Housing to Health

Nottingham City Council Housing Services

&

NHS Nottingham and Nottinghamshire Integrated Care Board

Evaluation of Year 7

April 2022 – March 2023

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 Council (NCC) Housing Services, 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 and its aftermath. This evaluation report covers the seventh full year of operation, from April 2022 to March 2023. During this period, the responsibility for managing the city's council housing transferred back in house to Nottingham City Council. The H2H project continues to work to support patients and their families, and supported 91 people to be re-housed. This brings the total rehoused over the lifetime of the project to 724.

The HHCs have continued to deliver a high-quality service this year, with patient satisfaction at consistently high levels at 9.8 out of 10. Evidence from healthcare partners and patients themselves shows that the service meets an essential need, to provide housing support and expertise (which is outside the remit and experience of health and social care professionals) at a time of extreme vulnerability or health crisis. This year, all but one of the H2H patients surveyed said that they could not have moved without the support of the HHCs.

Over recent years HHCs have already seen an increase in the complexity of health and social care needs amongst the patient group, and this year is no exception. H2H patients increasingly have poor self-reported health and a number of long-term health conditions, which, since the Covid pandemic, has been compiled by an increase in the proportion of patients with poor mental health. The complexity of health and care needs makes dealing with cases and finding an appropriate solution more and more complicated. Meanwhile the pressure on acute NHS care remains high as a result of dealing with the Covid backlog. 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.

In addition, the demand for social housing has continued to increase year on year, resulting in longer waiting times and fewer properties available to let. NCC Housing Services are working to tackle the backlog of accumulated voids where works were delayed due to staff or supply shortages as a result of the wider context in recent years, meaning 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. This year the HHCs have let the highest number of hard-to-let properties to date, reducing the number of long-term voids in Independent Living schemes.

Within this context, the H2H project has supported 91 patients, and despite the increasing complexities around patients' needs and property availability, the median rehousing time of 82 days (from referral to moving in) has remained fairly stable compared to previous years. 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 330 days on average for a similar property. This means that on average, the H2H project saves eight 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. A quarter of 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 under a third had already had a hospital admission in the last six months, and 82% 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, more patients report feeling socially isolated and feeling generally unsafe in their previous home than before.

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 a young amputee living in one room at his mum's home, who was able to be rehoused to live independently in a wheelchair accessible bungalow and have home dialysis; an older person who couldn't return home from hospital to their upper floor flat and was temporarily placed in a care home, who was able to move to an Independent Living flat; and a man who had previously been living in his car and following hospital treatment for his mental health had been discharged to temporarily hotel accommodation, who the HHCs helped find his own flat and supported to set up him own tenancy. In their own words, H2H patients have described the impact of the service: *"Moving here has improved my whole life"*, *"More independence, more opportunities – can do shopping and meet friends", "I was extremely unhappy at [my previous home]. Since moving… my life has changed so much. I am happy".*

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 80% 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 £10.79 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, although the total savings this year are lower than in previous years. H2H patients who were admitted to hospital in the six months before they were rehoused had on average 3.1 admissions per year, and stayed in hospital for a total of 28 days over the year

before the H2H intervention. Data from the six months after being rehoused shows that the same group only had 1.1 admissions per year, and average of 20 days in the year after H2H. Overall, this indicates that H2H results in 42 fewer admissions and 177 fewer hospital bed days this year. The total cost saving to the NHS from this is £70,653. The cost saving to the NHS from reduced hospital admissions is lower this year than in previous years. This is because, although H2H patients spend fewer days in hospital after the H2H intervention compared to before, this difference is smaller than in previous years.

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 709 NHS bed days and 2,400 Adult Social Care days, a total cost avoidance of £384,516.
- It supported 9 patients who would otherwise be homeless, avoiding £57,197 in costs to Nottingham City Council's homelessness services.
- It avoids 132 unnecessary home adaptations by moving patients to an already adapted property, saving Nottingham City Council £441,266.
- It increases rental income for NCC Housing Services and decreases costs from empty properties, a total financial value of £219,456.

The financial Return on Investment (ROI) assessment shows that the project is cost-effective overall. A central financial measure for the NHS is the actual savings from reduced in hospital readmissions following H2H, evidenced by admissions data. The NHS saves almost as much as it invests, just as a result of reduced readmissions. 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 £4.76 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 but one of 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 until March 2025 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 NCC Housing Services and Nottingham and Nottinghamshire ICB will continue to lead and promote good practice in health and housing-related developments, both locally and nationally. As an example of this, the H2H team has recently expanded to include an additional HHC to be part a pilot 'Anticipatory Care' project, working with a range of partners in the Bestwood and Sherwood areas of the city, to support complex, elderly patients who are at risk of becoming more unwell.

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 Council Housing Services (NCC Housing Services – formally Nottingham City Homes), jointly funded by NCC Housing Services 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 seventh full year of operation, and currently has funding to continue until March 2025.

The project partnership

Nottingham City Council Housing Services (NCC Housing Services) manages around 26,000 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. NCC Housing Services 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 7 include three HHCs and an admin support post, as well as management input from NCC Housing Services.

There are three criteria for inclusion in the H2H project:

- **H2H Supported Housing – NCC Housing Services or other RSL**. Patients who meet the criteria for supported housing, including properties managed by NCC Housing Services (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 NCC Housing Services 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 NCC Housing Services or RSL stock.

Case study: Reducing hospital re-admissions

Sylvia* is a 95-year-old lady that self-referred to the service after being given our details by healthcare staff. She was an incredibly anxious lady who was living in an upstairs flat and she was unable to access the community as she did not feel physically or mentally able to use the lift. Her flat also had a bath which she was not able to use due to the risk of falls.

In the months leading up to her referral she had had three hospital admissions and family were concerned for her future if she was to stay in her current flat. Sylvia recognised the flat was making her unwell, but she liked the location of the scheme and had made friends there.

The HHC made contact with Sylvia to discuss what support she needed and it was agreed that a ground floor flat with a wet room at her current Independent Living scheme would help her feel more safe and secure while encouraging her independence. The HHC completed the application and bidding process for her.

It was only 82 days between the date of referral and the date that Sylvia received the keys, which was much faster than the average waiting time for IL properties of 197 days for non-H2H clients in 2022/23. The HHC was there at the sign-up appointment to ensure that Sylvia had utilities set up and the correct benefits in place and was on hand to provide post-tenancy support for any questions she and her family had.

Moving to the ground floor flat has greatly improved Sylvia's health and independence. She no longer has severe anxiety about being in the upstairs flat, is now able to access her bathing facilities and the community and since being rehoused she has had no further hospital admissions. Being rehoused by Housing to Health has not only given her a safe and secure place to call home but it has also lessened the demand on hospital beds in Nottingham City NHS.

**Name has been changed*

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 7 of the project (April 2022 – March 2023), 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. NCC Housing Services 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 replaced 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 NCC Housing Services sits on the Nottingham City Place-Based Partnership.

The NHS Nottingham and Nottinghamshire ICB is currently developing its Joint Forward Plan (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, NCC Housing Services 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. The JNSA for Housing is currently being updated.
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 NCC Housing Services as a key partner in reaching and supporting Nottingham citizens in achieving the aims of the strategy.

Partner testimonial: Social worker

"I am a social worker from the adult safeguarding team, Nottingham City Council, Adult Social Care. I work with vulnerable adults (citizens) who have/are experiencing abuse. Some of my colleagues and I who have referred to this service have found Housing to Health to be a valuable asset. Housing to Health has enabled us to provide better outcomes for citizens in the city and help safeguard the most vulnerable.

