OXFORD UNIVERSITY PRESS | Journal of Public Health

http://mc.manuscriptcentral.com/jph

Taking preventative health messages into the wider caring professions: the views of housing staff and tenants.

Journal:	*Journal of Public Health*
Manuscript ID	JPH-18-0118.R1
Manuscript Type:	Original Article
Date Submitted by the Author:	n/a
Complete List of Authors:	Blank, Lindsay; University of Sheffield, School of Health and Related Research Holding, Eleanor; University of Sheffield, School of Health and Related Research Crowder, Mary; University of Sheffield, School of Health and Related Research Butterworth, Sally; Sheffield City Council Ferrari, Ed; Sheffield Hallam University Centre for Regional Economic and Social Research Goyder, Elizabeth; University of Sheffield, School of Health and Related Research
Keywords:	Communities, Housing, Social housing

Taking preventative health messages into the wider caring professions: the views of housing staff and tenants.

Authors:

Blank, Lindsay

l.blank@sheffield.ac.uk

University of Sheffield - School of Health and Related Research

Sheffield

United Kingdom of Great Britain and Northern Ireland

Holding, Eleanor

e.holding@sheffield.ac.uk

University of Sheffield Ringgold standard institution - School of Health and Related Research

30 Regent St Regent Court , Sheffield S1 4DA

United Kingdom of Great Britain and Northern Ireland

Crowder, Mary

m.crowder@sheffield.ac.uk

University of Sheffield - School of Health and Related Research

Sheffield

United Kingdom of Great Britain and Northern Ireland

Butterworth, Sally

sally.butterworth@sheffield.gov.uk

Sheffield City Council

Sheffield

United Kingdom of Great Britain and Northern Ireland

Ferrari, Ed

E.Ferrari@shu.ac.uk

Sheffield Hallam University Centre for Regional Economic and Social Research Ringgold standard institution

Sheffield, Sheffield

United Kingdom of Great Britain and Northern Ireland

Goyder, Elizabeth

e.goyder@sheffield.ac.uk

University of Sheffield - School of Health and Related Research

Sheffield

United Kingdom of Great Britain and Northern Ireland

ABSTRACT

Background: In order to harness the potential impact of the wider public health workforce, innovative services are providing opportunities for social housing staff to extend their public health role. This study explored the views of housing professionals and social housing residents on the delivery of preventative health messages by housing staff in the context of the evaluation of the roll-out of a new service.

Methods: We conducted semi structured interviews with 21 neighbourhood housing officers, 4 managers and 30 social housing tenants to understand their views on the widening role and the potential impact on the preventative health care messages being delivered.

Results: Neighbourhood officers were willing to discuss existing health conditions with tenants; but they often did not feel comfortable discussing their lifestyle choices. Most tenants also reported that they would feel discussions around lifestyle behaviours to be intrusive and outside the remit of housing staff.

Conclusions: Resistance to discussions of lifestyle topics during home visits was found among both housing staff and tenants. Appropriate staff training and the development of strong and trusting relationships between officers and tenants is needed, if similar programmes to extend the role of housing staff are to succeed in terms of health impact.

BACKGROUND:

Lifestyle factors such as lack of exercise and poor diet, along with smoking, drinking and other substance misuse have a significant impact on population health in terms of risk for heart disease, cancer and diabetes[1]. The link between housing, health and inequality has been well documented both in terms of the impact of poor housing conditions on physical and mental health[2,3] and the links between living in social housing and poverty[4,5].

Recent cuts to public spending have resulted in the need for strengthened integration of health and social care and a movement towards holistic, preventative support[6]. The increased cost of healthcare provision, alongside a progressively aging population and the rising prevalence of chronic conditions has led to unprecedented pressures on community and health services[7].

In light of these pressures, a move towards community centred approaches to prevention and support is advocated to ensure service sustainability[8]. Housing support, defined here as support 'to enable someone to manage on a day-to-day basis while living in their own home[9],' lies at the interface between health and social care. Consequently, the potential of housing services as a platform for a reorientation from acute care to preventative support has come under increasing attention[8]. This has led many housing providers to review their operational structures in order to manage costs more effectively whilst focusing on more holistic support for tenants[10].

One relatively inexpensive option is the incorporation of health and wellbeing discussions into everyday practice. Interventions such as "Making Every Contact Count" (MECC) aim to promote the use of everyday conversations with patients to instil behaviour change[11]. Some housing providers have adopted 'Housing Plus'[12] activities as a means of realising this potential; the aim being to mitigate the economic and social issues faced by tenants[13]. Although the composition of 'Housing Plus' activities varies by organisation, anecdotal evidence suggests activities often involve increasing community resilience and preventative measures to ensure tenancy sustainability.

Council housing services in Sheffield (a large city in the North of England) have recently adopted a city wide 'Housing+' programme after initial piloting in the South East of the City. The service involves a Neighbourhood Officer undertaking an annual home visit with a geographically based caseload of between 180-330 households. Housing+ neighbourhood officers take a holistic, preventative approach by dealing with low level issues directly; signposting people to resources within the local community, and refer to other services for more help as required. Alongside discussions of other sensitive topics (such as their financial position), Housing+ officers are encouraged to ask tenants about their health status and life style behaviours as part of their new role. Overall the intervention could be expected to impact on a range of public health outcomes. These would include preventive interventions; referrals to community, health and social care services; and reducing health inequalities.

While it has been recognised that the housing workforce is in a good position to improve the health and wellbeing of their customers through the use of interventions such as MECC, further work is needed to explore this potential role extension[14]. The aim of this research was to understand the views of housing staff and tenants on the widening role and, from a public health perspective, the potential impact of this on how successfully preventative health care messages are delivered.

METHODS:

Setting: The city of Sheffield, northern England.

Sample and data collection: As part of a larger evaluation project, we completed "face to face" semi structured interviews with 25 "neighbourhood officers" from junior staff to managers, all conducted at their place of work. Thirty "face to face" interviews with council housing tenants were completed in their homes. Interviews were conducted by three experience researchers (LB, EH and MC). Due to the potential risk to safety in entering tenant's homes, two researches attended each tenant interview.

Interview guides were initially developed by considering the main aims of Housing+ and further refined in workshops with tenants and housing staff, as well as with the project advisory group. Participants were asked about their knowledge of, views on, and experience with the Housing+ intervention. They were also asked about their views on the potential for the Housing+ intervention to impact on the health and wellbeing of the tenant population.

A sampling framework for the survey was developed by matching neighbourhood officer "patches" across the city in terms of population age, ethnicity, and property type. To select patches for the telephone survey we matched 12 patches in the Housing+ pilot area to 12 patches in the control areas (the rest of the city). We defined the patches according to whether they were higher or lower than the median patch value in terms of: property type (percentage of properties which we flats), ethnic diversity, population age, and average council tax band, so there were as similar as possible. One patch from each "type" was selected at random. The neighbourhood officer from each selected patch was invited to interview. The tenant sample was recruited purposively via a telephone survey also being conducted as part of the Housing+ evaluation. Telephone survey participants from selected patches were asked whether they would be willing to take part in a further qualitative interview. All those who consented to take part were re-contacted by the research team.

