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INVESTING IN PREVENTION HAS THE  
POTENTIAL TO FOSTER INNOVATION  
AND ACHIEVE BETTER OUTCOMES AT  
A LOWER COST

# 1 Introduction

Building a business case for prevention may at first seem difficult. We believe that if the process of constructing a business case for prevention can be made easier then more commissioners will choose to invest resources in tackling problems upstream. The aim of this guide is to demystify the activities required to make a decision to invest in prevention; and to make that decision rooted in robust, reliable data. We set out below the key questions that need to be answered to develop a business case for prevention and the steps and analysis that put the business case on firm foundations. Our focus is how to **shift spending earlier** by applying preventative services in the right area based on the analysis of potential costs and benefits.

## The need for prevention

In recent years commissioners have had to deal with growing demand for acute services but have been given less resources to manage that demand. The demand curves for housing services, acute hospital admissions and Children's Services all point towards further future increases in demand for services at the acute or crisis end:

- **Spending on crisis services in housing now far outstrips spending on increasing the supply of housing:**
  - The Government's affordable housing programme has been allocated funding of £4.5bil over 4 years whilst total spending on housing benefit is over £22bn every year<sup>1</sup>
  - In 2012 £2bn was spent housing vulnerable homeless families in short-term temporary accommodation<sup>2</sup>

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1 Office for Budget Responsibility (OBR), *Expenditure Tables* (2013) available at: <http://cdn.budgetresponsibility.independent.gov.uk/March-2013-EFO-44734674673453.pdf>

2 <http://www.thebureauinvestigates.com/2013/05/19/uk-housing-crisis-costing-taxpayer-2bn/>

- There were 53,130 households living in temporary accommodation at the end of 2012 which is 9% higher than 2011<sup>3</sup>
- **People are living longer with diseases but this comes at a cost of increased pressure on health services:**
  - According to the Centre for Disease Control and Prevention (CDC), death rates for those with diabetes dropped by 23% between 1997 and 2006<sup>4</sup>
  - Between 10-15% of older people in Britain are chronically lonely. As the population ages there will be a greater number of people experiencing loneliness which leads to physical and mental health problems in medium to long term such as obesity, cognitive decline and depression. Lonely older people are 3.5 times more likely to enter local authority residential care<sup>5</sup> and have twice as many GP appointments<sup>6</sup>
- **More children are coming into state care and being taken away from their families:**
  - Total looked after children (currently 67,050 in England) has grown at 3% per year for the last five years<sup>7</sup>
  - A survey of local authorities found an average 8% overspend in Children's Services budgets in the last three years despite a 12% increase in budgets<sup>8</sup>
  - Residential care for the most needy children can cost up to £180k p.a.

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3 *Ibid.*

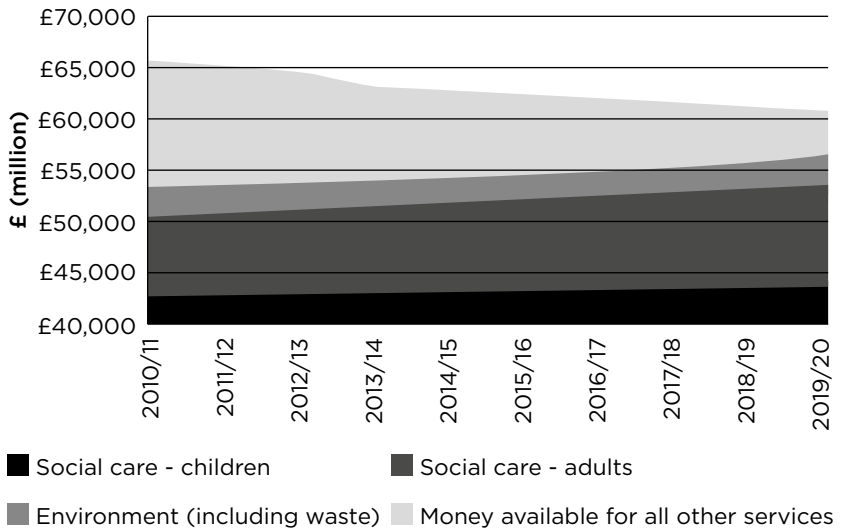
4 Gregg *et al.* (2012) Trends in Death Rates Among U.S. Adults With and Without Diabetes Between 1997 and 2006, *Diabetes Care Journal*.

5 Ellaway *et al.* (1999) *Loneliness and rural nursing home admissions*.

6 Russell *et al.* (1999) *Loneliness as a predictor of hospital emergency department use*

7 DfE (2013) *Children looked after in England (including adoption and care leavers) year ending 31 March 2012*.

8 Association of Directors of Children's Services (2010) *Safeguarding Pressures Project Phase 2: Exploring Reasons and Effect*.



The above graph from the Local Government Association shows this increasing demand trend set against local authorities’ decreasing budgets. In such an environment it is not surprising that prevention gets squeezed. The graph (sometimes referred to it as the “Graph of Doom”) starkly illustrates the funding pressures that Local Authorities are likely to face over the next 10 years:<sup>9</sup>

The above trends show that prevention is needed now more than ever and should be a catalyst for change. By fundamentally re-orientating services around preventing problems rather than dealing with the consequences it is possible to create a sea change in the effectiveness of services.

This is no easy task but there are reasons to be optimistic. More attention than ever before is being given to the issue of prevention and there are initiatives from the Big Lottery Fund and Cabinet Office to support local authorities to engage in thinking through the challenges to commission more prevention.<sup>10</sup>

9 LGA, Funding outlook for councils from 2010/11 to 2019/20: Preliminary modelling, (2012).

10 See Section 6 below.

## **The challenges in Early Intervention**

The work of the Early Action Taskforce (EAF) has championed and gained national recognition for prevention, including publishing research into the barriers preventing it from happening. They identified six barriers in *The Deciding Time*:<sup>11</sup>

- 1 We think and plan for the short-term, particularly in government.**
- 2 We work in silos particularly in the public sector.**
- 3 We can't afford the critical shift to earlier action.**
- 4 We don't really know what works on the ground.**
- 5 We don't have the skills to work differently.**
- 6 We lack the leadership and accountability structures to carry through the changes we need.**

Our aim is to help empower commissioners with the tools to change the pattern of spending and reduce the burden on acute services. This guide aims to address the primary barrier identified by EAF above – planning for the short term rather than the long-term – by setting out the key questions required to test whether prevention is the right option, and the activities required to answer those questions. Sometimes prevention may not be the answer – our guide aims to help commissioners understand when it is the right option.