From my experience, the team have been incredibly helpful, informative and supported citizens with sensitivity and efficiency. There has been a step-by-step process where the citizen has felt reassured and involved; which has been extremely important to the citizen considering the vulnerable position they have been in at the time of the referral.

Having a Housing and Health Co-Ordinator who is able to dedicate the time to provide guidance, support and advice from the start of the referral to when the property has been sourced, helps to ease the overwhelming experience for the citizen. I have also found that the benefits of having a Housing and Health Co-Ordinator is significant, as they are able to coordinate and facilitate the tasks required for citizens who do not have access to the internet or are in a position/environment where it is not safe for them to apply and bid for housing. This role is not in my remit and it meets the need of the citizen, it fills a gap in service which is required and is highly valued by my team."

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.

[4] See https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/managing-transfers-care-frequently-asked-questions

Social housing context

Nationally, the UK continues to face significant housing challenges, and the shortage of housing, high costs and barriers to home ownership, and reductions in funding for social and affordable housing construction have resulted in high demand for rented properties, and increased waiting lists for social and affordable homes. The wider context of the ongoing impact of welfare reform, the cost-of-living crisis and inflationary pressures mean that many people are facing significant housing problems.

The government's Social Housing (Regulation) Act was passed into law in July 2023.[5] In the wake of the Grenfell Tower fire, and subsequent high-profile cases of poor standards of social housing (including the tragic death of two-year old Awaab Ishak, linked to exposure to mould), the new law places the needs of tenants at the heart of reforms to improve the quality of life for those living in social housing. The law is underpinned by new regulatory powers with a significantly enhanced role for the Regulator of Social Housing (RSH) and the Housing Ombudsman.

In Nottingham, the responsibility for social housing was taken back in house by Nottingham City Council in April 2023, having previously been delivered by the Arms Length Management Organisation, Nottingham City Homes. Like many local authorities around the country, Nottingham City Council faces significant financial challenges, but is committed to prioritising investment to ensure decent and safe homes, and investments that help improve the quality of life of tenants and support to tackle the challenges they face.

NCC Housing Services 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,[6] which sets the vision and values of the council; a vision centred on improvement, transformation and placing citizens at the heart, and values rooted in equality, fairness, and inclusivity. The Council Plan recognises the challenging context in which we are operating whilst retaining the vison for the city as a 'Safe, Clean, Green, Proud and Ambitious' location to live, work and invest in. A city that is 'creative and culturally vibrant, where local people are proud of their city, their place, neighbourhood and their local community'. The Council Plan states that "We want our neighbourhoods to be safe, clean, green communities with good and safe housing where people want to live. A neighbourhood and environment that promotes healthy and inclusive communities where we are closing the healthy life expectancy gap, vulnerable people of all ages are protected, and people look out for each other. We will continue our work for clean, green neighbourhoods and spaces in our role as local leaders." NCC will publish an updated Housing Strategy for the city in Autumn 2023.

Despite the challenging context, in recent years NCC has supported the development of over 4,000 new homes, including increasing the number of social, affordable homes and homes for the homeless by 1,000. However, despite these achievements, the need for housing continues to grow and the supply remains limited. Throughout the period when the

[5] See https://www.gov.uk/government/news/landmark-social-housing-act-receives-royal-assent-to-become-law
[6] See https://www.nottinghamcity.gov.uk/media/3377077/enc-1-for-strategic-council-plan-2023-2027.pdf

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 locally. The result in Nottingham is that demand for social housing massively outweighs the supply of such housing. As a result, NCC Housing Services has to prioritise applicants, as set out in its current Allocations Policy. This places 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 Figure 1 below. Since the start of the project, the overall trend has been an increase in average waiting times for a council social housing 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.

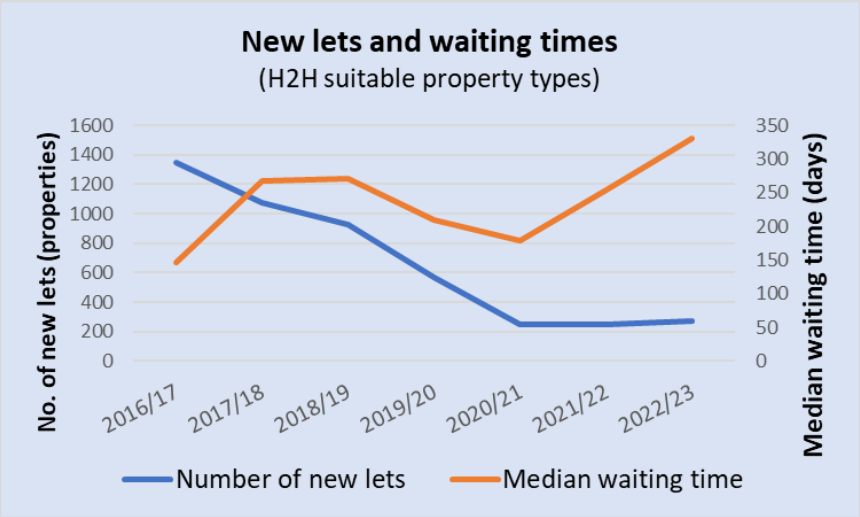


Figure 1: Number of new lets per year, and median waiting time

This has continued in the current year, exacerbated by the after-effects of Coronavirus pandemic. NCC Housing Services Voids Team are still working to tackle the backlog of accumulated voids where works were delayed due to staff or supply shortages during and after Covid. Additional resources have been allocated and a Voids Action Plan put in place, which resulted in an improvement in the turnaround time for void properties in the last quarter of 2022/23.

There has been a lower demand for some Independent Living properties, and some hard-to-let properties have been void for over 200 days. NCC Housing Services has developed a cross-company action plant to address wider sustainability of schemes and best use of stock within the IL portfolio. There have been a number of successes in letting hard-to-let IL properties this year, including via the H2H project.

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

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

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

Daniel* (aged 28) was referred to the Housing to Health service by Occupational Therapy. He had had a recent admission to hospital after a complication of his renal condition resulted in him having an amputation to his right leg. As well as suffering with renal failure and requiring dialysis three times per week, he was now an essential wheelchair user and his family home was not suitable for his medical condition.

The HHC made contact with Daniel and the OT to discuss his needs and it was agreed that he would require a wheelchair accessible bungalow, with an extra bedroom for him to receive home dialysis to reduce the amount of time spent in hospital. She was able to complete a housing application on his behalf and applied for medical priority which was quickly approved.

Due to the high demand for hospital beds, Daniel was discharged to his mum's home whilst a suitable property was found. Unfortunately this was not accessible for him, and he had to live a one room downstairs existence with a hospital bed and commode, needing to be strip washed in the kitchen. As a young man, he found this very distressing and was eager to regain his independence.

The HHC was able to source a bungalow, which have very high demand – Daniel was able to move into the bungalow after 84 days, compared to the average waiting time of almost two years for a bungalow on the general waiting list. The HHC was there at the sign-up appointment to ensure that Daniel had utilities set up and the correct benefits in place and was on hand to provide post-tenancy support for any questions he and his family had.

Without the Housing to Health service, it is likely that Daniel would have remained in his family home with a one room existence. This would have an increased cost to Adult Social Care as he was receiving extra care as the property was restricting his independence, and he would have still been travelling to hospital three times per week for his dialysis which he can now have in his own home.

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 city's two hospitals.

