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

Ways to Wellness Social Impact Bond

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Commissioning Better Outcomes Evaluation

COMMUNITY FUND

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Contents

1.0 Executive Summary

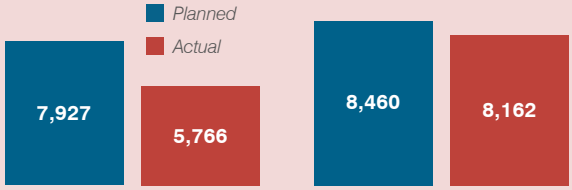
Project focus and stakeholders	
Commissioner(s):	Newcastle Gateshead Clinical Commissioning Group (CCG)
Service provider(s):	Ways to Wellness Ltd acting as social prime contractor. Four service providers: • First Contact Clinical • Mental Health Concern • HealthWORKS Newcastle • Changing Lives
Intermediary or Investment Fund Manager	Bridges Fund Management
Investor(s):	14 from Social Impact Bond Fund and Social Entrepreneurs Fund
Intervention:	Social prescribing using link workers to enable people to improve their self-care and management of their conditions
Target cohort:	People aged 40-74 with defined long-term conditions
Period of delivery	July 2015 – June 2021

Project achievements

Service users supported

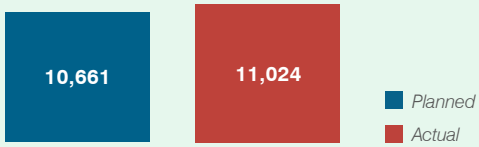
Service users engaged in intervention

Outcome A - Improved wellbeing payments



Funded by Social Outcomes Fund *Funded by CBO*

Outcome B - Tariff payments for reduced hospital activity and costs[1]



Tariff payments made by CCG

Payments and Investment	Planned[2]	Actual[3]
Outcome payments	**£7.951 m**	**£8.110 m**
Investment committed / drawn down	**£1.65 m**	**£1.72** (Committed) **1.11 m** (Drawn down)
Investment return	**£632k**	**£680k**
Internal Rate of Return (IRR)[4]	**11.3%**	**8%**
Money Multiple (MM)[5]	**1.38**	**1.61** (On draw down) **1.40** (On committed)

1.1 Introduction

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[6] (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 Ways to Wellness (WtW) project is one of these. It is the third and final review of this project and aims to draw overall conclusions about the success of WtW, its value for money, and the lessons that we think can be learned from it for other projects.

1.2 Ways to Wellness overview

WtW funded social prescribing for patients in the west of Newcastle with two overall aims:

- to improve the health and wellbeing of people living with long-term conditions (LTCs); and
- to reduce NHS costs related to their care.

A further key objective was also to provide a stronger evidence base for the effectiveness of social prescription at scale. This was largely unproven when WtW was developed in 2013, and WtW was much larger in both annual and total cohort numbers than any previous social prescription project.

The project aimed to improve outcomes for 8,500 patients in the first six years of operation. The delivery took the form of support from Link Workers, employed by specialist service providers, who worked with patients with LTCs, who were referred to them by local GPs and other organisations. The aim of the support was to help individuals improve their lives through understanding their own issues, motivating individuals to take up healthy activities, access services and tackle the aspects of their lives that were having a negative effect on their ability to manage their LTC.

The social case for the intervention was that it would improve the quality of life for people with LTCs. The financial case was that people with LTCs tend, without self-management, to visit A&E more often, to be admitted to hospital (for both planned and unplanned procedures) more frequently, and to stay in hospital longer. The project was therefore expected to reduce the cost of treatment in these areas. The Median scenario agreed with CBO projected savings of £8.42m over six years.

The main reason for using a SIB was to support the ambition described above of operating an effective social prescribing service at scale. Due to the uncertainty of the success of the project in terms of outcomes, the CCG was not prepared to take the risk of funding the service at scale without payment being linked to systemic financial outcomes, which would generate savings that enabled them to cover the outcome payments. They also were only comfortable paying if there was strong assurance that the outcomes (and savings) had been achieved – i.e. they wanted their payments linked to the achievement of outcomes.

1 Measured directly, according to WtW the cohort costs per head were 27% lower than the comparison cohort, and the cumulative costs avoided in secondary care were £4.6 million over the first 5 years of the service.

2 'Planned' means the amounts included in the CBO grant award. These are based on the 'Median' scenario (also referred to as the 'base case' i.e. the level of achievement that was thought likely to be achieved)

3 Actual means figures achieved at the end of the project, as reported in the CBO End of Grant report.

4 IRR is essentially a way of converting the total contribution beyond the investment amount (in this case fully dependent on the achievement of the outcomes) into a percentage rate, calculated over the length of the investment and varying according to cash flow – i.e. how quickly and soon payments are made.

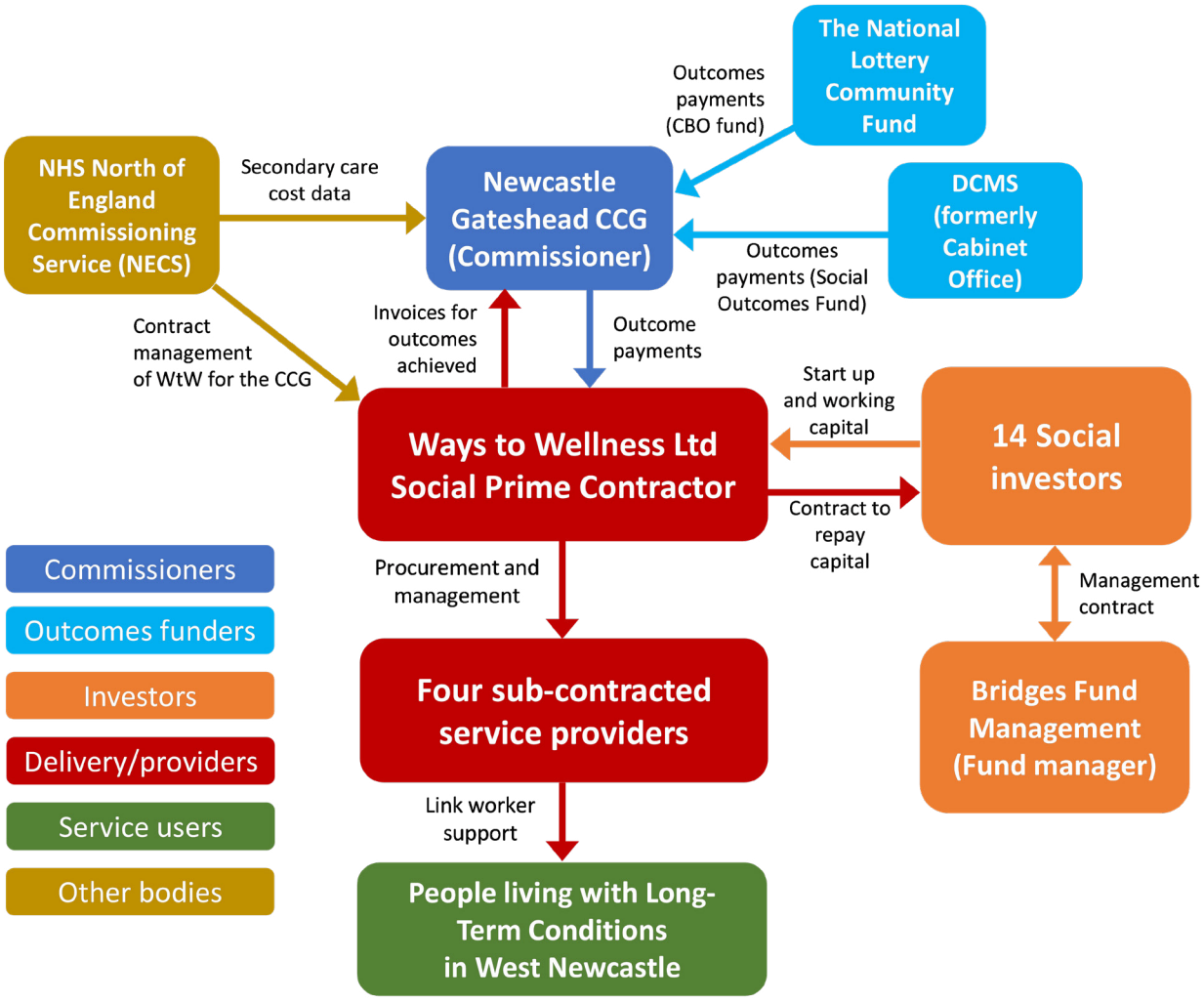
5 Money Multiple (MM) is another way of measuring returns. It is simpler than IRR and expresses the total returns as a simple multiple of the amount initially invested. See this report for more information on both IRR and MM

6 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.

Figure 1 provides an overview of the WtW structure, which is described in more detail in section 3 and Figure 2. The main stakeholders within WtW were

- Commissioners: Newcastle Gateshead CCG was the local commissioner, with co-commissioning payments from CBO and the Social Outcomes Fund[7].
- Social Prime Contractor: Ways to Wellness Ltd, which was newly created t0manage the project, and provided overall governance, partnership coordination and selected and managed service providers.
- Service providers: At the project launch (2015) there were four service providers: First Contact Clinical, Mental Health Concern, HealthWORKS Newcastle, and Changing Lives. The service providers employed Link Workers to work with service users and GPs.
- Investment Fund Manager (IFM) and investors: Social investment for this project was sourced and managed by Bridges Fund Management (BFM) from the Social Impact Bond Fund and Social Entrepreneurs Fund.

Figure 1: **WtW structure and operational and financial flows (simplified)**



Source: Ecorys/ATQ.

7 The Social Outcomes Fund was a fund set up by the Cabinet Office and launched in 2013. See main report for more details.

The project was 100% paid on outcomes[8]. There were two primary outcomes to which payment was linked, reflecting the social and financial objectives of the project. These were:

- Outcome A: Improvements in wellbeing after six months and every six months thereafter, up to a maximum of eight payments. Improvement was measured through the Wellbeing Star™, and the average improvement was used to weight a tariff payment per service user entering the programme in the previous six months (for SOF and CBO payments); and a lower payment per current user on the programme (for CCG payments).
- Outcome B: Difference in activities and associated cost of secondary healthcare services between treatment and comparison cohort. This measured the costs of hospital services used by the cohort receiving the intervention and compared them with the costs incurred by a comparison group with similar characteristics in Newcastle North and East. The difference in costs was then used to weight a tariff payment for every service user accessing the service. Relevant costs included those from planned and unplanned admissions, and use of out-patient and Accident and Emergency (A&E) services).

1.3 What has happened in practice

1.3.1 Key events

The following key events occurred between contract implementation and conclusion and had an impact on the project:

- The withdrawal of some of the service providers: The contract had four service providers engaged as sub-contractors to WtW Ltd on a two-year contract. The sub-contracts with all four of these providers were renewed on contract review after two years (in March 2017). The terms of the contracts changed at this renewal – originally the initial contracts included a significant base payment; in the contract renewal this changed so that payments were more linked to the completion of the wellbeing assessments, which meant provider payments were more closely tied to referral numbers actually obtained. As a consequence HealthWORKS Newcastle withdrew voluntarily from their new contract shortly after the contractual changes; and about a year later (around April 2018) Changing Lives also withdrew. The Link Worker interventions following this were delivered by the two remaining providers.
- Request to reprofile CBO outcome payments. By the third year of the contract it was clear that the WtW SIB was forecasting a lower level of referral and service engagement than planned, and the service providers were supporting service users that were of higher risk and had more complex needs than originally envisaged. There was thus a risk that the WtW project would not achieve sufficient outcomes over the contract life to be able to draw down all the funding committed from CBO. WtW therefore submitted a request, which The National Lottery Community Fund accepted, to reprofile outcome payments and increase the payment for each outcome (while not increasing the total funding commitment). The National Lottery Community Fund agreed to this request in March 2018.
- Outcome payment miscalculation: At the time of the interviews for the second IDR visit (mid-2018) the performance of Outcome B was variable, which was affecting the financial viability of the project and causing tension between stakeholders. In late 2018 it transpired that there had been a significant error in the way the data for Outcome B was collected and analysed, which meant that performance against Outcome B was, in fact, not variable and overall performance was very close to forecast levels.

8 This was the intention at design stage although when outcome payments were suspended during COVID-19 restrictions, payments of £40k were made without linkage to outcomes.

This data correction correctly recognised outcomes being catalysed by WtW. It also meant that outcomes payments could be forecast accurately, therefore reducing uncertainties and helping with project and WtW sustainability, and improving relationships between stakeholders.

- Roll-out of social prescribing: In early 2019 the NHS announced that the newly-formed Primary Care Networks (PCNs) would receive core funding to employ social prescribing link workers, including across Newcastle. The introduction of the national social prescribing service had several implications for WtW:
  - It reduced the robustness of the comparison group, because those that formed the comparison group now had access to a social prescribing service.
  - The national social prescribing had looser referral criteria than WtW, which made it easier for GPs to refer potential service users to the national social prescribing service. Consequently, referrals to WtW dropped.
  - The national service created additional demand for link workers, affecting the link worker job market and WtW staff retention.
- Relationships between key parties: At the point of the second IDR visit in 2018 it was apparent that the performance issues described above had affected relationships within and between the key parties to the project, and there had sometimes been disagreements about whether and how to take action. However, by the final IDR visit in 2022 relationships between parties had improved. The reason for this shift was primarily because the performance issues no longer existed: the two remaining service providers had taken over the delivery contracts and had improved performance, and the outcome payment miscalculation had been identified. In addition there were changes in the composition of the Board and operational team.
- Impact of COVID-19: In response to COVID-19 WtW adapted service delivery to provide a remote service to patients. Despite Link Workers reporting that COVID-19 was affecting the wellbeing of service users, the outcomes related to Outcome A (wellbeing) stayed relatively similar. This was surprising to stakeholders. Secondary care usage (Outcome B) became more variable post-COVID-19 in both the WtW cohort and comparison group, due to the confounding impact of COVID-19 on both the nature of hospital admission and on hospital usage. Stakeholders therefore believed that this outcome metric was no longer capturing the impact of the WtW intervention. The project continued on an outcomes basis, though The National Lottery Community Fund offered to extend its grant end date, from March 2021 to March 2022 – this would have given WtW more time to generate referrals and achieve Outcomes A from The National Lottery Community Fund. WtW and the CCG declined this offer in May 2021 as in order to meet the CBO requirements it would have meant a redesign of the outcome based payment mechanism to the provider organisations. According to WtW stakeholders it was felt that, at this late stage, any change to the payment mechanism could compromise negotiations around the sustainability of the programme..

1.3.2 Project performance

WtW performed as follows against key performance metrics:

- *Engagements;* WtW supported just over half (52%) of the intended number of service users – 5,848 against the intended 11,276 as set out in the Median scenario agreed with CBO at project launch. This was broadly due to over-optimistic modelling from the outset, but referrals were also affected by the roll-out of the national social prescribing service and COVID-19, as described above.
- *Outcome A 1 (Improvement in wellbeing):* According to CBO data on this outcome WtW achieved 5,766 outcomes against plan at Median scenario of 7,927 while co-funded by SOF, and 8,162 outcomes against a plan of 8,460 while

funded by CBO. It therefore achieved 73% and 94% of its respective targets, which were measured in slightly different ways and therefore cannot be combined. Separate data analysis by Triangle, owner of the Wellbeing Star assessment, found that 86% of 2,888 service users in the first five years (April 2015 to April 2020) reported an improvement in at least one area of wellbeing.

- *Outcome B (Reduced use and associated costs of secondary healthcare services between treatment and comparison group):* The payment for outcome B was a variable tariff related to the overall degree of saving per service user. WtW achieved 103% of its planned tariff payments at Median scenario (11,024 against a target of 10,661). Measured directly, the WtW cohort costs per head were 27% lower than the comparison cohort, and the cumulative costs avoided in secondary care were £4.6 million over the first 5 years of the service.

1.4 Successes, challenges and impacts of the SIB mechanism

The majority of stakeholders perceived the SIB to have been 'worth the effort' because it launched a service that would not have been commissioned otherwise. Particular successes of using the SIB mechanism were:

- Ability to test social prescription at scale at minimum risk: This was widely cited as a benefit of the SIB mechanism at its inception and it remains valid. Stakeholders reported that the scale of the programme was much larger, and deeper in terms of support, than many social prescription pilots that had been conventionally funded[9]. The CCG were of the view that they would not have been willing or able to test social prescription on this scale without the transfer of risk that is inherent in the outcomes-based payment mechanism.
- Providing real-time impact data in an efficient way: The commissioner reported that the real-time impact data showing the impact of WtW on both wellbeing and cost savings was critical in demonstrating the value of the service. Stakeholders reported that this was a direct consequence of the SIB, because these data requirements were put in place in order to learn and identify effective ways of supporting people along with providing evidence for the outcome achieved and with that, outcomes payments.
- Increasing referral numbers: Most stakeholders involved in delivery (WtW Ltd, delivery partner managers and practitioners) were of the view that attaching payments to referral numbers increased the providers' focus on achieving referrals, and ultimately led to more people being supported than would have happened in a fee-for-service contract (even if the overall number referred was lower than projected).

There was a general consensus, though, that the SIB did not increase the *quality* of support. There was a common view that the mechanism through which WtW Ltd made payments to providers, which was linked to referrals and thus an activity-based payment[10] focused on 'quantity over quality', and did not necessarily incentivise service providers to increase the quality of the support. It should be noted, however, that the wellbeing outcomes for WtW are generally in line with wellbeing outcomes for other social prescribing services, and that WtW service users interviewed (for this study and others related to WtW) were positive about the support they received. While there are limitations to such comparisons, due to differences between "social prescribing" interventions, this does suggest that WtW delivered good quality support.

9 Some other social prescription pilots appear to have treated similar numbers of cases on an annual basis (see for example https://www.shu.ac.uk/centre-regional-economic-social-research/publications/evaluation-of-the-rotherham-social-prescribing-service-for-long-term-conditions) but we are not aware of any that have treated total numbers on this scale. Comparisons between services should however be treated with caution due to wide variation in the nature and scale of support and partnership coordination offered by "social prescribing" services.

