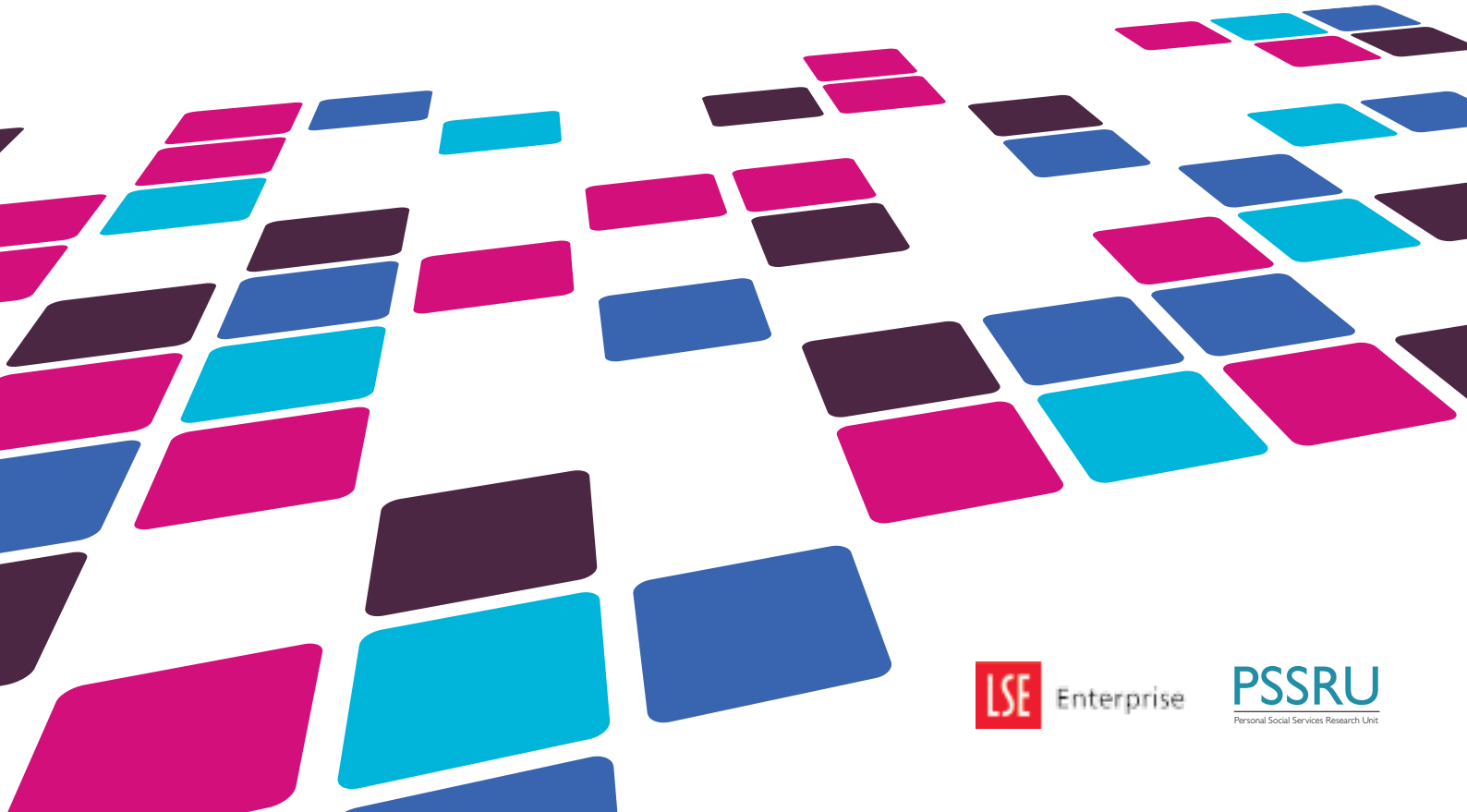
NATIONAL HOUSING FEDERATION

Prescription for Success

How housing can make the economic case to health



LSE Enterprise

PSSRU
Personal Social Services Research Unit

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Contents

Abbreviations

AQP	Any Qualified Provider
ASCOT	Adult Social Care Outcomes Toolkit
BCF	Better Care Fund
BRICSS	Bradford Intermediate Care and Support Service
CBT	Cognitive Behavioural Therapy
CCA	Cost Consequences Analysis
CCG	Clinical Commissioning Group
COBIC	Capitated and Outcomes-Based Contract
CPA	Care Programme Approaches
CQC	Care Quality Commission
CSRI	Client Service Receipt Inventory
CVS	Council for Voluntary Services
DH	Department of Health
EuroQOL	European Quality of Life Scale
FT	Foundation Trust
GP	General Practitioner
IT	Information Technology
KIT	Knowledge and Intelligence Team
LTC	Long Term Condition(s)
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
PSSRU	Personal Social Services Research Unit
QALY	Quality Adjusted Life Year
QIPP	Quality, Innovation, Productivity and Prevention challenge
QOF	Quality and Outcomes Framework
RCT	Randomised Control Trial
SYHA	South Yorkshire Housing Association
UK	United Kingdom
VCS	Voluntary and Community Sector
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
YHEC	York Health Economics Consortium

Introduction

In England, health services will account for around a fifth of all public expenditure in 2015/16. A pressing financial concern is the predicted shortfall of more than £30bn between NHS budgets and NHS expenditure by 2020, unless health providers make further efficiency savings. The challenge to the NHS is to increase productivity, divert spending from crisis intervention and treatment services towards prevention, and deliver better health outcomes for patients while using fewer resources. To do this the NHS needs to fundamentally transform the way that it works. We argue that this includes changing its relationship with partners and service providers to deliver greater efficiencies and better outcomes for service users and local communities. These changes should allow independent providers such as housing associations to work with health service commissioners to redesign health services and provide integrated community-based alternatives to hospital care.

The National Housing Federation's work to broker better conversations between housing associations and NHS colleagues has highlighted the need to raise awareness of the housing sector's potential contribution to the new health and wellbeing agenda. By the same token, housing associations need to generate robust and powerful evidence to convince health clinicians of the effectiveness of the services and interventions they can provide. Our conversations with health service commissioners confirm that housing associations will benefit from a deeper understanding of how effectiveness is assessed by the NHS. This includes engaging with and, where applicable, applying the principles of health economics to strengthen their case for investment. Having a basic understanding of health economics and health outcome measures will also help housing associations to have more productive and timely conversations with potential health partners.

This guide, written in partnership with the London School of Economics and Political Science, is aimed at housing association chief executives, business and service development managers and finance directors. It provides information on how to prepare a robust and clearly evidenced business case to inform housing associations' discussions with different parts of the NHS. It also describes how local health economies function, how money flows through different organisations, how services are commissioned and paid for, and the types of evidence and outcome measures that are used to determine health service spending.

Chapter 1

Where the money comes from

Understanding the local health economy

Your organisation's potential NHS partners, both providers and commissioners, exist as part of a local health economy. To make an effective business case, providers outside the NHS need to understand how these local health economies function. For example; how money flows through different organisations connecting purchasers, providers and outcomes, how services are paid for, and the focus and motivations of different parts of the system. This chapter ends with a round-up of some of the opportunities for housing associations to enter into contracts or partnerships to provide healthcare services.

Key points:

- The local health economy consists of Clinical Commissioning Groups (CCGs) which commission around 70% of the budget for the NHS, NHS England which directly chooses and buys primary care services and specialist services, local authorities who have responsibility for public health, and NHS trusts that both provide and commission services.
- The NHS is on a 'financial cliff edge'. NHS trusts are under pressure to reduce their costs and must generate efficiency savings of around 4% per year as part of the Quality, Innovation, Productivity and Prevention (QIPP) challenge. The Better Care Fund will require further savings of over £2bn in NHS spending, meaning an efficiency saving of 2-3% in 2015/16.
- There are few explicit incentives to promote integrated care. However, various new types of contracts are emerging, which support integrated care and offer opportunities to non-NHS providers to deliver integrated services.
- Opportunities for housing associations to provide healthcare services currently include bidding for CCG tenders, being sub-contracted by a health provider, redesigning pathways and services with providers, or entering into joint ventures with providers. The scale of these opportunities depends on the size, financial strength and risk appetite of housing associations, and the outcomes that commissioners are seeking to achieve.

What is the 'local health economy'?

The local health economy is a way of talking about all the main service funders, providers and regulators of health services within a defined geographical area. The National Housing Federation has produced a series of briefings called Routes into Health[1], which give a detailed overview of the key players in the local health economy and how they link with national structures. Housing associations need to be aware of the purchasers and providers of health services in their area (see figure 1) to develop and target their offer to health.

Clinical Commissioning Groups (CCGs) hold around 70% of the budget for the NHS and decide which health services to buy for their local population. They issue tenders for the provision of many services, although this is not mandatory for clinical services if they believe that there is only one capable bidder. Currently the bulk of service provision remains with existing health providers. The majority of NHS services (including most hospital services) are commissioned at local level. However, NHS England directly purchases primary care (GP) services and specialist services[2]. In 2013-2014, £25.4bn (23% of the NHS budget) was allocated to these specialist services[3]. Local authorities remain important stakeholders as, not only have they formed health and wellbeing boards, but they also have responsibility for purchasing public health services.

Figure 1- Key purchasers and providers of health and social care services

CCGs	• Commission most planned hospital care, rehabilitation, community health services, mental health services, and learning disability services
NHS England	• Purchases primary care services (GPs), specialist services, military health, and offender health services
Local Authorities	• Purchase public health services including health promotion and social care services • Integrate services through the health and wellbeing boards
NHS trusts	• Provide acute services and treat emergency cases • Run community-based services in addition to hospital services
GPs	• Main provider of primary care services

[1] National Housing Federation, Routes into Health, 2013
[2] A full list of specialised services is available at www.england.nhs.uk
[3] Powell T, Heath S. The reformed health service, and commissioning arrangements in England. London: House of Commons Library, November 2013. www.parliament.uk

What is a care pathway?