The HHCs have been able to fully resume in-person service provision this year, supporting patients to view properties in person and attend the hand-over day to help them through the move-in process. Some remote/flexible practices developed during Covid have been maintained, such as completing applications online rather than in person, which have proved to be helpful in making the process more efficient. HHCs continue to keep to safe working practices in settings with vulnerable people, such as wearing masks and completing Covid tests before going into residential care homes.

Referrals into the project have picked up to pre-pandemic levels, with 281 referrals into the project in Year 7. 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, GPs, Community/Care Coordinators) and social or other support workers.

The HHC for Integrated Discharge continues to work with the hospitals' Integrated Discharge Team, and attend the hospitals in person. Some of the IDT have continued to work remotely, particularly from the Adult Social Care side. Referrals via hospital-based staff have increased slightly from last year, but are lower than they were in earlier years of the project. The team have seen an increase in referrals via community pathways for patients who have previously been in hospital, but have been discharged home. This year, 27% of referrals were from staff in the hospitals – mainly social/support workers within the Integrated Discharge Team, ward Discharge Coordinators or Occupational Therapists.

Source of referral - Community	%
NCC Housing Services staff	32%
Occupational therapist	18%
Social/support worker	15%
GP	14%
Community coordinator/healthcare staff	14%
Self-referral	7%
Discharge coordinator	1%
TOTAL	**206**

Source of referral - Hospital	%
Social or support worker	45%
Discharge team	27%
Occupational therapist	16%
Other	12%
TOTAL	**75**

Table 2: Sources of referrals from community and hospital staff

Out of the 281 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 2022/23, 91 people had been successfully rehoused into social housing properties. A further 101 applications were live, still undergoing the assessment or allocation process

Partner testimonial: Homelessness support worker

"Just wanted to say a big thanks for all your support and assistance with [our client] surrounding his housing over the last 12 months. Really appreciate your flexibility and working in partnership with us at Framework. It supported [our client] in the best possible way and gave him realistic options and aspirations to work towards with his housing. … having this option and discussion around this, gave him a sense of dignity, ownership and independence with his housing, which I feel was really important and appreciated."

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

A total of 91 people were rehoused in Year 7. This brings the total to 724 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 82 days. This has increased slightly (by six days) from the median for Year 6, due to the increasing complexity of cases and limited availability of suitable properties. This rehousing time is still considerably below the average waiting time of someone outside of the H2H project, which in 2022/23 was 330 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.

In Year 7 this included 23 patients (25% of those rehoused). The proportion of DTOC cases has reduced since the start of the Covid pandemic, and continues to decrease slightly. Table 3 shows the breakdown of the location of H2H patients at the time of referral. The location on referral is similar to last year. Over the longer term, the proportion of patients in hospitals and social care beds on referral has been reasonably stable, whilst patients in community/rehab beds and

Location on referral	Count
Hospital	13
Residential social care	4
Mental health hospital	4
Community/rehab bed	1
Mental health step down unit	1

Table 3: Location of H2H patients on 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.

mental health hospitals or step-down units have gradually decreased.

The remaining 75% 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 68 early intervention cases, 56 individuals (82%) 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 66% of high-risk early intervention cases. A further 9% were at risk of hospitalisation due to unsuitable housing exacerbating existing health conditions, such as seizures, brain injuries or cancer. A further 12% 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 28% of early intervention cases 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 7, 81 H2H patients had Nottingham on Call facilities installed in their new home. This takes the overall total over the lifetime of the project to 530 H2H patients supplied with Nottingham on Call facilities (73% of all H2H patients).

Case study: Enabling independent living in the community

Linda* (aged 70) was referred to the Housing to Health service by the City Hospital Integrated Discharge Team. She had suffered two strokes and a brain injury which resulted in her becoming an essential wheelchair user. The occupational therapist at the hospital advised that Linda could not be discharged home to her upstairs NCC flat so she had to be transferred to a specialist neurological rehab unit while accommodation was being sourced.

The HHC contacted Linda and her OT to discuss her needs and it was determined that she would need a wheelchair accessible bungalow. She completed a housing application on Linda's behalf, submitted a medical report for medical priority and began bidding on suitable properties.

It took the HHC just under 6 months to find a suitable and available bungalow for Linda, as such properties are in very high demand. Outside of H2H, the average waiting time for this type of property is 18 months. The HHC was there at the sign-up appointment to ensure that Linda had utilities set up and the correct benefits in place and was on hand to provide post-tenancy support for any questions she and her family had.

Moving to a bungalow suitable for her needs has had a significant positive impact on Linda's health and independence. She was able to be discharged from the neurological unit to her own accommodation, both freeing up a high demand NHS bed and allowing her to live comfortably in the community. Without the assistance of the Housing to Health service, it is likely that she would have been discharged to a care home either permanently or temporarily while extensive adaptations were made to her previous home.

**Name has been changed*

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

2.3. Characteristics of re-housed patients

An overview of the data on the characteristics of re-housed patients in Year 7 shows that the older patient group, with accessibility/mobility issues, remains the primary group of H2H patients. Similarly to last year, 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. Over the lifetime of the project, patients' health needs have become increasingly complex. H2H patients 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. In Year 7, more H2H patients reported feeling socially isolated and generally unsafe in their home (see section 3.5 for more details) and more patients had a fall recently.

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. The proportion of applicants via the Over 55/65s pathway is increasing year on year, whilst the proportion of applicants via the Mental Health pathway is decreasing. Fewer patients are being referred directly from the mental health hospital and step-down unit within the timeframe that they are under their care, and therefore meeting the criteria for the Mental Health pathway into H2H.

Referral criteria	%
Over 55/60s	91%
Mental Health	5%
Essential Wheelchair	3%

Table 4: Service users' referral criteria

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 previous years.

Primary reason for move	%
Accessibility	66%
Wellbeing/ mental health	24%
Insecure housing/ homeless	10%
Disrepair/hazardous	5%
Other	14%

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.

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

Matthew* was a 37-year-old gentleman referred to the Housing to Health service by his support worker after a recent admission to an NHS mental health bed and step-down unit.

After his release from prison, he was living with his family which soon led to a relationship breakdown. The strain on his relationship with his mother often resulted in him sleeping in his car overnight for an escape and after a death in the family, his mental health was significantly impacted. Matthew made an attempted to take his life which resulted in his admission to hospital.

The HHC contacted Matthew to discuss his situation and what would benefit him. He expressed he had not been able to adjust to his life in the community as his home life was so strained and he wanted his own tenancy. The HHCs completed his application and after approval from our Tenancy and Allocations Panel, she was able to start bidding for properties.

Due to high demand for beds in the step-down unit, Matthew had to be discharged to temporary accommodation in a hotel with the understanding a permanent property was being sourced. This type of accommodation was likely to have an impact on his mental health if the HHC was not able to find him a home urgently. She was able to locate him a general needs flat in his preferred area, and it was just 57 days from the date of referral to the date Matthew received the keys and moved in. This was four months faster than the average time through the non-H2H route.

The HHC was able to support Matthew through the whole process and made sure that he had the correct benefits set up as well as utilities to ensure his first tenancy was successful. Within 2-3 weeks of moving into his home, he was able to start work within the construction industry which had been one of his long-term goals set during his health crisis.

Without the help of the Housing to Health service, it is likely that Matthew would have had to remain in temporary accommodation or alternatively he would have gone back to sleeping in his car as he could not return to his family home. With a safe and secure home, he was able to immediately settle back into life in the community, find work and focus on his health.

