Harnessing Housing Support:
Nottingham Housing to Health service

Review of project enablers and potential for spread

Contents

Executive summary 1

1. About the Nottingham Housing to Health service and the project review 5

1.1. About the Nottingham Housing to Health service 5

1.2. Impact of the Nottingham Housing to Health project 8

1.3. Aims and objectives of the project review 10

2. Findings from the project review: Key project enablers in Nottingham 11

2.1. Key factors in developing a shared local vision for housing and health 11

2.2. Key factors in building and sustaining an active housing-health partnership 13

2.3. Key factors in successful operational delivery 20

3. Potential for spread 29

3.1. Replication 29

3.2. Variation 29

4. Conclusion 30

May 2020

Alice Jones
IMPACT CONSULTING

Harnessing Housing Support:
Nottingham Housing to Health service

Review of project enablers and potential for spread

Executive summary

The Nottingham Housing to Health (H2H) project is an example of a successful joint project between housing and health, demonstrating the positive outcomes that can be achieved through such a partnership. By working together to provide fast-track housing solutions for patients in hospital and in the community, who are living in poor or unsuitable accommodation, the project has been able to deliver financial savings to the health service, local authority and housing provider. Vitally, the evidence also shows that the project has also improved the health and wellbeing of patients and their carers, enabling them to live independently and reducing their ongoing use of health and care services.

What makes this project work successfully in Nottingham? And could it be replicated in other areas to deliver the same benefits elsewhere? These questions were put to project stakeholders, to understand the essential requirements for rolling out similar projects in other areas. Three themes for project enablers were identified:

1. Developing a shared local vision for housing and health

Nottingham has a clear shared vision for housing and health. This is based on:

- **A place-based outlook, in a shared geographical footprint:** Partners are focused on meeting the needs of their shared local communities. The footprint for local strategies and funding are aligned for both housing and health partners. It simplifies the partnership structure by limiting the number of stakeholders.
- **A long-term background of making the case locally for housing as a health partner, through evidence and relationship building:** The housing provider has a proven track-record of delivering interventions that improve the local population's health, demonstrating its value as a health partner. This has given housing a place at the table within local health structures, so that housing is identified as a priority within local health strategic plans, and vice-versa.
- **A project model that meets a clear business need for both health and housing partners:** The H2H service meets the Clinical Commissioning Group's objectives to help drive down costs and improve patient outcomes through early intervention and reducing delayed discharge from hospital. The project benefits the housing provider by filling empty social housing properties with lower demand. The win-win situation creates a compelling business case for the project that gains support from stakeholders in both organisations.

"The greatest thing that we've learned as an organisation is that greater things can be achieved in partnership… your impactability as a partnership is much greater than if you were trying to commission something on your own."
CCG Commissioning Manager

2. Building and sustaining an active housing and health partnership

Nottingham has built bridges between housing and health at every level – from strategic and senior leadership, to management and frontline staff – linked by plans and policy, personnel, personal connections and proof.

	Strategic and senior leadership	Project management and delivery
Plans and policy	Housing is identified as a priority in Nottingham's Health and Wellbeing Strategy and Sustainability and Transformation Plan. The local housing strategy and housing provider's corporate objectives include a commitment to improve the health and wellbeing of their citizens.	The project started with a clear initiation document agreed by all partners. Key housing policies were adjusted to make the project operational. A process-mapping exercise gave the project clarity in terms of how it operated on the ground, across the health and housing landscape.
Personnel	Initial links were made as a result of each partner working to provide a 'face' to represent them at a strategic level. Nominating an individual and/or team on both the housing and health side to lead on partnership working helped build the first bridge between the two partners.	The project requires an active project manager from the health and housing side. They are an important point of connection- between the two organisations, with senior leadership within their own organisations, and with operational staff delivering the project. A key role of the project delivery staff (Housing and Health Coordinators) is to make and build working relationships with clinicians working with the target patient group – these links with health and care personnel are what sustain the day-to-day successful operation of the project.
Personal connections and commitment	The initial link was strengthened by personal connections as a result of the nominated lead from each organisation working together, developing a better understanding of the drivers and needs of each organisation. The project also connected senior leaders with the project's frontline staff and patients, showing them first-hand what difference the project makes. As a result, senior leaders from both housing and health are personally committed to the project, and work together to keep it operating successfully.	The Health and Housing Coordinators (HHCs) need to be good communicators with a range of people, from patients, to clinicians, to commissioners. The HHCs make the project a success by being willing to go the extra mile on behalf of patients, doing everything required to support them through the entire process.
Proof	Evidence of the project's impact is essential. The project is able to demonstrate the positive health outcomes achieved via a non-health intervention. It collects a wide variety of data on health service use, financial impact, and patient health and wellbeing outcomes. This provided proof of concept to continue the project beyond the pilot phase, and supports the business case for ongoing investment.	Contractual monitoring of Key Performance Indicators ensures that the project is on track to deliver its intended outcomes. At an operational level, the proof that frontline health staff need to see is first-hand experience of successful outcomes for their patients and their organisation.

3. Successful operational delivery

The following factors were identified as being essential to the successful operation of the project. Successful operational delivery results in achieving the project's outcomes, and in doing so also strengthens the overall health and housing partnership.

- **Insider access to social housing and housing expertise:** H2H is primarily a housing service, with the ability to provide patients access to the social housing lettings process and expertise to guide them through it.
- **Availability of suitable social housing stock:** The project depends on having available accommodation to move patients into quickly. Much social housing is in high demand, but certain types of properties have lower demand and higher turnover. The H2H project targets these properties. The housing partner then benefits from filling lower demand stock.
- **Clearly defined patient criteria, reflected in the Housing Allocations policy, and a fast-track rehousing process:** The patient criteria ensures the H2H project only works with patients with significant health needs, and also aligns it with available accommodation. Having the criteria in the Housing Allocations policy gives the project a formal mandate. The housing provider also approved a fast-track housing application process for H2H patients, enabling rapid rehousing solutions.
- **Funding, reflecting financial return to project stakeholders:** Innovative funding is needed to allow for investment in a non-health provider to deliver health outcomes. The source of funding reflects where the financial benefits from the project fall – in this case, the health partner (CCG) contributes significantly towards the costs of the project, reflecting the benefits to the health system from reduced burden on their services as a result of the project.
- **Integration into health systems- interdisciplinary team working for a holistic solution:** The foremost role of the health partner is to open doors into local healthcare teams and systems, to reach the project's target patient group. Beyond this, successful integration also creates two-way knowledge exchange, and ability to deliver holistic solutions for the patient.
- **Wrap around support, ensuring a sustainable housing solution:** A successful tenancy requires more than just the keys to the door – the HHCs support the patient with the moving process; they make sure they are set up to live independently, working with healthcare staff to install any adaptions/aids; ensure financial independence with benefits checks and setting up utilities; and connect patients to ongoing housing and social support networks.
- **Calibre and commitment of frontline project staff:** The knowledge, experience and dedication of the Housing and Health Coordinators is key to the project's success. Their ability to build trust with patients and clinicians is essential, based on their willingness to go the extra mile to find a solution and compassionate approach to patients.
- **Information management and data collection, to support project delivery and evidence of outcomes:** Underlying the project is an efficient platform of live ICT access and electronic data collection, providing the data required to support project management, contractual monitoring and annual evaluation of outcomes.

Potential for spread

There is potential to extend the beneficial outcomes achieved in Nottingham by replicating similar housing and health projects in other areas. Potential new partnerships could benefit from the learning from this, and other projects – providing a ready-made proof of concept and supporting business case. New partnerships could be built by inviting housing partners to join local health structures, particularly those focused on a Population Health approach (such as the Health and Wellbeing Board or Integrated Care Partnership). This could be targeted at local housing providers with a community outlook, who are focused on improving outcomes for a specific community or local area.

Every new project will need to take into account local context and drivers for each organisation, and so some variation will be necessary to ensure the project meets the needs of each partner. This may include variations in the service offered by housing providers, variation in the target patient group, and as a result, variation in the healthcare partner.

A successful partnership-led project can deliver significant benefits to local population health and relieve both immediate pressure on the healthcare system, as well as reducing the long-term burden through early intervention and holistic solutions to enable independent living. This review has highlighted that for

a project to be successful it needs: (1) a supportive local context, with a shared vision for housing and health; (2) a strong housing and health partnership sustained by cross-sector links at all levels, and (3) a clear map of how operational delivery of the project will lead to the achievement of its intended outcomes.

Full report

1. About the Nottingham Housing to Health service and the project review

The Nottingham Housing to Health (H2H) service is a joint project between the social housing provider Nottingham City Homes (NCH) and Nottingham and Nottinghamshire Clinical Commissioning Group[1] (CCG). The partners work together to identify patients in hospital and in the community who are living in poor or unsuitable accommodation that is negatively affecting their health, and provide fast-track housing solutions to rehouse them into good quality social housing. The annual evaluation of the H2H service shows that the project is delivering positive outcomes for the health service, housing provider, other local stakeholders and, importantly, for patients and their carers. This evidence of the success of the project has led NHS England to commission a separate review of the enablers for the project i.e. the key factors that make it work successfully in Nottingham, and consider how similar services could be spread across other areas. This report presents the findings from this review.

1.1. About the Nottingham Housing to Health service

Overview

The Nottingham Housing to Health (H2H) service aims to ease the strain on the health service and adult social care by finding suitable homes to speed up a patient's discharge from hospital, or directing people at risk of being admitted to hospital due to poor living conditions into good quality social housing. Delays in transfer of care has been identified as a significant issue for the NHS, placing additional burden on the health service, as well as putting patients' health at risk. Research estimates that the NHS spends around £820m a year treating older patients who no longer need to be there.[i]

The project is delivered by the social housing provider, Nottingham City Homes (NCH), enabled by funding and support from Nottingham City CCG (now part of Nottingham and Nottinghamshire CCG). NCH manages a significant amount of council-owned social housing[2] within Nottingham City, managing 25,000 properties that account for almost a quarter of the city's housing stock.

Three Housing and Health Coordinators (HHCs) provide the housing element to the integrated care system. They take referrals from health professionals in the hospital or in the community: one HHC is based full-time in the hospital's Integrated Discharge Team, whist the other two HHCs work with community healthcare staff and the Mental Health Trust. They help source suitable accommodation, such as Independent Living (sheltered housing) accommodation, flats, or accessible bungalows, and significantly reduce the length of the rehousing process. They support the individual and their family through the whole process, ensuring they are set up to live independently in their new home. The project supports three groups of patients:

1. Older people in hospital, or those in the community whose health is at risk due to their housing, to move into Independent Living (supported housing) accommodation
2. Essential wheelchair users (of any age) occupying a high-demand hospital bed, requiring accessible accommodation
3. Mental health patients (single people of any age) who are ready to move from a high-demand bed in a Mental Health ward/step down unit into one-bedroom flats in the community.

The project was launched in November 2015 and is currently in its fourth year of operation. To date, the project has rehoused 454 individuals into suitable social housing.

[1] At the time of the research the project was commissioned by Nottingham City CCG. On 1st April 2020 Nottingham City CCG merged with the four CCGs within Nottinghamshire to form the Nottingham and Nottinghamshire CCG.
[2] Nottingham City Homes is the Arms Length Management Organisation (ALMO) that manages the council-owned stock in the city, on behalf of Nottingham City Council.

