Health professionals' attitudes to evidence and the influence it has on decision making

This is the first 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 first of these areas. It sets out how the health sector uses evidence in practice, how this differs from theory, and the implications for housing associations and others who wish to work with and influence the health sector.

new nhs alliance

The Kings Fund

An assumption often made by those seeking to work with and influence the health sector is that the evidence trumps all other considerations and that this increasingly means the economics, cost saving, cost-effectiveness and related metrics, such as social return on investment and cost benefit analysis.

Evidence is indeed important to the health sector, but the above assumption is far from the whole truth. In reality, what is meant by evidence and economic evidence differs substantially, depending on which part of the health sector you are working within, such as general practice, acute care or public health. It also varies depending on whether the focus is on providers or commissioners, and who you are working with.

The objective of this element of the research was to explore and discover how important evidence is in decision making compared with other factors, and to determine what type and standard of evidence is required to give health professionals confidence to act. The overarching aim of this research was to increase the likelihood of fruitful cooperation between the health and housing sectors.

Rather than being a rigorous or full analysis of the topic, this study is simply aimed at raising awareness and understanding of some of the ways in which evidence is received and used. It draws on a limited number of in-depth and insightful views of individuals from within the health sector, offering varying perspectives, as well as case studies from housing associations. We have supplemented this with a search of the published literature, to provide some insights into how data, other forms of evidence, and economics are viewed and used in practice.

How important is evidence in decision making, compared to other factors?

Evidence is just one of many factors that health leaders consider when making decisions about what to commission and whether to work with an organisation.

There is a strong and widespread ambition to be evidence-based in the health sector, but constructing robust evidence can be an insurmountable challenge, particularly when it comes to decisions relating to non-clinical interventions. As a result, evidence often only makes up a relatively small part of the picture used by decision makers (Clarke et al 2013). This means that evidence is not usually sufficient in itself to prompt decision makers to take a course of action, and it is not always an essential part of the decision making mix. Robust evidence will not necessarily result in a positive decision in the absence of other factors.

> **"Evidence is only part of the picture and often not the first factor."**
>
> National policy lead and former hospital doctor.

There are various reasons why it can be difficult to establish a comprehensive evidence base, including:

- it is inherently difficult to research the vast array of influences and impacts that impact on health outcomes
- assembling the data and turning it into a robust evidence base can take a long time, particularly where longitudinal studies are required
- studies can be very expensive.

Another key issue is that there are many different sources for data and evidence in health, with no recognised standard approach for using them to inform decision making. There are high quality and important institutions in health that collate, judge and disseminate evidence, such as the National Institute for Health and Care Excellence (NICE)[1], the Cochrane Collaboration[2] and Public Health England[3], all of which are supported by a myriad of medical and wider health journals. However, in reality, local organisations vary considerably in how they use evidence to make decisions (Williams 2008; Wye et al 2015). A lot also depends on the degree of pressure managers are under at any given time.

> **"When people are in crisis mode, they definitely just wing it, because they're desperate for a solution tomorrow – there's no time to make a business case. When they're not in crisis mode, they are doing better research, looking for the evidence to make change happen."**
>
> National policy lead, former hospital manager.

[1] www.nice.org.uk
[2] www.cochrane.org
[3] www.gov.uk/government/organisations/public-health-england

Regardless of time and capacity, evidence is only one factor taken into consideration by decision makers. Other powerful influences include:

- **The Government's policy and requirements:** A national policy statement increases the imperative for action because NHS organisations are being measured on delivering policy. Conversely, a robust evidence base will not necessarily result in a positive investment decision in the absence of a policy driver.
- **Recognised best practice:** Commissioners tend to prefer examples of where an intervention has worked before because they can conceive of it working for them and it is perceived as less risky.
- **A decision maker's personal beliefs:** People accept evidence more readily that aligns with their values, personal beliefs and lived experience. This can be very personal to individuals, and so difficult to predict. It includes factors like who the person is influenced by and their previous positive and negative experiences.
- **Acceptability of the intervention or approach:** What becomes acceptable in the health community is not always related to evidence that it works, reduces demand or saves money.
- **Confidence in the approach, organisation or person presenting the evidence:** Commissioners may favour certain organisations over others because of their understanding of how they work. For example, some people feel that acute trusts are often trusted over primary or community care organisations. This makes it difficult for organisations outside of the sector to break into NHS commissioning or provider circles.
- **Local priorities, political support and timing:** Interventions have to support the local priorities and often also need the political backing of the local authority to be commissioned. Presenting a solution at just the right time, when it responds to a clear local priority, will also increase the chances of success.
- **The narrative or story of why your intervention will solve a problem:** A narrative without robust evidence is only likely to work where the intervention is innovative or something new to the NHS, and where the person delivering the message is familiar and influential.
- **Whether or not it will reduce NHS demand or save money:** Given the state of NHS and wider health finances, the imperative to reduce NHS demand and save NHS money in real cash terms has become a very significant driver.
- **Cost-effectiveness and value for money:** There is a strong focus on health economics in NHS decision making, and one role of the (NICE) is to recommend and support uptake of treatments that are cost effective or represent value for money against other metrics, such as social return on investment or cost benefit analysis.

Although evidence plays only a part, it is still a very important tool in making a strong business case. Aside from the other drivers listed above, health professionals do aspire to high quality evidence and an intervention that is supported by robust evidence is more likely to be commissioned than a similar one that is supported by weak evidence. An unfamiliar organisation presenting strong evidence is much more likely to get noticed than one that has weak or no evidence.

> **"Policy trumps evidence every time."**
>
> Director of commissioning support organisation.

What type and level of evidence is required to give health professionals confidence to act?

Interviews with a wide range of health professionals have revealed an equally wide range of views offering no simple or direct answer. The insights received, as outlined below, do however shed important light on the complexities of health decision making, and how evidence plays an important and unpredictable role. Those working with the health sector, or who are seeking to influence it, need to understand these complexities as context to the health sector's responses to evidence and other factors.

What are health professionals' attitudes to, and relationship with, evidence?

One common theme that several interviewees agreed on is that decision makers in health are significantly influenced by the clinical mind set. Those with medical roles, as well as those in other roles such as commissioning, are highly trained and experienced in interpreting clinical, biochemical and pharmacological data, meaning they have a strong grounding in scientific methodology in relation to clinical matters. The standards applied to medical evidence tend to be carried over and seen as the default approach to the evaluation of other types of intervention. This can lead to difficulties, because these standards don't transfer comfortably into service redesign or wellbeing interventions, for example. Evidence to support investment in non-medical interventions may therefore appear to fall short of decision makers' expectations and approach to evidence.

> **"The NHS isn't good on evidence with respect to how to structure your service or information flows – things that are critical to outcomes."**
>
> Mental health provider.

Decisions are made by taking in a range of different factors and – as is human nature – people take shortcuts when assessing the different options, sometimes seeking evidence to support or disprove their pre-existing preferences or feelings about the intervention. Some of this can be unstructured or informal, and it is often subconscious.

> **"I am minded to do this. Can someone just go and have a look at the evidence?"**
>
> National policy lead and former hospital doctor.

There is also a tendency to fall back on familiar interventions rather than trying something new and innovative. This is partly because of imperfect evidence about non-clinical interventions, and partly due to the conservatism of decision making driven by risk aversion, both in terms of safety and finances. It is also partly due to the hierarchical nature of the health service, and a fear of the consequences of failure. Sometimes, setting an unrealistically high evidence bar – for example the need to undertake or bring evidence from a randomised control trial – can be used to avoid taking a decision that is really not being taken for other reasons.

> **"No, Clinical Commissioning Groups don't do a lot of innovative stuff."**
>
> Clinical Commissioning Group lead.

> **"It's hard for commissioners to be the first to do things. If you give it to them for free, they'll take it, but if you're asking them to pay for it, they don't do it."**
>
> GP.

> **"Evidence is used as a way of holding things back."**
>
> GP.

How do attitudes and views about evidence vary in different parts of the health service?