Name has been changed

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 increasing gradually year on year, and in addition in Year 7 more patients are reporting that they have had a fall (just under a third of patients).

This year, 44% 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 decreased in recent years), 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 higher (almost double) than pre-pandemic years.

Over half of patients (56%) have one or more chronic health issues, such as arthritis, diabetes, cardiovascular or respiratory illness.

Health issues	%	Health issues	%
Restricted mobility or difficulty getting upstairs	78%	Breathing difficulties	13%
Mental health illness or issues	44%	Cancer	9%
Had a fall	29%	Dementia	8%
Frail / elderly	23%	Wheelchair user	8%
Arthritis	22%	Had a stroke	7%
Heart problems	19%	Visually or hearing impaired	5%
Diabetes	14%	Other	4%

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 0.59 (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 39 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.

[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] See 10

- 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.

The previous tenure of the 91 people who were rehoused is shown in Table 7. Existing NCC Housing Services tenants remains the biggest category, but this year there are fewer NCC Housing Services tenants and an increase in people from other tenures, particularly private rented sector and those living with family/friends.

Table 7: Previous tenure of H2H patients

Previous tenure	%
NCC Housing Services tenants	27%
Private rented	24%
Living with family/friend	21%
Other RSL tenants	8%
Owner occupier	8%
Residential/ Care home	7%
NHS hospital (inc. MH)	3%
Homeless	1%

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

Age group	%
<55	8%
55-59	16%
60-64	15%
65-74	30%
75-84	20%
85+	11%

Gender	%
Male	55%
Female	45%

Ethnicity	%
White British	73%
Ethnic minorities	27%

Table 8: Demographic information

Case study: Reducing pressure on resident social care with independent living

Trevor is an 89-year-old gentleman who was referred to the Housing to Health service by his Occupational Therapist. He had Parkinsons as well as COPD and diabetes, all of which were affecting his mobility and making it impossible for him to access his upper floor flat.

He had been admitted to hospital where he had remained for 4 weeks before being discharged to a care home. It was determined that he could not be safely discharged home and that he would need to remain in the care home until a suitable property was found – it was at this time that a referral to the Housing to Health service was made.

The HHC contacted Trevor and his family quickly to discuss his housing needs. He expressed that he would like to remain in a specific area to receive care from his family and that he would also need a ground floor flat and a wet room. The HHC completed his application form and was able to begin bidding for him in the specific area he wanted. A suitable flat was found in less than half the average waiting time for non-H2H customers.

Once the property was ready, the HHC took Trevor and his family for a viewing and soon after completed the tenancy paperwork. The HHC also completed all utilities transfers, ensured benefits were in place and was available throughout the moving process and post-tenancy to advise Trevor and his family.

Six months after the tenancy begun, Trevor was contacted to discuss the service and how it had helped him. He rated the service 10/10, stating he could not have moved without it. He said that Housing to Health is ***"a great service"*** and went on to say "***I was kept informed throughout the whole process."***

Trevor is now living comfortably in his new home without the risk of falls on the stairs or in the bath. He has had no admissions to hospital since being rehoused, compared to the two admissions before H2H intervention. Without the assistance of the service, he would likely have remained in the care home as there were no plans to discharge him to his old address. By finding him a suitable property, the service freed up both a care home bed but also an NCH general needs flat.

****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 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 513 people who gave permission to access and share their hospital admissions data since the start of the project. This includes 383 people rehoused since the beginning of the project, and a further 130 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 are 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 2021 – September 2022 Year 6/7[13]).

H2H re-housed group:

Overall, 40% of rehoused H2H patients had an emergency admission to hospital in the six months prior to the H2H intervention. This proportion has reduced over the last two years of the project, with 23% of rehoused patients in the dataset for Y6/7 having an emergency admission to hospital in the last six months.

[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 (23% in latest year's data, Year 6/7).

Of those who had an emergency admission prior to the H2H intervention, the average number of admissions is 3.6 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 £3,797.

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 £3,396, reflecting the shorter average length of stay.

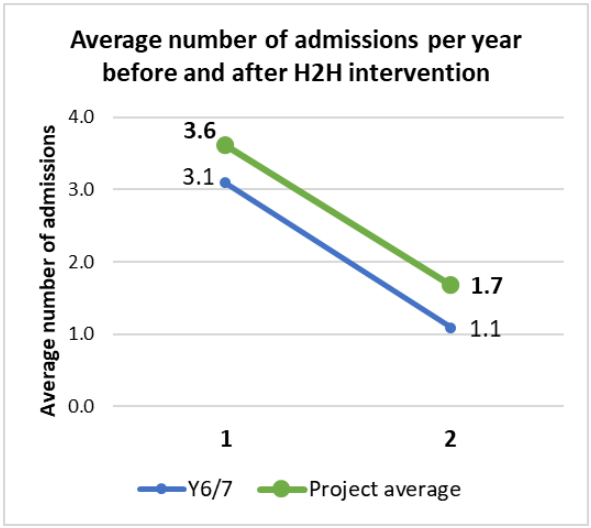


Figure 2: Change in average number of admissions before and after H2H

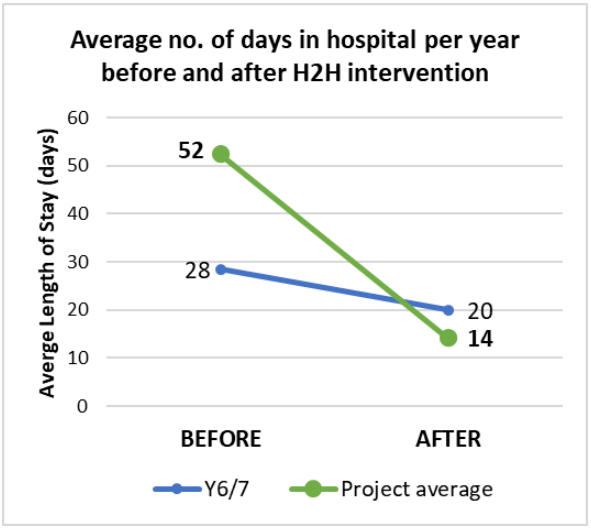


Figure 3: Change in average number of days in hospital before and after H2H

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 40% 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 266 H2H patients who were, or would have been, hospital users prior to the intervention.

The results show that for Year 6/7 (October 2021 – September 2022):

- Total admissions were reduced by 42 per year
- Total bed days were reduced by 177 per year
- Total cost-reduction of £70,653 over the year

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

- 514 fewer admissions
- 10,151 bed days saved, including 1,331 fewer EBD
- Total cost-reduction of £2.5m

	Year 6/7 (Oct 21 - Sep 22)			Cumulative over project (6 years, 10 months)		
	Before H2H	**After H2H**	***Difference***	**Before H2H**	**After H2H**	***Differ-ence***
% admitted to hospital	23%	23%	***0%***	40%	27%	***-13%***
Admits per person, per year*	3.1	1.1	***-2.0***	3.6	1.7	***-1.9***
Average length of stay per admission*	9 days	18 days	***9 days****	15 days	8 days	***-6 days***
% bed days that were Excess Bed Days*	0%	0%	***0%***	10%	1%	***-9%***
Total admissions	64	23	***-42***	961	447	***-514***
Total number of bed days (admit x length of stay)	594	417	***-177***	13,908	3,757	***-10,151***
Total cost (admits and EBD)	£189,754	£119,101	***-£70,653***	£3.99m	£1.52m	***-£2.47m***