10 The linking of payments to providers to activities and outputs is not usual practice in SIBs where BFM has managed the investment – see for example Be the Change where the provider was simply paid their actual costs

The SIB mechanism also created some challenges:

- Optimistic modelling and forecasting of referrals: The initial forecasts of referral volumes were extensively modelled by the team supporting the design of the SIB, but nevertheless proved optimistic and unlikely to be achieved. This has been a feature of other CBO projects[11] that we have reviewed. Whilst optimism bias is common in non-SIB projects too, the challenge with the SIB is that its whole financial performance hinges on the accuracy of this up-front estimate and, if it proves to be wrong, the whole project struggles financially irrespective of how well the intervention is performing overall.
- Relationships between key parties: One interviewee described the relationships between some stakeholders as *"tempestuous and not the easiest"*. These strained relationships were a direct result of the WtW SIB mechanism: They were brought about primarily because of the outcomes-based payment arrangements within the SIB, and accentuated by a lack of trust and unhappiness with the governance arrangements between the parties in the SIB. It is worth noting that these views were not universal – while some were critical of the perceived over-involvement of the investment fund manager, for example, others welcomed their involvement and expertise. Also, these tensions, identified during the second IDR visit in 2018, were not apparent during the final visit in 2022, as the issues were no longer present, organisations had worked through the issues and deepened relationships, and some people had moved on.
- Misaligned incentives: Both service provider managers and practitioners felt that there was a misalignment between where the most effective work took place, and what was financially rewarded within the outcomes contract. For them, this meant that, rather than incentivising higher quality delivery, the outcomes payment element was actually a *"distraction"* from the core purpose of the work. This was because the payment mechanism to providers created a tension between continuing to work with service users (so that better quality support and outcomes could be achieved) and bringing in new service users (for which there was a higher financial payment). Providers also had to strike a sometimes tricky balance between continuing to work with users to build resilience and self-sufficiency, and avoiding over-reliance on link worker support.
- Accurate outcome measurement: Achieving accurate outcome measures through which to attach payments was a challenge throughout the project. Some stakeholders had doubts over the links between improving management of LTCs and reduced secondary care usage, and so whether Outcome B was really capturing the impact of WtW. Furthermore, the measurement approach to Outcome B faced multiple challenges, to the degree that there was only a small period of time during the project that it was likely accurately capturing differences in hospital admissions. Practitioners also had doubts over the use of the Wellbeing Star™ (the methodology used to measure wellbeing improvement); practitioners interviewed were not convinced that the Wellbeing Stars were capturing the impact they were having on long-term conditions. However, it is worth stressing that (as outlined in Section 5.1.1.2) the data from the outcome measurements were valued by stakeholders, was key to enable learning and ongoing delivery improvement, and provided enough information to justify both the existence and expansion of the service.

Overall, based on our informed judgement (and drawing on the judgement of the stakeholders involved), we conclude that WtW was cost effective. We conclude this because a) it achieved against its core aims (even if it did not achieve as many outcomes as intended) and b) although some of the cost elements were high, overall these can be justified as it was a very innovative project. It also reduced the costs of secondary care compared to a robust comparator. The project also led to wider spillover effects, including increasing understanding of the use of outcomes contracts in health in both the

11 See for example the Mental Health Employment Partnership and HCT Independent Travel Training projects

outcomes-based commissioning community and in the health sector, leading to replication (see below), and supporting the sustainment of social prescribing in Newcastle. Stakeholders involved in the project believe it was value for money. However, there is some evidence to suggest it was not necessarily the *optimal* use of resources, largely because it engaged with considerably fewer participants than planned, and the same intended outcomes could thus have been achieved with fewer resources.

1.5 Legacy and sustainability

WtW has had a largely positive legacy, as judged both by its local sustainment (under a different funding structure), and its wider influence on other social prescription projects:

- **Legacy of the WtW social prescribing intervention:** In June 2021 WtW and the CCG agreed to expand the service, widening the client age group and geographical reach, securing funding for an initial 12 months. This additional funding was paid in block, effectively converting the WtW contract from a contract for outcomes to a fee for service contract. Stakeholders explained that this was primarily because, following the formation of the ICS in Newcastle and Gateshead in July 2022, it was no longer appropriate to base the contract on transactional payments for outcomes (because the ICS arrangements largely abolished inter-agency payments in the NHS), and also because WtW had now proved its effectiveness.
- **Legacy of WtW on wider social prescribing landscape:** WtW was one of the key projects demonstrating that social prescribing can effectively operate at a population-level scale. Whilst the national social prescribing service did not follow the model used in WtW, WtW was seen as influencing the decision to roll out social prescribing nationally, according to WTW stakeholders.
- **Legacy and sustainment through other SIBs and SOCs:** A number of other SIBs and social outcomes contracts (SOCs) have built on learning from WtW. As WtW was the first SIB launched in the health sector, multiple SIB projects (including the Reconnections SIB[12], which funded action against social isolation for people over 50 in Worcestershire) drew on the learning from WtW. Most substantially, three projects either part-funded by CBO or a subsequent SIB/SOC outcomes fund, the Life Chances Fund[13] all deployed a similar link worker-based delivery model, and were backed by investors managed by BFM.
- **Legacy of WtW as an organisation:** The surplus generated by the project has enabled WtW Ltd to continue, and to broaden its role and remit. The strategy now is to continue this role as an innovation hub / incubator and a place to experiment with new ideas. In June 2021 development work began on two innovative projects, one on how social prescribing can support children with neuro disability and their families, and one aiming to pilot a specialist social prescribing service for patients with chronic pain/fatigue.
- **Legacy of attitude and take-up of SIBs / SOCs:** While stakeholders involved in WtW have not pursued further SIBs or outcomes contracts to date, they were positive about the model when used appropriately. In their view the SIB model served a very particular purpose in WtW, namely to de-risk a project that commissioners would otherwise have been reluctant to fund. Stakeholders at WtW Ltd thus view SIBs or SOCs as potentially filling a similar function in their extended role as incubator and in funding innovation as outlined above.

12 See the third in-depth review of Reconnections here

13 The Life Chances Fund (LCF) is an £80m fund, committed by central government to help people in society who face the most significant barriers to leading happy and productive lives. It provides top up contributions to outcomes-based contracts involving social investment, referred to as Social impact Bonds (SIBs). These contracts must be locally commissioned and aim to tackle complex social problems. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876934/LCF_FAQs_FINAL_DRAFT.pdf

1.6 Conclusions

Overall we judge WtW to have been a success in many ways and to have been a well-designed SIB. While it fell short of its targets for referrals, it achieved its primary objective of delivering social prescription at scale, which meant that many thousands of people benefited from better management of their long-term conditions, with consequential improvements in their health and well-being. It also had a clear rationale for adopting a SIB mechanism: the 'SIB effect' – specifically the payment for outcomes element – enabled delivery to take place at scale with acceptable risk to naturally cautious and financially challenged health commissioners.

It was also well designed from a theoretical stand point, for example in terms of its payment mechanism. It was highly innovative in choosing to measure both a hard, system outcome (reduced cost of hospital services) and a soft, user-centred outcome (improvement in personal wellbeing) – albeit with some challenges to using both, and at the expense of simplicity and ease of understanding. It was one of very few UK SIBs to measure its hard system outcome against a clearly defined and robust comparator (and the only SIB to do so among those we have reviewed in depth for the CBO evaluation). It was thus able to prove that it would 'wash its face' in terms of avoided costs to the CCG. It was also the first to measure wellbeing through a defined soft measure – a model that has since been adopted by many other projects.

By combining these two outcomes it was able to prove its effectiveness to commissioners and give them confidence that it could continue to commission the intervention without the cost and complexity of an outcome structure, since the project had effectively proved its theory of change – that is it had demonstrated that using a social prescribing model of this type (personalised support designed around each person through a partnership coordinated by WtW) would improve people's management of their long-term conditions, boost wellbeing and reduce both primary and secondary care time and costs. The outcomes measured by the project – supported by additional academic studies that further bolstered evidence of its effectiveness for service users– also provided a solid evidence base for the service, which contributed to the national debate on the use of the link worker-based model of social prescribing. We note, however, that this did not have the full national consequences that stakeholders were hoping for, as the national roll-out of social prescribing did not adopt the WtW model (because it did not enable the personalised Link Worker support or partnership coordination that WtW did).

The project did however have weaknesses, though it is not surprising that it encountered challenges. These arose because it was one of the first SIBs to be commissioned locally in the UK, and the very first in the inherently complex and challenging health sector.

First, while the outcome structure was, at high level, largely well designed (and if the SIB were to be run again we still think it would be wise to use these two outcome measures as there are no better alternatives), there were some challenges. The measurement process for the Outcome A was not perfect, and the process for payment of both Outcomes A and especially B was arguably more complex than it needed to be.

Another downside of the project is that it was relatively expensive to develop and to deliver, compared to other SIBs that we have evaluated.. These high costs are largely justified, in our view, by the scale of the project and by it being one of the first locally commissioned SIBs to be developed. It would have been harder to justify the costs of WtW if it were being developed today. If developed today, we would also expect it to be able to make better forecasts of referrals and user engagement, and avoid the optimism bias to which we conclude this project was prone.

1.7 Lessons for other projects

- **Rigorous impact measurement has significant challenges.** The WtW SIB is one of very few in the UK to adopt a rigorous approach to measurement of its impact, using a quasi-experimental approach to measure performance relative to a comparison group. It is therefore important to note that its adoption by WtW had major challenges – firstly because errors in calculating performance relative to the counterfactual gave misleading results; secondly because the counterfactual was confounded by the roll-out of a different type of social prescribing by the NHS; and thirdly because the overwhelming effect of the COVID-19 pandemic (and associated restrictions) meant that in the latter stages stakeholders in the project no longer had confidence that it was accurately capturing the impact of the project. This is not to say that attempting rigorous outcome verification techniques should not be attempted, but rather that they too are riddled with challenges and will not solve all problems.

- **Managing cross-sector partnerships can be challenging and time consuming.** An often cited key benefit of SIBs is the extent to which they promote and enable cross-party collaboration, It is therefore interesting to note that WtW identified the management of multiple parties as one of their biggest challenges, and one requiring much time and effort to make it work.

- **Consider carefully the financial risk share between investors and service providers.** This was a lesson from our second review, where we observed that financial risk was more and more being shared between providers and investors, and that this had implications for providers if they were not aware of, or not comfortable with, the risk they were expected to bear. This remains a key lesson, but on further reflection stakeholders in WtW now think that providers might have taken more risk, not less. The reasoning is that if investors and their representatives hold most or all of the risk they may drive and control the project more than other stakeholders would wish, and in a direction with which other stakeholders are not entirely comfortable.

2.0 Introduction

This review forms part of the evaluation of the Commissioning Better Outcomes (CBO)programme and is the final review of the Ways to Wellness (WtW) project. Previous reviews of this project, and other reports from the CBO evaluation, can be found here.

2.1 The Commissioning Better Outcomes (CBO) programme

The CBO programme is funded by The National Lottery Community Fund and has a mission to support the development of more social impact bonds (SIBs) and other outcome-based commissioning (OBC)[14] models in England. The Programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2024. It originally made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar OBC models in complex policy areas. It also funded support to develop robust OBC proposals and applications to the programme. The project that is the subject of this review, WtW, was part-funded by the CBO programme.

The CBO programme has four objectives:

- Improve the skills and confidence of commissioners with regards to the development of SIBs
- Increased early intervention and prevention is undertaken by delivery partners, including voluntary, community and social enterprise (VCSE) organisations, to address deep rooted social issues and help those most in need
- More delivery partners, including VCSE organisations, can access new forms of finance to reach more people
- Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs/OBC.

The CBO evaluation is focusing on answering three key questions:

- 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
- Challenges in developing SIBs and how these could be overcome
- 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.

2.2 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:

14 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.

"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."[15]

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)[16], 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.

2.3 The in-depth reviews

A key element of the CBO evaluation is our nine in-depth reviews (IDRs), with WtW featuring as one of the reviews. The purpose of the IDRs is to follow the longitudinal development of a sample of projects funded by the CBO programme, conducting a review of the project up to three times during the project's lifecycle. This is the final review of WtW. The first IDR report (available here) focused on the development and set-up of WtW. The second IDR report (available here) focused on implementation of the project mid-way through the contract.

The key areas of interest in all final IDRs were to understand:

- The progress the project had made since the second visit, including progress against referral targets and outcome payments, and whether any changes had been made to delivery or the structure of the project, and why
- How the SIB mechanism and its constituent parts of PbR, investment capital and approach to performance management impacted, either positively or negatively, on service delivery, the relationships between stakeholders, outcomes, and the service users' experiences
- The legacy of the project, including whether the SIB mechanism and/or intervention was continued and why/why not, and whether the SIB mechanism led to wider ecosystem effects, such as building service provider capacity, embedding learning into other services, transforming commissioning and budgetary culture and practice etc.

The second IDR of WtW also identified the following areas to investigate further in the final review:

- Does the academic funded study provide the evidence base for the service? And if so, does this then lead to the national consequences that stakeholders hope it will?
- Does the performance of both Outcomes (A & B) validate the WtW logic model, and indicate that there is clear linkage between improved wellbeing and better management/lower costs in relation to long-term conditions?
- Are the commissioners comfortable that the intervention did lead to the level of savings they were hoping to achieve? How do they know this? How will it materially/ mathematically affect budgetary decisions?

15 See: https://golab.bsg.ox.ac.uk/knowledge-bank/glossary/#i

16 Payment by Results is the practice of paying providers for delivering public services based wholly or partly on the results that are achieved

- If the SIB were to be designed again, would it be wise to use outcomes A and B to trigger payment? If not, what outcomes should be used?
- Have stakeholders managed to re-build relationships and trust?
- How does the service ultimately perform compared to the other social prescribing services taking place in Newcastle, and to other social prescribing services nationally?
- How has the SIB model (including external investment) helped and hindered project delivery?
- What work has been done by project stakeholders to develop the project delivery beyond 2021 including exploration of changes to service user cohort, geographical coverage, commissioner and funding arrangements?
- What kinds of commissioning and performance management approach have the commissioners considered and selected for what they do next in funding social prescribing – and what influenced their thinking? How will this be funded?
- What has the impact of COVID-19 been on SIB service user cohort, delivery, outcomes funders and funding in the short and medium term, including anticipated savings and financials?

For this final review, the evaluation team:

- undertook semi-structured interviews with representatives from all the main parties to the project, including representatives from the commissioner (Newcastle Gateshead Clinical Commissioning Group (CCG)), Ways to Wellness Ltd, service providers (First Contact Clinical and Mental Health Concern), and Investment Fund Manager (Bridges Fund Management). These were conducted between June and September 2022;
- reviewed performance data and monitoring information (MI) supplied by the project stakeholders to The National Lottery Community Fund;
- reviewed key documents supplied by project stakeholders, in particular the WtW internal learning document 'Ways to Wellness: The First Six Years';
- reviewed other similar social prescribing interventions for comparability; and
- undertook one-to-one interviews and focus groups with a sample of service users.

2.4 Report structure

The remainder of the report is structured as follows:

- Section 3 provides an overview of how the project worked, including the SIB mechanism.
- Section 4 describes major developments and changes in the project since its launch, including the performance of the project against its planned metrics, and stakeholder experiences.
- Section 5 discusses the successes, challenges and impacts brought about by the SIB mechanism, including an assessment of the Value for Money of the SIB mechanism.
- Section 6 describes the sustainment and legacy of the project.
- Section 7 draws conclusions from this review.

3.0 Ways to Wellness overview

According to the 'Ways to Wellness: The First Six Years' report, the service was set up with two overall aims:

- to improve the health and wellbeing for people living with long-term conditions (LTCs) in the west of Newcastle; and
- to reduce NHS costs related to their care.

WtW funded a social prescribing model in pursuit of these aims, with the objective of improving outcomes for 8,500 patients in the first six years of operation. The intervention took the form of support from Link Workers, employed by specialist service providers, who worked with patients with LTCs, who were referred to them by local GPs and other organisations. The aim of the support was to help service users improve their lives through understanding their own issues, motivating service users to take up healthy activities, access services and tackle the aspects of their lives that were having a negative effect on their ability to manage their LTC.

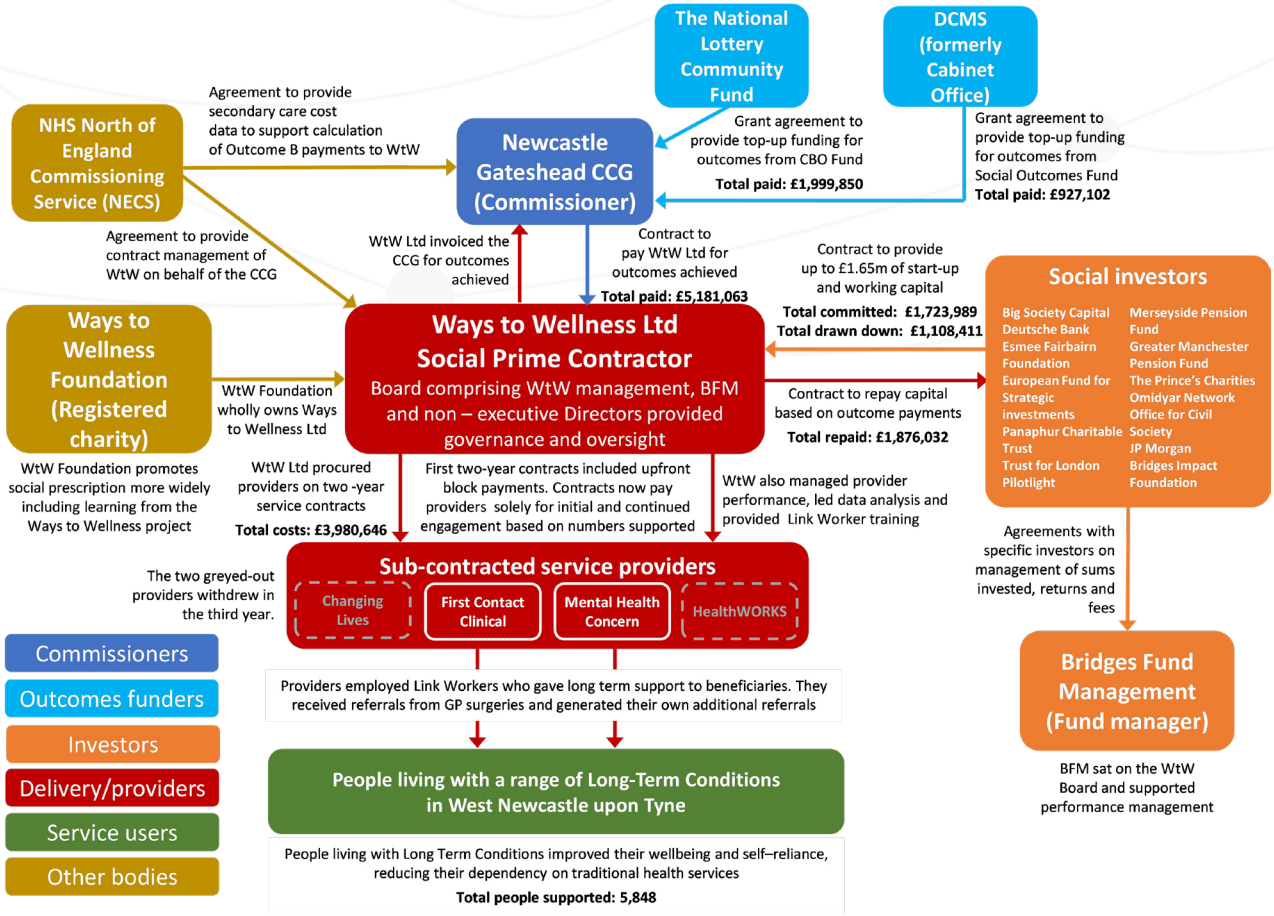
3.1 Set up of WtW and key stakeholders

Figure 2 provides an overview of the WtW structure and main financial flows. The main stakeholders within WtW were:

- Commissioners: Newcastle West CCG (later part of Newcastle and Gateshead CCG) was the local commissioner, committing £5,175,000 of potential outcome payments at Median scenario. The National Lottery Community Fund committed to paying £1,839,908 of the total outcomes payments, with the Social Outcomes Fund[17] (SOF) committing £935,092, again at Median scenario. As shown in 2, against these commitments Newcastle West CCG paid £5,181,063 in outcomes payments (100% of committed), The National Lottery Community Fund paid £1,999,850 (109%), the SOF paid £927,102 (99%).
- Social Prime Contractor: Ways to Wellness Ltd took this role, and was newly created to manage the project. It managed the financial flows and the contracts with the service providers; analysed performance data; undertook marketing activities; ran some Link Worker training; and provided funding for some patient-related activities.
- Service providers: At the project launch (2015) there were four service providers: First Contact Clinical, Mental Health Concern, HealthWORKS Newcastle, and Changing Lives. The service providers employed Link Workers to work with service users. Two service providers (HealthWORKS Newcastle and Changing Lives) withdrew from the contract during the third year of the project, following a change in contract terms (see Section 4.1 for further detail).
- Investment Fund Manager (IFM) and investors: Social investment for this project (from the Social Impact Bond Fund and Social Entrepreneurs Fund) was sourced via Bridges Fund Management (BFM). BFM was responsible for managing the investment as Investment Fund Manager (IFM) for the Social Impact Bond Fund.

