Housing to Health

Nottingham City Homes

&

NHS Nottingham and Nottinghamshire Integrated Care Board

Evaluation of Year 6

April 2021 – March 2022

Contents

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Executive summary

The Housing to Health (H2H) project is the embodiment of integrated care. Jointly funded by the NHS Nottingham and Nottinghamshire Integrated Care Board and Nottingham City Homes, it supports three housing specialists to work alongside health and social care workers both in the community, and in the two local hospitals. When healthcare staff encounter a patient whose health is being affected by inappropriate housing or who can't be discharged from care back to their home, they refer them to the H2H project. The specialist Housing and Health Coordinators (HHCs) speed up the process of finding and supporting that patient to move into suitable social housing, where the goal is that they can live independently. The aim is to intervene at an earlier stage, to improve health and wellbeing outcomes for patients and their carers, and reduce the number of (re)admissions into hospital.

The project was launched in 2015 and has continued since, including during the Covid pandemic. This evaluation report covers the sixth full year of operation, from April 2021 to March 2022. During this period, England was just coming out of its final lockdown, with social restrictions being lifted over the summer, but then new variants hitting the population over the winter of 2021/22. During this period, the HHCs continued to work to support patients and their families within Covid-safe working practices, and supported 89 people to be re-housed. This brings the total rehoused over the lifetime of the project to 633.

The HHCs have continued to deliver a high-quality service this year, with patient satisfaction at its highest ever levels at 9.9 out of 10. Evidence from healthcare partners and patients themselves shows that the service meets an essential need, to provide housing support and expertise at a time of extreme vulnerability or health crisis. This year, every single patient surveyed said that they could not have moved without the support of the HHCs.

But there is no doubt that Covid has made all aspects of the project more complicated. Remote working means it has been more difficult to make and maintain relationships with healthcare staff and patients and their families. The number of referrals directly from high-demand beds has reduced, as bed pressure means that patients are discharged home with support as soon as they are medically fit, and picked up by HHCs once in the community. Over recent years HHCs have already seen an increase in the complexity of health and social care needs amongst the patient group, and in the last year there has been a pronounced increase in the proportion of patients with poor mental health. This makes dealing with the case and finding an appropriate solution more and more complicated.

Meanwhile the demand for social housing has continued to increase year on year, resulting in longer waiting times and fewer properties available to let. This year, the ongoing effects of Covid-related staff shortages and supply issues to the building trade means that it has taken longer for properties that become available to be made ready for re-letting. The HHCs have worked innovatively during this time to find suitable properties for their patients, working closely with the lettings and void teams to prioritise available properties and targeting a higher number of lower-demand properties that are ready to let.

Within this difficult context, the H2H project has supported 89 patients, maintaining about 80% of pre-pandemic case load. The rehousing time (from referral to moving in) understandably increased over the pandemic, but this year has decreased by 10 days down

76 days, similar to pre-pandemic rehousing times. This is all the more impressive, given that general waiting times for social housing outside of the HHC project have increased year on year, now standing at 255 days on average for a similar property. This means that on average, the H2H project saves almost six months waiting to be rehoused, during which the patient would either be at risk in an inappropriate home or staying in costly health or social care.

The data shows that patients referred to the H2H project are highly vulnerable, have complex needs, and have frequently required periods of hospital or other health care. Just under a third of the cases were referred directly from high demand beds in hospital, other healthcare (including mental health), or social care. Of those referred from the community, just over a third had already had a hospital admission in the last six months, and three-quarters were judged to be at high risk of a future hospital admission. The primary patient group for H2H is the older patient group, with accessibility/mobility issues. Across all H2H patients, many have multiple health issues, and lower health-related quality of life, self-reported health and mental wellbeing compared to population averages for this age group. This year, there are higher levels of reported mental health issues. H2H has also supported more patients from minority ethnic groups this year.

The H2H service makes a huge difference to those they work with. The stories of people's experiences and the improvements to their lives from being rehoused convey the real value of the project. Examples include amputees who can't return to their upper-floor property, who are rehoused so they can live independently in their home and community; elderly people who have been living in one downstairs room with no access to a proper bathroom, who can now access all parts of their home, bathroom and garden; and people who have experienced a mental health breakdown, where H2H offers them the opportunity to leave institutional care and recuperate in a home of their own. In their own words, H2H patients have described how they now feel *"a lot happier – I have freedom"*, *"I love living here, I can't thank you enough", "I didn't know where to start… I was helped to find a bungalow, it was more that I could have ever hoped for".*

Patient outcomes are much improved following support to be rehoused through H2H. Survey data shows H2H patients feel safer in their new home, can better manage their health at home, have made more social connections, are financially better off, and have higher health, quality of life and mental wellbeing scores. Their carers also report a massive 63% improvement in their own wellbeing, as a result of improved housing for the person they care for. These improvements in patient outcomes indicates that every £1 invested in the H2H project results in £10.23 of social (wellbeing) value.

Data on actual hospital admissions for the H2H patient group this year shows that the project continues to be successful in reducing the number of readmissions, length and cost of stay after the patient is supported to be rehoused. This has been a consistent pattern throughout the project, and this year is no exception. H2H patients who were admitted to hospital in the six months before they were rehoused had on average 3.6 admissions per year, and stayed in hospital for 14 days per admission. Data from the six months after being rehoused shows that the same group only had 0.9 admissions per year, and average stay of 9 days. Overall, this indicates that H2H results in 86 fewer admissions and 1,310 fewer hospital bed days this year. The total cost saving to the NHS from this is £458,538.

The H2H project reduces the resource burden on other organisations within the Integrated Care Partnership in a range of ways:

- It speeds up discharge from hospital or care beds, reducing delayed discharge of care and associated costs. The evaluation model shows that this saves 393 NHS bed days and 2,657 Adult Social Care days, a total cost avoidance of £236,214.
- It supports patients who would otherwise be homeless, avoiding £71,082 in costs to Nottingham City Council's homelessness services.
- It avoids unnecessary home adaptations by moving patients to an already adapted property, saving Nottingham City Council £141,140.
- It increases rental income for Nottingham City Homes and decreases costs from empty properties, a total financial value of £135,789.

The financial Return on Investment (ROI) assessment shows that the project is cost-effective across all measures. A central financial measure for the NHS is the actual savings from reduced in hospital readmissions following H2H, evidenced by admissions data. The savings from this element alone are more than double the cost of the entire project. The additional financial benefits – from reducing Delayed Transfer of Care, reducing adaptations and homelessness costs, and increasing rental income – all add further weight to the positive financial impact of the project. The total financial ROI this year is £4.36 for every £1 invested.

Furthermore, the evaluation shows that the project continues to deliver clear, positive impacts on patient outcomes and their overall wellbeing. The insight into the personal stories of the patients revealed through the case studies demonstrates the significant impact on those who are assisted through the H2H project. This is supported by the survey data, which shows very high satisfaction with the service, improved physical and mental health, and improved wellbeing factors such as social connections, safety and financial comfort. All the patients surveyed this year state that they would not have been able to move without the help of the HHCs, and partner testimonials also point to the value and continued need for this type of service, to provide housing expertise within the integrated care system.

The project has funding secured for Year 7 (2022-23) and will continue to focus on individuals who have high previous use of hospitals, including those currently in hospital and those in the community with previous admissions, to continue to relieve pressure on the NHS.

The H2H project partnership of NCH and Nottingham and Nottinghamshire ICB will continue to lead and promote good practice in health and housing-related developments, both locally and nationally. NCH will continue to be a voice for housing on the Integrated Care Partnership in Nottingham. The H2H project partnership continues to work with local and national bodies to support the spread of good practice of housing-health partnerships into other areas.

1. Introduction

1.1. Project background and overview

The Housing to Health (H2H) project brings housing staff within Nottingham's Integrated Care System, providing a holistic approach for supporting people to regain or remain independent in their homes.

The project is delivered by Nottingham City Homes (NCH), jointly funded by NCH and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB). The project initially began as a 12-month pilot in November 2015, and has now completed its sixth full year of operation, and currently has funding to continue until March 2023.

The project partnership

Nottingham City Homes (NCH) manages around 27,500 council properties in Nottingham, including around 2,100 properties within its Independent Living (IL) communities. The IL communities provide supported accommodation for over 60s, with specialist Independent Living Co-ordinators and access to 24-hour telecare alarm through the Nottingham on Call service. NCH is also member of the Nottingham Homelink partnership, which enables staff to help individuals search and apply for properties managed by other Registered Social Landlords (RSLs) in Nottingham.

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) is a statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in our area. This project is funded from the Better Care Fund, which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The BCF brings together the ICB and Local Authority to integrate spending plans and services.

Housing has long been recognised as a wider determinant of health. The H2H project is a practical example of how housing interventions can improve health outcomes.

The H2H project is both a hospital discharge scheme and a preventative, early intervention initiative. The aim of the NHS in Nottingham and nationally is that people enjoy healthy and independent ageing at home or in their communities for longer. The NHS recognises that once people no longer need hospital care, being at home or in a community setting is the best place for them to continue recovery. Delays to discharge once the patient is ready to go home (known as Delayed Transfer of Care (DTOC)) puts patients' health at risk and places additional burden on limited NHS resources. The H2H project supports the timely discharge of patients occupying a high-demand bed, whose discharge is being delayed because they cannot be discharged to their current home.

The project also has a preventative, upstream intervention element. Healthcare and other community staff are able to refer individuals who are identified as living in poor or inappropriate housing, which is likely to have a negative impact on the individual's health or wellbeing – taking a proactive, early intervention approach.

As well as supporting the NHS in its aims, the project also helps social housing providers to make optimal use of social housing stock, ensuring the uptake of empty social housing properties across the city.

The project embeds Housing and Health Coordinators (HHCs) into the Integrated Care System. HHCs are housing officers with extensive knowledge of the housing system, who take referrals from healthcare staff from within the city's hospitals, Primary Care Networks (GPs and community health and social care teams) as well as other local community organisations. The HHCs support individuals (from any tenure) to be re-housed into suitable social housing. They are able to speed up the housing process and provide intensive one-to-one support to the individual and their families/carers, to help them through the entire process. One of the HHCs is based full-time in Nottingham University Hospitals, working within the Integrated Discharge Function to identify patients in hospital with potential for delayed discharge because of their housing. Another of the HHCs is a specialist in mental health, and works closely with local mental health hospitals and step-down units.

The HHCs are dedicated to the people they work with, going the extra mile to support them through their journey. Those helped through the service are often vulnerable and require a high level of support. The HHCs support each person in selecting, applying for and viewing appropriate properties. They also arrange a review by an Occupational Therapist and installation of aids and adaptations as required, source furniture where needed, support with the moving process and follow-on support after re-housing. They are able to signpost individuals to further support, for example for help with financial management including managing rent, maximising their welfare benefit income, managing fuel bills etc., and to activities and support offered in the Independent Living (IL) communities, providing the opportunity to engage with their community and/or social activities and reduce social isolation.

The project started in November 2015, initially as a pilot year. The project has proved to be successful and funding has been renewed year on year. The H2H team in Year 6 include three HHCs and an admin support post, as well as management input from NCH.

There are three criteria for inclusion in the H2H project:

- **H2H Supported Housing – NCH or other RSL**. Patients who meet the criteria for supported housing, including properties managed by NCH (largely Independent Living communities, for those aged over 60) or other RSLs in the city (criteria dependent on each scheme). For those occupying high-demand beds (DTOC) or in the community (early intervention).
- **H2H Medical Referrals - Essential wheelchair users.** Patients of any age who are essential wheelchair users, occupying high demand bed space. Rehoused into suitably adapted accommodation in NCH or other RSL stock.
- **H2H Social Recommendations – Mental Health.** Single applicants of any age who are occupying high demand beds in a Mental Health unit/facility. Rehoused into suitable single-person accommodation within NCH or RSL stock.

