Second in-depth review, produced as part of the independent Commissioning Better Outcomes Evaluation

The Zero HIV Social Impact Bond:

The impact of the COVID-19 pandemic

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About this report

The Commissioning Better Outcomes (CBO) Fund is a social impact bond (SIB) programme funded by The National Lottery Community Fund, which aims to support the development of more SIBs and other outcomes-based commissioning[1] (OBC) models in England. The National Lottery Community Fund has commissioned Ecorys and ATQ Consultants to evaluate the programme. A key element of the CBO evaluation is nine in-depth reviews, and this review of the Zero HIV SIB is one of these.

This report is the second in-depth review of the Zero HIV SIB. Its focus is entirely on the impact on the SIB of the COVID-19 pandemic, or of restrictions and non-pharmaceutical interventions (NPIs) imposed as a result of the pandemic, during 2020 and early 2021. It follows a first review[2] which was published in 2020 and considered stakeholder experiences and learning from the design and development of the SIB up to and immediately after the point at which it was launched. We will undertake a third and final review of the SIB in late 2021 and early 2022 that will consider the overall impact of and take learnings from the project as a whole, including delivery up to, through and beyond COVID-19.

We conducted the interviews with stakeholders whose views are reflected in this report between March and June 2021. We also reviewed data relating to the performance of the SIB during the pandemic and compared it to performance before it.

Through both qualitative research and data analysis we focus on the impact of the pandemic during three main periods: what is widely referred to as the 'first wave' of COVID-19 from the middle of March to July 2020; the period of relatively low prevalence of the virus, and relaxed restrictions, between July and early November 2020, and the period covering the second lockdown and 'second wave' of the virus from November 2020 to March 2021. The timing of this review means that we have not considered the effects of the relaxation of restrictions since May 2021, nor of the 'third wave' over the same period; we will do this in the third and final review referred to above.

As explained further below in section 1 of this report, SIBs differ greatly in their structure and stakeholder dynamics and a key focus of the evaluation and its in-depth reviews is how and to what extent these factors interact to create what we refer to as the 'SIB effect', leading to both benefits and challenges from designing and implementing a contract in this way. This review is however somewhat different in focus, and considers two slightly narrower research questions than typical in-depth reviews, namely:

- how and why did the SIB have to adapt to the impact of COVID-19 and restrictions/NPIs imposed because of it, with consequences for contracting arrangements and/or the delivery of interventions enabled by the SIB; and
- to what extent did the structure and dynamics of the SIB enable or hinder such adaptation – in other words was there a specific 'SIB effect' relating to the project's response to the pandemic?

1 Outcomes-based commissioning describes a way to deliver services where all or part of the payment is contingent on achieving specified outcomes. The nature of the payment mechanism in an outcome based contract can vary, and many schemes include a proportion of upfront payment that is not contingent on the achievement of a specified outcome.

2 See https://www.tnlcommunityfund.org.uk/media/insights/documents/EJAF-Zero-HIV-in-depth-review_FINAL.pdf

Background to this project

The Zero HIV SIB has been driven and part funded by the Elton John Aids Foundation (EJAF), which is the largest non-government funder of support to the prevention and treatment of HIV and AIDS in the UK, and one of the largest independent AIDS charities in the world.

As its name implies, this SIB aims to point the way towards the eventual eradication of HIV/AIDS in the UK. This is a realistic goal because antiretroviral drugs and therapy are now so effective that HIV is no longer an acute illness, and there is a very high likelihood that those receiving treatment will be able to live a long and largely normal life. Moreover, effective treatment reduces the risk that the infected person can pass on the virus to almost zero.

The problem the SIB addresses is that there remains a stubbornly higher number of people (estimated to be 10 - 15% of those who have HIV) who are not in treatment – either because they do not know they have the virus, or have been diagnosed but later dropped out of treatment – technically known as 'lost to follow up' (LTFU). This problem is particularly prevalent among high-risk groups – men who have sex with men (MSM) and men of Black African Heritage (BAH) – and in some parts of the country.

This SIB attacks this problem by using the mechanism of an outcomes-based contract to drive detection of HIV among these high-risk groups in the area where HIV prevalence is highest – the South London Boroughs of Lambeth, Southwark and Lewisham. As mentioned, it has been led throughout by EJAF, which has drawn on previous pilot projects, and its experience and leading role in the fight against HIV/AIDS, to drive the design and development of the SIB and its operating model, act as a co-investor in the SIB, and ultimately contribute to the funding of outcomes.

How the SIB works

The logic behind the SIB is summarised below and described further in section 2 of this report. Figure 1 shows the structure in simplified form and a more detailed diagram is in section 2.4

The key to the success of the SIB is its use of an outcomes-based contracting model to incentivise all parts of the health system to identify those living with HIV but not in treatment and support them into treatment (or back into treatment if they are deemed LTFU). In light of the benefits of early detection and treatment, it is already NICE guidance to test up to 100% of those at risk of HIV, but this rarely happens, and actual testing rates are habitually much lower. As EJAF's own projects and wider research shows, this is largely due to lack of funding and a reluctance among some health practitioners to offer testing to at-risk groups – even though tests cost very little (only about £7[3] in hospital or primary care settings).

The SIB overcomes this by switching funding from a low payment per test to a much higher payment per outcome – that outcome being the detection of those living with HIV and either getting them into treatment for the first time or persuading them to resume treatment. Outcome payments are made to providers across the health system (in primary, secondary and community settings) and supported by 'opt-out' rather than 'opt-in' testing when people attend hospital emergency departments or visit their GP – i.e. "We test everyone for HIV unless you tell us not to" rather than "Do you want to be tested for HIV?".

There have been extensions and additions to the delivery structure of the SIB since we conducted our first review:

- The number of providers has been extended: originally there were two hospital trusts, two GP federations, and two community providers

3 See NICE Resource impact report: HIV testing: increasing uptake among people who may have undiagnosed HIV (NG60), December 2016, Section 4.1.8

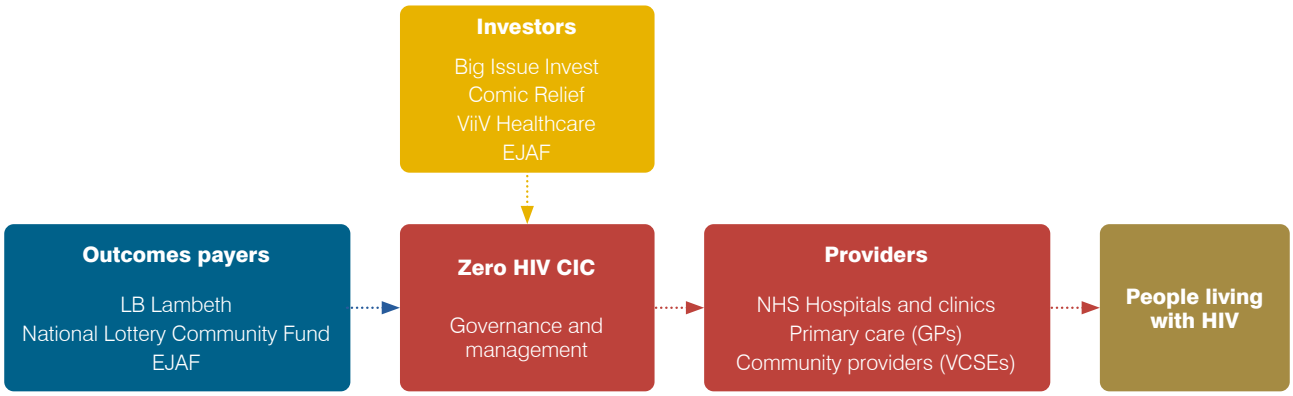
(respectively serving the MSM and BAH communities) contracted to deliver services. Over time, the Zero HIV CIC, which runs the project (see below) added further contracts so that there are now (July 2021) three hospital trusts, four GP federations and four community providers delivering services of different kinds, in different areas and/or addressing different communities;

- A further two hospital providers started the active identification and pursuit of people who are LTFU. University Hospital Lewisham (UHL) had been doing this since the start of the SIB, so that in addition to the Emergency Department testing for HIV when people attended, UHL had been actively analysing patient records to identify those who had been diagnosed and subsequently become LTFU. The clinical nurse specialist then contacted and attempted to persuade the person living with HIV to return to treatment. In 2020 the other original provider (Kings College Hospital NHS Foundation Trust or KCH) and one new provider (Guys and St Thomas' NHS Foundation Trust or GST) agreed contracts with EJAF to deliver a similar service. For shorthand, we have referred to the opt out emergency department service in this report as 'the inbound A&E service'; and the new service as 'the outbound LTFU service'.

The SIB is supported by social investment from both an established social investment fund manager (Big Issue Invest) and other investors who, at the time, had not previously invested in SIBs (Comic Relief and ViiV healthcare). Investors were attracted in part by EJAF's own commitment to be a co-investor. All investors have been fully repaid (in some cases ahead of schedule) even though the project is still in its delivery phase. We will explore investment arrangements fully in the third review.

The other interesting feature of this SIB is that EJAF is also the main contributor of outcome payments, alongside the CBO Fund. This reflects one of the key challenges of this SIB, which was to engage and then persuade local or specialist commissioners (notably NHS England (NHSE), the Clinical Commissioning groups (CCGs), and Local Authority Public Health (LA PH) commissioners) to pay for outcomes that would ultimately benefit them – because fewer people would contract HIV and more of those that did contract it would be treated earlier and therefore have less expensive inpatient stays. This was exacerbated by the very fragmented nature of HIV commissioning in England. While one of the LA PH commissioners (the London Borough of Lambeth) is contributing to outcome payments, and the other LAs (and CCG in Lewisham, where PH staff are joint appointments across LA and CCG) are contributing resources and expertise, the other CCGs and NHS England are not making any significant contribution to the operation of the SIB. The multiple roles adopted by EJAF as a co-commissioner and investor, and by the Zero HIV CIC as SIB designer and delivery manager, are a key feature of this SIB and had both benefits and challenges. Some of these were explored in our first review and we will return to them in the final review.

Figure 1 – the SIB Model (simplified)



What were the key effects of COVID-19?

Both performance data and our interviews with stakeholders show that the impact of COVID-19 varied considerably across the different strands of the project described above. The most directly impacted were the community providers, who were largely unable to deliver services at all during lockdowns, because the social and commercial venues in which they engage with people living with HIV (such as night clubs, gyms and barbers shops) were completely closed. Services did adapt where they were able to do so, but the scope for this was limited.

GP Practices were also adversely affected because fewer patients were seen face to face, reducing opportunities for engagement and testing, and GPs were in any case only allowed to order urgent blood tests, not routine blood tests (and therefore could not automatically add HIV testing to such tests) during COVID-19 restrictions. However GPs were able to carry on tracing those who were LTFU and persuading them to return to treatment, as they had done pre-COVID-19.