**Amongst those admitted to hospital in 6 months prior to intervention*

Table 9: Results from hospital admission data, H2H rehoused group

*** In Y6/7 the data shows a higher average length of stay per admission in the period after the H2H intervention, compared to the period before – in contrast with previous years when there has been a lower average length of stay after, compared to before. However, the data for Y6/7 still shows that overall, H2H patients have fewer days in hospital after the H2H intervention than in the period before – this is because, even though the length of stay per admission is longer after, patients have fewer admissions after the intervention (see Figure 3 above).*

Savings as a result of reduction hospital readmissions are lower in Year 6/7 than previous years. This is due to a number of factors; (a) the 'population' that the savings are calculated for is smaller this year – the model focuses on those with a hospital admission in the last six months, and this group is smaller this year (b) there is a smaller reduction in the number of bed days in the six months after compared to the six months before, as explained above (c) there were no Excess Bed Days, either in the six months before or after (and therefore no savings in EBD) – likely to be due to high bed pressures preventing long hospital stays. It should also be noted that the sample size for any one individual year is relatively low and so the results are not as reliable. Whilst changes in the data year to year should be noted, the most reliable results are provided by the cumulative results over the lifetime of the project.

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 22% 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 £2.2m 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 and excess bed days, 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

Siobhan is a 67-year-old lady that was referred to the Housing to Health service by Adult Social Care. She had generalised anxiety disorder and depression and there were concerns for her well-being due to an ongoing safeguarding investigation at her accommodation. The stress of this was having an adverse effect on her mental health which led to her taking an overdose and Safeguarding advised she would need to be relocated for her health and safety.

The HHC contacted Siobhan to discuss her housing needs and it was agreed that a level access flat in another area of the city would give her the opportunity to feel both physically and mentally safe. The HHC began bidding on suitable properties and the ideal one was located - it was 82 days between the date of referral and the date that Siobhan received the keys, which was much faster than the average waiting time for IL properties of 197 for non-H2H clients in 2022/23.

The HHC worked with her every step of the way, from application to bidding to sign up. She was there at the sign-up appointment to complete the needed paperwork, setting up of utilities and she ensured Siobhan was receiving all the benefits she was entitled to.

Six months after Siobhan moved in, the HHC made contact to complete a survey and discuss how the service had helped her. She rated the service 10/10 and was especially thankful for her HHC – ***"[HHC was] like a guardian angel and I could never give [her] enough thanks for all [she] did for me. I love it here and I am very happy. It was like a prison at [old address] and [HHC] helped me get out of there."*** She also went into detail about the friends she has made, exercise classes she attends and how she feels much healthier, is drinking less and is more comfortable financially.

Without the service it is likely Siobhan would have remained at her old address which was severely impacting her mental health. She could have been at risk of harm due to the ongoing safeguarding concerns and may have been at risk of further self-harm.

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 7 this included 23 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).

Since the Covid pandemic, due to the increased need to free up bed spaces and then remaining high demand for hospital beds to treat the backlog of patients needing hospital treatment, the project has seen an increase in the number of H2H patients who are discharged under Pathway 1 (home with social care package) or Pathway 2 (particularly discharges to residential social care).

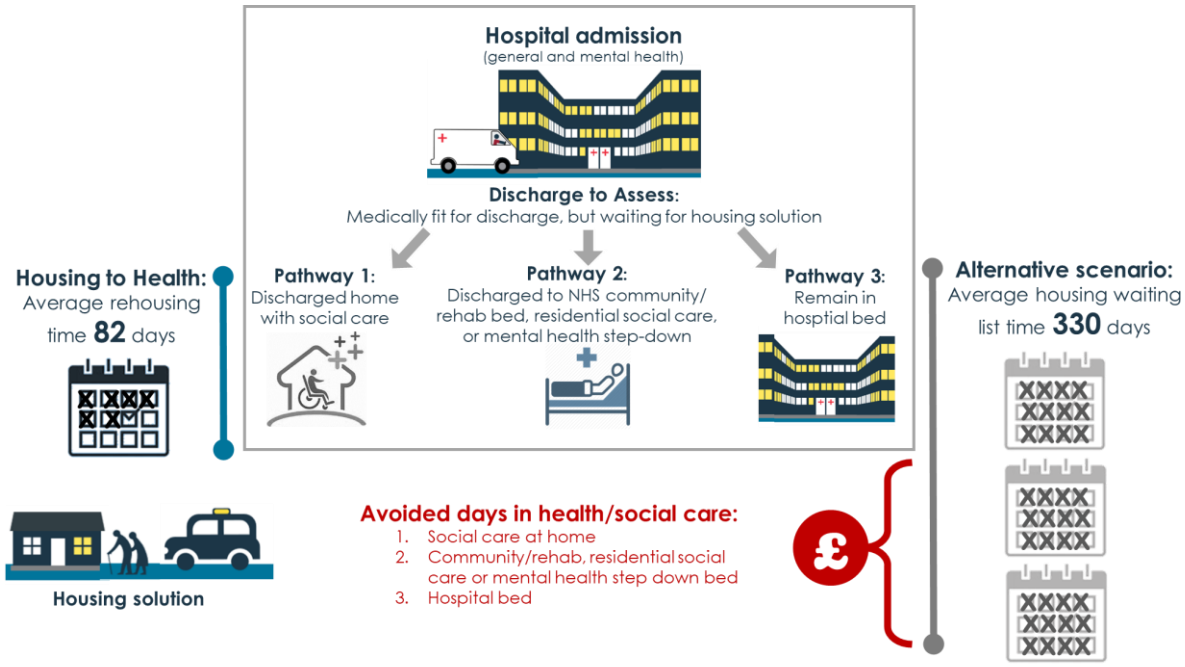


Figure 4: Cost avoidance model from reduced DTOC

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 330 days.

However, with the help of the H2H project the average rehousing time (from referral to tenancy start) is only 82 days. Thus **the intervention of the project avoids an additional eight 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.

[14] Based on hospital records where available, or case notes from the HHC.

Error! Reference source not found. 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) 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	7
Pathway 2	NHS community/rehab bed	3
	Residential social care	8
	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 five 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 (from 2022 onwards), 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[15] in 2022/23 (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	197
Independent Living bungalow	547
General needs 1 bed flat	184
General needs bungalow	629

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

Health/social care facility	Cost per day
Hospital ward	£304
NHS community/rehabilitation bed	£188-295
Mental health hospital or step-down unit	£373
Residential social care	£86-188
Home care (4 x 30min visits per day)	£46

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

[15] Bands A or D. Excluding H2H patients.

Using this model, the H2H project has **avoided a potential additional 3,109 bed days of health or social care**, over the 23 DTOC cases dealt with by the project in 2022/23. However, 6 cases were unable to be assigned a cost-saving in this model, due to (a) one cases where the complexity of their situation meant that their re-housing time exceeded the counterfactual waiting time, and (b) five 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 £384,516**. The average cost-avoidance per case where costs are available is £21,362.