Background and evolution of the project

The Nottingham H2H project was launched in November 2015, initially as pilot scheme for the first nine months. The initial partnership was provider-led, between Nottingham City Homes, the housing provider, and CityCare, Nottingham's community healthcare provider[ii]. From the outset, the project aimed to work both with patients at a crisis point, for example where they are already in hospital and are unable to be discharged due to unsuitable housing; but also to work as an early intervention initiative, to identify patients in the community where their health is at risk of deterioration due to housing issues. At first, the project focused on older patients, meeting the criteria to be housed in NCH's Independent Living (supported housing) properties.

At the time, CityCare was responsible for delivering an Integrated Care Programme, and as part of this was exploring the potential to better integrate housing into its care pathways. For example, CityCare had an 'Independence Pathway' that worked with patients currently in a hospital bed to support them to return to independent living at home, with appropriate support, as soon as possible. In addition, CityCare's Community Care team worked with patients in the community whose health was at risk. Both teams encountered patients where housing was negatively affecting patients' health. The HHCs were placed into these teams in order to integrate housing solutions alongside their healthcare. The project was overseen by the CCG's Commissioning Manager responsible for the Independence Pathway.

The pilot phase attracted some funding from the Better Care Fund's (BCF) 'Integrated Care Programme' element, which brought together the local Clinical Commissioning Group and Local Authority to integrate adult health and social care services. Because of the nature of the funding, it was more open to the inclusion of new types of projects where funding goes to other partners to deliver health outcomes. NCH also provided over half of the resources for the pilot phase, to support the project to get off the ground. The pilot phase was the opportunity to provide proof of concept for the project and the partnership.

The pilot proved to be a success, with the partnership operating successfully to the benefit of both housing and health stakeholders. An independent evaluation showed that the project was benefiting the health sector by moving patients out of hospital beds more quickly than would otherwise have been the case (reducing delayed transfer of care), as well as providing early intervention to prevent people's health from deteriorating in the community. It also benefitted the housing provider, by filling some of its more hard-to-let stock within its Independent Living properties.

Therefore, at the end of the pilot, the project successfully applied for further funding from the BCF, enabling the project not only to continue but to expand in scale and scope. The additional patient criteria for essential wheelchair users and mental health patients were added, and the team expanded to include an additional HHC and administrative support post. At this point, the CCG took over the lead on the health side as a commissioned project. The HHCs maintained the links with CityCare's teams, but no longer worked directly within these teams. The CCG took the lead for providing integration within the health landscape, as it implemented the new structures set out under the Sustainability and Transformation Plan (STP). In the third year, the team expanded to include an additional HHC for Integrated Discharge. This HCC is based full-time within the Integrated Discharge Team (IDT) at the two local hospital sites within the Nottingham University Hospitals (NUH) Trust. The IDT receive referrals from across the Trust when there are difficulties in discharging a patient, including housing. This provides a natural link to the H2H project, with the hospital-based HHC able to work alongside the IDT to identify and help resolve housing issues where they are causing a delay to discharge.

The project has continued to be funded through the Better Care Fund, on an annual basis. Each year the project has to put forward a business case to support its application for funding for the following year. In 2019 the project was successfully awarded two year's funding, with the potential to extend for a further year.

How the project works

In Nottingham the H2H project sits within the housing provider's Housing Options team, which manages the process of letting its properties to people who have applied for social housing. The HHCs are housing officers with extensive knowledge of the housing system, who take referrals from healthcare staff from within the city's hospitals, and community care teams as well as other local community organisations. Patients are referred when they are no longer able to live safely in their current home, for example due to accessibility issues or inappropriate or unsafe housing conditions. The HHCs support individuals (from any tenure) to be re-housed into suitable social housing, where they meet the criteria for the project. 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.

Those helped through the service are often vulnerable and require a high level of support. They may be experiencing a health crisis, and so are not equipped to deal with the stresses and strains of moving by themselves, despite this being part of the solution to their health issues. 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 offer wrap-around support to make sure that the patient is set up to live independently and sustain their tenancy. For example, the HHCs will help with or signpost patients to financial management including managing rent, maximising their welfare benefit income, managing fuel bills etc., and to activities and support offered in the Independent Living communities, providing the opportunity to engage with their community and/or social activities and reduce social isolation.

The HHCs follow up with patients following the move, and are available for further support. They visit the patient in their new home two weeks after moving in, and complete a final follow-up visit and survey six months after they have moved.

Case study 1:

David* was referred to the Housing to Health service by his Occupational Therapist after concerns were raised about the suitability of his private rented property.

David was a 65-year-old gentleman with a diagnosis of heart failure who had recently had a heart bypass and was struggling to mobilise around the property. He had fallen multiple times in the month prior to referral, had repeated hospital admissions and was sleeping in a hospital bed in his living room with district nurses visiting several times per day to provide treatment for him. He also had carers come daily to help him with meals, bathing and personal tasks.

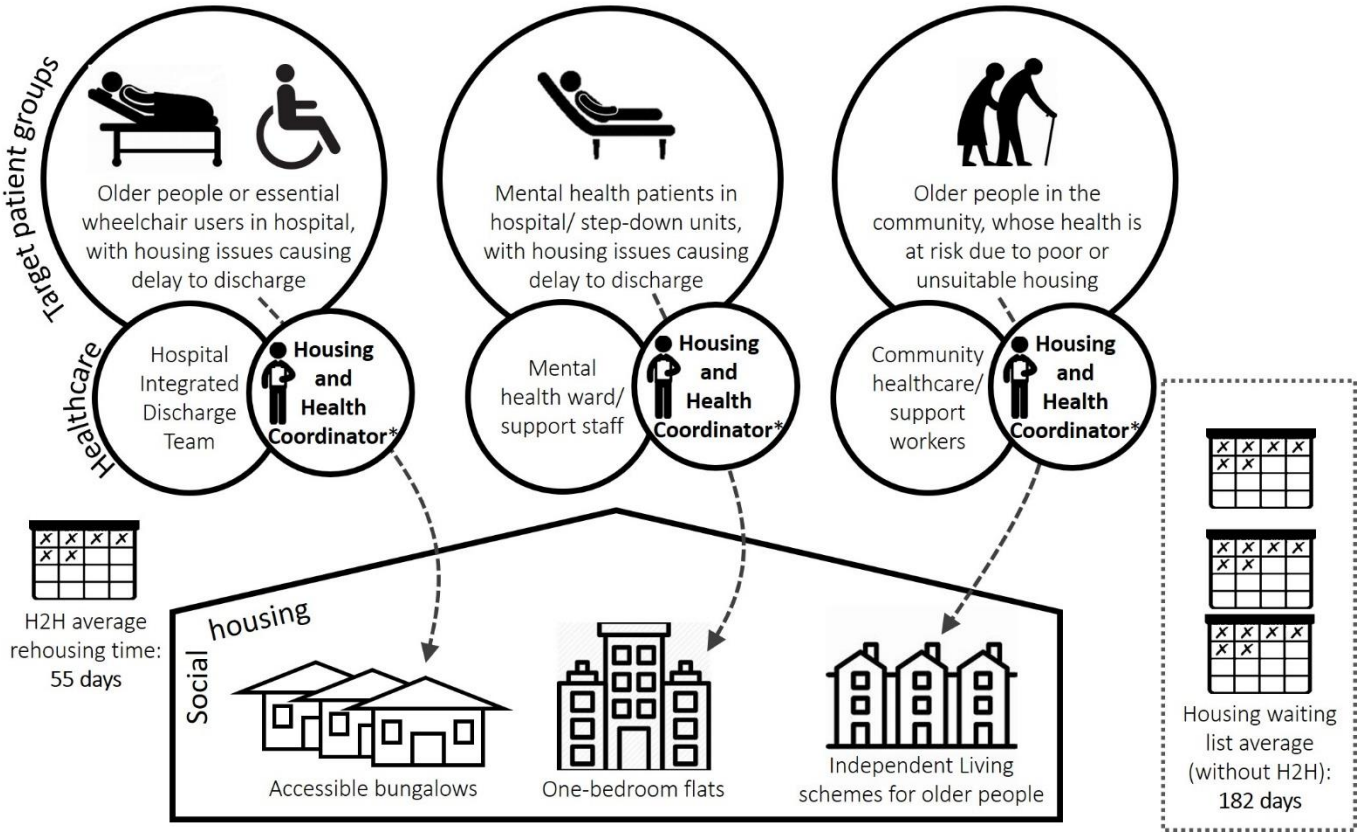
The HHC visited David in his home to discuss his housing options. She completed a housing application with him, submitted a medical report to get him priority and began to place bids on suitable properties close to his support network. Soon after referral, an Independent Living flat was identified as suitable for his needs and after a viewing he agreed to sign for the property.

The HHC worked with David and his family to facilitate the move and helped him to apply for benefits, council tax reduction and also switched over his utilities from his previous address. She also provided advice on removals and spoke with him several times after the move to ensure he was doing well.

At his six-month visit, David looked like a different man. He was happier, he had lost a lot of the weight and most importantly he was mobilising around the property and appeared in much better health. He was no longer having district nurses visiting him and no longer needed a care package to help with meal preparation and bathing. He said the service was *"fab"* and he loved how *"everything is on one level. I love my property, very quiet and great friends made."*

*Name has been changed

Figure 1: How the H2H project works



*One HHC works in hospital as part of the Integrated Discharge Team, two HHCs work in NCH's Housing Options team, with close links to healthcare staff

1.2. Impact of the Nottingham Housing to Health project

A process of evaluation research and reporting has been embedded into the H2H service from the very start. The evaluation measures the success of the project against its outcomes and provides an assessment of the financial and social value generated by the project.[iii]

The evaluation shows that the project has:

- Reduced Delayed Transfer of Care (DTOC) from hospital, community and Mental Health beds
- Reduced hospital re-admissions
- Helped improve the uptake of empty social housing properties and reduce long-term voids
- Reduced demand on other local authority services, such as Adult Social Care, Adaptations and Homelessness services
- Significantly improved patient outcomes, including the health and wellbeing of patients and their carers
- Generates very positive financial and social Returns on Investment (ROI)

Reduced Delayed Transfer of Care: With the help of the H2H project, the average rehousing time (from referral to tenancy start) is 55 days. Without the project, patients would have remained in care whilst going through the general social housing process as a medical priority – the average waiting time for individuals in this group is 182 days. Thus the intervention of the project avoids a potential additional 127 days in care 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. Over the lifetime of the project, the H2H service has avoided a potential additional 17,900 days in residential health or social care facilities by reducing delayed transfer of care.

Reduced hospital readmissions: By tracking the progress of H2H patients over the longer term, the project has been able to demonstrate a continued impact of reduced burden on hospitals as a result of being suitably rehoused. H2H patients' hospital admissions were recorded in the six months before and after they moved into their new home. This shows that:

- H2H patients are admitted to hospital less frequently after moving: the average number of admissions per person reduced from 4 per year prior to the intervention, to 1.7 per year afterwards.
- If admitted, H2H patients stay in hospital for less time after moving: the average Length of Stay also reduced from 16 days per admission before moving, to 9.5 days per admission after moving.
- H2H patients have fewer Excess Bed Days after moving: Excess bed days accounted for 8% of bed days in the admissions prior to the intervention, and only 1% in the period after intervention.

Cumulatively, the reduction in number and length of hospital admissions has been shown to save 310 fewer admissions to Nottingham's hospitals, 6,700 fewer bed days, of which, there are 680 fewer Excess Bed Days. This reduces costs to the NHS by £1.4m

Benefits to the social housing provider: NCH aimed to reduce the number of long-term empty properties amongst its stock through the H2H scheme, to optimise the use of their housing stock. NCH's performance data shows that the number of long-term empty properties achieved its lowest ever level, in part due to the contribution of the H2H project in letting empty Independent Living properties. This increases the rental income to NCH and avoids void costs such as Council Tax payments.

