Second In-Depth Review
Produced as part of the independent Commissioning Better Outcomes Evaluation

Ways to Wellness Social Impact Bond

Commissioning Better Outcomes Evaluation

COMMUNITY FUND

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Contents

Executive Summary

The Commissioning Better Outcomes (CBO) Programme 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 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, with Ways to Wellness (WtW) featuring as one of the reviews. This report is the second in-depth review on WtW. The focus is on stakeholder experiences and learning from the SIB delivery post-launch. This builds on the learning described in the first in-depth review report.[1]

This second report is based on a review of documents provided by stakeholders, and consultations between May and June 2018 with nine stakeholders and two focus groups (one with practitioners, one with beneficiaries) involved in the SIB. Stakeholders were consulted across all relevant organisations (commissioners, WtW, service providers, investment fund manager and beneficiaries).

SIBs are a form of outcomes-based commissioning[2] (OBC). 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 social investors. The Government Outcomes Lab (GO Lab) defines impact bonds, including SIBs, as follows:

> "Impact bonds are outcome-based contracts that incorporate the use of private funding from investors to cover the upfront capital required for a provider to set up and deliver a service. The service is set out to achieve measurable outcomes established by the commissioning authority (or outcome payer) and the investor is repaid only if these outcomes are achieved. Impact bonds encompass both social impact bonds and development impact bonds."[3]

SIBs differ greatly in their structure and there is variation in the extent to which their components are included in the contract. This difference underlies the stakeholder dynamics and the extent to which performance is monitored in the SIB. For the purpose of 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, capital from social investors, the social intent and approach to performance management.

1 See: https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_ways_to_wellness_report_190320_122441.pdf?mtime=20190320122441&focal=none

2 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.

3 https://golab.bsg.ox.ac.uk/knowledge-bank/glossary/#chapter_2_glossary-h-m__7d64b78b-831b-4a5a-9fa1-f6d7897cf180_impact-bond

How the SIB works

In **Figure 1** and the text below we provide a summary of the WtW SIB and how it works. Please note that there are now fewer service providers than shown in Figure 1, as explained further below. Please also see Figure 3 in the main body of the report which shows contractual relationships in more detail.

The intervention: The WtW SIB funds social prescribing for patients in Newcastle West with Long Term Conditions (LTCs) to enable them to improve their self-care and management of their conditions. The project aims to improve outcomes for 8,500 patients in the first six years of operation. The intervention takes the form of support from Link Workers, employed by specialist service providers, who work with patients with LTCs (referred to them by local GPs and others) to help them improve their lives through understanding their issues, motivating them to take up healthy activities, access services and tackle the aspects of their lives that are having a negative effect on their ability to manage their LTC.

The driving factors for using a SIB: The main reason for using a SIB was to support social prescribing at scale with a larger cohort and higher referrals than delivered previously in other projects, including a local pilot from which this project took learning. The effectiveness of social prescription in achieving outcomes and reducing costs at scale was largely unproven; and with that the CCG was not prepared to take the risk of funding the service without payment being linked to outcomes, which generated savings in secondary health costs that enabled them to cover the outcome payments.

The contracting model: The primary contract that underpins the SIB is between Newcastle Gateshead CCG[4] (the CCG) as commissioner and WtW as prime contractor. WtW (technically WtW Ltd) is a social prime contractor established specially to deliver this contract, and acting as the wholly-owned trading arm of Ways to Wellness Foundation Trust (WtW Foundation) which was set up subsequently to help sustain the legacy of the project in the longer term. The original contract had four specialist sub-contractors, procured by WtW, managing Link Workers and supporting referrals.

Social investment arrangements: Social investment for this project (from The Office for Civil Society, Esmee Fairbairn Foundation, Big Society Capital, Pilotlight, the European Investment Fund and other organisations) was sourced via Bridges Fund Management (BFM). BFM is the Investment Fund Manager (IFM) responsible for managing the investment. These social investors have provided an investment commitment of up to £1.65m[5], repaid from the outcome payments made by the CCG (see below) to set up the project. This capital is thus at risk and dependent on the success of the project in hitting outcome targets. The extent to which the investors' capital will be repaid is dependent entirely on the performance of the project, and is therefore difficult to forecast. Financial modelling by BFM as the IFM suggests that the likely repayment scenarios after eight years range from:

- A repayment of zero, resulting in total capital loss (called '0x Money Multiple' or MM[6]). This was forecast to occur if the project only breaks even for Newcastle Gateshead CCG, (i.e. the savings in secondary care costs generated over 10 years to the CCG are equal to or less than the cost of the project to the CCG). Note – in this scenario, also termed the low case[7] the estimated wider savings to other government departments would still be approximately £3m
- A repayment of approximately 1.4 times the amount of capital invested ('1.4x MM'[8]). This was forecast to occur if the project achieves enough success to save approximately £4m net for the CCG (i.e. the savings generated over 10 years in secondary care costs to the CCG are £4m greater than the cost of the project to the CCG). In this scenario, the estimated wider savings to other government departments would be approximately £14m

The success rates were set such that even in the low case, where investors lose 100% of their capital, the performance would still be better than other comparable social prescribing services. As such, in order to achieve repayment of their capital for investors (before any positive return) the project needed to find ways to deliver social prescribing at scale with a larger cohort, higher referrals and a more effective service than delivered previously in other projects, including a local pilot from which this project took learning.

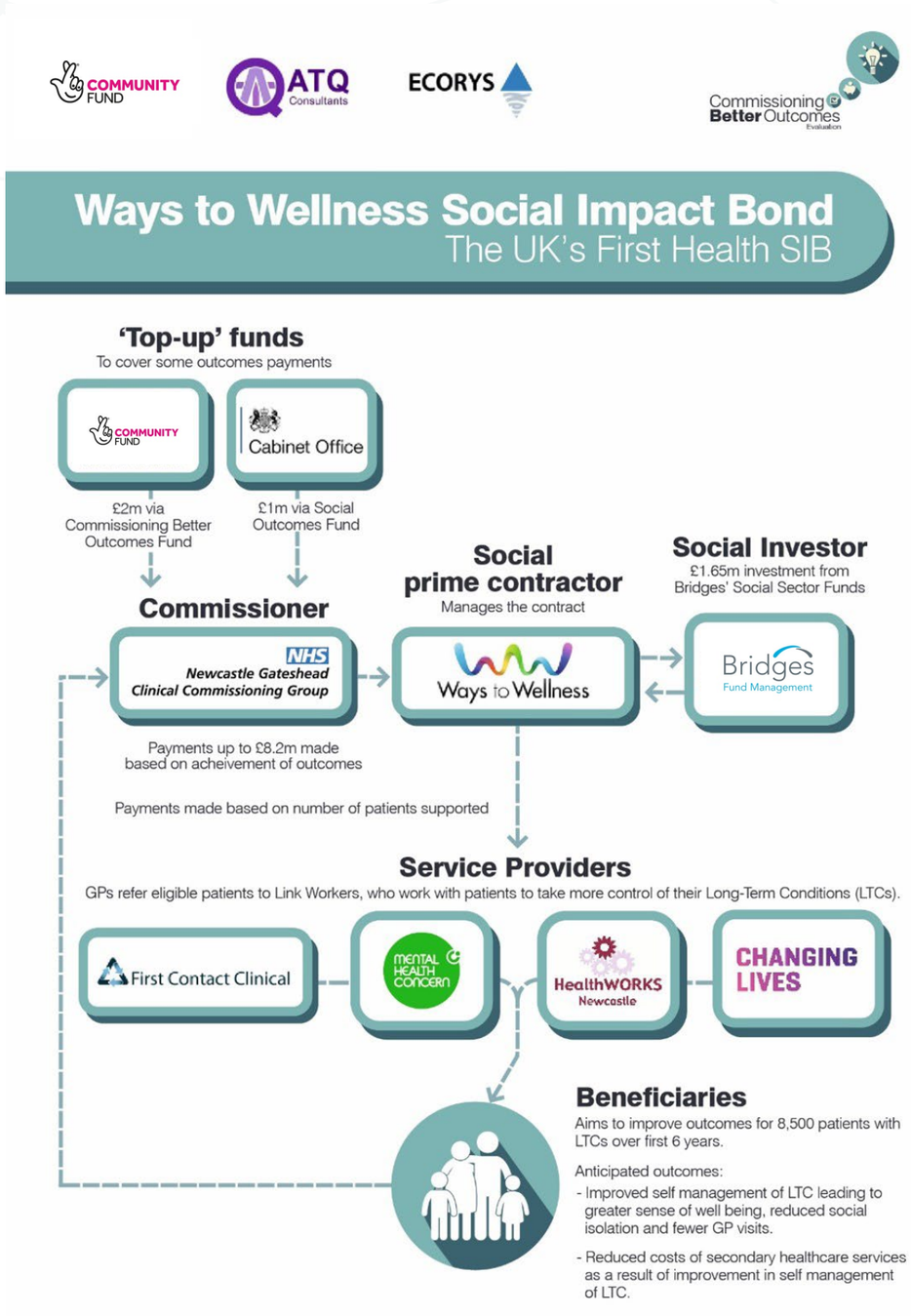
Outcomes payments: The total projected outcomes payments to be made to WtW in its first six years of operation are £8.2m, of which £5.2m (64%) will be paid by the CCG, £2m (24%) by CBO and £1m (12%) by HM Government's Social Outcomes Fund.