Days avoided from reduced DTOC	Days avoided	Costs avoided
NHS – General (hospital, community/rehab bed)	709	£209,155
ASC – Residential social care	1047	£113,123
ASC – Home care	1353	£62,238
Total NHS avoided care	***709***	***£209,155***
Total Adult Social Care avoided care	***2,400***	***£175,361***
Total DTOC avoided care	**3,109**	**£384,516**

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

The total cost avoidance from reduced DTOC is higher in Year 7 compared to the previous year, mainly as a result of higher waiting times for social housing properties outside of the H2H project, as assumed in the model's counterfactual scenario. This year's data shows the continuing trend of the savings in bed days shifting from the NHS towards Adult Social Care, either residential social care or social care at home. This reflects the continuing high pressure on NHS beds post-Covid, which means that patients are more likely to be discharged from hospital to a temporary residential care home placement, or return to their own home with a social care package, while a long-term housing solution is found. Part of this placement may be funded by the NHS under Discharge to Assess, but data is not available on what proportion of costs falls to the NHS. Therefore the cost is assumed to fall to ASC. Patients are less and less likely to remain in an NHS hospital or community bed while the rehousing process takes place.

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

Reducing the need for home adaptations

Two-thirds of H2H patients were re-housed due to problems with accessibility, either into or around their previous property. In some 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.

For this year's evaluation, additional information has been provided by NCC's Adaptations Agency Service on local costs of adaptations, as well as focusing on case data to comprehensively identify which cases would have been likely to return to their own home, with necessary adaptations, without the intervention of the H2H project. In Year 7, 51 cases were identified where 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 132 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. NCC's Adaptations Agency Service provided local costs for these adaptations, which range from £180 for support rails, to £6,001 for a level-access shower. 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 £441,266 in adaptation costs to Nottingham City Council**. The savings identified in this area are higher than in previous years, due to the focus on case data and identifying all likely instances where adaptations would have been required.

Avoiding homelessness

There were 9 cases where the patient was at risk of becoming homeless at the point where they were referred into the scheme[16]. 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 GMCA Unit Cost Database estimates that a homeless application and support for housing options costs the local authority £3,189 per case, plus a further cost of £137 per week for on-going temporary accommodation.[17] 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 £57,197.**

[16] Including patients in Mental Health Step-Down units who had reached the end of their maximum 8 week stay

[17] GMCA Unit Cost Database – Housing https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/

3.4. Impact on social housing provider

In the seventh year of the project, a total of 91 properties were successfully let via the H2H scheme. Of these, 79 were NCC Housing Services properties and 12 were managed by other RSL providers (let through the Homelink partnership).

Property data is only available for the 79 NCC Housing Services properties. This shows that, on average, these properties had been void for 148 days (with days void prior to letting ranging from 28 to 716 days). This is longer than the average void time for similar properties, indicating that H2H is continuing to let properties from NCC Housing Services' harder to let stock. Due to the shortage of available properties, HHCs have targeted hard-to-let properties, and this year 73% of properties let by H2H were officially defined as 'hard to let'.[18]

NCC Housing Services 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 58 hard to let properties this year, including a number of properties that have been long-term void. In addition, in supporting H2H patients to move to properties more suited to their needs, the project has also freed up 16 NCC Housing Services general needs properties, including flats and family housing, which are much in demand.

Empty properties have a cost implication for NCC Housing Services, 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 £194,500 in lost rental income.

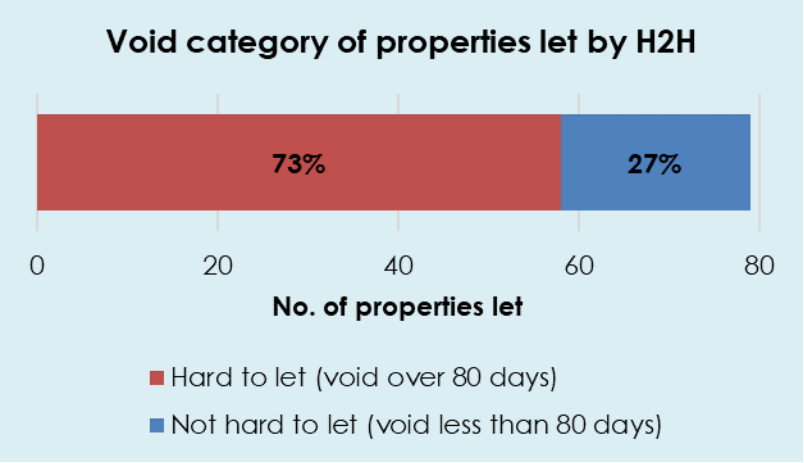


Figure 5: Void category (hard to let or not) of properties let via the H2H project

A measure of cost-benefit to NCC Housing Services from letting these properties is modelled to indicate the benefits to NCC Housing Services. The model is based on the evidence that (a) H2H continues to let properties from NCC Housing Services' 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.

[18] NCC Housing Services 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.

The model assumes that without H2H, the property would have remained empty for the average void time for that category of property.[19] 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 128 days of lost rental income per property. Therefore **by letting the properties more swiftly through the H2H scheme, NCC Housing Services has received £174,648 in rental income that it might otherwise not have received**. In addition, letting the properties more swiftly through the H2H project potentially **saved NCC Housing Services £44,808 in council tax payments** (at £30.92 per week).

As more NCC Housing Services IL properties have been filled and the choice of empty NCC Housing Services 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.

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 2022/23, 23 patients completed the six-month follow-up survey. This sample of 23 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 Y7
Patient satisfaction with service	9.8 out of 10
Patient satisfaction with new property	100% satisfied
Confidence managing their health at home	91% more confident now than 12 months ago
Health-related quality of life (EQ-5D)	3% improvement
Self-reported health score (VAS)	25% improvement
Mental wellbeing score (SWEMWBS)	12% increase
Social isolation/contact – have enough social contact	61% increase (96% have adequate/enough social contact now)

[19] Average void times are calculated from 2022/23 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.

Feeling safe – feel adequately safe	70% increase (100% feel adequately safe now)
Financial comfort – doing alright/living comfortably	17% increase (83% doing alright/ living comfortably now)
Employment – employed full/part time (those of working age only)	1 person more work ready
Carer's overall life satisfaction[20]	80% improvement (increased from 1 to 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 9.8 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 but one** H2H patients stating that they would not have been able to find and move to a more suitable home by themselves, i.e. without the Health and Housing Coordinators.

All patients are satisfied with their new property (100%). This compares to only 9% who were satisfied with their previous home. This is a very significant increase in patients' satisfaction with the home they live in.

> *"It was easy because I received so much help."*
>
> *"Excellent service. Very efficient and sorted out all issues during the beginning with the property."*
>
> *"Great service, I didn't know how to move and HHC did everything."*
>
> *"Everyone was very helpful and supportive. Very kind, couldn't do enough to help me"*
>
> *"You were like a guardian angel and I could never give you enough thanks for all that you did for me. I am so glad you have called me today so that I had a chance to tell you that."*

[20] 2 carers were present to complete a before and after question on their own life satisfaction

Partner testimonial: Social Care – Community Care Officer

"I have used the Housing to Health service several times and have found the service to be incredibly helpful.

As a social care professional, I often turn to this service when I have a citizen whose needs mean that they would not be suitable for mainstream housing, or for people who are difficult to house due to their mental health needs.

I have found the staff to be responsive, knowledgeable and reliable. In my experience, the service always manages to support citizens to find suitable housing. If a citizen doesn't meet criteria, then staff at Housing to Health are always helpful in signposting colleagues to other suitable services or providing advice on best courses of action"

Health and wellbeing outcomes

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

Almost two-thirds 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. **91% feel more confident managing their health at home** now, compared to 12 months ago. Only 1 patient feels less confident in managing their own health now.

The health scores show that respondents' health-related quality of life has shown an 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 0.59 to 0.62 (out of 1), i.e. a **3% improvement in their health-related quality of life**. This is a positive improvement, but slightly lower than average over the lifetime of the project, which shows a 13% improvement across all patients supported.

