



Developing a business case for health – what does good look like?

This is the second of three independent reports, commissioned by the National Housing Federation. It aims to illustrate how housing associations are already making the case to the health sector of the value of their services, maintaining and improving the health of residents and wider populations. It also looks at what more could be done to promote the housing sector's offer.

These reports, from the New NHS Alliance and The King's Fund, are linked and should be read together. They cover:

- the NHS and health sector's understanding of, attitudes towards, and use of evidence in decision making
- how the housing sector can go about making a stronger business case to health
- examples of how housing associations are making the case to health, through case study examples where their interventions demonstrate beneficial implications for NHS demand, cost-effectiveness and cost benefit.

This report focuses on the second of these areas. It sets out the six key steps to consider when developing a strong business case and presenting it to the health sector.



The insights set out in the first report on attitudes to evidence show that commissioners and other health professionals take evidence very seriously when they draw on it to inform decision making. While always aiming to be driven by a comprehensive evidence base, they nevertheless accept that there are limits.

Wye et al 2015 articulates how decision makers use evidence very well:

'Commissioners are highly pragmatic and will only use information that helps them create a compelling case for action.' The report calls on researchers to do the following in order to influence policymakers' decisions:

- learn more about local policymakers' priorities
- develop relationships of mutual benefit
- use verbal instead of written communication
- work with intermediaries such as public health consultants
- co-produce local evaluations.

Wye et al concluded: 'Clearly scientific and economic evidence play a role in health decision-making, but it is only one part. Despite the rhetoric of evidence-based health care, and the scientific model that clinicians are taught, the reality of commissioning is different. How evidence is framed and localised, who the messenger is and how evidence fits into a broader context and story will all influence how successful it is.'



When it comes to making decisions about whether to go ahead with a particular intervention, it is the wider business case that needs to be compelling.

As part of our research we interviewed a range of health professionals in a variety of roles in public health as well as local providers and commissioners, GPs and strategic system leaders. While economic evidence is clearly important, it is only one of a range of other considerations that interviewees cited as important. These include:

- the Government's policy and requirements
- recognised best practice
- a decision maker's personal beliefs
- acceptability of the intervention or approach
- confidence in the approach, organisation or person presenting the evidence
- local priorities, political support and timing
- the narrative or story of why your intervention will solve a problem
- whether or not it will reduce NHS demand or save money
- cost-effectiveness and value for money.

The NHS Five Year Forward View (NHS England and Partners 2014)¹ set out a vision for the future of health and social care. It focuses on new transformative models of care, a radical upgrade in prevention, and stronger partnerships between the NHS and others, including local authorities, the voluntary sector and communities themselves.

It recognised that our health and care are not determined by the NHS alone, and cannot be met by the NHS in isolation. Alongside the Care Act's requirement for closer cooperation of services that support health and wellbeing, the Forward View offers important context for the Memorandum of Understanding to support joint action on improving health through the home², supported by NHS England, Public Health England, the Department of Health and the National Housing Federation among others (National Housing Federation 2015).

This report unpacks the core elements of what a good business case to health looks like. It poses six questions aimed at helping housing associations construct a compelling business case, relevant to their particular intervention. Housing associations should consider:

1. Who do you face (in health)? What is their context, what are their drivers?
2. Do they know enough about you to trust you?
3. What's your logic model for your intervention?
4. How are you measuring the outcomes identified and defined by your logic model?
5. What type of economic evidence will be most appropriate and persuasive?
6. How will you present this to health to make the best business case possible?

A recent publication by Sitra and the New NHS Alliance, *Housing: Just what the Doctor Ordered*, might also offer some useful advice³.

¹ NHS England Five Year Forward View, 2014: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

² Memorandum of Understanding to support joint action on improving health through the home: www.housinglin.org.uk/Topics/browse/HealthandHousing/HealthPolicy/Policy/?parent=8683&child=9425

³ *Housing: Just what the doctor ordered*, Sitra and NHS Alliance: www.nhsalliance.org/wp-content/uploads/2015/10/sitra-what-the-doctor-ordered-brochure-print-1.pdf

Q1: Who do you face (in health)? What is their context, what are their drivers?

The first thing to do is to make sure that the issue you are trying to solve is one that your health partners are looking for a solution to, not just one that you think they should be taking an interest in.

There are now many relevant issues that housing associations can help address that will be of interest to health partners. The current mood in health is also towards more collaboration, with growing recognition that health across the life course, and the particular problems of an ageing society, cannot be fixed, or prevented, by the NHS acting alone.

The establishment of health and wellbeing boards (HWBs) and Clinical Commissioning Groups (CCGs), together with the more recent push towards new models of care and Sustainability and Transformation Plans (STPs) mean that health partners are now more likely to want to work with others to address an issue that is relevant to them than in the past. They are also more likely to be interested if you are also working with other relevant local partners. Nevertheless, the principle of matching your offer to specific issues they are looking to address at the time they are looking for solutions, still holds.

Information about the priorities of local health partners can be found in the HWB's strategy and in local CCG plans. It will also be useful to note whether they are part of the new models of care programme, such as the Vanguard, and how they are engaged in the STP process. Information about this will be available via minutes from meetings, but the most helpful approach would be talking directly face to face with members of the relevant board as well as the other implementation groups and forms of local governance that important health organisations are part of.

It is also useful to know when NHS planning rounds are, to help you better understand the response of the NHS to your approach. NHS health planning rounds vary and they change in response to national direction

and leadership. The most recent planning guidance was released in December last year (NHS England, 2015) and introduced the STP process as the prime place-based approach to planning, based on 44 regional footprints⁴. This national process will then be reflected in various ways in local planning.

The business case you construct will also depend on who in health you are facing. Housing associations need a clear understanding of who they would be working with for a particular initiative, and an appreciation of the subtle – and sometimes less subtle – differences in their attitudes to evidence and to its use in decision making. Another dynamic to consider this is whether, and how, these players interact, and how they share findings and evidence locally. For example, to what extent do they draw on the evidence in the Joint Strategic Needs Assessment? To what extent does public health support or advise the CCG and other local partners? Do they use a Commissioning Support Unit?