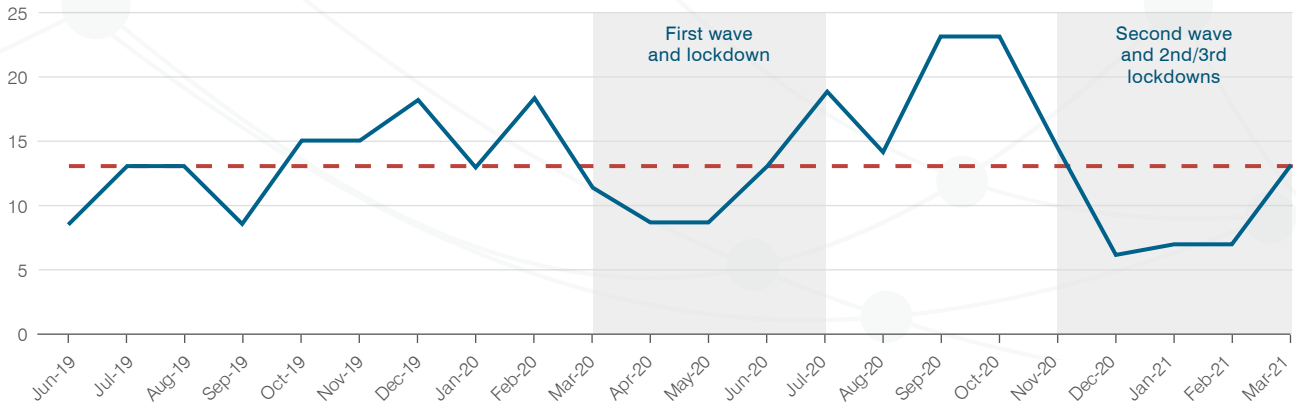
The inbound A&E service was much less affected, since a large number of patients continued to attend emergency departments and could still be tested. The main effect of COVID-19 was that those attending A&E had different conditions, with more attending because they had or believed they had COVID-19, and far fewer attending for other reasons. COVID-19 also affected the capacity of the hospitals to deliver testing – in part because some key staff were redeployed to COVID-19 wards, and in part because staff themselves were ill with COVID-19, or were forced to self-isolate. However it does not appear that these impacts were sufficient to impair the ability of the services to deliver a steady flow of outcomes.

In addition the existing outbound LTFU service in University Hospital Lewisham, and new services in the other hospital trusts, were able to operate largely normally because they did not require face to face contact to carry out the necessary audit of cases and follow – up contact work by phone or email. Thanks to COVID-19 the new services did not start on time (in April 2020) and all the services faced the capacity issues encountered in A&E, but once they were operational they performed strongly, and were able to tap into a reservoir of potential re-engagement outcomes in their early months, and especially during the summer and autumn of 2020.

So despite wide variation (which we explore in more detail in section 3 of this report) the overall performance of the project remained strong. Indeed measured on outcomes alone, the project has maintained a consistent level of performance from the point at which all the original services went live (in June 2019) until the end of the second lockdown (in March 2021). As Figure 2 shows, the trend across this period was exactly flat, with dips in performance during both lockdowns offset by a strong uptick in performance, especially from the LTFU contracts, in between.

There is also some limited evidence that the Zero HIV SIB was less affected by COVID-19 restrictions in comparison to other projects funded by the CBO programme, and exceeded its target for outcomes in the relevant period by a higher percentage than any other project.

Figure 2 – Outcome performance before and through COVID-19



Was there a SIB effect?

We also considered whether there was a specific 'SIB effect' in relation to COVID-19. Overall our conclusion is that the SIB did not have a strong effect in either helping or hindering the project to meet the impact of the pandemic, but we did observe that:

- The payment mechanism that underpins this project – based on initial fixed payments for an agreed number of outcomes to be achieved – meant that it was resilient to the potential requirement to change contracts (as has happened with some SIBs) and move temporarily to fixed fee arrangements. A combination of this payment mechanism and the natural resilience of some parts of the project meant that the project was able to maintain payment for outcomes throughout, and there does not appear to have been substantial pressure from providers to change payment arrangements. This appears to be consistent with other CBO projects which were 'commissioner-led', where in most cases commissioners agreed to continue to pay on outcomes through the pandemic.
- The payment by results structure – which provides large payments for the achievement of the two main outcomes – did indirectly enable the project to maintain a high level of performance through the pandemic because it was a key reason for the initiation of the new LTFU projects that did much of the 'heavy lifting' during COVID-19, as outlined above. Stakeholders responsible for these contracts were clear that although LTFU work is in theory already funded through the NHS block contract for HIV services, in practice they would not have been able to resource LTFU work at the intensive level needed to make it effective without the additional funding that the SIB provided. This is however a weak effect since it is not dependent on the SIB or its outcomes structure, and could have been achieved with additional, conventional funding.

While we would not argue that the SIB and its payment structure facilitated service adaptation, therefore, we do think that it enabled and supported service resilience, and enabled the project to maintain services and perform well through the pandemic.

Conclusion

Our main findings from this review are that:

- **Despite being a project that relies heavily on delivery in healthcare settings, which affected both service capacity and service access, the project did not have to make major alterations to its contractual structures to survive the pandemic.** Indeed the project not only survived, but managed to maintain a consistent and high level of performance compared to both pre-COVID-19 delivery and to other CBO-funded projects.

- **The fact that this project is a SIB did not materially help or hinder the project in navigating the pandemic, but the PbR mechanism and payment structure did support it to some extent.** The new outbound LTFU services which helped it maintain performance services was not funded through the conventional block contract structure; and it is more likely that the project would have had to alter its payment structure – perhaps moving temporarily to fee for service payments – if the SIB was not already designed to provide advance payments to providers where required against future outcomes.

- **Complex, multi-strand projects like this can be affected in numerous ways by an external factor as strong and unexpected as a global pandemic, including some effects that have rarely been seen elsewhere.** At the community level we saw some unique and long-lasting effects because of the way community services aimed at those at risk of HIV tend to work – relying heavily on outreach in unusual places such as entertainment, hospitality, leisure and even hairdressing venues. This appears to have made it even more difficult for these services to adapt, since they cannot be delivered in a different way easily, or sometimes at all. In the healthcare settings we similarly saw some impacts of COVID-19 that are not typical of impacts on projects in other sectors, notably services that were unable to operate, or only operate at reduced effectiveness, because the clinical staff who deliver them were moved to the COVID-19 front-line. Some services thus had to stop entirely – or be much curtailed – until staff could resume normal duties, rather than the more usual situation of being able to continue in a modified form, using virtual contact.

The key learning point from this, in our view, is that in assessing the risks to a project of this type of a major external event – and especially a future pandemic – it is important to think laterally about all the possible ways in which the project delivery could be put at risk, and also assess carefully whether some more obvious impacts really will occur.

1. Introduction

This review forms part of the evaluation of the Commissioning Better Outcomes (CBO) programme and is the second review of the Zero HIV Social Impact Bond. Previous reviews of this project, and other reports from the CBO evaluation, can be found here.

1.1 The CBO programme

The CBO Programme has a mission to support the development of more SIBs and other outcome-based commissioning models in England. The Programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2023. It originally made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar outcomes-based contractual models in complex policy areas. It also funded support to develop robust outcomes-based commissioning proposals and applications to the programme. The project that is the subject of this review, the Zero HIV SIB, is part-funded by the CBO programme.

The CBO programme has four outcomes:

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

The CBO evaluation is focusing on answering three key questions (although this review has a slightly different focus, as explained further below):

1. Advantages and disadvantages of commissioning a service through a SIB model; the overall added value of using a SIB model; and how this varies in different contexts;
2. Challenges in developing SIBs and how these could be overcome; and
3. The extent to which CBO has met its aim of growing the SIB market in order to enable more people, particularly those most in need, to lead fulfilling lives, in enriching places and as part of successful communities, as well as what more The National Lottery Community Fund and other stakeholders could do to meet this aim.

1.2 What do we mean by a SIB and the SIB effect?

SIBs are a form of outcomes-based commissioning. There is no generally accepted definition of a SIB beyond the minimum requirements that it should involve payment for outcomes and any investment required should be raised from investors. The Government Outcomes Lab (GO Lab) defines impact bonds, including SIBs, as follows:

"Impact bonds are outcome-based contracts that incorporate the use of private funding from investors to cover the upfront capital required for a provider to set up and deliver a service. The service is set out to achieve measurable outcomes established by the commissioning authority (or outcome payer) and the investor is repaid only if these outcomes are achieved. Impact bonds encompass both social impact bonds and development impact bonds."[4]

SIBs differ greatly in their structure and there is variation in the extent to which their components are included in the contract. For this report, when we talk about the 'SIB' and the 'SIB effect', we are considering how different elements have been included, namely, the payment on outcomes contract – or Payment by Results (PbR)[5], capital from social investors, and approach to performance management, and the extent to which each component is directly related to, or acting as a catalyst for, the observations we are making about the project.

1.3 The in-depth review reports

A key element of the CBO evaluation is our nine in-depth reviews, and the review of the Zero HIV SIB is one of these. The purpose of the in-depth reviews is to follow the longitudinal development of a sample of SIBs funded by the CBO Fund, conducting a review of the project up to three times during the SIB's lifecycle.

This report is the second in-depth review of the Zero HIV SIB. Its focus is slightly different to most in-depth reviews and is entirely on the impact on the SIB of the COVID-19 pandemic, or of restrictions and non-pharmaceutical interventions (NPIs) imposed as a result of the pandemic, during 2020 and early 2021. It follows a first review[6] which was published in 2020 and considered stakeholder experiences and learning from the design and development of the SIB up to and immediately after the point at which it was launched. We will undertake a third and final review of the SIB in late 2021 and early 2022 that will consider the overall impact of, and take learnings from, the project as a whole, including delivery up to, through and beyond COVID-19.

1.4 Report structure

This report is structured as follows:

- Section 2 provides an overview of how the SIB works and describes its structure.
- Section 3 describes how the COVID-19 pandemic and associated restrictions and NPIs affected the performance of the SIB, and how the SIB adapted to COVID-19 at both contractual and service delivery levels;
- Section 4 considers whether and to what extent the SIB and its structure enabled or hindered adaptation to the pandemic; and
- Section 5 draws conclusions from this review and points the way forward to the next and final review of this project.

4 See: https://golab.bsg.ox.ac.uk/knowledge-bank/glossary/#i
5 Payment by Results is the practice of paying providers for delivering public services based wholly or partly on the results that are achieved
6 See https://www.tnlcommunityfund.org.uk/media/insights/documents/EJAF-Zero-HIV-in-depth-review_FINAL.pdf

2. How the SIB works

This section provides a summary of the rational for the SIB and its structure. Please note that:

- Since this report focuses solely on the impact of COVID-19 on the SIB, this section concentrates on the elements of the SIB that are relevant to this issue, notably the services funded by the SIB and its outcomes and payments structure. Further and fuller details of the SIB and the logic model that lies behind it can be found in our first review of this project as referenced in section 1 above and further below.
- This section refers only at high level to changes made to the SIB since its inception, including a variation agreed with the CBO programme team in 2019-20. We will consider these changes in more detail, in the third and final review of this project. Please see section 5.2 for a summary of issues that we will address in more detail in the final review.

2.1 Overview and underlying logic for the SIB approach

The Zero HIV SIB was largely conceived and driven by EJAF. EJAF is the largest non-government funder of support to the prevention and treatment of HIV and AIDS in the UK, and one of the largest independent AIDS charities in the world. According to its website EJAF has to date raised $515m worldwide to fund 3,000 projects, saving an estimated 5 million lives.

From discussion with key stakeholders and based on documents provided to us by EJAF it is clear that there is a strong underlying logic to the approach that is enabled by this SIB, and that EJAF has drawn on significant existing research and new feasibility and pilot work to develop the project.