A care pathway is an approach to organise, standardise and improve the care of a defined patient group over a period of time. The pathways are processes that set out the journey a patient with specific needs will take from their first contact with a service, through to recovery, wellbeing or good health (or potentially end of life). They are based on agreed evidence, best practice and collated patient feedback about what is needed at different stages of this journey. Care pathways are often represented in a flow chart format to help coordinate the care of patients across the different teams, organisations and services required to make an effective response. For example, the acute care pathway starts when an individual is first referred to the service. The end of the care pathway is when responsibility for the individual's care is transferred to another team, or when the individual is discharged from acute care services. Care pathways are used widely in many areas of healthcare by commissioners and service providers to identify gaps and bottlenecks in existing services. There is an extensive evidence base for their effectiveness in improving the care provided to patients[4]. There are national care pathways for specific conditions and client groups, published by The National Institute for Health and Care Excellence (NICE)[5]. There may also be local care pathways designed by health commissioners and providers, which are specific to the delivery of services in their area.

NHS hospital services are run and managed by NHS trusts. Foundation Trusts (FTs), have more independence than non-foundation trusts, including the ability to retain surpluses to invest in improved patient care, appoint their own board, and provide a wider range of activities and services.

They subcontract services to other providers, as well as commission services out, to deliver their contracts and improve efficiency. In order to achieve the more independent foundation trust status, healthcare trusts must pass a rigorous assessment by the healthcare regulator, Monitor. The status, capacity and capability of trusts are examined, along with quality and safety governance and their ability to plan and demonstrate their performance in delivering their business plan.

Other providers include General Practitioner (GP) practices that are, in effect, private for-profit businesses that provide the bulk of primary care services. Their practice budgets are determined by the size of their practice lists. Budgets are modest at around £60 - £70 per registered patient per year, but practices can also receive additional payments if they achieve the specific quality targets set out in the national Quality and Outcomes Framework (QOF). There are opportunities for housing associations to work with GP practices to provide targeted and timely social support to improve health and wellbeing and reduce the need for medical or formal social care interventions. This is sometimes referred to as 'Social Prescribing' and the case study on page 9 describes how South Yorkshire Housing Association has secured health funding to develop this model in Sheffield and Doncaster.

[4] Renholm M, Leino-Kilpi H, Suominen T. Critical pathways: a systematic review. Journal of Nursing Administration 2002; 32(4):196-202.
[5] http://pathways.nice.org.uk

Case study: Social Prescribing in Sheffield and Doncaster – South Yorkshire Housing Association (SYHA)

SYHA's LiveWell at Home service is a unique blend of social prescribing and housing support to prevent unnecessary hospital admissions or referrals for formal social care. Following a self-funded pilot in Sheffield, the service has recently expanded into Doncaster, winning a contract and funding from Doncaster CCG and Doncaster Metropolitan Borough Council's Innovation Fund.

LiveWell at Home brings health, housing and voluntary sector services together into a single coordinated pathway. Area-based coordinators receive referrals direct from GPs, using risk assessment tools to identify patients who are likely to need acute care in future. The coordinators visit patients at home and carry out a home health check to determine whether their property meets current and future health needs. They also work with the patient themselves, to jointly design a self-care plan and help them to access support and activities provided by local community groups.

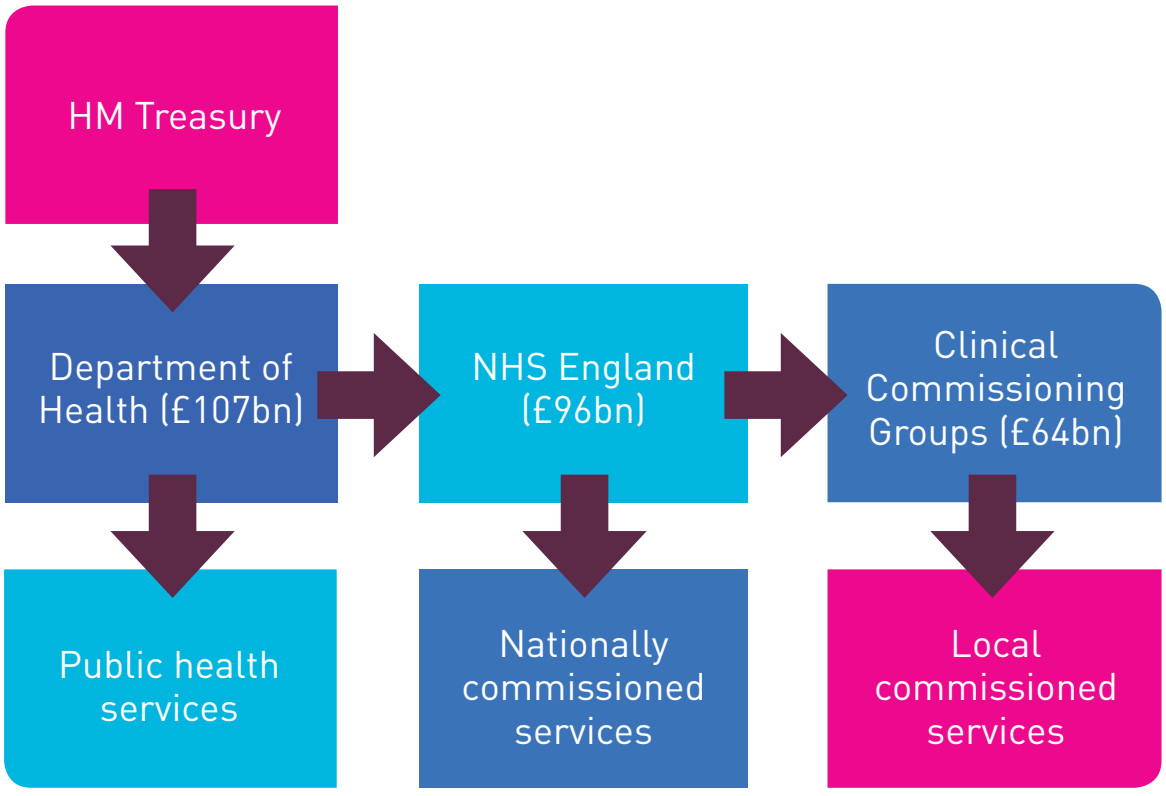
SYHA's willingness to invest in an initial pilot, working with 10 GP surgeries in North Sheffield, was vital. Through the pilot project, SYHA was able to trial and adapt LiveWell at Home based on early learning, while establishing a track record of delivery that formed the basis of the successful tender for health funding in Doncaster. SYHA's approach to partnership involved building strong relationships with local GPs and using NHS risk tools to target services and support. They also formed service delivery partnerships with third sector organisations in each area, SOAR (in Sheffield) and Doncaster CVS. This joined-up approach improves the patient's experience and maximises the impact of health investment.

How does money flow in the NHS?

To develop a business case for health service investment, housing associations need to understand how NHS providers are paid and how performance incentives work within the NHS, as they influence the motivations and priorities of healthcare commissioners and providers.

Figure 2 shows in simple terms, how money flows from central government and is distributed between the different layers of commissioning bodies within the NHS.

Figure 2 - How the money flows



Monitor, the health sector regulator in England, sets fixed prices (or 'tariffs') for the various healthcare service packages defined by NHS England. Tariffs are currently set for around 40% of all NHS services other than primary care or public health services, where local prices are usually set, rather than tariffs being used.

Mental health trusts are different because they still receive a fixed budget for the bulk of mental health services provided in a specified geographical area. In mental health, funding follows the patient and can cover the costs of any service. In theory, this makes it easier to shift money from hospital care into community services. Public health has a separate ring-fenced budget of £5.45bn for 2013/14 and 2014/15 with a further year of ring-fenced funding agreed for 2015/16.

The Coalition Government introduced the NHS Quality, Innovation, Productivity and Prevention (QIPP) initiative that aimed to make at least £20bn in efficiency savings between 2011/12 and 2014/15. CCGs have the primary responsibility for achieving these efficiency savings, but NHS Trusts are also under pressure to make savings of around 4% per year as part of the QIPP challenge. The tariff system is also intended to incentivise efficiency savings, with penalties for excess emergency admissions. For example, if acute trusts exceed a certain level of unplanned admissions, they will only receive 30% of their tariff for the excess admissions. The remaining 70% is retained by service commissioners to invest in measures to keep people out of hospital[6].

NHS England has already indicated a 5% shortfall in efficiency savings in 2013/14[7]. An analysis of NHS spending at the start of 2014 suggested that efficiency savings of more than £11.8bn had been made in the first two years of the QIPP programme. However, much of this has been through national activity such as a freeze on NHS pay and the tariff, rather than local service transformation[8]. Achieving this level of savings requires the NHS to go beyond technical efficiency savings, towards a more radical overhaul of how services are designed and delivered to move costs from the overall system.

How are providers commissioned in the NHS?

When commissioning services, CCGs must meet the needs of the people who use those services, improving on quality and efficiency. Procurement, patient choice and competition regulations require CCGs to buy services from providers who are most capable of delivering these objectives and who provide best value for money in doing so. Given the financial pressures, CCGs are putting an emphasis on reducing the use of services in high cost settings (where this is not clinically necessary) and unplanned emergency admissions, which are also expensive. This has led to an interest in preventative, integrated services delivered in the community.