17 The Social Outcomes Fund was a fund set up by the Cabinet Office and launched in 2013. Along with the CBO programme its aim was to support the development of more innovative approaches to improving social outcomes. It could only fund outcomes achieved by 31/3/18. Responsibility for SOF moved from the Cabinet Office to DCMS in 2017.

Figure 2: **WtW structure and operational and financial flows**



Source: Ecorys/ATQ. Financial figures based on CBO MI. Figures are 'actual' figures rather than the figures planned at Median scenario.

3.2 The intervention model

The WtW project provided social prescribing for patients in the west of Newcastle with LTCs, to enable them to improve their self-care and management of their conditions. It targeted people in the area which at launch was covered by Newcastle West CCG, later merged with Newcastle East CCG and Gateshead CCG. According to WtW's original application to the CBO an estimated 35,000 people in Newcastle West had at least one LTC, which was likely an underestimate due to under-recording of LTCs by local GPs.

Social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services. Recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. Schemes delivering social prescribing can involve a range of activities that are typically provided by VCSEs. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.[18]

There are different models of social prescribing being employed across England. Most involve

18 https://www.kingsfund.org.uk/publications/social-prescribing

a link worker (other terms such as community connector, navigator and health adviser are also used) who works with people to access local sources of support. They vary in intensity, in the balance between providing direct support and acting as a signpost service, and with the people they support.

The WtW project aimed to improve outcomes for 7,927 patients in the first six years of operation. The intervention took the form of support from Link Workers, employed by the service providers.

The Link Workers aimed to support 11,276 people with LTCs engage with the programme to help them improve their lives through understanding their issues. They also supported and motivated them to take up healthy activities, access services and tackle the aspects of their lives that were having a negative effect on their ability to manage their LTC. Box 1 below provides a brief case study of a service user supported by the WtW Link Worker model; three further case studies are included in section 4.7.6.

Box 1: **Case study of WtW Link Worker support**

The service user was an unemployed male in his 40s, a former carer with asthma and long-term mental ill health and suicidal thoughts, social isolation, low income and poor health but scope to improve with lifestyle change. He rarely left the house and was unable to mix with people due to mental ill health which also led to homelessness, and meant he did not attend medical appointments.

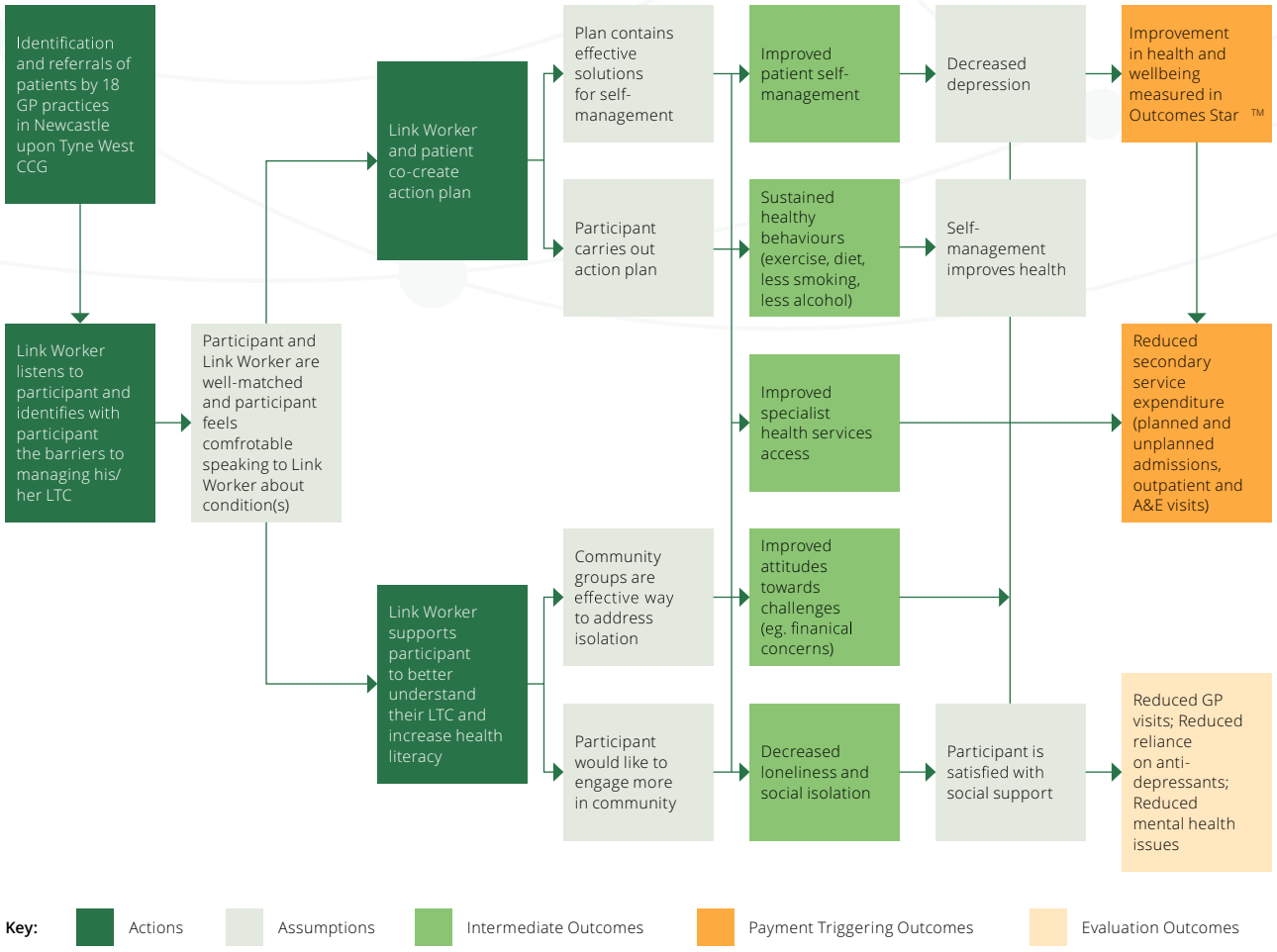
The Ways to Wellness Link Worker response was to signpost him to Shelter and HAC for housing advice; support him to attend GP appointments and address long-term health problems, support him to register with an NHS dentist; refer him to West Road Surgery's Vulnerable Patients Project; and refer him for food parcels

The result was that he is now living in supported housing, and has reduced his smoking. All physical and mental health problems are now being addressed, and he has been supported to apply for PIP

Specific referral criteria were focused on 12,787 people already diagnosed with a LTC at an age when behavioural changes might be expected to result in observable reductions in their use of health services: 7,734 eligible patients were 40 to 74 years of age, were actually registered with GP practices in areas where deprivation is often high, and had at least one of the following LTCs: chronic obstructive pulmonary disease (COPD), asthma, diabetes (type 1 or 2), heart disease (coronary heart disease or congestive heart failure), epilepsy or osteoporosis. Referrals mainly came from local GPs and other organisations, and in some cases through referrals generated by the providers themselves.

Figure 3 below provides further detail on the support provided by the WtW project to 5,848 engaged patients, of whom 5,766 achieved at least one outcome. This also includes information on the payment-triggering outcomes, which are explained in further depth in Section 3.3. There is a difference between the payment-triggering outcomes and evaluation outcomes because it was too challenging to attach payments to the evaluation outcomes for a range of reasons – this is explained further in the first IDR report.

Figure 3: **Ways to Wellness Logic Tree**



Source: Ways to Wellness: The First Six Years.

3.3 Payment mechanism and outcome structure

3.3.1 The payment mechanism

The project was designed so that 100% of payments would be on outcomes, although in practice (see section 4) £40k in payments were made during COVID-19 restrictions without reference to outcomes.

There were two primary outcomes to which payment was linked, reflecting the social and financial objectives of the project. These are described below and summarised in Figure 4.

- Outcome A: Improvements in wellbeing: Service user wellbeing was measured using Triangle Consulting's Wellbeing Star™, as both a direct indicator of improved wellbeing and a proxy for wider changes, including the ability to self-manage LTCs and reduce isolation.
  - Wellbeing was measured using the Star firstly on entering the programme, to establish a baseline, and then at six monthly intervals. Payments were made on a sliding scale according to the average improvement made by the whole cohort. every six months up to a maximum of eight payments (implying the

user stayed on the programme for up to 3½ years). There was a maximum tariff payment per user and the average improvement determined a weighting factor to be applied to the agreed tariff; this varied from 100% for an improvement of 1.5 points or more to 80% of payments for a 0.5 point improvement (and no payment below that point).

- There was a different tariff for payments by the CCG and by SOF and CBO, and different ways of calculating the average improvement and applying the weighting factor and then applying this across the cohort to calculate payment. For SOF and CBO payment, the average and payment were based on those entering the programme in the preceding six months; for CCG payments the average and payment were based on all those registered on the programme, plus those entering and less those leaving it in the preceding six months. Since the number joining the programme every six months was far fewer than the total currently registered, SOF and CBO were paying a larger tariff per user for a smaller number of people and vice versa for the CCG. We do not know why there was a difference between the CCG and SOF and CBO.

- Outcome B: Difference in cost of secondary healthcare services between treatment and comparison cohort. This measured the costs of hospital services used by the cohort receiving the intervention and compared them with the costs incurred by a comparison group with similar characteristics in Newcastle North and East.

  - The WtW project accessed Hospital Episode Statistics (HES) data from the North East Commissioning Service (NECS) to inform the comparisons with this counterfactual. Relevant costs included from planned and unplanned admissions, and use of out-patient and Accident and Emergency (A&E) services. Cost reductions were then converted into payments which were again based on a tariff per user, weighted according to the percentage difference in costs between the treatment group and the comparison group, with 100% of the tariff payable if costs were more than 22% lower in the treatment group, falling on a sliding scale to 5% if costs were 1-2% lower. The resulting tariff payment was than applied to the total number on the programme (as for the CCG outcome A payment) to calculate the total payment due.

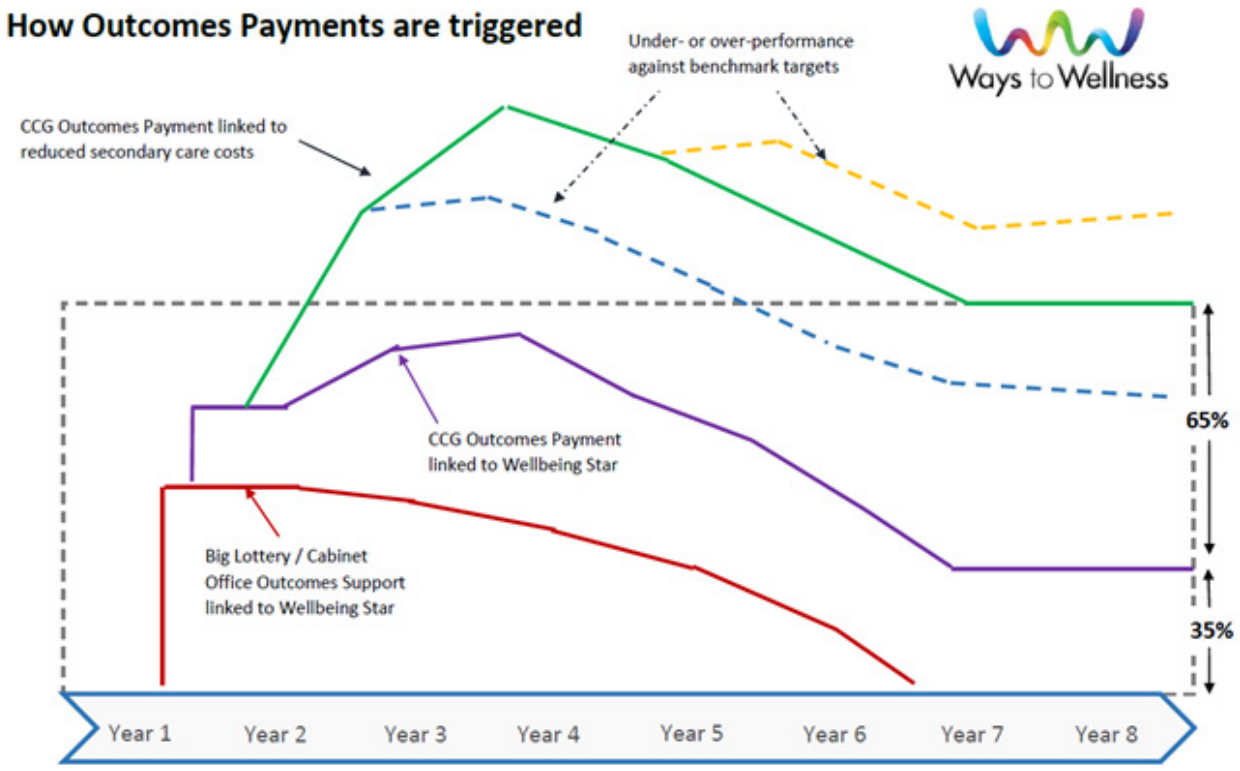
  - Both SOF and CBO, and the CCG made payments under Outcome A but only the CCG made Outcome B payments. The tariff paid by the SOF and CBO was originally intended to remain the same at £350 throughout, but the CBO payment was renegotiated to £650 in 2018 when there were concerns, as reported in our second review, about the sustainability of Outcome B payments. The tariff for CCG payments for both Outcome A and B also increased over time, from zero to a maximum o£142.50 for Outcome A and from Zero to £237.50 and then £332.50 for Outcome B. CCG payments for both outcomes were also part-adjusted for inflation, based on the CPI minus 1.5%.

  - There were no outcome B payments in the first two years, reflecting the delay in both the in both the measurement and accrual of savings to the CCG.

As a result of these adjustments the balance of payment between Outcome A and Outcome B changed over time, with Outcome A initially accounting for all and then a higher proportion of payment, and Outcome B replacing this in the long term. In addition, the proportion of payment made by CBO and SOF also fell over time, and the proportion met by the CCG increased – see Figure 4.

We reflect on the complexity of this metric in Section 5.2.4

Figure 4: **WtW outcome payments profile**



Source: Ways to Wellness. 'Big Lottery Fund' was the previous name and is the current legal name of The National Lottery Community Fund.

Payments to WtW Ltd from the CCG and CBO/SOF were linked to outcomes, but payments to the service providers were not on the whole. Payments to service providers were mainly linked to the number of service users they supported as follows:

- Each provider received a Referral Payment (for each patient referred to them); a Second Stage Payment (for each completion of the Wellbeing Star 6 months after referral); and a Service Continuation Payment, payable at 15 months after referral (12 months under revised contracts introduced after two years) and every 6 months thereafter.
- In addition in the first two years of the contract service providers received a block payment, to enable full mobilisation and hiring of a full team of Link Workers.
- After the first year of the contract, a further payment was introduced linked to the overall performance of the contract, effectively giving providers a share of total payments. According to stakeholders, this payment was introduced to improve the cashflow of providers, which had been lower than expected due to a) lower than forecast referrals and b) delays in the completion of six-monthly Outcome Stars (for example due to service user availability).

3.3.2 Investment and financial risk sharing

The plan at Median scenario was that social investors would commit investment of up to £1.65m[19] to set up and fund the project, repaid from the outcome payments made by the CCG. This capital (if drawn down– see below) was potentially at risk and dependent on the success of the project in hitting outcome targets. At the extreme, therefore, if the project performed well below expectations, all capital drawn down could be lost.

At Median scenario, it was expected that investors would be repaid their initial capital plus a return of £632,000, equivalent to a Money Multiple[20] (MM) of 1.38, while achieving net savings to the CCG of £2.4m, and wider savings to other government departments of £11.25m over six years.

In the end WtW did not require all of the £1.65m investment, and drew down £1,108,411. This was invested in tranches over the first three years, in which £31k, 670K and 208K were respectively drawn down. The remaining capital remained available to WtW and there was a charge for its availability, to reflect the fact that it was not available for investment elsewhere. According to stakeholders the amount drawn down was less than planned due to WtW engaging fewer service users than originally modelled (see Section 4.6.1), reduced demand for additional funding as an impact of COVID-19 in 2020; and WtW making arrangements to repay the investment earlier than planned, with a view to funding future provision through income generated by WtW instead of new social investment.

3.3.3 Performance management and governance

Performance of the service providers was managed by the social prime contractor, WtW Ltd. WtW was staffed by a CEO, Finance Director and Administrator, who all undertook elements of the performance management. Section 3.4.5 describes how this compares to other CBO projects, and we reflect on the effectiveness of this arrangement in the Conclusion.

The WtW Board managed the operation and delivery of the contract. It included the following roles:

- Chair
- Vice Chair
- CEO of Ways to Wellness
- Investment Fund Manager
- Doctor
- GP
- Director
- Senior Manager
- Accountant.

The Board thus comprised a mixture of executive staff and independent members representing WTW Ltd as an overarching entity, BFM as the IFM, and clinical interests.

A project steering group oversaw the development of Ways to Wellness and subsequently became a sub-committee of the Board in the year leading up to the service launch. The Chair of this Steering Group and the subsequent sub-committee became Chair of the main Board, which also had representation from VONNE. Other Directors were appointed following an open recruitment process.

Providers were not represented on the board but WtW executive staff met regularly with providers to review performance – initially fortnightly and then at less frequent intervals as the project progressed. BFM were also involved in reviewing performance and in setting contracts with providers, the drafting of which was supported by pro bono legal advice arranged by BFM.