Reduced demand on other local authority services: As highlighted above, the H2H service reduced the Delay in Transfer of Care from residential social care beds. By moving people into suitable, supported accommodation, it also reduces the burden on ongoing social care needs such as home care. The service also reduces demand on the local authority's adaptations agency, by moving people into already adapted properties rather than making potentially expensive adaptations to their existing home. This avoided the need for 129 adaptations, such as ramp access, support rails, stairlifts and level-access wet-rooms. In addition, the service has supported 40 individuals who were at risk of homelessness, reducing the burden on Housing Aid.

Improved health and wellbeing of patients and their carers: H2H patients are very satisfied with the service they receive, giving it an average score of 9.7 out of 10. Most patients (94%) state that they wouldn't have been able to move without the support of the HHCs.

Results for a sample of H2H patients in 2018/19 who have been living in their new property for over six months show a significant increase of 19% in their health-related quality of life (EQ-5D) on average, and 20% improvement in self-reported health. Mental wellbeing scores have improved from below the UK population average to above average, with three-quarters of patients reporting an improvement in their mental wellbeing. 29% of the H2H patients surveyed showed a substantial reduction in anxiety/depression, 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.

Those helped by the H2H project have also experienced a number of other positive changes since moving, which has significantly improved their quality of life. Social isolation was a significant issue for this group, with almost two-thirds reporting they had little or not enough social contact with others when living in their previous home. Since moving, 88% now have adequate or as much social contact as they would like. Reducing social isolation is vitally important as it has significant mental and physical health benefits – research shows that loneliness can be as damaging to health as smoking 15 cigarettes a day and can increase mortality by 26%.

Other positive changes include a substantial improvement in regards to people's own safety, both inside and outside their home. All H2H patients (100%) now report that they feel as safe as they would like, compared to two-thirds who stated this in relation to when they were in their old home. H2H patients also report an improvement in their financial comfort, and ability to manage their own health at home.

Carers also indicate that they have seen an improvement in their quality of life since their friend/relative has moved. From a sample of carers who were surveyed, carers' average life satisfaction score has increased by 40% in the six months since their friend/relative moved.

Financial and social value of the service: The total financial value generated by the project is estimated to be £5.4m. This gives a net financial Return on Investment (ROI) of £11.42 for every £1 invested. Of this financial value, £1.4m is from actual cost reductions by reducing hospital readmissions. There is also £2.6m of cost-avoidance to the NHS by reducing DTOC. The reduced burden on other local authority service avoids £1.1m in potential costs. Finally, the housing provider benefits from £355,000 in additional rent/avoided costs.

The positive outcomes for patients and their carers also have a social value to those individuals. A new 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 Wellbeing Valuation for the H2H project shows that every £1 invested creates £16 in social value.

1.3. Aims and objectives of the project review

The evaluation results above show clearly that the project is operating successfully and delivering a number of positive outcomes for the project stakeholders, and importantly to patients and their carers. The purpose of this project review is to understand in more detail the process of how these outcomes are achieved. The objectives are to:

- Understand the key features of the Housing to Health project that enable the project to work effectively in Nottingham
- Identify which features are essential requirements for rolling out similar projects in other areas
- Identify other key beneficiaries and explore flexibility of the project to operate with other beneficiaries as the primary funder
- Provide evidence base to NHS England to explore developing similar projects in other areas

To help guide the research for the review, three themes were explored with interviewees and within the desk-based review. This helped provide a framework from which to start to explore the many and often complex reasons for the projects' success. The themes were taken from a generalized theory[3] of the factors that need to be aligned for projects to achieve public good.

These three factors are:

1. Having a shared vision and clearly defined outcomes that the project is aiming to achieve (public value outcomes)
2. Building a partnership of stakeholders to support and sustain the project at every level (authorizing environment)
3. Harnessing the necessary resources (e.g. finance, staff, skills and technology) from inside and outside the organisation that are necessary to achieve the project outcomes (operational capacity)

The research for the review focused mainly on interviewing project stakeholders, both current and those who were involved in the early stages of setting up the project. A brief desk-based review was also conducted, focusing on reviewing documentation from similar housing/health partnership projects across England. The documents identified and reviewed are included in the bibliography at the end of this report. Table 1 below shows those interviewed for the review.

[3]The 'strategic triangle' of Public Value Theory, Bennington and Moore (2011)

Interviewees	Housing	Health
Senior leaders	Chief Executive Assistant Director of Housing Operations	CCG Locality Director, Nottingham City
Commissioning and management leads	Project Manager	CCG Commissioning manager (current) CCG Commissioning manager (start of project) Community Healthcare provider managers (initial project partners)
Frontline staff	Housing and Health Coordinators x 3 H2H Admin Support Officer	Hospital Integrated Discharge Team manager

Table 1: Interviewees for the project review

2. Findings from the project review: Key project enablers in Nottingham

2.1. Key factors in developing a shared local vision for housing and health

A place-based outlook, in a shared geographical footprint. The city of Nottingham is tightly defined geographical area, the boundaries of which are shared across the unitary local authority (Nottingham City Council, including its housing ALMO, Nottingham City Homes) and Nottingham City Clinical Commissioning Group (CCG). Although the CCG has expanded to include Nottinghamshire, the Nottingham Integrated Care Partnership retains focused on the city area. The H2H project only serves citizens of Nottingham city, as this is the defined area and local population for both the housing provider and health partners. Therefore, the CCG's patients and the housing provider's tenants are one and the same. Interviewees identified this as an important factor, for a number of reasons.

Firstly, it means that organisations have a shared focus on the local community and their priorities, so that stakeholders *'have the incentive to work with [other organisations within the local area] to improve things for local people, respond to what they want'* (Housing Chief Executive). Partners are able to focus on the specific health issues within that local population, as well as local pressure points on healthcare.

Secondly, it means that organisations have coterminous boundaries when it comes to strategic planning and funding. For example, strategic plans and therefore local priorities cover the same area and population across both housing and health, such as the Sustainability and Transformation Plan (STP). Similarly, the project is able to access funding that is assigned to the local population (such as CCG funding), because the footprint of the two organisations is aligned, so stakeholders can be confident that funding will benefit the specified patient group. Finally, it reduces the number of potential partners and therefore makes relationship-building simpler, as there is only one type of each organisation to build links with (e.g. one unitary authority, one CCG, and one main housing provider).

Not all housing providers have a geographical focus, as their housing stock may cover larger areas, across different local authorities and health boundaries. However, there are a group of housing providers who have established the PlaceShapers movement[iv], which represents housing providers committed to being community-based social housing providers who not only build homes, but help shape communities and agree to a set of shared values to act as a voice for change. Other groups of housing providers who are also likely to have a single community focus are members of the National Federation of ALMOs[v], and the Association of Retained Council Housing[vi]. Interviewees from the housing side suggested that focusing on these types of providers as housing partners would be of benefit in initiating the place-based partnership required to support a project such as this.

A long-term background of making the case locally for housing as a health partner, through evidence and relationship building: The national evidence base for the impact of housing on health is now well established, and the importance of strong housing-health partnership working is set out in the Memorandum of Understanding[vii] between national health, social care and housing partners. A decade ago there was a wave of evidence making the case for housing's role as a wider determinant of health, for example including the Marmot Review[viii] and the subsequent Marmot Review Team's report on the effects of cold housing and fuel poverty and health[ix], BRE's report on 'The Real Cost of Poor Housing', and a systematic review of the evidence indicating the health impacts of housing improvements[x].

Around this time, Nottingham City Homes was also starting to make the case for its own impact on local population health as a result of its extensive programme of social housing improvements, the Decent Homes programme. NCH, in partnership with Nottingham Trent University, invested in a two-year research programme into the wider social impact of the Decent Homes project, including on health.[xi] This not only provided evidence of the impacts of NCH's housing improvements on the health of its social housing tenants, but also highlighted the role of the social housing provider in engaging with those with the poorest health. The report concluded 'NCH is an important partner in achieving the city's social objectives, with a wider role than just 'bricks and mortar' issues… NCH provides services to the most deprived communities in Nottingham, and as the landlord is an established point of contact with the members of that community'[xii]. Following the publication and promotion of this report, the Chief Executive of NCH stated 'This has been the stepping-stone to building new and closer relationships with partners from other sectors, bringing together services that impact on our tenants' health and well-being. NCH now sits on the Nottingham Health and Wellbeing Board, gaining recognition both locally and nationally for the role of housing as an effective early-intervention health measure'.

NCH has continued in its commitment to invest in activities that improve its tenants' health, and evaluate the impact of these activities on health and wellbeing. Following from the health impact assessment of the Decent Homes programme, NCH also conducted an evaluation of the health impact of environmental (insultation) improvements. It then established a community fitness programme 'Fit in the Community' in partnership with NCC and Sport England, and evaluated its health impact.[xiii] The Housing to Health programme was then established, including annual evaluation. This meant that for each project NCH could provide evidence of health benefits and impact on the local health system.

This evidence base enabled NCH to promote itself as a valuable partner in achieving the area's strategic health aims. It laid the foundation for the inclusion of housing in a number of Nottingham's strategic health plans, as well as placing NCH at the table alongside health commissioners in implementing those strategies. For example, NCH is a member of the Health and Wellbeing Board, and the first Nottingham Health and Wellbeing Strategy includes an objective that 'Housing will maximise the benefit and minimise the risk to health of Nottingham's citizens'[xiv]. Just after the Housing to Health project was launched, the government announced the implementation of Sustainability and Transformation Plans (STPs) as 'place-based plans' for the future of health and care services in their area. Building on the existing relationships within health, NCH pushed to have a place on the STP board, and the resulting STP plan included a commitment to 'improve housing and environment'[xv]. A King's Fund review of all STPs states 'despite the fact that three out of every four of the 44 plans mentions housing (Buck 2017), only a few were far ahead in their planning and analysis (Care & Repair 2017). Nottingham and Nottinghamshire is widely acknowledged as having the most developed plan as regards housing (Nottingham City Council 2016), where it is a core theme, across the lifecourse.'[xvi]. Following on from the STP, Nottingham now has an Integrated Care Partnership, of which NCH is also a member, and is supporting the development of the Integrated Care System across the city and county.

In summary, prior to the project's initiation, the housing provider NCH had already developed a local evidence base for its role in improving local population health, and continued to do this on a project-by-project basis. NCH was then able to use this to help develop a clear commitment to the importance of housing in Nottingham's strategic health plans. This also brought NCH's senior leadership into contact with leads from local health organisations, including the Clinical Commissioning Group. The ongoing focus for housing in health is maintained by the inclusion of NCH at a strategic level such as on the Integrated Care Partnership.

A project model that meets a clear business need for both health and housing partners: The Nottingham H2H service arose from identifying a project that would mutually benefit both the health and housing partner. From the health perspective, the identified need was to help drive down costs and improve patient outcomes by reducing delayed discharge from hospital beds, as well as intervening earlier to prevent people from going into hospital. Health partners were able to use local intelligence to identify target patient groups with high levels of healthcare use, exacerbated by housing issues. There was therefore a clear business case for the CCG to get involved with (and fund) the project, as a means to reduce the burden on health services through effective integrated working.

From the housing side, the housing provider has a strategic objective to contribute to improving the health and wellbeing of Nottingham's citizens, that would be met by the project. In addition, there was a financial case for the project, due to low demand for certain types of social housing stock (mainly Independent Living accommodation) which would be filled through the project.

The partnership therefore identified a project that would meet priority objectives for both organisations. This created a win-win situation that helped gain the necessary buy-in from stakeholders from both organisations, and sustain the project over the longer term.