The H2H project has continued to operate successfully throughout the COVID-19 pandemic. The team have adapted working practices to be able to safely deliver housing support to those in need. At the start of this evaluation period, England had just come out of the final

lockdown, but social distancing restrictions remained in place. Restrictions were gradually removed by July 2021 as the vaccine programme built momentum, but some restrictions were re-introduced in December 2021 as the Omicron variant took hold. During the pandemic, there was increased risk to patients' health from being in hospital, and an urgent need to reduce pressure on bed spaces. Thus, the H2H project was all the more necessary to support the timely discharge of patients from hospital, and help prevent unnecessary admissions.

Case study: Reducing hospital re-admissions

Mr Andrews* (aged 57) was referred to the service by City Hospital after he was admitted following a severe fall. He had had numerous falls in the months leading up to his admission, with many being on the five flights of concrete stairs leading to his front door, as well as internal stairs. He had a long-term deteriorating condition that greatly affected his ability to breathe and mobilise, and the hospital had serious concerns about discharging him back to his property.

The HHC who received the referral quickly made contact with the gentleman and his partner to arrange a meeting where a housing application was completed and given medical priority. They also discussed his needs, corrected certain issues with his tenancy paperwork and started looking for suitable properties. Soon after, a two-bed Independent Living bungalow was found.

Mr Andrews and his partner loved the property and accepted the offer, with the HHC guiding them through the moving process, completing all the necessary paperwork and ensuring that benefits and utilities were set up correctly. Mr Andrews said that without the HHC's help, both himself and his partner did not know how to go about moving to more suitable accommodation.

Six months after moving in, the HHC contacted Mr A to check everything was going well. This is what he had to say: ***"Excellent service, very efficient… I love it. Great garden, no stairs and very peaceful. It has changed my life."***

**Name has been changed*

Partner testimonial: Social worker

"In terms of the Housing to Health service, I would say that this has been invaluable. I have worked with cases previously with younger adults [needing housing] … and it has been very difficult to achieve desired outcomes as there have been different staff members working on the case and limited resources available etc. With Housing to Health my experience has been that this is a very streamlined and structured service. The referral process is nice and clear and [the HHC] responds quickly and is always open to booking in joint visits and getting the process started as quickly as possible.

Overall, I could not recommend the service highly enough and I know that citizens report very positive outcomes when working with Housing to Health too."

1.2. Aims and objectives

The Housing to Health (H2H) project provides the housing options and housing support element to the Integrated Care Partnership. The project aims to support patients who are inappropriately housed, where this is impacting on their health and wellbeing. The aim of the scheme is to intervene at an earlier stage to support and enhance the best possible outcomes for citizens and their carers, and hopefully reduce the number of (re)admissions into hospital.

The evaluation aims to assess the success of the project against its objectives, and to measure the cost-effectiveness of the interventions, as well as the social value generated. The objectives for the project are to:

1. Support the patient's transition from a reablement bed to self-care/ supported living at home
2. Facilitate earlier discharge from hospital where inappropriate housing is the delaying factor in discharge
3. Provide early intervention in supporting patients affected by poor or inappropriate housing
4. Improve the uptake of empty social housing properties in the city
5. Improve the health and wellbeing of citizens who are negatively impacted by poor or inappropriate housing
6. Enable citizens to live independently for longer, with less reliance on intensive care packages

This evaluation update brings together all the data for Year 6 of the project (April 2021 – March 2022), showing progress against the outcomes set out above.

1.3. Background and context

Housing and health partnership context

Since the start of the project, the partnership between housing and health has been formally recognised and promoted in Nottingham's Memorandum of Understanding to Support Joint Action in Improving Health through the Home[1], signed in 2016. The MoU has the following long-term objectives:

1. Integrating health, social care and housing services
2. Maximising the impact from housing as part of the 'wider health workforce'
3. Maximising the housing contribution to reducing health inequalities between areas and social and cultural groups
4. Further developing the housing sector's role in reducing the demand for health and social care services
5. Communities and citizens playing their part in contributing to healthier lives strategies and activities

The H2H project has directly contributed to Priority Area 2, where the aims are to develop integrated health, social care and housing working practices, and to develop joint actions to prevent hospital admissions, reduce re-admissions, and which speed up hospital discharge.

[1] https://nottinghaminsight.org.uk/d/aAXMZI5

More recently, the partnership between housing and health has been formalised via the Nottingham and Nottinghamshire Integrated Care System. Nottingham City Homes is a part of the Integrated Care System, responsible for supporting local delivery of integrated health and care services in the city.

Health context

Nottingham's health landscape has been through a significant strategic shift as it has implemented one of the first Integrated Care Systems in the country. The Nottingham and Nottinghamshire Integrated Care System[2] brings together the local NHS, councils and voluntary sector to create an Integrated Care System (ICS), to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population of Nottingham and Nottinghamshire. The system has even closer collaboration between health and wellbeing partners, to ensure that the entire care system is well coordinated and working together to deliver the best care, across all settings – be that in clinics or hospitals, living in nursing homes, or at home.

The ICS has two statutory bodies working as equal partners. The Integrated Care Board (ICB) is the statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. From 1st July 2022, this replaces the functions previously provided by Clinical Commissioning Groups. The Integrated Care Partnership (ICP) is a statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within the ICS area. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area. These bodies are supported by four Place-Based Partnerships, covering Bassetlaw, Mid-Nottinghamshire, Nottingham City and South Nottinghamshire. Nottingham City's Integrated Care Partnership (ICP) was launched in November 2019. Nottingham City Council is a member of the ICP and Nottingham City Homes sits on the Nottingham City Place-Based Partnership.

The NHS Nottingham and Nottinghamshire ICB is currently developing its five-year plan. Its primary aim is to improve the health and wellbeing of our population, and within this (relevant to the context of the H2H project), has the ambition that 'our people will enjoy healthy and independent ageing at home or in their communities for longer'.[3]

As a partner in the Nottingham City Place-Based Partnership, Nottingham City Homes will support the role of housing in delivering these priorities. This builds on a clear foundation within Nottingham for housing as a partner in delivering wider health and wellbeing outcomes, as demonstrated in a number of other key strategic commitments and plans (see Table 1 below).

[2] For more information on the Nottingham and Nottinghamshire Integrated Care System see https://healthandcarenotts.co.uk/
[3] See https://notts.icb.nhs.uk/about-us/our-priorities/our-strategies-and-plans/

Table 1: Key health and wellbeing strategies in Nottingham and links between housing and health

Overview of strategy	Aspects relating to housing and health
Nottingham City Joint Strategic Needs Assessment (JNSA)	
The JNSA is a local assessment of current and future health and social care needs, and determines what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.	The JNSA for Housing, Excess Winter Deaths and Cold-Related Harm sets out how housing is a key determinant of health and poor quality or unsuitable homes can directly affect people's physical and mental wellbeing, creating or exacerbating health issues. The JNSA identifies that there is insufficient turnover in the housing market to enable or encourage households to move as their needs change. There is a need to optimise existing housing, increase the flexibility and choice in the housing offer as well as deliver increased provision overall. The JNSA recommends that the Health & Wellbeing Strategy retains a focus on housing as a means of improving health outcomes.
Nottingham and Nottinghamshire Sustainability Transformation Plan (STP)	
The STP brings together NHS organisations, the Local Authority and other local partners to develop an integrated approach to delivering services across the local geographical footprint.	Nottingham and Nottinghamshire's STP is one of the only STPs that specifically identifies a role for housing. The 'Housing and Environment' theme aims to maximise potential health and wellbeing improvements by addressing wider determinants of health such as housing standards and environmental factors. This includes the aim to support people to live independently at home, and an identified action to develop a common hospital discharge scheme across the footprint.
Nottingham and Nottinghamshire ICS Health Inequalities Strategy	
This 5-year strategic plan (2020-2024) sets out a shared vision to both increase the duration of people's lives and improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.	Health inequalities are driven by wider determinants of health, including the quality of housing. The strategy supports effective place-based working, including community-based interventions through collaborations and partnerships. Objectives in terms of housing are to: • Identify and commit to actions that further provide for safe homes and are targeted to areas of highest need • Support actions that help to keep people in their homes at a time of financial insecurity and increasing unemployment • As a system, provide support to community assets that are essential services for people in their own homes • Social housing embedded as part of integrated discharge approach
Joint Health and Wellbeing Strategy for Nottingham	
This sets the priorities for the Nottingham City Health and Wellbeing Board (HWB). The primary aim of the HWB is to improve health and wellbeing and reduce health inequalities across Nottingham City.	The priorities for 2022-25 are tobacco control, healthy eating and physical activity, serious and multiple disadvantage and financial wellbeing. Housing is considered to be an important factor in addressing the wider determinants of health, and Nottingham City Homes as a key partner in reaching and supporting Nottingham citizens in achieving the aims of the strategy.

The project also aims to have a more immediate effect on the levels of pressure on acute NHS services. The NHS continues to face high levels of bed pressure and demand on its acute services. Delayed discharge from hospital care is costly for hospital trusts. In addition to having to pay to provide places for patients who are ready to leave, there are then insufficient beds for people who need hospital care. Keeping patients in hospital longer than required can have long term detrimental effects on the individual and their families, and can place additional strain on health and social care resources. Prolonged stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections. Effects on mobility can be particularly felt by older patients. For every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80 years old, and building this muscle strength back up takes twice as long as it does to deteriorate. As well as leading to a detrimental loss of independence, this can also mean that patients may require additional health and social care support as a result.[4]

To help reduce DTOC, the H2H has a specific HHC for Integrated Discharge, who works alongside the hospital Integrated Discharge Teams to identify and support those in hospital who are medically fit for discharge, but awaiting housing solutions.

Social housing context

At a national level, the Government's social housing White Paper 'The Charter for Social Housing Residents'[5], published in 2020, sets the Government's policy focus, with emphasis on safety, quality, performance, fairness, respect and strengthening the voice of residents. Developing the themes set out in 2018's Green Paper on social housing, produced in the wake of the Grenfell Tower fire, the White Paper places a new and renewed focus on tenant and resident empowerment to drive improved service quality and standards for social housing. This is underpinned by new regulatory powers, given legislative force by the Social Housing Regulation Bill 2022, with a significantly enhanced role for the Regulator of Social Housing (RSH) and the Housing Ombudsman. NCH has been preparing for these changes to ensure that services are delivered appropriately, by, for example, adopting and implementing good practice guidance provided by the Regulator and the Ombudsman.

The White Paper recognises the importance of safe homes, but also the positive role that social housing can play in helping tackle loneliness, and supporting people to have meaningful social relationships which is crucial to people's physical and mental health. Well-designed homes and estates also serve to help improve such health outcomes: "Secure, safe and decent housing can support positive mental health."

The wider national context includes such matters as the dramatic impact of the post pandemic challenges faced by residents, which include the difficulties created by new variants of the infection, and the significant problems created by the cost-of-living crisis that has accelerated in the recent period – with inflationary pressures on fuel and food that have not been seen for a generation, and which fall particularly hard on low-income households. Such households make up the majority of residents in social housing.

[4] See https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/managing-transfers-care-frequently-asked-questions
[5] Social Housing White Paper: https://www.gov.uk/government/publications/the-charter-for-social-housing-residents-social-housing-white-paper

Locally, NCH works to support the strategic objectives for the City of Nottingham as a key partner to a range of other public, private and voluntary sector bodies. The Council's strategic direction is set out in the Strategic Council Plan 2021-2023[6], which sets out what the council aims to deliver over the Plan's life, with specific relevance to the post Covid-19 pandemic economic environment that Nottingham residents and businesses live and work in. This plan sets out an overall vision for Nottingham, and a set of eleven high level outcomes, one of which is housing, another is a healthy and inclusive Nottingham. Although the scale of ambition will necessarily reflect the future availability of Council investment, the fundamental commitment to accessing good quality, affordable homes remains.

The Council Plan is supported by a variety of strategies, including the emerging Housing Strategy which will commence in 2023. This strategy is currently under development, with the new Strategy having three underpinning principles:

- **Improving the Health, Wellbeing, and Quality of Life of Citizens through the Home** by delivering quality housing and services that meet the diverse needs of the City's residents.
- **Tackling the Climate Emergency** through the delivery of more energy efficient and affordable to run homes.
- **Supporting the Economic Growth of the City** by maximising housing delivery and investment that also supports opportunities for local employment, innovation, and wider economic growth.