It is also important to appreciate what is driving the various parts of the health sector, taking the issues they're facing into consideration and thinking about what mode they are in.

The main players in the health sector that housing associations face and need to convince are:

- public health
- clinical commissioning groups
- GPs and frontline clinicians
- acute trusts and providers
- mental health trusts and providers.

Each of these will have a different set of levers and drivers. It is important to understand what these are and how therefore to present your particular intervention so that it is relevant to them.

⁴ www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp



A summary of the insights into some of the key health sector attitudes to evidence, specific national requirements, current drivers, issues, and mode are set out in the table below.

However, it is important to remember that individuals vary considerably and there is also significant variation within each group.

Table 1: Approach to evidence and relevant key issues of different health sector perspectives

Features of their attitudes to evidence	Planning guidance and drivers
<p>Public health</p> <ul style="list-style-type: none"> ■ Commissioning decisions likely to be highly evidence-based ■ Used to handling and interpreting non-clinical data sets, focused on populations ■ Key driver of the comprehensive JSNA ■ Publishes independent local annual public health report ■ Can be persuaded to test previously untested initiatives ■ Will require good monitoring and evaluation to be put in place. 	<p>Planning and other guidance</p> <ul style="list-style-type: none"> ■ NICE guidance, especially public health www.nice.org.uk/guidance/published?type=ph ■ Public Health England data and intelligence, including fingertips www.fingertips.phe.org.uk/ ■ Public Health England guidance including housing www.gov.uk/government/news/new-resources-to-improve-health-through-the-home ■ HWB strategy, see searchable (including for housing) Local Government Association directory www.local.gov.uk/health-and-wellbeing-boards/-/journal_content/56/10180/6111055/ARTICLE <p>Drivers, issues and mode</p> <ul style="list-style-type: none"> ■ Cuts to upper-tier ringfenced public health budgets ■ Increasing focus on local authority business ■ Closer relationship with housing ■ High potential to be an ally for housing and to act as an honest broker in terms of making a case within the shift to place-based working.

Features of their attitudes to evidence Planning guidance and drivers

Clinical Commissioning Groups

- Look for coherence and consistency in evidence from different sources e.g. national and local
- Some more aligned with medical, some with social model
- Likely to look at where a similar thing is already being done
- Likely to question transferability – will it work here?
- Levels of resource for research vary
- Like pre-packaged evidence within a strong business case.

Planning and other guidance

- NHS England CCG Assurance and Improvement Framework www.england.nhs.uk/commissioning/ccg-auth/
- NICE Guidance (including housing as part of pathways of care) www.nice.org.uk/
- New NHS Alliance commissioning guidance on housing www.housingforhealth.net/

Drivers, issues and mode

- Pressure to address the growing acute trust deficit
- Developing new models of care (locally and as part of NHS England programmes) and co-commissioning role for primary care
- Balance and tensions between policy shift to collaboration and place (including STPs) versus health and Care Act and legal requirement to stimulate competition
- NHS Clinical Commissioners is the representative body for CCGs www.nhscc.org/

GPs and frontline clinicians

- Need their evidence packaged
- Feel responsible for patients and make decisions based on what they think will work in individual cases
- Can be persuaded to try new ways of helping patients/people, especially if it reduces demand on general practice
- Once persuaded, can be very supportive.

Planning and other guidance

- GP Contract www.england.nhs.uk/2016/02/gp-contract-16-17/
- NHS England GP Forward View www.england.nhs.uk/ourwork/gpfv/
- Leading Change, Adding Value: a framework for nursing, midwifery and care staff: www.england.nhs.uk/ourwork/leading-change/
- British Medical Association policy and research www.bma.org.uk/collective-voice/policy-and-research
- New NHS Alliance guidance on housing www.housingforhealth.net/

Drivers, issues and mode

- Challenged by changing demand and finance constraints
- Typically short of time
- Difficult to get away from the surgery
- Short-staffed
- Facing business change with New Models of Care Programme
- General Practice Forward View.



Features of their attitudes to evidence Planning guidance and drivers

Acute trusts

- Focused on clinical data and how actions effect pathways of care for patients
- Interested in NHS demand reduction if can be shown to maintain quality of care
- Can be motivated by high quality study designs (e.g. Randomised Control Trials) but other clinicians' views and experiences are also highly valued.

Planning and other guidance

- NHS Standard Contract www.england.nhs.uk/nhs-standard-contract/
- Leading Change, Adding Value: a framework for nursing, midwifery and care staff: www.england.nhs.uk/ourwork/leading-change/
- NICE standards and NICE Guidance (including housing as part of pathways of care) www.nice.org.uk/
- NHS Confederation www.england.nhs.uk/nhs-standard-contract/

Drivers, issues and mode

- Significant budget deficits across most providers
- Shift to place-based focus can be uncomfortable unless in the lead
- Balancing competing quality, financial and regulatory pressures.

Mental health trusts

- Strong narrative of shifting care into the community and reducing inpatient beds
- Innovative work with housing to reduce delayed transfers, and provide alternative settings for care which may reduce use of inpatient beds
- Compelled by people's lived experience, and patient stories are important as sources of evidence
- Comfortable with co-production
- Less driven by clinical data.

Planning and other guidance

- NHS England mental health forward view www.england.nhs.uk/mentalhealth/taskforce/
- NHS England specialised commissioning www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/

Drivers, issues and mode

- Block contracting in mental health provides Trusts with the flexibility to sub-contract with housing associations
- Greater recent policy focus on mental health, particularly the physical health of those with mental ill health
- Views of service users and communities relatively more important than in other parts of healthcare.

Q2: Do they know enough about you to trust you?