19 Note that this included a contingency buffer that was not needed – see section 4.2.1 for more details. The amount actually invested was c. £1,108,411

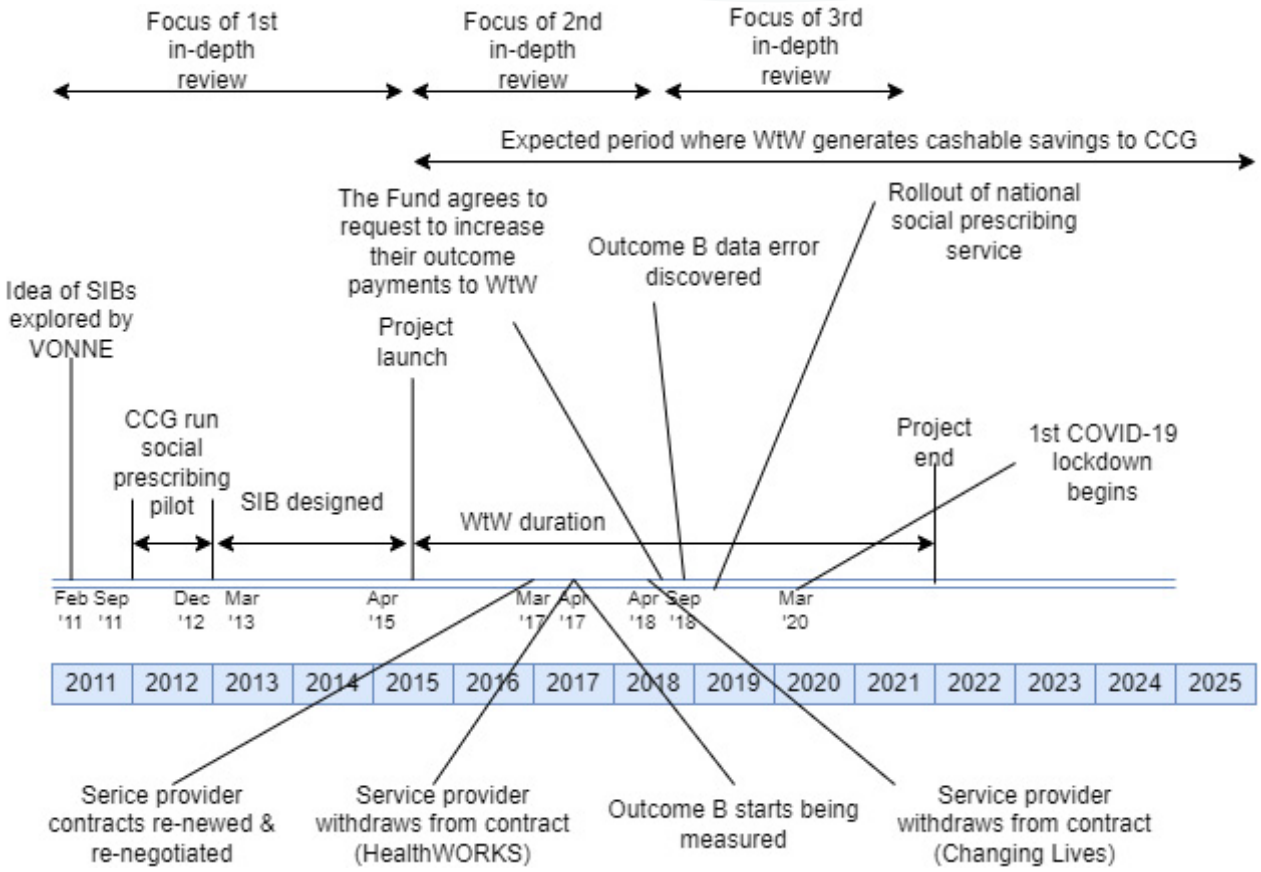
20 Money Multiple (MM) is s standard investment term which expresses the return on an investment as a multiple of the original capital investment – so an MM of zero means that all capital is lost, an MM of 1 means that the initial capital only is returned, and an MM of 1.4 means that for every £100 invested, the total return is £140.

3.4 History and development

This section of the report describes the key developments leading up to the project launch (2011 – 2015); Section 4 provides information on major developments during project implementation (2015 – 2021). Further information on the project design phase can be found in the first in-depth review; further information on the first half of project delivery (2015 – 2018) can be found in the second in-depth review.

Figure 5 summarises the major developments within the project, and below this is a more detailed breakdown of the key milestones and events during the launch phase.

Figure 5: **Ways to Wellness timeline**



Initial thinking around using SIBs in the North East of England began in 2011, after VONNE (umbrella organisation and support body for VCSEs in North East) attended a workshop run by Social Finance about the Peterborough Prison SIB and decided to explore idea of SIBs. Some local stakeholders, passionate about the potential of social prescribing, thought SIBs could be a low-risk approach to scaling social prescribing, which led to the exploration of using a SIB mechanism to launch a social prescribing service. Stakeholders received a series of grants to develop the SIB and the service (a grant from the North East Social Investment Fund was used to explore opportunities to fund and develop the conceptual idea; Department of Health Social Enterprise Investment Fund (SEIF) funding was used to develop the conceptual idea into a 'story' to engage social investors; a CBO Development Grant was used to develop the story into a proposition that was robust enough to be investible and to enter into a seven-year contract with the CCG).

3.4.1 Detailed timeline of the project development

2011 – 2012

- February 2011: Representatives from VONNE (umbrella organisation and support body for VCSEs in North East of England) attend workshop from Social Finance about Peterborough prison SIB and decide to explore idea of SIBs.
- May 2011: VONNE receives grant from the NE Social Investment Fund and commissions two consultants to explore the potential of SIBs further.
- September 2011 – December 2012: Newcastle Bridges CCG (forerunner to Newcastle West CCG) receives funding from Nesta People Powered Health Programme to run a social prescribing pilot.

2013

- March 2013: VONNE receives grants from Department of Health SEIF and ACEVO to develop the SIB further. Steering Group established and key local members invited to attend. The CCG is engaged and joins the steering group.
- September 2013: CBO-SOF expression of interest submitted.
- October 2013: CBO-SOF expression of interest agreed.
- October 2013: Social Finance engaged to support the refinement of the operational plan and financial model.
- November 2013: Heads of Terms agreed between WtW and the CCG.
- December 2013: CBO Development Grant applied for.
- November 2013 – July 2014: Discussions with a number of social investors begin, leading ultimately to engagement of Bridges Ventures (forerunner to Bridges Fund Management) (July 2014).
- December 2013: Ways to Wellness Ltd incorporated to deliver expected contract.

2014

- January 2014: WtW receives Development Grant from CBO to further develop the specifics of the SIB.
- March 2014 – October 2014: Outcomes metrics and payment structure developed.
- March 2014 – July 2014: Service provider procurement process.
- June 2014: Full application to CBO and SOF outcomes funds.
- July 2014: CBO in principle funding of up to £2m agreed.
- July 2014 – February 2015: Contracts developed by the CCG.
- November 2014: Revised metrics, draft contracts, data collection and verification submitted to CBO for final decision.
- December 2014: The CCG receives SOF funding from Cabinet Office.

2015

- January 2015: The CCG receives Final Agreement to fund from CBO.
- February 2015: Contracts between the CCG, WtW, and Bridges Ventures signed.
- February 2015: Contracts between WtW and service providers signed.
- March 2015: Project launched.
- April 2015: Service mobilised.
- July 2015: Service launched.

3.4.2 The rationale for commissioning the intervention

The social case for the intervention was that it would improve the quality of life for people with LTCs. The financial case was that people with LTCs tend, without self-management, to visit A&E more often and to be admitted to hospital (for both planned and unplanned procedures) more frequently and stay in hospital longer. The project was therefore expected to reduce the cost of treatment in these areas. The original financial case predicted savings in secondary care costs to the CCG of £10.8m, with further savings to other agencies (for example to local authorities, as a result of reduced demand for Social Care) of £13.5m.

A key objective was also to provide a stronger evidence base for the effectiveness of social prescription at scale. At the time of developing WtW (2013) the effectiveness of social prescription in achieving outcomes and reducing costs at population-level scale was largely unproven. At the time, one of the largest social prescribing projects was the Rotherham Social Prescribing Service, which supported 994 service users in 2014/15[21]; WtW was aiming to support 1409 in year one and an average of 1973 per year from year 2 – nearly double the reach of Rotherham. While the two services are not directly comparable, this does give an indication of the scale of WtW (in terms of numbers supported).

The project also drew on earlier work, including "Thanks for the Petunias", a toolkit providing guidance on how to commission non-traditional providers such as VCSEs to improve the self-management of LTCs[22] which focused on work in the North East and was part of the Year of Care programme at Northumbria Foundation Trust. This in turn helped inform an application to Nesta to run a pilot programme which ran during 2012. This pilot was part of Nesta's "People Powered Health Programme"[23].

3.4.3 The rationale for funding WtW through a SIB

The main reason for using a SIB was to support the ambition described above of operating a social prescribing service at scale. Due to the uncertainty of the success of the project in terms of outcomes, the CCG was not prepared to take the risk of funding the service at scale without payment being linked to financial outcomes, which would generate savings that enabled them to cover the outcome payments. They also were only comfortable paying if there was strong assurance that the outcomes (and savings) had been achieved – i.e. they wanted their payments linked to the achievement of outcomes.

"[T]he evidence base in this area is not strong enough yet to allow us to reduce payments to other services to pay for it. We need time to gather the evidence and to prove both the health outcomes, and cost savings, of this way of working. The input from the social investors, who pay for the service up front and share the risk of the new and innovative way of working, enables us to do this." (Full Application to the CBO Fund)

3.4.4 Stakeholder experience during the development phase

At the time of the evaluation's first visit to the WtW (early 2015) the project had just launched. Almost all stakeholders interviewed were fully engaged with the project and appeared excited about its inception. In particular, everyone believed in the intervention, and specifically its scale. This belief acted as a driving force that ensured the project launched despite facing challenges.

21 Dayson et al, 2015. *The Rotherham Social Prescribing Service for People with Long-Term Health Conditions*. See: https://shura.shu.ac.uk/17296/1/rotherham-social-prescribing-service-annual-report.pdf

22 See https://www.yearofcare.co.uk/sites/default/files/pdfs/Thanks%20for%20the%20Petunias.pdf

23 See https://www.nesta.org.uk/report/more-than-medicine-new-services-for-people-powered-health

All stakeholders felt that the project management team who set up the project consisted of the right components, including the right expertise (procurement, business management, finances); engaging people at the right time (including investors and front-line staff); and having the right attitude (passion, resilience and willingness to think innovatively). They also learnt that it was important to ensure good communication between parties to successfully launch the project: they managed this by establishing a steering group right at the beginning of the project development and inviting all the relevant parties (though in hindsight stakeholders recognised that procurement and legal teams should also have been involved at this stage).

"[T]he challenges…would never have been overcome without a strong and committed project team and steering group." (Representative from WtW)

However, the project took a very long time to implement and was subject to many delays. In total, it was three years from the idea of SIBs being explored to the project being set up (though it only took 18 months to design the intervention and SIB structure). One stakeholder described the delays as *"deeply frustrating"*. The length of time it took reflected the number of challenges stakeholders faced and the SIB's complexity.

"This is one of the most difficult things we've ever done." (Representative from WtW)

Challenges included:

- **Multiple stakeholders:** There were multiple stakeholders (CCG, WtW Ltd, four service providers, The National Lottery Community Fund, Cabinet Office and Bridges Ventures), each with their own interests and own contracts. Aligning them all was immensely difficult and led to a *"complex web of contracts." (Representative from WtW)*
- **Finding measurable outcomes that suit all parties** (i.e. demonstrate progress and a cost saving for the CCG): Many outcome metrics were tried, but were discounted for either being unmeasurable or not a direct or reliable proxy for the outcome sought. Due to the innovative nature of the project there was limited available evidence to draw on. Although all parties appeared on board with the measurement approach, stakeholders commented that the approach would not capture all the potential cost savings generated by the project. The project had to restrict its referral criteria based on what data could be accessed and stakeholders did not fully know whether the outcomes metrics would work. Quite a few stakeholders were nervous about some aspects of the measurement approach.
- **Operating a SIB within health services:** This led to two main challenges:
  - *Local health commissioning was complex due to the split between the CCG, NHS England and Public Health, the last of which is further split between Public Health England and local authorities*. This meant that different commissioners benefited from different outcomes. Ideally, the SIB would have reflected the benefits of improved outcomes to all the commissioners, all of whom would contribute payments based on the achievement of those outcomes. This proved challenging, however, as no public bodies other than the CCG were willing to co-commission the SIB due to funding constraints. Consequently, only the direct benefit to the CCG was reflected in the SIB outcomes and business case. Creating

an intervention that is funded only by the organisation that reaps the direct benefits is a challenge, and limits the scope of the SIB.

- *Although the CCG was familiar with PbR systems for hospitals, WtW was far more of a direct approach for commissioning for outcomes*. Consequently, the CCG's systems and processes were not geared to such commissioning, leading to cultural differences and tensions between the CCG and WtW Ltd when creating an outcomes-based contract. This was compounded by the new establishment of the CCG and a fledgling working relationship between the CCG and the Commissioning Support Unit (CSU).
- **Project was led by a VCSE, not the commissioner:** SIB operational development was initially led by a VCSE and the WtW team, although the CCG was engaged at an early stage. This created challenges at a later stage as contractual requirements stipulated by the CSU were different than to what WtW originally anticipated. These requirements led to additional costs which had to be factored into the financial model.

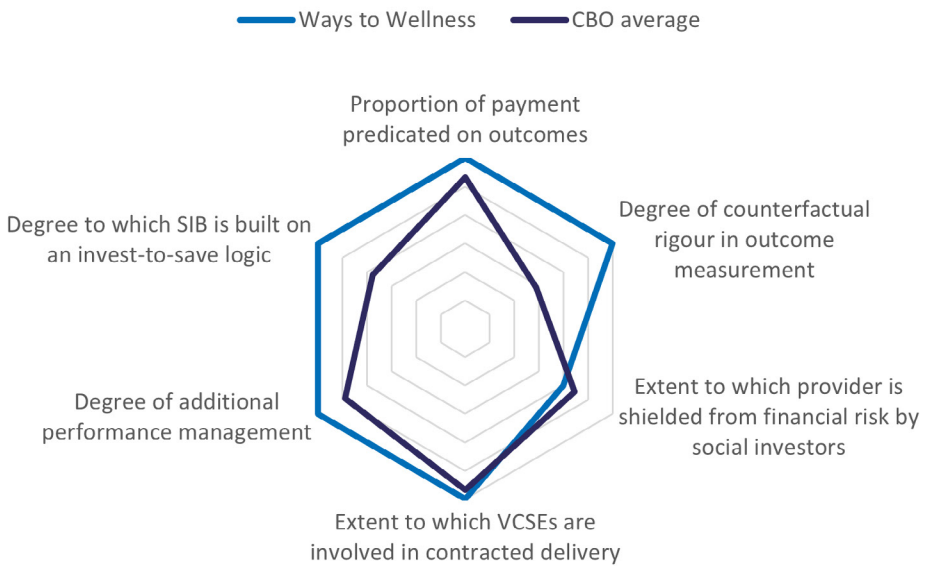
3.4.5 Comparing WtW with other CBO projects

The CBO evaluation team has developed a framework for analysis to compare the SIB models across the nine IDR projects. This draws on the SIB dimensions set out by the GO Lab[24], adding a sixth dimension related to cashable savings (Annex 1 describes the dimensions and the different categories that exist within it). The aim here is to understand how SIB funding mechanisms vary across CBO, and how they have evolved from their original conception. Figure 6 uses this framework to compare WtW with the average positioning for the CBO IDR projects against this framework. This provides information on the design of the SIB mechanism at the launch of the project.

It is important to stress that these are not value judgements – there is no 'optimum' SIB design, but rather different designs to suit different contexts.

For further information on how these categories were formulated, and the rationale behind them, see the CBO 3rd Update Report.

Figure 6: **SIB dimensions in WtW and other CBO in-depth reviews**



24 Carter, E., 2020. Debate: Would a Social Impact Bond by any other name smell as sweet? Stretching the model and why it might matter. *Public Money & Management*, 40(3), pp. 183-185. See: https://www.tandfonline.com/doi/abs/10.1080/09540962.2020.1714288

The positioning of WtW against the framework shows the following:

- Proportion of payment predicated on outcomes: The payment model was, as conceived, based 100% on payment for outcomes achieved. This is typical of the CBO projects that feature as IDRs: two thirds (six out of nine) of the projects have 100% of payments attached only to outcomes. In the remaining three projects (Mental Health Employment Partnership, West London Zone and Be the Change) commissioners also pay for engagements / outputs.
- Validation method: WtW measured outcomes through a 'quasi-experimental' evaluation design[25]; Outcome B payments were only made if secondary care usage in the west of Newcastle (where WtW operated) were lower than those in the north and east of Newcastle. This approach is rare across the CBO projects that feature as IDRs; WtW is the only project that uses a quasi-experimental approach. The majority of projects (six) do not build any attribution estimates into their payment mechanisms.
- Provider financial risk: In WtW providers were paid in-part based on engagement levels. This is the only CBO IDR project that pays providers in this way; in the majority (five) providers are fully shielded from financial risk by the investors; in the remaining three payment is partly tied to outcomes.
- VCSE service delivery: All service delivery in WtW was undertaken by four VCSE organisations, with performance managed by a VCSE social prime contractor. This is very common across CBO; in all the IDR projects delivery was in-part undertaken by VCSEs, though some public sector organisations are involved in delivery. There are also other examples of performance of VCSEs being managed by a social prime contractor (such as in West London Zone), though in other instances the performance is managed by an intermediary / IFM-led vehicle (such as the Mental Health Employment Partnership).
- Performance management: In the WtW project an organisation external to the ones providing direct delivery of the intervention monitored and managed the performance of service providers (WtW Ltd). This model - known as 'intermediated project management' is the most common type of performance management across the CBO IDR projects, with five projects adopting this approach. In the remaining four, two have 'direct performance management' (where the organisation delivering the service is also responsible for managing their own performance, and there is no external intermediary) and two have a hybrid approach (where a 'social prime' organisation is responsible for managing the performance of their own service provision, and the performance of other service providers).
- Degree to which project is built on an 'invest-to-save' logic: The 'invest to save' principle was very important to this project. In most of the CBO IDR projects there was a strong focus on the savings that will be generated by the project. One third (three) of the projects are built on an invest-to-save logic (including WtW), with the SIB is specifically designed to ensure (as much as possible) that it releases payments to cover the outcome costs. In the remaining projects the savings are either not large enough to cover the outcomes payments, are not cashable and so cannot be released to make payments, or do not fall to the outcomes payer.

25 Quasi-experimental research designs, like experimental designs, test causal hypotheses. Quasi-experimental designs identify a comparison group that is as similar as possible to the treatment group in terms of baseline characteristics. The comparison group captures what would have been the outcomes if the programme/policy had not been implemented. See: https://www.betterevaluation.org/sites/default/files/Quasi-Experimental_Design_and_Methods_ENG.pdf

4.0 What has happened in practice

This section covers major developments in WtW during project implementation.

4.1 Contractual and operational changes

There were two noteworthy changes to the operational or contractual model of the project since it commenced in April 2015. These were:

- **The withdrawal of some of the service providers.** At the beginning the contract had four service providers engaged as sub-contractors to WtW Ltd. These were First Contact Clinical, Mental Health Concern, HealthWORKS Newcastle and Changing Lives. The sub-contracts with all four of these providers were renewed on contract review after two years (in March 2017).

  However, the terms of the contracts changed at this renewal – originally the initial contracts included a significant base payment in order to: fund mobilisation and set-up costs; enable the delivery partners to recruit a full team of Link Workers; help delivery partners to engage with practices; and to build up referral numbers. In the contract renewal this changed so that payments were more linked to the completion of the wellbeing stars, which meant provider payments were more closely tied to referral numbers actually obtained. Different stakeholders had different accounts as to the reasons why this was done, with some of the view that this change was expected from the outset, and others of the view that this was introduced later in order to provide strong financial incentives for service providers to increase referrals.

  As a consequence of the above changes HealthWORKS Newcastle withdrew voluntarily from their new contract shortly after the contractual changes; and about a year later (around April 2018) Changing Lives also withdrew. The Link Worker interventions following this were delivered by the two remaining providers: First Contact Clinical and Mental Health Concern, who were willing and able to take on additional GP Practices (from which referrals were sourced) and delivery responsibilities from the providers that withdrew.