In terms of the future context for the project, it should be noted that in light of the recommendations of a government commissioned 'non-statutory review' of Nottingham City Council in late 2020, Nottingham City Council published its Recovery and Improvement Plan 2021-2024 in January 2021 which included the intention to review the Nottingham City Homes Group. Following this review, in April 2022 Nottingham City Council's Executive Board accepted the report's recommendation to take over the direct management of council housing, with 12 months' Notice to Terminate on NCH in respect of its housing functions.

The report further commits to putting in place the relevant practical processes to carry out this recommendation, alongside measures to transfer staff, arrangements for effective tenant and leaseholder engagement, the transfer of relevant third party contracts and other relevant arrangements as may be necessary. It is intended that this transition will happen on 31 March 2023.

Nottingham City Homes and Nottingham City Council have committed to ensuring that quality services are maintained for tenants and residents, and that it is 'business as usual' during this transition. NCH are determined to continue to do the best for the residents they serve in the run up to and during this process of transition. They will continue to implement the commitments detailed in the NCH Corporate Plan, with its focus on safe, decent homes and quality services, whilst supporting staff and residents as they work with the council to ensure an orderly service transition in due course.

NCH adopted its current three-year Corporate Plan in April 2021 which included a number of relevant commitments, for example:

[6] https://www.nottinghamcity.gov.uk/your-council/strategic-council-plan-2021-23/

- Continuing to update homes we manage for older people
- Look for new opportunities to expand services through our work with the Nottingham City Integrated Care Partnership, to provide specialist supported housing and amalgamate resources to provide better integrated health, housing and care provision
- Expanding our assistive technology offer

However, despite local commitments, the need for housing continues to grow and the supply remains limited. Throughout the period when the H2H project has been operating, discounted sales of social housing through the Right to Buy continue to reduce the stock of council homes at a greater rate than new social housing is constructed, despite the proactive approach to building new social housing pursued by NCH and NCC. The result in Nottingham is that demand for social housing massively outweighs the supply of such housing. As a result, NCH has to prioritise applicants, as set out in its current Allocations Policy which was implemented from 2020. This placed applicants with medical needs or occupying a hospital bed in a higher priority band than before, but places homeless households as the highest priority (also re-enforced by Government strategy on homelessness during the Covid pandemic).

The effects of the increased demand for properties are shown in **Error! Reference source not found.** below. Since the start of the project, the overall trend has been an increase in average waiting times for an NCH property on the general waiting list. There are also fewer properties of the type suitable for H2H patients[7] available, shown by the decrease in the number of new lets that are able to be made year on year.

This has continued in the current year, exacerbated by the after-effects of Coronavirus pandemic. For example, there have been acute problems in preparing empty (void) properties for re-letting, due to staff absences due to Covid and supply issues for trades/repairs.

[7] Figure 1 includes new lets and waiting times for Independent Living flats and bungalows, General Needs bungalows and one-bedroom flats.

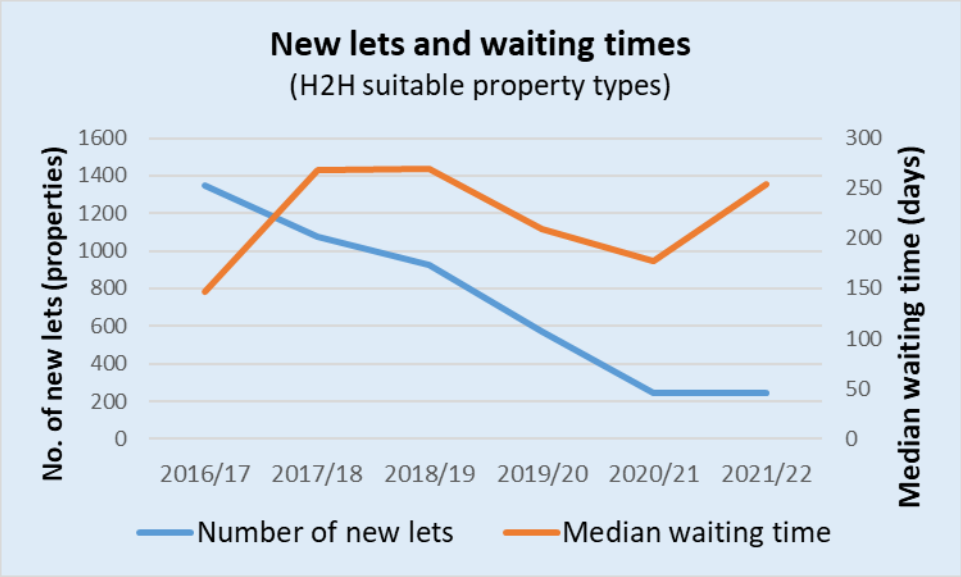


Figure 1: Number of new lets per year, and median waiting time

Whilst the availability of social housing properties for let has affected the project, the HHCs have continued to seek out appropriate properties for their patients, and are able to use the terms of the allocations policy to prioritise offers on newly available lets to H2H patients due their health needs.

Case study: Early intervention due to unsuitable housing

Ms Finch, aged 60, was referred to the service by an Occupational Therapist with the Early Intervention team. She was living in an upper floor flat and was struggling to safely mobilise around her home due to internal stairs.

She was not sleeping in her bedroom at the time, instead she was sleeping on the sofa downstairs. She had several health conditions, including cancer, arthritis and depression, and it was becoming dangerous for her to attempt the stairs at night. She had also mentioned to her carers that she was struggling to afford to heat her home, given its size.

The HHC contacted Ms Finch to complete a housing application, set up a repayment plan for arrears and apply for the housing benefit she was eligible for. The HHC began bidding for properties, and soon found a flat in Ms Finch's preferred area, close to amenities and family support.

After Ms Finch settled in, the HHC rang her to check how she was doing. She expressed how much she loved the flat and said that the Housing to Health service ***"saved my life."*** Without the intervention of the service, it is likely that Ms Finch would have had a fall that resulted in a hospital admission. She was also at risk of eviction due to her arrears and could have fallen into fuel poverty over the winter.

***Name has been changed**

2. Service delivery and patient characteristics

2.1. Engagement and generating referrals

The HHCs now have well established links to staff within Nottingham University Hospitals (NUH), local mental health units and healthcare in the community. The HHC for Integrated Discharge works as part of the Integrated Discharge Function within the hospital.

During the Covid pandemic and afterwards, the HHCs have continued to mainly work remotely to maintain the safety of staff and H2H patients. Referrals have been made electronically or over the phone, and the application process has also been completed over the phone or electronically. The HHCs have also worked innovatively within the safety guidelines, to ensure that they can continue to support vulnerable customers. Within this evaluation period, HHCs have been able to resume in-person property viewing and hand-over, ensuring they are able to support the patient during the move.

Despite the interruption to working practices, referrals into the project have only reduced slightly from previous years, with 228 referrals into the project in Year 6. The majority of referrals (just under three quarters of referrals) were from staff in the community, including housing staff, healthcare staff (e.g. Occupational Therapists, Care Coordinators, nurses) and social or other support workers.

The HHC for Integrated Discharge, who usually operates from within the hospital, has maintained links with the Integrated Discharge Team (IDT) and other hospital staff whilst working remotely. Referrals via hospital-based staff have been affected by turnover in staff members and continuation of remote working. This year, 28% of referrals were from staff in the hospitals – mainly social/support workers within the Integrated Discharge Team, Occupational Therapists or ward Discharge Coordinators. The team have seen an increase in referrals via community pathways for patients who have previously been in hospital, but have been discharged home.

Source of referral - Community	%
NCH staff	30%
Occupational therapist	19%
Self-referral	16%
Social or support worker	13%
Other healthcare staff	9%
GP	7%
Community coordinator/healthcare staff	5%
Discharge coordinator	1%
TOTAL	**164**

Source of referral - Hospital	%
Social or support worker	48%
Discharge team	29%
Occupational therapist	15%
Other	8%
TOTAL	**64**

Table 2: Sources of referrals from community and hospital staff

Out of the 228 referrals, around a third of cases were subsequently closed. Closure reasons include the patient being not willing to engage with the scheme, or other reasons further through the process – for example, in some cases patients chose to remain in their current

home with some home care support in place. In other cases, patients or the family refused the properties that were offered to them, and decided not to move.

In 2021/22, 89 people had been successfully rehoused into social housing properties. A further 61 applications were live, still undergoing the assessment or allocation process

Partner testimonial: Cancer support worker

"I rang the Housing to Health team to see if they could offer support to a client I was working with, after finding out a little more about the client a referral to the team was made which was easy and efficient. The team contacted the client soon after this and arranged a face-to-face meeting, which my client was happy about. Within days a flat had been found for my client with a view to move into when able.

My client was a changed person knowing that they had somewhere to go and the support in place to help, this was very important for someone with a life - changing and limiting diagnosis.

I am impressed by the time it took to contact the client and get the support started and I feel this shows positive joined up work from two services supporting people who need it in the community."

2.2. Service performance: Rehousing patients requiring early intervention or discharge from acute care

A total of 89 people were rehoused in Year 6. This brings the total to 633 people rehoused since the beginning of the project in November 2015.

The median[8] rehousing time for H2H patients (from the date the referral was received to the start of the new tenancy) was 76 days. This has decreased by 10 days from the median for Year 5, as the difficulties and delays due to Covid working practices have eased. This rehousing time is still considerably below the average waiting time of someone outside of the H2H project, which in 2021/22 was 255 days for a similar property (1 bedroom flat or bungalow in Independent Living or General Needs) for someone in the high priority bands on the general waiting list.

The first category of H2H patients focuses on those that are in a health or social care bed, or continuing to receive social care at home, who were medically fit for discharge from care but were receiving ongoing care because their home is unsuitable for discharge – resulting in a delayed transfer of care (DTOC). This includes H2H patients who were either in a hospital bed (general or mental health hospital), community or rehabilitation bed, mental health step down unit, or in residential social care at the point of referral.

[8] The median value for housing time (application to tenancy start) is used throughout, instead of the mean, due to a number of outliers (i.e. a small number of individuals whose cases took a long time to resolve) resulting in a positively skewed distribution of rehousing times which results in a higher mean value.

In Year 6 this included 26 patients (29% of those rehoused). The proportion of DTOC cases has reduced since the start of the Covid pandemic. Table 3 shows the breakdown of the location of H2H patients at the time of referral. This year, the number of cases where the patient was occupying a hospital bed on referral is back to levels seen pre-pandemic. However the number of cases of patients either in a community or social care bed, or a mental health bed have decreased slightly this year.

Location on referral	Count
Hospital	12
Residential social care	5
Community/rehab bed	3
Mental health step down unit	4
Mental health hospital	2

Table 3: Location of H2H patients on referral

The remaining 71% of cases were referred from the community, i.e. early intervention cases. The aim of early intervention is to help those at risk of hospital admission due to their housing conditions, and therefore avoid/reduce hospital (re)admissions.

Of the 63 early intervention cases, 47 individuals (75%) were judged to be at relatively high risk of imminent hospitalisation due to their housing conditions[9]. The most common reason is due to the risk of falling at home, or mobility issues – this was recorded as the primary risk factor in 72% of high-risk early intervention cases. A further 17% were at risk of hospitalisation due to unsuitable housing exacerbating existing health conditions, such as COPD or heart failure. A further 11% were at risk of admission due to serious impacts on their mental health from housing/neighbourhood conditions.

It is estimated (from either hospital admissions data or patient recall) that 29% had already had a hospital admission in the last six months.

In addition to being suitably rehoused, many H2H patients have the Nottingham on Call service in their new home, providing them with assistive technology, including a 24-hour monitoring and response service. In Year 6, 52 H2H patients had Nottingham on Call facilities installed in their new home. This takes the overall total over the lifetime of the project to 449 H2H patients supplied with Nottingham on Call facilities (71% of all H2H patients).

[9] According to the judgment of the clinical practitioner referring the case.

Case study: Enabling independent living in the community

Mr C*, aged 61, was referred to the service by the Integrated Discharge Team after a recent leg amputation had resulted in him becoming an essential wheelchair user. His home at the time, a two-storey council property, was not suitable for both his new mobility requirements as well as his other health conditions (Parkinson's disease and dementia).