Not all housing associations who are working to improve health outcomes will be providing formal health services. However, if your organisation wishes to become a provider of NHS funded services it will need to be licenced by the regulator Monitor, or sub-contracted by an organisation that is[9]. Organisations providing care services must be registered with the Care Quality Commission (CQC)[10].

One route to giving patients more choice and control over who provides their service is the Any Qualified Provider (AQP) scheme, where - once accredited for a particular service – a provider appears on a list of choices offered to a patient. Membership of AQP would include quality governance and regulatory oversight from Monitor, along with agreement to deliver the given service for a standard price according to the NHS tariff. However, local commissioners will decide which services, if any, will use the AQP framework. To date, AQP tends to be used in services where there are a limited range of standard service offers, including the provision of hearing aids and podiatry. Housing associations providing talking therapies may consider AQP if it is relevant in the geographic areas in which they work. Other than that, AQP may be less relevant to housing associations than alternative approaches, due to the kind of services they will offer the NHS.

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[6] Northern, Eastern and Western CCG, Reinvestment of Benefits from the Emergency Tariff Variations, http://newdevonccg.nhs.uk

[7-8] House of Commons Health Select Committee. Public expenditure on health and social care. Seventh report of the session 2013-2014. London: House of Commons, February 2014. www.publications/parliament.uk

[9] Government website, Independent Providers of NHS services: documents and guidance, www.gov.uk

[10] Care Quality Commission, Guidance for providers, www.cqc.org.uk

How should providers respond to this complex blend of regulators and markets? The advice, as always, is to check the regulatory requirements and ensure that your own governance systems will manage and respond to these requirements, prompting the right questions at the right time, from the start of the project planning process onwards. The Federation has published a briefing on governance that can be accessed from our health partnership hub[11].

CCGs are relatively new organisations with their own set of accountabilities and statutory duties. As such housing associations haven't always found it easy or straightforward to initiate a discussion with CCGs about how best to shape their healthcare offer as the new system beds in. However, given the huge and ongoing financial pressures, CCGs are expected to use national and local data and intelligence, and their commissioning powers, to reduce demand on acute services. This is driving CCGs' interest in investing in preventive, community-based approaches to integrated care.

The £3.8bn Better Care Fund (BCF) is also intended to help deliver more integrated services that will be managed by local authorities, with a 15% reduction in hospital emergency activities expected. However, this single pooled budget is not new money. Part of it will have to be funded by CCGs making substantial resource savings elsewhere in the NHS budget. The fund will require efficiency savings of over £2bn, implying an extra productivity gain of 2-3% across the NHS as a whole in 2015/16, reflected in the tariff. Given the existing challenge for NHS trusts in realising 4% savings a year to achieve the QIPP challenge, leaping to 6-7% will be very difficult. The King's Fund has described this as a 'financial cliff edge' as providers plan to cut emergency and other elective work in an attempt to make efficiency savings[12]. There are fears that without additional funding or rapid service re-configuration there will be serious negative impacts on care, from longer waiting lists for elective surgery and restricted access to treatments, through to NHS Trusts and CCGs becoming insolvent.

Some CCGs are trying out new approaches to contracting to support more integrated and efficient models of care. Currently the focus is on measuring and paying for activity, such as hospital admissions.

However, CCGs are beginning to explore a Payment by Results approach to contracts, focussing on outcomes achieved rather than levels of activity. This is a positive move for commissioners as it lends itself better to community-based services that are tailored to individual need. It gives providers more space and flexibility to design support services to meet real needs, instead of focussing all their attention on performance and throughput through traditional health service activities.

Year of Care Model

One project in this area is the 'Year of Care Model'[13] which is being piloted in order to better identify and meet the needs of people living with long term conditions (LTCs). There is a widespread recognition of the need for our health and care services to develop better responses for people with long-term conditions, and as part of this, to create the interventions and services to help people care for themselves more effectively in the community avoiding the need for hospital visits. The emerging Year of Care approach has involved finding ways to identify people with multiple LTCs, developing personalised care planning across formal health and non-traditional services, and the provision of supported self-management across integrated staff teams.

Creating and commissioning these services more systemically and across multiple areas, has required innovations to payment and contracting mechanisms. Challenges include the need to find ways to cost and value these kinds of patient-focused outcomes and overcome traditional barriers between services. The commissioning and contracting side of the Year of Care model requires the development of a payment mechanism to incentivise the integration of a capitated budget that reflects the health and care costs for a specific population of people with multiple long-term conditions. This has required the pilot sites to understand and test the year of care costs across health and care for particular client groups, to provide the evidence base for a capitated budget. This LTC year of care commissioning model is being tested and refined by early implementer sites with ongoing support from NHS England. The longer-term aim is to devise national prices, or a national year of care tariff, for people with long-term conditions by March 2016.

[11] National Housing Federation, Quality governance for housing associations, www.housing.org.uk/healthhub
[12] Appleby J, Galea A, Murray R, The NHS Productivity Challenge: Experience from the front line. London: King's Fund, 2014
[13] NHS Improving Quality, www.nhsiq.nhs.uk

Across a variety of service areas, there are a range of pilot projects exploring different approaches to integrated services involving different parts of the health and social care system. These pilots will often blend experimentation and innovation in commissioning and contracting, delivery models and outcome measurement, to reflect the changing health and care needs of the population.

Given the relative size of NHS contracts put out to tender and the capacity of housing associations, it seems likely that most housing associations that choose to get directly involved in competing for contracts will do so through consortia or partnerships with other providers.

Prime Provider Contracts

In a prime provider contract, the CCG contracts with one lead provider (the prime contractor). Payments under the contract are dependent on the achievement of specific outcomes rather than just levels of activity. The prime contractor is accountable for all communication with the commissioner and retains overall responsibility for delivering the service, as well as sub-contracting specific roles and responsibilities (allocating risk associated with their performance) to other providers, which might include housing associations. The prime contractor is likely to be a provider of clinical services, sub-contracting most if not all tasks other than the coordination role. This model is already in use across a range of public services and is likely to become increasingly common[14].

Capitated and Outcome-Based Contract (COBIC)

There is increasing interest in the COBIC model from health service commissioners as a mechanism for driving forward service improvement and integration. COBIC contracts have been used when services are recognised as 'failing', perhaps due to poor communication, high costs, poor standards and patient outcomes, or fragmented ways of working. A COBIC contract will usually seek to improve a whole range of services for a particular client group, for example, people experiencing problems with substance misuse. The commissioner will talk to local people using services, as well as carers, clinicians, patient interest groups and service providers, to identify the most important outcomes. The COBIC contract will be designed to ensure cost effective and joined up approaches are taken to care, producing better outcomes for people using services. COBIC contracting models may therefore involve one or more service providers, including community organisations like housing associations. It is recognised that transformational change may not happen overnight, so contracts are typically five to seven years in length, to encourage providers to deliver better outcomes and efficiency savings over time. Service providers receive a fixed sum per head for the population group included in the contract, plus additional bonus payments linked to improved outcomes.

A key difference, between a COBIC and a conventional prime provider contract is that the level of outcomes-based incentives for the providers involved can be much greater. There are currently limited COBIC contracts in place, but they are attracting growing interest and support[15]. This approach has already been successfully used to transform substance misuse services in Milton Keynes that partly aimed to keep service users in their own homes and in employment. This led to services becoming less hospital based, with a 15% to 20% drop in costs to commissioners in the first year of operation[16].

Alliance contracting

An alliance contract is between the CCG or local authority commissioner and an alliance of parties who directly provide the project or service, similar to the COBIC model. All service providers within the alliance share the risks and rewards of the contract, with payment linked to an agreed set of overall performance indicators that are outcomes-based rather than tied to the activity of any one service provider. The commissioner works with the providers as part of a single integrated team for a specific project defined within the contract. This form of contract incentivises multiple service providers to work collaboratively rather than compete with each other[17]. This approach is very new in health and social care services, although recently some tenders for alliance contracts have been published in the UK, including for integrated care pathways for community based elective care patients[18].

[14] Health Services Journal, 'Prime contractors' could run pathways for decade', 20 November, 2012
[15] COBIC, www.cobic.co.uk
[16] Corrigan P, Hicks N. What organisation is necessary for NHS commissioners to develop health outcomes based contracts for integrated care? NHS RightCare, 2012. www.rightcare.nhs.uk
[17] McGough R, Dunbar-Rees R. Team-effort: commissioning through alliance contracts. Health Service Journal 2013 22 November.
[18] Private consultancy firm lh alliance have produced a useful question and answer guide to alliance contracts on their website, http://lhalliances.org.uk

Opportunities for housing associations

There are a variety of potential opportunities for housing associations to develop partnerships with health.

Firstly, housing associations can deliver services through a direct contract with a CCG, ranging from small grants for limited activity to larger contracts to deliver a whole service (see case studies from Second Step and Gentoo on page 15 and 22). Housing associations can also be subcontracted by an NHS Trust to help to deliver a contract. For example, they might provide community-based crisis services as part of a wider mental health contract.

Secondly, housing associations can work directly with NHS providers to redesign services to optimise capacity and provide care closer to home. They have a range of services to offer, including floating support, life skilling and specialist housing, to support people to live at home.

There are also opportunities for housing associations to enter into a joint venture with an NHS trust to develop affordable housing on their land, providing both partners with a revenue stream.

Finding the right approach for your organisation to make an offer to the NHS depends a lot on your organisation's own ambitions around health and wellbeing. It also depends on the particular expertise, competencies and skills you have across housing, support and care. The precise contracting or payment mechanisms that will enable your organisation to maximise its value to health will vary between service areas and will be heavily influenced by your organisation's scale, financial capacity and appetite for risk.