Currently it is often the more visible problems that take priority – and the duty to help those in greatest need today rightly trumps tomorrow's problems. In services such as healthcare for the elderly, vulnerable adolescents and people involved in the criminal justice system there is a pattern of high spending on crisis services that leaves little available for prevention. Investing in prevention is often constrained by this lack of resources. It is therefore difficult for commissioners to build a robust business

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<sup>11</sup> Early Action Taskforce (2012) *The Deciding Time*.

case for investment in prevention, alongside prevention's potentially risky nature and a lack of information to make judgements:

- **Potentially limited resources** to invest in innovation due to the demand placed on crisis services and the requirement to deliver more for less
- **Prevention is risky business** – often preventative programmes suffer from implementation risk due to long feedback loops and issues of complexity. Previous programmes have not been 100% successful<sup>12</sup>
- **Insufficient information** – Treasury guidance<sup>13</sup> asks commissioners to consider the relative costs and benefits of introducing a new programme but often this information is not readily available

### **Building a business case for prevention**

This guide looks at the main arguments used for investing in preventative services and the information required to support those arguments. We review the activities and analyses that together inform the decision of whether investing up front in prevention is likely to produce good results down the line, and the level of risk involved in making that decision. We concentrate on the following arguments:

- **Prevention is cheaper in the long term** – the “invest to save” argument, namely, that getting to problems earlier can deliver cost savings down the line
- **Promoting service innovation** – preventative services often adopt more flexible models of working that test innovation.

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12 For more on this see Social Finance's blog posts on programme variation in outcomes amongst preventative programmes: <https://socialfinanceuk.wordpress.com/2012/05/30/prevention-better-than-cure/>

13 HM Treasury, The Green Book, Appraisal and Evaluation in Central Government, (2003, updated 2011).



One way of promoting service innovation is through **commissioning on outcomes** rather than outputs. Placing a focus on the social outcomes that a service is trying to achieve can potentially deliver stronger performance

- **Managing a shift in spending from acute to prevention to reduce demand over time** – over time commissioning priorities are likely to require greater levels of spending to address problems earlier so that demand is taken off acute services

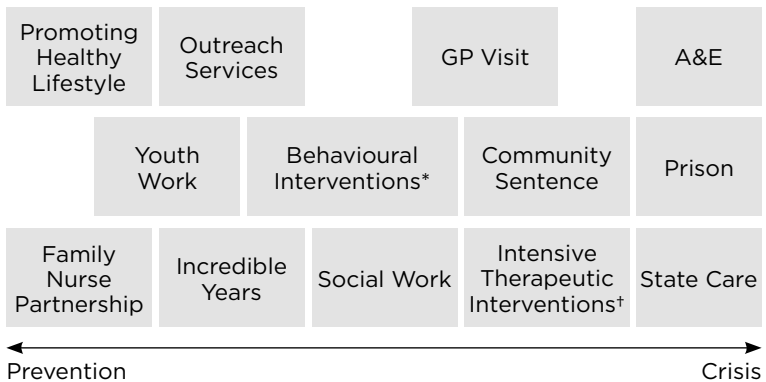
These arguments require us to answer a set of key questions regarding the costs and benefits of the proposed new service. The first step in this approach is to understand the social issue that needs to be addressed through the needs of those who suffer as a result. From this initial understanding a picture of funding for existing programmes and the costs of poor outcomes can be estimated and an intervention suggested that both addresses the poor social outcomes and delivers cost savings. Once an intervention strategy is in place to address the issue then the business case should focus on the economics of the intervention and the potential outcomes this new approach could achieve.

## The meaning of prevention

By “prevention” or “preventative services” we mean services that seek to intervene at an early point before problems become more serious. To borrow the Early Action Taskforce’s analogy, prevention is about building a fence at the top of the cliff rather than running an ambulance to the bottom. There is debate about how early services need to be delivered to qualify as prevention. We do not hope to offer a strict definition that settles the issue here but point towards the characteristics of what we normally consider prevention to be, services that:

- Address the root causes of a problem rather than its symptoms
- Reduce the size of the problem and its negative consequences by intervening earlier
- Act at a time when it is easier to address the problem due to behaviours that are less entrenched
- Aim to improve outcomes to a greater extent than acute or crisis services
- Reduce spending over the long term by reducing demand

Based on this interpretation of prevention there is a continuum between prevention and acute or crisis spending rather than a binary categorisation:



\* e.g. Group work for anger management such as Leap Confronting Conflict. † E.g. Multi-Systemic Therapy (MST)

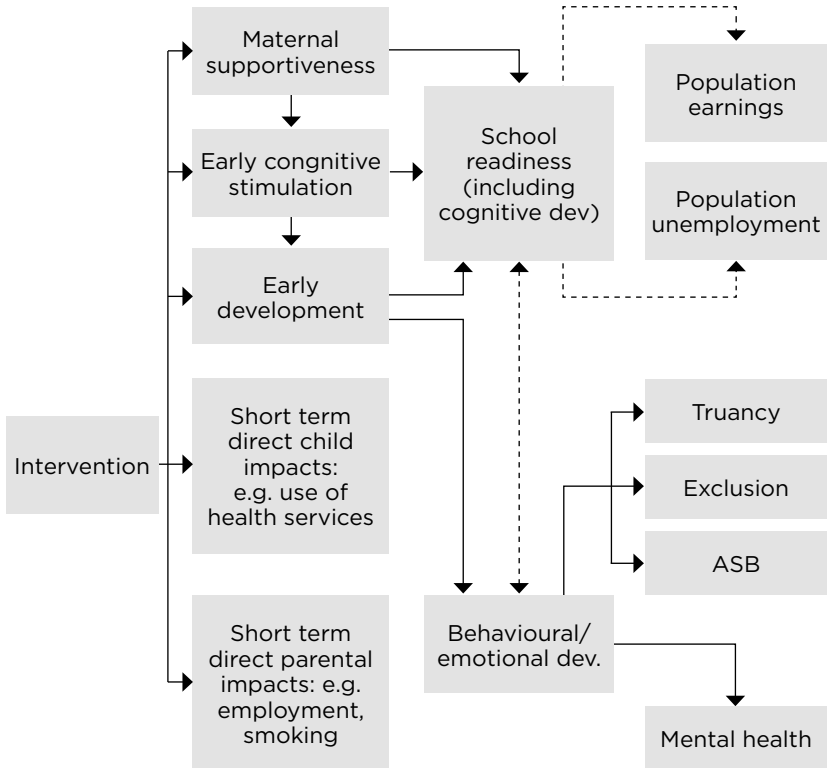
## 2 Case Study: Making a Business Case for Prevention Services in the Early Years in Greater Manchester

The early years (0-4) are increasingly looked at as a means of making the biggest improvements in outcomes for the most disadvantaged children. To date, while there is general consensus around the principle of this, commissioners have struggled to understand the financial and service impact this might have, which in the current climate can hamper efforts to focus more resources on the early years.