Essential requirements for developing a shared local vision for housing and health

- Start with a focus on a specific community or geographical footprint, and engage health and housing partners who are working within that community
- Build the case for housing as a local health partner, by evidencing the health impact of their work on the local population, and engaging with local health structures e.g. Health and Wellbeing Board, Clinical Commissioning Group, Sustainability and Transformation Plan boards
- Identify a project model that delivers priority objectives for both the housing and health stakeholder, demonstrating a clear business case for each organisation.

2.2. Key factors in building and sustaining an active housing-health partnership

Building bridges between housing and health at every level, linked by plans and policy, personnel, personal connections and proof: Housing and health can often feel that they are two very different worlds, separated by barriers in understanding of two very different and complex systems, and by the language used to understand and talk about those systems. This was an issue that stakeholders in Nottingham experienced[4]. To overcome this, Nottingham has developed links between its housing and health partners at every level, from the strategic platform, through to senior leadership, and at the frontline project level. The partnership is strengthened by building links horizontally at each level between the two sectors, for example connecting senior housing leadership with senior health leadership, and connecting frontline housing staff with clinicians working with patients. In addition, the partnership is further strengthened by making vertical links, for example by connecting senior leaders from both sides with experience from the frontline staff perspective. These horizontal and vertical ties create a stronger overall partnership environment in which the project flourishes.

At each of these levels, the interviews pointed towards linkages through (a) **plans and policy** directives and commitments, from strategic plans down to operating practices and contracts (b) finding the right **personnel** at each level to take the lead for partnership working (c) making **personal connections** between members of staff from each side of the divide, as well as a personal commitment to the project and its benefits, and (d) having the appropriate type of **proof** to show the project is working, to cement these other elements. These are the elements that help build the bridges between housing and health.

[4] NCH tried to recruit someone to be the 'translator' between the two sectors, to identify overlaps and joint opportunities, but couldn't recruit to the post because there were no applicants with extensive knowledge of both housing and health.

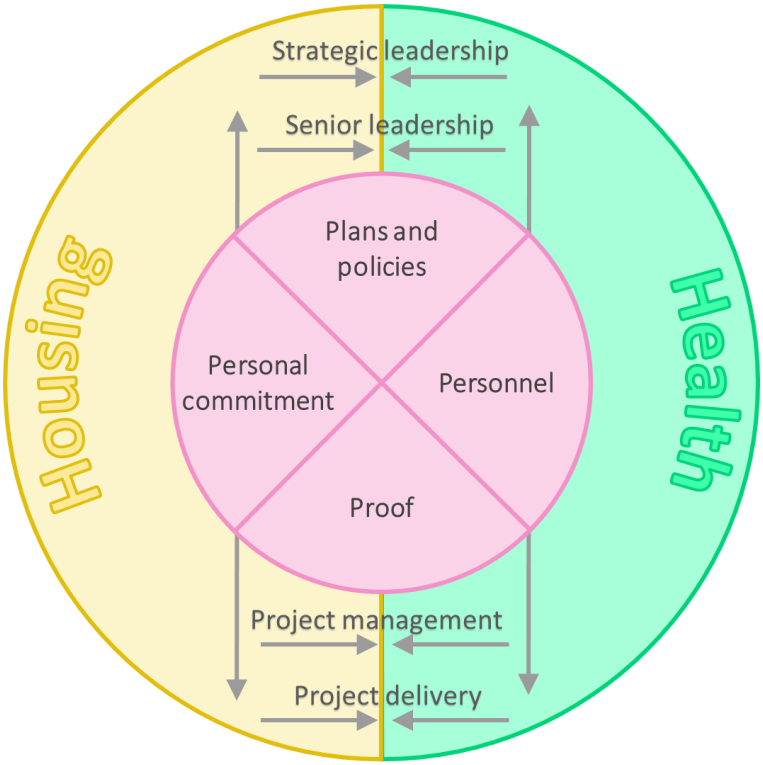


Figure 2: Model of a strong health and housing partnership

Strategic and senior leadership

Plans and policy: As set out in the previous section, the background of long-term evidence and relationship building means that there are now clear commitments to housing and health partnership at the strategic level. On the housing side, one of the four main themes of Nottingham City Council's Housing Plan is to 'Use the power of housing to improve health and wellbeing and prevent ill health'[xvii]. At a corporate level, NCH's Chief Executive states that *'Over the life of the current [three-year] Corporate Plan, we wanted to do more to help health and social care partners and deliver what was in the Health and Wellbeing Plan, and support the STP (now the Integrated Care Partnership). Our strategic objectives specifically talk about health and social care. Housing to Health is a corporate aim for us.'* On the health side, as previously stated, housing is included as a factor for health improvement and involved in delivering both the Health and Wellbeing Strategy, and the STP (taken forward into the development of the Integrated Care System).

Personnel: In the early days as the idea for the project was beginning to emerge, it took some time to make the connections between the right personnel in each organisation. Housing, or even narrowing down to social housing, is not represented by a single organisation, as there are multiple housing providers within the city. As the largest social housing provider in Nottingham, NCH took the lead in representing the social housing sector. NCH nominated a lead for health at a senior level, in the Director of Housing and/or Assistant Director for Housing Operations. These leads represent NCH, and often social housing more broadly, at a strategic level, for example on the Health and Wellbeing Board and ICP. This provides a 'face' for social housing at a strategic level, and these individuals have developed a more detailed understanding of the strategic drivers for health partners as well as connections to relevant personnel from the health side.

Similarly, there is no single point of contact for housing within the health sector, which is also made up of a range of different organisations and providers. In Nottingham it took multiple attempts to find where the project best sat within the health landscape at the time, and the right individual within that to take the lead for the project. The initial pilot phase of the project was provider-led, delivered by NCH and CityCare, Nottingham's community healthcare provider. The project embedded housing within CityCare's care pathways, under the umbrella of creating an Integrated Care Programme. Over the period that the project was implemented, the health landscape completely changed around it. After the pilot period, the CCG took over the lead on the health side as a commissioned project, but maintaining the links with

CityCare's community healthcare teams. As the CCG looked to implement the STP, operations are now implemented through area-based Primary Care Networks. The current CCG Manager highlights that a project such as this could sit within a range of areas within a CCG, such as *'community care team, integrated care team, transformation team, system benefits, project management office.'* The key point is that the project needs to find a 'home' within the CCG, were it is aligned with the team's objectives and supported by a Commissioning Manager (or other nominated lead) with relevant responsibilities.

Personal connections and commitment: One of the key success factors that has ensured that the project has survived the hurdles that it has faced, such as challenges to funding, is the personal commitment to the project of those in senior leadership roles on both the housing and health side. This is largely as a result of seeing first-hand what difference the project makes to patients and their families in Nottingham. All the senior leadership interviewees mentioned individual stories of patients whose lives had been transformed by the project (for example, see case study 2 below). The project team have encouraged senior leaders from both housing and health to shadow staff as they work on the project. As new CCG leads came into the project, they have attended case review meetings to hear the stories of patients, such as the difficult living conditions they were experiencing, and how the H2H project helped them resolve this. Therefore, when the project faced difficult times in finding funding, leaders from both sides pulled together and gave their time and energy into resolving the issues faced. This was also helped by the personal connections made between senior leads from both organisations. The project has always had regular meetings of the project team and senior housing and CCG leads, with the result that individuals have made personal connections and have a better understanding of the drivers and needs of each organisation.

"Personally, the driver was the story of people living in wrong accommodation, or socially isolated, impacting on social care and community health teams"
CCG Commissioning Manager

Case study 2:

The HHCs received a referral from NCC's Environmental Health team, for a gentleman who was living in hazardous conditions that were potentially harmful to his health. Mr Walter's* house was in a serious state of disrepair, with no running water, no gas supply or central heating, dangerous electrics, rat infestation, as well as structural damage to the property. Mr Walter had been using a bucket of rainwater on the flat roof to bathe and wash his clothes.

The Environmental Health team were forced to issue a no-entry order on the property. The HHC was able to find Mr Walter an Independent Living property for him to move into the next day. He left his previous home with a cup, teddy and a lamp. The HHC helped him get furniture from a charity, and supported him to get his benefits in place.

Mr Walters had neglected his health and didn't engage with any support to start with. Through the HHC, he now has 'comfort calls' from social services to ensure he is managing and spot any problems before they escalate. He is now managing by himself in his new home and is doing well.

*Name has been changed

Proof: Evidence has played a vital role in promoting and sustaining the project from the outset. A wide array of evidence is collected, so that it can be tailored to the audience to make the most convincing case to them. For example, at the early stages of the project the Integrated Care Programme Board need proof of concept that providing money to housing would result in positive health outcomes. At the time, health commissioners were used to commissioning health activities, rather than providing funds to non-health organisations in order to buy something that negates a health activity. Therefore, the project needed to provide proof that it was supporting people with health needs and show the change in their health needs before and after the intervention. Having

"Health require a more forensic analysis of outcomes, incredibly detailed. You have to prove your point with the NHS at a different kind of level to what I'd ever come across in housing."
NCH Assistant Director of Housing

this evidence enabled the project to continue beyond the pilot period.

Each year subsequently, the CCG Commissioning Manager has had to put together a business case for funding. Over time, the emphasis for that business case has changed, as the focus has shifted towards the acute health side. For example, initially the evidence was focused on the reduced burden on the NHS by reducing Delayed Transfer of Care, by showing the number of bed days saved across acute and community care from speeding up the re-housing process compared to the average waiting time for social housing. However, the focus is now on actual savings to acute care, using evidence of reductions in admissions and length of stay following the project intervention, by tracking hospital admissions data. As the CCG's Locality Director explained, *'[We] have tracked every patient in terms of their A&E activity prior and post the intervention. The decline in presentation to A&E pre- and post- intervention is significant and attributable to the project. This we can then convert into financial savings for the health service. For a CCG that has financial challenges to overcome unequivocal evidence of cost savings from an investment go a long way in securing support for a project.'*

"Evidence and evaluation are imperative in this climate that we're in… trying to prove the difference that we're making, whether its cashable savings or theoretical savings, is absolutely necessary in our business case that we have to pull together for any investment."
CCG Commissioning Manager

Throughout the project, it has been important to be able to show the Return on Investment (ROI) from the project, showing the financial impact on each of the project stakeholders – for example across acute health services, community health care, mental health care, social care, other local authority services and the housing provider.

But the financial impact is not the only evidence needed. The project also has to report to other strategic Boards, such as the Health and Wellbeing Board. This requires a slightly different focus, on patient outcomes that align with the goals of the Health and Wellbeing Strategy.

Furthermore, interviewees were also keen to emphasise the importance of qualitative information, about telling the story both from the patient side, but also from the frontline staff perspective and the impact of the project on their roles.

This more personal perspective is also important in providing proof of the success of the project. As the NCH Chief Executive highlighted, when the project faced challenges to its funding *'We were relying on evidence – we thought it was enough to be able to show that we're making financial savings. It's about having the evidence, but also making sure that relevant people are on board with that evidence – it's about relationships.'* This shows how the importance of proof is linked to the previous points regarding personnel and personal connections.

Project management and delivery

Plans and policy: From the start, the H2H project management have set out clear project objectives, patient criteria, and mapped out the procedures for how the project operates within the two systems. This provides clarity for project partners, staff and wider stakeholders.

At the start of the project, the delivery partners (NCH, CityCare and CCG) drew up an initiation document that set out the justifications for introducing the project, and the objectives that were aimed for. This was agreed by all project partners. This provided the framework for the evaluation, to measure success against these outcomes. This has also formed the basis of more formal contract reporting, as the project has progressed.