Housing associations need to be aware of what local health partners know about them and how they are perceived. Their standing with decision makers is surprisingly important. It is certainly equally important, and possibly even more important, than having good evidence. For example, one of our case study organisations spent several years building its in-house expertise in health and economic analysis. It also put effort into developing relationships with key health system leaders – including NHS England, and by appointing the local CCG lead to serve on their Board. This held them in very good stead when subsequently approaching local health commissioners.

There are several aspects to this, including what they understand about:

- **Your organisation's status** – Do they understand your not-for-profit status, how you are financed and how you reinvest profits? Do they know about your governance arrangements?
- **Your motivations for getting involved in health and wellbeing** – Do they appreciate the strong values and ethos that lie behind your work in the community? Do they know about the history of supported housing and Supporting People? Do they realise there is a financial business case for housing associations – that addressing residents' health issues and helping to raise their quality of life can be one way of reducing management costs?
- **Your ability to solve their issue** – Do they know how many or what proportion of their patients you can reach? That you can solve problems for residents living in private housing too? Do they realise that you can help solve their property or accommodation-related issues as well as help people with their health problems?

- **Your credibility** – Do you have credibility with the people they respect e.g. other health partners, such as the Health and Wellbeing Board, public health, the CCG, NHS England and the local authority?
- **Your trustworthiness** – Do they feel they could trust you with their patients? Do they know you already play local roles in Making Every Contact Count, or that you could do so in future? Can you demonstrate that you can be trusted with their patients e.g. that you have roles in safeguarding? Do they know about the regulatory requirements you have to meet with the Homes and Communities Agency and Care Quality Commission for example?
- **Your competency** – Can you articulate clearly and concisely what it is you intend to achieve? Can you back it up with a demonstration of your capability in a similar initiative? Do they know that you already deliver large contracts with local authorities or other clients?

Once you have considered these questions, and understood your starting position, you will have a better idea of the information they need to know about you, in order to trust you. You may find that pre-existing relationships with individuals, including for example with local public health colleagues or members of the Health and Wellbeing Board, can help to broker credibility with other parts of the health sector. It will be appropriate to include relevant information within your written business case, but you will need to make sure it is presented in the right way. It will need to support your case and lead your health partners to conclude that you are better placed than any other organisation to work with them on this particular intervention or interventions.



While it is absolutely essential to identify what the issues of the day are for local health partners, and to present a solution that will help to address precisely those matters, you need to be careful how you present this. Many in the NHS are resistant to slick marketing strategies, which they are subject to from a range of healthcare companies on a daily basis. This is why presenting a good, credible business case that includes economic and other forms of evidence is very important.

“Anything that resembles a sales pitch is not good.”

Deputy director, mental health.

Q3: What’s your logic model to link your intervention to outcomes?

It is important to describe, in a precise way, what it is that you believe will happen as a result of the actions you will take. Making the effort to do this will help to bring clarity and provide a framework around which evidence can be presented and discussions can take place.

Logic models are particularly useful for articulating precisely what, in theory, will happen when you take a course of action. They provide a means of plotting the anticipated cause and effect relationships between the action you take and the outcomes you expect. They give backbone to your story or narrative about your intervention. They can also make it possible to see the full range of types of outcomes – or benefits – that are possible, including financial, non-financial, quality of life, social benefits, as well as the party who is benefitting, such as the patient, the NHS, social care, or the housing association.

There are many ways to think about logic models. Some good examples which include housing and health are those brought together by the University of California, Los Angeles Health Impact Assessment Clearing House (2013)⁵, and the former Association of Public Health Observatories collection of causal pathways to health, now part of Public Health England (Public Health England, undated).

On pages 9 and 10 there are two examples of interventions that have been plotted using a particular logic model, the OpenStrategies Projects-Results-Uses-Benefits (PRUB) system⁶. This system embeds Uses, focusing on whether and how the community, individual or patient actually uses or responds to your intervention, as a core element of the logic model.

⁵ University of California Los Angeles Health Impact Assessment Clearing House: www.adaptationclearinghouse.org/resources/ucla-health-impact-assessment-clearinghouse-learning-and-information-center.html

⁶ See OpenStrategies Limited: www.openstrategies.com. Merron Simpson, New Realities Limited, is UK Lead on the OpenStrategies PRUB system for strategic planning.