Analysis: With the participant's consent, interviews were digitally recorded and lasted between 30 and 90 minutes. Interview data were fully transcribed, and thematic analysis was undertaken using Nvivo 11 software to organise the data. Framework analysis was undertaken to scrutinise the data in terms of key themes[15]. Transcripts were analysed by one member of the team and coding was

validated by a second. The final themes were developed through discussion and refinement within the team: including reaching consensus on any coding disagreements.

RESULTS:

Background and context:

The sample of 21 neighbourhood officers and four team managers (14 women and 11 men) ranged in age from 29 to 53 years (with a median age of 41 years). Their work history was varied; the longest serving officer had worked in housing for 28 years, the newest member of staff had less than a year of experience (median work experience was 12 years). The sample of 30 tenants ranged in age from 18 to 96 (with a median age of 51). Length of current tenancy ranged from 9 months to 72 years (median 15 years). Twelve tenants lived alone with the rest living with family members. The majority of tenants were not currently in employment and only six were working full or part time. The tenants were in receipt of a range of state benefits for themselves or on behalf of family members. Almost all the tenants reported health issues in their household; these included a variety physical health conditions and mental health issues.

Changing role of housing staff:

Many of the neighbourhood officers stated that both the new local service under Housing+ and the Housing sector more widely had seen an overall shift towards health and wellbeing or social care. One neighbourhood officer noted that they felt other services such as social workers and community support workers were being deprioritised due to Housing+; referencing issues to do with funding as the driver behind this change. There were also concerns that by focusing more heavily on health and social care the service was losing its focus on the 'bread and butter,' such as maintaining quality housing. The changing role was seen with concern by the tenants who were worried about the implications for their families and their tenancies and felt that there were “more appropriate people” for them to discuss their health concerns with. [Direct quotes given in Box 1]

Willingness to discuss sensitive issues:

Neighbourhood officers were willing to discuss their tenants’ current health conditions/concerns in most cases. They also noted that most tenants were happy to engage in discussion about their health problems with their neighbourhood officer. These discussions were considered to be particularly appropriate when they related to issues with their tenancy. However, topics which neighbourhood officers considered “sensitive” in discussion with their tenants included their lifestyle choices (as well as finances and relationships). Therefore, neighbourhood officers were less comfortable in discussing life style issues (such as weight, exercise, and drinking or smoking behaviours) and messages relating to preventative health with their tenants, than they were in discussing their current health problems. They were also concerned that tenants would feel uncomfortable discussing these issues with a neighbourhood officer, as they were not used to doing so with a non-health professional. The only exceptions to this related to smoking behaviour which was impacting on other tenants, or weight/mobility issues related to the suitability of a tenant’s property.

Tenants often stated they would be 'happy' to discuss health related issues but for many, discussions around lifestyle issues felt intrusive and outside the neighbourhood officer remit. Many tenants said that they would be more comfortable discussing potentially sensitive issues (including their lifestyle choices and financial position) with health care professionals or social workers. It was also acknowledged that it would take time for the neighbourhood officers to build trust within the local community and that the success of the relationship was dependent to some extent on the individual

personality of the neighbourhood officer. Despite reluctance, some tenants stated that the neighbourhood officer would be the 'right' person to deal with their problems if they were appropriately trained. In particular tenants felt that neighbourhood officers could be perceived as telling them how to behave rather than offering support – which may be addressed with appropriate training [Direct quotes given in Box 2]

Barriers to engaging in preventative health discussions:

Most neighbourhood officers expressed positive views on their ability to develop relationships with tenants in the new role. They tried to be supportive and ensure that tenants did not feel pressured into discussing sensitive things with them. Some noted that older people were easier to engage, with younger people being more reluctant. Some neighbourhood officers provided examples of where finding the right approach with a particular tenant had been challenging. Concerns were expressed over having to play "good cop, bad cop" within the role, especially around discussing lifestyle behaviours. Many of the neighbourhood officers felt that raising issues such as weight had the potential to impact on their relationship with their tenant. This was particularly perceived as problematic when initially building a relationship. Whilst some said that this may be a topic they would consider discussing at a later date, others felt that any discussion around weight and other lifestyle issues was beyond their remit. In addition, some neighbourhood officers questioned whether they should be responsible for encouraging their tenants to make lifestyle changes.

Neighbourhood officers also raised concerns about limited referral options available to them and how this may limit their willingness to discuss preventative health with tenants. It was reported that referral options for lifestyle interventions were lacking. There were also capacity issues in terms of whether an agency was able to take their tenant on. Once a tenant was referred it was often difficult to gain information on whether they had used the service and its impact on them. There were mixed views as to whether the tenants would actually take up the referral they were offered. It was also noted that Housing+ meant that more need for support was likely to be identified and that most tenants who were offered supported want it, meaning an even greater strain on overburdened services.

While some tenants acknowledged that smoking may be a concern of the council if it damaged property, most felt strongly that smoking and drinking is a matter of personal choice. This was particularly the case with tenants who stated they were reluctant to change their lifestyle. Some tenants acknowledged that unless they or their peers had the desire to receive help, conversations about lifestyle choices were unlikely to have an impact on their behaviour. For some tenants smoking and alcohol help them deal with stress in their lives. Even though they recognised their behaviour may have health consequences, tenants considered lifestyle behaviours a personal choice and not the business of the council.

Four tenants said that their willingness to discuss issues they considered sensitive with a neighbourhood officer would depend entirely upon their opinion of the individual person. This included whether they found them approachable, if they felt they could trust them, and whether they were able to build a relationship. Building a relationship with their neighbourhood officer was of particular importance to many tenants to avoid being 'passed from pillar to post' across different departments and staff members. Building a relationship would also instil confidence to discuss their issues with that individual, and would be facilitated by having the neighbourhood officer involved from the start of the tenancy. [Direct quotes given in Box 3]

DISCUSSION:

Main findings:

Whilst neighbourhood officers were willing to discuss existing health conditions (including both physical and mental health) with their tenants, particularly where this related to issues with their tenancy, in many cases they did not feel comfortable discussing health related behaviour change with them. They were also concerned that tenants would feel uncomfortable discussing these issues with a neighbourhood officer. The only exceptions to this related to smoking behaviour which was impacting on other tenants, or weight/mobility issues related to the suitability of a tenant's property. Neighbourhood officers felt that initiating conversations about issues sensitive to tenants had the potential to affect the officer/tenant relationship, which in turn was necessary to build trust. The reported barriers to engaging in discussion of preventative health approaches included: the potential impact on their relationship with the tenant; lack of knowledge, training, and therefore confidence in these topics; limited access to referral services; and questions over responsibility for lifestyle changes.