After his diagnosis several years ago, his wife had become his full-time carer. However, it became clear after his recent operation that the home was not suitable for his needs and it would be impossible for his wife to care for him long-term if they remained there. A care home placement was considered, however the family feared he would lose his independence in a care home setting.

It was agreed with the hospital that Mr C would return home, to be cared for by his wife until a suitable property could be found. This was not an ideal situation or without risk, as Mr C had a one room existence where he slept in a hospital bed in the living room with a commode nearby. He became confused during the night and would attempt to leave his bed, causing falls. His wife began to sleep by his bedside in a chair, fearing he would fall and face further hospital admissions.

The HHC worked quickly to complete a housing application, as well as for priority on medical grounds. The HHC searched for and found a two-bed bungalow that would meet all of Mr C's medical needs. The HHC carried out the viewing as well as all of the paperwork. She ensured that all correct benefits were in place, set up all utilities and benefits and made sure that there was an appropriate care plan in place – the couple moved in soon after.

Six months after they moved, the HHC visited them to see how they were doing. The couple were ecstatic with the property and the help that the service provided. When asked about the service, the couple said ***"Thank you so much for all of your help. Our bungalow is absolutely beautiful and we are so happy here. I can't say enough to praise the bungalow, the area and the help we had."***

This is what Mr C had to say about the difference it had made to him. ***"Before I moved here I was living in the living room with a hospital bed and a commode because I could get anywhere else in the property. The wheelchair wouldn't fit and I couldn't go up the stairs. Now I am able to go in and out to the garden and I sleep in my bedroom and I can now enjoy sitting in the living room with family when they visit."***

**Name has been changed*

2.3. Characteristics of re-housed patients

An overview of the data on the characteristics of re-housed patients in Year 6 shows that the older patient group, with accessibility/mobility issues, remains the primary group of H2H patients. In Year 6, there are higher levels of reported mental health issues amongst the whole patient group (not just those referred via the Mental Health pathway). This may reflect the impact of the Covid pandemic on the mental health of this patient group. In general, on referral the patient group has multiple health issues, and lower health-related quality of life, self-reported health and mental wellbeing compared to population averages for this age group.

The referral criteria for the project separates patients into three groups: older people requiring rehousing to Independent Living; people of any age needing wheelchair accessible properties; and those receiving mental health treatment who require rehousing. Table 4 opposite shows the spread of cases across the criteria for referrals into the project. This is similar to the spread of cases in the previous year.

Referral criteria	%
Over 55/60s	86%
Essential Wheelchair	7%
Mental Health	7%

Table 4: Service users' referral criteria

Case study: Supporting discharge from mental health hospital into independent living

Mr D, aged 27, was referred to the service by his support worker at the mental health step-down unit. He had previously been admitted to a mental health hospital before moving to the step-down unit as he was experiencing an episode of psychosis.

Due to his mental health, his relationship with his family had broken down and he was unable to return home. He had to take a leave of absence from his full-time employment as he was admitted to hospital, and was keen to return to work once he was in stable accommodation that could allow him to recover.

The HHC quickly made contact with Mr D, arranging to meet him at the step-down unit to complete a HomeLink application with him. She kept in contact with him at least once a week to discuss what properties were available and when one was sourced, she worked with NCH staff to ensure it was fast tracked for his discharge.

Once the keys were received, the HHC supported Mr D to ensure that all appropriate paperwork was completed, his benefits were in place and that his mental health team had the necessary support and care in place in the community. From the date of referral to the tenancy start date, the process took 35 days. The step-down unit where Mr D was staying only provided 8 weeks of support, so the quick turnaround by the Housing to Health team ensured that Mr D was rehoused before discharge was necessary and that his bed was quickly made available to the next client.

Without the help of the Housing to Health service, it is likely that Mr D would have been discharged to NCC Housing Aid for temporary accommodation. This could have resulted in further distress for him, potentially exacerbating his mental health condition. Being discharged directly to his new tenancy allowed him to make a fresh start, with all the support in place for him to succeed.

Name has been changed

Patients are referred into the project because they have health issues that mean their housing is unsuitable for their needs, which can be for a number of reasons. A review of each case classified the primary reason why the individual needed to move. The most common reason is that the property is no longer accessible due to restricted mobility of the individual – this on par with the previous year.

Primary reason for move	%
Accessibility	77%
Wellbeing/ mental health	21%
Insecure housing/ homeless	11%
Disrepair/hazardous	4%
Other	8%

Table 5: Primary reason for move (multiple reasons in some cases)

The second most common reason is as a result of the property or location negatively impacting on the individuals' wellbeing or mental health. For example, wellbeing issues could be where there are problems with neighbours or they have been victims of crime or anti-social behaviour, or they need to be closer to family or carers. The need may also arise more specifically from mental health needs, i.e. the need for suitable housing given the individual's needs.

Patients were also moved due to 'insecure housing' or threat of homelessness, i.e. where the individual's ability to remain in their current home is under threat, and this is negatively impacting on their health. This can be due to eviction/end of tenancy of a rented property, a family home being sold, overcrowding, or a relationship breakdown.

Finally, a small number of cases were referred because patients were not able to return to their home because it was in a hazardous condition. This includes issues such as homes in a state of general disrepair or specific repair issues that are impacting on health e.g. damp or cold housing.

The health status of patients was gathered via case notes from assessment visits by the HHC, and via the completion of a number of validated tools for the assessment of health and wellbeing. These assessments are completed when the patient is first referred to the project, and repeated six months after the patient moves to the new property, to assess change in physical and mental wellbeing (see Section 3.5).

Table 6 shows the pre-existing medical conditions experienced by H2H patients at the point of referral into the scheme. **The most common medical issues are related to mobility restrictions or difficulties**, reflecting the primary reason for people needing to move being accessibility to their current home. The proportion of patients reporting mobility issues has been rising steadily year on you, and in addition in Year 6 more patients are reporting that they are frail/elderly.

This year, just over half of the patient group report having mental health issues or illness on referral, which expands outside of those referred into the Mental Health pathway (numbers of which have remained stable), but instead reflects increased mental health issues across all patient groups. The proportion of patients reporting mental health issues jumped up in the first year of the pandemic, and remains high this year.

Just under a quarter of the group have already had a fall recently. A quarter of the patients have breathing difficulties, which is in line with the high incidence of respiratory conditions

amongst the Nottingham population. The number of wheelchair users has increased slightly from previous years.

Health issues	%
Restricted mobility or difficulty getting upstairs	79%
Mental health illness or issues	55%
Frail / elderly	36%
Arthritis	26%
Breathing difficulties	24%
Had a fall	21%
Heart problems	18%

Health issues	%
Wheelchair user	16%
Other	12%
Had a stroke	10%
Diabetes	10%
Visually or hearing impaired	8%
Cancer	5%

Table 6: Pre-existing health conditions reported by H2H patients

The validated health and wellbeing tools/measures used to assess baseline health include:

- **Health-related quality of life** (EQ-5D - 5 level) – assesses levels of mobility, self-care, usual activities, pain/discomfort and anxiety/depression, converted to an overall health utility index. This is the measure developed by the National Institute of Clinical Evidence (NICE) to evidence whether an intervention is cost-effective
- **Self-reported health scale** (Visual Analogue Scale) – asks patients to score their overall health between 0 (worst imaginable health) and 100 (best imaginable health)
- **Mental wellbeing** (Short Warwick-Edinburgh Mental Wellbeing Scale) – asks patients 7 questions that give an overall score for mental wellbeing of between 7 and 35.

At the point that they were referred to H2H:

- The **health-related quality of life** (EQ-5D) index indicates that almost two-thirds of patients have moderate to severe issues with mobility, and around half of patients have moderate-severe issues with self-care, performing their usual activities, pain/discomfort and depression/anxiety. The overall average **EQ-5D index score was 0.55 (on a scale of 0 to 1)**, which is on par with previous years. This is well below the England average for this age group, which is 0.785 for the 65-74 age group.[10]
- On average, the H2H patients scored their **self-reported health at 37 out of 100** on the scale. As may be expected, this is much lower than the England population norm of 82.5, and also lower than the average for population aged over 65 which stands at 70 out of 100.[11] The average self-reported health score for patients on referral has been gradually falling over the years the project has been operating.
- The average **mental wellbeing score was 19 out of 35**, which is lower than the England average of 23.6. This is a similar level to H2H patients in previous years.

[10] Fend, Devlin and Herdman. *Assessing the health of the general population in England: how do the three- and five-level versions of EQ-5D compare?* (Health and Quality of Life Outcomes, 2016 13: 171)
[11] Ibid 8

The previous tenure of the 89 people who were rehoused is shown in Table 7. The biggest category is existing NCH tenants, who were living in other NCH properties that no longer appropriate for their needs. There has been a slight increase in people rehoused from private rented accomodation.

Previous tenure	%
NCH tenants	51%
Private rented	18%
Other RSL tenants	13%
Living with family/friend	9%
Owner occupier	3%
NHS hospital (inc. MH)	2%
Residential/ Care home	2%
Homeless	2%

Table 7: Previous tenure of H2H patients

Other demographic information about the main patient is shown in the table below:

Age group	%
<55	7%
55-59	11%
60-64	21%
65-74	31%
75-84	21%
85+	9%

Gender	%
Male	54%
Female	46%

Ethnicity	%
Non-BME	75%
BME	25%

Table 8: Demographic information

Case study: Secure and appropriate housing for independent living

Ms G, aged 78, was referred to the service by an NCH Housing Patch Manager. She had recently been discharged from hospital with COVID and was living in her son's bungalow. Sadly, her son passed away and as she was not on the tenancy paperwork, she was unable to remain in the property long-term.

The HHC soon made contact with Ms G with a telephone appointment, adhering to COVID protocols, and set up a housing application. She applied for priority re-housing, given that she was unable to succeed her sons NCH tenancy.

A bungalow was sourced in an area that Ms G knew well, with a big enough garden for her to move with her family dog. The HHC guided her through the moving process, from the viewing to the sign-up paperwork and moving day.

Ms G was very thankful for the help of the service and felt much more secure in her own tenancy. The service was able to hold her hand through the process, taking away a lot of the stress and anxiety of moving from her son's home.

Name has been changed

3. Project outcomes and impact

3.1. Reducing hospital readmissions post intervention

The overall aim of the project is that by supporting individuals to move from housing that is negatively impacting on their health and wellbeing into more suitable housing, this will hopefully reduce the number of (re)admissions into hospital. This helps to reduce the long-term pressures and costs on the NHS, by having an ongoing effect on the number of hospital admissions.

It is also anticipated that reducing hospital (re)admissions will also help individuals to live independently for longer (one of the objectives of the project), as a stay in hospital – particularly a lengthy one – can often lead to loss of muscle strength for older patients, and can have increased risk of infection, low mood and reduced motivation.[12]

Through a data-sharing exercise with Nottingham University Hospitals, data on actual hospital admissions for a sample H2H patients (those who have given consent to access hospital records) is available, covering the six months before and after the intervention of the H2H project. This includes H2H patients referred via hospital pathway, or through early intervention in the community. The data covers the number of admissions, length of stay, excess bed days and costs of stay.

In total, hospital admissions data is available for 462 people who gave permission to access and share their hospital admissions data since the start of the project. This includes 335 people rehoused since the beginning of the project, and a further 127 who had contact with the scheme, but were not rehoused (reasons included patients refusing to move, or patients with live applications who have not yet accepted a property). This provides a comparison group of individuals with similar needs to those who have been rehoused (i.e. meeting the criteria for H2H project), but who haven't actually moved. This helps to isolate the difference that moving into more appropriate housing makes to hospital admissions.

The results from this sample is modelled to show the overall effects on long-term hospital admissions, extrapolated to demonstrate the effects over the whole H2H population of patients, over a year. The results are shown for the project overall, and for the latest year of data (October 2020 – September 2021 Year 5/6[13]).

H2H re-housed group:

Overall, 42% of rehoused H2H patients had an emergency admission to hospital in the six months prior to the H2H intervention. This proportion has remained fairly stable across the life of the project.