Agency actions and results



**Liverpool Housing Trust (LHT):
Strategy for helping hoarders to sort their hoards and overcome their compulsion**



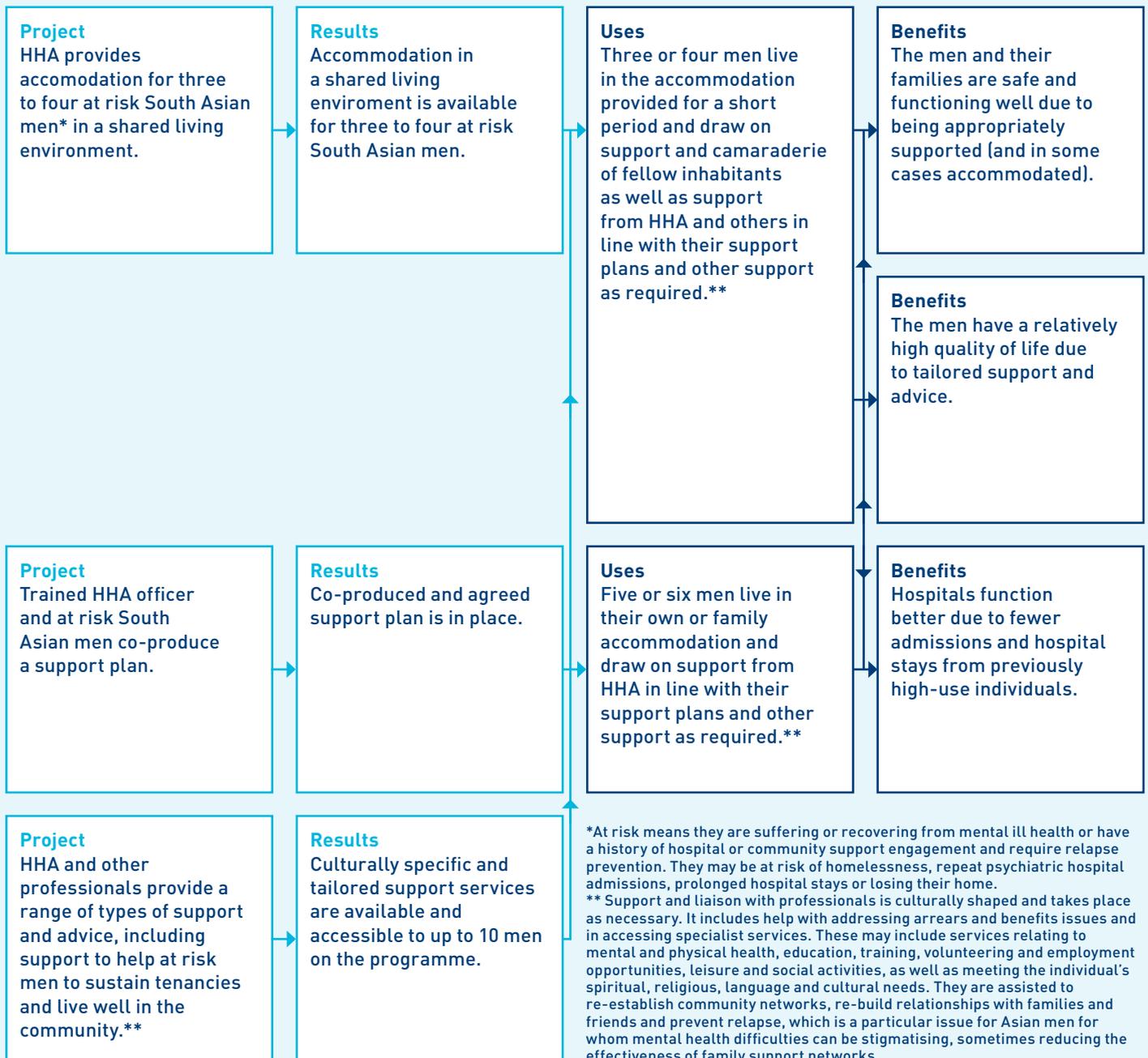


**Agency
actions and results**

**Community
actions and results**



**Heantun Housing Association (HHA):
Shaan Project**



Q4: What are the outcomes associated with your logic model and how are you measuring them?

Plotting the route from your intervention to the anticipated outcome using a good logic model allows you to explain clearly and precisely what you are proposing to do, and the outcomes you expect your intervention to deliver. If you can point to published, referenced examples, or to other places where the same or a similar intervention has worked, this will also help you to build your case.

Health partners will expect you to be clear about your anticipated outcomes, and how you can demonstrate them. This involves choosing the outcome, or outcomes, to focus on, and a method for demonstrating that your actions are responsible for those outcomes.

Choosing outcomes to measure

The outcomes that are important should be informed by your logic model, by conversations with the health organisations and people you are seeking to work with, and by guides such as Table 1, which give an indication of what is more likely to matter to different sorts of people, roles, and professional groups in the health sector and NHS. There is likely to be a natural preference for different sorts of outcomes depending on people's role and background, but this will also be strongly informed by national and other planning guidance – for example the current focus on reducing demand and delayed discharges of care – as well as the changes in costs and other resources associated with this focus. Our third report on the economics of housing and health gives more detail and case studies on how housing associations are helping with these issues.

An analysis for this study of the audit of National Housing Federation members (National Housing Federation 2016) showed that virtually all respondents to the survey were measuring resident or patient contacts as a measure of throughput. These tell health organisations about the scale of reach of housing associations, which is useful, but on

its own gives no indication of changes in use of the health service, such as GP visits, hospital admissions or reduced bed-days. Nor do they give an indication of future health outcomes, e.g. smoking rates – which are an indicator of future outcomes – or a final health outcome measure which shows how people's health has actually changed, such as a change in wellbeing or quality of life. One in three schemes is only counting numbers of people helped which will probably not be enough to satisfy most health decision makers.

The analysis of the audit did show that many housing associations are choosing a wider range of outcomes. Most schemes have at least one count of the numbers of people helped in some way, which is then paired with some measure of effect from the service. The typical scheme in the survey tracks at least four different measures – with one tracking 14 measures.

One in four schemes is including more complex measures of outcomes, using process indicators associated with health outcomes, like impact on A&E admissions, GP visits or prevented falls, as well as self-reported health outcomes.

Some of the final health outcomes that housing associations use, alongside the process indicators and indicators of final outcomes, are widely recognised in the health sector. These include:

- Domains of the NHS Outcomes Framework (Department of Health, 2016), such as enhancing quality of life for people with long-term conditions and helping people to recover from episodes of ill health or following injury.
- The EuroQoL-5D questionnaire tool, for measuring self-reported health as assessed by the impact on quality-adjusted life years (QALYs). This is a highly regarded and common tool in the health sector which some housing associations are starting to use. They are also often used in cost-effectiveness analysis. See Weinstein et al (2009) for an introduction to QALYs.



- The Warwick-Edinburgh Mental Wellbeing Scale (WEMWEBS) is another questionnaire tool which is suited particularly to measuring people's self-reported mental health. This is becoming more popular in the health sector. See Tennant et al (2007) for an introduction to WEMWEBS.
- Patient activation measures (PAMs) measure the skills, confidence, knowledge and motivation of patients in self-managing their conditions. These will increasingly be used in the health sector to assess readiness of the patient to self-manage (Hibbard, J. and Gilbert, H. 2014). NHS England has recently purchased 1.8 million PAM licences for use in England (NHS England, undated).

Others tools to measure the social impact of interventions, more commonly used by some housing associations and local authorities, such as the New Economics Foundation Social Return on Investment tool⁷ and HACT's social value tool (HACT 2016) are not commonly used in the health sector. This does not mean they are not relevant or valid, especially as the NHS, local authorities and housing work more closely together to develop more place-based models of care. However, the health sector will be less familiar with the benefits of using them, and will require support in order to understand and accept them.