- **Request to reprofile CBO outcome payments.** At project inception CBO contributed to the WtW SIB by making payments for outcome A of £350 per person, and began doing so in the 2018/19 financial year (with payments for outcome A prior to this funded by the Social Outcomes Fund). In 2018, because the WtW SIB was forecasting a lower level of referral and service engagement than originally envisaged (see Section 4.6), there was a risk that the WtW project would not achieve sufficient outcomes over the contract life to be able to draw down all the funding committed from CBO. WtW therefore submitted a request to The National Lottery Community Fund to reprofile outcome payments and increase the payment for each outcome (while not increasing the total funding commitment). The National Lottery Community Fund agreed to this request in 2018. The Fund considered that this was justifiable because the service providers were supporting service users that were of higher risk and had more complex needs than originally envisaged, and the project still met the CBO objectives and programme requirements. The National Lottery Community Fund were also concerned about the projects' financial viability[26] and wanted to ensure the project continued.

There were also some slight changes to the payment mechanism for Outcome B in response to the fact

26 According to CBO records WtW had potential liabilities of £1.98 m at the end of 2017/18 which was £120K more than Median plan. putting them at increased risk as a going concern

that there had been fluctuations in the underlying performance against this outcome and therefore in the payments made by the CCG. The change was technical, but essentially the current metric and sliding payment scale remained in place but changes were made to the calculation of the average price to reflect the fact that a service user could achieve more than one outcome, and therefore the average should be determined by the number of outcomes rather than the number of registered service users

4.2 Outcome payment miscalculation

At the time of the interviews for the second IDR visit (mid-2018) the performance of Outcome B was variable, which was affecting the financial viability of the project and causing tension between stakeholders. In late 2018 it transpired that there had been a significant error in the way the data for Outcome B was collected, which meant that performance against Outcome B was, in fact, not variable and overall performance was very close to forecast levels. This was due to a human error in creating formulas in Excel to calculate the costs of secondary care usage, meaning that A&E costs for the comparison cohort had been excluded from the total cost data from January 2017 to April 2018.

Using the corrected data, WtW recalculated the 12-month rolling averages of costs and the resulting Outcome B payments for each period. This showed that WtW had been underpaid for Outcome B for 12 of the previous 13 months of payments that had been invoiced (April 2017 to April 2018).

This data correction favourably shifted WtW's financial sustainability and reduced uncertainties. This reduced financial pressure also improved relationships between stakeholders (see Section 4.4).

4.3 Roll-out of social prescribing

In early 2019 the NHS announced that the newly-formed Primary Care Networks (PCNs) would receive core funding to employ social prescribing link workers, including across Newcastle, through the Additional Roles Reimbursement Scheme (ARRS).

The national social prescribing service was different to WtW in a number of ways:

- The two services supported different cohorts, with the national prescribing service having much broader eligibility criteria (being available for everyone aged over 18, compared to WtW which was for people aged between 40 and 74).
- The national service had virtually no restrictions on the support needs that could be met by the Link Workers, While WtW was limited to seven defined LTCs, NHS link workers could see adults for almost any reason – from physical health to mental health to practical reasons such as housing or benefits advice.
- The two services had different intervention models and approaches, with the national service more focused on providing direct support, and WtW more focused on coaching and building independence.

The introduction of the national social prescribing service had several implications for WtW:

- Affecting outcome validation approach: As mentioned above, the use of hospital services in the east of Newcastle was used as a comparison group to estimate the impact of WtW, with outcome payments attached to this measure. This was based on the assumption that people in the east of Newcastle were a good predictor of what would have happened in the absence of WtW – because they did not access a social prescribing service. The introduction of the national social prescribing removed this robust comparison, because those in the east now had access to a social prescribing service.

- **Affecting referrals:** The looser referral criteria for the national social prescribing service made it easier for GPs to refer all potential service users to the national social prescribing service, rather than assess whether someone was eligible for WtW or the national social prescribing service. Consequently, referrals to WtW dropped.
- **Affecting staff retention:** According to the Ways to Wellness Six Years report: *"The unprecedented additional social prescribing roles that came onstream across the country changed the link worker job market. NHS salary, terms and conditions put VCSE roles (funded through time-limited contracts rather than core NHS funding) at a competitive disadvantage. Ways to Wellness delivery teams experienced higher than normal turnover of staff in 2019, as a number of experienced and senior staff left for roles in PCNs…In response, Ways to Wellness service providers increased Link Worker salaries and added job progression options for staff."*

4.4 Relationships between key parties

At the point of the second IDR visit in 2018 it was apparent that the performance issues described in Section 4.1 had affected relationships within and between the key parties to the project, and there had sometimes been disagreements about whether and how to take action. These issues are covered in detail in the second IDR, but in summary the disagreements related to:

- How to manage the performance of the service providers, including in relation to the balance between creating a culture of collaboration and/or competition; and whether to extend the contracts of the service providers who were below engagement levels
- The role of the IFM in managing performance and liaising with the CCG.

However, by the final IDR visit in 2022 relationships between parties had improved. One person who joined the project after 2018 remarked that their experience has been quite different to some of the accounts from 2018.

The reason for this shift was primarily because the performance issues no longer existed: the two remaining service providers had taken over the delivery contracts and had improved performance, and the outcome payment miscalculation had been identified.

"The whole world changes, and as a result relationships change… Everyone was looking for fault and blame, and all that went away." (WtW representative)

Stakeholders also attributed improved relationships to the pandemic – during this period organisations had to work together more closely to overcome the challenges, which fostered a more collaborative ethos. In addition there were changes in personnel at both Board and operational level within WtW and across other parties, notably the commissioner.

4.5 Changes in response to COVID-19

4.5.1 Changes to the service

In response to COVID-19 WtW adapted service delivery to provide a remote service to patients. All Link Workers transitioned to home-based working in mid-March 2020. The teams liaised with GP practices, Newcastle City Council, and other partners to support vulnerable patients. For example, it was agreed with commissioners that Link Workers would offer support to hundreds of additional patients that the Council or GP practices identified as vulnerable (but did not meet WtW service eligibility criteria) in late spring and early summer 2020. Link Workers adapted their role to respond to the unique needs that some clients faced during COVID-19. The key areas of COVID-related need are listed in Table 1 below.

Table 1: **New or increased areas of client need arising due to COVID-19**

Link worker support: new areas of need for some Ways to Wellness clients during COVID
1. Emotional and psychosocial support to isolation, social distancing, and loss of routines
2. Access to provisions or supplies – e.g. - food, medications
3. Crisis response needs – e.g. self-harm or domestic violence
4. Informing and connecting people to emerging offers to manage impact of COVID
5. Helping patients to understand evolving government guidance and public health advice that are relevant and apply in their own situations
6. Helping patients to understand changes to benefits and other financial aid available
7. Supporting patients more extensively and in new ways due to limited accessibility or availability of services and groups that patients would normally be signposted to for social connections, support and advice

Source: Ways to Wellness: The first six years

Link Workers held some face-to-face support in shared spaces (e.g. libraries), but most support transitioned to online. Service providers faced challenges in delivering a remote social prescribing service:

- Referrals in 2020 reduced as GP practices focused on more urgent needs of patients (in the 2020-21 12-month Grant Monitoring Form submitted to The National Lottery Community Fund, WtW reported that referrals dropped by 55% in 2020/21)
- Delivering motivational interviewing and behaviour change methods remotely was challenging.
- Link Workers faced lower job satisfaction as they were unable to spend face-time with service users.
- It was not possible to signpost service users to community groups, as these were closed.

At the time of the final visit (2022) the service was still affected by some of the effects of COVID-19.

Link Workers struggled to work out of GP surgeries because space and access was still restricted (accentuated by surgeries introducing wider roles into their practice, such as dieticians). Link Workers were spending a lot of time trying to support service users to access health services, which faced a backlog due to cancelled appointments during lockdowns (one Link Worker gave an example of phoning a GP surgery 103 times). However, they had also seen benefits: there were efficiency gains in undertaking some sessions remotely, reducing time lost to travelling; completions of Wellbeing stars increased, as these could be done virtually (before they had to be completed face-to-face, and it was difficult to arrange times to do this).

4.5.2 Changes to the SIB mechanism and impact on finances

Despite Link Workers reporting that COVID-19 was affecting the wellbeing of service users, the outcomes related to Outcome A (wellbeing) stayed relatively similar. This was surprising to stakeholders.

Secondary care usage (Outcome B) became more variable post-COVID-19 in both the WtW cohort and comparison group. Stakeholders therefore believe that this outcome measurement was no longer capturing the impact of the WtW intervention during COVID-19:

> "The effect of COVID on hospital services appears to have overshadowed any visible impact that might be attributed to the Ways to Wellness service." (Ways to Wellness: The First Six Years)

WtW discussed their options with The National Lottery Community Fund; according to WtW stakeholders The National Lottery Community Fund said they would do what was needed, but would prefer to continue paying on outcomes. WtW also decided to continue operating on a payment for outcomes basis, as they wanted to demonstrate that the service could be successful under this model. However, to support the project, and in recognition of the impact COVID-19 was having on WtW referrals, The National Lottery Community Fund agreed to consider extending its grant end date, from March 2021 to March 2022 – this would have given WtW more time to generate referrals and access Outcome A payments from The National Lottery Community Fund. However, in May 2021 the CCG decided not to proceed with this so as not to compromise the negotiations which were underway regarding the longer term sustainability of the programme.

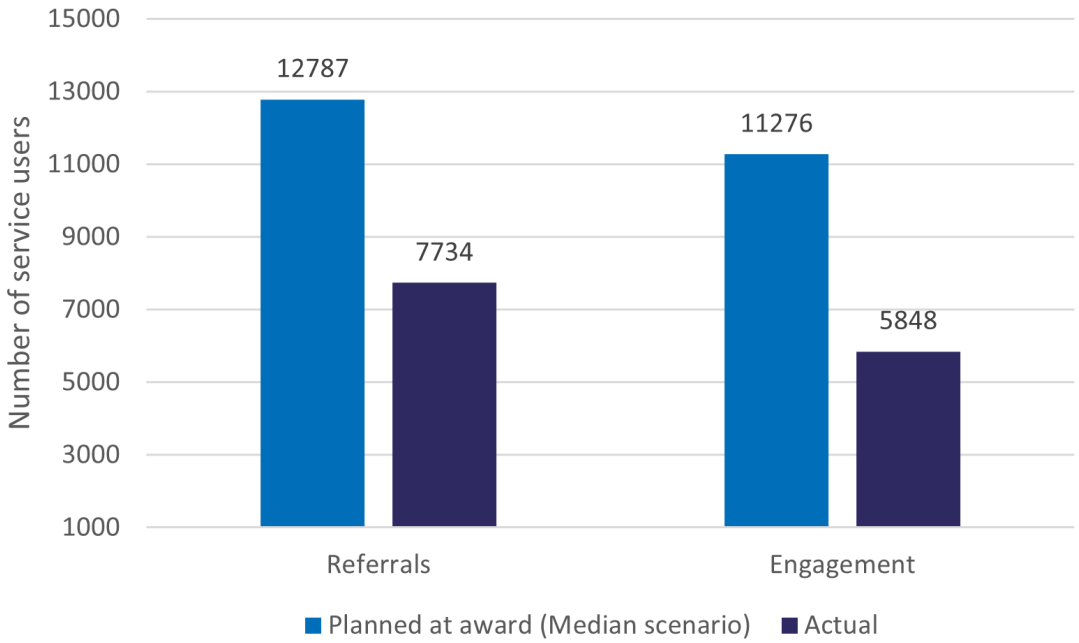
4.6 Project performance

This section provides information on how the project achieved against its targets.

4.6.1 Volume targets

Figure 7 below shows that WtW supported just over half (52%) of the intended number of service users – 5,848 against the intended 11,276 as set out in the Median scenario agreed with CBO at project launch.

Figure 7: **WtW engagements: Actual vs planned**



Source: The National Lottery Community Fund Management Information. 'Planned' refers to the 'Median' scenario presented in The National Lottery Community Fund grant award letter. 'Referral' means people referred to the project; 'engagement' means people who actively engaged with the project.

The number of service users engaged was lower than originally estimated due to a number of reasons. These were (in broadly this order of influence):

- Optimistic modelling of expected referrals. There was a broad consensus that the original forecast and modelling of referrals, as included in the SIB business case, was optimistic and, with hindsight, not possible to achieve. The initial forecast and modelling assumed that a very high proportion of the total population of those with appropriate LTCs would be referred over the entire life of the programme. There was therefore likely to be a shortfall unless all those eligible for the intervention visited their GP and were referred when they did so and consented to be referred. Furthermore, the initial case over-estimated the growth rate in people with LTCs, thereby over-estimating the size of the eligible population
- Rollout of national social prescribing service: As described in Section 4.3, the roll-out of the national social prescribing service created 'competition' for WtW, and some people eligible for WtW were referred to the national service instead;
- COVID-19: As described in Section 4.5, COVID-19 created challenges in receiving referrals from GPs and engaging potential service users.

While the total number of referrals and subsequent engagements in WtW remains impressive compared to many other social prescription programmes, this impacted on the project in a number of ways:

- It was difficult for some of the providers to continue to be sub-contractors to the WtW, because their payment was in-part linked to referral numbers. This led to some providers to withdraw from the contract (see Section 4.1);
- It was difficult for the WtW SIB to achieve outcomes – especially Outcome A, which links directly to numbers referred and engaging successfully; and
- It reduced the total amount of investment needed, as already explained in section 3.3.2.

4.6.2 Outcome performance

4.6.2.1 Outcome A (wellbeing)

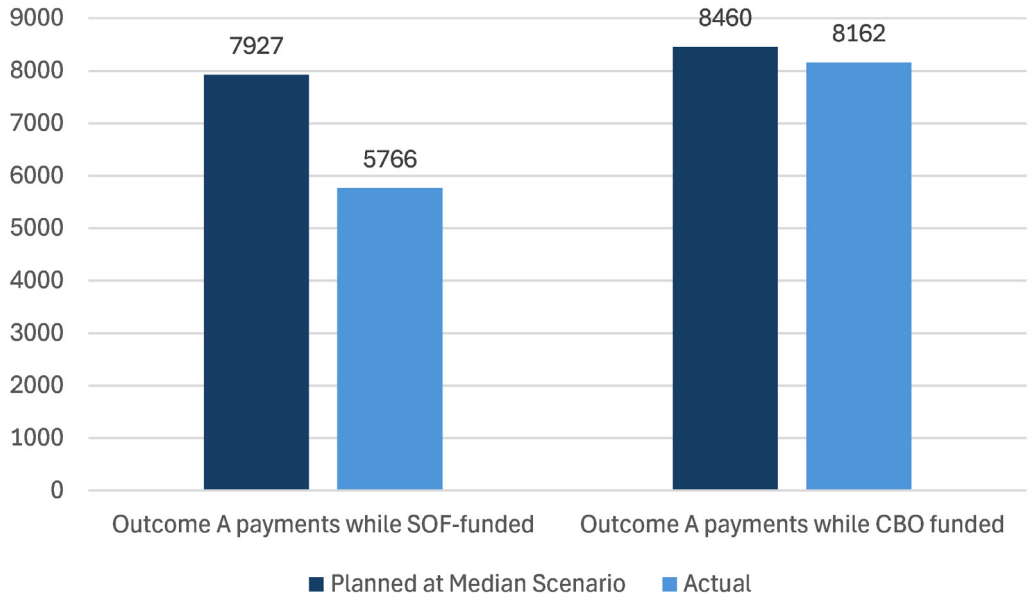
Outcome A refers to the wellbeing outcome. As already outlined this was measured using the Outcomes Star firstly on entering the programme, to establish a baseline, and then at six monthly intervals. Payments were made on a sliding scale according to the average improvement made by the whole cohort every six months up to a maximum of eight payments.

According to CBO data on this outcome there were slightly different metrics and payments when WtW was supported by SOF and when supported by CBO. As Figure 8 shows, WtW achieved 5,766 outcomes against a plan at Median scenario to achieve 7,927 outcomes while co-funded by SOF, and 8,162 outcomes against a plan to achieve 8,460 outcomes while funded by CBO. It therefore achieved 73% and 94% of its respective targets.

Both these outcome metrics did not directly measure wellbeing, however, and were partly dependent on the number of people registered as being on the programme. It is therefore difficult to assess from the Outcome A data alone how the project directly impacted on service user wellbeing.

Other data does help us understand the project's impact on wellbeing, however. Triangle, owner of the Wellbeing Star assessment, conducted data analysis on the 2,888 WtW service users who had engaged with the service and had subsequently been discharged in the first five years (April 2015 to April 2020). This analysis found that 86% of service users reported an improvement in at least one area of wellbeing. This data is *broadly* in line with the outcomes from others social prescribing projects run on a smaller scale. For example, the Rotherham Social Prescribing Service used a very similar wellbeing tool to measure outcomes (though this was a specific tool designed for the service and not the Wellbeing Star); the evaluation found that 82% of service users experienced positive change in at least one outcome area.[27] In the SPRING Social Prescribing project, in Scotland and Northern Ireland, 84% of service users saw an improvement in their wellbeing, measured through the Wellbeing Star.[28]

Figure 8: **Planned and actual wellbeing outcomes achieved (Outcome A)**



Source: The National Lottery Community Fund Management Information.

27 Dayson et al, 2015. The Rotherham Social Prescribing Service for People with Long-Term Health Conditions. See: https://shura.shu.ac.uk/17296/1/rotherham-social-prescribing-service-annual-report.pdf

28 https://www.tnlcommunityfund.org.uk/media/insights/documents/SPRING_EvaluationReport.pdf?mtime=20210618134201&focal=none

Caution needs to be taken when trying to compare these services; these were different services, operating in different areas and supporting different cohorts. Furthermore, different wellbeing measurement tools were used. However, the fact that the wellbeing levels were *broadly* similar with other social prescribing services does add an interesting dimension to the debate about how the SIB mechanism affected the quality of the service (see Sections 4.7.3 and 5.3.4).