Every situation is unique because of the interplay of the range of factors that affect decision making and the role evidence plays within it. However, the following factors are important to be aware of and give an indication of how evidence will play into a given decision.

- **The type of organisation:** The feedback from interviewees suggests there may be differences in views between public health, Clinical Commissioning Groups (CCGs), GPs, mental health and acute trusts about the relevance of different data sources, of how to use them to make the case for change, and how evidence should be used to inform decision making.
- **Local relationships between organisations and the informatics workforce:** Where relationships are good and there is a desire to use what data there is to build evidence to inform decision making, there is likely to be greater agreement between professionals from different parts of the health sector as to how evidence can be used. In this instance, the likelihood of evidence being used well to inform decisions is higher than in places where organisations operate more independently.
- **The individual:** Personal perspectives, aspirations for evidence-based decision making and previous experience all come into play. Rational people bond more with evidence that is closely aligned with their pre-existing beliefs and values than with evidence that isn't (see Edwards et al 2013 regarding large differences in the types of information used and valued by health managers).

Our study provides some insight into the differences between the prevailing culture and attitudes towards evidence within different parts of the health service. However, it must be appreciated that there is significant variation in attitudes held by individuals within each type of organisation.

There is also a range of types of evidence that different organisations in different parts of the system, and at different levels, will favour (see Clarke et al 2013, Edwards et al 2013, Wye et al 2015). The characteristics identified on the next page should not be seen as universally held by individuals within each group, but there are some defining features for the ways which public health, CCGs, GPs, mental health and acute trusts each understand the relevance of different types of evidence, and in how it is used to inform decision making.

Public health

Public health professionals are schooled in epidemiology and population health, which have a focus on physical and social sciences, increasingly including health economics. Commissioning led by public health is therefore highly evidence-based (see Clarke et al 2013 regarding staff working in public health being more likely to report using empirical evidence compared to any other department). They are driven by population-level, statistical data and have skills in collecting and interpreting large non-clinical data sets relating to population health.

Professionals in public health have a statutory duty to prepare local authorities' and Health and Wellbeing Boards' Joint Strategic Needs Assessments (JSNA), which feed into local health strategies. They also prepare an independent annual report on local populations' health.

While there can sometimes be a tendency to use the lack of robust evidence as a reason not to take action, public health professionals are often willing to embark on a course of action without having gold standard evidence up front, but they will require that adequate monitoring and evaluation takes place to establish whether or not the intervention is working.

> **"Public Health drags its feet a bit. It uses the evidence as a reason for not doing things."**
>
> GP.

> **"Public health are the only people who have the skills in this way."**
>
> GP.

The transfer of public health to local authorities in 2013 has changed the relationship with local partners, including NHS partners. Some public health teams continue to straddle the NHS and the local authority by building collaborations, packaging and showcasing existing evidence to help inform the evidence-base of a range of local partners, including CCGs, Trusts and community partners. Where they are doing this, they are often seen as an honest broker, but public health professionals in other localities have less capacity to do this.

> **"In some Boroughs, public health seems to have a knack of turning evidence into something relevant, to use evidence to sell what you're trying to do."**
>
> Mental health professional (London).

It is also important to remember that the NHS also employs public health specialists directly.

Clinical Commissioning Groups

Clinical Commissioning Groups (CCGs) aspire to use evidence well and appropriately, but each has its own approach to using data and evidence to make decisions. Some are more aligned with the medical model, while others more so with the social model of health. There is a significant focus on getting things right for the local population and CCGs will pay a lot of attention to whether another area where an intervention has been tested has a similar demographic for example, before adopting something that has worked elsewhere.

> **"Commissioners are fairly hard on their evidence."**
>
> GP.

> **"Even where there's evidence nationally, there can be local barriers. How do we know it will work here?"**
>
> National policy lead and former acute trust manager.

Interviewees told us that many CCG commissioning decisions are based on evidence that has significant subjective elements to it. There are several reasons for this, including the fact that there is neither the time nor the money to undertake the quality of local research that commissioners would like to access.