The underlying rationale is that anti-retroviral therapy (ART) for those with HIV is now so effective that HIV has been redefined from an acute to chronic illness, and there is a very high likelihood that those receiving ART will be able to live a long and healthy life. There are thus huge benefits to individuals if they can be diagnosed and start to receive treatment. But Public Health England (PHE) estimates that about 6% of the 105,200 people living with HIV are unaware of their condition[7].

The benefits of treatment are much greater if people with HIV are diagnosed early: a late diagnosis means that the virus has already started to damage the immune system, and poses the greatest threat to the health of those with HIV. PHE data show that 43% of those diagnosed in 2018 were diagnosed late, with late diagnosis being much higher among certain groups (e.g.: 65% among black African men).

It is extremely important to note that the benefits of getting people with HIV into effective treatment and retaining them in care are much greater than their individual health and wellbeing, because **effective treatment reduces the risk that the infected person can pass on the virus to almost zero.**

These health benefits have concomitant financial benefits for the health system through avoidance of the costs of treatment both for those whose HIV goes undetected and those who may be infected through onward transmission. There is no recent independently validated estimate of the scale of such benefits, but EJAF's own calculation is that they amount to an estimated £220,000 per person, based on £140,000 of cost avoided through treatment, and £80,000 avoided by reduced onward transmission.

Drivers of an outcomes-based approach

Both the outcomes sought through the SIB, and the services which it funds, have been shaped by existing professional guidance, substantial research, and development work by EJAF to identify the shortcomings in the current HIV testing arrangements

7 Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019, PHE

and the reasons for them, and to test alternatives. Some of this work pre-dated the development of the SIB and was undertaken as part of a wider review of EJAF's strategy in the UK and how it could make best use of its funding. This work comprised:

- ethnographic research and stakeholder engagement in the three boroughs of Lambeth, Southwark and Lewisham (LSL) which have some of the highest prevalence of HIV in the UK and are now the focus of this SIB; and
- two pilot projects to test the efficacy of increased testing in both secondary and primary healthcare settings.

The research found that barriers to testing exist among both health practitioners and potential service users. Those working in healthcare settings may be reluctant to increase their workload, resistant to the cost of testing and/or uncomfortable about the implications of engaging with service users – for example because they are uneasy about identifying those in high-risk groups or engaging people in conversations about their lifestyle. Equally patients may be reluctant to get tested due to fear of a positive diagnosis or the perceived stigma associated with it, or may be in denial about their condition.

It is arguable that these barriers could be addressed through more support to overcome them, without the need for an outcomes-based approach, such as better funding of support to address cultural concerns and HIV awareness among clinical staff in both hospitals and primary care. However, the pilots which EJAF funded, described in more detail in our first report[8], indicated that such support would not on its own be enough to effect major change, and further incentivisation was likely to be needed.

2.2 The Zero HIV SIB services and interventions

Both the services which are funded through the Zero HIV SIB, and the outcomes which it pays for, are designed to overcome the barriers highlighted above and build on the pilot research in order to achieve very high levels of testing and detection in the target areas. In summary[9], and as explained further below, the SIB achieves this by:

- **paying providers for outcomes rather than activities.** Instead of paying providers a fee per test, the SIB pays the providers for each person they identify who has the virus and needs to receive treatment (see below for details of the outcomes paid for). It directly incentivises providers to achieve the key outcomes of HIV testing – detection, treatment and ultimately improved health.
- **incentivising providers massively to increase testing and reengagement levels.** Since they are only paid for new HIV cases identified or existing cases returned to the health system, providers must undertake the high levels of testing (up to 100% in high-risk groups) that are considered good practice and recommended by PHE and NICE, but rarely achieved at present (as mentioned above current testing levels appear to be as low as 3%).
- **setting outcome payments to drive tests** in a way and at a level (several £000s per payment) that incentivises all parts of the health system (across primary, secondary and community care) to conduct them. It thus overcomes the 'wrong pocket' problem outlined above. We explain further how the SIB achieves this below.
- **funding a range of services that sit around the testing itself and providing support** to both healthcare professionals and the community, to ensure high levels of testing and appropriate support to those found to be HIV positive.

Unlike many SIBs, the Zero HIV SIB does not fund a single defined intervention delivered by one or more providers. Instead outcome payments enable a range of providers to deliver a varying range of services

8 See https://www.tnlcommunityfund.org.uk/media/insights/documents/EJAF-Zero-HIV-in-depth-review_FINAL.pdf, page 24
9 See ibid, pages 25 ff for more details

to ensure that people potentially living with HIV are engaged and tested however they enter the health system. Thus within the target LSL boroughs:

- two acute providers (hospital trusts) are incentivised to detect HIV among those who present at hospital, usually when they attend Accident and Emergency (A&E);
- the same providers, plus a third are also incentivised to identify and reengage in treatment those who were previously diagnosed and who have since fallen out of the system (technically known as "lost to follow up" or LTFU).
- four GP Federations / Primary Care Partnerships are incentivised to ensure testing by GPs; and also incentivised to identify and reengage LTFU in treatment.
- four VCSE providers are incentivised to reach out to people at risk of HIV/AIDS within the community and encourage them to be tested, working in particular with the high-risk groups: men who have sex with men (MSM) and men of Black African heritage (BAH).

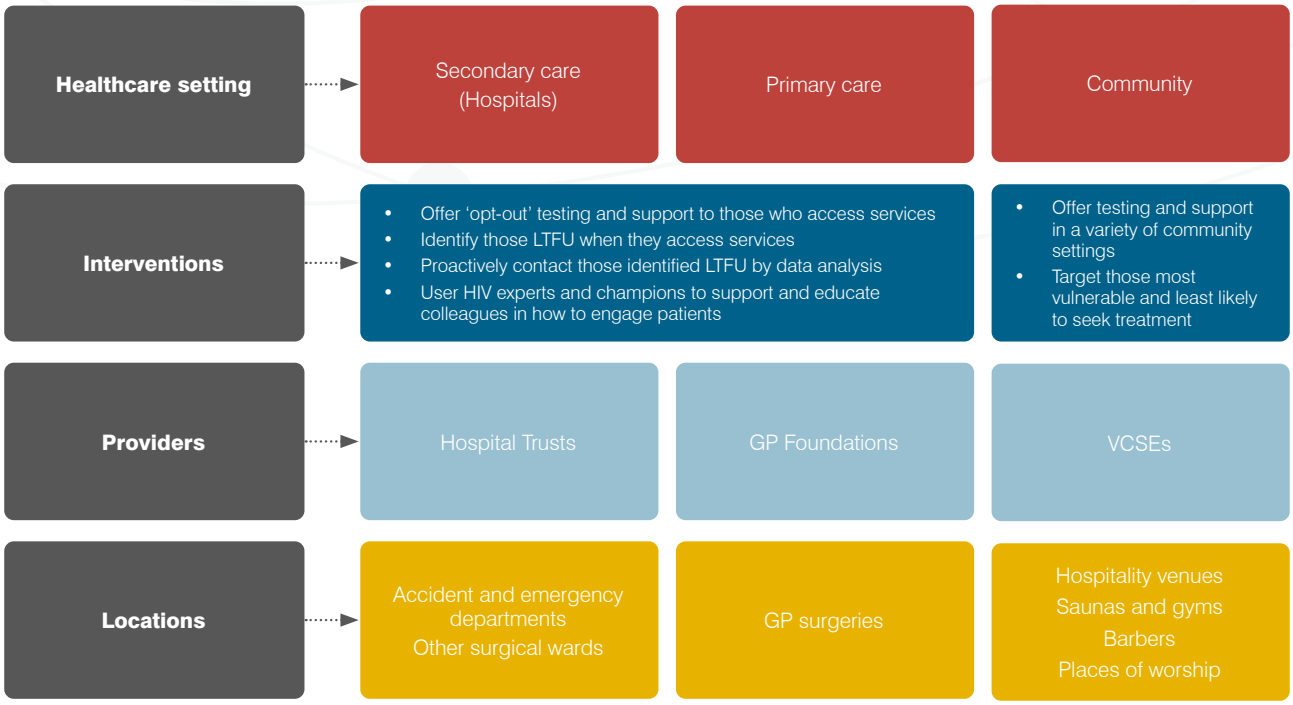
The services delivered by the providers vary according to their type and role, and are summarised in figure 2.2, with more detail in section 3 below. In overview, the hospital and GP providers are:

- ensuring tests are built into routine practice on an opt-out basis, while allowing patients to decline to be tested if they wish;
- reviewing test results and liaising with patients, and offering them support to enter and stay in care if needed;
- engaging with practitioners, increasing their awareness of HIV prevalence and risk and technical understanding of HIV, and thus enabling and encouraging them to offer testing. In hospitals, this engagement and awareness raising role is carried out by clinical specialists such as HIV consultants. In primary care this role is supported by 'HIV GP Champions', who are GPs with an interest in HIV funded by the EJAF CIC to spend a small amount of time engaging more widely with colleagues and supporting this project's implementation; and
- identifying those who have been LTFU by analysis of health records and then seeking to contact them, usually by telephone or email, and persuade them to re-engage in treatment.

The community providers are similarly encouraging and offering testing, and providing support to those newly diagnosed or identified as LTFU to accept or return to treatment. They are doing so in a range of community settings which are appropriate to the groups which they are supporting – for example clubs, bars and saunas for MSM, and barbers' shops for men of BAH.

There is an expectation, underpinned by the target outcomes which each provider is expected to achieve, that nearly all those at risk within the three Boroughs who come into contact with the health system, or are engaged within the community, will be offered testing and encouraged to take it up. At the outset the SIB aimed to test 395,450 people at base or median case, which after a contract variation agreed with The Fund was amended to 250,000. At the time of this review a total of 226,595 people had been tested via the project.

Figure 3 – Provider settings and roles



2.3 Outcomes structure and payments

All providers are paid for the achievement of two outcomes:

- Each new case of HIV infection identified and linked into HIV care; and
- Each LTFU patient re-engaged into HIV care.