More information about relevant outcome measures can be found in the NHS outcomes framework and the related CCG outcome indicator set (NHS England, undated c), the public health outcomes framework (Public Health England, 2012) and the social care outcomes framework (Department of Health, 2014). Local Joint Strategic Needs Assessments (JSNAs) and health and wellbeing board strategies will also have outcomes and other indicators of relevance.

Person-centred outcomes

As well as the more formal outcome measures above, health decision makers will take into account patient or stakeholder views when considering whether or not to take action. Mental health providers are perhaps most likely and used to doing so, and are mostly likely to readily co-produce with stakeholders to design a service or intervention. For others, if stakeholder feedback corroborates other forms of evidence, such as those above, they will find it more compelling than if it is stand alone.

Among the case studies investigated for this project, we found housing associations employing approaches to evidence that are centred around people's experiences, with some success. Including these methods within your business case will help to raise levels of exposure of the health sector to them and this should, over time, help to increase their acceptability.

Communicating, in the words of people and patients the very specific impacts that an intervention has on their day-to-day life can be very powerful, even though it's sometimes hard to measure or to put a value on. GPs and nurses, in particular, often respond to well-articulated patient stories where they can see specific ways in which their patients' quality of life has improved. They know the problems their patients have and the impact that has on demand if the problems continue without being solved.

In one instance, an advocate educator working for a housing association on a domestic violence programme presented service user stories, without reference to numbers or statistics. They talked passionately about the difference the service had made to people and got the backing of the CCG for a further year. Bringing service users with lived experience along to tell their own story can be even more powerful.

⁷ www.neweconomics.org/issues/entry/social-return-on-investment

Another housing association told us about the hugely positive difference a falls prevention scheme had made for one older person. As a result, they were able to leave their flat for the first time in months without worrying about falling over. The important things, when articulating the patient experience, are to be very specific about what it is that made the difference. Many case studies are too opaque and therefore offer insufficient rigour. Inviting service users to tell their story in their own words, and asking them questions to draw out some specifics, is possibly the best way of getting to the nub of what, specifically, makes the difference for them.

Outcomes stars⁸ that show the degree of change that has taken place across several aspects of an individual's life can be useful. Many housing associations now use them but NHS professionals can be put off by the associated costs. Nevertheless, interest from the NHS in this sort of assessment is also growing through the health sector's work, through an NHS England programme on Patient Centred Outcome Measures (PCOMs),⁹ and through a growing appreciation of the need to focus on outcomes for patients. Including this approach in your business case may therefore pay dividends. However, you should aim to complement these with other economic evidence that will be more immediately recognisable across the health sector.

Self-assessments can be very powerful where they help to raise people's self-awareness. One housing organisation co-produced a self-assessment tool with a hoarder, to assess the level of control they have in their lives compared with the hold their possessions have over them. Coupled with a simple room-rating scale, their tool was found to have considerable impact on their motivation levels, which led to behaviour change, in particular a reduction in hoarding tendencies and a willingness to work through and let go of their hoards.

For the individuals involved, self-assessment – through which they could see themselves changing – were more relevant than either QALYs or social return on investment (SROI) assessments. This is not, typically, appreciated by health professionals, but needs to be pointed out more frequently and to be articulated within business plans.

Demonstrating impact

Choosing relevant outcome measures is an important step, and shows how your goals are aligned with those of the local health system. But a further important question is how do you know it is your intervention that is having the impact on the outcome, and not something else? This is a question that you will often face when dealing with the health sector. Many of its staff, particularly those with clinical backgrounds, are well versed in the strengths and weaknesses of different sorts of methodologies, and study designs to detect changes in outcomes.

“You can't present them with sub-standard evidence. They can see past it – they're clever people. It must be very comprehensive – even if it's 65 pages. They'll read it all and pick up on things.”

GP/CCG.

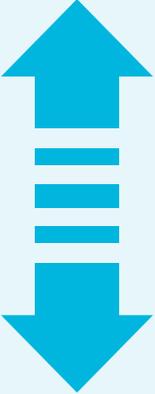
With this in mind, it is important to be aware of the different types of study methods that the health sector is familiar with in relation to demonstrating impact.

⁸ Outcomes Star website: www.outcomesstar.org.uk/

⁹ NHS England Person Centred Outcome Measures programme (seven sites): www.england.nhs.uk/ourwork/pe/pcoms/



Table 2: A common hierarchy of health evidence and demonstrating impact

Demonstrating impact	Type of evidence
 <p>Best evidence of causality</p>	Systematic reviews and meta-analyses
	Randomised control trials
	Cohort studies
	Case-control studies
	Cross-sectional surveys
	Least evidence of causality

Source: Based on Petticrew and Roberts (2003).

There are different versions of evidence hierarchies, but more weight is placed on methods where causality is clearer and it can be proven that an action has led to a chosen outcome.

It is important to be aware of this hierarchy when understanding the health sector’s reactions to the logic model, choice of outcomes and approach to demonstrating impact used in the business case and assessment. Even though the hierarchy is not rigidly adhered to, and its importance also differs among sectors, the most weight is laid on it by those with a strong scientific clinical background and those in public health.

In practice most commissioners and providers are flexible, and hierarchies of evidence is only one of

many factors they consider in reaching decisions, as our report on attitudes to evidence explains in more detail. The health sector is often pragmatic in its approach to demonstrating impact on outcomes. Patient and resident stories resonate as much as they do elsewhere, and the health sector will in practice often compromise on strength of evidence if you can show that you are seeking to meet the outcomes it values – be they final health outcomes, behaviours, or changes in use and costs of health services.

More useful information on demonstrating impact, and some of the challenges for housing, third sector organisations and others in doing so, is set out by Petticrew and Roberts (2003), HACT (undated) and Buckland and Fiennes (2016).