Despite the complexity of health problems faced by some tenants there was also broad reluctance to discuss such issues with a neighbourhood officer on home visits. For many, health and wellbeing discussions would feel intrusive, offensive and outside of the role of a neighbourhood officer. Engaging in lifestyle behaviours represented an act of 'personal choice' outside of the governance of housing management. Despite this reluctance, some tenants were open to sensitive discussions if the neighbourhood officer had appropriate training to deal with the issues likely to be raised. The importance of building a relationship and trust at an individual and community level is central for increased receptiveness to health messages. However, the impact of these messages on behaviour is dependent on individual willingness to change.

What is already known on this topic:

Within social housing there is currently an impetus to broaden roles and to develop staff to become part of the wider public health workforce[14]. There is a growing evidence base on the feasibility and effectiveness of 'MECC' style brief interventions for producing small-scale behaviour change[16,17], and the impact of implementing such interventions on health care staff[18,19]. However, since the recent uptake of these preventative health roles within social housing professions, little research has been done to understand the views of social housing staff on their widening role and the potential impact of this on social housing tenants and the preventative health care messages being delivered.

What this study adds:

This study is the first to qualitatively explore the views of both social housing professionals and tenants on the inclusion of preventative health promotion within their roles. The study indicates combined resistance to the idea of participating in conversations about lifestyle. Therefore issues such as the potential impact on the tenant/officer relationship; lack of knowledge, training, and confidence; limited access to referral services; and questions over responsibility for lifestyle changes are impacting on the effective delivery of preventative health messages by these professionals.

Our interviews suggest that moving conversations about lifestyle outside the realm of the health professional - patient relationship is highly problematic. Talking about health and lifestyle requires that housing staff engage tenants in a discursive strategy designed and mobilised within non-medical institutional processes. This results in resistance to such engagement from tenants who do not see the relevance to a housing role, and are unsure whether neighbourhood officers have the required knowledge to help with these issues.

Limitations of this study:

At the time of interview, some officers were very new to the role, and the intervention was in the process of being rolled out across the city. Therefore some of the opinions given here may have

been affected by stress associated with starting a new job, potentially amplifying some of the concerns expressed. Tenant participants were recruited via a telephone survey by a commercial research company as part of a wider evaluation of the Housing+ programme. This will have excluded those without a telephone or a stable home – tenants who may have disproportionate health and lifestyle issues. Those who were not at home often (for example full time employed) may also have been excluded. The telephone survey did however use interpreters for those whose first language was not English. The excluded groups are important for future research to gain a comprehensive assessment of the feasibility of health interventions targeting the diverse range of social housing tenants. Despite these limitations, this study draws important attention to the likelihood of resistance to health initiatives based on lifestyle discussions with housing staff. We are currently following up the respondents in the second year of the study to explore how opinions have changed as the intervention has been implemented.

Conclusions:

This research shows that there is reluctance among social housing staff (and therefore, potentially, other relevant professional groups) to engage in preventative health discussions as part of their widening job role. This is re-enforced by concerns expressed by tenants. More prior discussion and better understanding of why such conversations are beneficial to tenants may be helpful. Whether this resistance can be reduced through improved communications between housing officers and tenants remains unclear at this stage, an uncertainty underpinned by findings that suggest estate culture is resilient and resistant to outside influences, especially when change is initiated by government agencies[20,21].

Organisations looking to implement Housing+ type interventions should be aware of these concerns and the potential limitations on the effectiveness of delivering preventative health care messages in this way. It may be of benefit to promote community awareness of the widening role of social housing staff, as well as to provide staff with more training and support to deliver preventative health messages. This is likely to require considerable investment in time and resources and must be underpinned by developing trusting relationships between tenants and officers. Another limiting factor is the perceived lack of referral services to support lifestyle change, and this should be addressed in any training given. Closer working between health professions and others engaging in a public health role could help to drive the preventative health agenda forward for all. Further qualitative research in these areas has the potential to explore the scope for expanding the workforce in ways conducive to a holistic approach to public health.

Funding

This work was supported by the National Institute for Health Research (NIHR) School for Public Health Research (SPHR). It was commissioned under the Public Health Practice Evaluation Scheme (PHPES) [IS-SPH-0211-10022].

Acknowledgements

We are grateful to our project advisory group who contributed to the successful completion of this work. We would also like to thanks Viewpoint Research for assisting with recruiting the tenant sample.

References

[1] NHS Digital 2017. http://content.digital.nhs.uk/lifestyles Accessed 19.07.2017

[2] Wilkinson D. Poor housing and ill health: a summary of the research evidence. Edinburgh: Scottish Office Central Research Unit, 1999

[3]Macintyre, S. Ellaway A, Hiscock R, Kearns A, Der G, McKay L. What features of the home and the area might help to explain observed relationships between housing tenure and health? Evidence from the west of Scotland. Health & Place 2003;9(3):207-218

[4] Shaw M. Housing and public health. Annual Review of Public Health 2004;25:397–418

[5] Saugeres, L. The Social Construction of Housing Management Discourse: Objectivity, Rationality and Everyday Practice. Housing, Theory and Society 1999;16(3):93-105

[6] Ham C, Alderwick H. Place-based systems of care: A way forward for the NHS in England. The Kings Fund, 2015. Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-

[7] Roberts A, Marshall L, Charlesworth A. A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22. Research report. Nuffield Trust, 2012. Available at: https://www.nuffieldtrust.org.uk/research/a-decade-of-austerity-the-funding-pressures-facing-thenhs- from-2010-11-to-2021-22. Last accessed: 17/07/2017

[8] Chevin, D. Housing associations and the NHS: new thinking, new partnerships. The Smith Institute, 2014. Available at: http://www.smith-institute.org.uk/wp-ontent/uploads/2015/09/Housingassociations-and-the-NHS.pdf. Last accessed: 10/07/2017

[9] Housing Support. Shelter: the housing and homeless charity. 2015. Available at: http://england.shelter.org.uk/get_advice/housing_with_support/housing_support. Last accessed:10/07/2017

[10] Power A. Provan B. Herdern E. Serle N. The impact of welfare reform on social landlords and tenants. Joseph Rowntree Foundation, 2014. Available at: https://www.jrf.org.uk/report/impact-elfarereform- social-landlords-and-tenants. Last accessed: 12/07/2017

[11] MECC 2017. http://www.makingeverycontactcount.co.uk/ Accessed 19.07.2017

[12]Housing Plus Academy. Trafford Hall. 2017. Available at: http://www.traffordhall.com/housing-plusacademy/

[13] Joseph Rowntree Foundation. Implementing 'Housing Plus' on five housing association estates. 1997. Available at: https://www.jrf.org.uk/report/implementing-housing-plus-five-housing-associationestates. Last accessed: 13/10/2017

[14] Patten K, Scriminger, S, Baxter, S, Leng, G. Public Health: housing workforce holds the key. Sitra; 2015. http://www.sitra.org/documents/public-health-housing-workforce-is-the-key/?preview=true Accessed 19.07.2017