There are two primary outcomes to which payment is linked, reflecting the social and financial objectives of the CCG as commissioner of the project: Outcome A: Improved self-management of LTC leading to a greater sense of well-being and reduced social isolation. This is measured using Triangle Consulting's Long Term Condition Wellbeing Star; and Outcome B: Reduced cost of secondary healthcare services (A&E attendance, Outpatient appointments, and scheduled and unscheduled hospital admissions). This is measured by direct comparison of data on usage and costs with data from a comparison group with similar characteristics in Newcastle North and East.

4 The original contract was with Newcastle West CCG, which merged with Gateshead CCG and Newcastle North and East CCG to form Newcastle Gateshead CCG in April 2015.
5 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. £1.1m
6 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.

7 In financial modelling the low case (or worst case) refers to a reasonable assumption of the worst possible outcome – in this case a level of performance that means that that investors lose all their capital invested. There may also be a high case (shown here as the scenario which provides a significant return of 1.4xMM to the investors) and a 'base case' (sometimes termed the median case) between the two extremes
8 It should be noted that this estimate of MM is different to the one stated in the first review of WtW, which showed an MM at base case of 1.38. We understand that this early estimate of returns was incorrect, and returns at base case will be much lower and around break-even - i.e. an MM of 1.0

Figure 1: The SIB model (simplified – see Figure 3 in Section 4 for more detail)



What has happened in practice?

The intervention:

- Stakeholders were universally positive about the intervention and its effectiveness. The most important aspect stressed both by the beneficiaries and practitioners seems to have been the time that the intervention allows Link Workers to spend with users.

- There have to date been two research projects that have explored the effectiveness of the intervention; both have reported positive results. A qualitative study of 30 beneficiaries undertaken by Newcastle University's Institute of Health and Society[9] found that WtW increased patients' feelings of control and self-confidence, reduced their social isolation and had a positive impact on their health-related behaviours, including weight loss, healthier eating and increased physical activity. The Institute of Health and Society in collaboration with Ways to Wellness also conducted a pilot quantitative research project.[10] This found that participants reported improvements across all measures, particularly with self-care, pain and discomfort.

Contract performance:

- In the SIB's first 2.9 years of service (April 2015 to February 2018), just under 4,200 patients had been referred to the service, of whom almost 3,200 patients had engaged. This is out of the base population of 140,000 of whom approximately 10% met the defined referral criteria. Stakeholders observed that this made WtW the largest social prescribing service at the time with a conversion rate that was significantly higher than comparable projects. Patient referral and initial engagement rates were however somewhat lower than originally forecast in the original business case for the SIB; the number of patient referrals and 'starts' on the service was, at this point, approximately 32% lower than originally projected.

- Performance against Outcome A (Wellbeing Improvement) has been good and generally on or ahead of forecast.

- Up to the point at which this review was conducted (mid 2018) the payment received for Outcome B (difference in secondary care usage and costs between treatment and comparison cohort) was more variable. The usage fluctuation was broadly aligned to what was observed in historic data.

- It is important to note that, since this research took place, errors were found in the way Outcome B was being calculated; these meant that the SIB was actually over-performing (rather than under-performing as it appeared at the time), and many of the performance difficulties described in this in-depth review are no longer apparent. Appendix A describes the nature of the error and the impact that its correction had on WtW's performance, which has been very positive. We will provide more detail on the changes in Outcome B performance in the final in-depth review.

- However, this in-depth review is still of relevance, as it captures some of the dilemmas and difficulties stakeholders face when a SIB (or any contract) appears to be performing differently from what was originally planned, even though it was still delivering significant levels of outcomes that were higher than other comparable programmes at that time.

9 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

10 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

Operational and contractual changes:

- **The withdrawal of some of the service providers.** At the beginning the contract had four service providers engaged as sub-contractors to WtW. After two years the contracts were renewed and the terms changed, with less of the budget provided as a fixed 'block payment', and more payment contingent on measures of total patient beneficiaries supported, including payments for referral, engagement – measured through the completion of wellbeing stars - and long term support through a Service Continuation Payment. As a consequence, two service providers withdrew during year three (the first year of the revised contracts), believing that their contracts were no longer financially viable. However the other two delivery partners did not share this view and were keen to take on additional GP practices (from whom the project draws referrals) and delivery responsibilities.

- **Request to renegotiate outcomes and payment terms.** WtW sought to make changes to both Outcome A (by asking The National Lottery Community Fund to reprofile payments so that they would support delivery of the project in the longer term and reflected the fact that referrals had had more complex needs than expected); and Outcome B (by asking the CCG to consider changes to the metric and the payment attached to it). In the first case we understand that changes were agreed after the fieldwork for this review was completed; in the second the CCG was resistant and insisted that the WtW SIB should operate on the agreed terms.

These changes illuminate some of the dilemmas stakeholders face when SIBs do not perform as expected. All stakeholders had a shared vision for what the intervention was trying to achieve - improving the lives of people with long term conditions in West Newcastle through a social prescription model that offered long term support. However when performance is at variance with the initial assumptions, there can be tension between maintaining the initial vision for the intervention (in which case the payment terms might need to be amended), or moving away from that vision (or even shutting down the project) in order to maintain the 'purity' of the original payment terms. This dilemma appears to be heightened when the SIB is predicated – at least for the commissioner – on cashable savings or other concrete financial benefits that cover the outcome payments. So when the service is achieving better outcomes than what was observed before but not generating enough savings to cover its own costs, is it more important to have the improved service and social outcomes or have a savings funded project?

Successes and challenges of the SIB approach

- **Proving the effectiveness of the delivery model**: it is too soon to draw solid conclusions about overall impact (and the data errors discussed in the Appendix gave a misleading impression of performance at the time of this review). However as noted above, independent research has already been positive about the effectiveness of the Link Worker approach that this project was aiming to test at scale, with both qualitative and pilot quantitative research showing significant improvements in health, wellbeing and other factors for service users.

- **Ability to test social prescription at scale at minimum risk:** This was widely cited as a benefit of the WtW SIB at its inception and it remains valid. While referrals are below levels outlined in the original assumptions, stakeholders observe that the expected scale of the programme will still be much larger than many social prescription pilots that have been conventionally funded. In addition, the CCG remains 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, and being sure that (through the use of a counterfactual) that they generate savings that can cover the cost of the outcome payments.

- **Increasing referral numbers, and possibly outcomes:** Most stakeholders involved in delivery were of the view that attaching payments to referrals increased the providers' focus on achieving referral numbers, and ultimately led to more beneficiaries being supported than would have happened in a fee-for-service contract (even if the overall number referred was lower than projected). There were divergent views, though, on whether the SIB had increased the number of outcomes per person. The delivery partners who withdrew felt the outcomes targets meant there was a focus on quantity over quality, and that they could not provide the normal level of support to beneficiaries they would ordinarily. Conversely, others felt that the quality of the service was not diminished by the SIB mechanism, though they also did not think improved it either; service provider managers and practitioners were of the view that they would have delivered a similar number of outcomes, and overall impact, per person if they had been paid on a conventional fee-for-service basis.

It is difficult to form a clear view on these competing claims, but WtW stakeholders observed that part of the rationale for the SIB was always to explore the maximum caseload and case mix that could reasonably be managed by link workers while still delivering individual improvements in wellbeing and savings in hospital costs, and also promoting service user autonomy rather than dependency. There was thus always bound to be a degree of tension and trade-off between service quantity and quality, and in finding the optimum balance of long term support to users and link worker caseload. It is important to highlight that, as outlined above, this model did support more people than comparable projects and it did achieve target outcomes for all of those individuals.

- **Objective measurement of financial benefits to the CCG:** Notwithstanding the issues around the accuracy of Outcome B, any benefits that do accrue to the CCG are less open to doubt than is often the case. That's because the SIB uses a rigorous metric that relates directly to the costs incurred by the WtW SIB cohort, and compares these costs to those incurred by a robustly constructed comparison group.. WtW is very rare among SIBs in the UK in having such a robust measure of the counter-factual, and it will be interesting to see if this pays dividends in the longer term, and demonstrates objectively the effectiveness of this social prescription model. However such a robust approach also has its drawbacks if, as here, the management team expend much time and effort checking how the measurements are being performed – and can still miss errors.