4.6.2.2 Outcome B (Secondary care usage)

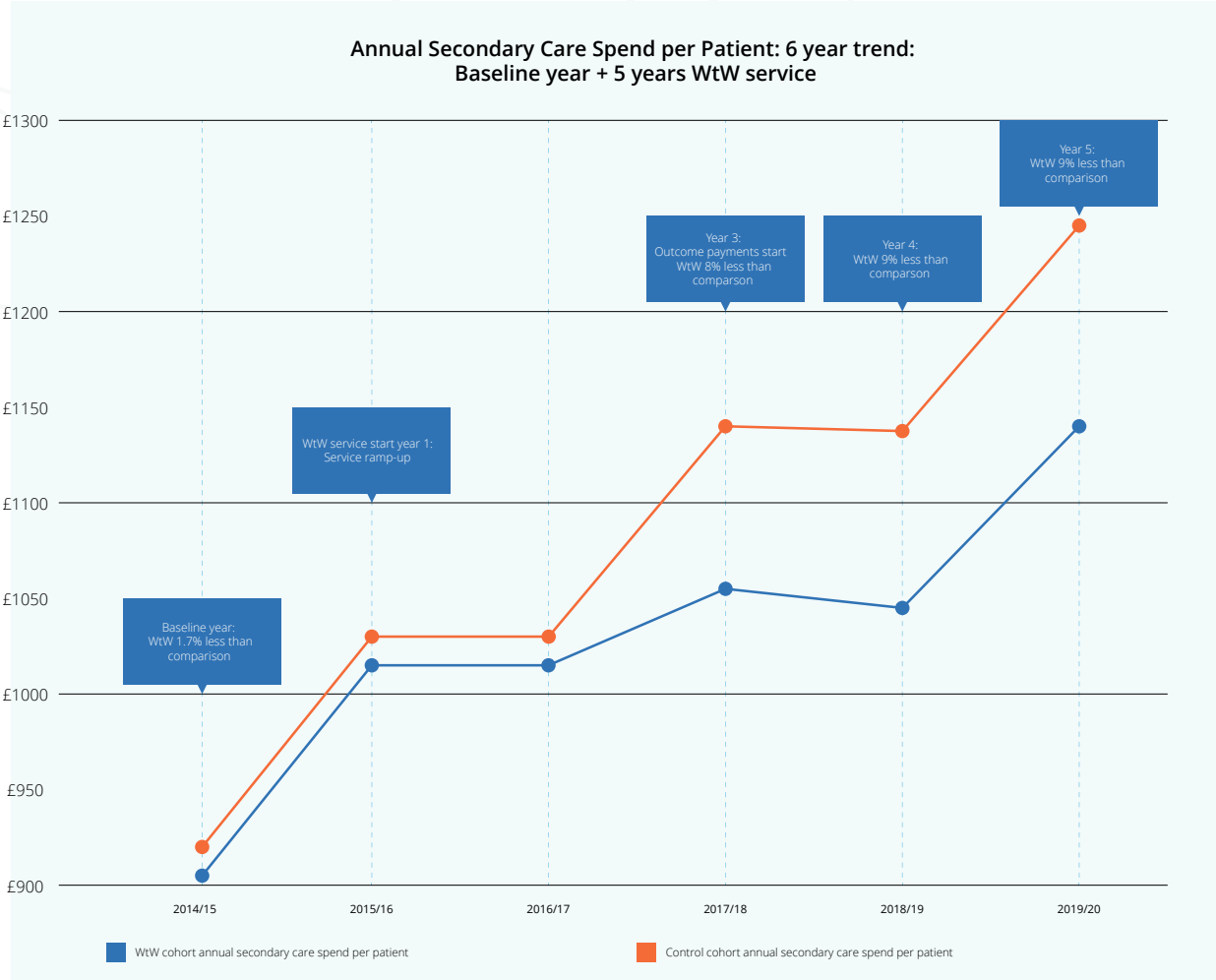
As explained above, Outcome B was a measure of the difference in the costs of hospital services used by the cohort receiving the intervention compared to the costs incurred by a comparison group with similar characteristics. Cost reductions in the treatment cohort were then converted into tariff payments, weighted on a sliding scale according to the percentage difference in costs between the treatment group and the comparison group. According to CBO data, the project achieved a total of 11,024 tariff payments, 103% of its plan at Median scenario which was to achieve 10,661 payments.

Further analysis of the impact of the project in reducing costs to the CCG is provided in the 'Ways to Wellness: The First Six Years' report. According to that report, in 2019/20 the secondary care cost per service user across the full eligible WtW cohort was 9.4% (£107 per head) lower than the comparison cohort. When you scale costs to account for the service users who had engaged with the service, **the WtW cohort costs per head were 27% lower than the comparison cohort**. Across the full eligible WtW cohort (14,652 patients), this equates to an **annual secondary care cost reduction of £1.56 million in 2019/20**. The cumulative costs avoided in secondary care were **£4.6 million over the first 5 years** of the service (£1 million net). The trend from the baseline year (prior to service launch) is illustrated in Figure 9, below.

The original intention, as set out in the project's Full Application to the CBO programme, was that the reduced demand on secondary care would generate cashable savings and allow the CCG to renegotiate contracts elsewhere (and thus pay for the outcomes). Figure 9 shows that in reality secondary care costs increased in both the WtW cohort and the comparison group, but the costs increased at a lower rate in the WtW cohort; this means that WtW led to *avoided* costs but did not lead to cashable savings. However, the CCG was still content with these results because they believed the outcomes data showed that the intervention saved the CCG money, even if these savings could not be realised (see Section 4.7.1 for more detail on the commissioners' experiences).

"This was sometimes referred to as Ways to Wellness "washing its own face", meaning that the service should largely, if not entirely, pay for itself. In reality, the NHS is limited in its ability to release cashable savings from costs avoided within the system." (WtW six-years report)

Figure 9: **Annual secondary spend for WtW and comparison cohorts.**



Source: Ways to Wellness: The First Six Years

Further and more detailed research was conducted into the impact of the WTW intervention on non-elective hospital care costs, funded by a grant from the National Institute for Health Research. This was a high quality quasi-experimental study[29] and tends to confirm the positive impact of the intervention. It compared the costs of non-elective admissions for the WtW cohort with a control group for those with Type 2 diabetes alone. It found that the intervention:

"…resulted in large, significant reductions of up to -£77.57 per year, in non-elective inpatient care costs among a population aged 40 to 74, with a diagnosis of type 2 diabetes and living in an area of high socioeconomic deprivation. ……. If similar reductions were seen across the approximately 9000 patients who participated in the intervention across seven years, then the reductions would present an upper bound of approximately £4.8 million."

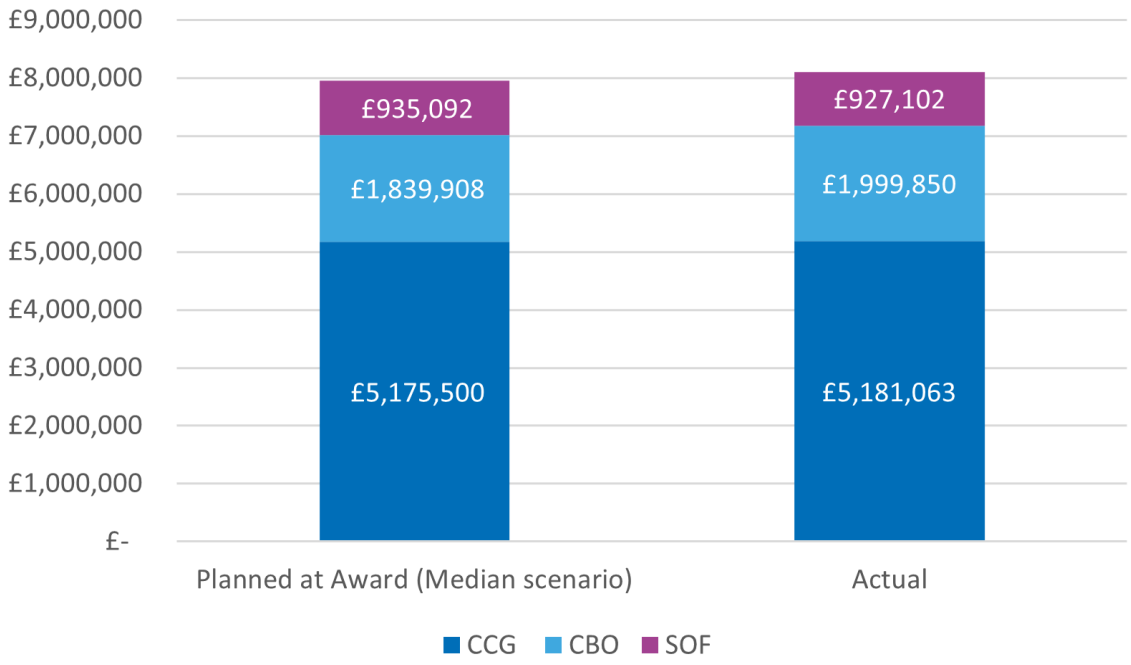
29 See https://www.sciencedirect.com/science/article/pii/S0277953622009042?via%3Dihub

4.6.3 Commissioner payments and investor returns

4.6.3.1 Commissioner payments

The Median scenario estimate of outcome payments was £7,950,500. Figure 10 and Error! Reference source not found.2 show that this was exceeded slightly, with £8,108,015 of outcome payments made – 102% of the projected Median scenario. This was due to the rate payable for outcomes changing twice during the life of the SIB. The CCG paid 65% of the outcome payments (£5,181,063, 100.1% of their Median scenario); CBO 23% (£1,999,850, 109% of the Median scenario of £1,839,908); and SOF 12% (£927,102, 99% of the Median scenario of £935,092).

Figure 10: **Commissioner outcome payments, broken down by outcome payer**



Source: The National Lottery Community Fund Management Information.

4.6.3.2 Investor return

Based on the MI supplied by The National Lottery Community Fund, the investors committed £1,723,989 to WtW, which was slightly more than Median plan to commit £1.65m. Of this £1,108,411 was drawn down. WtW returned this initial capital plus interest of £680k – i.e. £1,788,411 in total. This is equivalent to a money multiple of 1.40 on the amount committed, and 1.61 on the amount drawn down.

4.7 Stakeholder experiences

4.7.1 Commissioner experience

Stakeholders within the CCG were very pleased with the success of WtW, particularly relating to its impact on reducing secondary care usage.

Some stakeholders commented that they had *"prejudices"* against the SIB model initially, based on their perception of the use of private finance initiatives (PFIs) in the health sector.

"My prejudices against SIB in the first instance were informed by capital PFI projects, and I don't think they're good for the NHS as a whole – so I had a prejudices of private investment based on some bad experiences… and the whole philosophy of the NHS – it's a public service, free at the point of delivery….and private investment is something that…for many, is frowned upon in the crown jewel of the country of the NHS." (CCG representative)

However, they were in the end pleased with the SIB mechanism, primarily because they recognised that, due to the risk sharing, it was essential to launching the project.

They were also very pleased with the dual focus of the outcome payment, which encouraged both a focus on cost savings *and* outcomes (wellbeing). They felt that PbR in the last 20 years had focused mainly on cost savings, and were pleased that the SIB expanded beyond this and focused on service user impact also.

Finally, the CCG was also pleased with the level of data and evidence they felt the SIB mechanism embedded into the WtW service; it provided them with the information and reassurance they needed in relation to both the impact of the service on service users, but also in the savings it was contributing to. They acknowledged the limitations of the measurement approach, and that they could not explicitly calculate the savings from the project. But they reported that it still provided them with the information they needed to both justify funding the service during budget cuts, and to continue funding the service after the end of the SIB (see Section 6.1).

"WtW has been one of the highlights of my 9 years of the CCG. It's been enlightening." (CCG representative)

The CCG also learnt lessons from the experience. They found the complexity of the project challenging, particularly in relation to how the payments were calculated. However, they did not think this was an overall problem, and that in future things could be simpler because their initial needs had been met through this project. For example, they felt they no longer needed to tie any future payments of WtW to cost savings, because the financial case of WtW had already been demonstrated.

Based on all of the above they were *"undoubtedly"* satisfied with the value for money of the service and the SIB mechanism.

4.7.2 Ways to Wellness Ltd experience

On the whole representatives from WtW Ltd thought the service had gone better than they had anticipated. They were pleased that they had managed to prove the concept of social prescribing at population-level, and also created a surplus that would help with the sustainability of the organisation (see Section 6.3).

They also felt they had learnt a lot about the role of Link Workers in health services, and were excited about their ideas on how this concept could be applied more broadly (also covered in Section 6).

They were pleased with the use of the SIB mechanism, and thought the outcomes approach had imparted a higher degree of rigour in impact measurement than is normally seen in such services (though it should be noted that similar social prescribing services have been evaluated in very similar ways, such as the Rotherham Social Prescribing service). In particular, they thought attaching payments to referral numbers

was imperative to pushing the boundaries of the service and achieving population-wide scale. Some senior stakeholders would like to see outcomes-based contracts being used more across health services.

However, those closer to the ground found this approach to be stressful, especially for a small organisation that did not have a lot of buffer, and so small changes in monthly income could have substantial effects.

However some members of WtW felt bruised after the experience. They felt that WtW was caught in the middle between investors and service providers, and when the project was under-performing they were under a lot of pressure, and did not always feel like they had the autonomy to try to resolve problems, due to the strong steer from the IFM (we reflect on role of social primes more in the Conclusion). Some stakeholders wanted to explore how to use outcomes-based contracting without investors in the future.

4.7.3 Service provider experience

Practitioners and service providers were positive of the service delivery model. They liked the fact that it provided long-term and meaningful support.

Service managers and practitioners we interviewed knew very little of the SIB / social investment side of the project, but were aware of the outcomes-based payment element (because they were similarly paid for referrals). They had mixed experiences of the SIB contracts. As mentioned above two service providers pulled out because they felt they could not operate within the contract parameters. The majority of service provider stakeholders we interviewed, including those that stayed in the contract, thought there were limitations to the outcomes payment model, which affected their service delivery. In essence they felt the contracts incentivised quantity over quality, as the priority in the service was referrals (see Section 5.2 for more details).

All of the above meant that practitioners were often dealing with very high caseloads. Practitioners felt that the national social prescribing service gave practitioners more freedom to provide broader support(though they also acknowledged that the national social prescribing service was a different model, which provided slightly different support to a different cohort, as explained in section 4.3). In the final years one service provider tried to proactively reduce caseloads in order to boost the quality of the support.

However, practitioners also commented that, whilst the targets and measures were present, they did not feel under strong amounts of pressure to achieve them. The general consensus from a focus group with practitioners was that the outcomes payment element was not their primary focus.

"We are aware of it but it's not the be-all-and-end-all…No one is saying, 'You must do this or we won't get paid'."
(Practitioner from service provider)

4.7.4 IFM experience

Bridges regard WtW to have been a success. They thought it was a hugely exciting project when they first decided to support it and invest, and still did at the end of the project although it required significant development as well as education and management effort to gain the support for such an innovative project. They thought the achievements were brilliant, in terms of the thousands helped to improve their lives, and the impact this had on primary and secondary care usage along with the learning created for future delivery.

4.7.5 The National Lottery Community Fund experience

Overall The National Lottery Community Fund was pleased with progress of WtW, and feel like the project had *"a lot of successes"*. Over time though they felt like their relationship with the project diminished – CBO's grant agreement was with the CCG and so they needed to interact primarily with the CCG. However, the move to integrated care systems (ICS)[30] plus the impact of COVID-19 made it increasingly difficult for CBO to interact with the CCG.

The CBO Programme learnt a lot from work with this project and its stakeholders. Particular learning of note includes:

- The need to look at projects holistically when varying CBO-commissioner contracts, focusing not just on the immediate issue, but looking at the entire set of metrics and financials to give context to any changes agreed
- The need to engage with all stakeholders, particularly those who hold the information and data on the project, relationship building to ensure that information is available for grant management, project and programme evaluation and wider learning
- Continually thinking about the financial robustness of projects and reviewing this annually, rather than largely waiting until the end of the project to help ensure that the intervention and project programme endure their intended length and leave a legacy, including continuity of provision post-CBO funding
- Thinking outside the box when dealing with Covid-related issues, including allowing a variety of funding options in tune with the aims of the CBO programme and the wider organisational objectives of The National Lottery Community Fund
- Working more closely with VCSE providers directly, within the confines of limited provider capacity, to get a strong understanding of their perspectives and needs to feed into future learning and funding.

4.7.6 Service user experience

Stakeholders (including service users) were universally positive about the intervention and its effectiveness. There have been two local research projects that explored the effectiveness of the WtW intervention:

- In 2017, Newcastle University's Institute of Health and Society published research[31] with a sample of 30 individuals who engaged with the WtW service. They found that most of the participants experienced multi-morbidity combined with mental health problems, low self-confidence and social isolation. All the patients were adversely affected physically, emotionally and socially by their health problems and typically had challenging social and economic circumstances. The WtW intervention was found to increase the patients' feelings of control and self-confidence, reduce their social isolation and have a positive impact on their health-related behaviours, including weight loss, healthier eating and increased physical activity. The researchers found that the WtW service's effectiveness with those who engaged with the service was due to its holistic, user-led and long-term approach. Patients reported improved management of their LTCs, improved mental health, greater resilience and more effective problem-solving strategies. The researchers concluded that the positive health and wellbeing impacts observed had, over the longer term, potential to impact within wider family, friendship and community networks.
- The Institute of Health and Society, in collaboration with WtW, also conducted a pilot quantitative research project funded by the School for Public

30 Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. See: https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

31 Moffatt S, Steer M, Lawson S, et al. Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. BMJ Open 2017

Health Practice Evaluation Scheme.[32] This asked 286 service users to complete five questionnaires looking at quality of life, loneliness and social isolation, depression, anxiety, and managing long-term illness. Well over half the participants reported problems with quality of life and managing their health, but after attending WtW, improvements were found across all measures, particularly with self-care, pain and discomfort. Those aged 60-74 reported much greater levels of improvements.

These findings were corroborated by our own consultations with service providers and service users. Service users told us that they valued the time that Link Workers had spent with them, which was in contrast to the (understandably) limited time they could be afforded by GPs and other clinicians. There was praise both for the time they had been worked with – one service user had been on the programme for 2½ years, and another for two years – and also for the length of individual Link Worker sessions and the opportunities they provided for deeper understanding of issues. Several stressed the impact Link Workers had merely by taking the time to explain properly the nature of their condition, and thus help them understand how to manage it better, rather than just telling them what the condition was with minimal explanation.

Others stressed the value of the Link Worker support in motivating them to do something about their condition rather than simply live with it, which can lead to further complications such as depression. One said that *"the biggest difference was the motivation"* while another commented that the most important thing was that the Link Worker had *"time to listen"*. Importantly, service users also said that they did not feel like a 'statistic', because of the personalised approach – this is important because there is a risk that an outcomes-based approach could lead to people feeling like this.

"Ways to Wellness is the way forward….it's a brilliant organisation because they actually listen to you, and they have the time for you….They're not telling you what you should be doing – they guide you and give you options." (Service user)

Further to this, at the time of the interviews (May and June 2018) the project had received a £518k grant from the National Institute for Health Research for more in-depth analysis. Stakeholders were pleased that this would help them understand the full impact of the intervention and the value of social prescribing, which, alongside helping thousands of patients, was one of the primary aims of launching the service. This research, already summarised and referenced in section 6.4.1.2. above, ultimately showed that the project was:

"associated with improved glycemic control, suggesting that these types of interventions may help to reduce the public health burden of type 2 diabetes."

32 Moffat, S. et al, 2017. Ways to wellness: feasibility study of the impact of a social prescribing intervention. See: https://sphr.nihr.ac.uk/wp-content/uploads/2018/08/SPHR-final-report-Ways-to-Wellness.pdf

There was also evidence of a measurable reduction in demand placed on primary care by the WtW SIB cohort. Audits conducted in Autumn 2017 in three of the GP practices participating in WtW measured change in GP and nurse consultations for 260 patients before and after involvement in WtW. The results showed that for a cohort of 100 patients, WtW SIB patients' GP consultations reduced annually by an average of 139 consultations. WtW also reported that anecdotal evidence showed that primary care staff were better able to divert their time to work with patients to address medical needs (rather than non-medical needs).

Box 2 below provides a further case study (see also Box 1 in section 3.2) summarising the experiences of a service users who received support from WtW, as reported to The National Lottery Community Fund by WtW link workers.

Box 2: **Ways to Wellness Case study: Ian**

"Ian" came to WtW with issues including substance use, social anxiety and personal debt. Due to his anxiety he had become increasingly house-bound however he agreed to attend his initial appointment with his Ways to Wellness Link Worker. Reducing his alcohol use was his main priority and a range of treatment options were discussed with him, including one-to-one and mutual aid group support. Although Ian decided that he would like to engage with structured one-to-one support with the local drug service, he failed to attend his initial appointment with them. In a follow-up session with his LW he said that he was too anxious to attend and his LW offered to accompany him to his first meeting with them, with the understanding that he would be expected to attend follow-ups appointments. Ian engaged with alcohol treatment and attended follow-up appointments on his own, and as his drinking reduced his confidence began to grow.