[15] Srivastava A, Thomson B S. Framework Analysis: A Qualitative Methodology for Applied Research Note Policy Research. JOAAG 2009;4(2)

[16] Crawford, R. (2006) Health as a meaningful social practice. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine 2006;10(4):401–420

[17] James A, Hockey, J. Embodying health identities. Palgrave Macmillan, 2007

[18] Lawrence W, Black C, Tinati T et al. Making every contact count: Evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. Journal of Health Psychology 2016; 21(2):138–151

[19] Local Government Association. Making every contact count: Taking every opportunity to improve health and wellbeing. Report; 2014. Available at: https://www.local.gov.uk/sites/default/files/documents/making-every-contact-coun-e23.pdf. Last accessed: 15/07/2017

[20] McKenzie, L. Getting by: Estates, Class and Culture in Austerity Britain. Policy Press, 2015

[21] McKee, K. (2010) Sceptical, Disorderly and Paradoxical Subjects: Problematizing the "Will to Empower" in Social Housing Governance. Social Housing Governance, Housing, Theory and Society 2010;28:1:1-18

Box 1: Changing role of neighbourhood officers

"One thing about Housing+ is that we're being ruled more out of housing and more into social care and I think we're losing the bigger picture on housing a little bit. So there's things now that's not being picked up that were being picked up before due to the fact that we are picking up other stuff and we are looking at other stuff now so we're taking our eye off the ball really". [Officer]

" We have a phrase in housing plus and sometimes we say it's social work on the cheap...And that's how a lot of people see it because that's the way it's moving more from housing into social care and social work"; [Officer]

"I think there are people who are more appropriate than your housing officer. Your housing officer should just talk about council because obviously you're a council tenant and it's their job to make it all flow and make you happy by doing repairs, doing everything around your area... I think you've got your health officer, your doctor and your hospitals, for that." [Tenant]

"….You know, I might be a bit sceptical like but I think these Housing Officers and that like, I think that there are just there for the money, I do really and I know that it is wrong to say...perhaps it's the name Housing Officer that, that gets um like, you know, perhaps, you are now going to get a visit from the Housing Officer, oo what have I done...it makes people worried"[Tenant]

Box 2: Willingness to engage in sensitive discussion

"I will address it if it is complaint. Not many people will complain about somebody smoking cigarettes because normally it's within their own home. I have had blocks where people are smoking in the communal areas and addressed that because it's communal, but if it's within their own home I don't feel like I have the right to say you shouldn't be doing that". [Officer]

"Personally, absolutely not, and do you know what, in all the time I've been doing it, have I ever discussed weight? Once, with a lady, because she was so big. She needed to move for health reasons. Her property was in pretty poor condition, but she'd got her husband and her son, who were perfectly fit and able, to get that house decluttered and clean, to a standard that we'd be able to look at moving her. That's the only person I've ever discussed it with, and actually I was a good healthy weight at the side of her". [Officer]

"If I have a problem, I'll go to them, not them coming to me... I understand if I was living with a family or maybe I can't really speak about a lot of things, but me personally, I can take care of myself and I don't need somebody to know anything about me. I'm more like a private person so I don't really like these things" [Tenant]

"I'll be honest with you. Let's say you were the housing officer, right, and you're coming here to talk to me. If you were a doctor, you'd more than likely have some medical back up or experience to know what my problem is. If you're a housing officer, and I've got a crack in the wall, I wouldn't ask my doctor about that, would I?" [Tenant]

Box 3: Barriers to discussing lifestyle issues

Tenant relationship:

"You're negotiating… Typically, I suppose, a rent professional will say, hello, this is Mr Smith. I need to talk to you about your rent account. I can't do that and I don't know whether they've recognised that we can't do that necessarily as [neighbourhood] officers, because you can't be David one minute, or Dave as the badge says, and then become Mr Smith the next. It doesn't… I don't think you can be as formal as the training would say. [Officer]

Yes, it's how they take it on and what their intentions are etc. It becomes like, if you're in a relationship, then you're together. He'll tell you your problems, you'll tell your problems, and it's a relationship together. If you're talking to somebody in the street, which is what you're talking about, you haven't got a relationship with them, have you" [Tenant]

Responsibility for lifestyle change:

"But even if they say they want support and we refer them, if they decide not to engage then the support doesn't happen". *[Officer]*

"I don't think it's anything to do with them...I know exactly what I'm doing wrong there. I know I smoke too much and I know I drink too much, and I know I don't eat, but that's for me to sort out...I mean I've took little one into work this morning and I were like, I can't, I feel sick, I feel sick. And it was like, what's up with her? I says, I know exactly what's up. I says it's too much caffeine and too much nicotine and not enough food, I know exactly what's up with me. And too much stress. But, there's only me can do something about that. A housing officer can't." [Tenant]

"If somebody came into my home and started telling me how I should live my life, as in how you should eat, how you should perform things to make your life better, they would pretty much get told what I eat is my business…. Because it, that to me, I will have help about anything, but I put in my mouth is my own doing" [Tenant]

Lack of knowledge/training/referral options:

'I think, every now and again, they [neighbourhood officers] *do find it incredibly daunting. They're very, kind of, I haven't got the foggiest idea of what I'm doing. I don't know who to ask. What do I do here? You know, very, kind of, what I call huffy and puffy, because there's lots of huffing and puffing going on. It gets very stressful and things like that.'[Officer]*

"Yes, and a lot of people fall between the cracks. So they're not quite there and they're not quite there and there's nowhere in the middle for them to go. We get that quite a lot, but we're trying to… it doesn't fit anywhere else, unfortunately, and we can't do anything else". [Officer]

Box 1: Changing role of neighbourhood officers

"One thing about Housing+ is that we're being ruled more out of housing and more into social care and I think we're losing the bigger picture on housing a little bit. So there's things now that's not being picked up that were being picked up before due to the fact that we are picking up other stuff and we are looking at other stuff now so we're taking our eye off the ball really". [Officer]

" We have a phrase in housing plus and sometimes we say it's social work on the cheap...And that's how a lot of people see it because that's the way it's moving more from housing into social care and social work"; [Officer]

"I think there are people who are more appropriate than your housing officer. Your housing officer should just talk about council because obviously you're a council tenant and it's their job to make it all flow and make you happy by doing repairs, doing everything around your area... I think you've got your health officer, your doctor and your hospitals, for that." [Tenant]

"….You know, I might be a bit sceptical like but I think these Housing Officers and that like, I think that there are just there for the money, I do really and I know that it is wrong to say...perhaps it's the name Housing Officer that, that gets um like, you know, perhaps, you are now going to get a visit from the Housing Officer, oo what have I done...it makes people worried"[Tenant]

Box 2: Willingness to engage in sensitive discussion

"I will address it if it is complaint. Not many people will complain about somebody smoking cigarettes because normally it's within their own home. I have had blocks where people are smoking in the communal areas and addressed that because it's communal, but if it's within their own home I don't feel like I have the right to say you shouldn't be doing that". [Officer]