While the average CCG's budget grew by 3.4% in 2016/17 (NHS Clinical Commissioners 2016), this masks both existing and new financial pressures for commissioners, for example their committed programme allocations, national tariff uplift and contribution to provider deficits. There is substantial local variation in CCG allocations and the smaller CCGs often lack an internal business intelligence function, relying instead on Commissioning Support Units.

Other reasons include a lack of confidence in, or familiarity with, non-clinical data and different sorts of evidence. Relationships with public health teams, as well as knowledge, understanding and acceptance of JSNAs and accompanying strategies are variable. Individuals also have their own ideas about what works.

> **"Every CCG has its favourite intervention that they think will reduce admissions."**
>
> GP.

The consequence of this, coupled with the fear of litigation in the event of taking a decision in the absence of adequate evidence, means commissioners can be risk averse and disinclined to innovate.

> **"The status quo is a powerful thing – they commission what they know."**
>
> Senior nurse (acute care).

GPs and frontline clinicians

Frontline clinicians, including GPs, are focused on making a good decision for the individual patient. They will translate evidence that shows the statistical probability of something occurring into what that means for the patient or person sitting in front of them. 'Whatever helps the patient' is a strong guiding principle. This can also work in reverse, with a GP being less inclined to take the recommendations of a particular piece of research on board if they feel that the findings don't reflect the patients they see. Much of the background analysis of these trials and recommendations for action comes from national organisations such as NICE or by Universities, so it is rare for GPs to do the analysis themselves.

GPs are also focused on generating and presenting data required to fulfil the requirements of the Quality and Outcomes Framework (QOF) and other standards frameworks[4]. The training on evaluating evidence that GPs receive is focused on evaluating the impact of medical interventions through scientific methodology, involving placebos and control groups for example. They receive little if any training in other types of evaluation method.

GPs are becoming increasingly restricted in what they can prescribe and treatments they can offer, with guidelines providing a strong steer along a particular pathway. While NICE guidelines are not obligatory, a GP would have to show why they had ignored them if challenged. This is reducing the scope that GPs have for innovating, whether that be in relation to medicines, treatments or other interventions.

Acute trusts

Hospitals are strongly aligned with the medical model of health. They often have sizeable informatics teams that work with large datasets, and are strongly focused on producing evidence that relates to clinical matters and to meeting financial targets. They encounter similar difficulties to others when it comes to interpreting information in order to turn it into actionable insight and then management action when it relates to non-clinical matters. In some places, the influence of individual hospitals over service design is diminishing as more place-based models of healthcare shift the balance to local commissioners and accountable care organisations (see Alderwick 2016).

Hospitals are strongly focused on the quality standards they have to meet and on attempting to break even financially. These drivers can overshadow even strong evidence of achieving any other outcomes. The way that hospitals are paid could also be counter-productive in some instances, particularly in those areas where they are paid on the basis of episodes of care. This can incentivise over use when there are better and cheaper non-hospital alternatives.

[4] Information about QOF and other standards frameworks GPs are required to fulfil: NHS Employers website www.nhsemployers.org/qof NHS England website www.england.nhs.uk/commissioning/gp-contract/ NICE website: www.nice.org.uk/standards-and-indicators/qofindicators

There is currently a particular focus on reducing delayed transfers of care (DToCs), emergency admissions and length of stay in hospital. They are therefore looking to shorten the patient pathway and improve patient flow. This is an area where housing providers can make a strong offer to acute trusts.

> **"Housing providers could specifically target these trusts that are struggling and ask "What can we do to help?"**
>
> National policy lead and former hospital manager.

Mental health providers

People's lived experience is now very important in mental health. Providers will usually place significant value on the patient story as an aid to understanding what's required, and this will frequently trump the requirement for other types of evidence. This standpoint has become more common over the last five years or so, as people living with mental health problems have strengthened their collective voice, and as mental health has gained political focus.

> **"Let's do something that is safe and co-produced – let's not let a lack of evidence stop us. Quality adjusted life years are great, but they don't mean anything to people."**
>
> Deputy director in mental health care.

Mental health professionals are likely to look through a person-centred lens when assessing evidence. This is in contrast to many others who will generally consider stakeholder experience, stories and feedback as part of the mix – but rarely on their own. Evidence of this nature is more likely to be acted upon if it supports other, more formal types of evidence.