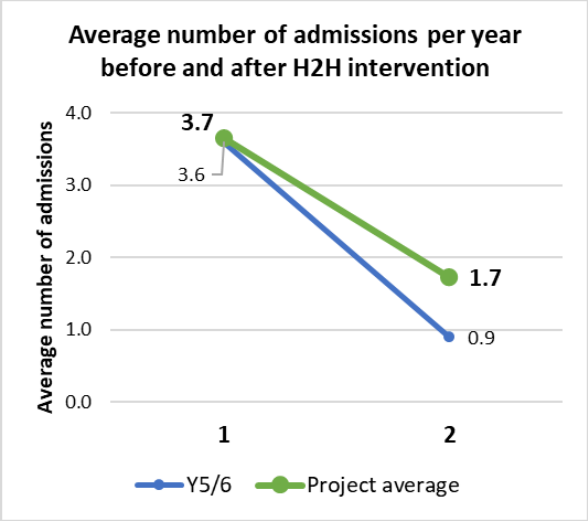
[12] The Kings Fund https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide

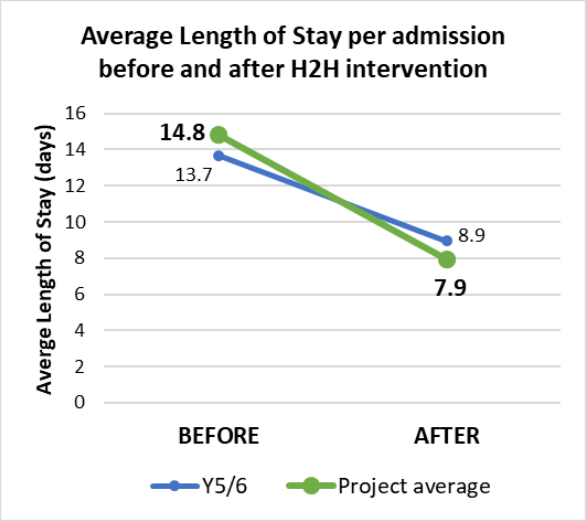
[13] The need to wait six months after the tenant has moved, in order to collect data in the post-intervention period, means that there is a six-month lag in the hospital admissions data, compared to the rest of the evaluation data. The most recent year's figures are included to show changing trends in the data, but it should be noted that results for the cohort as a whole are statistically more reliable than looking at an individual year, due to the larger sample size.

In the period after the H2H intervention, the proportion of the group that has a hospital admission reduces down to 27% overall (24% in latest year's data, Year 4/5). The latest year's data shows the biggest drop in admissions following the H2H intervention to date.

Of those who had an emergency admission prior to the H2H intervention, the average number of admissions is 3.7 per person in the year before the intervention, averaging 15 days stay in hospital per admission. Of the total hospital bed days, 10% were Excess Bed Days. The average cost of stay in the period before the intervention was £3,850.

For the same group (those admitted to hospital prior to H2H intervention), the average number of admissions in the year after the intervention reduces to 1.7 admissions per person, and average length of stay per admission reduces to 8 days. There are also fewer Excess Bed Days in the period after the intervention, only accounting for 1% of total bed days. The average cost of stay in the period after the intervention is £3,300, reflecting the shorter average length of stay.





To model the full extent of the impact of the project, the results from the sample of H2H patients with hospital admissions data is applied to the full population of individuals rehoused via H2H. The modelling focuses on the 42% of patients who did have an admission in the six months prior to the intervention i.e. the group of 'hospital users' – applying these results to the same proportion of the overall H2H group. This gives the overall results in regards to an anticipated 244 H2H patients who were, or would have been, hospital users prior to the intervention.

The results show that for Year 5/6 (October 2020 – September 2021):

- Total admissions were reduced by 86 per year
- Total bed days were reduced by 1,311 per year, including 80 fewer EBD per year
- Total cost-reduction of £458,538 over the year

The results show that over the whole project since November 2015:

- 470 fewer admissions
- 9,875 bed days saved, including 1,318 fewer EBD
- Total cost-reduction of £2.4m

	Year 5/6 (Oct 20 - Sep 21)			Cumulative over project (5 years, 11 months)		
	Before H2H	**After H2H**	***Difference***	**Before H2H**	**After H2H**	***Differ-ence***
% admitted to hospital	36%	24%	***-12%***	42%	27%	***-15%***
Admits per person, per year*	3.6	0.9	***-2.7***	3.7	1.7	***-1.9***
Average length of stay per admission*	14 days	9 days	***-5 days***	15 days	8 days	***-7 days***
% bed days that were Excess Bed Days*	6%	3%	***-3%***	10%	1%	***-9%***
Total admissions	114	29	***-86***	891	421	***-470***
Total number of bed days (admit x length of stay)	1,566	256	***-1,311***	13,207	3,332	***-9,875***
Total cost (admits and EBD)	£572,877	£114,339	***-£458,538***	£3.77m	£1.40m	***-£2.37m***

**Amongst those admitted to hospital in 6 months prior to intervention*
Table 9: Results from hospital admission data, H2H rehoused group

Not re-housed (comparison) group:

Data for the not re-housed (comparison) group is only available cumulatively over the project. This is because, since Covid there has been limited/no face-to-face contact with those who initially engage with the project but don't go on to be rehoused (the comparison group), so it has been difficult to get consent from this group to access their hospital data. Therefore the number of individuals within the control group in recent years has been low, and so only the cumulative data over the whole project (with enough individuals collectively to provide a meaningful sample) is used.

In the six months before being referred to the project, 40% of this group had an admission to hospital. This reduced to 23% of the group in the six months after the contact with the project – although this is a significant reduction in admissions within this group, the reduction is smaller than that for the re-housed group.

Of those admitted in the 6 months before contact with the project, the average admissions per person per year reduced from 3.3 to 1.7 after contact with the project, a significant but slightly smaller reduction than in the rehoused group. There was a significant reduction in length of stay per admission for this group before and after, from 16 days to 8 days. The proportion of bed days that were Excess Bed Days also reduced from 7% to 2%.

The results suggest that if scaled up in the same way as the rehoused group, there would be a reduction in overall cost for this group (in the region of £1.9m in total), but that this cost saving is less than for the re-housed group.

There are a few comments/implications from the results for the non-rehoused group:

- Despite not being rehoused, this group may have benefited in some way from contact with the H2H project – for example, HHCs may refer individuals to further support (e.g. aids and adaptations, other support services) even though they are not rehoused i.e. some level of intervention may have occurred amongst this group.
- The results suggest that people referred to the H2H project, whether rehoused or not, are potentially at a crisis point in their life where their health has deteriorated in recent months. This crisis point is likely to lead to multiple interventions, both medical and non-medical, that result in fewer and shorter hospital admissions in the future.
- However, the results show that the changes experienced by the rehoused group are slightly larger than those experienced by the non-rehoused group, resulting in larger reductions in number of admissions, length of stay, and thus overall cost reductions.

This seems to suggest that **being re-housed through the H2H project does have a positive impact on reducing the number of hospital admissions, over and above those who are in similar circumstances but do not actually move home.** The H2H project is achieving its aim to reduce hospital readmissions, and in doing so helps 'enable citizens to live independently for longer, with less reliance on intensive care packages'.

Case study: Re-housing for safety and mental wellbeing

Mrs B, aged 68, was referred to the service by Nottingham City Homes staff after a traumatic incident where she had been sexually assaulted by somebody who lived close to her home. While the incident was being investigated by police, there was a further incident in the local area with the perpetrator approaching Mrs B and her daughter and becoming aggressive.

Mrs B became very anxious and fearful in both her home and community which was exacerbating her existing mental health and physical health conditions. She had previously suffered a stroke and required a wheelchair to access her community, as well as a zimmer-frame inside her home.

The HHC quickly made contact with Mrs B to complete a housing application. She began to place bids on Mrs B's behalf, sourcing a ground-floor flat that was both suitable for her medical needs as well as being located in an area where she could feel safe and secure but still access the support from her daughter that she relied upon.

Once the property was ready, the HHC supported Mrs B by making sure all the appropriate paperwork was completed, utilities were set up and that all the correct benefits were in place. The process took 25 days from the very first day she was referred to the day she was able to move in. Without the service taking such fast action, it is possible that Mrs B's mental health could have declined, resulting in a hospital admission. It is also possible that the perpetrator may have continued to harass her, causing further pain and distress.

Six months after moving in, the HHC contacted Mrs B to see how she had settled into her new home. Both Mrs B and her daughter rated the service 10 out of 10. Her daughter said ***"an excellent, fast service – my mother is now safe and secure."*** When asked what the biggest difference was, Mrs B said ***"I have no people harassing me when I go to the shops and following me home. It's a more secure area."***

**Name has been changed*

3.2. Reducing Delayed Transfer of Care

One of the main aims of the project is to facilitate earlier discharge from hospital where inappropriate housing is the delaying factor in discharge. In Year 6 this included 26 patients, who were medically fit for discharge from care but were receiving ongoing care because their home is unsuitable for discharge – resulting in a delayed transfer of care (DTOC). This includes H2H patients who were either in a hospital bed (general or mental health hospital), community or rehabilitation bed, mental health step down unit, or in residential social care at the point of referral.

The effectiveness of the scheme in reducing DTOC is assessed by comparing discharge pathway and timescales under the H2H project with an alternative scenario of the generalised care pathway without the intervention of the H2H project. This provides an estimate of the potential additional days in health and social care that are avoided as a result of the H2H intervention.

The alternative scenario is determined by the pathway that the patient would most likely be placed on under Discharge to Assess (D2A). Once medically fit for discharge but awaiting a housing solution, patients will either be discharged home with an extensive package of social care (Pathway 1), be discharged to an NHS community or rehabilitation bed, residential social care, or mental health step-down unit (Pathway 2), or remain in a hospital ward (Pathway 3).

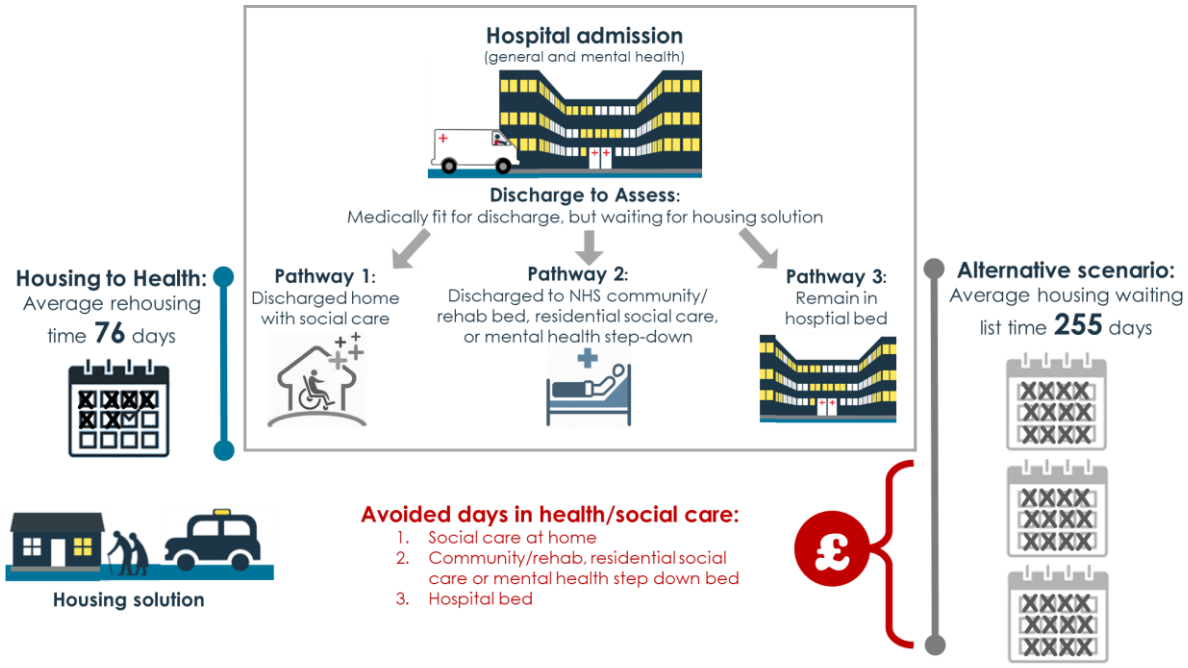


Figure 2: Cost avoidance model from reduced DTOC

Patients remain in one of these three care pathways until a housing solution is found. The counterfactual situation assumed is that without the H2H project, patients would go on the general social housing waiting list in a higher priority band because of their medical needs. The median waiting time for individuals in this group, applying for a flat or bungalow, is 255 days.