"Personally, absolutely not, and do you know what, in all the time I've been doing it, have I ever discussed weight? Once, with a lady, because she was so big. She needed to move for health reasons. Her property was in pretty poor condition, but she'd got her husband and her son, who were perfectly fit and able, to get that house decluttered and clean, to a standard that we'd be able to look at moving her. That's the only person I've ever discussed it with, and actually I was a good healthy weight at the side of her". [Officer]

"If I have a problem, I'll go to them, not them coming to me... I understand if I was living with a family or maybe I can't really speak about a lot of things, but me personally, I can take care of myself and I don't need somebody to know anything about me. I'm more like a private person so I don't really like these things" [Tenant]

"I'll be honest with you. Let's say you were the housing officer, right, and you're coming here to talk to me. If you were a doctor, you'd more than likely have some medical back up or experience to know what my problem is. If you're a housing officer, and I've got a crack in the wall, I wouldn't ask my doctor about that, would I?" [Tenant]

Box 3: Barriers to discussing lifestyle issues

Tenant relationship:

"You're negotiating… Typically, I suppose, a rent professional will say, hello, this is Mr Smith. I need to talk to you about your rent account. I can't do that and I don't know whether they've recognised that we can't do that necessarily as [neighbourhood] officers, because you can't be David one minute, or Dave as the badge says, and then become Mr Smith the next. It doesn't… I don't think you can be as formal as the training would say. [Officer]

Yes, it's how they take it on and what their intentions are etc. It becomes like, if you're in a relationship, then you're together. He'll tell you your problems, you'll tell your problems, and it's a relationship together. If you're talking to somebody in the street, which is what you're talking about, you haven't got a relationship with them, have you" [Tenant]

Responsibility for lifestyle change:

"But even if they say they want support and we refer them, if they decide not to engage then the support doesn't happen". *[Officer]*

"I don't think it's anything to do with them...I know exactly what I'm doing wrong there. I know I smoke too much and I know I drink too much, and I know I don't eat, but that's for me to sort out...I mean I've took little one into work this morning and I were like, I can't, I feel sick, I feel sick. And it was like, what's up with her? I says, I know exactly what's up. I says it's too much caffeine and too much nicotine and not enough food, I know exactly what's up with me. And too much stress. But, there's only me can do something about that. A housing officer can't." [Tenant]

"If somebody came into my home and started telling me how I should live my life, as in how you should eat, how you should perform things to make your life better, they would pretty much get told what I eat is my business…. Because it, that to me, I will have help about anything, but I put in my mouth is my own doing" [Tenant]

Lack of knowledge/training/referral options:

'I think, every now and again, they [neighbourhood officers] *do find it incredibly daunting. They're very, kind of, I haven't got the foggiest idea of what I'm doing. I don't know who to ask. What do I do here? You know, very, kind of, what I call huffy and puffy, because there's lots of huffing and puffing going on. It gets very stressful and things like that.'[Officer]*

"Yes, and a lot of people fall between the cracks. So they're not quite there and they're not quite there and there's nowhere in the middle for them to go. We get that quite a lot, but we're trying to… it doesn't fit anywhere else, unfortunately, and we can't do anything else". [Officer]

ABSTRACT

Background: In order to harness the potential impact of the wider public health workforce, innovative services are providing opportunities for social housing staff to extend their public health role. This study explored the views of housing professionals and social housing residents on the delivery of preventative health messages by housing staff in the context of the evaluation of the roll-out of a new service.

Methods: We conducted semi structured interviews with 21 neighbourhood housing officers, 4 managers and 30 social housing tenants to understand their views on the widening role and the potential impact on the preventative health care messages being delivered.

Results: Neighbourhood officers were willing to discuss existing health conditions with tenants; but they often did not feel comfortable discussing their lifestyle choices. Most tenants also reported that they would feel discussions around lifestyle behaviours to be intrusive and outside the remit of housing staff.

Conclusions: Resistance to discussions of lifestyle topics during home visits was found among both housing staff and tenants. Appropriate staff training and the development of strong and trusting relationships between officers and tenants is needed, if similar programmes to extend the role of housing staff are to succeed in terms of health impact.

BACKGROUND:

Lifestyle factors such as lack of exercise and poor diet, along with smoking, drinking and other substance misuse have a significant impact on population health in terms of risk for heart disease, cancer and diabetes[1]. The link between housing, health and inequality has been well documented both in terms of the impact of poor housing conditions on physical and mental health[2,3] and the links between living in social housing and poverty[4,5].

Recent cuts to public spending have resulted in the need for strengthened integration of health and social care and a movement towards holistic, preventative support[6]. The increased cost of healthcare provision, alongside a progressively aging population and the rising prevalence of chronic conditions has led to unprecedented pressures on community and health services[7].

In light of these pressures, a move towards community centred approaches to prevention and support is advocated to ensure service sustainability[8]. Housing support, defined here as support 'to enable someone to manage on a day-to-day basis while living in their own home[9],' lies at the interface between health and social care. Consequently, the potential of housing services as a platform for a reorientation from acute care to preventative support has come under increasing attention[8]. This has led many housing providers to review their operational structures in order to manage costs more effectively whilst focusing on more holistic support for tenants[10].

One relatively inexpensive option is the incorporation of health and wellbeing discussions into everyday practice. Interventions such as "Making Every Contact Count" (MECC) aim to promote the use of everyday conversations with patients to instil behaviour change[11]. Some housing providers have adopted 'Housing Plus'[12] activities as a means of realising this potential; the aim being to mitigate the economic and social issues faced by tenants[13]. Although the composition of 'Housing Plus' activities varies by organisation, anecdotal evidence suggests activities often involve increasing community resilience and preventative measures to ensure tenancy sustainability.

Council housing services in Sheffield (a large city in the North of England) have recently adopted a city wide 'Housing+' programme after initial piloting in the South East of the City. The service involves a Neighbourhood Officer undertaking an annual home visit with a geographically based caseload of between 180-330 households. Housing+ neighbourhood officers take a holistic, preventative approach by dealing with low level issues directly; signposting people to resources within the local community, and refer to other services for more help as required. Alongside discussions of other sensitive topics (such as their financial position), Housing+ officers are encouraged to ask tenants about their health status and life style behaviours as part of their new role. Overall the intervention could be expected to impact on a range of public health outcomes. These would include preventive interventions; referrals to community, health and social care services; and reducing health inequalities.

While it has been recognised that the housing workforce is in a good position to improve the health and wellbeing of their customers through the use of interventions such as MECC, further work is needed to explore this potential role extension[14]. The aim of this research was to understand the views of housing staff and tenants on the widening role and, from a public health perspective, the potential impact of this on how successfully preventative health care messages are delivered.

METHODS:

Setting: The city of Sheffield, northern England.