The ten local authorities of Greater Manchester and partners developed a new delivery model for the early years, a key public service reform priority within the Greater Manchester Strategy, Stronger Together. Working with Greater Manchester and New Economy Manchester, we undertook the task of building an ‘invest-to-save’ business case for an early years delivery model. The delivery model is designed to address the multiple needs that disadvantaged children and families may encounter in the early years. This seeks to intervene in a range of ways to ensure that every child has the maximum chance of being school-ready and then having good educational outcomes. Interventions include speech and language therapy programmes, behavioural programmes, cognitive development and maternal attachment/supportiveness programmes.

A major challenge in building an ‘invest-to-save’ business case for early years work is the time-lag between intervention and outcome. This time-lag creates a secondary challenge that intervention evaluations will typically only focus on what is observable at the time of intervention. For the early years, these factors are typically not outcomes that can be easily interpreted in a financial sense.

**Logic Tree linking interventions to later outcomes**



To overcome this we built a financial model and performed cost-benefit analysis to help us understand the link between the immediate impact of interventions and monetisable outcomes later in life. Our analysis looked at 27 outcomes that cover short term outcomes for parents and children (maternal employment, smoking, breastfeeding, avoidable hospital attendances), medium term child outcomes (school readiness) and longer-term outcomes (employment, earnings and likelihood of being involved in crime).

- As most evidence-based early years interventions only look at direct impact at the time of the intervention, understanding

these outcomes over a longer-time horizon required us to build a 'logic tree' (shown left) of the linkages between factors that can be measured at the time of the intervention (maternal supportiveness, cognitive development etc.), and our medium and long-term outcomes. We used a range of evaluations and longitudinal cohort studies to build a picture of the statistical relationships between these variables.

- Using the logic tree (left) we were able to look at the impact of a range of early years programmes on our 27 outcomes, and to understand the financial and social implications. We then used a 25 year financial model to analyse how the benefits of the programme would accrue, over time, to the various different public sector agencies.

Measuring and valuing outcomes does not need to be a complicated process but sometimes complexity is unavoidable. This example demonstrates that it is possible to measure the impact of interventions over 25 years by applying a research-based approach to how early intervention is linked to benefits over a longer time horizon.

Greater Manchester plan to introduce a measurement framework that looks at outcomes achieved on an ongoing basis. Data analysis and capture has become an important feature of the proposals both now and into the future. Data has/will be used to

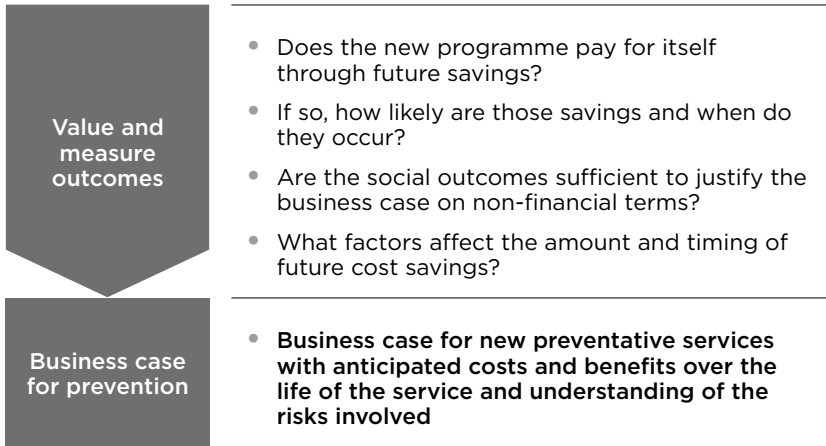
- provide an assessment of the costs and benefits of preventative programmes under consideration at present
- measure the performance of preventative programmes into the future

Greater Manchester took a decision to pilot a programme of early years interventions focusing on evaluation and data capture to support the case for a wider roll-out. It is hoped that the New Delivery Model will help improve educational and social outcomes for around 1,600 of the most disadvantaged children in Greater Manchester each year.

### 3 Building a Business case: Key Activities

This section goes through the four activities required to build a business case and attempts to explain how the key questions are answered. Each activity is explained with reference to a previous piece of work with commissioners in a different social issue area. It is intended to be a tool to help commissioners think through the key issues to consider when investing in prevention.

Activity	Key Questions
<p>Understanding needs</p>	<ul style="list-style-type: none"> <li>• What is the nature of the social problem and how does it affect people on a day-to-day level?</li> <li>• What are the barriers to achieving better outcomes?</li> <li>• Which target population could benefit from prevention?</li> </ul>
<p>Understand current costs</p>	<ul style="list-style-type: none"> <li>• What is the cost profile over time of the current problem?</li> <li>• Which commissioners' budgets bear these costs?</li> <li>• What is the service use of members of the target population?</li> </ul>
<p>Assess interventions</p>	<ul style="list-style-type: none"> <li>• What interventions are able to improve outcomes for the target population?</li> <li>• What is the evidence base for these interventions?</li> <li>• What is their theory of change - how do they work?</li> <li>• How do they fit with existing services - do they address a gap?</li> </ul>



## Analysing and understanding need

The first part of building a business case involves understanding the needs of those individuals who experience the social problem. For example, when looking at outcomes for vulnerable children on the edge of care it is important to understand what features of a young person's situation and family environment made care a necessity. Social workers do not follow the lengthy and trying legal pathway to removing children unless it is strictly necessary. To understand this issue it is important to develop an appreciation for why children were suffering from abuse and neglect to try to develop ways of addressing these root causes.

We worked with Essex County Council to build a business case for prevention for adolescents on the edge of care. In this work we surveyed front line social workers to better understand the needs of children and young people who they had worked with. The key needs identified were the “toxic trio” of domestic abuse in the household, parental substance misuse issues and parental mental health problems. These problems affect parenting capacity and can, at the extreme end, make removing children and placing them in state care the best option.

In order for the business case to be robust we wanted to go beyond reported issues and look for the data to back this up. Data can show the prevalence of these issues across the population and highlight other important factors. We worked with social workers to analyse individual case files to see whether there was a pattern in the needs that young people entering care had that were not being met by existing services. This work eventually led us to recommend an intensive therapeutic intervention for adolescents aged 11-16 who are on the edge of care: Multi-Systemic Therapy.<sup>14</sup> This has now been introduced within Essex as part of a wider strategy to stem the flow of adolescents entering care.

The needs of the individuals affected by the problem are at the heart of building a solution. There is not one single way of determining these needs but interviews with service users, interviews with practitioners, case file reviews, data analysis and desk-based research are all good sources of data. The needs uncovered by such work should be understood within the system that seeks to address them; the barriers to those needs being addressed need to be understood at the same time. This may cover a service gap or the way that services are funded that inhibits service effectiveness. An example is the way that drugs services were previously funded in prison – payment was based on the number of people assessed (whether they had professed a drug problem or not) leading to a large number of assessments on people who hadn't come across drugs before whatsoever.

The views of service users and front-line professionals can build a picture of how the problem is experienced from the bottom-up. By first understanding the needs of individuals and then the barriers to achieving change we can then start to research interventions and organisations that are able to deliver the programme.