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 39 to 64 (out of 100) – **a statistically significant increase of 25% in self-reported health**.

Levels of reported **anxiety and depression have also decreased significantly since moving**. 61% of patients reported that they were moderately, severely or extremely anxious or depressed when they first engaged with the project, indicating continued higher mental health issues at baseline in the post-Covid period, compared to previous years. This has decreased to 30% who feel this way now, a decrease of 30%. 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 73% of patients reporting an improvement in**

their mental wellbeing. The average mental wellbeing scores increased from 21 out of 35, to 24 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. **All (100%) 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. 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, 65% 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%.[21] **Since moving, all those surveyed (100%) 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. Only one person still feels that they would like more social contact.

Just under a fifth of residents have experienced an improvement in their financial wellbeing, but this is less than in previous years due to the impact of the cost-of-living crisis. Before moving, around 35% were just about getting by or finding it 'quite' or 'very' difficult to get by. 61% of the group have received help with finances, mainly support from the HHCs with benefits, switching utilities and dealing with rent arrears. **Six months after moving, 83% of H2H patients surveyed now report that they are 'doing alright' financially or 'living comfortably'.** Only one respondent reports 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, 85 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 small sample of 2 carers in Year 7 have shown a big increase in life satisfaction, from 1 to 9 out of 10. This is **a huge improvement in the quality of life of those caring for those helped by H2H**.

> *"Thank you so much. [Our family member]'s journey to a new flat would have been nigh on impossible without you and your hard work, patience, kindness and understanding"*
> **H2H patient family member**

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

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. Patients' satisfaction with their new home is the highest reported to date. Improvements in social contact and sense of safety are higher than in previous years. Changes in health and wellbeing measures are positive across all measures, but show slightly lower improvements 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?

"My independence is the biggest thing. More opportunities i.e. can visit local friends in scooter can do shopping and meet friends."

"No steps, ground floor and a wet-room, lovely little front garden."

"My whole life. Moving here has improved my whole life.
I am really very, very happy. I love it here."

"No stairs to worry about, I'm comfortable, love where I live now."

"Happier than before, not crying and generally upset as often."

"Being close to my sister and getting away from a place that has been very traumatic for me."

"I can get in and out of my flat in my wheelchair. I couldn't do that in the upstairs flat but on the ground floor I don't have the big step at the front door."

"I was extremely unhappy at [my previous home]. Since moving … my life has changed so much. I am paying off my credit card and saving, I now receive more money because I get pension credit. I am healthy and don't drink much anymore. I have made new friends and go with them to groups. I am happy."

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

5.1. 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 2022 to March 2023.

The total running costs for H2H project for 2022/23 were £203,714. 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 7 of the project, Nottingham City ICB provided £77,000 of funding. The remainder was resourced from NCC Housing Service budgets.

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 £70,653.[22] The Return on Investment (ROI)[23] to the NHS's direct funding element, looking at the cost reduction from reducing re-admissions in isolation, is marginally negative this year. This is mainly due to a small number of cases in this year's sample group that had lengthy re-admissions to hospital after being moved, and a smaller group in this year's sample. However, overall since the start of the project, the ROI to the NHS's total funding is positive, at £3.98.

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 £384,516. Of this, 54% of the costs avoided fall to the NHS, and 46% to Adult Social Care.

Additional cost-avoidances are made that positively impact on the wider 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 7 are £498,463.

There are cost-benefits to the housing partner, NCC Housing Services, 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. These benefits are particularly strong in Y7, when the H2H project let a considerable number of properties that had been previously empty. The total financial benefit to NCC Housing Services in Year 7 is £219,456.

The **cumulative financial value of the H2H project in 2022/23 is £1,173,087.**

[22] Hospital admissions data calculated over the period October 2021 – September 2022.

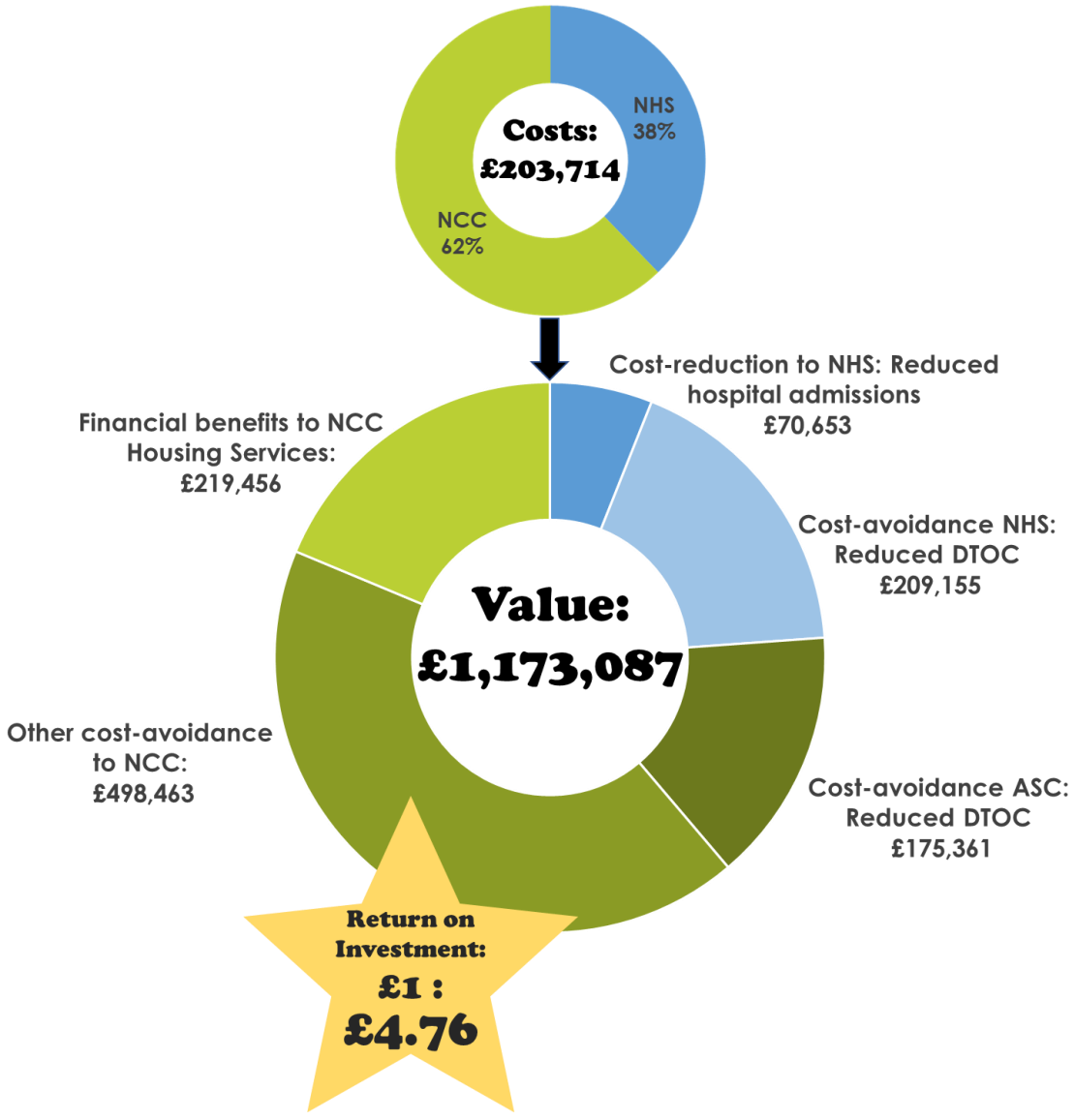
[23] Return on Investment is calculated as (Total financial benefit – Cost of project)/(Cost of project)

The total net financial value achieved by the scheme in Year 7 is £969,373. The estimated **(net) financial Return on Investment is therefore £4.76 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, as well as cost-avoidance from reducing DTOC. 24% of total savings fall to the NHS. The overall ROI to ICB funding in terms of the cumulative value to the NHS is £2.63 for every £1 invested.