However, with the help of the H2H project the average rehousing time (from referral to tenancy start) is only 76 days. Thus the intervention of the project avoids an additional six months on average per patient, in either full social care package at home, a bed in either NHS community care or residential social care, or a hospital bed. In the evaluation, the days avoided are calculated on a case-by-case basis, taking into account the actual or assumed D2A pathway that the patient is on[14], their rehousing time, and the alternative waiting time for the type of property that they move into.

Table 10 shows the breakdown of discharge pathways for the H2H patients, and therefore the location of where the bed days are saved (and therefore who the cost-avoidance falls to[15]) compared to the counterfactual scenario. This shows a higher proportion discharged home with care this year, due to the Covid-related pressure on hospital bed spaces.

D2A pathway for H2H patients		Count
Pathway 1	Discharged home with care	8
Pathway 2	NHS community/rehab bed	6
	Residential social care	6
	Mental health step-down unit	0*
Pathway 3	Remain in specialist hospital bed	0

Table 10: H2H patients by D2A pathway

* Due to pressures on bed spaces, the mental health step-down unit can no longer extend a patients' stay beyond 8 weeks. Of the six patients referred from mental health facilities, all had already been in the step-down unit for 8 weeks at the point of being re-housed. If H2H had not re-housed them at that point, these individuals would have been registered as homeless to find housing in the community via that route. This is therefore assumed as the counterfactual pathway for these patients this year, rather than remaining as a long-term patient at the step-down unit.

Other elements of the DTOC model include:

- The counterfactual waiting time - the average time for rehousing an applicant (application to tenancy start date) in a high priority group on the general waiting list[16] in 2021/22 (Table 11)
- The average costs per bed day for various types of health or social care (Table 12)

Property type	Median rehousing time (days)
Independent Living flat	95
Independent Living bungalow	183
General needs 1 bed flat	181
General needs bungalow	684

Table 11: Median waiting times per property type for priority groups on general waiting list

[14] Based on hospital records where available, or case notes from the HHC.
[15] In this year, some social care placements were funding by the NHS through emergency Covid funding. These were identified in the data. Other social care placements were funded by the Local Authority.
[16] Bands 1 or 2, or Band A. Excluding H2H patients.

Health/social care facility	Cost per day
Hospital ward	£269
NHS community/rehabilitation bed	£167-285
Mental health hospital or step-down unit	£360
Residential social care	£82-163
Home care (average 12.8 hours social care per week)	£58

Table 12: Health and social care unit cost data, source Nottingham City ICB/PSSRU

Using this model, the H2H project has **avoided a potential additional 3,050 bed days of health or social care**, over the 26 DTOC cases dealt with by the project in 2021/22. However, 10 cases were unable to be assigned a cost-saving in this model, due to (a) 3 cases where the complexity of their situation meant that their re-housing time exceeded the counterfactual waiting time, and (b) 7 cases of individuals in mental health step-down units who would have otherwise been referred to homelessness services – these costs are captured in Section 3.3. below, so are not included here to avoid double-counting.

This results in **total cost-avoidance of £236,214**. The average cost-avoidance per case where costs are available is £14,763.

Days avoided from reduced DTOC	Days avoided	Costs avoided
NHS – General (hospital, community/rehab bed, residential care placement)	544	£66,311
ASC – Residential social care	90	£10,721
ASC – Home care	2,416	£141,370
Total NHS avoided care	***544***	***£84,122***
Total Adult Social Care avoided care	***2,506***	***£69,902***
Total DTOC avoided care	**3,050**	**£236,214**

Table 13: Total cost-avoidance from reducing Delayed Transfer of Care

The total cost avoidance from reduced DTOC is less in Year 6 compared to the previous year. This is partly due to lower number of DTOC cases this year compared to previous years. The main reason is due to the 10 cases that couldn't be assigned a cost in this year's model, as explained above. This year the savings have shifted away from NHS and residential social care, towards social care at home – this reflects the circumstances that many patients were (or would have been) discharged home with care as a temporary measure while suitable housing was sought, due to the pressures on bed spaces in hospital and care homes.

3.3. Impact on other service providers in the wider integrated care system

Reducing the need for home adaptations

Three-quarters of H2H patients were re-housed due to problems with accessibility, either into or around their previous property. In the majority of these cases, the issue was due to the property being on an upper floor, accessed by stairs or steps, with no alternative access such as level-access or lift access. As identified in the JNSA: *'Making the best use of our existing housing stock will be a challenge, terraced properties are difficult to adapt and access upstairs is often problematic'*. Therefore in most cases where upper-floor access is the issue, it would not be possible to resolve this with any form of adaptation to the existing property.

However, in 20 cases there would have been some potential to make one or more adaptations to the patient's existing home that would have reduced their problems with accessibility. There were 50 potential adaptations required, included ramp access to the front door, support rails for steps, a stair-lift for internal staircase, or conversion of a bathroom to a level-access wetroom. The average costs of these adaptations range from £100 for support rails, to £5,600 for a level-access shower.[17] These costs would fall to NCC's Adaptations Agency Service.

By moving these individuals to properties that are already adapted (with ground floor/lift access, and level-access wetrooms), this has avoided incurring these costs. Therefore the H2H project has **avoided £141,140 in adaptation costs to Nottingham City Council**.

Avoiding homelessness

There were 12 cases where the patient was at risk of becoming homeless at the point where they were referred into the scheme[18]. Without the H2H intervention, these individuals would most likely have sought help from NCC's Housing Aid team, requiring temporary accommodation until suitable housing could be found. The New Economy Unit Cost Database estimates that a homeless application and support for housing options costs the local authority £1,500 per case, plus a further cost of £127 per week for on-going temporary accommodation. It is assuming that these individuals would have been in temporary accommodation until an appropriate property could be found under the general housing register (using median waiting times shown in Table 11). Therefore the **total cost avoided for Nottingham City Council's Housing Aid as a result of the H2H intervention is £71,082.**

[17] National figures, sourced from the PSSRU Unit Costs for Health and Social Care 2019.
[18] Including patients in Mental Health Step-Down units who had reached the end of their maximum 8 week stay

Case study: Suitable housing to support independent living

Mr E, aged 57, was referred to the service by hospital occupational therapists after a recent amputation resulted in him becoming an essential wheelchair user. His home was on the third floor with no lift access and it was deemed not safe for him to return.

Due to COVID, he was temporarily discharged to his mother's house, with the understanding Housing to Health would source him permanent accommodation. Unfortunately, his mother's house was also unsuitable and he was having to sleep in a hospital bed in her living room, with a commode. His mother was in her 80s and was finding it difficult to mobilise around the equipment, so Mr E had to move to an upstairs bedroom where he became more isolated.

The HHC soon made contact with Mr E to complete a housing application form and to request priority rehousing on medical grounds. She began to place bids for him in an area close to family and a two-bed bungalow was offered to him within 3 months of referral – currently finding a bungalow can take almost two years on the general waiting list. She was able to quickly arrange for the move to go ahead, assisting with setting up utilities and ensuring he was claiming the benefits he was entitled to.

Having a bungalow meant that Mr E could become independent and adjust to his new life using a wheelchair. As the property had a garden, he was able to have a dog which was a great improvement for his state of mind. Due to the local transport links, his mother is able to visit on a regular basis for them to enjoy each other's company, without either of them being responsible for the others care needs. Since moving, he has made excellent progress with his physiotherapy and he is beginning to walk with the use of a prosthetic limb.

**Name has been changed*

3.4. Impact on social housing provider

In the sixth year of the project, a total of 89 properties were successfully let via the H2H scheme. Of these, 80 were NCH properties and 9 were managed by other RSL providers (let through the Homelink partnership).

Property data is only available for the 80 NCH properties. This shows that, on average, these properties had been void for 103 days (with days void prior to letting ranging from 14 to 490 days). This is longer than the average void time for similar properties, indicating that H2H is continuing to let properties from NCH's harder to let stock. Due to the shortage of available properties, HHCs have targeted hard-to-let properties, and this year 56% of properties let by H2H were officially defined as 'hard to let'.[19]

NCH aimed to reduce the number of long-term empty properties amongst its IL stock through the H2H scheme, to optimise the use of their housing stock. The H2H project has let 45 hard to let properties this year. In addition, in supporting H2H patients to move to properties more suited to their needs, the project has also freed up 45 NCH general needs properties, including flats and family housing, which are much in demand.

[19] NCH has an operational definition of 'hard to let' of 80 days void, i.e. properties that are ready to let for 50 or more days, plus an average void turnaround time of 30 days.

Empty properties have a cost implication for NCH, as there are associated costs (such as council tax) and lost rental income. For example, while these properties were empty prior to being let through the H2H project, this accrued £131,466 in lost rental income.

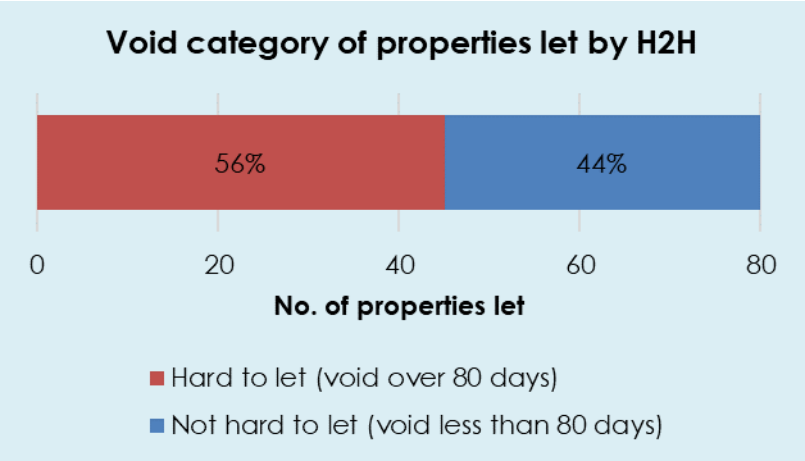


Figure 3: Void category (hard to let or not) of properties let via the H2H project

A measure of cost-benefit to NCH from letting these properties is modelled to indicate the benefits to NCH. The model is based on the evidence that (a) H2H continues to let properties from NCH's harder to let stock, reducing the number of properties that are empty for a long period of time, and (b) the intensive support provided by the HHCs means that the letting process is quicker for H2H patients, compared to the via the general lettings process.

The model assumes that without H2H, the property would have remained empty for the average void time for that category of property.[20] It is assumed that the H2H scheme is able to let these properties more quickly, thus reducing the time they are left void and therefore accruing void costs and lost rental income. The model assumes that the HHCs are able to let 'hard to let' properties in the time it usually takes to let a non-hard to let property, and that non-hard to let properties are let without delay.

Applying these assumptions, the H2H project has saved on average 84 days of lost rental income per property. Therefore **by letting the properties more swiftly through the H2H scheme, NCH has received £108,284 in rental income that it might otherwise not have received**. In addition, letting the properties more swiftly through the H2H project potentially **saved NCH £27,504 in council tax payments** (at £28.54 per week).

As more NCH IL properties have been filled and the choice of empty NCH properties reduces, the project has expanded to offering properties managed by other social housing organisations to H2H patients. The project team have worked to make links with other RSLs in the city with appropriate available properties. This enables them to provide a wider choice of homes and optimise the use of housing stock across the city.

[20] Average void times are calculated from 2021/22 lettings data, showing the average void time by property type (e.g. Independent Living, General Needs), and whether the property was 'hard to let' or not.