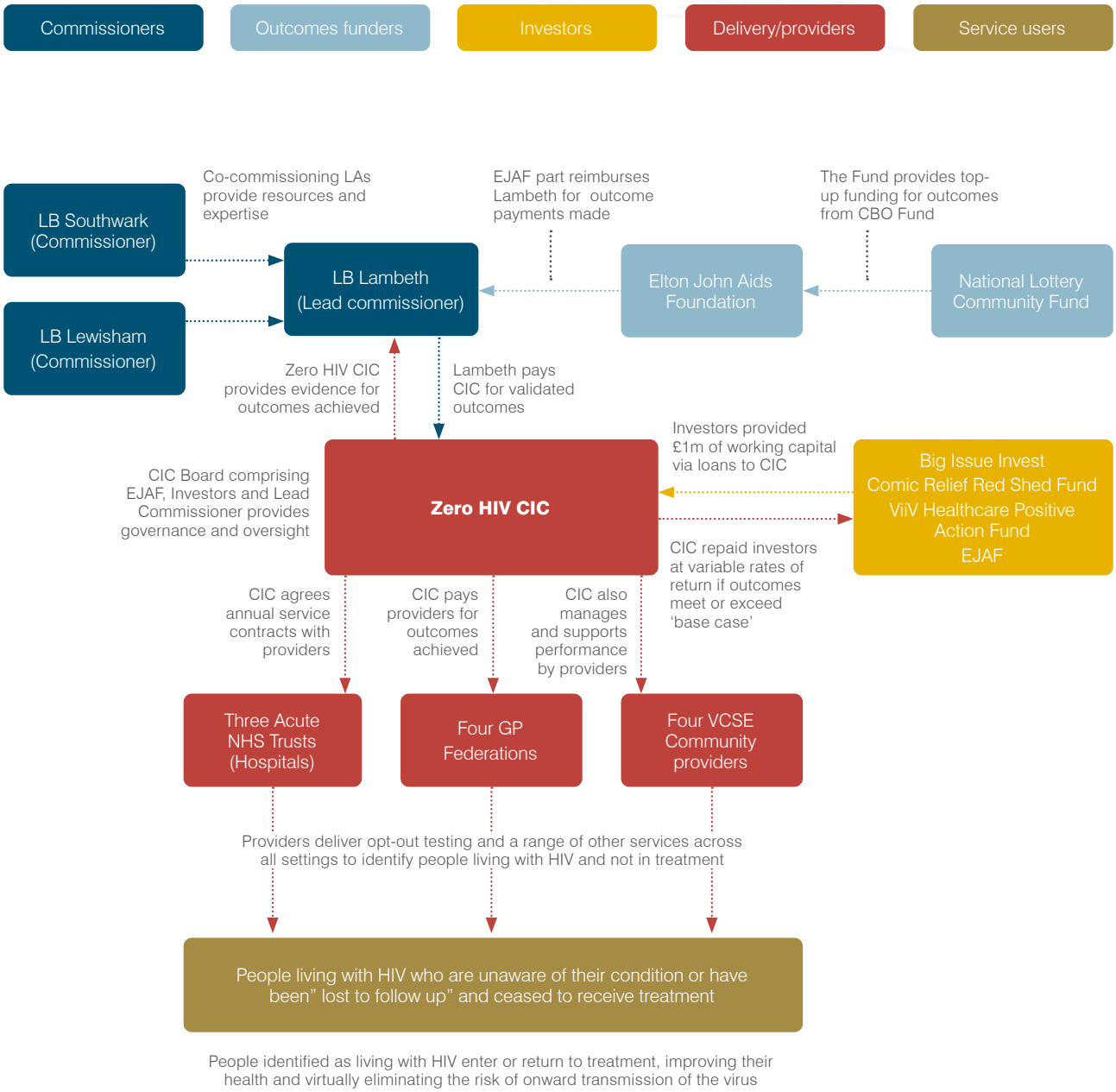
Under the contracts providers may receive an initial lump sum payment which covers a defined number of outcomes – effectively a 'minimum order' for outcomes. These advance payments vary as a proportion of possible total payment and are not recoverable if the agreed number of initial outcomes is not achieved. Once the number of outcomes set out in this initial payment is exceeded, each provider is paid per outcome achieved. To qualify for an LTFU re-engagement payment the patient must have had no care visit for more than twelve months or be deemed to have stopped treatment based on the date of their last dispensed ARVs, or been recently released from prison or an institution and had no regular HIV care provider.

The contracted outcome payments vary by provider and they have not been disclosed to us because of their commercial sensitivity, but they are in a range of around £5-6k per outcome achieved. The payments are thus substantial, and amount to several thousand pounds per outcome: effectively a small payment of less than £10 for each test has been converted by the SIB into a much larger payment for each new case identified or re-engagement made.

2.4 SIB contracting and governance structure

The nature of the Zero HIV SIB and the number of parties involved mean that it has a complex structure, as shown in Figure 4 below. Please note that this shows only the commissioners who are contributing to outcome payments or otherwise actively involved in the project – i.e. the three local authorities. Technically health bodies (NHS England and the three local CCGs) are also 'commissioners', but do not have an active role, as explained further below.

Figure 4 – SIB operating and governance structure



This structure has a number of interesting features:

- **The main contracting party and delivery body is a Community Interest Company, Zero HIV CIC, whose Board includes representatives from EJAF and the other investors in the SIB, and London Borough of Lambeth (LB Lambeth) as the lead LA PH commissioner.** Service providers do not sit on the CIC Board. The CIC selects and contracts with the service providers, and manages their performance. Performance management is supported by a performance manager employed by the CIC, and underpinned by a data recording and reporting system that is used by all providers, developed in Microsoft Power BI.

- **The SIB has a relatively complex and interesting investment structure.** There are four investors, including EJAF itself, Big Issue Invest (BII), Comic Relief and ViiV Healthcare. Investors therefore include one established social investor (BII), two charities that are relatively new to investing and usually provide grants rather than repayable finance (EJAF and Comic Relief) and one private sector provider (ViiV) though it should be noted that ViiV is also investing where it would normally provide a grant, because it is doing so from its Positive Action fund which is dedicated to community-based support. It should also be noted that BII has invested from its balance sheet, rather than through its specialist Outcomes Investment Fund; it is thus investing its own capital rather than capital it manages on behalf of other investors as an investment fund manager.

- **The investment is 'tiered', with each investor receiving a different return and being paid out sequentially according to the total number of outcomes achieved.** Importantly, EJAF is paid out last and is therefore effectively acting as a 'first-loss' investor, substantially de-risking the deal for other investors. This was always EJAF's intention, and means that it was able to market the SIB to other investors on the basis that they would accept relatively low returns. Investors provided a total of £1m in capital between them[10].

A further important feature is that there is a significant difference between the organisations who are technically commissioners of the SIB and those who are actively involved and paying for outcomes. This is unlike the majority of CBO projects where public sector bodies who are 'commissioning' tend also to be making the majority of outcome payments – with the remainder contributed by the National Lottery Community Fund, via the CBO, as a co-commissioner. The position of commissioners of this project is, in summary, as follows.

- **Technically, there are seven commissioners:** three Local Authorities (LAs) as PH commissioners, three CCGs as local commissioners of some health services for those living with HIV, and NHS England as a national commissioner of other HIV services in England.

- **In practice, however, only the three LAs are actively involved,** with the CCGs nominally being co-commissioners because there are joint commissioning and staffing arrangements for health services in the three London Boroughs covered by this project (and across London as a whole). In addition NHS England is taking learning from this project (and is involved in discussions about future funding) but is similarly disengaged.

- **All three LAs are active in supporting the project** (for example staff from the three LAs sit on the SIB Project Advisory Board, which meets every 3-4 weeks to advise the CIC about HIV and wider sexual reproductive health issues). However LB Lambeth is the only one contributing to outcome payments.

- **LB Lambeth also holds the contract to pay for outcomes with the Zero HIV CIC,** and makes the outcome payments to the CIC in the first instance. Lambeth is the lead commissioner for this project and commissioned on behalf of Lambeth, Southwark and Lewisham. It has acknowledged expertise in HIV service commissioning, including commissioning the pan-London HIV Prevention Programme.

10 See ibid, pages 31-2 for more details

- EJAF then reimburses LB Lambeth for outcome payments net of the borough's contribution of £50,000 each year. There is a single contract for the outcome payments between LB Lambeth and the CIC, and a single contract agreement between EJAF and LB Lambeth for the reimbursement.

In practice, therefore, the majority outcomes payer is EJAF itself, with the Foundation making most payments alongside LB Lambeth and The National Lottery Community Fund funding a proportion of payments as co-commissioner.

While not a major issue for this review, it is worth noting that this was not the original aspiration for this project, which was that local commissioners would, as usual, make be 'full' co-commissioners and make outcome payments. However despite constructive discussions between EJAF and both NHS England and all the local commissioners, all bar Lambeth were unable to agree to contribute to outcome payments as originally hoped, and LB Lambeth was able to contribute only a small amount. The reasons for this are complicated, and we will explore them in more detail in the 3rd and final review, but it appears mainly to have been due to general constraints on funding across all potential commissioners, and the fact that savings from earlier treatment and prevention of infection are absorbed in the health system, and do not provide a source of funding for outcome payments as happens in some SIBs.

This unconventional structure means that EJAF is acting as both an outcomes-payer and an investor, which is highly unusual and possibly unique in UK SIBs. It clearly makes the project attractive to both the LAs (because they are not paying for a substantial uplift in local HIV testing) and the CCGs (because all the outcome payments are being met by other funders). In the context of this particular review, it meant that the local commissioners were largely detached from the process of deciding whether and to what extent contracts need to be amended in order to adapt to the impact of the COVID-19 pandemic; such decisions largely devolved to EJAF itself as the ultimate payer for the majority of outcomes – see section 3 for more details.

3. What happened during the pandemic?

This section describes and analyses what happened when COVID-19 hit the UK and, in particular, when the UK government-imposed restrictions and NPIs, initially in March 2020. It focuses on the impact of the pandemic during three main periods: what is widely referred to as the 'first wave' of COVID-19 from the middle of March to July 2020; the period of relatively low prevalence of the virus, and relaxed restrictions, between July and early November 2020; and the period covering the second lockdown and 'second wave' of the virus from November 2020 to March 2021.

The views of stakeholders included in this section are based on:

- interviews with the EJAF CIC, two of the SIB investors, the lead and one other LA PH commissioner, two hospital trusts and two VCSE community providers. We conducted these interviews between March and early June 2021;
- the views of two of the GP HIV Champions, from different GP federations, gathered by responses to written questionnaire during April 2021. As explained in section 2.2, GP Champions support the SIB in their respective areas and engage with GP colleagues to encourage them to offer testing. We were not able to interview these Champions due to their lack of capacity (itself a result of the pandemic and the surge in non-COVID patients needing attention once the second wave started to ease).

This section considers:

- what happened to SIB performance as measured by outcome achievement;
- how and why performance was affected across each of the service strands and healthcare settings, due to various impacts of the pandemic and associated restrictions; and
- how the project and individual providers adapted to the pandemic, in terms of both delivery and contractual arrangements.

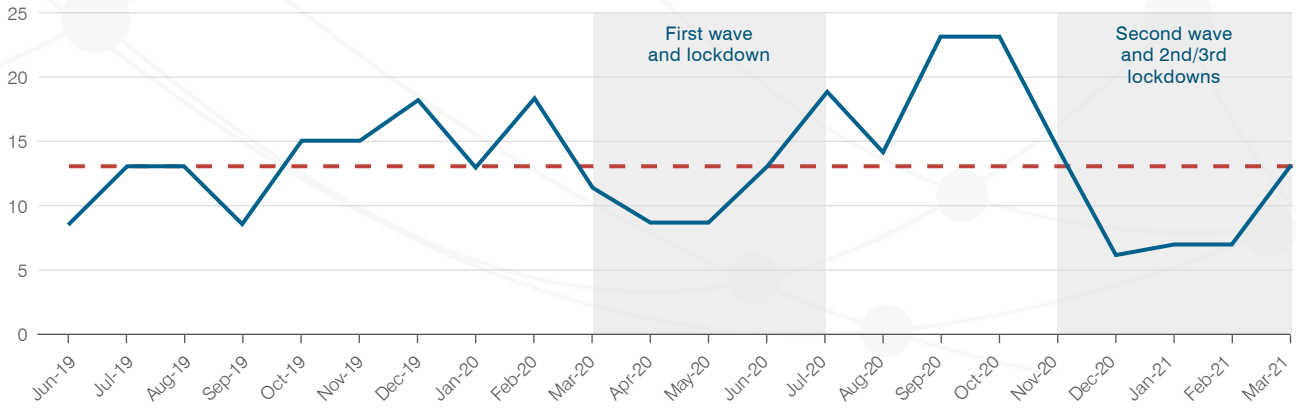
3.1 The impact of COVID-19 on outcome achievement

We assessed the impact of the pandemic on SIB performance by reviewing EJAF data on total outcomes achieved before and through the period of the pandemic. We should caution against over-interpretation of trends within this dataset because the overall volume of outcomes is low, and therefore liable to be somewhat 'noisy', with natural variations in monthly outcome achievement.