Q5: What type of economic evidence will be most appropriate and persuasive?

Alongside the choice of outcomes, and methods to demonstrate impact on outcomes, the health sector is also increasingly interested in the economic case due to financial constraints and an a growing culture of value for money. There is no standard way to make the economic case that will be universally received or appreciated by health professionals. There are many plausible ways of going about it, with some approaches being more appropriate for particular interventions, while others will be more compelling to different parts of the health sector. It is, however, important to understand how to construct the best and most rigorous economic case you can for your intervention and operating environment.

Housing associations have used several different approaches which have been met with varying degrees of success. Appendix 1 sets out some examples of the sort of experience the case study housing associations have had when constructing their evidence base. One housing association, whose interventions are small scale, challenged commissioners regarding the high cost of meeting their rigorous evaluation requirements in relation to the size of the contract. In doing so, they suggested a less onerous, less expensive and more directly meaningful evaluation method, which was accepted by commissioners.

There are five approaches to the economic case that we think are most relevant to the health sector, and that can be used in combination with each other, as well as separately, to make a business case. They build on each other in terms of their complexity and what they require to use them credibly to make a good case, but all of them have their place.

1. Housing association homes are safe and decent homes that enhance wellbeing. This has health impacts that are valued, and can save the NHS money, quickly.

High quality social housing provided by housing associations creates social value, through its impacts on health and wellbeing and through reductions in NHS utilisation – for example through reducing excess cold, and reducing the likelihood of falls through safety improvements.

Estimates vary due to different methodological approaches, but the case is strong that housing association homes are good environments for wellbeing. It is accepted that they are less likely to suffer from issues like noise, lack of gardens or outdoor space, vandalism, poor lighting and rot and damp. They are more likely to be safe homes, with the appropriate safety equipment and are more likely to be decent homes. Our third report in this series sets out the economic value of the wellbeing, safety and decent homes standards associated with housing association homes.

2. Housing associations' role helps alleviate the overall economic and cost burden of illness and treatment.

The economic burden is the overall cost to the NHS of a particular issue – which can be a health condition, something that is known to exacerbate a health condition, or a sub-optimal process or service. Examples include diabetes type 2, cold homes, smoking, hospital discharge and domestic violence. In many instances, assessments of the national economic burden are available, and in some instances local figures will also be available.

This will be a useful focus where your intervention is expected to address one or more issues in such a way as to reduce the cost burden. Researching and defining the economic burden helps to establish the scale of the problem in your health partners' minds. Our companion report sets out examples and references on the economic costs of common health burdens to the NHS and on wider society.



3. Housing associations can help offset and reduce the NHS and social care costs of delivering care to individuals.

Reducing NHS activity and costs is what happens when an intervention offsets or reduces either the degree of NHS activity – such as GP consultations or A&E attention – or the cost of addressing the particular issue, or both.

This approach can be used whenever it is possible to show that an intervention can reduce the level of NHS activity or the cost to the NHS. It is advisable to be clear about which parts of the NHS your intervention will have an impact on.

Constructing this case involves a two-step approach. Firstly, explain precisely what you will do to address the issue, and how you expect your intervention to reduce the activity or cost through using a logic model and choice of outcomes. Secondly, define the degree to which you expect to be able to address the issue, and the size of the off-set – whether this is in terms of costs or usage. You can do this by drawing on a variety of sources to back up your claim including the hierarchy of evidence, your own evaluation, and examples from where it's been done elsewhere. Our companion report sets out examples.

4. Housing associations can demonstrate cost-effectiveness in meeting health and NHS objectives.

Cost-effectiveness analysis (CEA) is very commonly used to inform strategic decisions in the NHS and the wider health sector. It is essentially an assessment of the relative costs and health effects of a new course of action versus a defined alternative or a range of alternative actions, usually including normal practice. CEA therefore brings together information about outcomes and about costs, rather than looking at them separately. CEAs in health are often, but not exclusively, expressed in how much an intervention costs per Quality Adjusted Life Year (QALY).

This approach can be used when you believe that you have an intervention that will do one of the following:

- reduce costs and at least maintain outcomes compared to the current model of care
- improve outcomes and at least not lead to any cost increase
- improve health outcomes at a reasonable increase in costs.

With this last point, the definition of reasonable is open to debate, but in practice, this is often thought to be around £20,000 to £30,000 per QALY, reflecting guidelines from NICE, which guides the NHS on whether new treatments are value for money (NICE 2015). Constructing the case involves following widely accepted formal techniques. A good guide is Drummond et al (2015).

CEAs are far less common in the housing sector, although innovative housing associations are starting to undertake and publish them, and an example is included in the third report in this series on the economics of housing and health.

5. Housing associations can demonstrate positive cost-benefits of their interventions in terms of the value of health produced and savings to the NHS.

Cost benefit analysis (CBA) is a step further than cost effectiveness in that it takes into account all of the benefits that the intervention delivers, and attaches a monetary value to them in pounds so that they can then be compared to the cost of delivery.

Some benefits are financial benefits and others can be relatively easily monetised. There are also those that require significant judgements to be made. In practice, forms of CBA where the social value of impacts are given a monetary evaluation are becoming an increasingly common measure of social return on investment (SROI).

Like CEAs, CBAs are useful when considering alternative courses of action, but also in determining whether to intervene or act in the first place. Some CBAs are also called social return on investment where monetary value is given to the social value that the intervention delivers, as well as other specific benefits. Most CBAs are expressed in terms of spending or investing £1 and receiving £X in value in return.

CBAs and SROIs are now a fairly common way of assessing the value of interventions across central and local government (see Her Majesty's Treasury et al. 2014 on CBA) and are increasingly being used by housing associations. Several case studies are included in our companion report on the economics of housing and health. They are also accepted widely in public health e.g. The Kings Fund and Local Government Association, 2014) but are far less common in the NHS where currently there is a clear preference for CEA, especially cost per QALY type measures. This may change over time and CBA and SROIs may become more popular as the NHS focuses more on working with other organisations and valuing wider social benefits, rather than those that are purely in QALY-type terms.