> **"Evidence is not the whole piece. We have to take account of stakeholders too."**
>
> CCG manager.

It is now fairly well understood that housing has an important role to play in mental wellbeing. There are many instances where mental health professionals have been persuaded by evidence of the benefits of housing support.

> **"The evidence is significant. There's masses and masses of it. There was a good report out last week about housing and mental health – it's a good document."**
>
> Deputy director in mental health care.

What sort of evidence do health partners look for and how do they view it?

In our research, the information we gained in response to this specific question was patchy, and the sample size was too small to gain a coherent understanding of any patterns that might exist. It is likely that this reflects a significant degree of variation across the sector as to what kinds of evidence health partners are looking for. We are, however, able to offer a few insights from the interviews.

We learned that, while cost-benefit analysis is generally seen as the gold standard, it is also something that more usually tends to be carried out at national level. For example, NHS England is likely to use this when trying to determine interventions that it wants to recommend, rather than it being used at a local level where the cost is usually prohibitive.

> **"It is almost impossible to do a decent cost benefit analysis in wellbeing terms because to make it truly meaningful it would have to be done at what I call Lancet Level – in other words being exceptionally sophisticated – which costs a lot of money, and which up until now no-one has decided to pay for."**
>
> GP and CCG lead.

Similarly, return on investment is seen as being mainly used in national-level guidance and in publications.

Our literature review reflects this variation in what health partners look for, and how they view and use evidence. A survey of 345 NHS managers involved in commissioning in Primary Care Trusts showed variable use of empirical evidence according to professional background. Only around half of survey respondents stated that clinical guidelines and cost-effectiveness evidence were important for health care decisions. Staff working in public health were more likely to report using empirical evidence compared to any other department, and more senior members of staff – at NHS grade 8b or higher – were more likely to report using practical evidence, such as local intelligence, benchmarking data and expert advice (Clarke et al 2013).

A study of how health care commissioners accessed and used data and academic research in their decision making highlighted how commissioning involves juggling competing agendas, priorities, power relationships, demands and personal inclinations in order to build a persuasive and compelling case. Commissioners are highly pragmatic and will only use information that helps them to create a compelling case for action, and in some cases local data was more influential than national research evidence or academic evidence (Wye et al 2015).

More details of the range of health economic measures can be found in the second report in this series.

Expectations relating to packaging and presentation of evidence

Health professionals, whether providers or commissioners, rely heavily on pre-packaged evidence. Evidence that is packaged and presented in a way that they are used to is more likely to be met with a positive response. Some of the institutions that prepare evidence in this way include NICE, Public Health England and the Cochrane Collaboration, and many medical and broader health journals also fulfil this role.

Figure 1: Sources and types of knowledge used by health commissioners

	Department of Health	NICE	NHS Improving quality	Public health	Commissioning Support Unit (CSU)	Think tanks e.g. The Kings Fund	Royal colleges	Local healthcare providers	Non-local CCGS/CSUs and healthcare providers	Commercial and not-for-profit providers
Best practice	✓		✓			✓	✓		✓	✓
Local relationships					✓					
Electronic newsletters			✓			✓				
Organisational development					✓	✓				✓
Commissioning guidance	✓					✓	?			
Clinical guidelines		✓					✓			
Horizon scanning										✓
Academic research		✓		✓		✓				
Improvement tools			✓							✓
Project management					✓					✓
Service/population data				✓	✓			✓		
Commissioning experience				✓		✓			✓	✓
Products										✓
Patient pathways								✓	✓	
Advanced data – interrogation skills										✓

> **"NICE guidance is brilliant because it comes pre-packed."**
>
> Deputy director in mental health.

We also know that health commissioners in particular get their evidence from a far broader range of sources, including Royal Colleges and think tanks, as Figure 1 shows. This is from an in-depth qualitative study on the use and sources of evidence in real world decision making by local health commissioners. (Wye et al 2015).

In the report, Wye et al found that:

- 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.