Sample and data collection: As part of a larger evaluation project, we completed "face to face" semi structured interviews with 25 "neighbourhood officers" from junior staff to managers, all conducted at their place of work. Thirty "face to face" interviews with council housing tenants were completed in their homes. Interviews were conducted by three experience researchers (LB, EH and MC). Due to the potential risk to safety in entering tenant's homes, two researches attended each tenant interview.

Interview guides were initially developed by considering the main aims of Housing+ and further refined in workshops with tenants and housing staff, as well as with the project advisory group. Participants were asked about their knowledge of, views on, and experience with the Housing+ intervention. They were also asked about their views on the potential for the Housing+ intervention to impact on the health and wellbeing of the tenant population.

A sampling framework for the survey was developed by matching neighbourhood officer "patches" across the city in terms of population age, ethnicity, and property type. To select patches for the telephone survey we matched 12 patches in the Housing+ pilot area to 12 patches in the control areas (the rest of the city). We defined the patches according to whether they were higher or lower than the median patch value in terms of: property type (percentage of properties which we flats), ethnic diversity, population age, and average council tax band, so there were as similar as possible. One patch from each "type" was selected at random. The neighbourhood officer from each selected patch was invited to interview. The tenant sample was recruited purposively via a telephone survey also being conducted as part of the Housing+ evaluation. Telephone survey participants from selected patches were asked whether they would be willing to take part in a further qualitative interview. All those who consented to take part were re-contacted by the research team.

Analysis: With the participant's consent, interviews were digitally recorded and lasted between 30 and 90 minutes. Interview data were fully transcribed, and thematic analysis was undertaken using Nvivo 11 software to organise the data. Framework analysis was undertaken to scrutinise the data in terms of key themes[15]. Transcripts were analysed by one member of the team and coding was

validated by a second. The final themes were developed through discussion and refinement within the team: including reaching consensus on any coding disagreements.

RESULTS:

Background and context:

The sample of 21 neighbourhood officers and four team managers (14 women and 11 men) ranged in age from 29 to 53 years (with a median age of 41 years). Their work history was varied; the longest serving officer had worked in housing for 28 years, the newest member of staff had less than a year of experience (median work experience was 12 years). The sample of 30 tenants ranged in age from 18 to 96 (with a median age of 51). Length of current tenancy ranged from 9 months to 72 years (median 15 years). Twelve tenants lived alone with the rest living with family members. The majority of tenants were not currently in employment and only six were working full or part time. The tenants were in receipt of a range of state benefits for themselves or on behalf of family members. Almost all the tenants reported health issues in their household; these included a variety physical health conditions and mental health issues.

Changing role of housing staff:

Many of the neighbourhood officers stated that both the new local service under Housing+ and the Housing sector more widely had seen an overall shift towards health and wellbeing or social care. One neighbourhood officer noted that they felt other services such as social workers and community support workers were being deprioritised due to Housing+; referencing issues to do with funding as the driver behind this change. There were also concerns that by focusing more heavily on health and social care the service was losing its focus on the 'bread and butter,' such as maintaining quality housing. The changing role was seen with concern by the tenants who were worried about the implications for their families and their tenancies and felt that there were “more appropriate people” for them to discuss their health concerns with. [Direct quotes given in Box 1]

Willingness to discuss sensitive issues:

Neighbourhood officers were willing to discuss their tenants’ current health conditions/concerns in most cases. They also noted that most tenants were happy to engage in discussion about their health problems with their neighbourhood officer. These discussions were considered to be particularly appropriate when they related to issues with their tenancy. However, topics which neighbourhood officers considered “sensitive” in discussion with their tenants included their lifestyle choices (as well as finances and relationships). Therefore, neighbourhood officers were less comfortable in discussing life style issues (such as weight, exercise, and drinking or smoking behaviours) and messages relating to preventative health with their tenants, than they were in discussing their current health problems. They were also concerned that tenants would feel uncomfortable discussing these issues with a neighbourhood officer, as they were not used to doing so with a non-health professional. The only exceptions to this related to smoking behaviour which was impacting on other tenants, or weight/mobility issues related to the suitability of a tenant’s property.

Tenants often stated they would be 'happy' to discuss health related issues but for many, discussions around lifestyle issues felt intrusive and outside the neighbourhood officer remit. Many tenants said that they would be more comfortable discussing potentially sensitive issues (including their lifestyle choices and financial position) with health care professionals or social workers. It was also acknowledged that it would take time for the neighbourhood officers to build trust within the local community and that the success of the relationship was dependent to some extent on the individual

personality of the neighbourhood officer. Despite reluctance, some tenants stated that the neighbourhood officer would be the 'right' person to deal with their problems if they were appropriately trained. In particular tenants felt that neighbourhood officers could be perceived as telling them how to behave rather than offering support – which may be addressed with appropriate training [Direct quotes given in Box 2]

Barriers to engaging in preventative health discussions:

Most neighbourhood officers expressed positive views on their ability to develop relationships with tenants in the new role. They tried to be supportive and ensure that tenants did not feel pressured into discussing sensitive things with them. Some noted that older people were easier to engage, with younger people being more reluctant. Some neighbourhood officers provided examples of where finding the right approach with a particular tenant had been challenging. Concerns were expressed over having to play "good cop, bad cop" within the role, especially around discussing lifestyle behaviours. Many of the neighbourhood officers felt that raising issues such as weight had the potential to impact on their relationship with their tenant. This was particularly perceived as problematic when initially building a relationship. Whilst some said that this may be a topic they would consider discussing at a later date, others felt that any discussion around weight and other lifestyle issues was beyond their remit. In addition, some neighbourhood officers questioned whether they should be responsible for encouraging their tenants to make lifestyle changes.

Neighbourhood officers also raised concerns about limited referral options available to them and how this may limit their willingness to discuss preventative health with tenants. It was reported that referral options for lifestyle interventions were lacking. There were also capacity issues in terms of whether an agency was able to take their tenant on. Once a tenant was referred it was often difficult to gain information on whether they had used the service and its impact on them. There were mixed views as to whether the tenants would actually take up the referral they were offered. It was also noted that Housing+ meant that more need for support was likely to be identified and that most tenants who were offered supported want it, meaning an even greater strain on overburdened services.

While some tenants acknowledged that smoking may be a concern of the council if it damaged property, most felt strongly that smoking and drinking is a matter of personal choice. This was particularly the case with tenants who stated they were reluctant to change their lifestyle. Some tenants acknowledged that unless they or their peers had the desire to receive help, conversations about lifestyle choices were unlikely to have an impact on their behaviour. For some tenants smoking and alcohol help them deal with stress in their lives. Even though they recognised their behaviour may have health consequences, tenants considered lifestyle behaviours a personal choice and not the business of the council.