3.5. Impact on the health and wellbeing of patients and their carers

H2H patients completed a survey at the first assessment visit when they signed up to the project, and the survey is completed again six months after the patient moved into their new home. This provides data on their satisfaction with the scheme and new home, comparison of their health and wellbeing scores since being rehoused, and assessment of changes in other social outcomes.

During 2021/22, 43 patients completed the six-month follow-up survey. This sample of 43 is used to measure changes in outcomes before and since rehousing. These outcomes are summarised in Table 14 below, with further details in the following sections.

Outcome	Score/change in Y3
Patient satisfaction with service	9.9 out of 10
Patient satisfaction with new property	98% satisfied
Confidence managing their health at home	93% more confident now than 12 months ago
Health-related quality of life (EQ-5D)	11% improvement
Self-reported health score (VAS)	32% improvement
Mental wellbeing score (SWEMWBS)	24% increase
Social isolation/contact – have enough social contact	47% increase (91% have adequate/enough social contact now)
Feeling safe – feel adequately safe	67% increase (98% feel adequately safe now)
Financial comfort – doing alright/living comfortably	44% increase (98% doing alright/ living comfortably now)
Employment – employed full/part time (those of working age only)	Slight decrease (2 people left employment)
Carer's overall life satisfaction[21]	63% improvement (increased from 2.6 to 8.9 out of 10)

Table 14: Summary of social outcome changes after 6 months

Patient satisfaction

H2H patients are extremely happy with the service that they received through the project. Patients gave an **average score of 9.9 out of 10** for 'the support you received from the Health and Housing Coordinator throughout the process of finding and moving to your new home'.

The support provided by the HHCs is essential to patients in supporting them to move to a more suitable property, with **all** H2H patients stating that they would not have been able to

[21] 11 carers were present to complete a before and after question on their own life satisfaction

find and move to a more suitable home by themselves, i.e. without the Health and Housing Coordinators.

Almost all patients are satisfied with their new property (98%). This compares to only 14% who were satisfied with their previous home. This is a very significant increase in patients' satisfaction with the home they live in.

"Fabulous service. I couldn't have done the move without your help."

"Within 5 days I was registered, allocated a property, shown photos and signed up - all from my hospital bed."

"We really appreciate all the help we received from you. Thank you so much, you have been amazing."

"I didn't know where to start. I was in hospital and had an amputation. I couldn't go home to my flat because it was on the top floor. I was helped to apply and found a 2-bedroom bungalow which was more than I could have ever hoped for."

Partner testimonial: Social prescriber

"I made a referral into Housing to Health for a person that needed more support in the home, looking at Independent Living as would be more beneficial due to mobility issues and some social issues.

The social prescribers and Housing and Health Coordinator supported with the move, down to getting removals, carpets and a decorator in the new property before moving in. Also both teams supported getting settled into the new property from making the bed to sorting out the housing benefits and telephone line as only access to outside world.

The Housing and Health Coordinator was very responsive and this all happened within two weeks of the referral."

Health and wellbeing outcomes

The results show that health outcomes and ability to manage health at home have improved for this group since moving.

Just under half of respondents felt they had received some help managing their health at home since moving, including from carers, support workers, nurses/healthcare workers, and as a result of moving closer to family members. **93% feel more confident managing their health at home** now, compared to 12 months ago. No patients felt less confident in managing their own health.

The health scores show that respondents' health-related quality of life has shown a significant improvement. This covers aspects such as mobility, self-care, undertaking usual activities, pain or discomfort, and anxiety/depression. It gives an overall index score, with a maximum score of 1 – this is the measure used by NICE to prove the cost-effectiveness of interventions. The average score increased from 0.55 to 0.66 (out of 1), i.e. a **11% improvement in their health-related quality of life**.

Respondents were also asked to rate their own health state, using a scale from zero (worst imaginable health) to 100 (best imaginable health). Respondents' average self-reported health score increased significantly, from 37 to 69 (out of 100) – **a statistically significant increase of 32% in self-reported health**.

Levels of reported **anxiety and depression have also decreased significantly since moving**. Two-thirds of patients reported that they were moderately, severely or extremely anxious or depressed when they first engaged with the project, indicating significantly higher mental health issues at baseline than previous years. This has decreased to 23% who feel this way now, a decrease of 44%. A fifth of H2H patients have gone from feeling moderately/extremely anxious or depressed, to now not feeling at all anxious or depressed.

H2H patients also completed a set of questions on mental wellbeing. **Mental wellbeing also showed a significant improvement, with 86% of patients reporting an improvement in their mental wellbeing**. The average mental wellbeing scores increased from 19 out of 35, to 26 out of 35. This indicates that this group now have higher mental wellbeing scores than the average for the England population.

Other social outcomes

The biggest improvement reported by H2H patients is in regards to their own safety, both inside and outside their home. **Almost all (98%) of those helped by H2H now report that they feel as safe as they would like**, compared to only 30% who stated this in relation to when they were in their old home. Prior to moving, 70% of people felt less safe than they would like or not at all safe – now, only one person state that they feel less safe than they would like. Comments indicate that improved safety is due to the Independent Living Coordinators, the safety systems in place (such as secure entry fobs, and Nottingham on Call telecare alarm), as well as friends and other residents.

The next biggest improvement reported by H2H patients is in levels of social contact. When living in their previous home, 56% of respondents reported that they had little or not enough social contact with others. Social isolation has significant mental and physical health impacts – research shows that loneliness can be as damaging to health as smoking 15 cigarettes a day and can increase mortality by 26%.[22] **Since moving, 91% now have adequate or as much social contact as they would like.** Many people have made new friends with neighbours and enjoyed social activities in the communal areas, as Covid restrictions have eased. A very small group (1%) still feel that they don't have enough social contact, partly due to Covid restrictions or being housebound.

Similarly to last year, more people are reporting an improvement in their financial wellbeing. Before moving, around 47% were just about getting by or finding it 'quite' or 'very' difficult to

[22] See https://www.campaigntoendloneliness.org/threat-to-health/

get by. 60% of the group have received help with finances, mainly support from the HHCs with benefits, and also referrals to other support organisations. **Six months after moving, all but one H2H patients surveyed now report that they are 'doing alright' financially or 'living comfortably'.** No respondents report that they are finding it difficult to get by since moving.

Carers were also asked about the impact of their friend/relative moving. Since the start of the project, 83 carers have completed a question on their own quality of life. This shows that their overall satisfaction with their quality of life has increased from 3.4 out of 10 whilst their friend/relative was living in their previous accommodation, to 8.9 out of 10 now. The sample of 11 carers in Year 6 have shown a big increase in life satisfaction, from 2.6 to 8.9 out of 10. This is **a huge improvement in the quality of life of those caring for those helped by H2H**.

Conclusions on social outcomes

The results from this sample of H2H patients who have completed six-month follow-up surveys evidences that the H2H project helps improve health, wellbeing and other social outcomes. This year's results indicate that the patient group initially had poor health and many had poor mental health, similar to the previous year. Improvements in mental wellbeing, social contact, safety and financial comfort were higher than in previous years. The project has also massively improved the quality of life of those caring for those supported by the H2H project. This provides further evidence to show that the H2H project is achieving its aim, to 'improve the health and wellbeing of citizens who are negatively impacted by poor or inappropriate housing'.

What is the most important change you experienced since moving?

"Being able to use a bathroom and have a bedroom to sleep in instead of the chair or a mattress on the floor."

"The thought of not having to face the stairs everyday, meaning I feel safer. Being able to access the garden and enjoy it."

"Finding different shops and finding my way around, having my independence, feeling free."

"Getting out of that old mouldy flat being able to breath."

"I love my home, I can shop for myself and take care of myself. I am very happy."

"Just feel a lot happier. I have freedom and fresh air, and it's so peaceful."

"Before I moved here, I was living in the living room with a hospital bed and a commode because I could get anywhere else in the property. The wheelchair wouldn't fit and I couldn't go up the stairs. Now I am able to go in and out to the garden and I sleep in my bedroom and I can now enjoy sitting in the living room with [the HHC] or family when they visit."

"When I had my amputation, I was so worried about being homeless. I am able to move in my wheelchair all around the bungalow and into the garden. I love living here. I am so happy. Thank you so much. Can't thank you enough properly."

4. Financial and social cost-benefit of the H2H project

4.1. Financial value and Return on Investment

The evaluation aims to assess the financial value and Return on Investment (ROI) of the H2H project, comparing the costs of delivering the scheme with the various financial benefits that result from the service. The costs and benefits are shown for the financial year April 2021 to March 2022.

The total running costs for H2H project for 2021/22 were £194,551. This includes staff costs for the three HHC officers, admin support post and manager from the Homelink team, as well as project running costs.

For Year 6 of the project, Nottingham City ICB provided £77,000 of funding. The remainder was resourced from NCH budgets (on behalf of NCC).

The main measure of financial impact is the cost-reduction to the NHS as a result of reducing hospital readmissions following the H2H intervention. This is an actual cost-reduction, and therefore forms the basis of the NHS's business case for the project.

The estimated total cost-reduction of reducing hospital admissions, length of stay and Excess Bed Days over the latest year is £458,538.[23] This gives a Return on Investment (ROI)[24] to the NHS's direct funding element, in terms of cost reduction from reducing re-admissions only, of £4.96 for every £1 invested.

There is an additional amount of cost-avoidance as a result of the project's impact on reducing Delayed Transfer of Care. The total cost-avoidance from reducing DTOC is £236,214. Of this, 36% of the costs avoided fall to the NHS, and 64% to Adult Social Care.

Additional cost-avoidances are made that positively impact on the local authority, Nottingham City Council (NCC). Cost-avoidances are made to the Adaptations Agency and Housing Aid, by helping people that would otherwise have relied on these services. The total additional cost-avoidance to NCC in Year 6 are £364,313.

There are cost-benefits to the housing partner, Nottingham City Homes, from letting properties more quickly than would otherwise be the case. The financial benefits include increased rental income and reduced costs while void, such as Council Tax payments. The total financial benefit to NCH in Year 6 is £135,789.

The **cumulative financial value of the H2H project in 2021/22 is £1,042,763.**

The total net financial value achieved by the scheme in Year 6 is £848,212. The estimated **(net) financial Return on Investment is therefore £4.36 for every £1 spent on the scheme**.

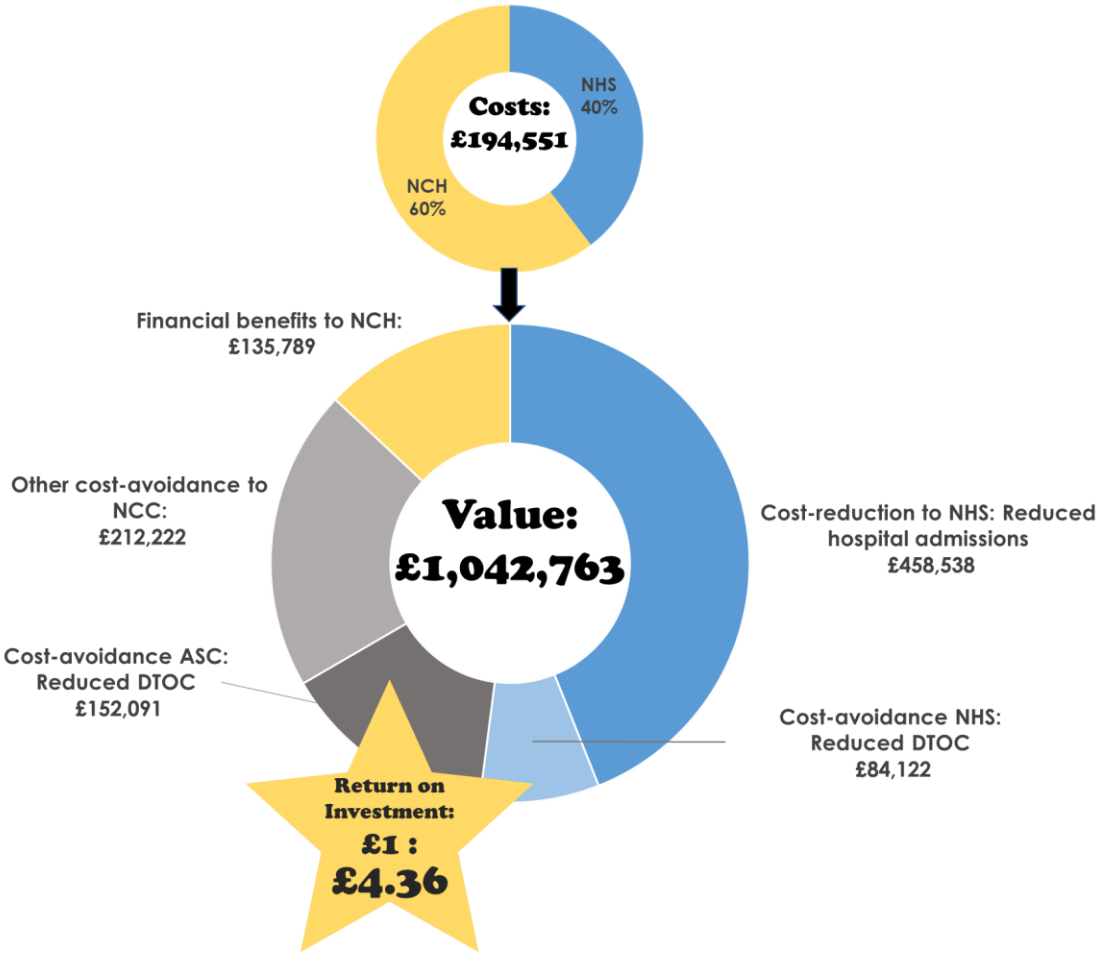
The ROI is split between the project stakeholders. The NHS benefits from cost-reductions from reduced hospital admissions, and the ROI on ICB funding in regards to this cost-reduction is £4.96. The cumulative benefits to the NHS include this cost reduction, plus the cost-avoidance from reducing DTOC. 52% of total savings fall to the NHS. The overall ROI to ICB funding in terms of the cumulative value to the NHS is £6.05 for every £1 invested.