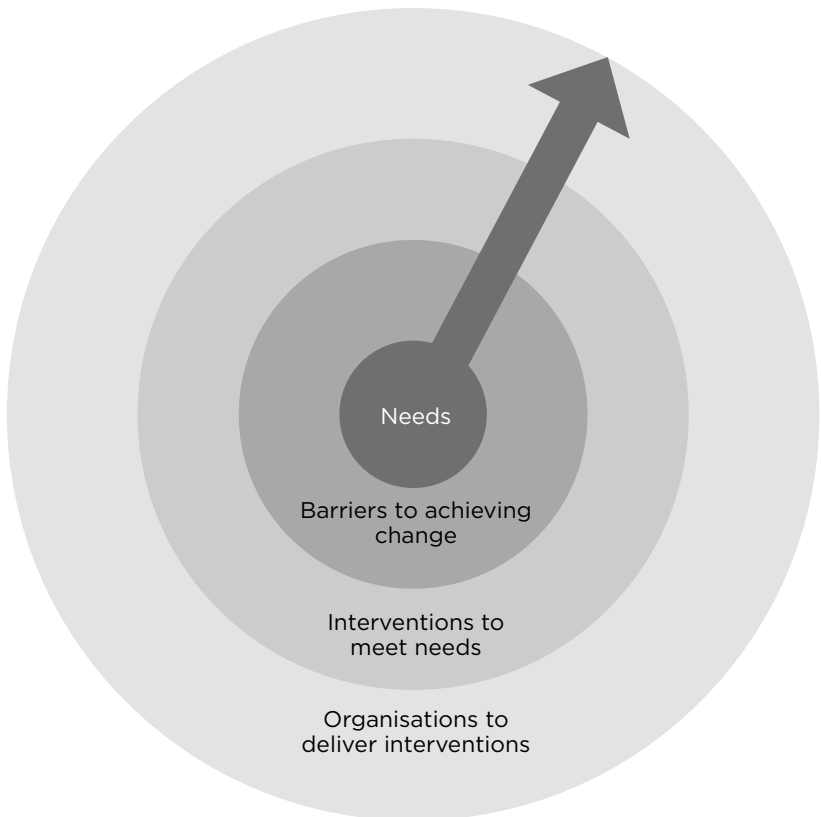
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14 Multi-Systemic Therapy or MST is an intensive therapeutic intervention for the family of adolescents that looks to improve the overall functioning of the ecosystem by providing an intensive family therapist who works with the family in their house over a 6 month period.



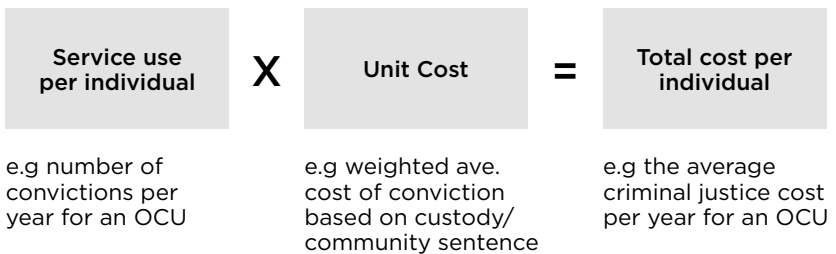
Starting with needs and barriers is the logical first step to understanding a social issue and starting to build a business case for prevention. An understanding of need requires grasping the **theory behind why** a certain aspect is important – such as how attachment theory suggests that children without a strong nurturing adult relationship are unlikely to build resilience – and **how this affects peoples lived experience** – such as how a lack of resilience means children are more likely to get into fights when they suffer stress or embarrassment. These two elements together will provide a solid understanding of the issue and the first building block of the business case.

#### **BUILDING OUT FROM AN UNDERSTANDING OF THE NEEDS OF THE INDIVIDUAL SERVICE USER**



## Analysing and understanding current costs

Calculating the economics of the business case is the second step and this starts with trying to put costs on the existing situation. The most common methodology for this involves taking the service use of the target population and multiplying this by unit cost figures for each service included in the analysis. This section is illustrated with examples from our exploratory work funded by the Home Office and Essex County Council to looking at recovery for opiate and crack users (OCUs) in Essex.



Available data guides this process and whilst local data for the precise target population from the previous (complete) five years would be the best possible source to build a robust business case, it is not always available in the format required. In general we look for the most robust data within reasonable limits of time, analytical capability and reliability. There are often some benefits that we know will result but which cannot be included in the analysis because there is not sufficiently robust data to do so. For example we did not include care costs despite strong links that around 34% of children in care have parents with a substance misuse problem.<sup>15</sup> This was because it was not clear that there would be a strong causal link between working with all OCUs and a reduction in care proceedings as a direct result. It is important to only include robust costs in the analysis.

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<sup>15</sup> Home Office, *Hidden Harms*, (2006)

Factors that increase robustness include:

- Data specific to the target population
- Data specific to the local area
- Recent data
- Data over several years to understand trends
- Data with consistent measurement approach

In analysing the levels of service use it is important to account for national or local policy changes e.g. a local strategy to recruit and retain foster carers could have increased the overall amount of time that children spend in care spend in foster care placements (on average). As such the data that relates to the previous period before this change may skew the results.

The cost calculations are specific to the individual business case and so general principles are difficult to set out. It is helpful to focus on those costs that we can be sure of and ignore those that would be too speculative. This helps the business case retain a robustness that survives the scrutiny of commissioners and section 151 officers<sup>16</sup> who hold a fiduciary relationship to the local taxpayers (they hold the trust and confidence of local taxpayers to manage their council's finances). This guide will not focus on different cost methodologies but will instead elaborate on the purpose of this part of the business case and how it can be used as a tool to engage commissioners from across different services.

### **The purpose of analysing and understanding current costs**

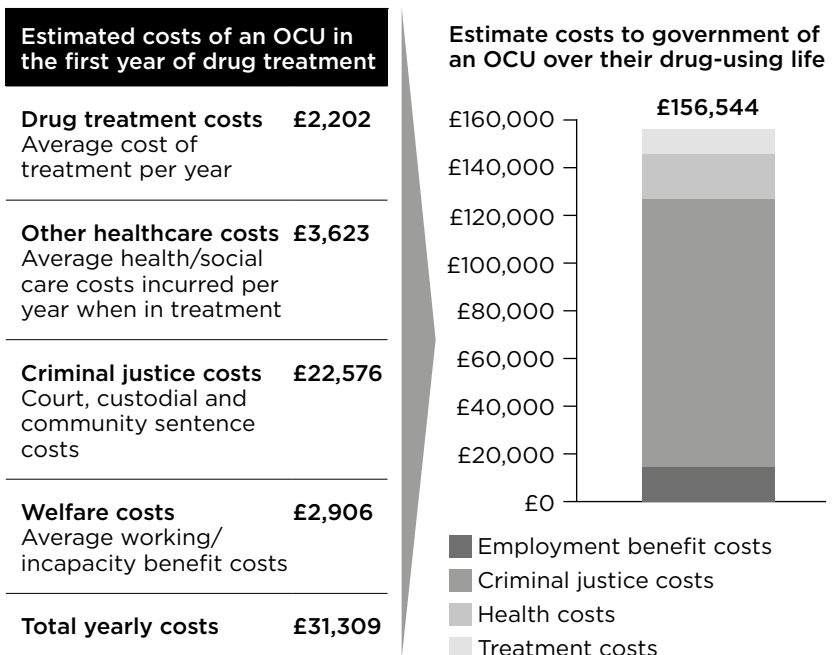
We have found that it is effective to take a financial lens to social problems as it enables discussion to move past anecdote and