The project team then developed two key policies to make the project operational. These are: (a) a set of project criteria, that sets out groups of patients that are eligible to be rehoused through the project, and (b) incorporating the project criteria into the Housing Allocations policy, and creating a fast-track housing allocation processes. Further details are set out in section 2.3.

Finally, the project management team also undertook a detailed process-mapping exercise to set out the processes of each stage of the project. This covered the referral process, housing application and allocation process, and further support and follow up. Undertaking this mapping process created clarity between the partners regarding the position of the project within the housing and health systems, and the roles of each organisation in supporting the project. It gave a clear directive for the Housing and Health Coordinators to operate within as they engaged in their new roles.

Personnel: Project management and project delivery personnel also clearly play a vital role in building and sustaining the project partnership. The NCH project manager has an important coordinating role, linking in closely with the CCG Commissioning Manager and working to translate strategic directives into operational practices. The CCG Manager is the main point of contact for the H2H project from the health side. They oversee the H2H project and connect with strategic and funding structures within the CCG. The project delivery staff, the HHCs, also play a vital role in building working relationships with clinicians working with patients both in the community and the hospital. These frontline connections are what sustain the day-to-day successful operation of the project.

The Nottingham H2H project is managed operationally by an NCH Housing Options manager, with the function written into the job role. They manage the H2H project within NCH and are responsible for line management of the H2H staff, managing the budget, contract monitoring and reporting. The CCG Commissioning Manager highlights the importance of having an effective project manager: *'Great leadership from [the project manager] - best investment in having her there. Someone to steer and drive the project forward, not just operational staff - it's about developing all the standard operating processes that they follow, assurance to CCG, KPI collection etc. The project needed someone at management level who can translate between commissioners and operational staff level. She is crucial to operational success - she comes up with ideas, knows the market, and is a subject matter expert'*.

The CCG Manager's role within the project is to provide the primary link with the H2H team from the health side, overseeing the project and managing contractual performance. The CCG Manager puts together the annual business case for funding, and connects with strategic and funding structures within the CCG (such as BCF committee, Health and Wellbeing Board) to report on the project's outcomes. They also work to open up the healthcare system to the HHCs, gaining them access to local health care teams and awareness raising opportunities.

A core part of the project from the start has been the building and maintaining of connections and relationships with clinical practitioners from across the local healthcare system. This has been part of the HHC's job role, facilitated by support firstly from CityCare, and latterly from the CCG Manager. The health partners help the HHCs to gain access into the health world, both in the community and in the hospital. For example, they have initiated meetings or presentations to locality meetings of community care professionals, GP practices, physios and occupational therapists, as well as hospital Integrated Discharge Teams. The project team reported that this awareness raising activity was a large part of their job in the first year of the project. Initially it was difficult to get the message through, as *'people are set in a groove – it's hard to effect system change, even at small scale. For example, getting health professional to see that they can make a phone call to address housing, rather than just deal with medical issues'* (NCH Chief Executive). The process had to be repeated and maintained as NHS staff turnover meant that new individuals needed to be briefed on the project. To begin with, referrals came from a small number of clinicians who had worked with the HHCs and seen the positive results they could achieve. Over time, this expanded and the HHCs now receive 200-300 referrals a year. *'Now there is a lot of trust between the project team and health partners – they trust team to deliver, and the team have been proven to be effective. Positive experience breeds trust.'* (NCH Project Manager).

Case study 3:

Michael's* case was picked up by the HHC for Integrated Discharge, working in the hospital. Prior to his admission, Michael had been lodging with various friends. Unfortunately, he had to undergo an emergency leg amputation and had no suitable home to be discharged to. His case was very complex, as Michael described himself as 'living under the radar' for all of his adult life. This meant he had nothing in place to prove that he was eligible for social housing – no income, benefits, bank account or formal ID such as National Insurance number or birth certificate. These issues had already delayed his discharge from hospital for several months, as hospital staff were unable to resolve them without specialist help.

At first, Michael was reluctant to engage with any support. Gradually, the HHC build a relationship with him, and he gave the go-ahead for her to support him in a housing application. The HHC supported Michael with all the steps required to set up a tenancy - applying for ID, setting up a Post Office account and applying for benefits - and then found him a wheelchair-accessible Independent Living property. With the HHC's help, he reconnected with his brother who provided support alongside the HHC in order to organise the move.

Michael is now safe in his first ever tenancy, with an income and is no longer at risk. Soon after he was rehoused, the HHC received an email from Michael's brother with a photo showing him out in the community shopping. He thanked her for all the help provided and said they were both grateful for all of her help.

The Integrated Discharge Team manager highlighted this case as one that would have been very difficult to resolve successfully without the H2H project. The alternative would have been an even longer stay in hospital, most likely ending with discharge to a care home. Instead Michael is able to live independently in his own home, and has not been readmitted to hospital since.

*Name has been changed

In the last two years of the project, there has been an increased focus on working with the acute hospital team. One of the HCCs is now based full-time within the Integrated Discharge Team (IDT) at the two local hospital sites within the Nottingham University Hospitals Trust. The IDT receive referrals from across the Trust when there are difficulties in discharging a patient, including housing. This provides a natural link to the H2H project, and working with the IDT helps direct patients to the HHC, rather than having to navigate the 80 odd individual wards and discharge teams. The benefits from the HHC being part of the IDT are two-way, as *'information and knowledge passes both ways when you're sat in an office together. It builds up trust and relationships.'* (HHC for IDT). Having the HHC on site means that *'they're not a distant housing team. They see the pressures in the hospital – it means that they're really proactive and understand why the patient needs to get out of hospital'* (IDT Manager). There have been a number of very high-profile cases where the H2H project has been able to support the discharge of very long-term patients (see case study 3 above).

Personal connections and commitment: The connection between housing and health project management and delivery staff, and personal commitment to the project is another very important factor in the project's success. Interviewees were asked about their experience of working with partner organisations, and the response was positive. For example, the CCG Commissioner stated *'Individuals within housing organisations are very approachable, it's been a good experience working with them'*. Several interviewees stated that the HHCs needed to be, and are, good communicators with a range of people, from patients, to clinicians, to commissioners.

Another clear message from the interviews was the personal commitment of the project team to the project and their patients. The phrase 'willing to go the extra mile' was used several times in relation to the HHCs. The HHCs support the patient throughout the whole process of applying for housing and moving into their new home. They often work out of hours to complete a case. They do everything that is required to help a person move – anecdotes from the project team include transporting a budgerigar in their car, getting fish and chips for the patient at the end of a long moving day, cleaning, putting furniture together, and going to a patient's home to collect his razor so that he could do his daily shave to give him confidence to face the day.

"The person makes the difference – [the HHC] is so passionate, so proactive, so keen to resolve people's issues and problems."
IDT Manager

Health staff also see the value of the project and are committed to it. The CCG Locality Director stated that *'having a passionate advocate for the project on the health commissioning side has been a key success factor'*. The CCG Commissioning Manager raises awareness and support for the project within the organisation, as well promoting the project more widely with local and national stakeholders. This raises the profile of the project and its benefits. For example, the project was visited by NHS England's Director of Primary Care and System Transformation, Dominic Hardy, who used the project as a case study at subsequent meetings with housing leads.

There is also clear support from healthcare staff on the frontline level. For example, the IDT Manager stated that *'The IDT team recognise that there's an absolute need and demand for that service. The [H2H] team made it easy for them to work with them. … We've had some successes with really tricky cases… Without [the HHC], we would have been fumbling around in the dark on where to go next'*. Other testimonials from project partners within the healthcare sector highlight how much they value the project.

"When the funding was threatened, it was the NHS staff on the ground that objected."
NCH Project Manager

Proof: At a project management level, the proof of the project's success is monitored through Key Performance Indicators (KPIs) set out in the project contract. The project now operates within a standard NHS contract, and the project management (NCH Project Manager and CCG Manager) *'have designed the contract so that through the contract monitoring process we can show that the project is delivering what it's supposed to deliver'* (CCG Manager). From the outset, the NCH project manager recognised that the monitoring data is essential to demonstrate the project's success and ensure future funding. The NCH project manager had to work to get the HHC staff on board with the importance of data collection within their role, and there was a clear lead from management on its importance. In the second year of the project, the H2H team expanded to include an administrative support officer, whose role includes the collection and reporting of contractual monitoring data. The HHC team now see the benefit of the data collection, seeing how this feeds into contractual monitoring and the annual evaluation, which secures the ongoing funding and therefore the future of the project.

At an operational level, the relationship between the HHCs and frontline health staff is cemented by first-hand experience of successful outcomes for their organisation and their patients. The proof that they need to see is that the HHCs resolve housing issues in a timely way and that this helps improve the health and wellbeing of patients. Testimonial statements from partner organisations demonstrate that this is the case.

Partner testimonial: Hospital Discharge team

"Suitable housing is one of the major challenges that we can encounter when arranging a discharge, but thanks to your team we have been able to ensure numerous safe discharges to appropriate accommodation via the Housing to Health project – it really does make a difference to our patients, especially the ones here as they have usually spend many months in hospital undergoing rehab after a life-changing illness or accidents.

The service the team deliver is so much more than just 'priority housing' and you all do such a great job!"

Hospital Discharge Coordinator (Housing to Health Year 3 Evaluation Report)

Partner testimonial: Moving Forward

Moving Forward City support people who are in psychiatric settings, either homeless or have a tenancy at risk.

"Since liaising with the Housing to Health project, it has made a huge difference to the patients we support who are currently of no fixed abode or their current accommodation is deemed unsuitable and is affecting their mental wellbeing. They interact at an early stage to support the individuals by rehousing them fast, which has lightened some of the bed pressure of the NHS Mental Health services due to increases in their waiting list.

Myself and my colleague heavily depend on this service as they are efficient, productive and the staff are just fantastic and go an extra mile to support us. We have had successful stories for our service users who have been re-housed through this service.

There has been an improvement in their quality of life especially with their mental wellbeing since we have further supported them to maintain their tenancy. We have received positive feedback from their family/friends and their care team."

Moving Forward support worker (Housing to Health Year 3 Evaluation Report)

Essential requirements for building and sustaining a housing and health partnership

- Connections need to be made between health and housing organisations at all levels – from the strategic platform, through to senior leadership, and at the frontline operational level
- The connections need to be made in several ways:
  - Through plans and policies, giving the partnership a formal mandate
  - By connecting appropriate personnel within each organisation, to provide a nominated lead for partnership/joint project working at both senior leadership and operational management/delivery levels
  - Making personal connections between individuals working from the health and housing side, who have a strong personal commitment to the objectives of the project
  - Providing appropriate proof of the positive outcomes and impact of the project, that is tailored to specific stakeholders whose support is necessary to sustain the project

2.3. Key factors in successful operational delivery

Insider access to social housing and housing expertise: Interviewees emphasised the importance of operational delivery of the project being led from within the housing provider. There are two aspects to this: firstly, that the project is able to access social housing properties for its patients, by operating within the housing organisation and team that is responsible for allocating and letting social housing properties; and secondly, that project staff are primarily housing experts, working within a health landscape.

In Nottingham the H2H project sits within the housing provider's Housing Options team. This team is responsible for processing applications for social housing, managing the housing waiting list, and overseeing the process of letting empty social housing properties to new tenants. The team process housing applications, and gather the relevant evidence to place applicants in the correct priority grouping (or band) within the housing waiting list. Applicants are then placed on the Choice-Based Lettings system, which enables them to see and bid for properties as they become available. The team also has access to a real-time list of available social housing properties, to help facilitate this process by matching available properties with those at the top of the waiting list. They then complete the sign-up process to enable the individual to become a new tenant and move into the property.