In a later appointment with his LW Ian spoke about a time in the past when he had enjoyed working out at the gym and how this had helped his moods. With encouragement from his LW, he then re-engaged with his local gym, and after a while he started volunteering there by supporting the boxing training sessions. This greatly helped his confidence and he found value in helping other people. As he had not wanted to engage in formal support for his mental health, he worked with his LW to develop strategies to manage his anxiety, supported by information from Northumberland Tyne and Wear NHS workbooks. With his new-found confidence he also started talking about his struggles with his own mental health with people at the gym, where he found out that other men were also struggling with their mental health. He shared with his LW that talking about his own anxiety had helped other people to open about their problems and that it felt *"really good to be able to be there for other guys who are struggling".*

However, it has not all been straight forward for Ian, and he has had some lapses in his drinking and anxiety management. He has however learned to ask for help, which he mentioned he wishes he could have done sooner: *"I think it's easy for guys to bottle things up… and then everything builds and gets worse"* he said, adding *"It's OK for guys to ask for help"*.

Ian is now tackling his debt issues with support from Money Matters and is confident about the future. He has started applying for jobs, and as he has a passion for cooking and is now considering training to be a chef.

5.0 Successes, challenges and impacts of the SIB mechanism

This chapter discusses the overall learning, in terms of the successes, challenges and impacts of funding the WtW intervention as a SIB, compared to funding this project through another mechanism (such as fee for service) – aka 'the SIB effect'. It also addresses overall value for money, as judged by both stakeholders and, so far as possible, independently by us as evaluators.

5.1 Successes

The majority of stakeholders perceived the SIB to have been 'worth the effort' because it launched a service that would not have been commissioned otherwise, as we describe below.

5.1.1 Ability to test social prescription at scale at minimum risk

This was widely cited as a benefit of the SIB mechanism at its inception and it remains valid. While referrals were below those expected, stakeholders reported that the scale of the programme was still larger than many social prescription pilots that have been conventionally funded. The CCG were of the view that they would not have been willing or able to test social prescription on this scale without the transfer of risk that is inherent in the outcomes-based payment mechanism.

"[B]y moving [WtW to a] SIB it shifted the dial in the risk share….social investor, Ways to Wellness, and the NHS…..it really was pivotal to getting it over the line…" (CCG)

Considering all stakeholders regarded the WtW project to have been successful, the SIB mechanism sits at the centre of the success of the project.

"None of this would have happened if it weren't a SIB." (WtW representative)

5.1.2 Providing real-time impact data in efficient way

The commissioner reported that the real-time impact data showing the impact of WtW on both wellbeing and cost savings was critical in demonstrating the value of the service. The fact that it had a quasi-experimental impact evaluation including a counterfactual really helped because it made the data more convincing. Stakeholders reported that this was a direct consequence of the SIB, because these data requirements were put in place in order to provide evidence for the outcome payments. Whilst academic studies were also published, these did not provide the real-time data that the SIB did. The commissioner reported that the data generated due to the SIB mechanism was critical to saving the project during budget cuts.

"If we had not had the hard measures…I would suspect the programme would have been scrapped…these are usually the ones on the bonfire….. vs hip operations…." (CCG representative)

Furthermore, the new CEO who took over WtW in 2021 was very impressed at the project's ability to satisfy NHS requirements in terms of data without overloading providers and passing some of the burden onto them. They described this as being *"quite unique"* amongst VCSE health projects that the CEO had experienced working with, and attributed this to the bespoke management information system the project developed to generate data for the SIB outcome payments. The CEO also found only having to report on two outcome metrics quite refreshing, compared to reporting for grant-funding, which they felt could be more cumbersome and restrictive.

5.1.3 Increasing referral numbers

Most stakeholders involved in delivery (WtW Ltd, service provider managers and practitioners) were of the view that attaching payments to referral numbers increased the providers' focus on achieving referrals, and ultimately led to more service users being supported than would have happened in a fee-for-service contract (even if the overall number referred was lower than projected). Crucially, some stakeholders were of the view that this was pivotal to the success of WtW – by setting ambitious referral targets, and linking them to payments, it enabled the project to operate at a population-level scale, which had not been done with social prescribing previously. (See legacy section later).

Practitioners described their persistent approach to reaching out to potential service users and experimenting with new approaches, and adapting and improving this as the project progressed; they shared ideas on how to improve referral numbers on a monthly basis.

"There's always that push, that we need to get the referrals." (Practitioner from service provider)

Members of WtW also thought the SIB had introduced a more data-driven approach to referrals – examining the data in more depth and adapting based on this.

"We have had to analyse the data much more rigorously, in terms of what is going on here – why is this happening? It's partly around variations in referral rates, and how can we change referral practices – that's not something the CCG really does." (WtW representative)

There was a general consensus from service providers, though, that the SIB did not increase the *quality* of support. There was a common view that the outcomes payment mechanism focused on 'quantity over quality', and did not necessarily incentivise service providers to increase the quality of the support. Views differed on whether the focus on quantity over quality was a good thing or not: some thought this prevented Link Workers from having the time to provide the normal level of support; others felt it created lighter-touch support, which reduced the likelihood of service users becoming dependent on the service, and also enabled the project to achieve population-level impact. It should be noted that, as mentioned earlier, the wellbeing outcomes for WtW are generally in line with wellbeing outcomes for other social prescribing services, and that WtW service users interviewed (for this study and others related to WtW) were positive of the support they received.

5.2 Challenges

5.2.1 Optimistic modelling and forecasting of referrals

As described above, it proved challenging since the start of the contract to achieve the level of referrals assumed in the initial financial and business case for the SIB. The initial forecasts of referral volumes were extensively modelled by the team supporting the design of the SIB, but nevertheless proved optimistic and unlikely to be achieved. It is noteworthy that our first IDR of the WtW SIB highlighted that a perceived benefit of the SIB was that is strengthened the up-front design work and modelling of the service – it would appear that, whilst this may still be correct, there were assumptions in the modelling that proved to be erroneous.

The over-optimistic modelling by the SIB design team, based on data from local GPs and the CCG, is not a disadvantage of the SIB model per se – this would likely have occurred regardless of the contracting mechanism, since assumptions would always have been made by the contract design team about likely referrals. That said, we have now seen multiple CBO-funded projects struggle to achieve targets[33] because the underlying business model had optimistic assumptions built into it, and we suggest business models take more heed of the advice in the Green Book with regards to controlling for optimism bias.[34]

Whilst optimism bias is common in non-SIB projects too, the challenge with the SIB is that its whole financial performance hinges on the accuracy of this up-front estimate and, if it proves to be wrong, the whole project struggles financially irrespective of how well the intervention is performing overall. This issue is less likely to occur in fee-for-service contracts, since the provider will be paid irrespective of referral volume unless and until volumes are so low as to suggest ending the contract.

5.2.2 Relationships between key parties

Our research has tended to show that SIBs work best when there is full alignment and shared understanding between commissioners, providers and investors and IFMs, and all three are working together to achieve common objectives and maximise social impact. This was not always the case in WtW; there was antagonism from some individuals within the commissioning organisations towards involvement of the IFM, and some disconnect between expectations of some providers (who appear to have been surprised to find themselves under pressure to increase referrals) and the IFM – with WtW management sometimes caught in the middle. One interviewee described the relationships between some stakeholders as *"tempestuous and not the easiest"*.

33 See for example the Mental Health Employment Partnership and HCT Independent Travel Training projects

34 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191507/Optimism_bias.pdf

"There have been stages where staff morale was rock bottom."

These strained relationships were a direct result of the WtW SIB mechanism: They were brought about primarily because of the outcomes-based payment arrangements within the SIB, and accentuated by a lack of trust and unhappiness with the governance arrangements between the parties in the SIB.

It is worth noting that these views were not universal – while some were critical of the perceived over-involvement of the investment fund manager, for example, others welcomed their involvement and expertise. Similarly and as already noted, some providers found the process of close performance management uncomfortable, while others embraced it and were keen to take on more work when contracts were renegotiated. Also, these tensions identified during the second IDR visit in 2018 were not apparent during the final visit in 2022, as the issues were no longer present, organisations had worked through the issues, and some people had moved on.

5.2.3 Misaligned incentives

Both service provider managers and practitioners felt that there was a misalignment between where the most effective work took place, and what was financially rewarded within the contract. For them, this meant that, rather than incentivising higher quality delivery, the outcomes payment element was actually a *"distraction"* from the core purpose of the work.

This was because for Outcome A (Wellbeing) the majority of the payments to providers was attached to Outcome 1A (which paid on completion of second wellbeing star and six months of patient engagement on service), with lower payments for Outcome 1B (which paid for engagement from six months onwards). However, the service manager and practitioners reported that in reality most service users required support longer than six months. This therefore created a tension between continuing to work with service users (so that better quality support and outcomes could be achieved) and bringing in new service users (for which there was a higher financial payment). The consequence was high caseloads, and service providers reported trying to make concerted efforts to make caseloads more manageable.

"I don't think it's an ideal contract structure for it, for the nature of the work that we do…There is that kind of tension I think between the payment by results and actually how it is on the ground, if you like, in terms of some of those particular service users." (Service provider)

5.2.4 Accurate outcome measurement

Achieving accurate outcome measures to which to attach payments has been a challenge throughout the project. Outcome measurement had to meet the dual aims of the programme: demonstrate improvements in managing long-term conditions, and produce cashable savings for the CCG. During the design stage many outcome metrics were tried, but were discounted for either being unmeasurable or not a direct or reliable proxy for the outcomes sought. Although all parties appeared on board with the measurement approach, stakeholders commented that the approach will not capture all the potential cost savings generated by the project.

These concerns broadly materialised during delivery. Some stakeholders had doubts over the links between improving management of LTCs and hospital admissions, and so whether Outcome B was really capturing the impact of WtW. Furthermore, the measurement approach to Outcome B faced multiple challenges, to the degree that there was only a small period of time during the project that it was likely accurately capturing differences

in hospital admissions: challenges were both internal (the data miscalculation) and external (the treatment group being compromised by the rollout of the national social prescribing programme; and the 'noise' generated by COVID-19 which likely shrouded any measurable impact of WtW).

Practitioners also had doubts over the use of the Wellbeing Star. Again these concerns were both in relation to the choice of metric, and in its execution. Practitioners interviewed were not convinced that the Wellbeing Stars were capturing the impact they were having on long-term conditions, since they felt that not all elements of the star really related to the long-term condition. Some also felt that the initial scores were not a true baseline from which to measure progress, since there was an element of self-reporting (though other stakeholders pointed out that the Star was completed by the client and the link worker in tandem, which provided a degree of quality assurance of the ratings)

A further observation is that the outcome metrics ultimately chosen, and their underlying payment mechanism, were inherently complicated and not easy to understand. One commissioner stakeholder referred to WtW as a *"monster"* in terms of the complexity of payments. Both Outcome A and B were imperfect proxies for the actual outcomes sought, and the payment tariff for outcome B in particular involved a complex calculation of the difference in costs between two groups, the averaging of the difference across registered service users and its conversion to a tariff on a sliding scale, differential payments for different outcome payers and an adjustment for inflation for the CCG payment only. This means that a simple statement of outcomes achieved and payments made means little without significant context, which contrasts with other SIBs we have evaluated where the outcome metric is easy to understand, even though it may be challenging to calculate accurately. Examples of metrics which "do what it says on the tin" from SIBs we have reviewed in depth include the Positive Families Partnership (a child avoids entry to care for one week), HCT travel training (a child with special needs is able to travel independently), and the Zero HIV SIB (a person living with HIV is identified and enabled to enter treatment).

Against that, it is worth stressing that (as outlined in Section 5.1.1.2) the data from the outcome measurements were valued by stakeholders, and provided enough information to justify both the existence and expansion of the service. Furthermore, an added strength of WtW was that it combined both a 'hard' metric (reduced secondary care service usage) with a 'soft' metric (improved wellbeing), thereby balancing out the limitations of both approaches. Other impact bonds that have focused on one type of metric over the other have often concluded that dual approach applied in WtW would have been better; for example the Fair Chance Fund Evaluation concludes that adding a soft wellbeing measure to the 'harder' outcomes of employment would have helped capture the broader outcomes of the service, whilst our Reconnections in-depth review concludes that it would have been beneficial to include a 'hard' outcome measure to balance out the limitations of just using a soft outcome measure (loneliness).

Overall therefore, the measurement approach had its limitations, but these were recognised and accepted by stakeholders. It is also arguable that no perfect metric existed, and any attempt to make the metrics simpler (for example replacing Outcome B with a simpler measure of hospital admissions avoided) would, we suspect, have been opposed by stakeholders who wanted the metric to reflect both usage and costs as closely as possible.

In addition, local commissioners have extended the WtW service without the outcomes payment mechanism (see section 6). This is in part because the move to an integrated Care System (ICS) renders payment by outcome redundant, but also that local commissioners have recognised that detailed measurement of hospital service usage is no longer needed, and thus WtW has effectively proved its theory of change – that improvements in wellbeing will in due course reduce demand on acute services.

5.3 Value for money of the SIB mechanism

This section provides an overall assessment of whether the project offered value for money, based on the views and experiences of stakeholders and, so far as possible, our own independent evaluation.

As we intend to do for all final in-depth reviews of projects under this evaluation, we have assessed value for money against the 'four E's' framework for assessing value for money recommended by the National Audit Office, namely Economy, Efficiency, Effectiveness and Equity.

5.3.1 Economy

Short definition: Spending the right amount to achieve the required inputs

Economy, and keeping costs to a minimum, is generally of less importance than the other VFM dimensions in SIBs and Social Outcomes Contracts (SOCs). This is because keeping it can work against the overriding objective of maximising outcomes achieved – especially when those outcomes are intended to create savings or otherwise justify the spending on the intervention.

It is however still important that costs are as low as they can be while being consistent with this overriding objective.

Table 2 summarises the costs of WtW. Compared to other social impact bonds for which cost data is available, some of the cost items are high:

- The project received multiple sets of grants to develop the concept. It had a development grant of £150,000 from the CBO programme, the maximum allowable, a similar sum from the Department of Health SEIF and further grants from ACEVO. Even allowing for this being one of the first SIBs to be developed (and the first in the health sector) the amount spent directly on development is considerably more than most CBO projects.
- For impact bonds for which we have data, the investor return in WtW is the highest as a percentage of the project budget (11%). In West London Zone the investor returns were 2% of the project budget; in the Quality Education India Impact Bond[35], the returns were 6%.

35 See https://www.britishasiantrust.org/our-work/education/quality-education-india-development-impact-bond/

Table 2: **Ways to Wellness costs**

Type	Description	Amount	% of Total
Core costs	Delivery by providers	£3,940,646	61%
	Management by WtW	£1,436,425	22%
SIB costs	Investment return	£680,000	11%
	SIB management	£168,250	3%
Other	Evaluation (funded by CBO – other grants excluded)	£200,000	3%
Total Costs		£6,425,321	100%
Total Income		£8,109,765	
Retained Surplus		1,684,444	

Source: Cost information submitted by WtW to The National Lottery Community Fund.

To consider whether these areas of cost meet the 'Economy' principle, one needs to consider whether they are as low as they could feasibly be, whilst still enabling the project to operate, i.e. whether the right amount was spent to achieve the required inputs. Overall, our analytical view is that most of these costs appear justified:

- The providers were competitively procured, and stakeholders confirm that price was included in the assessment criteria.
- WtW engaged with 14 investors
- This was the first impact bond ever launched in the health sector in the world, and so it is broadly reasonable that a large amount of development funding was required – though note to the best of our knowledge WtW received more development funding than other SIBs being developed at the same time. It is also reasonable that investors might require the level of returns seen here to justify the risk (and it is noteworthy that Bridges was, according to WtW stakeholders, the only investment manager willing and able to raise the total investment needed[36]).

The aspect that is harder to justify is the level of surplus of £1,684,444 – making up almost a quarter of the budget (24%). This is payments made to the project that were not spent on delivery. This suggests the same outcomes could have been achieved with commissioners paying substantially less as had been planned originally at £700K (though the surplus was used to support the further development of WtW, which helped with its sustainability – see Section 6).

In conclusion, less money could have been spent to achieve the required inputs.

36 This need not have prevented WtW choosing other investors, but they would have had to find an FCA-qualified intermediary to set up an investment vehicle and raise investment from multiple sources – thus making the set-up of the SIB both more complicated and more expensive.

5.3.2 Efficiency

Short definition: Ensuring sufficiency and optimisation of agreed resources to deliver expected activities and outputs as well as possible

Efficiency, like economy, is in broad terms less important than the effectiveness dimension in assessing SIBs and SOCs. However one critical aspect which falls under the efficiency dimension is whether the project was able to deliver the right number of referrals, since these are a critical output which in turn drives outcomes.

The Ways to Wellness project supported less than half of the intended number of service users (see Section 4.6.1), and yet spent the intended budget (receiving £8.1M in outcome payments against a plan of £8.0M). WtW was therefore not as efficient as it was originally intended, as it did not deliver the expected outputs for the agreed resources.

5.3.3 Effectiveness

Short definition: Achievement of desired effect of the project as measured by achievement of outcomes and other objectives.

Since effectiveness is a measure of outcome it is almost by definition the key dimension for an outcomes-based contract.

As outlined elsewhere in this report in detail, WtW had mixed results against its intended outcomes, and yet received its intended level of outcome payments. It achieved 73% of planned outcomes for Outcome A1, 94% for Outcome A2, and 103% for Outcome B, using 102% of the planned budget to achieve this (£8.1M against £8.0M). It was therefore reasonably effective in achieving outcomes but at higher cost per outcome than originally planned.

However, WtW did broadly achieve against its two core aims: to improve the management of long-term conditions, and reduce costs for the CCG. WtW also left a positive legacy and contributed to the evidence base in relation to social prescribing (see Section 6). Stakeholders from the CCG were also very pleased with the overall achievements from WtW.

Therefore, whilst WtW did not achieve its intended level of outcomes, it can be regarded as effective overall.

5.3.4 Equity

Short definition: Extent to which other VFM objectives are achieved equitably for service users and other key stakeholders.

At the service user level WtW can be deemed equitable. Service user needs were considered in the design and delivery of the project (the project had a service user group who provided feedback on delivery). There was no evidence of cherry picking – the project targeted the most deprived areas of Newcastle. Overall the SIB mechanism was designed to discourage cherry-picking: the focus on referrals meant there was no scope or incentive to not accept people onto the project.

The payment structure of Outcome A (Wellbeing) did create some tensions around quantity over quality, and whether to provide people with the length of support they required, or to remove them from the project to free up space to take on more referrals.

Overall, though, it would appear this tension was well managed: Many of the service users we interviewed had been supported by the project for multiple years.

Whether the project was equitable at a broader stakeholder level is harder to say. Two VCSEs had to withdraw from the contract because they felt they could not deliver the terms and take on the financial risk. Some members of staff were put under huge amounts of pressure and struggled a lot with the project. However, these activities *did* lead to more outcomes being achieved. Some stakeholders felt the same outcomes could have been achieved but through creating a more trust-based and collaborative atmosphere, but it is impossible to know this. Ultimately whether it is worth achieving more outcomes at the expense of two providers withdrawing and creating a difficult atmosphere for some staff is a value judgement that is for the reader to decide.