Challenges and disadvantages of the SIB approach

- **Relationships between key parties:** It is apparent from our discussions with stakeholders that the performance issues described above have affected relationships within and between the key parties to the SIB, and there have sometimes been disagreements about whether and how to take action. The single most important issue to have affected relationships is the action taken to manage the performance of providers in order to incentivise them to achieve maximum levels of referrals. There is general agreement that the management procedures described previously, addressed issues and led to improved performance and greater outcomes; however they also led to a breakdown in trust between some of the stakeholders involved in the project, and it is clear there were robust discussions and disagreements about how best to resolve the issues. For example, some members of the WtW Board resigned because they did not agree with the decision to extend provider contracts beyond their initial two years, and would have preferred some contracts to be terminated. There were also disagreements about whether there should be management changes within WtW. Some stakeholders also wondered whether a more 'relational' and trust-based approach would have achieved the same results but in a more collaborative manner – though ultimately this is impossible to determine.

- **Optimistic modelling and forecasting of referrals:** It has 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. There is disagreement about whether this was in part due to provider under-performance, or to other factors such as the difficulties posed by the population and environment of some GPs surgeries. It does however seem probable that the initial forecasts of referral volumes were optimistic and unlikely to be achieved, even though referral performance improved when contracts were revised and some providers assumed responsibility for generating more referrals.

- **Lack of flexibility:** One purported benefit of SIBs is that they enable more flexible service delivery, because there is less monitoring on service provider 'outputs' and they are more free to flex and adapt to achieve the stated outcomes. It seems clear that providers do have flexibility to change the intervention to suit individual user needs. However, representatives of the CCG felt that the social prescribing service delivered under the WtW SIB was less flexible than the social prescribing service provided on the east of the city, because the non-SIB social prescribing service had looser referral criteria, which meant they could be more flexible in who was referred to the service. It should however also be pointed out that the referral criteria for the SIB were set by the commissioner, who could have made them looser had they chosen to do so.

- **Perverse incentives due to engagement targets:** Providers described how the Service Continuation Payment (which meant service providers were paid every six months after a beneficiary had engaged with the project for 15 months under the original contracts, and 12 months under the revised contracts) could create a perverse incentive for the providers to 'park' beneficiaries – that is, continue to have the beneficiary engaged in the service even though they require no more support, simply so the provider can claim further payments for them. Some providers reported doing this, and some beneficiaries participating in the focus group had experienced this. However WTW stakeholders pointed out that it was critical to the success of the intervention, and its underlying logic model, that Link Workers were incentivised to work with beneficiaries over the long term They argued that the fundamental ethos of the intervention is to place individuals' strengths at the forefront of the service and enable them to lead their own journey by addressing or overcoming their challenges. This is supported through the long-term relationship with the Link Worker, which aims to achieve sustained behavioural change and ensure people do not relapse.

Conclusions and areas for further investigation

The WtW SIB is a fascinating case study of the pushes and pulls a SIB faces when the data suggest that it is performing differently from original assumptions. This led to a number of issues even though it later transpired that the project was performing well, and the apparent performance variation was due to a data measurement error.

The issues arose even though the WtW SIB was delivering social prescribing at scale with a larger cohort, higher referrals and a more effective service than delivered previously in other projects, including a local pilot from which this project took learning. Stakeholders were universally positive about the intervention and its effectiveness and proud of the fact that the original vision of helping thousands of people improve their lives was being achieved. This is a phenomenon that we have observed in other CBO projects that we have reviewed – the project can be performing well in the views of stakeholders and when compared to other projects, but still considered by some of those same stakeholders to need action to improve performance which is at variance with what was originally forecast.

> "In our opinion what is most interesting about these issues and how they were addressed, is that a purported benefit of a SIB is the bringing together of different worlds – the public, voluntary sector and investment worlds – that creates a merging of expertise and collaboration. But what the WtW SIB reveals is that when problems emerge, people from these different worlds perceive the problems in different ways, and have different opinions as to what the solutions should be."

At times this led to substantial disagreements between stakeholders. In addition, some providers withdrew from the project because they were uncomfortable with revised contracts, designed by the SIB's managing stakeholders to incentivise a higher volume of referrals in order to address one of the key performance variables (engagement) and resolve apparent concerns .

What is much more difficult to determine is whether this process was ultimately beneficial or not, or whether it is even possible to make such a binary judgement. It is clear from our discussions that some stakeholders found the process uncomfortable, and others said that some parties had been 'too tough', and that a more collaborative approach might have been possible. However others argued that all parties were prepared to take tough decisions to make sure that the original vision for the SIB was preserved, and ultimately that people with long term health conditions continued to benefit from the intervention. As one stakeholder commented "If it all becomes a bit wishy washy and you're all buddies together you don't achieve anything."

Moreover the collaborative dimension of the project ultimately won out: the key stakeholders worked through the issues and found solutions – although we will never know whether this would have been the case if Outcome B performance had continued to be variable, rather than shown to have been erroneously reported.

The SIB has also highlighted a number of **lessons learnt** in being involved in, and designing, SIBs:

1 There are risks and potential benefits in this kind of Outcomes structure. Providers can directly influence Wellbeing Outcome A through their work with beneficiaries and the quality of support they bring, but Health Costs Outcome B has risks because it cannot be exclusively influenced by either WtW or the service providers, and is subject to other factors that they cannot fully control. Instead it relies on WtW's logic model, which assumes that improved wellbeing will result in better self-management of LTCs, and ultimately in lower health service demand. We will explore whether this logic model is working in the third review. The evidence that it does is encouraging, but if Outcome B had continued to show variable performance there would have been much risk in having the bulk of payment tied to an outcome over which the delivery bodies do not have exclusive influence.

2 One must consider carefully the financial risk share between investors and service providers. The principle of a SIB (in contrast to a Payment by Results (PbR) approach) is that financial risk is transferred from the service providers to the investors. This was true in WtW as delivery partners were paid block budgets over the course of the initial two years to enable full mobilisation and hiring of full Link Worker teams. In later years this shifted to payments related solely to work with individuals, although they still did not bear outcome risk. In reality what we are now seeing in a multitude of SIBs in CBO (such as MHEP, West London Zone and WtW), is more of a sharing of risk between providers and investors. In designing SIBs, stakeholders need to strongly question: If financial risk needs to be transferred from the commissioner, who is in the best position to take this on? If it is service providers, what are the potential consequences of this if under-performance occurs, and are we comfortable with these consequences? If it is investors, how will this be reflected in the price of outcomes - or in later renegotiations? In WtW it seems clear that some service providers were more comfortable with an outcomes-based commissioning approach - and in particular the payment-per-engagement regime that was introduced to leverage their effort in making that viable - than others. Service providers therefore need to have a good understanding of what

3 Organisations need to carefully consider what their priorities are within a SIB and - if a project performs differently from original assumptions - whether it is more important to support the delivery and outcomes achievement, or to maintain the exact approach agreed on day one. The principle built into outcomes-based contracts – that you only pay for success – has ramifications that organisations only realise when projects under-perform – namely that this principle can in practice, lead to the halting of the delivery (whether at the behest of the commissioner or the investment intermediary), which limits the evidence-base from the project, and can financially affect small voluntary sector organisations. Commissioners need to carefully consider upfront whether they are truly comfortable with this: what is apparent in this SIB is that some stakeholders in the CCG became uncomfortable with some of the implications, especially for VCSE providers.

4 Allied to the above, this can mean that there are challenges with using a SIB to fund pilots, especially if the project is dependent on financial payback to the commissioner via savings achieved. One stakeholder within the CCG remarked that the focus on the achievement of outcomes and generation of savings 'blinkers' people's views on the fact that the project is intended to be a pilot, as they prioritise the financial performance of the project for the CCG over its aim to test an intervention at scale and use an innovative contracting and funding model. This means that there are inherent challenges with building the case around savings that are expected to fund the project, and such an approach does bring constraints.

5 Transparency and communication is key: There have been mixed interpretations in relation to the expectations and roles of different stakeholders, and how issues should be managed. Stakeholders reported that relationships generally improved when there was stronger communication between the different stakeholders

6 The SIB also highlights the difficulty of trying to mitigate against possible perverse incentives. The Service Continuation Payment is designed to incentivise service providers to support service users over the longer term, and promote sustained life change rather than dependency, but could, and to some extent did, also incentivise providers to 'park' service users. There does not seem to be an obvious solution to this dilemma, except to select providers on the basis that they share the vision for the service, and will not seek to exploit payments in this way; or to continuously monitor how financial payments incentivise service provider behaviour and adapt payments until the 'optimum' balance is reached (if such an optimum even exists).

7 In a SIB, having strong internal management information systems and data feedback loops is essential. This is not just because services need to evidence achievement against outcomes, but also because the outcomes focus means there is a stronger need to implement data-driven adaptive management processes. Stakeholders felt it was necessary to generate this data in-house because it would not be possible to rely on NHS systems to produce it with the speed and accuracy that is required – a view that is somewhat supported by the error later revealed in the Outcome B data.

