants were asked to rate the effectiveness of each session using the same evaluation forms for each training day:

- To rate between 0- 5 as to whether the session achieved its learning aims
- To rate between 0- 5 as to how interesting and engaging were the resources used
- To comment on what could have been done differently to improve the session

From feedback the training was refined after every session but by the end of the fourth training day the fundamental changes made were as follows:

- Greater emphasis on local health and social bodies (greater relevance for front line staff) with an interactive quiz to assess knowledge gained
- Greater emphasis on poor housing conditions and health impacts – by providing scenarios and interesting workshop sessions to further embed knowledge learnt.
- Greater focus on the health issues that housing workers are likely to come across e.g. mental health (anxiety and depression) and hoarding, dementia.

²⁹ PHE (2015) From evidence into action https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

Appendix Two

Housing workforce competencies delivering health messages

Knowledge and Skills

1. Basic knowledge of priority health issues and their potential impact on the whole household:
 - Tackling obesity
 - Smoking cessation
 - Reducing harmful drinking
 - Giving every child the best start in life
 - Reducing dementia risk
 - Reducing Tuberculosis (TB)
 - Anxiety & depression
 - Preventing accidents at home
 - Promoting active lifestyles
2. Knowledge of the underlying reasons for poor health including the links between health and social deprivation, poverty and ill health.
3. Knowledge of the potential impact of poor housing conditions on health. (eg: damp and asthma)
4. Knowledge of available statutory services, eligibility criteria and how customers can access these.
5. Knowledge of non-statutory health and support services, eligibility criteria and how customers can access.(e.g. aids and adaptations, benefits advice, telecare, community and third sector services)
6. Knowledge of the legal responsibilities of the role including: Safeguarding, disability discrimination, diversity and data protection.
7. Understanding and sensitivity to the cultural needs and expectations of different groups (race, religion, ethnicity, language, gender, age and sexuality).
8. Knowledge of physical and sensory disabilities and how these impact on health and housing environment.
9. Knowledge of the welfare benefits system
10. Knowledge of health and safety at home for different client groups
11. Knowledge and understanding of appropriate professional and personal boundaries.

Behavioural Competencies

| | |
|-----------------------------|--|
| Observational Skills | Being alert to and aware of signs of potential health problems, including those affected by poor housing conditions. |
| Risk Management | Using observational skills, being able to assess potential risks to health within customers' homes and the surrounding environment. |
| Positive Approach | The ability to take responsibility for providing an excellent, responsive service and to look for opportunities for continuous improvement |
| Motivating Others | The ability to enable others to progress through providing support and opportunities for involvement and personal development. |
| Analytical Thinking | The ability to give proper consideration to problems and to come up with effective solutions. |
| Engaging People | The ability to treat every customer and colleague as an individual and to develop productive relationships with them |
| Listening | The ability to listen to customers with an open, objective mind and without making value judgments. |
| Adaptability | The ability to adjusting verbal and non-verbal communication to reflect different audiences, taking into account cultural, and religious differences |
| Partnership Working | The ability to work cooperatively and supportively with relevant health and wellbeing agencies. |
| Solution Focused | The ability to research resources and identify options to enable customers to improve their health and wellbeing. |
| Reliable | The ability to deliver on commitments made. |
| Personal Boundaries | The ability to deliver an accessible and objective service without becoming personally involved in cases |
| Confidence | The ability to face situations and challenges with customers and colleagues with confidence |

Sitra

Sitra is the leading charity in the housing, care and support sector providing training, consultancy and advice with a membership of over 400 practitioners.

We have 30 years' experience of providing technical support to providers and commissioners. This includes training and consultancy on Supporting People and the QAF, needs identification, care practice, housing management and development, together with associated activities such as personnel and staffing and financial management. The current focus on welfare reform, personalisation of services, co-production and outcomes focused support also forms the context of much of our current work.

Sitra has recently incorporated the Health and Social Care Partnership (HSCP) within its wider portfolio. A key element of HSCP's work is the integration of health and social care and this furthers Sitra's wider agenda of integration of health, social care, housing and public health.

We carry out work both on a policy level and in providing specific support for individual organisations. We are a leading training provider, running both public programme and tailored in-house courses for clients around the country. We provide a range of seminars and conferences on housing with support and care themes.

Sitra is recognised and consulted by Government departments and other bodies, including the Department for Communities and Local Government (DCLG), the Department for Work and Pensions (DWP) and the Homes and Communities Agency (HCA), as representatives of providers of supported housing. The incorporation of HSCP brings with it a close relationship with Department of Health (DH).

The linking of our policy and representative role with our detailed work providing support to the sector makes for a strong combination. Our work on good practice and policy & procedural development draws on the strength of our large membership base and on our role in discussing and developing policy at a national level.


We are a non-profit organisation, established by supported housing providers in order to offer cost-effective technical support and representation. As such, we aim to offer a quality service at a lower charging rate than that levied by commercial consultancies which choose to build a profit element into their charges.

Our members keep in touch through the regular Sitra Bulletin which is widely recognised as a key source of technical information and policy development news throughout the housing with care, support & health sector. You can also keep in touch via our Facebook and Twitter pages

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