Tendering and sub-contracting

CCG funding mechanisms vary enormously in scale, ranging from smaller grants for pilot projects to formal contracts for a required service, or even for a whole care pathway. Larger contracts might cover a mixture of hospital and community-based services delivered by several service providers to a specific population group, such as people who have experienced a stroke. While there are clear opportunities for housing associations to bid for smaller grants and innovation funding, the opportunities to bid independently for major health service contracts will depend on the type of contract and the size and capacity of the housing association. In most cases, opportunities will involve housing associations joining a consortium with traditional healthcare providers, to offer services outside of hospital. Potential non-NHS providers, including housing associations, will need to convince CCGs that they can improve the overall quality and outcomes of a service in a financial climate where CCGs need to reduce their overall levels of expenditure. In some cases, housing associations may be able to take a lead in the bidding process (see the case study from Second Step on page 15).

As well as bidding for a CCG contract, housing associations could be sub-contracted by NHS trusts or independent providers that are awarded contracts by CCGs. This will depend on the nature of the contract and tendering processes. CCG contracts may already cover and fund the role of other service providers on the care pathway, while others, including the prime contractor model, allow greater scope for lead providers (often trusts) to sub-contract with organisations like housing associations.

There are also opportunities to deliver public health services for local authorities. For instance, some housing associations have contracts from local authorities related to the prevention and mitigation of substance misuse. There are newly emerging contract models for this type of service, including Payment by Results and COBIC.

Case study: Working in consortia – Second Step Housing Association

Second Step has developed an innovative partnership to provide mental health services in Bristol. The partnership combines the strengths of the Voluntary and Community Sector (VCS) with excellent clinical care. Initially they drew together a number of Bristol's community organisations to provide a broad range of skills and bring added value to the partnership. An assessment of NHS mental health trusts was carried out to identify an innovative partner that could sign up to a true partnership with the VCS. They became Mental Health Bristol, bringing Avon and Wiltshire Mental Health Partnership NHS Trust together with Second Step, Missing Link and seven other voluntary sector organisations.

When Bristol Clinical Commissioning Group tendered for the delivery of mental health services, Mental Health Bristol was successful in winning two substantial elements - an annual £20m contract. As system leader, Mental Health Bristol will oversee an innovative new mental health model bringing together a broad range of integrated services from 18 organisations, all with specialist expertise and experience. There is a wholesale change in service delivery, including a shift from inpatient care to community-based rehabilitation services.

Care pathway redesign

Few contracts have been agreed by CCGs which focus on improving quality and outcomes through integrating the way in which services are delivered. This is in part because the bidding process can be complex and time-consuming. It may therefore be more fruitful for housing associations to work directly with a trust to redesign care pathways, particularly if the trust already has capacity to provide community services such as reablement services or community mental health services.

Housing can play a vital role in delivering more effective care pathways, particularly when looking at out-of-area treatments, the use of residential care, and tackling delayed discharge. For example, a housing association could partner with a trust to improve the recovery pathway for people with acute mental health needs, or work with an acute trust to improve hospital discharge for people with dementia. The opportunity here would be to improve outcomes for patients and clients by using housing expertise to bring in community based support throughout the whole pathway of care. This might include peer support services for people with mental health problems, specialist housing with integrated care for people with dementia, or step-down facilities from specialist psychiatric inpatient services.

NHS trusts may establish a partnership to redesign a service. The trust will then issue an external tender for the service or, alternatively, directly sub-contract with other providers for specific types of services that help them achieve the outcomes set for them in their contracts with CCGs (as mentioned above).

In another approach, trusts could work with commissioners and housing associations to co-produce a whole pathway approach or design a more efficient pathway intervention, agreeing local outcomes. The CCG would then tender for the redesigned pathway or services. Housing associations that are interested in redesigning care pathways to include a stronger housing element, will need to develop a shared approach to quality and risk, as well as mechanisms for safe and effective transfers of care and support between providers if they are to assure themselves, and the wider public, that they are safe and capable of delivering the required results[19]. As described in the following case study, housing associations that have gone through this process have found it useful.

Case Study: Innovative solutions to hospital discharge – Midland Heart

Housing and care provider Midland Heart developed an innovative partnership with the Heart of England NHS Foundation Trust and Good Hope Hospital, to open a new reablement service called 'Cedarwood' that supports a return to independence for people leaving hospital. They redeveloped an existing ward at the Sutton Coldfield hospital to provide a purpose-built, 29-bed reablement facility. Cedarwood is not a medical facility, however, it provides specialist care to help people regain full independence or to allow them to return home with a package of care. Ensuring that the right care is in place once people return home is crucial, and a social worker is assigned to the unit to ensure this is a seamless process.

The service aims to free up hospital beds that would otherwise have been occupied by patients who were not quite ready to go home on their own. The service was developed as a response to the foundation trust's need to deliver services more efficiently by reducing a patient's length of stay in the acute hospital. The service was tendered by the foundation trust, which funds both the revenue costs and the initial capital costs for redesigning the ward.

[19] National Housing Federation, Quality governance for housing associations, www.housing.org.uk/health hub

Joint ventures

In a joint venture, housing associations can develop partnerships to build affordable housing on NHS land. There are two advantages for housing associations here: firstly they are able to build on land, which is often in good locations; secondly they can secure land at a lower cost, sharing a return on the land with the trust. If a trust simply disposes of NHS land, the housing association would have to compete for the land in an open market, making affordable and social development less viable.

There are different options for the role of land in a joint venture. For example, a housing association could simply enter into an agreement with a trust where NHS land is leased to them instead of purchased outright. Alternatively, the NHS can contribute their land in exchange for an equity stake in the partnership. The trust could then receive a share of the returns as an ongoing independent revenue stream and/or as a deferred payment for the land. Trusts are likely to get a higher return through this approach as they will take a share in uplift in value as a result of the development of the land. This may be attractive to some hospital trusts as it can help strengthen their balance sheets, which helps hospital trusts meet financial security requirements set out by Monitor. It is important for housing associations to openly discuss budgets and cost sharing with the trust, in order to put together a detailed joint venture shareholders' agreement with protections for both the trust and the housing association.

Housing associations can also use a joint venture to work in partnership with a trust, both to provide an independent revenue stream and to improve health outcomes. By delivering supported housing on NHS land, with integrated health, care and support provision, housing associations can manage health needs in a community setting, allowing trusts to focus on clinical care. NHS Trusts are starting to recognise that they can invest the land in a joint venture to benefit from a developer's return, while attracting the necessary finance and providing the accommodation required to deliver health services in a local area. This also helps trusts with care pathway redesign and in meeting targets from their cost improvement programmes.

The National Housing Federation has produced a briefing on the creative use of NHS estate[20], which provides more information on the disposal process and options for using NHS land.

Case Study: Unblocking care pathways - One Housing Group

One Housing Group forged a joint venture with the Camden and Islington NHS Foundation Trust and the London Borough of Camden to create Tile House in the King's Cross redevelopment. Both clinical and support staff provide a service to 15 people with complex mental health needs, who may otherwise be in hospital wards or expensive out-of-borough placements. One Housing Group estimates this approach could make over £1bn in efficiency savings for the NHS each year.

Through the partnership, they created a Care Support Plus service, bringing together housing with health, care and support, and developing supported housing with a recovery-focussed support ethos. One Housing Group has combined its existing support services (life skills, tenancy sustainment and medication management), with an enhanced support model which includes services such as Cognitive Behavioural Therapy (CBT), occupational therapy and clinical psychology. The Foundation Trust then provides the Care Programme Approaches (CPA), psychiatric consultancy and care coordination. The resulting hybrid service combines both NHS and housing support within a purpose-built and secure scheme, yet one that is far from a clinical setting and more of a home. NHS staff such as care coordinators, occupational therapists, psychologists and psychiatrists work alongside on-site support staff. A shared approach to risk-taking, governance, protocols and policies means they can manage incidents quickly and carry out medication reviews and CPA on site.

[20] National Housing Federation, Creative use of NHS estate, www.housing.org.uk/healthhub

Chapter 2

How to think more like health

Evidence, effectiveness and outcomes

There is a familiar concern that health commissioners 'speak a different language' to our sector and it is essential that we overcome this barrier if we are to effectively make an economic case to health. It is therefore important to understand the types of evidence and outcome measures that health commissioners will look for when evaluating business proposals and in making investment decisions.

Key points:

- A significant challenge for housing associations is that housing research differs in methodology and scale to health service research. To develop more robust business proposals for health service investment, housing associations need to learn how to 'think more like health'.
- There is a hierarchy of evidence in health, with preference given to peer-reviewed evidence and randomised control trials. Health commissioners are rarely convinced by single site case studies or interventions involving one service provider.
- Health commissioners will be looking for robust and convincing evidence that a service development proposal will deliver in three core domains: *outcomes*, that is; 'what's changed?', *impact* - the 'so what?' question, and *cost-effectiveness* – in financial terms, is it worth the investment and will it release resources for investment elsewhere?
- In the context of ever-present budget constraints, evidence on quality alone will always be insufficient for commissioners. They rely on economic evaluation to determine whether or not it is worth investing in a housing association service rather than looking elsewhere.

The importance of evidence in health decision-making

Health commissioners draw on a wide range of evidence to decide on and prioritise spending. This is sometimes referred to as a 'what works' approach, and is used to justify investment in particular health interventions. Clinicians and commissioners will also want to know 'why' and 'for whom' to ensure interventions are targeted effectively.