As with many SIBs we have analysed, the WtW SIB is a mixed picture of benefits and challenges, and it is difficult to summarise the overall value for money and benefit of the SIB mechanism. But ultimately one needs to bear in mind that the majority of stakeholders, whilst arguably bruised, continue to be dedicated to the SIB because it is achieving its original objectives –helping thousands of people improve their lives, the transfer of financial risk (to investors and providers), and the linkage of the pricing of these outcomesbased payments to future savings for the CCG – which enabled the CCG to launch a socially innovative project at a scale that has not been seen before. Stakeholders are convinced that the service is proving to be effective, and the CCG is scaling up its use of Link Workers, with one stakeholder thinking this is partly due to the success of the WtW service. They also think the project (combined with the funded research studies, and supported by a robust measure of the counter-factual) will provide an evidence base for social prescribing that will have national consequences. And whilst everyone acknowledges there have been tensions, some see this as leading to positive developments. Ultimately, most stakeholders think the positives outweigh the negatives. Therefore, when assessing this SIB it is important to remember the quote from one stakeholder: "It's gone at least well as could have been expected, but boy has it been difficult."

Areas for future investigation in visit 3

- Does the 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 LTC management/lower costs?
- 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?
- 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?

- What makes some service providers more disposed towards working on a project funded through an outcomes-based commissioning approach?
- 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?

1. Introduction

This review forms part of the evaluation of the Commissioning Better Outcomes programme (CBO) and is the second (mid-point) review of the Ways to Wellness (WtW) social impact bond (SIB), following an initial review completed at the start of the project in 2015.

It should be noted that this in-depth review reflects a particular point in time (May to June 2018), and substantial developments have occurred since the stakeholder interviews took place. Most importantly, an error was identified in the outcomes reporting system; once rectified it revealed that the SIB had in-fact been over-achieving against its outcome targets. More information on this will be provided in the next in-depth review report.

1.1 The CBO Programme

The CBO Programme is funded by The National Lottery Community Fund, and has a mission to support the development of more SIBs and other outcome-based commissioning[11] (OBC) models in England. For The Fund this is to enable more people, particularly those most in need, to lead fulfilling lives, in enriching places and as part of successful communities. The programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2024. It made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar outcomes-based contractual models in complex policy areas. It also funded support to develop robust outcomes-based commissioning proposals and applications to the programme. The project that is the subject of this review, the WtW SIB, is part-funded by the CBO programme.

The CBO programme has **four outcomes**:

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

2. Increased early intervention and prevention is undertaken by delivery partners, including VCSE organisations, to address deep rooted social issues and help those most in need

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

4. Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs.

The CBO evaluation is focusing on answering **three key questions**:

1. Advantages and disadvantages of commissioning a service through a SIB model; the overall added value of using a SIB model; and how this varies in different contexts

11 Outcomes-based contracting/commissioning is a mechanism whereby service providers are contracted based on the achievement of outcomes. This can entail tying outcomes into the contract and/or linking payments to the achievement of outcomes.

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

3. The extent to which CBO has met its aim of growing the SIB market in order to enable more people, particularly those most in need, to lead fulfilling lives, in enriching places and as part of successful communities, as well as what more The National Lottery Community Fund and other stakeholders could do to meet this aim.

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

SIBs are a form of outcomes-based commissioning. While there is no universal definition of SIBs, the Government Outcomes Lab[12] (GO Lab) posit that a 'core SIB' is comprised of four components[13]. A core SIB comprises:

- 100% payment on outcomes
- Independent and at-risk capital (social investors)
- High degree of performance management
- Strong social intent.

While having these components distinguishes a SIB from other types of commissioning, including fee for service[14] and traditional Payment by Results (PbR) contracts[15], SIBs differ greatly in their structure and there is variation in the extent to which these four components are included in the contract. This difference underlies the stakeholder dynamics and the extent to which performance is monitored in the SIB. For the purpose of this report, when we talk about the 'SIB' and the 'SIB effect', we are considering how these different elements have been included – namely the social intent, the payment on outcomes contract, capital from social investors, and approach to performance management.

1.3 The in-depth review reports

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

This report is the second in-depth review of the WtW SIB. Its focus is on the developments of the SIB mid-way through its implementation.

The interviews with stakeholders whose views are reflected in this report were conducted between May and June 2018.

12 See: https://golab.bsg.ox.ac.uk/knowledge/glossary/
13 Carter, E., FitzGerald, C., Dixon, R., Economy, C., Hameed, T., and Airoldi, M. (2018) Building the tools for public services to secure better outcomes: Collaboration, Prevention, Innovation, Government Outcomes Lab, University of Oxford, Blavatnik School of Government.
14 Fee for service is where payment is based on service levels or outputs delivered, rather than outcomes
15 The practice of paying providers for delivering public services based wholly or partly on the results that are achieved. Accessed at: https://golab.bsg.ox.ac.uk/knowledge/glossary/#chapter_3_glossary-n-s__6b0a343c-76d2-4ed5-9d3c-aa767a36eab9_payment-by-results-pbr

1.4 Report structure

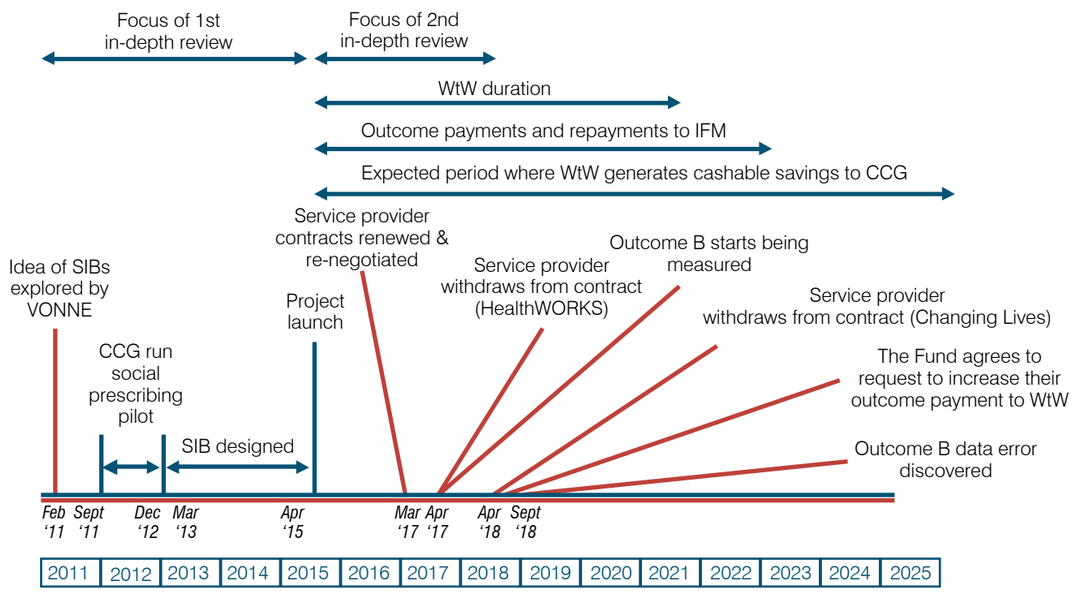
This report is structured as follows:

- Section 2 provides an overview of how the SIB works
- Section 3 describes major developments and changes in the SIB since its launch
- Section 4 summarises stakeholders' experiences of the SIB
- Section 5 discusses the successes and benefits brought about by the SIB approach
- Section 6 discusses the challenges and disadvantages of the SIB approach
- Section 7 describes other interesting findings captured during the research
- Section 8 draws conclusions from this review and highlights areas to explore in the next review.

2. How the SIB works

Figure 1 above provided a summary of the WtW SIB and how it works. This is detailed further below. Figure 2 below provides a timeline of key events that occurred leading up to the SIB launch, and during the period that this in-depth review covers (April 2015 to June 2018) – these are also detailed throughout this report.

Figure 2: Ways to Wellness timeline



The intervention

The WtW SIB funds social prescribing for patients in Newcastle West with Long Term Conditions (LTCs), to enable them to improve their self-care and management of their conditions. The project aims to improve outcomes for 8,500 patients in the first six years of operation. The intervention takes the form of support from Link Workers, employed by specialist service providers. The Link Workers support people with LTCs (referred to them by local GPs and others, and in some cases through referrals generated by the providers themselves) to help them improve their lives through understanding their issues. Link workers support and motivate clients to take up healthy activities, access services and tackle the aspects of their lives that are having a negative effect on their ability to manage their LTC.

The social and financial case for 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 Accident and Emergency (A&E) more often and to be admitted to hospital (for both planned and unplanned procedures) more frequently and, stay in hospital longer. The SIB is 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.