To avoid further distortion we also excluded data on outcomes before June 2019 (because some of the providers were not delivering services prior to that date); and after March 2021 (because EJAF reported that the last two months of data available, for April and May 2021, were likely to show a lag in outcomes reporting).

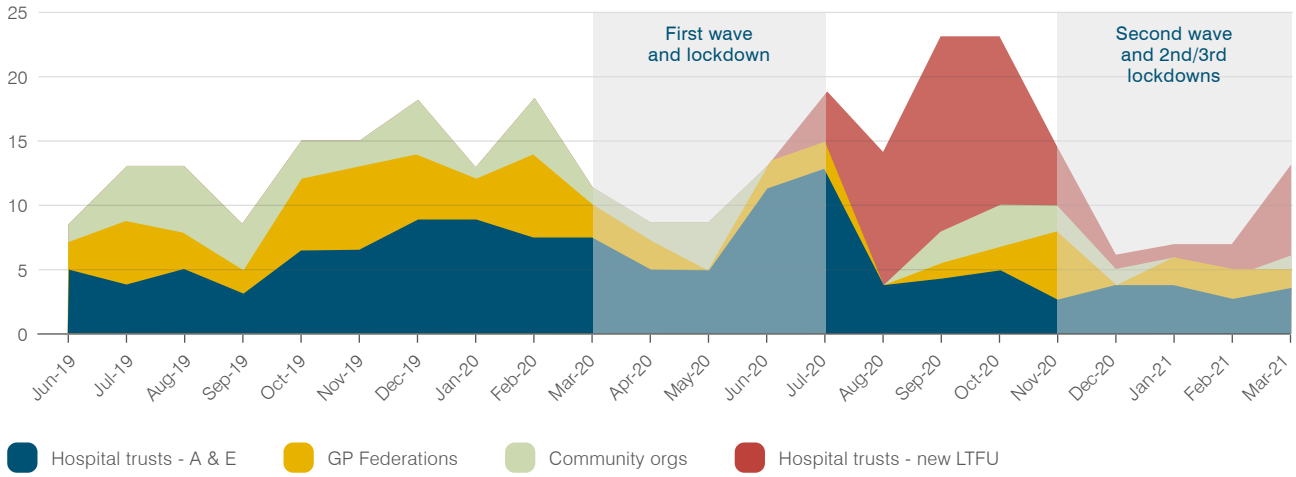
Based therefore on data from June 2019 to March 2021, Figure 5 shows that overall performance remained at the same level through the pandemic, with the trend line completely flat, and average outcomes totalling 13 per month throughout. Some effect of the two waves of the pandemic is also visible, with dips in outcome achievement during both the first and second waves and associated lockdowns, and a peak during the autumn of 2020 when there was a partial return to nearer normal working, especially in the hospitals.

Figure 5 – Total outcomes achieved June 2019 - March 2021



However this overall flat trend disguises wide variation in performance between the different strands of the SIB delivery model, as figure 6 shows. Both this data, and our discussions with stakeholders, described further below, appear to show that:

Figure 6 – Total outcomes achieved by service strand June 2019 – March 2021



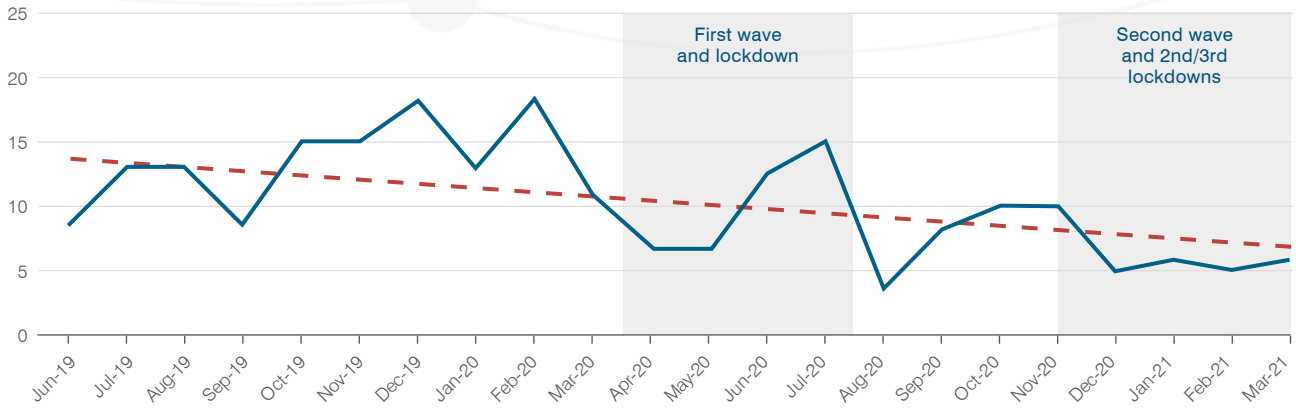
- Performance in hospitals of the in-bound A&E service was broadly maintained through the pandemic. This appears largely to have been because opt-out testing in A&E was able to continue with a substantial, but slightly different, target cohort. The outbound service that was already being delivered in one hospital was also able to continue through the first and seconds waves;

- Performance fell sharply across both the primary care and community settings, reflecting major challenges of delivery, for a range of different reasons (see section 3.2 below), across both these strands; and

- Underperformance in these areas was offset by very strong performance in the new out-bound LTFU service in two hospitals. These services appear to have performed strongly both because although the new contracts did not start until July (having been delayed by the first wave, for reasons explained below) they were able to tap into a reservoir of potential re-engagement outcomes in their early months; and also because they were able to operate largely normally during lockdown conditions (since they were not dependent on face-to-face contact to be effective).

The impact of the new out-bound LTFU service in offsetting under-performance elsewhere can be seen clearly in Figure 7 below. As this shows the trend would have been noticeably down without these new contracts, and total outcomes over the pandemic period (March 20 – March 21) would have been 107 rather than 165, with the two outbound contracts accounting for 35% of all outcomes over this 13 month period. We explore the reasons for and implications of this below and in later sections

Figure 7 – Total outcomes achieved excluding new LTFU contracts June 2019 – March 2021



3.2 What affected performance across each service strand?

Qualitative research with stakeholders indicated a number of reasons why the different strands of service delivery were affected by COVID-19, as summarised below.

3.2.1 A&E testing in hospitals

The delivery of 'opt-out' testing for HIV in A&E under this SIB was not adversely affected by COVID-19 to a significant extent. According to stakeholders there were two main reasons for this:

- The service is not an intensive intervention requiring much additional resource, since it mostly involves existing A&E clinical staff offering HIV testing to those who present with a range of conditions that require their blood to be tested for other reasons (see Figure 8). As a result the service was not significantly impacted by the loss of capacity caused by COVID-19, because in both hospitals A&E continued to be adequately staffed and therefore the opportunity to offer testing remained. This is despite the fact that in one of the hospitals clinical staff overseeing the testing (an HIV consultant and nurse) were redeployed to treat COVID-19 patients on the

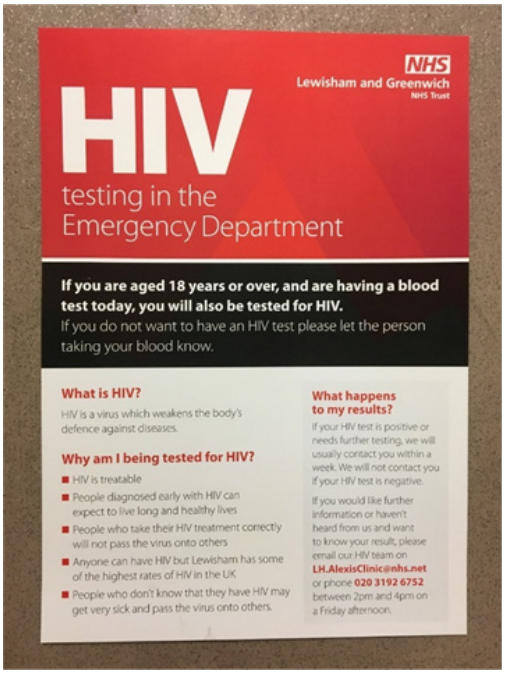


Figure 8 - A & E poster

wards during both waves, and in the other capacity was stretched due to a general shortage of staff caused by COVID-related sickness and self-isolation.

- Although COVID-19 deterred many from attending A&E (and patients were discouraged from attending unless in a genuine emergency) this was offset by many more attending with COVID-19 symptoms. Overall, therefore, there were enough patients for testing to continue to be offered at scale, and the slightly narrower range of conditions presenting did not appear significantly to affect the prospects of new HIV cases being identified. Indeed some new HIV cases were identified because the COVID-like symptoms with which patients presented turned out to be Pneumocystis Pneumonia (PCP) – a condition frequently associated with HIV/AIDS.
- In contrast to primary care (see below) the hospital A&E Departments were able to order routine blood tests, and simply add the HIV test to those being undertaken for other reasons.

In summary, therefore, the delivery of 'opt-out' testing for HIV in A&E was not unduly affected by COVID-19, in terms of ability to continue testing and meet outcome targets, due to A&E remaining open throughout COVID-19 restrictions and attendance at A&E remaining high. While COVID-19 did adversely affect staff capacity, due to staff redeployment and absence, the ability to carry our routine blood tests did not require high resource and was largely able to continue.

3.2.2 Primary Care

The service offered in primary care involves both routine testing of those who attend GP surgeries for appointments (see Figure 9) and a degree of proactive tracing and contact of those LTFU, in similar vein to the outbound service now operating in the hospitals.

The testing offered by GPs in surgeries was severely affected by the pandemic, with knock on effects on outcome achievement. According to the GP champions that we consulted this was because:

- People were reluctant to attend GP surgeries in person, and most consultations were only by telephone or on-line. This reduced opportunities for blood tests and GPs were in any case only allowed to request urgent blood tests;
- There was thus a significant decrease in the number of routine blood tests taken and thus a decrease of opportunities to add HIV tests to patients' usual 'blood panel'; and
- Some clinicians felt less comfortable raising sensitive issues such as assessing risk for HIV or offering an HIV test over the phone than face to face

These challenges did not significantly abate between the first and second waves and accompanying lockdowns; indeed at the time of the fieldwork for this review (March to June 2021) a proportion of appointments continued to be undertaken without face-to-face contact – though GPs were again allowed to request routine blood tests and surgeries had started offering routine bookable face to face appointments.

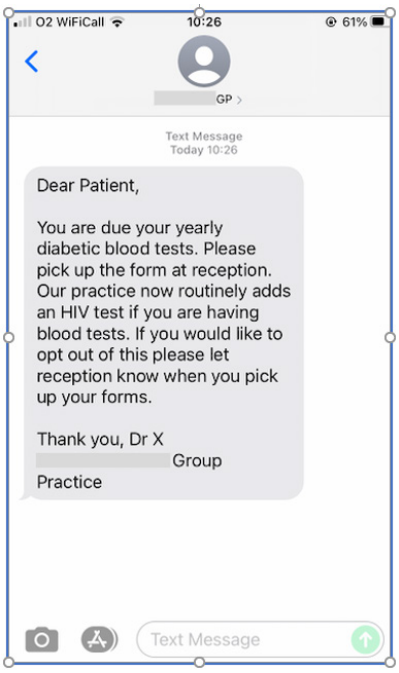


Figure 9 - GP practice text message to patient

The GPs had however been able to achieve some outcomes by focusing on LTFU and using proactive outbound contact. One stakeholder thought this had been somewhat easier during lockdown because "Patients were more receptive to phone calls from their GPs during the uncertain times and were more concerned about their health." In general, the view of all stakeholders was that LTFU cases are very difficult to track down and even more difficult to persuade to return to treatment for a range of reasons, as explored further in section 3.2.4 below.