One significant challenge for housing associations is that housing research differs in methodology and scale to health research. Unlike health and social care, there is currently no single source of 'best practice' guidance on the value of housing interventions in health. Nor is there a central database of existing research. Most housing evaluations consist of small scale studies or descriptions of single site interventions. Housing evaluation reports are usually commissioned from an external consultant working on behalf of the service provider, and they often rely on descriptive case studies and qualitative data.

From a health commissioner's perspective, a perceived weakness in this type of research is that it seldom includes robust analysis of health economic impact and, in contrast to health service research, is rarely subject to independent and critical peer review. Therefore, in order to attract health investment, housing associations need to 'think more like health' in the way that they present their case and measure outcomes and impact, which starts with understanding what evidence means in health commissioning terms.

The hierarchy of health evidence

Health commissioners attach different value or weight to particular types of evidence when deciding whether to introduce or commission different approaches to health services. This is sometimes described as a 'hierarchy of evidence', with preference given to peer-reviewed evidence that has been generated through robust scientific methods and published in medical journals. The hierarchy of evidence looks like this:

Figure 1 - The hierarchy of evidence

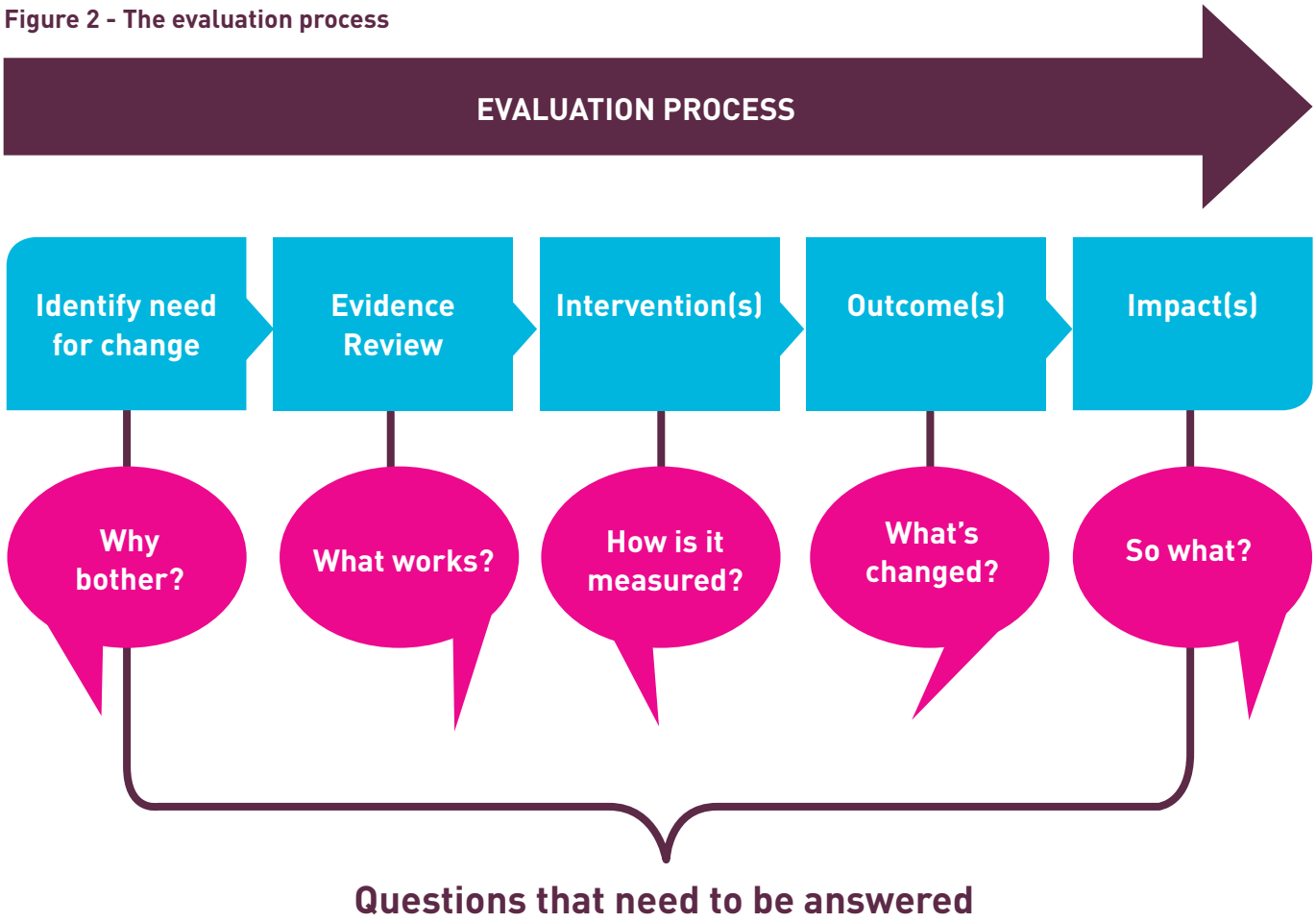
Systematic reviews are at the top of the evidence hierarchy or preference list. They are simply articles or reports that bring together all of the relevant published studies on a single topic or type of intervention. They are then summarised, appraised for their quality and scrutinised for their reporting of results, health impact and cost-effectiveness.

While health commissioners place added value on the principles of systematic reviews and Randomised Control Trials (RCTs), this doesn't mean they only regard RCTs as robust evidence. Commissioners require evidence that demonstrates both the impact and value of an intervention, so if housing associations can use this type of data to boost their business case, they will have a stronger case for external investment. You can also be reassured that your organisation's proposals for service innovations are based on valid evidence of what works.

Measuring 'what works:' the evaluation process

In order to fund new approaches to care, or to move health services into the community, health commissioners will need convincing evidence that the service will efficiently achieve results. They will also want to determine whether it will free up resources for investment elsewhere. Health commissioners will be looking for robust evidence of what the intervention will achieve across three core domains: *outcomes* – that is; what's changed?, *impact* – what difference will it make? and *cost-effectiveness* – in financial terms, is it worth the investment? These questions form part of the evaluation process (see figure 2 below) that should begin as soon as the need for any new health-related service is recognised, regardless of the type or scale of the intervention.

Figure 2 - The evaluation process



Housing associations should be reassured that this form of evaluation will look a lot like their existing business planning models. However, while the terms 'outcomes', 'impact' and 'cost effectiveness' are familiar to housing associations, they may mean slightly different things to health commissioners, and these differences are reflected in the methods that are used to demonstrate them. There are three points to bear in mind:

- The most important economic question for health commissioners is whether or not it is worth investing in a particular service, compared with other possible ways that commissioners could spend their health budgets.
- When assessing the business case, they will consider the quality and reliability of any data presented as well as the quantity. They will also consider the likely difference that the outcomes will make against their own performance frameworks.
- Most health commissioners will only be interested in costs to the health sector. However, joint commissioners of health and social care services will be interested in cost impacts to both areas. Housing associations should bear this in mind when designing integrated service models.

Inevitably, this approach will require housing associations to develop new relationships with health and invest time and resource into their evaluation processes. While it is important to take a proportionate approach to evaluation, it is also important to get it right first time to sustain a particular service or be successful in presenting a business case. The main outcomes frameworks used in the health sector are described below to help housing associations design robust approaches to evaluation.

Quality Adjusted Life Years (QALYs)

One of the most influential outcome measures used by healthcare decision makers in England is the Quality Adjusted Life Year (QALY). This is used in a type of economic evaluation known as cost-utility analysis which is discussed later in this chapter. However, being able to devise QALY calculations requires a degree of health economic expertise. Most housing associations are unlikely to need to collect this information themselves. They may however, make use of existing published QALY data when making a case for investment for a service. It is also worth knowing how QALYs are used in systematic reviews and in the commissioning guidance that is published by the National Institute for Health and Care Excellence (NICE) as both of these are influential in shaping commissioning decisions at local level.

A year spent in perfect health is considered to be 1 QALY. The number of QALYs associated with different health investment decisions can be estimated – for instance whether there are more QALYs gained by an individual who receives a heart transplant compared to someone who receives a hip replacement. The cost per QALY gained is the preferred method of economic evaluation in the health sector.

QALYs can be estimated in many different ways using different instruments, and all involve asking members of the public to give their opinion on the quality of life associated with different health problems. One of the most well-known approaches is the EuroQOL, or European Quality of Life Scale (also known as the EQ-5D). Individuals using this are asked to rate different health states on a scale from zero to one, where zero indicates the worst possible health condition while one indicates perfect health. These quality scores are then combined with life expectancy to estimate a QALY. For instance, if someone lived in a health state which was rated as being equivalent to 80% of full health and life expectancy was five years then an individual could expect to have 4 QALYs (0.8 x 5 = 4).

NHS commissioners will consider QALYs gained when they compare different interventions across health and other sectors. In simple terms, if a new intervention is both less costly and more effective than existing treatments or health services then it is more likely be commissioned. However, if it is more effective but more costly, then a value judgement (from both a socio-economic and a moral perspective) must be made as to whether any proposed treatment or service intervention justifies the investment.

As a general guide, in England, NICE recommends that health interventions should be funded when they achieve one extra QALY at a cost of no more than £20,000 to £30,000. Therefore, a proposed housing programme to improve health at £28,000 per QALY would fall within the accepted value-for-money parameters. This is still no automatic guarantee that it would be funded. However, demonstrating value for money in this way might increase competitive advantage when tendering for services, as long as the association is confident in the reliability of this claim. The case study below shows how two housing associations are working with health economists from a university to estimate the QALYs gained from their energy efficiency programme.

Case Study: Boilers on Prescription – Gentoo Living

Boilers on Prescription is a cross-tenure service funded by a Sunderland CCG innovation grant, which improves people's homes with new boilers, double glazing, and other environmental measures such as external insulation. People are referred to the service by their GP based on medical need.