The driving factors for using a SIB

The main reason for using a SIB to support the intervention was to deliver social prescribing at scale with higher referrals than in other social proscribing projects, including the service delivered previously in a local pilot that preceded this project. Given that the effectiveness of social prescription in achieving outcomes and reducing costs at scale was largely unproven, the CCG was not prepared to take the risk of funding the service without payment being linked to financial outcomes, which would generate savings that enabled them to cover the outcome payments. A key objective was and is to provide a stronger evidence base for the effectiveness of social prescription at scale, while also helping thousands of people to improve their lives; at the time of developing the SIB (2013) small-scale social prescribing pilots existed but social prescribing had not been tested at scale and so its evidence base was still low.

The contracting and investment model

The primary contract that underpins the SIB is between Newcastle Gateshead CCG (the CCG) as commissioner and Ways to Wellness Ltd (WtW) as social prime contractor. Ways to Wellness and Ways to Wellness Foundation are dedicated to improving people's lives through delivery and education which preserves and protects the health of people with long term conditions. The structure of specialist sub-contractors providing the intervention changed since the launch of the project (see section 3) but the original contract had four specialist sub-contractors managing Link Workers and supporting referrals.

Social investment for this project (from The Office for Civil Society, Esmee Fairbairn Foundation, Big Society Capital, Pilotlight, the European Investment Fund and other organisations) was sourced via Bridges Fund Management (BFM). BFM is the Investment Fund Manager (IFM) responsible for managing the investment. These social investors have provided an investment commitment of up to £1.65m, repaid from the outcome payments made by the CCG (see below) to set up the project. This capital is thus at risk and dependent on the success of the project in hitting outcome targets. The extent to which the investors' capital will be repaid is dependent entirely on the performance of the project, and is therefore difficult to forecast. Financial modelling by BFM as the IFM suggests that the likely repayment scenarios after eight years range from:

- A repayment of zero, resulting in total capital loss (called '0x Money Multiple' or MM[16]). This was forecast to occur if the project only breaks even for Newcastle Gateshead CCG, (i.e. the savings in secondary care costs generated over 10 years to the CCG are equal to or less than the cost of the project to the CCG). Note – in this scenario, also termed the low case[17] the estimated wider savings to other government departments would still be approximately £3m

- A repayment of approximately 1.4 times the amount of capital invested ('1.4x MM'[18]). This was forecast to occur if the project achieves enough success to save approximately £4m net for the CCG (i.e. the savings generated over 10 years in secondary care costs to the CCG are £4m greater than the cost of the project to the CCG). In this scenario, the estimated wider savings to other government departments would be approximately £14m

The success rates were set such that even in the low case, where investors lose 100% of their capital, the performance would still be better than other comparable social prescribing services. As such, in order to achieve repayment of their capital for investors (before any positive return) the project needed to find ways to deliver social prescribing at scale with a larger cohort, higher referrals and a more effective service than delivered previously in other projects, including a local pilot from which this pr oject took learning.

The WtW board (which includes BFM representation) is managing the operation and delivery of the contract. We provide further details of contractual and governance arrangements in section 4 and Figure 3.

Outcomes payments

There are two primary outcomes to which payment is linked, reflecting the social and financial objectives of the project:

- **Outcome A: Improved self-management of LTC leading to greater sense of well-being and reduced social isolation.** Not all these specific outcomes are measured directly. Instead, beneficiary wellbeing is measured using Triangle Consulting's Wellbeing Star, with payments made on a sliding scale according to the average improvement made by the whole cohort every six months. This measure is thus a direct indicator of improved wellbeing and a proxy for wider changes, including the ability to self-manage LTCs and reduce isolation. Over the course of the contract 30% of the outcomes payments to WtW are made against the achievement towards this outcome.

- **Outcome B: Difference in activities and associated cost of secondary healthcare services between treatment and comparison cohort.** This measures the activities and costs of hospital services used by the cohort receiving the intervention (from planned and unplanned admissions, and use of out-patient and A&E services) and compares them with the costs incurred by a comparison group with similar characteristics in Newcastle North and East. The project accesses Hospital Episode Statistics (HES) data from the North East Commissioning Service (NECS) to inform the comparisons with this counterfactual. Payments are again on a sliding scale according to the percentage difference in costs between the treatment group and the comparison group. Over the long term 70% of the outcomes payments to WtW are made against the achievement of this outcome.

The total projected outcomes payments to be made to the WtW in its first six years of operation are £8.2m, of which £5.2m (64%) will be paid by the CCG, £2m (24%) by CBOand £1m (12%) by HM Government's Social Outcomes Fund.

All outcomes payments are made to WtW but service payments to the four service providers are not tied to outcomes, but to a number of measures of total patient beneficiaries supported. Each provider receives 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 and as explained above, in the first two years of the contract providers received a block payment, to enable full mobilisation and hiring of full Link Worker teams.

We provide further details of current contract terms and how they have changed since the project started in section 3 below.

16 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.

17 In financial modelling the low case (or worst case) refers to a reasonable assumption of the worst possible outcome – in this case that investors lose all their capital invested. There may also be a high case (shown here as the scenario which provides a significant return of 1.4xMM to the investors. There may also be a 'base case' (sometimes termed the median case) between the two extremes

18 It should be noted that this estimate of MM is different to the one stated in the first review of WtW, which showed an MM at base case of 1.38. We understand that this early estimate of returns was incorrect, and returns at base case will be much lower and around break-even - i.e. an MM of 1.0

3. What has happened in practice?

The contract commenced and first referrals were made in April 2015. At the time of the stakeholder interviews for this review (in May – June 2018) the contract had therefore been running for just over three years, or nearly half its planned duration of seven years. Below we describe:

- What we know about the performance of the SIB contract to date based on available data
- What local research and evaluation to date has revealed about the performance of the intervention
- What else has happened in terms of contract operation and relationships since contract commencement.

Please note that this section simply reports the facts of what has occurred. We report the views of key stakeholders on the reasons for these events and their implications in section 4.

3.1 Contract performance

A report by the WtW team to The National Lottery Community Fund in March 2018 showed that:

- In the SIB's first 2.9 years of service (April 2015 to February 2018), just under 4,200 patients had been referred to the service, of whom almost 3,200 patients had thus far engaged. This is out of the base population of 140,000 of whom approximately 10% met the defined referral criteria. Stakeholders observed that this made WtW the largest social prescribing service at the time with a conversion rate that was significantly higher than comparable projects. Based on achieved referral rates across the WtW SIB service to date, the seven-year contract is now projected to generate over 9,000 patient referrals, of which over 7,000 are expected to engage in the service.
- Patient referral and initial engagement rates are thus somewhat lower than forecast in the original business case for the SIB; the number of patient referrals and 'starts' on the service is approximately 32%% lower than originally projected. Stakeholders believed this was because original projections (based on modelling of data from local GPs and the CCG undertaken by consultants engaged to support the SIB design team) over-estimated the number of eligible patients for the service in the local area.
- Performance against Outcome A (Wellbeing Improvement) had been good and generally on or ahead of forecast. By February 2018 almost 1,800 patients had completed a second assessment of their wellbeing, approximately six months after starting with the service. These assessments show an average wellbeing improvement of 3.3 points across the eight assessment domains which form part of the Wellbeing Star, which is considered to be a significant improvement when compared to similar interventions and data held by Triangle consulting on outcomes from use of the Wellbeing Star elsewhere. In descriptive terms, these changes represent a client moving from describing themselves as "finding out how they can improve things in their life to feel more in control" to "making changes" or even moving to where they feel they are "managing their lives pretty well". The five domains where patients reported the most significant improvements in wellbeing were: lifestyle; feeling positive; engagement in work, volunteering and other activities; and managing symptoms.
- Up to the point in the contract at which we conducted this review (mid-2018) the payment received for Outcome B (difference in secondary care usage between treatment and comparison cohort) had been more variable based on the data available at the time (which included an error; see below). The usage fluctuation was however broadly aligned to what was observed in historic data. This outcome started to be measured in April 2017 and differences in per head costs between the WtW SIB cohort and the comparison cohort had varied. The WtW SIB cohort was lower cost than the comparison cohort in six of the eight months for which final data was available for the 2017-18 financial year (using 12-month rolling annual average cost per head). However, since payments were on a sliding scale, the outcome payment triggered was often lower than the maximum available. Furthermore, in the other two months the WtW SIB cohort incurred higher costs than the comparison cohort.

In addition, and although not a paid outcome under the SIB contract, there has been a measurable improvement in demand placed on primary care by the WtW SIB cohort. Audits conducted in Autumn 2017 in three of the GP practices participating in the WtW SIB measured change in GP and nurse consultations for 260 patients before and after involvement in the WtW SIB service. The results show that for a cohort of 100 patients, WtW SIB patients' GP consultations reduce annually by an average of 139 consultations. WtW also reported that anecdotal evidence shows that primary care staff are better able to divert their time to work with patients to address medical needs (rather than non-medical needs).