They concluded that commissioners are highly pragmatic and will only use information that helps them create a compelling case for action, calling on researchers to start producing more useful information.

In order to influence policymakers' decisions, the report authors advised that researchers need to:

- 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.'

Housing association views and experiences on health attitudes to evidence

Housing associations understand the financial pressures facing the health sector and therefore appreciate why commissioners and providers would want to know what value they would receive from their financial investments. There is growing acknowledgement and acceptance of the need to speak the same language as health care organisations.

> **"Economic evaluation is important for housing associations, and it builds a level of respect with commissioners by showing we understand their needs. We know the health sector is under phenomenal economic pressure and it isn't easy for health commissioners to do something different. Having evaluation data very much helps the conversation. The health model needs scientific methods to legitimise knowledge in the same way that NICE run clinical trials. Sometimes this is entirely valid in relation to housing, sometimes not."**
>
> Housing association.

There is a strong perception among housing associations that health care commissioners and providers hold return on investment or cost benefit analyses in very high regard. They are right in this assumption although, in reality, the use and understanding of economic techniques varies in the NHS as it does among housing associations. Learning to recognise when complex economic evidence is called for, and when it is not, is an important skill for housing associations. Not least because there are challenges for housing associations in carrying out rigorous economic analysis due to a lack of standardised measures, experience, capability and capacity.

However, a small number of housing associations have recognised the demand for this expertise and have invested in capability and capacity. As a result, they are very well placed to engage successfully with the health sector and are reaping the rewards through commissions and partnership working.

Opinions among housing associations are divided as to whether commissioners are interested in any other forms of evaluation, such as qualitative assessments of impact – for example non-standardised measures of person-centred impact or tenants' stories of change. Our interviews showed that some housing association staff believed that health care commissioners and providers are only interested in evaluations that demonstrate hard impact, such as the return on investment.

> **"Qualitative stuff doesn't always count with health as much as it does with social care. Unless you can count it, it doesn't count."**
>
> Housing association.

Others believe that qualitative data have strong potential to influence commissioning decisions by giving the hard data some meaning.

> **"Do not believe health and housing working together is always about showing what we can achieve in pounds and pence."**
>
> Housing association. The interviewee then referred the researcher to a written, qualitative case study which was submitted to a CCG as evidence of impact.

One interviewee described his personal beliefs that qualitative and quantitative data share equal importance in discussions with commissioners:

> **"No data without stories, no stories without data."**
>
> Housing association.

Another interviewee described presenting clients' stories to GPs on the board of the local CCG when the housing association was applying for continued funding. The stories were very compelling examples of how clients' lives had been changed for the better, and the ultimate decision to continue funding the service indicates that decision making can be emotionally driven too.

As well as making working lives easier for health professionals by diverting non-clinical issues to more appropriate and experienced services, the interventions can appeal to commissioners' intrinsic desire to help people in need:

> **"GPs are human too!"**
>
> Manager at a housing charity.

Approaches to evaluation are not perceived as mutually exclusive and mixed methods were important in understanding how interventions do or do not have impact. One interviewee recommended housing associations use case study or narrative evaluation methodologies that are consistent and rigorous and follow established best practice guidance in order to maximise influence with commissioners and providers.

Are health attitudes to evidence changing?

Existing constraints

The strong desire to base health-related decisions on robust evidence has been forged over many decades and is deeply embedded in NHS and medical culture. The idea that clinical decisions and actions should be based on evidence, rather than reliant on a doctor's instinct, is strongly associated with standards of professionalism and credibility. Any suggestion of acting without sufficient evidence is viewed as compromising these high standards.

The many national requirements in the NHS – including targets, regulator requirements and NICE guidance – reinforce this desire for good evidence. These make daily demands on health professionals and restrict the extent to which they feel able to operate outside of those limits and with autonomy.

> **"A lot of people, even in very senior positions, feel very constrained and more comfortable taking decisions within the constraints, rather than taking risks outside them."**
>
> National policy lead and former hospital consultant.