Gentoo, in partnership with Nottingham City Homes and Bangor University, are undertaking a study to establish to what extent warm homes improve health outcomes, using the QALY measure to determine the effectiveness of the intervention.

As part of their investment plans, customers are being asked about their health and quality of life before and after the improvements have been undertaken. The study will capture the benefits to two communities in the North East and Midlands, regardless of health, age or gender. The study will investigate how retrofitting a home can impact on a recognised indicator of the quality of life of the customer and support further expansion of the service.

Durham Dales, Easington and Sedgefield CCG has already committed to further funding the project to encompass their local residents based on the robust evaluation being carried out. The results of the first six months of this trial will be made available around mid-September.

Better Care Fund metrics

The Better Care Fund, provides a single pooled budget to incentivise health and social care commissioners to work more closely in local areas. There are five key measures that local authorities must include and monitor in their plans for using this fund to commission integrated care:

- a reduction in admissions to residential and care homes
- the demonstrable effectiveness of reablement services
- a reduction in delayed transfers of care
- a decrease in avoidable emergency admissions
- improved patient/service user experience.

These measures help to shape the allocation of the £1bn fund that is related to performance against outcomes. There is scope to use locally developed measures too. Housing associations need to take account of both national metrics and locally determined outcome measures when developing their proposals for integrated service investment. It is important to demonstrate how service proposals will help Better Care Fund managers reach their priority targets of reducing hospital admissions and achieving positive outcomes and efficiencies through service integration. Further information on making best use of the Better Care Fund is available from the Kings Fund website and this may be helpful to associations in building their case for investment[21]. NHS England has also issued guidance to CCGs and local authorities on how they should use the fund and monitor outcomes[22].

Measuring wellbeing

Wellbeing measures that focus solely on positive wellbeing rather than on wellbeing as one element of quality of life are still rarely used in health economics. This may change as evaluation tools become more sophisticated and there is stronger evidence available about the wider health and social care benefits of better wellbeing. Housing associations may wish to use wellbeing measures when planning the evaluation of new projects with health partners. If housing associations can demonstrate that costs are reduced it is likely to have more impact with health commissioners than simply demonstrating an improvement in wellbeing. The Office for National Statistics is developing a national definition and tool for measuring wellbeing[23].

One tool that has been validated in health service research in England, Scotland and Iceland, and is currently being used by several housing associations, is the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). It consists of 14 positive statements which respondents use to rate their mental wellbeing (see appendix 1). This tool is free to use.

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[21] The Kings Fund, Making best use of the Better Care Fund, www.kingsfund.org.uk
[22] NHS England, Better Care Fund planning, www.england.nhs.uk
[23] Office for National Statistics, Measuring national wellbeing, www.ons.gov.uk

Case Study:
Tackling the social determinants of health – Regenda

Regenda have set themselves the ambitious target of improving the health and wellbeing of their staff and 1,000 customers across the North West of England. In their health and wellbeing strategy, they aim to tackle the social determinants of health, focussing on early intervention and prevention, personalised support and community development. Their approach includes: remodelling sheltered housing; investment in extra-care; independent living and community dementia support; investing in training, employment and youth projects, as well as tenancy support, digital inclusion and environmental improvement initiatives. They have also invested in training and support for a network of community wellbeing champions. The strategy is underpinned by a wellbeing theory of change that can capture multiple impacts across a range of interventions – a so-called 'multiple results chain model' of evaluation.

Recognising the importance of measuring impact and the return on investment for their board members and potential partners, they have adopted the WEBWBS scale as a 'before and after' evaluation tool across a diverse range of interventions. They will use self-administered questionnaires to generate this data. To support this they have developed a comprehensive toolkit and training programme for staff and volunteers and a centralised system for collecting the results of the WEMWBS evaluations across all of the different projects. The quantitative and statistical analysis will be complemented by qualitative research and case studies and they will use a range of visual methods to present their findings to key stakeholders.

Another wellbeing measure is the ICECAP approach. This measures wellbeing broadly and has been designed for use in economic evaluation[24]. There are several versions of ICECAP for different target groups including older people, carers and adults of working age. The evaluation tool for older people has five attributes of wellbeing: attachment (love and friendship), security (thinking about the future without concern), role (doing things that make you feel valued), enjoyment & pleasure, and control (including independence)[25]. The ICECAP tool has already been used as part of a major economic evaluation of tele-health devices in the homes of people with long term conditions[26]. It is also being used to measure outcomes in a number of trials and evaluations, predominantly in social care and public health.

Personal care related quality of life

Although our main focus is on health outcome measures, there is an important new measure of personal care related quality of life that will be of relevance to housing associations - ASCOT – the Adult Social Care Outcomes Toolkit[27]. Appendix 2 gives an overview of the areas of quality of life that it measures. All of these are rated against four levels of need: ideal state – all an individual's wishes and preferences are accounted for, no needs, some needs and high level of need[28]. A short questionnaire is used to collect data from service users[29]. It has already been used to assess the impact of extra care housing as an additional measure alongside QALYs[30]. The ASCOT toolkit may be particularly useful when looking at interventions that are part of an integrated health and social care service. The tool can be used freely with permission for non-commercial purposes.

Having briefly described some of the main health outcome and impact monitoring tools, the final section provides a basic overview of the approaches that are used to measure cost-effectiveness. Understanding these approaches will help housing associations demonstrate the economic value of a particular service.

How to demonstrate economic value

Economic evaluation is all about finding ways to make the best use of available resources. Health commissioners are likely to include some of the following questions in their deliberations:

- Will the service narrow the gaps in health inequalities and/or promote more equitable distribution of resources among people with different socio-economic status?
- What is the overall cost of the service and what is the overall benefit? For example: two interventions could have identical costs per QALY, but one could cost £100 and the other £10,000 to implement.
- Will the proposed service bring new resources to offset costs to the health service budget? The move towards pooled budgets and service integration brings new opportunities for housing associations to demonstrate how housing assets and investment can help achieve better health outcomes in cost effective ways.

Housing associations need to understand the true meaning of economic evaluation when constructing their business case. If something is cost effective, this does not necessarily mean that it will save money. It could achieve better quality outcomes for the same cost as an existing service.

An evaluation framework that uses the right type of economic evidence is crucial, bringing together cost information with outcome evaluation to demonstrate cost effectiveness.

[24] University of Birmingham, ICECAP capability measures, www.birmingham.ac.uk
[25] Coast J, Flynn T, Natarajan L, Sproston K, Lewis J, Louviere J et al. Valuing the ICECAP capability index for older people. Social Science and Medicine 2008; 67(5):874-882.
[26] Henderson C, Knapp M, Fernández JL, Beecham J, Hirani SP, Cartwright M, Rixon L, Beynon M, Rogers A, Bower P, Doll H, Fitzpatrick R, Steventon A, Bardsley M, Hendy J, Newman SP, for the Whole System Demonstrator evaluation team (2013). Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. The BMJ, Research, www.bmj.com
[27] Personal Social Services Research Unit, ASCOT, www.pssru.ac.uk/ascot
[28] Netten A, Burge P, Malley J, Potoglou D, Towers AM, Frazier J, Flynn T, Forder J, Wall B. Outcomes of social care for adults: developing a preference-weighted measure, Health Technology Assessment 2012; Vol. 16: No. 16
[29] Personal Social Services Research Unit, ASCOT questionnaire, www.pssru.ac.uk/ascot
[30] Glendinning C, Jones K, Baxter K, Rabiee P, Curtis L, Wilde A, Arksey H, Forder J. Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study). Social Policy Research Unit, University of York, 2010.

Key health economic techniques

All economic evaluations measure and treat costs in the same way, but they differ in the way that they measure outcomes. Cost effectiveness analysis, cost consequences analysis and cost utility analysis are the most common approaches used in health economics.

Cost effectiveness analysis

This focuses on a single outcome such as a change in symptoms or health status and then compares the difference in costs between two interventions to measure which has the greatest impact. If one intervention is both more effective and less costly, then it would clearly be seen as the more cost-effective of the two. But, if it's more effective and more costly, a trade-off has to be made.

Cost consequences analysis

An alternative to focussing on just one outcome measure would be to analyse cost differences and look at a range of outcomes, which is called cost-consequences analysis (CCA). This approach has the advantage of breadth, and can highlight not only a change in the need for hospital care, but many different health outcomes, as well as other impacts such as better social functioning. Some of these markers of success may be achieved earlier than the desired change in hospital use and can add important dimensions to studies. It does pose a challenge if one outcome is better and another worse for a particular intervention compared to an alternative. However, the evaluation can stress which intervention is to be preferred from the outset.

Cost utility analysis

A significant limitation of cost-effectiveness analysis is that the outcome measures used often vary depending on the health problem being addressed, meaning that the results of the interventions are only comparable within the same category of disease or health condition. A series of multiple outcomes, separately reported, as in cost consequences analysis, can also make interpretation of study findings quite difficult. One way to overcome this is to use a single outcome measure, quality of life, which can be used for all health issues. An economic evaluation which measures outcomes in QALYs is known as a cost-utility analysis.

Case study: The cost effectiveness of reablement services

Work funded by the Department of Health compared the experiences of 654 people in five local authorities who received home care reablement services with 361 people in five different local authorities who received routine home care services only[31]. Both groups were monitored for one year. Reablement was associated with small, but significantly improved levels of health and social care related quality of life compared to conventional care. Quality of life was measured using the EQ-5D and ASCOT tools. There was no significant difference in costs between the two groups. It was concluded that the service would almost certainly be cost effective because of the better outcomes achieved with no change in costs.