As mentioned in the Introduction, it is important to note that, since this research took place, errors were found in the way Outcome B was calculated. This meant that the SIB was actually over-performing, and many of the difficulties described in this in-depth review are no longer apparent. However, this in-depth review is of relevance, as it captures some of the dilemmas and difficulties stakeholders face when performance is different from original assumptions and a SIB appears to be under-performing. We will provide more detail on the changes to Outcome B in the final in-depth review, but in fact performance was almost exactly (99% of target) in line with what it should have been to achieve the improvements originally forecast, rather than variable as it appeared at the time. More details of the error and the impact of its correction are provided in Appendix A.

3.2 Intervention effectiveness

Stakeholders were universally positive about the intervention and its effectiveness.

At the time of this in-depth review there had 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[19] with a sample of 30 individuals who engaged with the WtW SIB 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 SIB service's effectiveness with those who engage with the service is due to its holistic, user-led and long-term approach. Patients reported improved management of their long-term conditions, improved mental health, greater resilience and more effective problem-solving strategies. The researchers concluded that the positive health and wellbeing impacts observed have, over the longer term, potential to impact within wider family, friendship and community networks.

- The Institute of Health and Society, in collaboration with Ways to Wellness, also conducted a pilot quantitative research project funded by the School for Public Health Practice Evaluation Scheme. This asked people 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 beneficiaries. Beneficiaries 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 elapsed time they had been worked with – one beneficiary has 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 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 simply 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 - often leading 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"

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[20]. 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.

19 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

20 The research protocol is available at https://bmjopen.bmj.com/content/9/1/e026826

3.3 Operational and contractual changes

There had been two noteworthy changes to the operational or contractual model of the SIB since it commenced in April 2015. These are:

- **The withdrawal of some of the service providers.** At the beginning the contract had four service providers engaged as sub-contractors to WtW. 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. 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. There are different accounts as to the reasons why this was done (see Section 4). As a consequence, HealthWORKS Newcastle withdrew voluntarily from their new contract shortly after; and subsequently (around April 2018) Changing Lives also withdrew (we explore the circumstances under which these providers chose to withdraw in Section 4.) 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 are sourced) and delivery responsibilities from the providers that withdrew.

- **Request to reprofile CBO outcome payments.** At the time of the research CBO contributed to the WtW SIB by making payments for outcome A of £350 and began doing so in the 2018/19 financial year (with payments for outcome A prior to this funded by the Social Outcomes Fund). Because the WtW SIB was forecasting a lower level of referral and service engagement than originally envisaged, there was a risk that the WtW SIB 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). At the time of the stakeholder consultations this request was under consideration, but we understand since that The Fund subsequently agreed to this request in 2018. The Fund considered that this was justifiable because the service providers were supporting beneficiaries that were of higher risk and had more complex needs than originally envisaged, and the project still met the CBO objectives and programme requirements.

We also understand that further variations were considered but did not take place. This was to make changes to the payment for Outcome B – reflecting the fact that there have been fluctuations in the underlying performance against this outcome and therefore in the payments made by the CCG. Our understanding is that there were discussions between WtW and the CCG about possible changes to the outcome metric and associated level of payment, but it was decided that the current metric and sliding payment scale should remain in place. Again, we explore the background to this further in Section 4, but as noted much of the scrutiny of Outcome B arose because of erroneous data, and WtW stakeholders now believe that they would not have requested changes to Outcome B if the data had been correct.

4. Stakeholder experiences of the SIB up to June 2018

4.1 Introduction

This section reports the views and experiences of stakeholders interviewed during the second visit to the WtW SIB. It includes the views of the following stakeholders who were interviewed either separately or in a group. In some cases as indicated we interviewed several separate stakeholders in the organisation:

- **Newcastle Gateshead CCG:** Separate interviews with a number of key stakeholders;
- **Bridges Fund Management:** WtW Board representative interviewed
- **WtW Board:** Two members interviewed;
- **Providers:** We interviewed managers from both one of the current providers and from another provider which has now withdrawn from the contract;
- **Practitioners:** We held a focus group with a number of Link Workers about their experiences of the intervention and working in a SIB model;
- **Service users:** We undertook a focus group with people who had been receiving Link Worker support through the WtW SIB about their experiences of the service and intervention and its benefits and disadvantages;
- **The National Lottery Community Fund:** the Grant Officer with responsibility for administration of the CBO grant to the WtW SIB was interviewed.

We have described below what we learnt from these stakeholders across a number of aspects of the SIB and its operation.

The relationship between stakeholders (both contractual and otherwise) is complicated. Much of the detail is in the sections below and it is also summarised in Figure 3 overleaf.

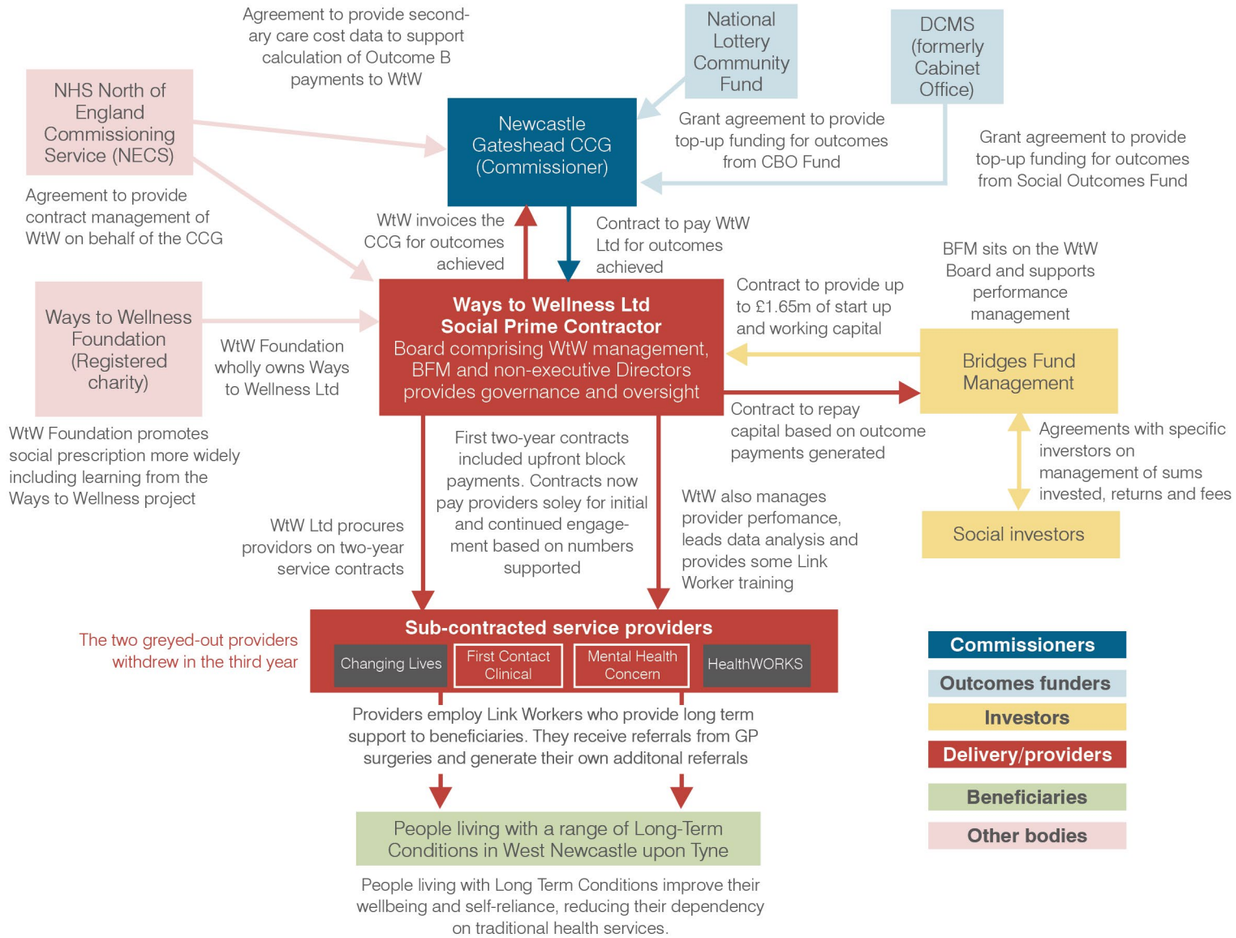
4.2 SIB performance management

As explained in Section 3, management of the performance of this SIB has been dominated by two issues:

- Different levels of referrals and engagement when compared to initial ambitious forecasts and assumptions
- Perceived under-performance against Outcome B, based on the cost of hospital admissions and outpatient appointments for the WtW SIB cohort compared to a comparison group.

We heard a variety of views, sometimes conflicting, on the reasons for these issues and the response of various stakeholders to them, as described further below.