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<sup>16</sup> Section 151 of the Local Government Act 1972 requires every Council in England and Wales to 'make arrangements for the proper administration of their Finance affairs and shall secure that one of their Officers has responsibility for the administration of those affairs.' Source: <http://www.burnley.gov.uk/sites/default/files/Statutory%20Officer%20Protocols%20-%20-%20Appendix%202.pdf>

grounds decisions in data. By building a picture of current costs that is accurate we are able to have an informed debate about the cost of inaction.

For commissioners who are looking to introduce preventative services, understanding the true “as-is” cost can provide an incentive to act as it reveals the potential cost savings that can result from improved outcomes. When these costs are assigned to specific services and budget lines this incentive to act can become significant. The costs of a social issue such as substance misuse or domestic abuse cuts across multiple budgets and this helps focus on a specific problem with both high social and economic costs. The diagram below shows how local and national budgets bear the costs of an opiate and crack user (OCU):<sup>17</sup>



<sup>17</sup> Note: other costs such as local authority Children’s Services costs were identified but not included in the analysis as they were not felt to be sufficiently robust.

The only costs of these that are borne locally are the drug treatment costs and other healthcare costs (equal to 18% of the total when combined). As such this analysis provides an incentive for local commissioners to collaborate with national commissioners. This sort of analysis can provide a way of moving past the single service-single commissioner pattern and help provide reasons for working together.

Cost data can be a way of starting a conversation with commissioners more widely from across different services by putting forward the economic consequences of bad social outcomes. It is clearly an important part of building any internal or external investment case for prevention.

### **Assessing interventions to establish what works**

The early parts of the business case aim to establish the social issue which imposes significant costs on the public purse. The next step is to establish whether there is an intervention that has the ability to improve outcomes and deliver costs savings. Social Finance worked with four Local Authorities in the South West (Cornwall County Council, Devon County Council, Plymouth City Council and Torbay Council) to look at the issue of adolescents on the edge of care and supported Cornwall and Torbay to make internal investment cases for Functional Family Therapy (FFT), an intensive therapeutic intervention. The key questions for assessing which interventions work are illustrated with reference to FFT in the South West.

When researching interventions we ask the following questions:

#### **I What is the evidence base of the intervention?**

Interventions with a strong evidence base are more likely to produce good outcomes. When looking at interventions for adolescents at the edge of care we have previously reviewed a number of interventions including Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) based on the strength

of their evidence bases. These interventions aim to work with vulnerable children and their families to improve overall family functioning. Both interventions have multiple randomised controlled trials (RCTs) mainly within youth justice settings in America. RCTs are considered the gold standard of evidence as individuals are matched for relevant characteristics and then randomly assigned to either the intervention group or the control group (which does not receive the intervention). RCTs, where possible, are thought to be the best way to assess the impact of an individual intervention as we are able to say with some certainty that the difference between the two groups is due to the intervention.

The below table summarises the key information we used to assess the evidence base of FFT and MST:

<b>Functional Family Therapy (FFT)</b>	<b>Multi-Systemic Therapy (MST)</b>
<p><b>Background</b></p> <ul style="list-style-type: none"> <li>• Around 25 years of research</li> <li>• Some evidence of consistent and long term outcomes</li> <li>• UK developing but still in its infancy</li> </ul>	<p><b>Background</b></p> <ul style="list-style-type: none"> <li>• Over 30 years of scientific research</li> <li>• Good evidence for consistent and long term outcomes</li> <li>• Transportability and UK based research</li> </ul>
<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>• Strong but less so compared to MST</li> <li>• 25 published studies and 17 randomised trials</li> <li>• Multiple RCTs in US in youth justice setting</li> <li>• Brighton and Hove trial in UK (awaiting results)</li> <li>• Encouraging trials in Dublin yet to be published</li> </ul>	<p><b>Evidence Base</b></p> <ul style="list-style-type: none"> <li>• Worldwide: 26 published outcome, transportability and benchmarking studies including 20 randomised trials</li> <li>• 2 large-scale transportability (dissemination) studies</li> <li>• UK: Brandon Centre RCT - strong evidence focused on young offenders</li> <li>• Large national RCT with promising interim findings</li> </ul>

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**Outcomes include:**

- Reduction in recidivism shown by multiple RCTs
- Reduction in substance use shown by multiple RCTs
- Reduction in foster care placements shown by two studies

**Outcomes include:**

- Reduction in recidivism shown by multiple RCTs
  - Increased family cohesion and adaptability
  - Reduction in entry to care and custody (UK START trial)
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Questions to ask regarding the quality of evidence:

- What group of people did the intervention work with? How close is this to the group that has been identified in the business case for prevention?
- How old is the study?
- Where was the study conducted?
- Was the study independently evaluated?
- What is the sample size?

Evidence from America's youth justice system does not necessarily directly map across to a social care setting in England. Ideally evidence would be from a directly comparable group and would be published in an academic journal or have an independent evaluation. We should aim at perfection but we are very unlikely to find an exactly applicable study with a large enough sample of similar people. The strength of evidence makes the interventions more likely to achieve the results anticipated.

## 2 What about new interventions?

Some innovative interventions may be too young to have been evaluated and replicated widely but have a strong rationale for why they are able to meet the needs of the target population and transform outcomes. Interventions without a good evidence base will be more risky but might also be the most innovative. When assessing FFT and MST we also looked at an intervention with

less of an evidence base, the Adolescent Multi-Agency Support Service (AMASS) in Islington. AMASS consists of social workers, teachers, a child psychiatrist, psychologists and outreach workers over a six month, high intensity parental/carer empowerment intervention. AMASS has not been widely replicated or evaluated using an RCT. As the National Children's Bureau report into interventions for this group noted 'the study did not involve a control or comparator group, however, which makes it impossible to assess the changes that may have occurred if the children had received a different , or no, intervention.'<sup>18</sup>

### **3 What local conditions should we bear in mind when assessing interventions?**

When assessing the fit of MST and FFT to cover four Local Authorities in the South West we had to consider the area that the intervention needed to cover. MST has a restriction that therapists must be within a 90 min drive in order to be able to provide a rapid response, 24/7. This restriction (amongst other consideration) made FFT's more flexible model better suited to the local conditions in the South West. FFT was able to fit with the desire for integrated step-down provision post-intervention and had very few exclusionary criteria, such as for domestic abuse, which covered a large number of cases of children entering care.