[31] Glendinning C, Jones K, Baxter K, Rabiee P, Curtis L, Wilde A, Arksey H, Forder J. Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study). Social Policy Research Unit, University of York, 2010.

Chapter 3

How to use the evidence

Using health economics to build a case for investment

This final chapter provides practical information on the different ways that housing associations can build a case for health investment, either acting alone or as part of a consortium or service delivery partnership. Case study examples are used to show how different associations are using robust evidence to make a convincing business offer to health.

Key points:

- In making an offer to health, housing associations need to recognise the pressures on different parts of the NHS and the need to reduce hospital admissions and improve health outcomes in cost effective ways.
- Health service commissioners expect a business case that identifies the need for change and demonstrates the outcomes and cost-effectiveness of an intervention.
- Housing associations need evidence of 'what works' to develop their case for change. Findings from previous studies should be used, where available, to show which interventions are most effective.
- Service evaluations should use validated tools and robust methods to measure the outcomes and the impact of a service. In presenting your business case it is important to be realistic and not overstate these. Improvements limited to individual health and overall costs savings to the NHS may be significant but relatively modest.
- The business case should answer two questions: 'Does it work?' and 'Is it worth it?' To answer these questions effectively, housing associations will need to look at both the direct and indirect costs of the service. Where evidence is hard to find, housing associations can use existing evidence from the UK or international studies to demonstrate the impact of a particular intervention.

Identifying the need for change

Health commissioners will expect housing associations to develop a business case, which identifies the need for change and demonstrates the effectiveness of a particular intervention. Therefore, identifying evidence that supports this and acknowledging any gaps in the evidence base for your project should form a part of your service planning and business case development. This should include, for instance, clear, agreed meanings and descriptions of the specific outcomes and objectives that a service is trying to achieve[32].

It may be impossible to do this rigorously from a standing start and promising ideas may need to be tested or developed through piloting and learning as you go. However, ultimately if you cannot define the service goals clearly then it will be difficult to demonstrate and evaluate progress to convince external commissioners and potential partners. This will undermine your chance of securing sustainable investment. A poorly designed evaluation makes it difficult to scale up promising ideas and transfer learning and good practice. These are important considerations for health commissioners when funding pilot projects.

Housing associations need to be clear whether their objective is to redesign healthcare services with a CCG, improve integration between services jointly commissioned by health and social care, work with public health to tackle health inequalities by focussing on the social determinants of health, or develop a service delivery or land-use partnership with an NHS provider.

Whatever the objectives, the business case needs to show an awareness of the pressures and priorities influencing health commissioners. They have two overriding concerns: first, to improve health outcomes through high quality and personalised healthcare and second, to make health services more cost-effective. For a CCG, the most pressing financial concern is to make efficiency savings as part of the QIPP challenge in order to sustain budgets, and in a significant minority of cases, to reduce their overall budget deficit.

When shaping an offer to an NHS provider, housing associations should present a clear offer that is based on robust evidence that can support a trust to deliver services more effectively and maximise their revenue. An NHS trust will want to see greater efficiencies in the delivery of care to ensure they maintain a steady flow of patients and, for some, maintain a strong presence in their local area as they attempt to assert more control over the types of patients they see arrive in hospital.

Demonstrating what works

In order to demonstrate the cost effectiveness of an intervention, housing associations need to find or be prepared to generate evidence on 'what works'. As mentioned earlier, health commissioners will usually have more confidence in evidence from systematic reviews of randomised control trials (RCTs) and longitudinal studies than they will in other sources of evidence. However, gathering this information is costly and time-consuming. Housing associations may lack the time or resources to undertake this type of research or to source and translate technical findings into practice. It is important to note, that it is not a compulsory requirement. There are other ways of developing evidence-based proposals for health.

Accessing existing reviews of evidence

Where possible, housing associations should make use of findings from previously published studies to show which interventions are known to be the most effective. In an ideal situation, this evidence will be drawn from a systematic and independent review of the findings from a range of different studies. Adopting this type of evidence-based approach helps health commissioners to be more confident that the benefits from a small-scale study can be replicated in different geographical locations. They will also want to be reassured that reported outcomes for small groups of individuals can be scaled up to benefit larger population groups in different healthcare settings. Appendix 3 reviews some of the existing economic literature on housing and health and demonstrates the robustness of these studies.

[32] University of York, Demonstrating the Effectiveness of Housing Support Services for people with Mental Health Problems, www.york.ac.uk

Obtaining evidence

There are renowned centres of clinical and research excellence which conduct reviews of established evidence on a wide range of topics to support decision making in healthcare. Increasingly, their work is complemented by robust financial assessments by specialist health economists and this is used to inform the type of commissioning guidance issued by NICE. With no central database for finding evidence on housing and health, housing associations may have to be more creative in finding relevant reviews from other sources. Appendix 4 provides a list of useful sources of evidence, as well as details of training that is available to help with information retrieval.

Translating research into practice

It is recognised that obtaining the information to bridge the gap between research and practice is of little use if housing associations lack the resources to make practical sense of the findings. However, help and advice to do this is available from local Public Health Knowledge and Intelligence Teams (or KITS) who can be contacted via local Public Health Centres. Some housing associations have had help with research design and evaluation, including gaining access to literature reviews, via direct contact with applied research institutes at local universities.

Addressing any evidence gaps

In many cases there will be limited evidence for housing associations to present a robust case to health service commissioners. There are a number of ways in which associations can address gaps in evidence to demonstrate the effectiveness of different housing interventions.

Pilot evaluation

A housing association could present a case for investment in a pilot project, in which evaluation is a critical part of the project proposal. Help may be available through local NHS Innovation Forums that provide advice, practical help (and sometimes grant funding) to small and medium enterprises to bring innovations to the wider NHS market. Any business proposal for a new service will have greater credibility if it either builds on an established body of evidence of what works, or alternatively, helps to address a known knowledge gap through innovation and evaluation of promising practice from frontline experience.

Where housing associations are proposing to evaluate promising practice or test an innovative approach delivering integrated services, they need to take a robust approach to evaluation from the start. Ensuring that potential service funders and key stakeholders (including experienced academic researchers and information specialists) are involved in a project steering or reference group will help ensure their buy-in to a new proposal. This might also attract additional independent expertise and resources to fund and carry out the evaluation. The case study on page 30 shows how Horton Housing Association achieved this for a new intermediate care service linking housing, social care and health for homeless people in Bradford.

Again, it is important to carefully consider the best models for evaluation. A light touch evaluation might make sense for the initial phase of a pilot, moving to a more comprehensive evaluation if enough progress has been made. The evaluation should be designed around the outcomes it is intended to test and focused on proper recording of service activity. The housing association will need to use existing evidence to establish comparative outcome indicators and costs. If an evaluation can show that a service delivers benefits to the people using it, it is important to be clear about what it does and what it costs - both in overall terms and on a per-capita (typical cost per service user) basis.

Case Study:
Bradford Respite and Intermediate Care Support Services (BRICCS) - Horton Housing Association

Horton Housing Association opened its 14-bed respite and intermediate care facility in Bradford in December 2013. The BRICCS project is part of a network of linked services to provide specialist healthcare and support for people who are homeless or are living in unsuitable, insecure or dangerous accommodation. Horton Housing Association work closely with Bevan Healthcare - a primary care social enterprise, and local health providers, including the CCG and Bradford Public Health.

The BRICCS project was funded through the Department of Health's 2013 Homeless Hospital Discharge Fund which paid for a major part of the purchase and refurbishment of the building with a further contribution from Horton Housing Association. However, the initial revenue grant only provided three month's revenue funding, leaving Horton Housing Association the challenge of finding multi-agency support and a sustainable future revenue funding stream. An early decision was taken with project partners to pool available research and evaluation funding to pay for an independent external health economic assessment of the project's impact. Independent consultancy, York Health Economics Consortium (YHEC) was commissioned to carry this out.

To evaluate early impact, YHEC completed a rapid review of published research on similar interventions, sourcing the equivalent information on outcomes and costs to allow a comparison. They then analysed the first 16 referrals to the project in the first three months of operation to look at reasons for referral, details of the care and support provided, and the outcomes and impact. YHEC's interim evaluation report provided detailed, but anonymous, case studies following five clients. Using Department of Health reference costs for 2012-13 the report outlined the likely costs to the NHS, had the BRICCS project not been in place. The early findings have shown that the project has been successful in reducing acute hospital stays for people with complex needs, facilitating early discharge and also ensuring that people are connected to appropriate support services. The ongoing evaluation will provide more detailed data on the impacts of the service, for example, monitoring rates of hospital re-admission and the outcomes for individual service users. The researchers will also provide further assessment of the cost savings and potential impact to the NHS.

The positive early findings and quality of the quantitative health economic data convinced Bradford City CCG and Bradford Public Health to provide revenue funding for a further year. In addition, Horton Housing Association has been contacted by a neighbouring CCG to discuss service expansion.

Longitudinal studies

The need for robust studies on the effectiveness of a housing service and its contribution towards health priorities would be met through longitudinal evaluations that look at impact over a significant period of time. Demonstrating significant changes will usually not happen quickly. Size and time matter, as it takes both time and resources to set up the service and develop the evaluation framework. One way of achieving this is through a randomised control trial (RCT), which draws together two properly matched samples (one of which receives the service being evaluated while the other does not, although they usually receive alternative services) and then compares changes in outcomes and costs over a specified period. An RCT would most likely happen if a housing association were to be successful in applying for a research grant in partnership with an academic institution. It is worth housing associations exploring how they can work with academics to bid for research funds and further develop a robust evidence base on the health impact of housing interventions.