Figure 3 – Ways to Wellness contractual relationships and governance



4.2.1 Referrals

The number of referrals to the intervention by GPs and others appears to have fallen short of forecasts from the early days of the contract period, and as explained in Section 3, referrals are now forecast to be around 32% lower than originally modelled over the contract as a whole. While the total referrals and subsequent engagements that the WtW SIB expects to achieve remains impressive compared to many other social prescription programmes, this has impacted on the SIB in a number of ways, including:

- Making it more difficult for the WtW SIB to achieve outcomes – especially Outcome A, which links directly to numbers referred and engaging

successfully; and

- Reducing the total amount of investment needed.. The original investment estimate of £1.65m included significant contingency for personalised support to service users which was not needed. The investment requirement net of this contingency was £1.1m and this amount was fully drawn down, as planned, in the first 18 months of the programme.

We heard a number of different explanations for the difference, including the following:

- **Optimistic modelling of expected referrals.** There seems to be broad consensus that the original forecast and modelling of referrals, as included in the SIB business case, was optimistic and, with hindsight, unlikely to be achieved. The primary referral route is via GPs, generated when patients with the LTCs appropriate for the intervention visit a surgery.

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. Indeed, it appears that referral numbers at or close to the expected level can only be achieved if the GP referral route is supplemented by providers directly contacting those eligible for the WtW SIB and encouraging them to self-refer, as explained further below;

- **Variation in referral levels across GP surgeries.** The provider we spoke to who had now withdrawn from the WtW SIB (in part because of lower than expected referrals) argued that it was more challenging to generate referrals from some of the surgeries with which they were working than some others, since they were in more deprived areas (where potential participants were less likely to visits their GP) and/or had poorer facilities. In particular some surgeries did not have space for a WtW SIB Link Worker to be on the premises, which meant that the person referred could not see a Link Worker immediately and would have to go elsewhere at a later date, risking a loss of referrals as patients change their mind, could not make time to see a Link Worker etc. Some of the other stakeholders (including one commissioner representative) thought that this argument was valid, but others did not think it was significant, pointing out that following the withdrawal of providers these 'more challenging' surgeries were reallocated to the remaining providers, who were able to increase referral levels as explained below.

- **Variation in provider operating practices.** Several stakeholders thought that the variation in referral performance had more to do with differences in working methods than in referral challenges. Most importantly, the provider that we interviewed who is still engaged in the project was proactive in contacting those that might benefit from the WtW SIB intervention (using pre-prepared lists) rather than waiting for patients to visit their GP. In consequence, they were able to increase referral levels in surgeries where they had previously been low when reallocated to them.

Irrespective of the reason for low referrals, the shortfall meant that the WtW took action to encourage and incentivise providers to improve performance in this area. This had a number of knock-on effects on relationships between the parties as described further in section 4.3 below.

4.2.2 Outcome B performance

As explained in section 3, Outcome B had only been driving payments since April 2017 and, across the period for which data were available when we conducted this review, performance had been variable. As explained earlier and in more detail in Appendix A, this variable performance later turned out to be the result of errors in data collection and reporting.

It is worth noting that at the time of the stakeholder interviews all parties to the contract were finding it challenging to understand fully the reasons for this shortfall in performance. The Outcome B metric is inherently complicated, relying on the interaction between two challenging data sets (the HES and NHS payment tariff) and their comparison with a counterfactual through a process that requires some weighting and adjustment of the comparison group to allow for differences in characteristics between the WtW SIB treatment and comparison groups. In addition (and in part because of the data complexity) data is collected and matched independently of the WtW SIB by North of England Commissioning Support (NECS). This has the advantage of providing independent verification of data but makes it more difficult for the WtW SIB easily and quickly to analyse data and understand performance shortfalls, as we discuss later.

The very fact that it transpired that there were errors in how Outcome B was calculated over three years after the project began demonstrates the complexity of the measure, and also perhaps explains why stakeholders were finding it so hard to explain why there was a difference.

Most importantly, we learnt that WtW management had held discussions with the CCG about making changes to Outcome B in order to reduce WtW's and investors' financial exposure to variations in outcome performance. Our understanding is that the proposal was that the CCG should pay more for outcome A to balance underpayment against Outcome B. The CCG y resisted this, arguing that the SIB had been sold to them by WtW based on an agreed payment mechanism tied to an outcome that directly measured secondary care costs and would ensure direct linkage to the costs that they would otherwise have to bear if the intervention were unsuccessful – and the benefits if it were effective. The CCG also argued that such a change to the outcome metrics and payment mechanism would inevitably change the balance of risk towards them and away from the investors and the WtW. It is however worth pointing out that the service was already achieving significant social impact by this point, and also that if the right data on performance had been available, it is, in the view of WtW stakeholders, unlikely that they would have asked for any change to the outcome metrics.

These discussions illuminate some of the dilemmas stakeholders face when SIBs do not perform as expected, and whether it is more important for the intervention to continue (and therefore to change the original terms contract), or for the financial terms to remain (and therefore to change, downscale or even shut down the intervention). This dilemma appears to be heightened when the SIB is predicated, at least for the commissioner, on savings or other concrete financial benefits that cover the outcome payments. So when the service is achieving better outcomes than what was observed before but not generating enough savings to cover its own costs, is it more important to have the improved service and social outcomes or have a savings funded project?

"I was sitting there going, 'We have got to save this thing, it is of national importance. We cannot let this thing fail.' But others were saying, 'Why would we accept an enormous shift in risk from the investor? Why would we take the removal of the cap when we are completely cash strapped?... We really hit a really tricky moment." (Commissioner)

"I'm genuinely excited about it, so I wouldn't want to throw the baby out with the bathwater." (Commissioner)

4.3 Relationships between key parties

It is apparent from our discussions with stakeholders that the performance issues described above have affected relationships within and between the key parties to the SIB, and there have sometimes been disagreements about whether and how to take action. We discuss the most important instances of this below.

4.3.1 Management of providers

The single most important issue to have affected relationships is action taken to manage the performance of providers in order to incentivise them to achieve maximum referral levels. As explained in previous sections, delivery partners in the WtW SIB were paid block budgets in the first two years and in year 3 – after successful mobilisation and initial delivery of the project – delivery partners started being paid in relation to referrals made and subsequent engagement and were therefore at financial risk if referrals were lower than expected. Two of the original four providers have now withdrawn from the WtW SIB and are no longer providing services – reportedly because they could not deliver the services for the payment received. We did however encounter different views as to the sequence of events leading up to these changes, and the extent to which they were expected to happen. There were differences in opinion from stakeholders in relation to:

- **Expected balance of competition and collaboration between providers.** The four providers originally appointed through open competition to deliver the WtW SIB service were all delivering a similar Link Worker intervention, but with different skill sets and clinical knowledge – with some focusing on physical health and others on mental health issues, for example. It was therefore always expected that there would be both competition and collaboration between providers: they would be judged in part on their success in achieving referrals and engagement compared to the other providers, while being expected to collaborate and work together to maximise the effectiveness of the service as a whole.

  We did however encounter differences of opinion about the expected balance between these factors. A number of stakeholders thought that the emphasis on competition – and consequent pressure on those performing less well – was much stronger and introduced much more quickly than they had expected. Essentially, they thought that they had been under significant pressure to justify their performance relative to other providers from day one. However other stakeholders have pointed out that the process of reviewing performance was highly collaborative rather than confrontational. For example, there were impact workshops with delivery partners and joint link worker learning sessions, designed to encourage constructive knowledge sharing.

- **Assumed reduction in the number of providers.** Similarly, some stakeholders said that it was always assumed and intended that the number of providers would reduce over time, with those who performed well being retained and others not having contracts renewed. However, others said that they had understood that it was possible for all providers to retain their contracts, and had never assumed that there would be a reduction.

- **Early termination of provider contracts.** It appears that during the second year of the contract there was a difference of opinion as to whether and when the issue of variable performance between providers should be brought to a head. There appears to have been some pressure from the IFM and others on the Board of WtW to not renew some contracts once the initial contracts expired (and possibly run a new procurement process to find replacement providers), while other Board members argued that the initial two-year contracts should be extended. The decision appears to have come down in favour of the latter course, but as a compromise the contracts were changed to link payments more closely to performance. We understand that two Non-Executive Directors resigned because the Board decided not to terminate contracts early (or otherwise take earlier action to improve performance). In the event, two of the providers decided to withdraw during the third year (i.e. the first year of the amended contracts) This did not affect the reach of the programme since the remaining two providers were keen to expand their service by taking on the GP practices from the delivery partners who withdrew from their contracts.

4.3.2 Relationship with investment fund manager

A side effect of the performance issues encountered by WtW has been that the IFM, BFM, has been perceived as interventionist and putting undue pressure on other parties to address performance issues. The high level of interest in performance is understandable since the IFM, who is funded by and works to protect the interests of the social investors is, by definition, the representative of the part(ies) with the strongest financial imperative to try to make the project succeed. As the IFM itself explained to us, the fund manager has a duty to the social investors to try as hard as possible to achieve the social goals of the project – improving wellbeing as much as possible, for as many people as possible – because this will then translate into the maximum possible benefit for the CCG and wider government stakeholders, and achieving this is the only way for the social investors both to achieve their social impact targets, and to ensure that their financial investment is repaid.