The project staff (HHCs) operate within this team. This means that they are able to find and allocate suitable social housing properties to H2H patients in a timely manner. Operation from within the housing provider is essential in being able to fast-track the housing process, which creates the benefits to the health partners by being able to speed up discharge from hospital. For example, due to the increased

demand for social housing, a general application could take up to six weeks or more to be processed, i.e. just for the applicant to be put onto the Choice-Based Lettings system. By contrast, the HHCs can do this for their patients in one day. The HHCs are also able to access the real-time list of empty properties, to see which are available for their patients. They are then able to bid for those properties on the patients' behalf, and then complete the sign-up process once a property is found.

There was universal agreement from across health and housing partners in the project that frontline HHC staff need to be housing officers, or have a background in housing, rather than healthcare workers. This is because their primary role is to navigate the housing system on behalf of the patient. The H2H HHCs are housing officers, with experience in lettings, whilst also having experience of working with vulnerable groups and individuals. The H2H patients need a high level of hand-holding through the process, as they are frequently experiencing a health crisis or episode of poor health, and not able to cope with the additional burden of the application, search and bidding process. They are often unable to access to the usual points of access to the housing system whilst in hospital or unwell, for example via online bidding portals or by visiting the local housing office. The HHCs are therefore able to do this on their behalf. As described by the IDT Manager, this is of great help at this point in the patients' journey: *"It's such a minefield, for example when you've been ill or had an amputation and suddenly your home isn't accessible, it's an absolute nightmare. For someone to help navigate that process was just an absolute godsend."*

The HHCs complete the process from start to finish, including: collecting information to complete the application form and also assess what type and location of property would meet the patients' needs; collect evidence from relevant health professionals to verify their health needs and place them in the highest priority band on the housing waiting list; review the list of empty properties to identify suitable homes; support the patient and/or their family to visit the property; arrange for any adaptations, furnishing etc required; complete all the paperwork to create the tenancy.

The HHCs' experience of the housing system means that they are also able to manage expectations of both patients and clinical staff. They know whether an individual will be able to access housing through the project, the types and locations of suitable properties, and the timescales for completing the rehousing process.

Availability of suitable housing stock: A key objective of the H2H project is speeding up the rehousing process, in order to get patients out of hospital or community beds more quickly and therefore reduce the cost to the NHS. This can only be achieved if there is suitable housing stock that is readily available for patients to move to. NCH is a large housing provider, with around 25,000 properties within Nottingham city. However, as is the case across much social housing nationally, there is a high level of demand for properties for social let. Due to the revitalisation of the Right to Buy scheme, council housing stock in Nottingham has reduced by 2,000 properties in the last five years. Meanwhile there have been an additional 4,600 applicants on to the housing register over the same period, an increase of 125%. As a result, the waiting time for an NCH property has significantly increased, even within top priority bands, due to a shortage of available social housing.

"The whole thing hinges on there being accommodation for people to move into."
NCH Assistant Director of Housing

However, the demand levels vary across different types of housing stock. The demand is particularly high for general needs family houses, whilst there is less demand for other type of stock such as older people's housing and single bedroom flats. Therefore the project has been careful to only target the types of housing stock that has higher level of availability, either due to higher void levels (empty properties) or stock with higher turnover. This is achieved by ensuring the patient criteria match up to the available stock, for example targeting older people who would be suitable to live in Independent Living (Supported Housing) accommodation.

Over recent years, NCH has particularly invested in improving and upgrading its housing for older people, in its Independent Living schemes. These community schemes provide self-contained homes (one- or two-bedroom flats), with access to shared communal facilities such as a lounge or activity area. Many are already adapted to have accessible bathroom facilities, and a 24-hour emergency pendent alarm system (Nottingham on Call). Each community is supported by an Independent Living Coordinator, who checks the wellbeing of residents and helps facilitate social activities.

Despite these improvements, at the time the H2H project was being set up, NCH was finding that there was still low level of demand for these types of properties and had a considerable number of empty properties. This was therefore why the project initially focused on rehousing older people. Part of the project's work has been to help change the perception of Independent Living communities, so that they are not seen as only a housing option for the very elderly, but as a longer term solution for older people at an earlier stage, to ensure they can remain living independently in their home.

"The most important [skills and knowledge for project staff] is housing knowledge. It's useful to know some of the challenges and specific housing needs arising from certain conditions, but clinicians here to help with that"
IDT Manager

This approach ensures that the project is of benefit to the housing provider, by filling lower demand stock that would otherwise remain empty. There is therefore a financial return to the housing provider as a result of the additional rent that the project generates, as well as reduced void (empty property) costs. Having a clear benefit to the housing provider creates buy-in from its stakeholders, such as its own Board and also its main stakeholder, Nottingham City Council. It has been extremely important to the project that the housing provider also benefits from the project, as the project could not have got off the ground without the support and investment of the housing provider partner. For example, during the pilot year NCH invested its own resources into the project, and has continued to do so, in order to support the functioning of the project.

The project works because it creates a 'win-win' situation, i.e. benefits to both health partners and housing partners. By targeting stock with higher levels of availability, this ensures that the project is able to meet its aim of rehousing people more quickly. This also benefits the housing provider by directing demand towards its low-demand stock.

"[NCH] have a lot of properties that are bespoke to older people - 67 Independent Living Schemes, plus lots of bungalows. We have the 'housing offer' for certain groups."
NCH Chief Executive

Clearly defined patient criteria, reflected in the Housing Allocations policy, and a fast-track rehousing process: At the start of the project, the H2H team agreed a set of criteria for the types of patients to be referred to the project. This was important from the health perspective to ensure that the project was supporting those with significant health needs. It was also important from the housing perspective, to ensure that the project wasn't used as a short-cut to bypass the standard housing applications process and waiting list.

Importantly, as noted above, the referral criteria made sure that the project directed patients towards the type of housing stock that was available. Initially, the project started small, limiting the criteria to older people suitable to be housed in Independent Living accommodation, who were either occupying hospital beds and unable to be discharged due to housing, or were identified in the community as their health being at risk due to housing issues. Over the course of the project additional patient criteria have been added. The project now also supports essential wheelchair users who are occupying a high-demand hospital bed, rehousing them in accessible properties such as bungalows. The final patient group is mental health patients occupying high-demand hospital or step-down beds, who are ready to be rehoused in the community. These patients are rehoused into one-bedroom flats. Again, the expansion of the project criteria reflects the types of housing stock that are more readily available, as well as focusing on patient groups with high levels of health service use.

Clear communication is needed to make sure that project partners, such as clinicians, understand the project criteria. The project developed communication materials such as leaflets and posters to advertise the project, but also to set out the criteria. Over time, both clinicians referring into the project, and the

HHCs, have developed a clearer understanding of the patient group that they are targeting. The HHCs are able to offer wider housing advice where patients don't meet the criteria, such as onward referrals to other housing teams; but are clear to clinicians that they are not able to help all patients with housing issues.

NCH has also ensured that the project is reflected within its Housing Allocations policy, and that the application process for H2H patients is fast-tracked. Having the project criteria in the Housing Allocations policy gives a formal mandate to the project, as the policy is agreed by both NCH leadership and by Nottingham City Council. It also ensures that there isn't any slippage in the types of people referred into the project. Working through the Housing Allocations policy, the H2H project is able to prioritise H2H patients within the housing waiting list, so as to be able to find them housing in a timely manner. The Allocations Policy gives priority to people who are occupying a high-demand hospital bed and need to be rehoused, or who are at risk of harm in their own home. Under this element of the Allocations Policy, H2H patients are given priority and moved up the waiting list.[5] In certain circumstances where the patient has very specific needs, the HHCs can put a hold on a property as it becomes empty, offering it to the H2H patient before it is advertised on the lettings system.[6]

Importantly, the housing provider also made changes to the application process to ensure that applications via the H2H project are able to be fast-tracked. For example, in the general rehousing process, applications for priority rehousing are considered and approved by a panel of representatives that meets every two weeks. However, for H2H it was agreed that priority applications would be processed via an electronic proforma and signed off by a Housing Manager on a daily basis. The applications are still passed to the Panel for review. This therefore ensures formal safeguards are in place, such as are required for formal audit processes. However, the fast-tracking of the process is key to the project's ability to rehouse patients quickly, a key part of the project's success.

Case study 4:

Kenneth* was referred to the Housing to Health service by his social worker, after concerns were raised about his physical and mental wellbeing in his current property. Kenneth (aged 58) has a diagnosis of schizophrenia, anxiety and a learning difficulty. He had been living in his NCH flat since 1988, but was beginning to feel unsafe. He was being targeted by local youths who were verbally abusing him, terrorising him and smashing his windows and it was believed he was being targeted due to his vulnerabilities. The harassment was causing him to become mentally and physically unwell so it is likely he would have presented at hospital in the future.

The Housing and Health Coordinator visited Kenneth in his home to discuss his housing options. A housing application form was completed, his application was made live and the HHC placed bids on suitable properties for him. Within weeks, a property was found for him in one of NCH's Independent Living schemes for people over 55.

The HHC guided Kenneth through the move and even funded carpets for him as he was unable to afford these himself and it was a potential barrier to him moving. Advice on removals was given and the HHC spent time with Kenneth at the sign-up appointment to ensure utilities were switched and that benefits applications were in place. The HHC then visited several times after he had moved to make sure he was settled.

At his six-month visit, he stated that the service was excellent and that the move went smoothly. He is now living in a *"peaceful, nice and quiet"* complex where his neighbours are all *"very friendly".* He explained that he felt secure, and that not having the constant threat of neighbours harassing him was the biggest positive and that he loved the complex.

*Name has been changed

Funding, reflecting financial return to project stakeholders: The project requires funding to cover the cost of staff posts, associated staff costs and expenses, and a small hardship fund to assist with

[5] In housing terms, this is referred to as an 'application accelerator', where the start date for the application is set 12 months earlier, effectively moving the applicant up the waiting list.

[6] In housing terms, this is known as a Direct Offer on a property. An example where this may be used is where certain property features are required, such as a concrete floor to support bariatric aids and adaptations.

removals, furnishing etc in exceptional cases. For the housing provider, interviewees made it clear that external funding is essential, as the service is outside the scope of core housing services. NCH does contribute resources to the project (such as management time and contribution to staff costs, and commissioning external evaluation services), partly due to its belief in the purpose of the project, to improve the health and wellbeing of its residents; and partly in recognition of the benefits to their own organisation that it generates in terms of filling empty properties.

"All of the funding for the project is highly contested - has to prove its worth." CCG Commissioning Manager

Funding via the CCG has therefore been essential to the project's operation. The project is funded through the Better Care Fund (BCF). The BCF is a pooled budget between the Local Authority and CCG, aimed at helping local areas plan and implement integrated health and social care services. Interviewees highlighted that the project benefited from accessing this type of funding, which allows for innovative funding of projects outside of the usual healthcare landscape, as a means to explore alternative ways for integrated working. Nottingham was also an accelerated site for the Integrated Care Programme element of the BCF, which meant *'there was a lot of support for innovations – this meant it didn't have a lot of the barriers that might be faced by new projects'* (CityCare manager).

To date, funding for the project has been on a year-to-year basis, so that an application for funding is required every year. The level of funding provided from the BCF has fluctuated each year. Project partners from both the housing and health side agree that it would be preferable to have some form of longer-term funding certainty. As described by NCH's Chief Executive*, 'austerity and the drive for other services having to make cuts makes a very unstable background for the project. If there was year on year consistency it would be a much better environment for us to provide the service'*.