### **4 What outcomes are reported and how are they sustained over time?**

When assessing the fit of FFT we wanted to know whether it had the potential to reduce care entry for adolescents – therefore the reported outcomes in reduced recidivism and reduced substance use were positive but not strictly related to the outcome we wanted to investigate. As such the lack of directly applicable studies measuring the outcomes we were concerned with makes the programme more risky.

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18 NCB (2013) *Vulnerable children on the edge of care: Review of promising interventions.*



## 5 What is the variation in outcomes between different locations?

Greater variation in outcomes between locations indicates greater implementation risk.

### **Valuing and measuring outcomes**

The purpose of valuing and measuring outcomes is to understand what improvements in outcomes and cost savings can be achieved by a new preventative programme and what performance is necessary for the programme to be a good investment. To illustrate this activity we will refer to work with the Greater London Authority (GLA) and Department for Communities and Local Government (DCLG) in which we helped analyse the financial and social value gained by helping entrenched rough sleepers move into stable accommodation and towards employment. This work enabled GLA to commission innovative services to support rough sleepers through a SIB.

**Determining key outcomes** – first commissioners must determine the key outcomes that are going to be measured as part of the analysis. The social outcomes to be measured will be those that are strategically important to the commissioner and express the reasons why the programme has been introduced in the first place.

Rough sleepers are amongst the most vulnerable people in society. Most have one or more support needs, including alcohol misuse, substance misuse and mental health problems. We worked with commissioners to identify five outcomes that demonstrate progress towards a sustainable lifestyle away from the streets and that represent success for the service. The five outcomes are:

- Reduction in the number of individuals with bedded down street contact each quarter
- Confirmed sustainment of tenancy in a non-hostel setting

- Confirmed reconnection to country in which individual enjoys local connections
- Sustainment of volunteering, part-time or full-time employment
- Decrease in the average number of A&E episodes per person per year

**Linking social outcomes to cost savings over time using financial modelling** – in the above example it is clear how a reduction in A&E episodes will result in a cost saving. Conversely sustainment of tenancy in a non-hostel setting might involve a previously “uncounted” person claiming housing benefit for the first time and so increase costs to the public purse.<sup>19</sup> The costs to be included in the analysis will follow from understanding the current costs.

For the business case to be investable the overall cost savings need to be greater than costs of the intervention. As such it is important to explore the link between improved social outcomes and cost savings over time. This can be conducted through financial modelling and/or cost benefit analysis. A good financial model will start with a series of assumptions regarding the target population, their behaviour and their service use and then model the change in these factors over time based on the addition of a new preventative programme. The best models are simple and transparent; they should show over time how social outcomes improve and the demand for crisis services reduces under a range of different scenarios that flex key assumptions.

In the rough sleepers analysis it was necessary to start with the outcomes and calculate the impact on costs. There are three examples on the next page.

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<sup>19</sup> The outcomes that the programme is measured and actually paid on should incentivise the right behaviour rather than being linked strongly to cost savings at all times.

Cost	Outcomes	Impact on costs
Rough sleeping costs	Reduction in the number of individuals with bedded down street contacts	Reduction in rough sleeping will reduce pressure on outreach services
Accommodation costs	Confirmed sustainment of tenancy for 6 months in non-hostel setting with no more than 1 bedded down street contact in London	Sustaining long-term accommodation will reduce evictions, reduce the use of expensive short-term hostels and has been shown to impact the risk of offending
Health costs	Average number of emergency admissions per head	Normalisation of health care usage and stabilisation of health needs will reduce unnecessary emergency admissions, a key driver of health costs

In this work we tested the model by producing a range of scenarios in which the level of performance was flexed within the range indicated by research. This produced a base case, high case and low case to understand the sensitivity of the model to different factors.

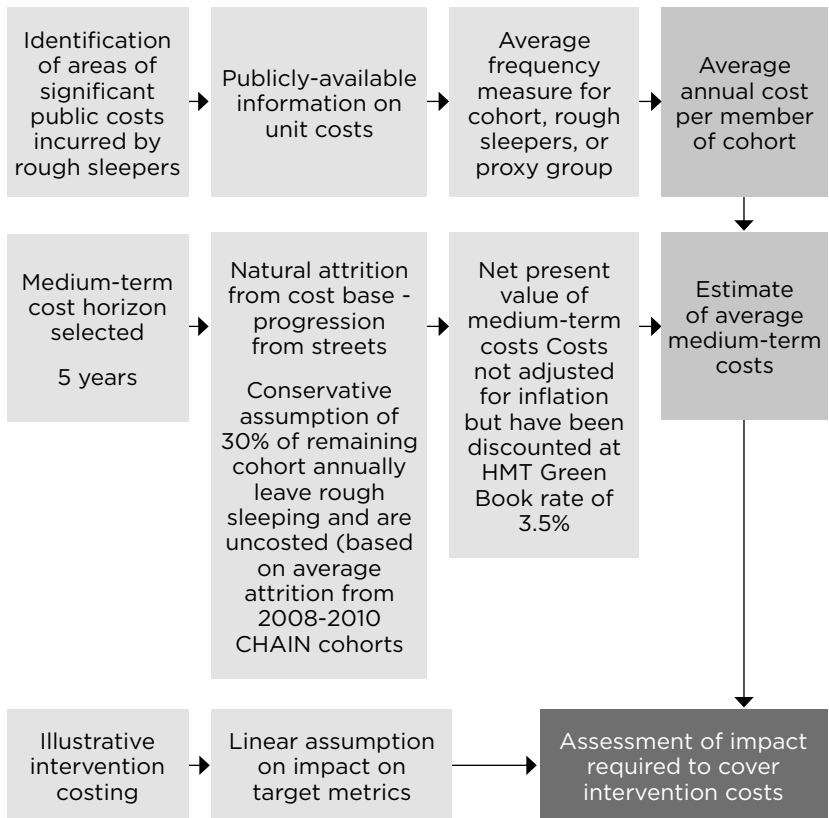
To build the profile of benefits and costs over time it is necessary to understand when these costs are incurred and when subsequent savings are made, for instance due to a decrease in demand for services over the long term. It is also necessary to discount future gains – the costs and benefits are expressed in net present value terms to understand the benefits in “today’s money”.

The business case also needs to account for the cashability of savings generated since not all notional cost savings will result in cash money saved. For example, a reduction in reoffending does not necessarily save prison costs unless a prison wing can

be closed down. Meanwhile moving someone off benefits and into work creates an almost instant cashable saving. In the long term preventative programmes that reduce future demand to a sufficient extent stand a good chance of delivering cashable savings as they can play a part in preventing the requirement to build new prisons, hospitals and residential care homes based on demographic trends increasing demand.