In summary therefore, primary care was more adversely affected by COVID-19 than A&E, due to fewer appointments and therefore fewer opportunities to offer testing, and restrictions on routine blood testing, Practices could however deliver some outcomes, especially by tracing those LTFU.

3.2.3 Community providers

We interviewed two VCSEs who have been contracted as community providers under the SIB. One of these has been delivering services under the SIB since June 2019 and focuses on outreach testing for HIV and other Sexually Transmitted Infections (STIs), and associated support, with MSM. The second VCSE was a relatively new provider, awarded a contract by EJAF in 2020 to promote testing in hairdressers and barbers shops, and predominantly targeting the BAH community.

Both these contracts were severely affected by COVID-19 and associated restrictions. The principal reason for this was the forced closure under the restrictions of the venues in which the providers customarily delivered services. For the established provider, these were venues where MSM/gay men socialise such as night clubs and bars, as well as gyms and saunas. Most if not all of these venues were closed completely during both the first and second waves and associated lockdowns, and some key venues such as night clubs remained closed throughout from March 23rd 2020 until July 19th 2021. While others reopened at various times, there were continuing restrictions that made it difficult for the provider to deliver services efficiently (for example limits on total numbers able to enter venues) and the stop/start nature of restrictions at different times made it challenging to organise services.

A further factor affecting this provider was that people were in general socialising less, and thus there was a reduction in casual sexual activity. Since such activity naturally drives risk awareness and increases demand for HIV/STI testing, there were fewer people needing or wanting to be tested irrespective of venue access.

This provider did try to adapt to COVID-19 restrictions and offer some of its services online, and also amend some of its contracts to deliver services differently. These adaptations worked better for some contracts than others, and had limited success with regard to the Zero HIV SIB contract. The provider attributed this to having no track record of delivering their services online in the LSL boroughs, and therefore not being known to potential users. In addition this provider explained that the SIB contract enabled them only to offer HIV testing in isolation, rather than combined with tests for other STIs, which users prefer (though EJAF point out that there were no restrictions on how the outcome payment was used, and this may therefore be more of an adequacy of funding issue than a contract constraint). This provider's point of comparison was a conventional contract in LB Greenwich, where both being a known online 'brand' and having the ability to offer combined testing for all STIs meant that online take up was already high and increased substantially through the pandemic.

The second provider was similarly affected since it was unable to start the planned contract because all hairdressers and barbers were closed during the first lockdown from March 23rd to July 4th 2020. Once facilities reopened some proprietors who had previously signed up to participate in the programme, for example by offering free haircuts to those who agreed to be tested – see Figure 10 – were understandably reluctant to take part because of other pressures – e.g. of operating under COVID-19 safety protocols, and catching up on backlogs caused by lockdown. As a result this contract started late and did not deliver an outcome until November 2020 – just

in time for further lockdowns to be imposed and hairdressers and barbers to be closed again.

In summary, therefore, both community providers that we interviewed were hugely affected not only by reduced ability to engage with people face to face (a factor which has affected numerous projects through the pandemic) but also by the complete closure of venues to an extent that could not have been foreseen when the services were devised. We discuss the implications of this in section 5 of this report.

Figure 10– Poster promoting barber's shop testing

3.2.4 New LTFU contracts

As already outlined above EJAF agreed new contracts in 2020 with two hospitals (one already delivering A&E testing services under the SIB, one entirely new) to deliver an 'outbound' service that would proactively analyse data to identify those previously in treatment and now LTFU, and then seek to re-engage them by various means such as contact by telephone and email, and persuade them to attend clinic and restart treatment. We interviewed a key stakeholder in one of these contracts, an HIV consultant leading the contract in one of the hospitals.

These new contracts are interesting for a number of reasons and we will want to explore them further in the third, full review of this project. A key feature is that in the opinion of one of the stakeholders we spoke to, with direct responsibility for initiating and implementing one of these contracts, they would not have been initiated or implemented without the targeted additional funding that the SIB was able to provide. This is because outbound tracing and reengagement work is resource intensive, and needs nurse and/or admin support, plus a clinical lead able to give the service at least one session a week, in order to analyse data, make contact calls etc, and when successful follow up to persuade people to reengage.

In theory this work is already funded and paid for within the generic NHS HIV services specification contract (as one commissioner stakeholder pointed out to us), but pro-active re-engagement of this kind is, according to other stakeholders, extremely challenging and funding is simply inadequate to cover the dedicated resource needed.

The challenge and cost of such re-engagement is however viable in the context of this SIB because each successful re-engagement attracts a high outcome payment, and therefore enough funding is available if only a few successful re-engagements can be made. Indeed we would note that the other hospital provider was already doing some outbound work as part of its own outcomes-based contract with EJAF, alongside A&E testing, and using a different delivery model.

The impact of COVID-19 on these contracts and the role they played through the pandemic is also interesting, because:

- in the short term, the contracts were unable to start on time and as intended in April 2020. This was shortly after the start of the first wave and first lockdown, and the contracts could not start for the simple reason that staff were not available to implement and run them. Clinical staff critical to the delivery of the outbound service were deployed to treat patients with COVID-19 (and HIV clinics that would treat any LTFU patients once re-engaged were closed). In addition in the hospital we spoke to, a crucial new staff member who would lead data analysis of those LTFU, could not be recruited;

- however once the first wave eased and the contracts could start, in July 2020, they were very successful, and were able to achieve significant outcomes. As already noted in section 3.1 above these two contracts achieved 58 outcomes between July 2020 and March 2021, and in the three months August – October 2021 (when the contracts had a month to start working and restrictions were at their lightest) these two contracts delivered nearly two-thirds of all outcomes achieved – 38 out of 60.

There appear to have been two main reasons for this strong performance relative to other service strands, one COVID-related and one not. Unrelated to COVID-19 is the fact that there seems to have been real potential in these contracts (as the clinicians in the hospitals had realised) to tap into a reservoir of people who were LTFU but would re-engage if enough resources and effort was put into tracing and persuading them.

Related is the fact that these contracts were also able to operate relatively unencumbered by COVID-19 restrictions, since they did not require face-to-face contact to operate unless and until people were successfully engaged and persuaded to return to clinic. They could then be treated once clinics reopened (and most could be treated even if specialist clinics were operating at reduced capacity under COVID-19 restrictions, because their condition would pose an imminent and serious threat to their health). They were thus able to continue to operate at a much higher level throughout the pandemic and especially when restrictions eased (and we would note that service and outcome achievement by these contracts fell away during the second wave, when staff were again redeployed to treat patients with COVID-19).

We would note that a similar though weaker effect was observed in primary care. As explained above, the delivery of services under this contract was severely impacted in GP surgeries due to the lack of face-to-face appointments, but surgeries were able to continue some outbound work because it did not require face to face contact.

3.3 Alteration of contracts to respond to the pandemic

3.3.1 Alteration to give supplier relief to providers

The context for consideration of whether and how contracts were altered is that many contracts, both conventional and outcome-based or payment by results, have been severely impacted by COVID-19. At the outset of the pandemic, in March 2020, the Cabinet Office issued a Procurement Policy Note (PPN)[11] which provided information and guidance on how all public authorities should respond to contract disruption, and seek to ensure service continuity through COVID-19, by providing what was termed 'supplier relief'. Amongst other things authorities were instructed to:

- Urgently review their contract portfolio and inform suppliers who they believe are at risk that they will continue to be paid as normal (even if service delivery is disrupted or temporarily suspended); and

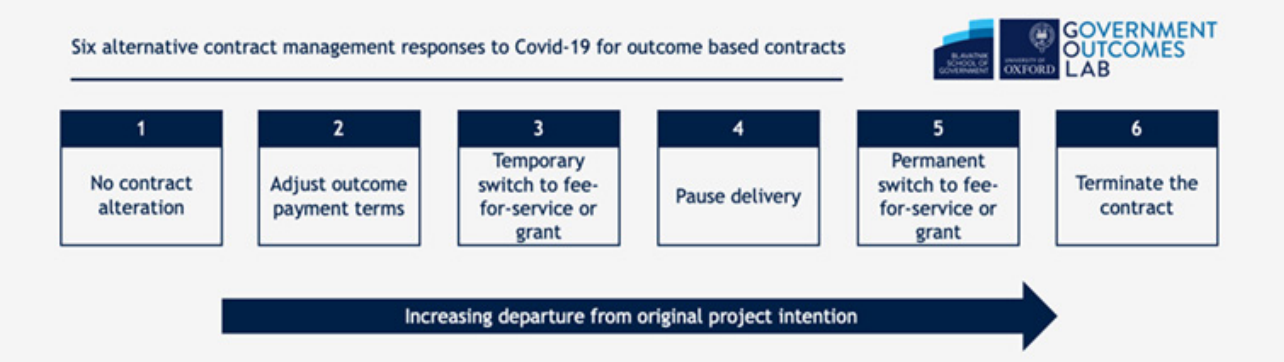
11 See https://www.gov.uk/government/publications/procurement-policy-note-0220-supplier-relief-due-to-covid-19

- Put in place the most appropriate payment measures to support supplier cash flow including approaches such as forward ordering, payment in advance/prepayment, interim payments and payment on order (not receipt).

For contracts involving payment by results the PPN advised that payment should be on the basis of previous invoices, for example the average monthly payment over the previous three months.

Subsequently further guidance specific to SIBs was issued by GO Lab[12]. It identified six options for responding to COVID-19 depending on the extent to which the original intention of the project had been disrupted, and ranging from making no alteration to contract through to contract termination (see Figure 11 below)

Figure 11: Alternative contract management responses to COVID-19 (Source GO Lab)



While there has to date been little published research on the extent of such adjustment, there is emerging evidence that the majority of SIBs and outcomes-based contracts have had to make alterations in line with this framework and the original Cabinet Office PPN, with responses typically involving at least temporary adjustments to payment terms and frequently a temporary switch to fee-for-service or grant payments because outcomes could not be maintained through the pandemic.

For example, we know that:

- across many CBO projects there has been some adjustment (see Box 1) although we should note that the situation has since changed and some projects did not in practice need as much adaptation as originally anticipated. We will therefore revisit the comparison with other projects in our third review.
- The GO Lab COVID-19 Resource Hub provides insight[13] into the financial and contractual impact of COVID-19 on projects, noting that options included *'…to continue providing services but to put the outcomes contract on hold, and shift to grant or fee-for-service payments for at least the duration of the lockdown…'* and/or *'…to negotiate changes to the payable outcomes themselves – either changing the definition of some or all of the payable outcomes, adding entirely new payable outcomes that better aligned with the current priorities for the service users, or increasing payment amounts to secure service viability'.*
- we are aware from other projects that we have evaluated (but where our research has not been published) that there has been significant contractual adjustment including the suspension of payment structures and a switch to fee-for service payments.