Various Nottingham City Council departments also benefit from the project. 76% of the total savings fall to Nottingham City Council. Within this,19% fall to NCC Housing Services. The cumulative value to NCC is £893,280, giving a ROI to the resources contributed by NCC to the project of £6.05.

This brings the cumulative financial value over the lifetime of the project (November 2015 – March 2022) to £10,482,741. The total costs over this period were £1,195,890, giving an overall net ROI of £7.77 for every £1 invested.



5.2. 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 23 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.[24]

The Wellbeing Valuation approach was used to assess the social value generated amongst the 23 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	5	£196,509
Feel safer	Not worried about crime (feel as safe as they want)	£12,274	16	£165,573
Improve physical wellbeing	Good overall health (increase to above average VAS score)	£20,141	6	£121,118
Achieve secure housing	Temporary accommodation to secure housing (individuals at risk of homelessness)	£8,019	12	£96,228
Reduce social isolation	Talks to neighbours regularly (have as much social contact as they want)	£4,511	14	£71,056
Improve economic wellbeing	Financial comfort (increase to 'living comfortably' or 'doing alright')	£8,917	5	£44,393
Total social value*				**£555,723**
***Net benefit** (Total SV minus project costs)*				***£504,235***
Social Return on Investment				**£1: £10.79**

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

[24] 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 23 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. A fifth 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 70% 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 quarter of the sample (26%) went from having below average to above average self-reported health for their age.

6. Conclusions and next steps

In 2022/23, the H2H project supported 91 people who were living in housing that was unsuitable or negatively impacting on their health, to be re-housed into appropriate social housing accommodation.

The H2H project has continued to operate successfully this year, despite working within challenging contexts within both the housing and health sectors. The health sector continues to face pressures on beds as a result of the backlog of cases from Covid-19. There is also continuing high demand for social housing and limited availability of properties ready to let. H2H patients have increasingly complex health and social needs. Despite the challenges, the HHCs have continued to support patients to be rehoused to suit their needs.

This year the H2H rehousing time is slightly increased from the previous year, largely due to the ever-increasing demand for social housing and continued backlog of properties being made ready to let. 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 7 is very similar to the number completed per year over the last few years. The number of patients referred directly from high-demand NHS beds is falling slightly, as the NHS responds to continuing pressures to free up bed spaces and discharge patients out of hospital. However, the HHCs still pick up these cases in the community, and the project has largely retained its focus on patients with high levels of hospital use, with just under half of patients having reported a previous admission in the last six months. The proportion of patients with previous admissions in the last 6 months has been decreasing slightly over the last few years (according to both patient recall and hospital admissions data), and the project team have noted this finding to inform practice going forward.

The financial Return on Investment (ROI) assessment shows that the project is cost-effective overall. A central financial measure for the NHS is the cost savings from actual reduction in hospital readmissions, which for the first time shows lower total savings than the cost to the NHS. It should however be noted that the calculations are based on a sample of patients, and that per year the sample is relatively small, which can affect the reliability of the findings. The evidence is strongest when taken cumulatively, and the cumulative findings shows that every £1 invested by the NHS saves them £3.88 in reduced hospital readmissions, over the lifetime of the project.

Together with the additional financial benefits of the project – from reducing Delayed Transfer of Care, reducing adaptations and homelessness costs, and increasing rental income – the overall financial impact of the project is positive. The overall rate of return is a net of £4.76 in financial benefits for every £1 invested. The project creates financial benefits for several stakeholders. 24% of the cumulative financial benefits are to Nottingham City ICB (NHS), 57% benefit local authority (NCC) budgets including Adult Social Care, homelessness and adaptations, and 19% fall to NCC Housing Services.

The financial ROI is slightly higher this year than last year. The main factor is an increased saving to NCC Aids and Adaptations, due to a focus this year on accurately measuring and costing these savings. Savings as a result of reduced Delayed Transfer of Care (DTOC) are also higher this year than last, due to a number of cases where patients could not return home with care, and so remained in an NHS bed until rehousing could be sourced. The higher waiting times for social housing outside of H2H, due to longer waiting lists, also increase the savings within the model. There are also higher savings to NCC Housing Services from re-letting empty properties more quickly, with HHCs able to let a number of Independent Living properties that have been long-term void. However, as noted above, the savings to the NHS from reducing hospital readmissions are significantly lower this year.

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 but one 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.

6.2. Next steps for the H2H project

Funding has been secured for the project until March 2025. 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.

NCC Housing Services will continue to lead and promote good practice in health and housing-related developments, both locally and nationally. Most recently, NCC Housing Services were approached by the Nottingham City ICB to recruit an additional fully-funded HHC post to be operationally managed within the H2H project. The purpose is to deliver a new 12-month Anticipatory Care project in Bestwood and Sherwood. The pilot scheme focuses on a specific complex cohort of patients within the Bestwood/Sherwood area. This will be delivered through the Anticipatory Care pathway, which aims to prevent patients from becoming more unwell. The cohort of patients will be comprised of patients who are 80+, living at home with 5 or more comorbidities and a high frailty score. The pilot, as well as including a HHC role, also includes specialist dementia nurses, geriatricians, an Age UK finance and benefits advisor, case manager, care coordinator, GPs and nurses.

NCC Housing Services 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.

	Y4 2019-20		Y5 2020-2021		Y6 2021-22		Y7 2022-23		Cumulative	
	No. cases	Value	No. cases	Value	No. cases	Value	No. cases	Value	No. cases	Value
Total cases	106		90		89		91		724	
DTOC cases	44	£887,035	29	£499,581	26	£236,214	23	£384,516	250	£4,942,497
Early intervention cases	62		61		63		68		474	
Hospital re-admit reduction	48	£537,819	37	301,646	32	£458,538	21	£70,653	266[1]	£2,465,297
Homeless (at risk)	9	£49,955	15	£114,958	12	£71,082	12	£83,537	88	£521,492
Adaptations	84	£222,658	56	£153,551	50	£141,140	38	£123,370	357	£1,019,884
NCH properties	93	£68,495	84	£61,279	80	£135,789	79	£219,456	648	£840,887
TOTAL	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**	**Cost**	**Value**
	£183,737	**£1,765,963**	**£181,548**	**£1,131,015**	**£194,551**	**£1,042,673**	**£203,714**	**£1,173,087**	**£1,195,890**	**£10,482,741**
NHS	£77,000	£1,283,957	£77,000	£653,322	£77,000	£542,660	£77,000	£279,808	£538,419	£6,630,470
NCC Housing Services	£106,737	£68,495	£104,548	£61,279	£117,551	£135,789	£117,551	£219,456	£657,471	£840,887
NCC		£413,510		£416,414		£364,314		£673,824		£3,011,385
ROI (net)		**£8.61**		**£5.23**		**£4.36**		**£4.76**		**£7.77**

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 514.