During the pilot phase, both partners (NCH and CityCare) contributed financially to the project to get it up and running and provide proof of concept. An evaluation of the financial return on investment to each of the project stakeholders was built into the pilot. This evidence was helpful to the project in two ways: firstly, it provided evidence that the project was generating a positive return on investment to stakeholders, particularly the health service. The majority of the financial benefits fell to the health system, from reductions in Delayed Transfer of Care and avoided admissions to hospital. It also showed financial benefits to other stakeholders, including local authority services (mainly adult social care, but also homelessness services and adaptations agency), as well as benefits to the housing provider. This was vital in making the case for ongoing funding, as the project team were able to put together a well-evidenced business case for funding, in a competitive financial environment. The strength of the evidence was such that, following on from the pilot period, the project was not only able to get further BCF funding to continue the project, but also increase the level of funding to expand the scope and scale of the project.

Secondly, the evidence of the difference levels of return on investment to each stakeholder provided justification for health partners to be a significant funding contributor as the project continued. Following the pilot period, the CCG increased its contribution to the funding for the project. Subsequently the level of funding from the CCG has varied each year. Cumulatively, over the first four years of the project, the CCG has provided funding to cover 50% of the running costs, and NCH has contributed the remaining resources.

Integration into health systems- interdisciplinary team working for a holistic solution: Integration into the local health systems is necessary primarily to increase the reach of the project; not only to increase the number of patients referred into the project, but also to specifically reach the target group of high health service users. A factor in developing integration has been the physical co-location of the HHCs within the various health teams, at least for the early stages of relationship building. The interviews also highlighted other benefits of a deeper level of integration of housing support within the healthcare landscape. Knowledge transfer between housing and health staff means that the HHCs are better able to identify the target patient group and their health needs, and that clinicians have an increased awareness and therefore earlier identification of housing issues. Working together, housing and healthcare staff are able to find holistic solutions for the patient.

In the pilot phase the integration into the healthcare system was achieved by placing the HHCs within CityCare's Reablement team (working with patients being discharged from hospital) and Community Care team (identifying patients at risk in the community). The HHCs worked with these teams to achieve a housing solution alongside their health care. During the pilot phase, the HHCs were partly co-located on-site along within CityCare's staff, to increase the awareness of the project with staff and identify patients with housing issues. As described by the original CityCare manager*, 'when you're trying to identify a section of the population at risk, in this case from poor housing, it's better to do that in an integrated way i.e. working with allied healthcare staff in the same team. It's an actual multi-disciplinary team situation, people working together for the holistic solution for the benefit of the patient'*.

As the project has progressed, the competitive nature of the funding environment has meant that the project has had to tighten its focus on those with highest health service use, in order to maximise the project's impact on reducing the burden on the health services, particularly acute care. The HHCs were already working with discharge coordinators and other staff within the hospital, but this relationship was formalised in year 3 of the project, when an additional post for an HHC for Integrated Discharge was introduced. Since the introduction of this post, the proportion of patients with high levels of acute health care use (e.g. currently in hospital or with previous admissions) has increased, as per the targets set within the contract. Interviewees from both the housing and health side identified that by working with clinicians, the HHCs have been able to more clearly identify and support the target patient group, rather than working with patients with housing issues but with relatively lower health needs.

In turn, both the original community care partners and the IDT Manager highlighted that their health staff have increased their awareness of housing issues, and are able to identify them at an earlier stage. For example, in a hospital setting, rather than housing issues being identified at the point of discharge, they are recognised earlier so that housing issues can be resolved during their stay and the solution is ready for as soon as the patient is medically fit for discharge. The HHCs have also found that healthcare staff are asking more detailed questions about housing at the earlier stages, so the referrals they receive are more detailed and appropriate to the project's criteria. As well as working with patients that meet the project criteria, the HHC is also able to advise clinicians more generally about housing issues for other patients.

The result is a more timely and holistic solution for the patient. The HHCs work alongside a number of different clinical specialities, from Occupational Therapists (OT), to cardiac nurses, to mental health support workers. In doing so, they are able to find a housing solution that meets the needs of the patient to enable them to live independently in the long term. For example, HHCs often go to properties with an OT, so that the suitability of the property can be assessed and/or any further aids and adaptations installed prior to the move. Similarly, mental health support workers will help ensure the property and area are suitable for their patient, such as access to support networks. Such holistic solutions reduce the likelihood of a 'revolving door' of the same individuals coming back into the system.

Wrap around support, ensuring a sustainable housing solution: Despite the importance of a timely housing solution to reduce delays in discharge for patients, the H2H project always works to ensure that the housing solution is sustainable, enabling the patient to live independently in their new home. The HHCs provide wrap-around support for the patient to ensure they are set up to manage their health and wellbeing in their new home. This support is essential in enabling the move, as the project evaluation shows that 94% of H2H customers felt that they wouldn't have been able to move by themselves, without the support of the HHCs.

The HHCs assist with financial management and benefits checks, so that they can be confident that patients can manage their rent payments and receive other income. For example, they may have to help an individual set up a bank account for benefit and rental payments. They also help set up new utilities and payments.

The HHCs make sure that the new home is equipped and furnished adequately. Many of the targeted properties are already adapted, but the HHCs work with Occupational Therapists so that any further aids and adaptations are provided. The HHCs also help source carpets and furnishings where needed, either through local charities or drawing on a small hardship fund within the project.

Importantly, the HHCs are with the patient on the move day. If the patient has no other support, the HHCs will help with packing, arranging transportation, and any practicalities needed to help settle the patient in – from hanging curtains, to putting together furniture.

The HHCs are available to support the patient in the run-up to the move and afterwards. They also introduce them to the local housing management team, such as Housing Patch Managers or Independent Living Coordinators, who can provide long-term support to the individual in their new home.

Case study 5:

Ernest* was referred to the Housing to Health service by his discharge coordinator at City Hospital, who had concerns regarding his repeated hospital admissions.

Ernest was an 80-year-old gentleman living in a second floor flat, with 28 concrete steps leading to the front door. He had deteriorating COPD as well as mobility problems, and climbing the stairs to his property was exacerbating these and had led to repeated admissions. Every time that Ernest was discharged home, he would be readmitted within days.

Ultimately the decision was made to keep him in hospital until a more suitable property was found. His wife was left alone at home, with illnesses of her own, and was growing increasingly anxious and depressed without him there. She was also having falls herself, one of which fractured her spine, and was at risk of being admitted to hospital.

The Housing and Health Coordinator visited both Ernest and Brenda in hospital and discussed their housing options. The HHC completed a housing application, wrote a medical report and awarded the couple priority banding on medical grounds. After placing bids on suitable properties, a bungalow was soon found for the couple much faster than the standard process.

Brenda had recently fractured her spine after a fall in the property and was struggling with the idea of moving house for the first time in 28 years, with no family or friends around to help and her husband in hospital. The HHC and support officer visited Brenda on numerous occasions to help pack all of their belongings. The HHC put Brenda in contact with a reputable removals company and was there on the day of the move to facilitate. She visited the property many times after Brenda had moved in to help her get set up, and she even bought her a TV aerial and helped with the sale of the family car which was no longer needed.

Unfortunately, shortly after the move it became apparent that Ernest would not be able to return home as he had become too unwell and he passed away in hospital. Whilst this was unexpected and devastating news to Brenda, she could not thank staff enough for getting her moved to a property where she could be safe and had a secure future.

Whilst Ernest sadly passed away, Brenda is now safer in a property that is suitable for her needs and without the intervention of the H2H project she would have been at high risk of hospital admission due to the unsuitability of the property.

*Names have been changed

Calibre and commitment of frontline project staff:
Interviewees emphasised the importance of the calibre of the frontline project staff members (the HHCs) in making the project a success. This included qualities such as their knowledge, experience and dedication to the project and their patients.

"If we lost key staff, that would put us back to basics. The passion that they have shows through in the work that they do and the outcomes they achieve."
CCG Commissioning Manager

As stated earlier, the HHCs are housing officers, seconded to the project from within NCH. The HHCs have individual areas of experience and expertise within the housing system. All the HHCs are familiar with the lettings process, i.e. processing applications and supporting individuals to find a home. Individual HHCs have specialist skills within this process, helping facilitate the project processes. For example, one of the HHCs has a background of working with mental health patients, supporting them in a social housing setting. Another has detailed knowledge of the lettings process and report writing to

support applications. *'Jointly they have the knowledge that the project needs. We have recruited additional team members for specific skills and knowledge'* (NCH Project Manager).

In terms of their personal skills, the HHCs have the experience and qualities necessary to work with vulnerable individuals. The interviews highlighted specific qualities that the HHCs have. An important factor is their ability to build trust with the individual and their family. They do this by being with them at every stage of the process, offering constant encouragement and support. This is vital to the process, as individuals are often going through a difficult time and struggle with the concept of moving, and frequently have doubts or change their mind. The HHCs have patience to explain and support them through the process. They care for the patients, and are willing to go the extra mile to support them, whatever that takes. They have a problem-solving attitude, and never give up on a case when it experiences difficulties. As described by the IDT Team Manager, *"[The IDT team] feel that all the members of the H2H team are so approachable, flexible, and have a problem-solving attitude – they turn every stone to try and find a solution. They are very open and honest with patients, and some of their demands. They are clear about people's entitlements, managing expectations - whilst being compassionate".*

As stated in earlier sections, the HHCs also need to have good communication skills and work with a range of other professionals, such as clinicians support workers, and other housing staff. This is also vital to the success of the project, in raising awareness and getting other stakeholders and frontline staff on board with supporting the effective running of the project.

Case study 6:

Mr Moore* was referred to the service by a housing officer after she conducted a routine visit to his property and was concerned by what she found. Mr Moore was living in a second floor flat, but in recent years had become wheelchair-bound due to brittle bones caused by his long-term alcohol dependency. He had been dependent on a close friend to buy his groceries and help him with tenancy matters, but this friend had recently passed away. Despite having three carer visits a day, Mr Moore was becoming malnourished.

The HHC worked closely with the housing manager as well as his social worker to find him appropriate housing urgently. Soon after being referred, a ground floor property was sourced with a partner Registered Social Landlord. The property was fully wheelchair accessible and came fully carpeted with blinds fitted. The HHC also made a referral to the Adaptation Agency Service for grab rails and chair risers to be installed.

The HHCs made sure that he had the correct benefits in place and helped arrange removals as well as transport to get Mr Moore out of the property. The HHC even carried his large wheelchair down four flights of stairs after the ambulance staff were unable to.

Since being rehoused through the service, Mr Moore's health has improved greatly. He has stopped drinking and has completely ceased all carer assistance, as he is now able to live independently.

*Name has been changed

Information management and data collection, to support project delivery and evidence of outcomes: An operational factor underlying the project operations is the collection and availability of project data and information. Building IT solutions into the project means that frontline staff are able to both access and record information whilst on cases. It enables the collection of data that supports the running of the project, and builds the evidence base necessary to demonstrate the achievement of outcomes.

The NCH project manager built supporting IT requirements into the project from the outset. The HHCs have remote IT devices, to both access live information (such as applications process and lists of available properties, as well as email etc), and to record information. Data collection is built into the housing management system, meaning that it can be entered electronically, and then all project data can be compiled into monthly management reports.

At the first meeting with a patient, the HHCs gather all the information needed to support their application and property search, as well as completing a baseline health and wellbeing survey. Progress on the application process is recorded throughout the case, both for project management purposes (for

example, enabling other project staff to pick up a case if staff are on leave etc), and to show Key Performance Information (KPIs). For example, the start and end date are used to calculate the total rehousing time for each case, indicating the success of the project in rehousing a patient in a timely manner. Once the patient is successfully rehoused, the HHCs complete a follow up visit two weeks after move date, and six months afterwards. At the six-month visit, the HHCs complete a follow up health and wellbeing survey with patients, to assess how their health, wellbeing and other social outcomes have changed since the start of the intervention.