The costs and cost savings can be modelled to assess what level of performance is required to make a strong business case to introduce the new programme:

**Modelling to show cost savings**



The business case will assess whether the interventions proposed are able to achieve the impact required to cover the intervention costs. It will ask: does the new programme pay for itself through future savings? If so, how likely are those savings and when do they occur? If not, are the social outcomes sufficient to justify the business case on non-financial terms? In the case of the rough sleepers SIB, the business case was accepted on the grounds of promoting service innovation and paying for success only if outcomes were achieved rather than on a short-term cashable cost savings basis.

The answer to these questions will be taken from the analysis using the financial model which will use assumptions based on the intervention research. It may be necessary to undertake an additional evidence review to understand the statistical links between what evaluations observe and the targeted outcomes. Often a range of possible performance is considered based on the variation in outcomes observed in other sites where the intervention has been implemented. This range of possible performance – and the resulting cost savings (or, lack thereof) will give an indication of the risk of the proposed business case.

The output of this work will be a financial case for the intervention including the likely costs and benefits and sensitivity of these to a range of important variables.

## 4 Summary business case for prevention

Business Case argument for investing in prevention	Analysis used to inform decision-making
Delivering value for money through cashable cost savings	<ul style="list-style-type: none"><li>• Cost of the existing problem and which budgets this falls on (including drivers of overspend, if applicable)</li><li>• Cost of the proposed intervention</li><li>• Articulation of outcomes metrics that demonstrate improved financial outcomes</li><li>• Improvement in outcomes and cost savings that result from intervention</li><li>• Understanding of trends and how costs change over time</li></ul>
Promoting service innovation, flexibility and local empowerment in the delivery of services	<ul style="list-style-type: none"><li>• Identification of service gap and ways in which current service could be improved</li><li>• Identification of intervention to address unmet needs and improve outcomes</li><li>• Understanding of evidence base of intervention</li><li>• Understanding of intervention's theory of change</li><li>• Assessment of implementation risk involved</li></ul>

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<p>E.g. commissioning on outcomes is one approach to prevention which may prove particularly effective due to the complex nature of social needs</p>	<p>In order to commission on outcomes:</p> <ul style="list-style-type: none"><li>• Current social outcomes and how this affects an individual's everyday life, including relevant comparisons (e.g. to statistical neighbours)</li><li>• Articulation of outcomes metrics that demonstrate improved social outcomes</li><li>• Improvement in outcomes that a new intervention is able to achieve</li></ul>
<p>Managing a shift in spending from acute to prevention to reduce demand over time</p>	<ul style="list-style-type: none"><li>• Understanding of demand trend for services in this area</li><li>• Understanding of how this reduces demand over time based on impact of intervention</li></ul>
<p><b>All of the above</b></p>	<ul style="list-style-type: none"><li>• Clear definition of the problem and the target population for a new intervention</li><li>• Understanding of the intervention, what success looks like and how it would be measured</li></ul>

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## 5 Financing the business case

The four steps listed previously should provide sufficient information upon which to make an informed commissioning decision about the potential of a new intervention. The steps provide an assessment of the cost of funding prevention to deliver improved outcomes and cost savings and the riskiness of adopting the new approach.

Based on this framework there are three options that commissioner might pursue:<sup>20</sup>

- The business case for prevention is **low risk/contains risks that the commissioner is able to mitigate** – there is an ability to build an internal investment case and invest internal resources
- The business case for prevention contains **some risks that the commissioner is not well-placed to manage** (such as implementation risk) – under such circumstances it may be worth externalising this risk to investors in a Social Impact Bond (SIB) or to providers using a Payment by Results (PbR) approach
- The business case for prevention contains **significant risks or those that neither commissioner, investors or providers are capable to mitigating** to a great extent – in this case it might be seeking potential sources of grant funding or R&D funding if the intervention is to be taken forward.

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<sup>20</sup> Note – for this guide we will not cover questions regarding the commissioning as Social Finance has previously written on this subject. Please see: Ben Jupp, Commissioning for Social Impact Bonds, (2012), available here: <http://www.socialfinance.org.uk/resources/guide/technical-guide-commissioning-social-impact-bonds>



## 6 The Social Impact Bond (SIB) to finance prevention

Social Impact Bonds can be a way of delivering improved outcomes and fostering innovation when applied to the right circumstances. Variable outcomes and a thin evidence base can lead to significant implementation risk for preventative programmes. This level of risk can make commissioners unwilling to test such services, particularly at a time where budgets for testing innovation are squeezed.

Feedback from commissioners indicates there are two ways in which a SIB might be able to help construct a business case for prevention:

- 1 **Delivering value for money through cashable cost savings**  
e.g. Essex SIB – in the context of rising numbers of children coming into care Essex developed a strategy to reduce the flow of children in care and take the pressure off a stretched budget. Essex commissioned MST (described above) to improve outcomes for adolescents and prevent children entering care for such long periods – this is forecast to produce significant cost savings based on the expensive care placements avoided for those children.
- 2 **Focusing on service innovation to improve and measure outcomes whilst transferring the risk of failure. Crucially this helps to shift spending from acute to prevention in managed way – reshaping services to manage demand over long term.** For example the GLA rough sleepers SIB introduced a new service for people for who existing services just weren't working. In the short-term costs might increase (e.g. health costs due to revealed health problems from living on the streets for a number of years) but over longer term this helps reduce A&E admissions, police call outs and emergency accommodation costs.

We have worked with commissioners who favour either argument (or sometimes, both). We do not want to privilege either form of business case – both are equally valid and it is for commissioners to decide how they wish to approach the problem and whether they think a SIB is appropriate.

SIBs have the potential to drive innovation and promote prevention by enabling commissioners to take greater risks. Under a SIB the risk of programme failure is transferred to those best placed to manage it and thus gives the programme the best chance of success.

A social investment approach offers commissioners the chance to test prevention and only pay if the service is successful. This means we test more preventative programmes and drive progress with commissioners paying only when the programme delivers on the outcomes metrics that have been developed jointly as part of the business case.

## 7 Conclusion

Investing in prevention has the potential to foster innovation and achieve better outcomes at a lower cost. We need prevention now more than ever. Constantly growing demand on crisis services needs to be addressed upstream to reduce pressure over the long term. This guide aims to help make investing less risky by detailing how to interrogate data to build a business case so that prevention is only brought in where it has a good chance of improving outcomes and producing cost savings. The implementation of prevention can be made less risky for commissioners under certain circumstances by transferring this risk to private investors through a SIB. Under a SIB, data is used to robustly performance manage the delivery of the programme to give it the best chance of success. In the next Technical Guide in this series we will explore the issue of data collection and measurement in greater detail.