Four tenants said that their willingness to discuss issues they considered sensitive with a neighbourhood officer would depend entirely upon their opinion of the individual person. This included whether they found them approachable, if they felt they could trust them, and whether they were able to build a relationship. Building a relationship with their neighbourhood officer was of particular importance to many tenants to avoid being 'passed from pillar to post' across different departments and staff members. Building a relationship would also instil confidence to discuss their issues with that individual, and would be facilitated by having the neighbourhood officer involved from the start of the tenancy. [Direct quotes given in Box 3]

DISCUSSION:

Main findings:

Whilst neighbourhood officers were willing to discuss existing health conditions (including both physical and mental health) with their tenants, particularly where this related to issues with their tenancy, in many cases they did not feel comfortable discussing health related behaviour change with them. They were also concerned that tenants would feel uncomfortable discussing these issues with a neighbourhood officer. The only exceptions to this related to smoking behaviour which was impacting on other tenants, or weight/mobility issues related to the suitability of a tenant's property. Neighbourhood officers felt that initiating conversations about issues sensitive to tenants had the potential to affect the officer/tenant relationship, which in turn was necessary to build trust. The reported barriers to engaging in discussion of preventative health approaches included: the potential impact on their relationship with the tenant; lack of knowledge, training, and therefore confidence in these topics; limited access to referral services; and questions over responsibility for lifestyle changes.

Despite the complexity of health problems faced by some tenants there was also broad reluctance to discuss such issues with a neighbourhood officer on home visits. For many, health and wellbeing discussions would feel intrusive, offensive and outside of the role of a neighbourhood officer. Engaging in lifestyle behaviours represented an act of 'personal choice' outside of the governance of housing management. Despite this reluctance, some tenants were open to sensitive discussions if the neighbourhood officer had appropriate training to deal with the issues likely to be raised. The importance of building a relationship and trust at an individual and community level is central for increased receptiveness to health messages. However, the impact of these messages on behaviour is dependent on individual willingness to change.

What is already known on this topic:

Within social housing there is currently an impetus to broaden roles and to develop staff to become part of the wider public health workforce[14]. There is a growing evidence base on the feasibility and effectiveness of 'MECC' style brief interventions for producing small-scale behaviour change[16,17], and the impact of implementing such interventions on health care staff[18,19]. However, since the recent uptake of these preventative health roles within social housing professions, little research has been done to understand the views of social housing staff on their widening role and the potential impact of this on social housing tenants and the preventative health care messages being delivered.

What this study adds:

This study is the first to qualitatively explore the views of both social housing professionals and tenants on the inclusion of preventative health promotion within their roles. The study indicates combined resistance to the idea of participating in conversations about lifestyle. Therefore issues such as the potential impact on the tenant/officer relationship; lack of knowledge, training, and confidence; limited access to referral services; and questions over responsibility for lifestyle changes are impacting on the effective delivery of preventative health messages by these professionals.

Our interviews suggest that moving conversations about lifestyle outside the realm of the health professional - patient relationship is highly problematic. Talking about health and lifestyle requires that housing staff engage tenants in a discursive strategy designed and mobilised within non-medical institutional processes. This results in resistance to such engagement from tenants who do not see the relevance to a housing role, and are unsure whether neighbourhood officers have the required knowledge to help with these issues.

Limitations of this study:

At the time of interview, some officers were very new to the role, and the intervention was in the process of being rolled out across the city. Therefore some of the opinions given here may have

been affected by stress associated with starting a new job, potentially amplifying some of the concerns expressed. Tenant participants were recruited via a telephone survey by a commercial research company as part of a wider evaluation of the Housing+ programme. This will have excluded those without a telephone or a stable home – tenants who may have disproportionate health and lifestyle issues. Those who were not at home often (for example full time employed) may also have been excluded. The telephone survey did however use interpreters for those whose first language was not English. The excluded groups are important for future research to gain a comprehensive assessment of the feasibility of health interventions targeting the diverse range of social housing tenants. Despite these limitations, this study draws important attention to the likelihood of resistance to health initiatives based on lifestyle discussions with housing staff. We are currently following up the respondents in the second year of the study to explore how opinions have changed as the intervention has been implemented.

Conclusions:

This research shows that there is reluctance among social housing staff (and therefore, potentially, other relevant professional groups) to engage in preventative health discussions as part of their widening job role. This is re-enforced by concerns expressed by tenants. More prior discussion and better understanding of why such conversations are beneficial to tenants may be helpful. Whether this resistance can be reduced through improved communications between housing officers and tenants remains unclear at this stage, an uncertainty underpinned by findings that suggest estate culture is resilient and resistant to outside influences, especially when change is initiated by government agencies[20,21].

Organisations looking to implement Housing+ type interventions should be aware of these concerns and the potential limitations on the effectiveness of delivering preventative health care messages in this way. It may be of benefit to promote community awareness of the widening role of social housing staff, as well as to provide staff with more training and support to deliver preventative health messages. This is likely to require considerable investment in time and resources and must be underpinned by developing trusting relationships between tenants and officers. Another limiting factor is the perceived lack of referral services to support lifestyle change, and this should be addressed in any training given. Closer working between health professions and others engaging in a public health role could help to drive the preventative health agenda forward for all. Further qualitative research in these areas has the potential to explore the scope for expanding the workforce in ways conducive to a holistic approach to public health.

Funding

This work was supported by the National Institute for Health Research (NIHR) School for Public Health Research (SPHR). It was commissioned under the Public Health Practice Evaluation Scheme (PHPES) [IS-SPH-0211-10022].

Acknowledgements

We are grateful to our project advisory group who contributed to the successful completion of this work. We would also like to thanks Viewpoint Research for assisting with recruiting the tenant sample.

References

[1] NHS Digital 2017. http://content.digital.nhs.uk/lifestyles Accessed 19.07.2017

[2] Wilkinson D. Poor housing and ill health: a summary of the research evidence. Edinburgh: Scottish Office Central Research Unit, 1999

[3]Macintyre, S. Ellaway A, Hiscock R, Kearns A, Der G, McKay L. What features of the home and the area might help to explain observed relationships between housing tenure and health? Evidence from the west of Scotland. Health & Place 2003;9(3):207-218

[4] Shaw M. Housing and public health. Annual Review of Public Health 2004;25:397–418

[5] Saugeres, L. The Social Construction of Housing Management Discourse: Objectivity, Rationality and Everyday Practice. Housing, Theory and Society 1999;16(3):93-105

[6] Ham C, Alderwick H. Place-based systems of care: A way forward for the NHS in England. The Kings Fund, 2015. Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-

[7] Roberts A, Marshall L, Charlesworth A. A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22. Research report. Nuffield Trust, 2012. Available at: https://www.nuffieldtrust.org.uk/research/a-decade-of-austerity-the-funding-pressures-facing-thenhs- from-2010-11-to-2021-22. Last accessed: 17/07/2017

[8] Chevin, D. Housing associations and the NHS: new thinking, new partnerships. The Smith Institute, 2014. Available at: http://www.smith-institute.org.uk/wp-ontent/uploads/2015/09/Housingassociations-and-the-NHS.pdf. Last accessed: 10/07/2017