12 See https://golab.bsg.ox.ac.uk/community/covid-19-resource-hub/selecting-alternative-funding-arrangements-uk-sibs-response-covid-19/
13 See https://golab.bsg.ox.ac.uk/community/covid-19-resource-hub/read-what-go-lab-learning/#financial-impact

Box 1 – Changes to CBO - funded projects due to COVID-19

The Fund agreed CBO programme changes in May 2020 and, at the time the evaluation received information from The Fund (September 2020), The Fund was implementing the following changes with individual projects or families of projects:

- 15 families/projects moved to online delivery platforms supported by their commissioners and investors. Two of these saw increases in service user uptake possibly linked to the accessibility of WhatsApp for service users.
- Eight families/projects, particularly those supporting health-related outcomes, needed to bring in additional soft outcomes payments to help sustain projects where the existing outcomes metrics did not generate outcomes due to barriers to access. The Fund was supporting these for an initial six months to September 2020, with a review point by October 2020 to allow for further extension at The Fund's discretion. These were normally agreed at the expected contract median scenario and had been agreed for six projects in October 2020, with further information awaited from the remaining two projects.
- Seven projects wanted to extend the length of their projects, so The Fund extended the length of the programme by up to a year to March 2024, allowing delivery to run to August 2023. Extensions of length had been agreed for four projects, with agreement on the remainder due by April 2021.
- Commissioners in five projects moved temporarily to a fee-for-service block payment arrangement, with one blending fee-for-service and outcomes. The Fund agreed this, subject to the commissioners aiming to return to a full outcomes model from between October 2020 and April 2021. In these projects The Fund supplemented this by paying for soft outcomes. In two projects both the commissioners and CBO paid for soft outcomes temporarily
- Commissioners in two projects asked to adapt service user targets to widen age ranges. The Fund agreed this in one case and, subject to final metrics, intended to agree to this in the other.
- Two projects paused delivery temporarily. The Fund was working with the projects to support them to return to delivery. One returned to delivery in June 2020 and the other was anticipated to re-start in September 2020.

In light of this arguably the single most important finding from this review is that this project did not need to make any significant contract adjustments to provide supplier relief, and none were requested or thought necessary by any of the providers, including those most adversely affected by the pandemic as described above.

The main reasons why the primary and secondary care providers did not require contract alteration have already been described above, and include that:

- Hospital A&E testing was able to maintain a reasonable level of service throughout, and thus achieve sufficient outcomes to avoid the need for contract alteration. This was confirmed by the contract manager for one of the hospital A&E contracts, who indicated that a request for contract alteration was neither considered nor thought necessary; and
- Although the service offered by GPs was more severely affected, stakeholders told us that they were nevertheless able to meet minimum outcome targets, due to some inbound outcomes still being

achieved and it still being possible – indeed to some extent easier – to achieve outbound LTFU outcomes by remote/virtual means.

The position with regard to the community providers was more complicated, and as already explained above one of the providers we spoke to did experience a downturn in outcome volume that might have caused significant issues, while the other was unable to get the contract implemented at all for many months.

However they too were able to avoid significant alteration to contracts because the EJAF contract already pays providers for payment in advance against a number of outcomes, as explained in section 2.3 above. This meant that there was already an element of supplier relief, especially of cashflow pressure, built into existing arrangements. As a result, there was no need for EJAF to make any further payments to the community providers and EJAF expects that they will still be able to cover all or most of these advance payments from outcomes once delivery returns to more normal conditions.

There were also other factors that helped one established provider (working with the gay/MSM community) manage through the pandemic. These were that:

- The EJAF contract (which is renewed annually) expired shortly after the first lockdown started and the provider asked to delay its renewal, and was thus not under outcome pressure during a period when almost no service delivery was possible; and
- This provider did get supplier relief on other, conventional contracts, funding from which enabled it to sustain operations and retain staff when it might otherwise have been difficult to do so. Indeed this provider did not need to furlough any staff during the pandemic, including those employed on the EJAF contract.

In the context of wider understanding of how providers have adapted to COVID-19, it is worth noting that this provider made other adjustments to its operations as it became apparent that the impact of COVID-19 would be felt over a longer period than anticipated. In particular it sought to:

- Renegotiate some conventional 'block' contracts so that they allowed the provider to operate in other locations – such as parks and public spaces – as well as entertainment and hospitality venues. However it proved very difficult to achieve this due to commissioner resistance; contracts were eventually changed, but it took nearly a year to do so; and
- Purchase and equip a bus so that it could deliver testing in any reasonable location, rather than in venues. This again is now in place, but took time to implement.

3.3.2 Views of commissioners and investors

In the contractual context it is also worth noting the views of commissioners and investors, which again are different to those observed in a number of SIBs responding to the pandemic, based on evidence across the CBO projects and GO Lab's insights from its COVID-19 resource hub as outlined above. Again, the differences appear to reflect the design and structure of this project.

With regard to LA PH commissioners, those we spoke to were aware of the potential effects of the pandemic but also content to leave it largely to EJAF to consider and make any changes needed. This reflects the unusual payment and funding structure of the SIB (explained in section 2.4 above) whereby EJAF is itself ultimately responsible for making the bulk of outcome payments, and the Zero HIV CIC has responsibility for setting and managing individual contracts with providers. This meant that the commissioners were largely at arm's length from any decisions on contract alteration; indeed the commissioners noted that this contract was, from their viewpoint, handled very differently to other sexual health contracts that they were commissioning and funding directly, especially from community providers. For these conventional fee-for-service

contracts, the commissioners had to put in place significantly different arrangements to ensure supplier relief, in line with Cabinet Office guidance

This appears to be because conventional contracts are largely activity-based, and provide a block payment for a specified number of tests conducted. If this volume of tests cannot be delivered the contract is immediately unviable, and payments need to be made to provide supplier relief until volume returns to normal. Paradoxically, although an outcomes-based contract is in theory more risky the providers had already 'baked in' that risk when they accepted the PbR mechanism – and as explained earlier all the contracts are based on a high payment for a low volume of outcomes, rather than a low payment for a high volume of tests. Thus provided some outcomes could still be achieved (or were covered by the advance payments made by EJAF CIC) the contracts did not need immediate supplier relief.

The position of investors is also interesting, because in some SIBs affected by COVID-19 we are aware that the investors (or an Investment Fund Manager or IFM) have been central to discussions around contract alteration and the granting of any supplier relief. This is because the investor/IFM is often the contract holder, and party at risk and in need of relief if outcomes cannot be achieved. However the investors in this SIB injected capital into the Zero HIV CIC, which acted as the contract holder and in turn provided working capital to providers in the form of advance outcome payments. Moreover the SIB was performing well and investors were being repaid as expected. There was thus no pressure on commissioners or other parties from investors to change contracts, and indeed by the time we conducted this review the four investors had already been fully repaid by the CIC. Investors were thus in a similar position to local commissioners: they kept a watching brief via their representation on the CIC Board, but were able to leave it to EJAF and the CIC contract management team to consider whether any changes to contracts might be needed.

4. Was there a SIB effect in relation to COVID-19?

In this section we consider whether the fact that this contract is a SIB helped or hindered the project and individual services to adjust to the impact of the pandemic – i.e. was there a specific 'SIB effect'. Overall our conclusion is that the SIB did not have a strong effect, either positive or negative, but we did observe some weak positive effects as explained further below.

4.1 The SIB effect – contract alteration

As noted in section 3.3 above, some SIBs have had to make significant alteration to contracting arrangements in the wake of COVID-19 and its impact on a range of factors, but this project was not one of them. In general there has been some debate post-COVID about whether outcomes contracts and impact bonds facilitate alteration (because their outcomes structure and use of external capital makes them more flexible and able to adapt) or impede it (because outcomes and payment structures, and sometimes other factors such as required referrals, tend to be quite rigidly specified in some SIB contracts). In this case the issue is largely moot, since there was no requirement for significant alteration.

We do however think it reasonable to argue that the project was able to avoid such alteration in part because of its design, and especially its payment structure. Since most providers are paid in advance for a set number of outcomes, an element of 'supplier relief' is already built into the SIB structure. As we explain in section 3.3 above, by using this facility the Zero HIV CIC project team was able to avoid what might have been a more significant alteration – especially if the contracts had either been 100% outcomes-based (with no advance payments) or had been conventionally based on funding a specified number of tests – which as explained earlier would have made the contracts almost immediately unviable in some community settings, because there was no-one to test and nowhere to test them.

It is also arguable that there was less pressure to change the structure and contractual arrangements than there would have been if investors were more heavily involved in the decision-making process. As we explain above investors were also relatively disengaged because the investment structure (and success of the SIB in achieving outcomes) meant that investors were not significantly at risk from the likely impacts of COVID-19 on the project.

In our view, however, this is a weak effect and based on the views of all stakeholders, we do not think it likely that the project would have had to make significant alteration even if investors had been more directly involved. Through a combination of up-front funding to some providers and the resilience of some service strands to COVID-19 effects, there does not appear to have been substantial pressure to change payment arrangements. This appears to be consistent with other CBO projects which were 'commissioner-led' where in most cases commissioners agreed to continue to pay on outcomes through the pandemic.

It is however interesting that commissioners had to make significant alteration to other sexual health contracts – including some to promote HIV testing in the community – which were more conventionally constructed, usually on a block payment basis to conduct a specified number of tests. This adds some further weight to the view that this project's payment structure – which offers high payments for a small number of outcomes, rather than low payments for a high volume of tests –might have been more resilient to the external shock of COVID-19, because the funding stream can be maintained with relatively few outcomes. It is however difficult to test this hypothesis because there are no comparable contracts elsewhere.

4.2 The SIB effect – service adaptation

In other SIBs impacted by COVID-19 there has also been a debate about the extent to which SIBs have enabled providers to respond differently and more flexibly to the need to adapt services through the pandemic and especially through the first lockdown – for example it is sometimes argued by SIB investment fund managers (IFMs) that providers funded by social investment can spend more flexibly, and on items that would not be permitted under a different type of contract, and thus do 'whatever it takes' to help service users through the pandemic. Again this effect is debatable, since the Cabinet Office PPN and other guidance have strongly encouraged all public authorities to be flexible and pragmatic across all types of contract in response to the pandemic. However preliminary indications from CBO projects are that this claim of increased flexibility holds true, and reduced the need for service adaptation through the pandemic.

Our research with stakeholders in this project indicates that the SIB or its funding did not have a significant effect on the way they adapted services to COVID-19 one way or the other, and all provider stakeholders indicated that they would have responded similarly if the project had been conventionally funded. They observed that for the most part they were responding to factors that had little or nothing to do with the contract's objectives, and which were largely outside their control. Notably these included clinical staff not being available to deliver services when dealing with COVID-19, changes in service user behaviour in response to COVID-19 or NPI restrictions, reduced opportunities to offer opt-out testing, and the closure of venues in which services could be offered. Providers responded to these changes as one would expect, and in line with other projects – most obviously by delivering services through remote means where it was possible to do so.

The one area where we do think it is possible to see an effect is in the success of 'outbound' services in enabling the SIB to maintain a high level of performance, as measured by outcome success, throughout the pandemic. It was a commissioner stakeholder who first observed to us that the SIB as a whole would have performed differently and much less well if the new outbound contracts had not been implemented in the summer of 2020; and stakeholders leading those contracts told us that the services provided were not affordable through the standard NHS HIV services contract. Moreover stakeholders in both primary and secondary care indicated that this type of outbound service – which only involves face to face contact once the patient who is LTFU has agreed to attend a clinic or GP surgery – was already well adapted to lockdown conditions.