## ABOUT THE AUTHOR

### **Harry Hoare**

Harry is an Associate who has worked on SIB feasibility studies looking at improving outcomes for vulnerable adolescents across four local authorities in the South West and for Essex County Council (ECC) looking at recovery from drug addiction and reducing the harms caused by alcohol. He works as part of the Impact Incubator team which partners with charitable foundations to co-develop innovative social investment models.

Harry previously worked at the politics think-tank Demos conducting research in the Capabilities Project and the Families and Societies Project. He holds an MPhil in Political Theory and BA in Politics, Philosophy and Economics from Oriel College, Oxford. Whilst at Oxford Harry founded a business offering summer school courses.

## Appendix I – Support available to develop Social Impact Bonds (SIBs)

### **What financial support is available?**

- In Summer 2013, the Big Lottery Fund launched a £40m Commissioning Better Outcomes fund with the aim of growing the market in social impact bonds and other outcomes based investment instruments. The fund compliments the £20m Social Outcomes Fund launched by the Cabinet Office in November 2012.
- Applicants to the Funds will be public service commissioners (such as local authorities) who will use the funding to top up payments to a delivery partner or via a social investment intermediary for providing certain services and delivering pre-agreed outcomes.
- Big Lottery Fund has appointed Social Finance in partnership with the Local Government Association (LGA) to offer a support package for those developing Social Impact Bonds (SIBs) and other Payment by Results (PbR) based social investments as part of Commissioning Better Outcomes.
- Social Finance and LGA provide a range of support, including the publication of technical guides, development of online tools, holding webinars and production of podcasts, as well as offering workshops and diagnosis of further development needs. This will support proposals that could then go on to access technical development grants from Commissioning Better Outcomes, leading to a possible contribution to outcomes payments from either or both of the outcomes funds.

- The Big Lottery Fund has made £3m available as 'Development Grants' to help Commissioners develop SIBs. This can be accessed on the condition that they have had an Expression of Interest (EOI) approved by the Fund. Commissioners can apply for between £10k-150k and the funding can be used to undertake financial modelling work, local data analysis, provider engagement, intervention selection and costings, outcome metric design, capital raising, procurement and commissioning work.

## Appendix 2 – Social Impact Bond explained

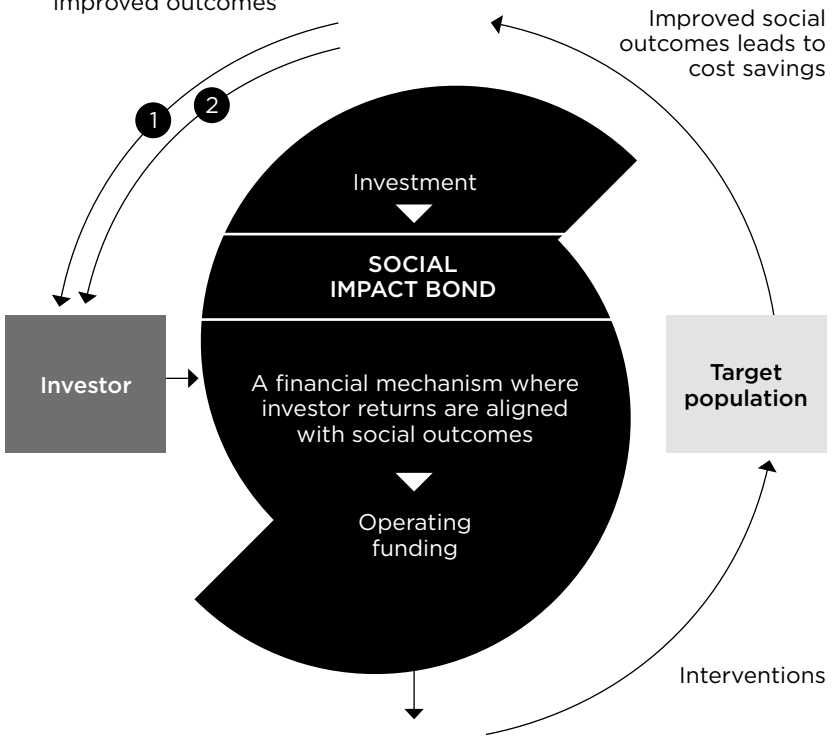
Social Impact Bonds are a form of outcomes-based contract in which public sector commissioners commit to pay for significant improvements in social outcomes (such as a reduction in offending rates, or in the number of people being admitted to hospital) for a defined population.

Social Impact Bonds are an innovative way of attracting new investment around such outcomes-based contracts that benefit individuals and communities. Through a Social Impact Bond, private investment is used to pay for interventions, which are delivered by service providers with a proven track record. Financial returns to investors are made by the public sector on the basis of improved social outcomes. If outcomes do not improve, then investors do not recover their investment.

Social Impact Bonds provide up front funding for prevention and early intervention services, and remove the risk that interventions do not deliver outcomes from the public sector. The public sector pays if (and only if) the intervention is successful. In this way, Social Impact Bonds enable a re-allocation of risk between the two sectors. The following diagram is an example of a typical Social Impact Bond structure.

1 Define outcomes metrics and valuation in contract

2 Payment for improved outcomes





## Appendix 3 – What are the Funds looking for?

**Each fund has its own specific focus that reflects the respective missions of the Big Lottery Fund and the Cabinet Office.**

**The programme outcomes for Commissioning Better Outcomes fund are:**

- Improved skills and confidence of commissioners with regards to the development of SIBs.
- Increased early prevention being undertaken by delivery partners, including VCSE organisations, to address deep rooted social issues and help those most in need.
- More delivery partners, including VCSE organisations, able to access new forms of finance to reach more people.
- Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs.

**The programme outcomes for Social Outcomes Fund are:**

- Increased innovation in public service delivery through outcomes based commissioning.
- Improved cross-government working in public service delivery and encouraging co-payment by different commissioners.
- Increased number of SIBs addressing complex needs and demonstrating ability to replicate by standardising the process.

- Increased capacity for SIBs as a long term tool of government to improve outcomes and reduce costs, by supporting SIBs that test cashability of savings and ensure evidence is gathered to:
- Determine performance of interventions on their primary outcome
- Increase evidence on the impact of interventions on wider outcomes
- Improve outcome valuation.

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WE BELIEVE THAT  
IF SOCIAL PROBLEMS  
ARE TO BE TACKLED  
SUCCESSFULLY, THE  
ORGANISATIONS SEEKING  
TO SOLVE THEM NEED  
SUSTAINABLE REVENUES  
AND INVESTMENT TO  
INNOVATE AND GROW.

Our role is to devise the financial structures and raise the capital to enable this to happen.

Social Finance injects market principles into funding in a way that stands or falls on results – both social and financial. We support social organisations to raise and deploy capital; we work with government to deliver social change; and we develop social investment markets and opportunities.

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