The NHS and health sector will respond well to economic evidence being included in your business case, but with a range of types of economic evidence available, it is important to be clear which you are using to avoid misunderstanding. It is also important to be aware of the different preferences for types of economic evidence held by the housing and health sectors. More detailed information on the techniques and metrics available to make the economic case for housing and other determinants of health is available (see Public Health England and University College London Institute of Health Equity, 2014).

Q6: How are you going to present all of this to health to make the best business case possible?

A convincing business case is one that draws together all of the available, relevant information and presents it in a way that helps decision makers justify a particular course of action over the alternatives. It contains much more than just economic evidence since, as we established in the first report, decisions to proceed are rarely made on the basis of evidence – however good it may be – but on a wide range of considerations.

As cited in the first report, Wye et al found:

- The art of commissioning entails juggling competing agendas, priorities, power relationships, demands and personal inclinations to build a persuasive, compelling case.
- Policymakers seek information to identify options, navigate ways through, justify decisions and convince others to approve and/or follow the suggested course.
- Evidence-based policy making usually meant the pragmatic selection of evidence, such as best practice guidance, clinicians' and users' views of services, and innovations from elsewhere.
- Inconclusive or negative research was unhelpful in developing policymaking plans and did not inform disinvestment decisions.
- Information was exchanged through conversations and stories, which were fast, flexible and suited the rapidly changing world of policymaking.
- Local data often trumped national or research-based evidence. Local evaluations were more useful than academic research.



Key elements of a good business case

A good business case will present a well-reasoned and well-evidenced rationale for decision makers, helping them to feel comfortable and secure about taking a course of action. It will have a balance between narrative and numbers, problem-based and solution-based evidence and qualitative and quantitative evidence, and these will be assembled in such a way as to make a compelling case for action.

“You have to find reasons for enabling people to take risks, provide a lubricant on risk-taking solutions. If you want to move a group or team, you have to use both qualitative and quantitative evidence.”

National policy lead and former hospital doctor.

Your business case will also have to be fitting for the intervention or interventions you are presenting.

Some important elements to include in the business case are as follows:

The nature and size of the issue being addressed

This might include:

- a sophisticated assessment of the size of the issue – both national and local, but localised as far as is possible
- explanation about the method used to assess this, its limitations, and any known inaccuracies
- standards of variation – to demonstrate the best or worst-case scenario

- assessment of the economic burden to the NHS
- assessments of trends that could make the issue worse, or better, in the future
- implications and impacts of the issues if left unchecked.

“It depends what you’re trying to do. If you’re trying to set up something that’s well known, like a Walk-in Centre, then it needs to be very evidence-based – you need to get it exactly right. But if you’re trying to do something innovative and new that nobody has heard of, you’d be much more likely to go with a story or narrative... and they’re interested in the person who’s delivering the message.”

GP/CCG.

Statements or guidance from the Government that might support action on the issue

This might include, for example:

- compliance with relevant NICE guidance
- statements taken from key policy documents, such as the NHS England Five Year Forward View
- quotes from key national figures in high profile speeches e.g. Simon Stevens, CEO of NHS England.

“It will help you to hit NICE guidelines.”

National policy lead and former hospital doctor.

The mechanism – an explanation of your intervention, what you anticipate will happen and how it will help to address the issue

This should include:

- a short narrative explaining the intervention
- a logic map, showing precisely what outcomes you are expecting and how the intervention leads to the outcomes – or how you expect it to do so
- approximate timescales for when the outcomes might be expected to emerge. It is common within the health sector to distinguish between either immediate or short term outcomes and longer term outcomes
- who is involved and what the relationship is between partners – generally it will carry more weight if they can see you are working in partnership
- how people or patients are involved and the roles they play in making your intervention a success.

Economic evidence you are able to point to

Including (see Q5):

- any contribution you are making to safe, and decent homes that enhance wellbeing, and for which the health and cost impacts are valued
- the overall economic burden
- the reduction to NHS activity and/or cost
- the cost effectiveness
- the cost benefit.

Other types of evidence you can draw on

Some parts of the health sector are now more open to considering interventions that offer benefits that go beyond economics. GPs in particular are often interested in what works for their patients – as are those working in mental health – even if it can't be quantified fully in economic terms. There is also increasing awareness in some quarters that wider impacts are also important, such as the money that is saved for other, non-health, agencies.

“Not everything is about money, it's sometimes about outcomes.”

GP/CCG.

For example, in making a case for a social prescribing service, one CCG used the following outcome headings:

- Improved physical/mental health/early intervention
- Accessing education / learning
- Life skills development
- Social cohesion and engagement
- Community asset building.



Examples of where it's worked elsewhere

Illustrating success nationally or internationally can be very powerful:

- This needs to be accompanied by a rationale as to why it is also likely to work in your locality. Draw attention to the similarities, and the dissimilarities, especially if you have reason to think it could be even more successful in your locality.
- A powerful draw for commissioners is if a project has been tried on a small scale in-house, and you have already generated some outcomes that are consistent with outcomes from other localities.

“This works in New Zealand – do you want to trial it with us? If you do this, you will be able to reduce your... by two days, because Solihull did it.”

National policy lead, former hospital manager.

Data or information you are looking to collect

Consider the following:

- How you will use it to verify the outcome and also the impact on the health service?
- What do you need, in terms of measurements, and from which health professionals?
- If you want them to co-produce your evaluation with you, then say so.