Various Nottingham City Council departments also benefit from the project. 35% of the total savings fall to Nottingham City Council, and 13% to Nottingham City Homes. The cumulative value to NCC/NCH is £500,102, giving a ROI to the resources contributed by NCH/NCC to the project of £3.25.

This brings the cumulative financial value over the lifetime of the project (November 2015 – March 2021) to £9,309,654. The total costs over this period were £992,175, giving an overall net ROI of £8.38 for every £1 invested.

[23] Hospital admissions data calculated over the period October 2020 – September 2021.

[24] Return on Investment is calculated as (Total financial benefit – Cost of project)/(Cost of project)


Costs:
£194,551
NHS
40%
NCH
60%
Financial benefits to NCH:
£135,789
Value:
£1,042,763
Other cost-avoidance to NCC:
£212,222
Cost-reduction to NHS: Reduced hospital admissions
£458,538
Cost-avoidance ASC: Reduced DTOC
£152,091
Cost-avoidance NHS: Reduced DTOC
£84,122
Return on Investment:
£1 :
£4.36

4.2. Social value of the H2H project

The H2H project aims to increase the social wellbeing of patients, supporting them to achieve a number of improved outcomes, such as:

- Improved perception of their own physical health and mental wellbeing
- Increase in their economic wellbeing
- Reduction in social isolation
- Feel safer in their home and community

Section 3.5 above indicates that a number of these outcomes have been achieved, amongst the sample of 43 H2H patients who have had a follow-up assessment after six months.

These outcomes also have a social value to the individual. A government-backed approach to understanding people's wellbeing allows us to place a financial valuation against some of the positive changes achieved. 'Wellbeing Valuation' allows you to measure the success of a social intervention by how much it increases people's wellbeing. The approach works by measuring how much uplift achieving an outcome makes on people's life satisfaction scores (using large national surveys) and then equates this to the same amount of money that would generate the same uplift in life satisfaction. This value is not a 'cashable' saving, but is a way of indicating the value of the outcome to the individual.[25]

The Wellbeing Valuation approach was used to assess the social value generated amongst the 43 H2H patients who have been re-housed for six months or more.

Project outcome	Indicator	Value per person	No. patients	Total social value*
Improve mental wellbeing	Relief from depression/anxiety (improved, now state 'no problems')	£36,766	9	£258,212
Feel safer	Not worried about crime (feel as safe as they want)	£12,274	28	£235,407
Improve physical wellbeing	Good overall health (increase to above average VAS score)	£20,141	11	£162,096
Improve economic wellbeing	Financial comfort (increase to 'living comfortably' or 'doing alright')	£8,917	19	£136,641
Reduce social isolation	Talks to neighbours regularly (have as much social contact as they want)	£4,511	22	£88,820
Achieve secure housing	Temporary accommodation to secure housing (individuals at risk of homelessness)	£8,019	10	£80,190
Total social value*				**£961,367**
***Net benefit** (Total SV minus project costs)*				***£867,371***
Social Return on Investment				**£1: £10.23**

Table 15: Wellbeing Valuation for sample of H2H patients *(*less of deadweight)*

[25] Wellbeing Valuation has been developed by HACT and Daniel Fujiwara, for more information see www.socialvaluebank.org

This indicates that the project is generating considerable social value. Even amongst a sample of 43 H2H patients, the wellbeing value achieved far exceeds the cost of delivering the project to those individuals.

The largest contribution to the Wellbeing Valuation is from improved mental health, measured by relief from anxiety/depression. This outcome has the highest per person valuation, at £36,766, indicating the high value that relief from depression/anxiety has on people's overall life satisfaction. 21% of those surveyed showed a substantial improvement; from stating that they were moderately, severely or extremely anxious or depressed at first engagement, to stating that they were 'not at all anxious or depressed' six months after moving.

The second largest contribution to the Wellbeing Valuation is from individuals' improvement in personal safety. This is a large contributor to the overall total due to the large number of people reporting an improvement in their safety, with 65% of those surveyed showing an improvement from previously feeling 'less than adequately safe' or 'not at all safe', to now feeling 'as safe as I want'. Another significant contribution to the Wellbeing Valuation is from individuals' improvement in health. This also has a high wellbeing value, reflecting the importance of physical health to overall wellbeing. Over a third of the sample (37%) went from having below average to above average self-reported health for their age.

5. Conclusions and next steps

In 2021/22, the H2H project supported 89 people who were living in housing that was unsuitable or negatively impacting on their health, to be re-housed into appropriate social housing accommodation during the Covid pandemic.

The pandemic has continued to make working conditions for the project more difficult, with remote working meaning forming and maintaining relationships with patients, their families and other health and support workers has been more difficult. However, the HHCs have managed to maintain a near normal level of service, and have managed to still work with patients and their families and other agencies to implement a holistic package of support.

This year the project has speeded up the rehousing time compared to the previous year, returning to a similar rehousing time as pre-pandemic. This in spite of the difficulties faced by the HHCs, who are faced with increasingly complex cases (with multiple health and social care needs) whilst working remotely, and with the time taken for empty properties to become available also adding to the delay slightly due Covid-related staff shortages and supply issues affecting the whole building industry. Despite this, rehousing time remains significantly quicker than for those outside of the project.

The total number of cases completed by the project in Year 6 remains slightly down on pre-pandemic numbers, but not significantly (89 cases compared to 104 in 2019/20). This reflects some of the difficulties of maintaining referrals into the project without direct contact with healthcare colleagues referring into the project. However, it also reflects the HHCs dedication to making the project work, despite the circumstances of a global pandemic. Whilst fewer patients were referred directly from high-demand beds this year, the project has largely retained its focus on patients with high levels of hospital use, with a higher proportion of patients having reported a previous admission in the last six months.

The financial Return on Investment (ROI) assessment shows that the project is cost-effective across all measures. On the main financial measure, the cost savings from the actual reduction in hospital readmissions, the savings exceed the cost of the project. The additional financial benefits – from reducing Delayed Transfer of Care, reducing adaptations and homelessness costs, and increasing rental income – all add further weight to the positive financial impact of the project. The project creates financial benefits for several stakeholders. 52% of the cumulative financial benefits are to Nottingham City ICB (NHS), 35% benefit local authority (NCC) budgets, and 13% fall to NCH.

The financial ROI is lower this year than previous years, mainly reflecting the changing context around the project and the effects on the costing model. The main reduction is in the estimated savings to the NHS from reducing Delayed Transfer of Care. This is due to a number of factors: (a) fewer patients are likely to remain in an NHS hospital or community bed whilst waiting to be rehoused, due to Discharge to Assess policy and intense bed pressures. Some of the impact has shifted to Adult Social Care, as more H2H patients are being sent home once medically fit for discharge, with a home care package to help them manage while they seek rehousing. (b) Similarly in mental health beds, patients are no longer able to exceed an eight-week stay, and so the counterfactual model can no longer show that these patients would remain in a mental health bed whilst waiting for rehousing – again, the cost shifts to the local authority, as they would instead be passed to the homelessness team to seek rehousing.

The model assumes that H2H patients would have otherwise applied for a suitable social housing property through the general housing register. In reality, many of those supported through H2H would not have been aware of the alternative housing options, or have been able to go through the process without a high level of support. Of those surveyed, all respondents stated they wouldn't have been able to move without the support of the HHCs. Therefore, in many cases the alternative scenario without the intervention of H2H would have been remaining in inappropriate housing or health/social care beds, with even higher long-term cost implications. The financial benefits are therefore a conservative estimate.

The evidence continues to show year on year the strong, positive impact of the project on patient outcomes and their overall wellbeing. The insight into the personal stories of the patients revealed through the case studies demonstrates the significant impact on those who are assisted through the H2H project. This is supported by the survey data, which shows very high satisfaction with the service, improved physical and mental health, and improved wellbeing factors such as social connections, safety and financial comfort.

5.1. Next steps for the H2H project

Funding has been secured for Year 7 of the project. The project will continue to focus on individuals who have high previous use of hospitals, including those currently in hospital and those in the community with previous admissions, to continue to relieve pressure on the NHS. NCH will continue to lead and promote good practice in health and housing-related developments, both locally and nationally. NCH will continue to be a voice for housing on the Integrated Care Partnership in Nottingham. The H2H project partnership continues to work with local and national bodies to support the spread of good practice of housing-health partnerships into other areas.

Appendix: Cumulative costs and financial benefits over the project lifetime (November 2015 – March 2022)

The cumulative figures below bring together the results from all annual evaluations since the start of the project in November 2015. The breakdown for the last four years is shown to demonstrate trends.

	Y3 2018-19		Y4 2019-20		Y5 2020-2021		Y6 2021-22		Cumulative	
	No. cases	**Value**	**No. cases**	**Value**	**No. cases**	**Value**	**No. cases**	**Value**	**No. cases**	**Value**
Total cases	112		106		90		89		633	
DTOC cases	52	£1,489,276	44	£887,035	29	£499,581	26	£236,214	227	£4,557,981
Early intervention cases	60		62		61		63		406	
Hospital re-admit reduction	61	£501,130	48	£537,819	37	301,646	32	£458,538	244[1]	£2,370,846
Homeless (at risk)	16	£80,641	9	£49,955	15	£114,958	12	£71,082	76	£437,955
Adaptations	66	£161,766	84	£222,658	56	£153,551	50	£141,140	269	£755,374
NCH properties	103	£68,721	93	£68,495	84	£61,279	80	£135,789	569	£621,431
TOTAL	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**
	£170,855	**£2,305,942**	**£183,737**	**£1,765,963**	**£181,548**	**£1,131,015**	**£194,551**	**£1,042,673**	**£992,175**	**£9,309,654**
NHS	£79,419	£1,792,513	£77,000	£1,283,957	£77,000	£653,322	£77,000	£542,660	£461,419	£6,350,662
NCH	£91,436	£68,721	£106,737	£68,495	£104,548	£61,279	£117,551	£135,789	£530,756	£621,431
NCC		£444,708		£413,510		£416,414		£364,314		£2,337,561
ROI (net)		**£12.50**		**£8.61**		**£5.23**		**£4.36**		**£8.38**

Savings from early-intervention cases are captured through the cost-reduction from hospital admissions reductions.

[1] Total number of patients with reduced admissions. Total number of reduced admissions is 470.