Direction of travel for the NHS

Recent NHS England policy documents and activities associated with them have opened up new possibilities for doing things differently. For the first time, the Five Year Forward View[5] is encouraging more locally driven models of healthcare to emerge, guided by a suite of seven models, allowing for an increased degree of local context within a national framework.

It states 'England is too diverse for a one-size fits all care model to apply everywhere. But nor is the answer to let a thousand flowers bloom.'

And NHS Shared Planning Guidance that introduced new Sustainability and Transformation Plans[6] for 44 new transformation footprints across England has stressed the need to release energy and ambition to enable faster transformation, warning that 'we don't have the luxury of waiting until perfect plans are completed.'

There is also significant focus now on patients and people as experts in their own treatment and care and in community-based approaches to health as briefly described in Chapter 2 of the Five Year Forward View[7]. NHS England is also leading a programme in which seven sites across the country are developing person-centred outcome measures for children and young people experiencing a range of health conditions[8]. This programme could help to establish new ways of measuring the impact of approaches that are focused more on people's own experiences.

Some believe that these reforms provide decision makers with significantly more freedom to try new things that are not necessarily fully evidenced, or that relate more to social outcomes. Some are prepared to adopt new interventions and to monitor and evaluate new models of care, and to test how well they are working. They are prepared to apply scientific method, making a hypothesis and testing it. However, a natural inclination to rely on prepacked evidence causes many others to avoid that inventive approach.

"People have more freedom than they think. It's a programme that gives people permission. They already have the powers, but putting it in the devolution deals gives them the mandate to move ahead. It's important to monitor and evaluate along the way, to check what you are doing is working. I'm not sure everyone's doing that."

Director of public health.

"CCG's main point of reference is what NICE says – clinical outcomes mainly – although NICE is now starting to look at social outcomes too."

Director of commissioning support.

[5] NHS Five Year Forward View: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[6] NHS Shared Planning Guidance: www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
[7] NHS England programme relating to chapter 2 of Five Year Forward View: www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-ch2/
[8] NHS England Person Centred Outcome Measures: www.england.nhs.uk/ourwork/pe/pcoms

However, the financial and demand pressures on the NHS are also bringing opposing tensions to the fore. As a result of the Sustainability and Transformation Plan process, the NHS is taking place-based planning seriously for the first time, rather than purely NHS organisation-based planning. Ensuring these plans are driven by the health and wellbeing transformation agenda, and the evidence for it, rather than an inward focus on sustainability of the NHS through controlling costs is a key challenge. Our interviewees eloquently expressed this tension in their reflections to us.

> **"I have yet to see evidence of new policies changing things."**

Senior nurse, acute care.

> **"Attitudes are changing very slowly – people like living in their trenches."**

GP.

> **"We do have to take some risks, don't we?"**

CCG chair.

> **"Is it changing? Yes, they are thinking differently – what that looks like varies."**

GP.

> **"CCGs have a duty to innovate as well."**

GP.

How should housing associations respond?

Influencing health professionals is not a straightforward business. Good quality, fit-for-purpose evidence that is packaged in the right way is one key part of that. However, our findings suggest that, on its own, this is not enough. Other factors are also very important to commissioners and other decision makers, including national policy, what others think, financial constraints and planning cycles. It is quite possible to make a compelling case without having the very highest standards of evidence, if the timing is right and the opportunity is there.

For housing associations, getting the timing right and learning to spot those opportunities – while understanding the constraints and attitudes towards evidence of the relevant part of the health system – is the key to success. This is all part of having a good business case. Sometimes, for some health professionals in some places, that business case needs to be full of very strong evidence-based and costed proposals.

> **"We will do a big business plan beforehand with as many figures as we can get. Other organisations let themselves down, coming with a business plan that isn't adequate at all. You have to say it in the right language and put it in the same way. It has to be solving the right problem."**
>
> Director of public health.

The most important thing is having the right mix of elements, making a business case that is fit for purpose and is directed at the right part of the health sector.

In the second report in this series, we set out more detailed guidance on how housing associations can get this mix of elements right, through posing and addressing six critical questions while developing a business case for health:

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 associated with 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?

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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.

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NATIONAL HOUSING FEDERATION

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