5.3.5 Overall cost effectiveness

Short definition: The optimal use of resources to achieve the intended outcomes.

Overall, based on our informed judgement (and drawing on the judgement of the stakeholders involved), we conclude that WtW was cost effective. It achieved against its core aims (even if it did not achieve all of its intended outcomes). Some of the cost elements were high, but overall these can be justified as it was a very innovative project. The project also led to wider spillover effects, including understanding of the use of impact bonds in health in both the outcomes-based commissioning community and in the health sector, leading to replication (see Section 6), and supporting the sustainment of social prescribing in Newcastle.

Stakeholders involved in the project also believe it was value for money.

However, there is some evidence to suggest it was not necessarily the *optimal* use of resources, and the same intended outcomes could have been achieved with fewer resources.

6.0 Legacy and sustainability

WtW was a high-profile project – both as a social impact bond (being the first health SIB in the world) and as a social prescribing intervention (being one of the first social prescribing programmes to operate at a population-wide scale). The project was also very proactive in sharing learning. As such, it received a lot of attention, including a Royal Visit. WtW has had a positive legacy, as judged both by its local sustainment (under a different funding structure), and its wider influence on other social prescription projects.

Royal visit to WtW in 2021.

6.1 Legacy of the WtW social prescribing intervention

In June 2021 WtW and the CCG agreed to expand the service, widening the client age group and geographical reach, securing funding for an initial 12 months.

This additional funding was paid in block, effectively converting the WtW contract from a social impact bond to a fee for service contract. Stakeholders explained that this was primarily because, following the formation of the ICS and Integrated Care Board (ICB) in Newcastle and Gateshead in July 2022, it was no longer appropriate to base the contract on transactional payments for results (since a key aim of ICS is to remove internal cross-charging for services within the NHS), It was also unnecessary to continue payment for outcomes because WtW had now proved its effectiveness. The ICB thus took the view that, provided there was fidelity to the proven link worker approach, it was confident WtW would continue to deliver good results without direct measurement of and payment for outcomes. We note that a similar approach has been taken elsewhere – for example the Zero HIV SIB in South London deployed outcomes contracts to prove the effectiveness of 'opt-out' Testing for HIV, and testing was subsequently continued and sustained by the ICS on a block basis, as part of a wider campaign of which the SIB was a part.

6.2 Legacy of WtW on wider social prescribing landscape

According to WtW's Six Years report, WtW encouraged the wider roll-out of social prescribing across the NHS. The report observes that:

"Though social prescribing was an established intervention approach (often by other names) when Ways to Wellness launched, it was not well known or widespread; it typically occurred as small-scale, VCSE-delivered services with short-term funding. In Ways to Wellness' early years, the uptake of social prescribing increased across the country, with Ways to Wellness as one of the key players in building awareness and evidence of the value of the intervention approach. By early 2019, NHS England announced that the newly-formed Primary Care Networks (PCNs) would receive core funding to employ social prescribing link workers. This substantially increased the pace of uptake of social prescribing across the country."

There are however significant differences between the WtW approach and that adopted by the NHS. The WtW model is an intensive, long-term intervention model where the Link Worker provides a lot of direct support; the NHS England model provides shorter-term, less intense support where the main focus is on signposting people into community-based services rather than providing direct support, and helping users deal with immediate crises rather than building long-term resilience.

Thus, whilst WtW Ltd stakeholders felt that the WtW project had provided a proof of concept for social prescribing, they were disappointed that the national social prescribing service did not follow the WtW delivery model in terms of focusing on coaching and building independence over hands-on support. Therefore, whilst they felt WtW had contributed to the wider evidence base and understanding of social prescribing, this had not fully translated into what was being delivered more widely.

6.3 Legacy and sustainment through other SIBs and SOCs

A number of other SIBs and SOCc have built on learning from WtW. As WtW was the first SIB launched in the health sector, multiple SIB projects (including Reconnections) drew on the learning from WtW. Most substantially, three projects either part-funded by CBO or a subsequent SIB/SOC outcomes fund, the Life Chances Fund[37] all deployed a similar link worker-based delivery model, and were backed by investors managed by BFM:

- The first social prescription SIB after WtW was the **Thrive.NEL**[38] project, commissioned by North East Lincolnshire CCG and originally available to anyone living in NE Lincs, aged between 18 and 65, and diagnosed with one or more of five LTCs: Asthma, Atrial Fibrillation, COPD, Type 2 Diabetes and Hyper-tension. The project was later extended to a wider range of LTCs including Type 1 Diabetes, Osteoporosis, Osteoarthritis, Fibromyalgia and Epilepsy. It was developed with support from some of the same advisory team that worked with WtW.
- The second CBO social prescription project was **Healthier Devon**[39], commissioned by Devon County Council, which focused more narrowly on adults at risk of developing Type 2 Diabetes.
- BFM has subsequently taken learning from all the CBO projects and is now managing investor involvement in a further project, also known as **Spring** Northamptonshire[40]. This aims to deploy a similar link worker-based, social prescription approach to the management of LTCs across Northamptonshire, and is co-funded by the Life Chances Fund.

6.4 Legacy of WtW as an organisation

The surplus generated by the project has enabled WtW Ltd to continue, and to broaden its role and remit.

In February 2022 WtW announced that they were merging with Blue Stone Collaborative to create *"a new innovation hub for the North East and North Cumbria."*[41] This reflects a slight change of direction for WtW Ltd. under the leadership of a new CEO (appointed in May 2021). WtW Ltd. saw its role in the WtW programme as an incubator for innovation – seeding an idea, bringing in capital to de-risk the initiative and encouraging commissioners to engage. The strategy now is to continue this role as an innovation hub / incubator and a place to experiment with new ideas.

According to its press release[42], the new venture will:

- Sponsor and develop innovative programmes and prototypes
- Support place-based working, building on existing local assets
- Use data and clear reporting and accountability processes to demonstrate impact and outcomes.

In June 2021 development work began on two innovative projects; one on how social prescribing can support children with neurodisability and their families, through a partnership with the Great North Children's Hospital. By December 2021, WtW began recruiting for this work to commence in 2022.

37 The Life Chances Fund (LCF) is an £80m fund, committed by central government to help people in society who face the most significant barriers to leading happy and productive lives. It provides top up contributions to outcomes-based contracts involving social investment, referred to as Social impact Bonds (SIBs). These contracts must be locally commissioned and aim to tackle complex social problems. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876934/LCF_FAQs_FINAL_DRAFT.pdf

38 See https://www.northeastlincolnshireccg.nhs.uk/support/socialprescribing/

39 See https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0116/

40 See https://www.springnorthamptonshire.org/ and https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0228/

41 https://waystowellness.org.uk/news/2022/02/ways-to-wellness-and-bluestone-collaborative-announce-merger/

42 Ibid

The second will pilot a specialist social prescribing service for patients with chronic pain/fatigue.

WtW also believes that the Link Worker role need not just be confined to social prescribing but could work in other health fields, and they want to experiment further with that. Though it is worth noting that concepts similar to the 'link worker' are already established in other health fields, such as Dementia Navigators across the Health and Social Care Trusts in Northern Ireland.

6.5 Legacy of attitude and take-up of SIBs / SOCs

While stakeholders involved in WtW have not pursued further SIBs or outcomes contracts to date, they were positive about the model when used appropriately. In their view the SIB model served a very particular purpose in WtW, namely to de-risk a project that commissioners would otherwise have been reluctant to fund. Stakeholders at WtW Ltd thus view SIBs or SOCs as potentially filling a similar function in their extended role as incubator and in funding innovation as outlined above. WtW stakeholders are also supportive of contracting for outcomes, and believe that the NHS should do it more often. They are however less certain that the best model involves using external social investment to pre-fund services, and might prefer to use their own capital to de-risk future initiatives, possibly within a blended block/outcomes payment model.

Overall, therefore, WtW has had a positive legacy. This was in-part aided by the surplus generated through the WtW SIB, and this has been factored into our VfM assessment (see Section 5.3.5).

7.0 Conclusions

7.1 Overall conclusions and evaluative insight

Overall we judge WtW to have been a success and to have been a well-designed SIB. While it fell short of its targets for referrals, it achieved its primary objective of delivering social prescription at scale, which meant that many thousands of people benefited from better management of their long-term conditions, with consequential improvements in their health and well-being. It also had a clear rationale for adopting a SIB mechanism – the 'SIB effect' – specifically the Payment by Results element – enabled delivery to take place at scale with acceptable risk to naturally cautious and financially challenged health commissioners.

It was also well designed from a theoretical stand point, especially in terms of its payment mechanism. It was highly innovative in choosing to measure both a hard outcome (reduced cost of secondary care) and a soft, user-centred outcome (improvement in personal wellbeing) (albeit with some challenges to using both). It was one of very few UK SIBs to measure its hard outcome against a clearly defined and robust comparator (and the only SIB to do so among those we have reviewed in depth for the CBO evaluation). It was thus able to prove that it would 'wash its face' in terms of avoided costs to the CCG. It was also the first to measure wellbeing through a defined soft measure – a model that has since been adopted by many other projects.

By combining these two outcomes it was able to prove its effectiveness to commissioners and give them confidence that it could continue to commission the intervention without the cost and complexity of an outcomes-based payment structure, since the project had effectively proved its theory of change – as in, it had demonstrated that using the WtW model can improve people's management of their long-term conditions, boost wellbeing and reduce both primary and secondary care time and costs. The outcomes measured by the project – plus the additional academic studies – provided a solid evidence base for the service, which contributed to the national debate on the use of the link worker-based model of social prescribing (though this did not have the full national consequences that stakeholders were hoping for, as the national roll-out of social prescribing did not adopt the WtW model).

The project did however have weaknesses, though it is not surprising that it encountered challenges given that it was one of the first SIBs to be commissioned locally in the UK, and the very first in the inherently complex and challenging health sector.

First, while the outcome structure was, at high level, well designed (and if the SIB were to be run again we still think it would be wise to use these two outcome measures as there are no better alternatives), there were some challenges. The measurement process for the soft Outcome A was not perfect, and the process for payment of Outcome B was arguably more complex than it needed to be – with one senior commissioner stakeholder commenting that, *"We created a monster in terms of complexity of payment"*.

Secondly, the overall governance structure of the project, with delivery being managed through WtW Ltd. as SPV, created challenges for some stakeholders. According to WtW's Six Years report, this structure created challenges because WtW Ltd was too remote from front-line delivery. These challenges led to difficult relationships and a breakdown in trust part-way through the project (which were resolved by the end of the project). The report noted that:

"Although an SPV does not necessarily require outsourcing of the core service delivery work, in the case of Ways to Wellness the service delivery was subcontracted in order to draw from and build upon existing local VCSE expertise in social prescribing as well as to enable swift early mobilisation. This outsourcing revealed some disadvantages. In sub-contracting the service delivery, Ways to Wellness involvement in delivery has been one degree removed from the 'front line'. This distance reduces the SPV's influence and deep understanding of the service delivery work."

As one senior stakeholder noted:

"The SPV isn't a great way to go, I wouldn't do it again….We've outsourced our core competency and don't feel like we're involved and able to take part, and making sure there's cross learning."

Against that, another senior WtW stakeholder thought that the WtW SPV played an essential role in managing providers as sub-contractors and ensuring service integration. The WtW website similarly notes that:

"The SPV also ensures that a dedicated team remains focused on supporting the service and outcome achievements, provides a 'middle ground' position to lead the collaboration (and potential negotiations) amongst the key stakeholders and keeps a central repository for evidence base and knowledge building."

A similar view emerges from other reviews undertaken as part of this evaluation. For example, BFM stakeholders in the HCT travel training SIB noted that HCT were able to manage delivery directly, without BFM acting as intermediary, because HCT was the only provider and there was no need for service integration. It is difficult to see how WtW could have been constituted without an intermediary – referred to by its own stakeholders as a 'social prime contractor' – when it originally had four providers, operating a similar link worker model but delivering different specialist interventions at the same time. Without an intermediary, the CCG would have had to make substantial payments directly to four small providers (which would have increased complexity and costs and might not have been possible under procurement rules) and a different type of intermediary – to raise and manage investment and other financial flows - would likely have been required in any case.

So a more nuanced conclusion might be that WtW Ltd as intermediary needed to be there but might have been constituted differently, with risk being shared by providers and investors, rather than investors, via BFM, holding all the risk. As the same senior stakeholder as above observed:

"I do wonder about the social investor holding all the risk. If they hold all the risk they will inevitably drive the financial return and the pace regardless of any local context. They will also expect a greater return for higher risk. Sharing risk with the provider carrying at least some of the risk will tend to act as an incentive for more effective partnership working."

A third downside of the project is that it was relatively expensive to develop and to deliver, compared both to other SIBs that we have evaluated and to conventionally funded projects. As we note in our value for money assessment these high costs are largely justified, in our view, by the scale of the project and by it being one of the first locally commissioned SIBs to be developed. This inevitably meant that it could not learn as much as other projects from earlier experience. It would have been harder to justify the costs of WtW if it were being developed today. If developed today, we would also expect it to be able to make better forecasts of referrals and user engagement, and avoid the optimism bias to which we believe this project was prone.

7.2 Achievement of CBO programme aim and objectives

The CBO programme's overriding aim was to grow 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. Against this aim, WTW can be seen as largely successful It has also provided learning for a number of other social prescribing SIBs, including three funded by the CBO and LCF.

Against the four specific objectives of the CBO we assess WtW as follows:

- *Improve the skills and confidence of commissioners with regards to the development of SIBs.*

  Partly achieved. Unlike in many other SIBs we have reviewed, the principal stakeholders from the commissioner remain broadly involved, and thus their skills with regards to managing SIBs have increased. However, there is no evidence that these skills have been transferred beyond the principal stakeholders to other parts of the commissioning organisation, and these skills have not been applied, as the CCG has not commissioned further SIBs.

- *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.*

  Achieved. The term 'early intervention' in this project can be debated, as arguably it is supporting people who have already been diagnosed with long-term conditions. But it is targeted at preventing these conditions from having more serious consequences, and the SIB mechanism itself enabled the commissioner to fund a more targeted and preventative service.

- *More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people*

  Partly achieved. It is almost certain that the service providers could not have participated in an outcomes-based project without the social investment, and even the two providers who chose to withdraw from the project were initially enabled to deliver a service for two years that they would not have been able to deliver otherwise. The changes to the payment arrangements did however mean that providers had more financial risk in the later stages of the project (see Section 4.1).

- *Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs*

  Achieved. Some of the stakeholders involved in the SIB (notably the WtW team and BFM) were proactive in sharing learning with other stakeholders outside of the SIB. WtW has already funded and published its own evaluations as noted above, and both data and wider learning has been shared openly on its website. In addition it has provided learning that BFM has taken into other projects, and offered useful evidence for link worker based social prescription for the NHS both locally and nationally

7.3 Lessons for other projects

We would draw the following key lessons for other projects from our in-depth review of WtW. These have changed since our second review, when we were reflecting on the operational lessons of apparent underperformance of the project which are no longer applicable.

- Rigorous impact measurement has significant challenges. The WtW SIB is one of very few in the UK to adopt a rigorous approach to measurement of its impact, using a quasi-experimental approach to measure performance relative to a comparison group. There has been much debate about the value of such measurement – and the true impact of SIBs where it is not in place – and it is regarded as the 'gold standard' for SIBs[43]. It is therefore important to note that its adoption by WtW had major challenges – firstly because errors in calculating performance relative to the counterfactual gave misleading results; secondly because the counterfactual was confounded by the roll-out of a different type of social prescribing by the NHS; and thirdly because the overwhelming effect of the COVID-19 pandemic (and associated restrictions) meant that in the latter stages stakeholders in the project no longer had confidence that it was accurately capturing the impact of the project. This is not to say that attempting rigorous outcome verification techniques should not be attempted, but rather that they too are riddled with challenges and will not solve all problems. .

- Managing cross-sector partnerships can be challenging and time consuming. An often cited key benefit of SIBs is the extent to which they promote and enable cross-party collaboration, It is therefore interesting to note that WtW identified the management of multiple parties as one of their biggest challenges, and one requiring much time and effort to make it work. In their first annual report to the CBO team WtW stakeholders observed that *"The main strength of the programme is also in some ways its biggest challenge"* and in their Six Years report WtW further observed that:

  "It is critical to the success of this kind of work that partners are aware that challenges are likely to arise and are prepared to devote time and patience to working collaboratively to reach decisions or resolve issues. This can be supported by putting in place processes and guidance that can be used to resolve disputes or manage conflicts of interest and/or loyalty, should they arise. Scenario planning for a wide range of possible outcomes might help prepare all parties for difficult conversations."

- Consider carefully the financial risk share between investors and service providers. This was a lesson from our second review, where we observed that financial risk was more and more being shared between providers and investors, and that this had implications for providers if they were not aware of, or not comfortable with, the risk they were expected to bear. This remains a key lesson, but on further reflection stakeholders in WtW now think that providers might have taken more risk, not less. The reasoning is that if investors and their representatives hold most or all of the risk they may drive and control the project more than other stakeholders would wish, and in a direction with which other stakeholders are not entirely comfortable.

43 See for example https://golab.bsg.ox.ac.uk/toolkit/technical-guidance/evaluating-outcomes-based-contracts/

Annex 1: **SIB dimensions used for comparative analysis**

Dimension	1: Nature of payment for outcomes	2. Strength of payment for outcomes	3. Nature of capital used to fund services	4. Role of VCSE in service delivery	5. Management approach	6. Invest-to-save
Question examining degree to which each family aligns with SIB dimensions (1 = a little, 3 = a lot)	To what extent is the family based on payment for outcomes?	To what extent does the outcome measurement approach ensure outcomes can be attributable to the intervention?	To what extent is a social investor shielding the service provider from financial risk?	Is delivery being provided by a VCSE?	How is performance managed?	To what degree is the family built on an invest-to-save logic?
Scale	**3** - 100% PbR and 100% of the PbR is tied to outcomes **2** - 100% PbR, with a mix of outcome payments and engagement/ output payments **1** - Partial PbR: Split between fee-for-service payments and PbR	**3** - Quasi-experimental **2** - Historical comparison **1** - Pre-post analysis	**3** – Investor taking on 100% of financial risk; service provider fully shielded and receives fee-for-service payments **2** – Investor and service provider sharing risk; service provider paid based on number of engagements **1** – Investor and service provider sharing risk; service provider paid (at least in part) on outcomes and/or has to repay some money if outcomes not achieved	**3** - VCSE service provider **2** - Public sector service provider **1** - Private sector service provider	**3** - Intermediated performance management: An organisation external to the ones providing direct delivery of the intervention is monitoring and managing the performance of service providers **2** - Hybrid: A 'social prime' organisation is responsible for managing the performance of their own service provision, and the performance of other service providers **1** - Direct performance management: The organisation delivering the service is also responsible for managing their own performance, and there is no external intermedia	**3** – SIB designed on invest-to-save logic, with savings generated used to pay for outcome payments **2** – SIB designed on a partial invest-to-save logic; SIB anticipated to generate savings to commissioner but these are either not cashable and/or will not cover the full outcome payments **1** - SIB not designed on invest-to-save logic; savings either do not fall to outcome payer and/or savings not a key underpinning logic for pursuing a SIB

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