RCTs can be costly and time consuming and many other approaches to evaluation are cheaper and easier to organise, such as using comparison groups that are broad, but not exact, matches. Some research uses administrative data from existing housing and other databases and compares outcomes over time, without directly collecting evidence from services or service users themselves. Housing associations could consider rolling out a particular pilot across other sites or in partnership with other housing associations, pooling resources to fund an evaluation which makes use of existing comparative data (see the case study on Gentoo on page 22).

A few robust studies that show the impact of housing services on health can then be used to make the case for the sector as a whole. Housing associations can look at these evaluations and their results, and modify their monitoring to demonstrate that they are replicating any good practice found by these evaluations and that they are against relevant measures of success. If a housing association has a contract to provide services, or has been successful in receiving innovation funding, they could access funding opportunities in the UK for health service research in partnership with academic research organisations. Alternatively they could pool budgets with other housing associations to both assess the impact of the service and provide a comparison group.

Case study: Assessing the economic case for a health at home intervention – Family Mosaic

Family Mosaic is currently assessing the economic case for a health at home intervention through a randomised control trial[33]. They worked with London School of Economics and Political Science and have developed a credible research methodology. Family Mosaic recruited a sample of 600 tenants aged 50+, who agreed to complete a detailed survey at regular intervals over 18 months. Participants were randomly split into three equal-sized groups. The control group of 200 residents receive no extra services and are being assessed at regular intervals. The first 'treatment' group of 200 receive support from Neighbourhood Managers who have received additional training in health issues and know how to refer and connect people to other services. The third group of 200 residents receive direct support from specially trained health and wellbeing staff and additional help to attend community activities that support better health and wellbeing. This can include exercise and cookery classes.

All participants are encouraged to access community groups and charities (focussed around healthy lifestyles and tackling isolation). Any participants in need are referred to Family Mosaic services for debt management, understanding welfare reform, finding employment or improving their IT skills. Participants in need also get a home MOT assessment - looking at the property issues that could affect their health, such as poor heating, falls risk, and poor accessibility.

[33] Family Mosaic, Health Begins at Home, www.familymosaic.co.uk

Economic modelling

Housing associations may not have the resources, time or capacity to undertake research on a large scale. However, you may choose to buy in this support if you don't have it available in-house. This could either be through commissioning projects, or by partnering with academic researchers to develop models which use existing UK or international evidence to demonstrate the impact of particular interventions.

There are some limitations to this approach. Evidence on cost effectiveness may come from a country where health and housing services are organised in very different ways, or there may be little data beyond 12 months on the costs and benefits of any health intervention. If this is the case, housing associations can provide expert opinion that will help inform the way in which the model is built. They can explain how they believe a service will be operated and provide estimates of the necessary staff input, equipment and infrastructure. In the absence of long term effectiveness data, a housing association is likely to have to draw on theories on the likely long-term benefits of an intervention.

Models might also be used to estimate the cost effectiveness of targeting specific sub-groups of the population, rather than the general population. A housing association intervention might be more cost effective if targeted at high risk groups. Where this is the case, housing associations can consider presenting information on cost effectiveness both for the general population and any specific high risk groups, exploring relevant issues such as gender, age, environmental risk factors, health status or ethnicity for example.

Demonstrating cost effectiveness

When preparing their business case for health commissioners there are three key points that housing associations should address:

The cost of not taking action

Not taking any additional action is usually not a cost-free decision, but evidence is needed on the impact to the local health economy. This impact will depend on what the risks are of a problem occurring without intervention and, in the case of a chronic disease, how prevalent that problem is in the local community. If individuals with poor health do not come to the attention of healthcare services until they are in a very poor state, then the costs of treatment may end up being much higher than they would have been with early intervention.

The cost of taking action

If the costs of the health problem are substantial, then commissioners will want to have as much information as possible about options for effective intervention to mitigate these costs. Health commissioners will then be interested in how much these interventions will cost to implement. Questions to consider are: 'Can this be done with the existing workforce or does this require different types of staff?' and 'If new infrastructure is needed, what are the ongoing costs of maintenance?' Crucially, in the case of any intervention delivered by the housing sector, commissioners will want to know how this would compare against the cost of the same intervention being delivered by a longstanding healthcare provider.

Value for money

The most important economic question for commissioners is whether or not it is worth investing in a housing delivered service compared with other possible ways that commissioners could spend their health budgets. That is, does the housing intervention achieve improved outcomes at a cost that is worth paying for?' Most health commissioners will only be interested in costs to the health sector, but joint commissioners of health and social care services will be interested in cost impacts to both areas.

Measuring costs in health economics

It is not enough to simply provide the results of an evaluation. The source of the data, its quality and reliability, and how it has been collected (for example through independent research or self-administered questionnaires) is critical. Common approaches to measuring resource use and cost include:

- making use of routine records on service use
- asking a sample of service users to complete structured questionnaires
- asking a sample of service users to keep diaries
- making use of resource data reported in literature
- asking service professionals for their opinions on resources required to deliver services

One realistic approach to recording resource use for services is to collect this data as part of a research project or service evaluation. This typically would be through interviews with service users, family members or service professionals. The Client Service Receipt Inventory (CSRI) is a questionnaire that is widely used for this purpose[34]. It is available free of charge.

Questionnaires should only be used to cover relatively short time periods, as respondents may not accurately remember exactly how often they have used services over a set period.

If it is not possible to collect information then it may be worth looking at previously published government reports and any published evaluations and information from academic publications. Ideally these external sources of information would report resource use separately from costs. This would allow a housing association to better compare its own service with another that has been fully evaluated. If this external information is taken from a different country, the entire set-up might be very different and estimates of resources would need to be adapted to reflect the local context.

Once information has been collected on what services are being used and how often, the next task is to estimate their cost. The Personal Social Services Research Unit (PSSRU) provides an annually updated compendium of the costs of health and social care for public use[35]. Estimates of service costs in this compendium take account of overheads and also allow for increased costs in the London area. Where cost data are not available, it will be important to ensure both running costs, including overheads, and any capital investments needed for buildings and equipment are factored in.

Health commissioners will be mainly interested in direct costs to the healthcare system which should include staff costs, medicines and healthcare procedures, training and overheads, or the impact on subsequent use of healthcare resources. Indirect costs, including productivity losses (absence from or loss of paid employment), will not be of immediate interest as they do not directly impact on their budgets. However, estimating changes in these costs can be an additional argument for continued investment.

Demonstrating impact

Health commissioners will look for transparency about the way in which the results of any cost effectiveness analysis are reported, making it clear where the evidence on effectiveness and costs has come from, with their different strengths and weaknesses. Housing associations must shape interventions that recognise the pressures on different parts of the NHS and be realistic about its impact.

It is therefore vital that housing associations are clear about what the new service aims to achieve, with distinct definitions of success. Housing associations should work with health commissioners, providers and other relevant partners to develop the service aims and to identify any potential challenges, such as likely delays in generating referrals to a new service in the early start-up period. The evaluation should also provide interim reporting to commissioners of useful observations to inform the next stage of service development and ensure the pilot is sticking to its intended aims.

[34] King's College London, Client Service Receipt Inventory, www.kcl.ac.uk
[35] Personal Social Services Research Unit, Unit Costs of Health and Social Care, www.pssru.ac.uk

Conclusion

To construct a compelling business case, housing associations need to be aware of how money flows through the NHS, and the financial pressures faced by the health service. The NHS is heading towards a financial cliff edge, with constant pressure to increase productivity with limited resources.

Housing associations must also use sound evaluation techniques in building their business case as Commissioners will look for strong evidence when assessing proposals and making decisions on where to spend their health budget.

To build a robust and clearly evidenced business case, housing associations should act on these four areas:

1. **Be clear about the offer:** To develop partnerships with NHS providers, housing associations should be clear about whether they want to be a sub-contractor, be part of a bidding consortium, redesign a particular care pathway, or develop a joint venture, before presenting a clear case that is evidentially robust and demonstrates an ability to provide services more effectively.

2. **Find out what works in health:** Housing associations should make use of existing evidence to demonstrate to commissioners what works. Where there are gaps, they can design their own research, whether through evaluating a pilot project, modelling from existing evidence or carrying out a longitudinal study. Regardless of the size of a service, economic evaluation is essential. Make sure the evaluation focuses on outcomes that are relevant to the health sector to properly demonstrate its effectiveness and value for money to commissioners.

3. **Focus on quality rather than cost reduction:** It is almost impossible to save the NHS money. For every rapid discharge or avoided admission, there are ever-increasing waiting lists for acute services. By placing a strong emphasis on the quality of outcomes, with robust evidence on the cost-effectiveness rather than cost savings of a particular service, housing associations can start to carve their place in the future of the NHS.

4. **Be transparent about impact:** Recognise that hospital use and costs are not the only important impact measures, particularly when developing an integrated service. Ensure that the outcomes measured are the right ones for the service and the service user(s), making it clear where the evidence on effectiveness and costs has come from and being honest about its different strengths and weaknesses. Most importantly, be conservative about the likely impact of a particular service and avoid providing highly optimistic (and potentially unachievable) forecasts on likely cost savings and outcomes.

5. **Accept that change takes time:** Large-scale transformation of the health system will take years to achieve. Housing associations may need to be prepared for a long-term investment of time and effort to build engagement plans and relationships with health. These long-term health improvement goals do not always fit neatly into short-term commissioning plans so there is a need to be realistic about what can be achieved within authorities' current business plans and commissioning cycles.

Housing associations can use this knowledge to build a robust business case and transform their offer to health. Through becoming a crucial part of the future of the NHS, they can develop innovative community-based services and reduce the demand on acute health services.

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