However this is a very weak SIB effect since it appears that the same effect could have been achieved through dedicated, conventional funding. The key issue is that there is not enough funding in the standard NHS contract for the additional resource required to run an effective LTFU service – not that such a service can only work if it is outcomes-based.

While we would not argue that the SIB and its payment structure facilitated service adaptation, therefore, we do think that it enabled and supported service *resilience*, and enabled the project to maintain services and perform well through the pandemic.

4.3 How does the Zero HIV SIB compare to other CBO-funded SIBs?

In order to get a further view on whether the EJAF project has been resilient to the impact of the pandemic and associated restrictions, we compared its performance plan against other SIBs and outcomes-based contracts that have been supported by the CBO programme, based on data included in the returns to the CBO team for 2020/21. We emphasise that this is not a judgment on which project has done 'better' or 'worse', since we are only comparing each project against its own performance plan, which may have been more or less challenging in each case. For this reason we have not included full data for all projects, only averages and the range from lowest to highest. Moreover there are a number of factors that can affect performance against plan (although COVID-19 is likely to have had the greatest impact over this period) and projects have spent a varying amount of time operating under COVID-19 conditions depending on contract timing and duration - although the average time spent under COVID-19 restrictions by all projects (9.2 months) is almost identical to that spent by the EJAF contract (9 months)

While being mindful of these caveats, the data does suggest that the Zero HIV project has been resilient and has over-achieved against plan. Table 1 shows how the project performed relative to plan and in comparison to the performance of 11 other CBO projects across the five key metrics on which CBO collects data.

As this shows the Zero HIV project exceed its performance plan across all five metrics and also performed well relative to the average across all 12 projects – although it is also true that some other projects performed even better against plan, and the averages are somewhat distorted by the extremes of some projects' performance against some metrics, as the ranges indicate.

There is therefore some relatively weak evidence that corroborates the findings from our qualitative research. While COVID-19 restrictions on venue opening and face to face contact clearly had an impact on the project, and in particular reduced its ability to test as many people as planned, it was still able to exceed its target for engagement of those testing positive, and maintain and indeed exceed outcome targets over time. This was because it was still able to target those not diagnosed in some settings, notably A&E, and still able to focus on those LTFU.

Table 1 – Zero HIV SIB compared to overall CBO project performance against plan in 2020/21

Performance measure		Zero HIV	Average/range all CBO projects (n=12)
Engagements (Zero HIV narrow measure[14] – engaged after positive test)	Planned	172	258
	Actual	195	288
	Actual vs plan (%)	113%	111%
	Actual vs plan range (%)	N/A	69% - 204%
Total spend on delivery (£)	Planned	£783,000	£528,629
	Actual	£938,000	£511,211
	Actual vs plan(%)	120%	97%
	Actual vs plan range (%)	N/A	56 - 120%
Outcomes achieved	Planned	168	184
	Actual	191	222
	Actual vs plan (%)	114%	121%
	Actual vs plan range (%)	N/A	0 - 399%
Total outcome payments (£)	Planned	£1,410,438	£600,833
	Actual	£1,726,100	£552,692
	Actual vs plan (%)	122%	92%
	Actual vs plan range (%)	N/A	0-122%
Estimated savings/avoided costs (£)	Planned	£1,829,550	£1,421,948
	Actual	£2,366,218	£2,810,722
	Actual vs plan (%)	129%	198%
	Actual vs plan range (%)	N/A	0-490%

(Source CBO grant returns submitted by projects)

14 Note that CBO also measures EJAF against a broad engagement measure – all those who are tested. EJAF caried out c. 89,000 test over the period, which was 83% of its target of c 108,000.

5. Conclusions and next steps

5.1 Key findings

This review has provided us with an opportunity to consider in depth the impact of COVID-19 on a SIB, and has produced some interesting and sometimes unexpected findings.

Perhaps most interesting is the fact that this project did not have to make major alterations to its contractual structures to continue to operate at a sustainable level through the pandemic. As a project that relies heavily on delivery in healthcare settings, we might have expected the project to have been much more affected by a pandemic that, by definition, took away both capacity and access to services in those settings. But in practice the project not only survived without substantial changes to its structure and contracts, but also managed to maintain a consistent and high level of performance. This is not to say that COVID-19 did not have a significant impact – especially in primary care and, most markedly, among community providers who could not operate at all for long periods. But the project was able to continue to achieve what it was meant to do – identify and provide treatment to those living with HIV – due to the resilience of opt-out testing in A&E and the implementation of new contracts to trace and re-engage those who had been lost to follow up, as well as similar outbound services in the third hospital and in primary care.

As we argue in the previous section, the fact that this project is outcomes-based and has a particular funding and payment structure did help it sustain this high level of performance. The new outbound services would not, in the view of stakeholders, have been viable without the additional funding provided by the SIB; and it is more likely that the project would have had to alter its payment structure – perhaps moving temporarily to fee for service payments – if the SIB was not already designed to provide advance payments to providers against future outcomes. Overall therefore we conclude that the SIB did have a small but positive effect on the ability of the project to navigate the pandemic, although we also believe that it would have been sustainable if these elements had not been in place.

Our preliminary view is also that this project was somewhat more resilient – and also needed less contract alteration – than some other projects funded by CBO. However we need to confirm this view in the light of better and more complete data, and will aim to do so in the third review.

Our second major conclusion is that this project has shown just how many ways a project of this type (whether or not funded through a SIB) can be affected by an external factor as strong and unexpected as a global pandemic. Table 2 summarises all the effects we have seen from this project, both positive and negative.

What is also interesting is that some of these impacts have not been widely observed elsewhere. Many projects have shown the types of impact that affected this project at the community level – such as the closure of settings in which services can be delivered, and the need to move services into virtual settings where it is possible to do so. But even in this service strand we saw some unique and long-lasting effects because of the way community services aimed at those at risk of HIV tend to work. They rely very heavily on outreach in unusual places – not public sector offices or community facilities, like many statutory services, but entertainment, hospitality, leisure and even hairdressing venues. This appears to have made it even more difficult for these services to adapt, since they cannot be delivered in a different way easily, or sometimes at all. Moreover business

owners who normally allow access to such services are perhaps less likely to do so when they are trying to recover from the major impact of an external shock like COVID-19 on their livelihood, and may be subject to continuing restrictions. It will be interesting to see in our third review of this SIB whether the community-based services are able to return to normal or near-normal as restrictions ease, since at the time of fieldwork for this review many of those restrictions (for example on social interaction and venues that could open) were still in place.

Table 2 – Impact of COVID-19 on service delivery

COVID-19 impact on:	Hospitals – A&E	Hospitals –LTFU	Primary care	Community
Staff capacity to deliver the service	Unchanged - A&E staff still available to offer testing	No capacity during lockdowns – staff redeployed to COVID-19 wards. Reduced capacity throughout due to illness or self-isolation	Reduced capacity to counsel patients and no face to face appointments	Unchanged – staff available even when unable to provide services
Access to users/cohort volume	Similar volume of a different cohort with fewer presenting issues	Unchanged – targets no more likely to be contactable during lockdowns	Reduced – patients discouraged from seeing a GP and unable to see face to face	Not directly affected - although venue access and user behaviour changed, as below,
User behaviour and willingness to engage	Patients with COVID-19 symptoms and some others still willing to attend A&E	Largely unchanged – users no more willing to return to treatment	Fewer patients willing to visit GPs even when able to do so due to concerns about COVID-19	Fewer social interactions, less casual sex and less demand for sexual health testing
Access to venues to deliver service	Unchanged – A&E remained open	Venues not required for LTFU tracing	Venues available but access reduced and users more reluctant to visit as above	Reduced – all venues closed during lock down and some closed throughout pandemic
Delivery of service (Testing and support)	Unchanged – testing could be offered in A&E	Unchanged – returning patients could be seen due to high health risk	Reduced – GPs not able to order routine blood tests and less willing to counsel patients	Reduced – remote self-testing less effective
Achievement of outcome – patient enters or returns to treatment	Unchanged – patients still able to enter or return to treatment	Unchanged – patients still able to enter or return to treatment	Unchanged – patients still able to enter or return to treatment	Unchanged – patients still able to enter or return to treatment

In the healthcare settings we similarly saw some impacts of COVID-19 that are not typical of impacts on projects in other sectors, notably services that were unable to operate, or only operate at reduced effectiveness, because clinical staff were not available. The more usual pattern seen in projects working through COVID-19 has been that staff are available to provide the service or intervention, but service users are unable to access them. The difference is perhaps that this SIB – unlike most others – relies on direct delivery by front-line clinicians in hospital, where the impact of COVID-19 was most direct and most pronounced.

The key learning point from this, in our view, is that in assessing the risks to a project of this type of a major external event – and especially a future pandemic – it is important to think laterally about all the possible ways in which the project delivery could be put at risk, and also assess carefully whether some more obvious impacts really will occur. Based on this project it seems likely that some of the effects will be surprising, with major impact in areas where it was not foreseen, and little or no impact in areas where it might have been expected.

5.2 Areas for future investigation

In our third and final review of this SIB we will revisit the project as a whole to assess its overall performance, its strengths and weaknesses, and its potential legacy. We identified some specific areas to explore at this stage during our first review, and will also now wish to review a number of further issues that we did not cover in this report because of its narrower focus on COVID-19. At the same time, we will also wish to review our preliminary conclusions on the impact of the pandemic, in the light of further and better information on the impact of the pandemic on both this project and on others.

The specific issues we want to investigate in the final review fall into five broad areas:

1. SIB structure and roles. Was the Zero HIV more (or less) effective and efficient than other SIB models? How effective was EJAF in each of the roles it undertook in this SIB? What economies of scale, if any, did in generate? What conflicts, if any, did it create? What benefits or disadvantages did it have for other stakeholders, notably commissioners? How did the drawdown, deployment and repayment of capital from investors compare to what was planned at the start of the project? And why was the project unable to attract the levels of funding originally intended from both NHSE and local commissioners?
2. Effectiveness and value for money How does The Zero HIV SIB compare to other interventions and projects? Do levels of engagement and testing prove to be significantly higher than achieved on projects which have not deployed an outcomes-based structure, such as the Leeds pilot project which EJAF itself funded? What further lessons does the EJAF SIB offer in terms of recruiting, embedding and funding SIB design capacity and expertise into commissioning bodies when developing an outcomes-focussed partnership? And does the success of this project (if so proved) influence local and other commissioners to increase funding for HIV testing and reengagement – either on an outcomes-basis, like this project, or on a conventional basis but with other learning from this project?
3. Performance within the SIB. How does the performance of the different strands within the project compare? Has there been different performance within strands – for example between GP Federations that pass on outcome payments to the practice achieving the outcome, and those sharing payments with all practices? How did COVID-19 affect performance of the SIB overall and how does the extent of any

impact compared with the performance of other projects funded by the CBO programme? And how and to what extent were providers across all strands able to return to business as usual during the last year of the contract and especially from June 2021 as COVID-19 restrictions started to ease substantially?

4. Role of the CBO programme. To what extent did CBO outcomes payments support achievements of this SIB, did the SIB contribute to the CBO programme aims and objectives and did the SIB achieve its qualitative aims and base case financial performance as agreed with the CBO team and varied in 2020?

5. Sustainment beyond the end of the project. What external factors that could affect the future sustainability of this project changed during the life of the SIB? And to what extent did the SIB provide evidence that could be used to influence national or policy in relation to HIV testing and reengagement, and with what outcome?

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