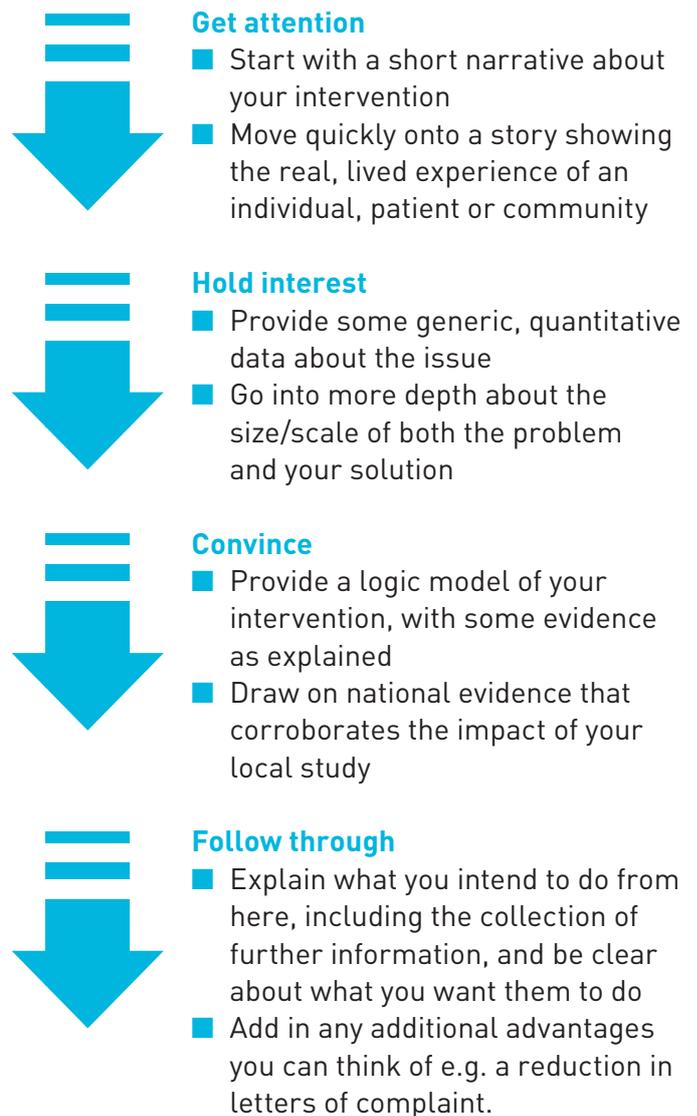
Other matters to consider

Be clear about what your long term plans are. Are you asking them to become involved in a pilot? This might meet with favour as it can be terminated if it is shown not to be as effective as you expect. Or are you aiming for a long term contract?

You might also want to consider the fact that commissioners and others are keen to avoid grievances, or reduce the number they receive. A letter of complaint is a very powerful motivator compared to a letter of thanks. If you believe that your intervention might help to improve satisfaction and reduce the number of complaints received, then mentioning this could enhance your business case.

Sequencing your business case

How you sequence the various elements of your business case, to navigate your health partners through the information it contains to draw conclusions, can be important. Below is a suggested sequence you might want to try.



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Annex 1: Methodology

Introduction

The goal of the research was to better understand and articulate how the health and housing sectors understand, value and use evidence – including the economic evidence – in their decision making, in order to support stronger joint working for health.

Our methodology is based on semi-structured interviews, case studies, literature review and some further analysis. The findings from each of these elements are reflected in the three separate reports from this project:

- **Report 1:** What counts as evidence and attitudes towards it – the differences in health and housing
- **Report 2:** guidance for housing associations on what will make a strong business case to health partners
- **Report 3:** the economics of housing associations and their impact on the NHS and health.

Summary of methodology

Our methodology is set out below, Information from each strand of these approaches contributed to all three reports.

Semi-structured interviews with health professionals

15 telephone interviews were undertaken with individuals from across the health (and local government) sectors, including:

- two chairs of CCG, also GPs
- two national policy leads, one of whom is a former doctor the other a former manager in acute NHS settings

- three GPs
- a director of a commissioning support organisation
- two senior hospital-based clinicians with responsibilities for discharge planning
- two directors of Public Health
- a head of Public Health Intelligence
- the CEO of a local authority
- a deputy director in mental health.

Literature search of attitude to and use of evidence in health

Our literature review focused on studies on how evidence (including economic evidence) is perceived, valued and used in practice in the NHS.

The search (covering 2005 to 2016) was undertaken via The King's Fund's information and knowledge services, which has access to the following databases: British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Health Business Elite, HMIC (this database combines resources from the Library and Information Services of both the Department of Health and The King's Fund, with a focus on the NHS and health service quality and health service policy, management and administration), PubMed and Social Care Online.



This was supplemented by hand-searching and conversations with experts.

The search terms included:

{su: (evidence based policy or evidence based management or evidence based practice or evidence based medicine) and su: (literature reviews or systematic reviews or utilisation review or research implementation or decision making or access to information or policy formulation or health service managers or commissioning or randomised controlled trials)}

{su: decision making and (ab: economics or ti: economics or su: economics or ab: economic or ti: economic or su: economic)}

{su: decision making and su: (commissioning or health service managers or health service management or service provision or service delivery or case studies or managerial behaviour or directors or boards or NHS)}

su: (housing or independent living) and su: (decision making or evidence or economic evaluation)

The outcomes of this search were used across the three reports.

Case studies from housing associations

The case studies were selected on the basis of a structured analysis of the Analysis of National Housing Federation's 2015 audit of their members which asked for case studies of working with the health sector. Our approach was to analyse the database to identify case studies on the basis of:

- strength of study design evidence e.g. RCT, case-control, longitudinal study
- mix of intervention types e.g. to find a diverse range of interventions relevant to different ages, needs and parts of the health sector

- mix of outcomes e.g. saved NHS utilisation, wellbeing, patient experience and health outcomes
- text search for economic terms including: costs, (social) return on investment, cost-effectiveness, cost-benefit analysis
- geography i.e. to have a mix from across England.

We followed this with a hand search using the database, to visually identify studies of promise that the formal search above may miss and supplemented with existing studies known to us through other routes.

This resulted in 14 case studies which we interviewed with a semi-structured questionnaire and requested and received relevant additional material which was used to inform our reports.

Notes



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