The data collected throughout the case and at follow-up is the foundation for both contract monitoring and evaluation of project outcomes. As described earlier, this evidence base has been crucial in accessing and renewing funding for the project. As well as internal project data, the H2H project has also drawn on wider data sources. An information sharing agreement and protocol was agreed with the NUH Information and Insight team, providing access to patients' hospital admissions data in the six months prior and subsequent to the housing intervention.[7] This data has been important in showing the hospital admissions reductions following the intervention, and therefore the actual savings to the CCG.

From the start of the project it has been the intention for HHCs to also have access to hospital-based IT systems and patient data relevant to the case. Although information sharing agreements have been put into place, this has not yet become operational practice.

Essential requirements for successful operational delivery

- In this project model, it is important that the project is led from within the housing provider, to bring the insider knowledge of the housing system into the healthcare landscape and provide timely access to social housing properties for patients.
- The project depends on having suitable properties that are available for patients to move into. Thus, the patient group supported by the project needs to be aligned to the types of properties that are available locally.
- The project needs to have the buy-in from housing leadership to be able to fast-track the housing process to give patients priority; supported by a formal mandate within the housing organisation's Housing Allocations policy.
- Adequate funding is crucial, with the source of funding reflecting where the financial benefits from the project fall. The funding sources need to allow for more innovative investment in projects delivered by non-health partners, but delivering health outcomes. Evidence to demonstrate these positive health outcomes is necessary to sustain funding in the longer term.
- The role of health partners is to support the project to be integrated into the health landscape, to enable the project to deliver holistic solutions for the patient that include housing. Co-location of housing officers within appropriate health teams helps build relationships, trust and knowledge sharing to improve the effective delivery of the project.
- A wrap-around support service is required, not only to remove all barriers for the patient in finding and moving to a new property, but also to ensure that the patient is set up to manage their tenancy and health at home in the longer term.
- The project's success depends on the quality and commitment of the project officers on the ground, whose skills in dealing with patients and other stakeholders are essential in delivering positive outcomes.
- Effective data collection and management supports the efficient running of the project and is a vital foundation for building a convincing evidence base for the project.

[7] Governance leads from NCH and NUH agreed data collection and consent practices, to align with GDPR and other personal data collection guidelines.

3. Potential for spread

3.1. Replication

The first potential route for spread is by replicating the Nottingham H2H model in other areas. The review has identified the main features and essential factors that have produced successful results in Nottingham. The aim in doing so is that this gives other potential partnerships a head-start, providing an existing proof of concept of the benefits of such a partnership, as well as the practical considerations of what needs to be in place to establish and run the project.

A number of recommendations emerged from the review, in terms of assisting with the spread of similar projects in other areas. The learning from the Nottingham project could help expedite some of the stages in setting up and rolling out the project. This includes:

Facilitating the connection between potential housing and health partners:

- **Identifying and reaching out to potential housing partners with a community-based focus:** Interviewees highlighted organisations such as PlaceShapers, the National Federation of ALMOs and the Association of Retained Council Housing as a route to identifying potential housing partners, who are focused on improving outcomes for a specific community or local area. This provides a route to identifying and supporting housing partners who already have a focus on improving local health and wellbeing, or wish to do so.
- **Opening up the health landscape to housing via local Population Health forums**: As exemplified by the Nottingham project, housing leads initially found it difficult to find the right part of the health service to engage with, and much time was spent in the early stages trying to identify the appropriate lead within health. This could be overcome by inviting housing to participate in local forums leading on a Population Health approach. Current examples include STP Boards and Integrated Care Partnerships, or Health and Wellbeing Boards or Better Care Fund committees. There is a clear case for including housing in these forums, as a wider determinant of health. Inviting housing representatives to attend relevant Boards/committees that lead on these approaches would open up the health landscape to housing, and enable the connections to be made between relevant leads on both sides.

Providing proof of concept:

- A number of housing and health projects have now been proved to be successful, including the Nottingham H2H projects and others. Highlighting existing models that have worked helps provide that first step in proving the concept. The Housing Learning and Improvement Network (LIN) has developed a directory of housing and health projects, categorised by four basic delivery models. This helps potential partnerships find examples of other local projects.[xviii]
- There is a considerable evidence base pulled together by housing and health experts, which also helps prove the concept of this type of partnership working. This existing evidence could be used to form a business case for investment in potential new projects.[xix] [xx]

3.2. Variation

Underlying the Nottingham H2H project's success it that it has provided a win-win outcome for both partners. For the CCG, it has helped relieve pressure on health services by housing patients quickly and suitably. For the housing provider it has benefited their organisation by meeting their community objectives and increasing the uptake of empty social housing properties. The dual benefits to each stakeholder ensure that they are both committed to the ongoing operation of the project. Therefore, each new potential housing and health partnership needs to consider how it will benefit their organisation, and the design of the project needs to take this into account. It is therefore likely that there will be some variations between local projects, in order to fit the local context and benefit local stakeholders.

The Housing LIN directory of housing and health projects[xxi] highlights that there are a range of ways in which housing and health partners can work together to deliver shared objectives. Some of the variations could include:

- **Variation in the service offered by housing partners:** Rehousing people into housing providers' own accommodation is one service that can be offered by housing partners. Other services that have been rolled out include providing handyman, repair or other adaptation services to improve the safety of people's existing homes. Another variation is to provide temporary step-down accommodation for patients so that they can be safely discharged from hospital, whilst waiting for a long-term housing solution.
- **Variation in the target patient group:** Local health intelligence will help identify appropriate target patient groups. For example, this could be by identifying specific co-morbidities that drive healthcare use, that are exacerbated by poor or unsuitable housing. Population groups could also be identified that have preventable health conditions, linked to housing. For example, Housing LIN research identified three major groups affected by delayed discharge due to housing.[xxii] Due to the ageing population, older people are the primary group affected by delayed discharge due to housing issues. Other at-risk groups include those with mental health problems – around 1 in 20 mental health bed days are due to delayed discharge, with a negative impact on individuals' psychological wellbeing.[xxiii] The final group is people experiencing homelessness, where the lack of housing can cause delays in discharge, or where discharge to temporary accommodation can result in repeated readmissions to hospital.
  Delayed discharge from hospital is only one example of a healthcare service that could benefit from housing support. Other healthcare services may experience an additional burden on their services due to housing issues – including primary health services, mental health services, Adult Social Care, and homelessness services. A project could target any of these high-service use patient groups, with the aim of reducing their healthcare use through the provision of appropriate housing solutions.
- **Variation in the healthcare partner:** As identified in this report, the main role of the healthcare partner is to facilitate links with the appropriate patient group, and to help source funding based on the financial return to the stakeholder from reducing demand on their services. The most appropriate healthcare partner will therefore vary, depending on the target patient group as set out above. Agencies working most closely with the target patient group could therefore be the healthcare partner for a housing-related project, working with the housing partner to reduce demand on their services. For example, this could include social care providers (home care or residential social care), Mental Health Trusts, or local authority homelessness services.

4. Conclusion

This review has identified the key enabling factors for the successful delivery of the Nottingham Housing to Health service, leading to positive outcomes for stakeholders and patients. The aim in doing so is to support the replication of the project in other areas, to help facilitate the spread of similar projects and therefore scale up the potential benefits from doing so. It is important to recognise that some of the factors that have made the project a success in Nottingham may be specific to that local context and the mechanisms operating within that context. Therefore, some variation may be necessary to the project in order to meet the local needs of stakeholders and patients in other areas. Despite some potential variations, the key principles from the Nottingham H2H review are helpful to consider in the context of spreading housing and health projects in other areas, alongside the learning from reviews of other joint housing and health projects.[xxiv] The key features of successful implementation from the Nottingham H2H project are:

- Having a supportive local context, in which both partners are committed to a shared vision for the improvement of a specific local population's health and wellbeing outcomes, and where housing is considered to be an important partner in achieving these outcomes.
- Building a sustaining a strong partnership between housing and health partners from top to bottom, building cross-sector links at the strategic and senior leadership level, and between management and frontline delivery staff.
- Mapping out how the project's activities will lead to successful delivery of its intended outcomes and impact, and considering the key elements of operational delivery that are necessary to the project's success.

References

[i] National Audit Office (2016) *Discharging older patients from hospital* https://www.nao.org.uk/report/discharging-older-patients-from-hospital/
[ii] Nottingham CityCare https://www.nottinghamcitycare.nhs.uk/
[iii] Nottingham Housing to Health evaluation report (full and summary) https://nottinghamcityhomes.org.uk/about-us/housing-to-health/
[iv] Placeshapers www.placeshapers.org
[v] National Federation of ALMOs (NFA) http://www.almos.org.uk/members
[vi] Association of Retained Council Housing (ARCH) http://www.arch-housing.org.uk/about/arch-members.aspx
[vii] Improving Health and Care through the home: A National Memorandum of Understanding https://www.gov.uk/government/publications/improving-health-and-care-through-the-home-mou
[viii] Marmot, M. (2010) *Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010*.
[ix] Friends of the Earth & the Marmot Review Team (2001) *The Health Impacts of Cold Homes and Fuel Poverty*
[x] Thomson, H., Thomas, S., Sellstrom, E and Petticrew, M (2009) '*The Health Impacts of Housing Improvement: A Systematic Review of Intervention Studies*' American Journal of Public Health 2009; 99:S681-S92
[xi] Jones, A., Valero-Silva, N., and Lucas, D (2016) *The effects of Secure Warm Modern in Nottingham: Decent Homes Impact Study*.
[xii] Ibid ix, p.211
[xiii] Evaluation reports for 'Warm Homes for Health' and 'Fit in the Community' can be found at https://www.alicejonesimpactconsulting.co.uk/projects
[xiv] Happier, Healthier Lives: Nottingham City Joint Health and Wellbeing Strategy 2016 – 2020 (p.20) http://www.healthynottingham.co.uk/health-and-wellbeing-strategy-2016-2020/
[xv] Nottingham and Nottinghamshire Sustainability and Transformation Plan (p.12) https://www.nottinghamcitycare.nhs.uk/stakeholders/stp.html
[xvi] The Kings Fund, National Housing Federation (2018) *Housing and health opportunities for sustainability and transformation partnerships* https://www.kingsfund.org.uk/sites/default/files/2018-03/Housing_and_health_final.pdf
[xvii] Nottingham City Council, *Quality Homes For All: Nottingham's Housing Strategy 2018-2021*, available at https://www.nottinghamcity.gov.uk/information-for-residents/housing/strategic-housing/the-citys-housing-strategy/
[xviii] Housing Learning and Improvement Network, *Hospital to Home tool* https://www.housinglin.org.uk/home-from-hospital/tool/
[xix] National Federation of ALMOs, PlaceShapers, New NHS Alliance (2018) *Health Creating Practices: Shining a spotlight on housing initiatives* http://www.almos.org.uk/include/getDoc.php?did=8214&fid=9722
[xx] National Housing Federation, *Home from hospital* https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Home_from_hospital.pdf
[xxi] Ibid xiii
[xxii] Ibid xv
[xxiii] Healthwatch England analysis of My NHS Mental Health Hospitals in England data at October 2014 http://www.nhs.uk/Service-Search/performance/ Results?ResultsViewId=1014
[xxiv] Skills for Care and the Chartered Institute of Housing (2017) *The role of housing in effective hospital discharge* https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Sector-showcase-The-role-of-housing-in-effective-discharge-from-hospital_2017_Correct.pdf