[9] Housing Support. Shelter: the housing and homeless charity. 2015. Available at: http://england.shelter.org.uk/get_advice/housing_with_support/housing_support. Last accessed:10/07/2017

[10] Power A. Provan B. Herdern E. Serle N. The impact of welfare reform on social landlords and tenants. Joseph Rowntree Foundation, 2014. Available at: https://www.jrf.org.uk/report/impact-elfarereform- social-landlords-and-tenants. Last accessed: 12/07/2017

[11] MECC 2017. http://www.makingeverycontactcount.co.uk/ Accessed 19.07.2017

[12]Housing Plus Academy. Trafford Hall. 2017. Available at: http://www.traffordhall.com/housing-plusacademy/

[13] Joseph Rowntree Foundation. Implementing 'Housing Plus' on five housing association estates. 1997. Available at: https://www.jrf.org.uk/report/implementing-housing-plus-five-housing-associationestates. Last accessed: 13/10/2017

[14] Patten K, Scriminger, S, Baxter, S, Leng, G. Public Health: housing workforce holds the key. Sitra; 2015. http://www.sitra.org/documents/public-health-housing-workforce-is-the-key/?preview=true Accessed 19.07.2017

[15] Srivastava A, Thomson B S. Framework Analysis: A Qualitative Methodology for Applied Research Note Policy Research. JOAAG 2009;4(2)

[16] Crawford, R. (2006) Health as a meaningful social practice. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine 2006;10(4):401–420

[17] James A, Hockey, J. Embodying health identities. Palgrave Macmillan, 2007

[18] Lawrence W, Black C, Tinati T et al. Making every contact count: Evaluation of the impact of an intervention to train health and social care practitioners in skills to support health behaviour change. Journal of Health Psychology 2016; 21(2):138–151

[19] Local Government Association. Making every contact count: Taking every opportunity to improve health and wellbeing. Report; 2014. Available at: https://www.local.gov.uk/sites/default/files/documents/making-every-contact-coun-e23.pdf. Last accessed: 15/07/2017

[20] McKenzie, L. Getting by: Estates, Class and Culture in Austerity Britain. Policy Press, 2015

[21] McKee, K. (2010) Sceptical, Disorderly and Paradoxical Subjects: Problematizing the "Will to Empower" in Social Housing Governance. Social Housing Governance, Housing, Theory and Society 2010;28:1:1-18

Box 1: Changing role of neighbourhood officers

"One thing about Housing+ is that we're being ruled more out of housing and more into social care and I think we're losing the bigger picture on housing a little bit. So there's things now that's not being picked up that were being picked up before due to the fact that we are picking up other stuff and we are looking at other stuff now so we're taking our eye off the ball really". [Officer]

" We have a phrase in housing plus and sometimes we say it's social work on the cheap...And that's how a lot of people see it because that's the way it's moving more from housing into social care and social work"; [Officer]

"I think there are people who are more appropriate than your housing officer. Your housing officer should just talk about council because obviously you're a council tenant and it's their job to make it all flow and make you happy by doing repairs, doing everything around your area... I think you've got your health officer, your doctor and your hospitals, for that." [Tenant]

"….You know, I might be a bit sceptical like but I think these Housing Officers and that like, I think that there are just there for the money, I do really and I know that it is wrong to say...perhaps it's the name Housing Officer that, that gets um like, you know, perhaps, you are now going to get a visit from the Housing Officer, oo what have I done...it makes people worried"[Tenant]

Box 2: Willingness to engage in sensitive discussion

"I will address it if it is complaint. Not many people will complain about somebody smoking cigarettes because normally it's within their own home. I have had blocks where people are smoking in the communal areas and addressed that because it's communal, but if it's within their own home I don't feel like I have the right to say you shouldn't be doing that". [Officer]

"Personally, absolutely not, and do you know what, in all the time I've been doing it, have I ever discussed weight? Once, with a lady, because she was so big. She needed to move for health reasons. Her property was in pretty poor condition, but she'd got her husband and her son, who were perfectly fit and able, to get that house decluttered and clean, to a standard that we'd be able to look at moving her. That's the only person I've ever discussed it with, and actually I was a good healthy weight at the side of her". [Officer]

"If I have a problem, I'll go to them, not them coming to me... I understand if I was living with a family or maybe I can't really speak about a lot of things, but me personally, I can take care of myself and I don't need somebody to know anything about me. I'm more like a private person so I don't really like these things" [Tenant]

"I'll be honest with you. Let's say you were the housing officer, right, and you're coming here to talk to me. If you were a doctor, you'd more than likely have some medical back up or experience to know what my problem is. If you're a housing officer, and I've got a crack in the wall, I wouldn't ask my doctor about that, would I?" [Tenant]

Box 3: Barriers to discussing lifestyle issues

Tenant relationship:

"You're negotiating… Typically, I suppose, a rent professional will say, hello, this is Mr Smith. I need to talk to you about your rent account. I can't do that and I don't know whether they've recognised that we can't do that necessarily as [neighbourhood] officers, because you can't be David one minute, or Dave as the badge says, and then become Mr Smith the next. It doesn't… I don't think you can be as formal as the training would say. [Officer]

Yes, it's how they take it on and what their intentions are etc. It becomes like, if you're in a relationship, then you're together. He'll tell you your problems, you'll tell your problems, and it's a relationship together. If you're talking to somebody in the street, which is what you're talking about, you haven't got a relationship with them, have you" [Tenant]

Responsibility for lifestyle change:

"But even if they say they want support and we refer them, if they decide not to engage then the support doesn't happen". *[Officer]*

"I don't think it's anything to do with them...I know exactly what I'm doing wrong there. I know I smoke too much and I know I drink too much, and I know I don't eat, but that's for me to sort out...I mean I've took little one into work this morning and I were like, I can't, I feel sick, I feel sick. And it was like, what's up with her? I says, I know exactly what's up. I says it's too much caffeine and too much nicotine and not enough food, I know exactly what's up with me. And too much stress. But, there's only me can do something about that. A housing officer can't." [Tenant]

"If somebody came into my home and started telling me how I should live my life, as in how you should eat, how you should perform things to make your life better, they would pretty much get told what I eat is my business…. Because it, that to me, I will have help about anything, but I put in my mouth is my own doing" [Tenant]

Lack of knowledge/training/referral options:

'I think, every now and again, they [neighbourhood officers] *do find it incredibly daunting. They're very, kind of, I haven't got the foggiest idea of what I'm doing. I don't know who to ask. What do I do here? You know, very, kind of, what I call huffy and puffy, because there's lots of huffing and puffing going on. It gets very stressful and things like that.'[Officer]*

"Yes, and a lot of people fall between the cracks. So they're not quite there and they're not quite there and there's nowhere in the middle for them to go. We get that quite a lot, but we're trying to… it doesn't fit anywhere else, unfortunately, and we can't do anything else". [Officer]