Whilst it is true that all stakeholders should in theory wish to maximise the improvement of wellbeing to as many patients as possible, and therefore all parties have much to lose if a project ends when it has the

potential to benefit thousands of people with long-term conditions, the reality is that performance issues in a project with very stretching targets such as this, are sometimes tolerated if a stakeholder has many other competing priorities. This may explain why some of the stakeholders said that they had not expected the IFM to be as 'tough' as they had been, in their efforts to maximise outcomes from the project , and thus the number of people whose wellbeing was improved.

There has also been some disagreement between the IFM and the commissioner about the former's role in the management of the contract. Some individuals within the CCG NECS resisted a request from the IFM to be directly involved in contract review meetings, on the grounds that they were not directly a party to the contract (though others believe this resistance was coming from NECS rather than the CCG itself). Again, this is not a consistent view since another stakeholders within the CCG told us that they thought it would have been sensible to involve the IFM in discussions, recognising both that the IFM had a legitimate interest and that their involvement could have been beneficial in resolving performance issues.

4.3.3 Role of WtW management

We also heard some interesting and sometimes conflicting views on the role of WtW management and especially the Chief Executive. The role of the WtW is effectively one of prime contractor and partnership coordinator, responsible for both performance and contract management. Stakeholders recognised the tension within and between these roles. The WtW has to both encourage providers to collaborate and to manage and – where necessary – criticise their performance; it also has to maintain a good relationship with the commissioner and work with them to address performance issues.

These are issues that can arise in any contract delivered by prime and sub-contractors, but the fact that this contract is a SIB adds layers of complexity. In particular, the IFM has an interest in both performance and contract management – and is accountable to its investors – but is not directly responsible for either, as in this SIB it is WtW who holds those responsibilities - leading to the tensions already mentioned above.

There is a general agreement that these management structures and procedures successfully addressed issues and led to improved performance and greater outcomes; however they also led to a breakdown in trust between some of the stakeholders involved in the project, and some stakeholders wondered whether a more 'relational' and trust-based approach would have achieved the same results but in a more collaborative manner – though ultimately this is impossible to determine. We explore this question further in subsequent sections.

5. Stakeholder experience of the SIB mechanism

Although at the time of the research the WtW SIB was considered by its stakeholders to be significantly more successful than comparable programmes, it was working with a smaller number of individuals than originally envisaged; and there remained concerns about whether it would eventually achieve the 'at-scale' level of benefit envisaged – especially as regards financial benefit to the CCG. However, the SIB still appeared to be delivering the following benefits that would not have accrued from a conventional contract. Ultimately, 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.

However, this had not been a universal view throughout. When Newcastle West CCG (who originally let the SIB contract) had merged with its neighbouring CCGs including Gateshead, there had been some debate about whether social prescription should be conventionally funded, in line with a model favoured by Gateshead. However, the combined CCG had decided to continue with the SIB.

5.1 Ability to test social prescription at scale at minimum risk

This was widely cited as a benefit of the WtW SIB at its inception and it remains valid. While referrals are below those expected, the expected scale of the programme will still be much larger than many social prescription pilots that have been conventionally funded. In addition, the CCG remains 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. Even though there are concerns about the level of savings being achieved by the SIB, these are offset by the fact that the CCG is not paying for the service regardless: the underperformance is reflected in the amount it is paying, and it is investors and providers that are bearing financial risk.

5.2 Increasing referral numbers

Most stakeholders involved in delivery were of the view that attaching payments to referral numbers increased the providers' focus on achieving referral numbers, and ultimately led to more beneficiaries being supported than would have happened in a fee-for-service contract (even if the overall number referred was lower than projected). Practitioners described their persistent approach to reaching out to beneficiaries 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)

Members of WtW also thought the SIB had introduced a more data-driven approach – 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 were divergent views, though, on whether the SIB had increased the number of outcomes per person. The service providers that withdrew were of the view that the outcomes targets meant there was a focus on quantity over quality, and that they could not provide the normal level of support to beneficiaries they would ordinarily because of the need to generate large referral numbers and subsequently have larger caseloads.

However, this was not a universal view, and others felt that the quality of the service was not affected, and that the requirement to provide lighter-touch support was a positive because it reduced the likelihood of beneficiaries becoming dependent on the service. However, whilst these stakeholders did not think the SIB mechanism diminished the quality of support, they also did not think it improved it either; service provider managers and practitioners were of the view that they would have delivered a similar number of outcomes, and overall impact, per person if they had been paid on conventional fee-for-service basis. They attributed this to the fact that only Outcome A was something they could directly influence, and they were used to working intensively with high needs beneficiaries in a variety of different contract models – the outcomes-based nature of this contract thus made no difference. It is important to highlight that, as outlined above, this model did support more people than comparable projects and it did deliver ahead-of-target outcomes for all of those individuals.

5.3 Objective measurement of financial benefits to the CCG

There has been considerable debate about the merits of Outcome B, but the use of a rigorous metric that relates directly to the costs incurred by the WtW SIB cohort, and compares them to a robustly constructed comparison group, means that any benefits that do accrue to the CCG are less open to doubt than is often the case.

6. Challenges and disadvantages of the SIB approach

While stakeholders appear to agree that the benefits of the SIB outweigh the disadvantages, there have undoubtedly been considerable challenges, some of which had not been fully resolved at the time of this review. While some of these might have occurred under a conventional contract or a grant, most are unlikely to have arisen if this were not a SIB and/or payment was not linked to outcomes. These challenges include the following.

6.1 Optimistic modelling and forecasting of referrals

As described above, it has 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 in-depth review 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 now 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 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.[21]

Whilst it 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 unlikely to occur in fee-for-service contracts.

6.2 Lack of flexibility

One purported benefit of SIBs is that they enable more flexible service delivery, because there is less monitoring on service provider 'outputs' and they have more freedom to flex and adapt to achieve the stated outcomes.

Service providers do have considerable flexibility to modify the intervention to suit the needs of individual service users. However, representatives of the CCG felt that the social prescribing service delivered under the WtW SIB was less flexible than the social prescribing

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

service provided on the east of the city, because the non-SIB social prescribing service had looser referral criteria, which meant they could be more flexible in who was referred to the service. Furthermore, the CCG could not expand the service because this would then contaminate the comparison group.

> "It's just not flexible enough to tweak this contract." (Representative of CCG)

The SIB thus enables flexibility at the day to day delivery level, as regards the way the service is provided to individuals, but lacks flexibility at the referral level. Ironically this appears to be largely because the CCG itself wanted to restrict referral criteria.

6.3 Perverse incentives due to engagement targets

Practitioners described how the payment attached to completing the second wellbeing star had a positive effect, because it incentivised practitioners to ensure everyone engaged with the service.

"It keeps you focused to contact people." (Practitioner)

However, providers also described how this was also was driving some (though not substantial) perverse incentives – the Service Continuation Payment (which meant service providers were paid every six months after a beneficiary had engaged with the project for 15 months, later reduced to 12 months) incentivises the providers to 'park' beneficiaries – that is, to continue to have the beneficiary registered with the service even though they required no more support, simply so the provider could claim further payments from them. Some providers reported doing this. This was also corroborated by some beneficiaries interviewed, who reported not receiving regular support but being contacted every three months to ask if they needed support, and were asked to complete a wellbeing star.

This shows how a payment designed to incentivise positive behaviour can sometimes have an adverse consequence. The Service Continuation Payment is, in the view of WtW, crucial to the underlying logic model of the SIB – because it aims to promote long term improvement and self-management of conditions, and reduce user dependency on traditional health services. The 'check-in' element of the intervention, supported by the Service Continuation Payment, is critical to this. In light of this it is arguable that the risk of some limited perverse incentive is worth the price. It is also hard to see how the perverse incentive could be avoided, except by selecting providers on the basis that they share the vision for the service and will not seek to exploit payments in this way, (which is what WtW aimed to do), or to take a more transactional approach, and continuously monitor how financial payments incentivise service provider behaviour and adapt payments until the 'optimum' balance is reached (if such an optimum even exists).

6.4 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 all three are working together to achieve common objectives and maximise social impact. This does not always appear to have been the case in WtW thus far. In particular, there has been antagonism from some individuals within the commissioning organisations towards involvement of the investment fund manager, and some disconnect between expectations of some providers (who appear to have been surprised to find themselves under pressure to increase referrals) and the investment fund manager – with WtW management sometimes caught in the middle. One interviewee described the relationships between some stakeholders as "tempestuous and not the easiest."

> "There have been stages where staff morale was rock bottom." (Stakeholder)

The fact that despite these issues the SIB remains intact and is still delivering a quality service to beneficiaries appears largely to be due to the extent that the key parties have worked round these issues. It is also 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.

7. Conclusion

The WtW SIB is a fascinating case study of the pushes and pulls a SIB faces when the data suggest that it is performing differently from original assumptions. This led to a number of issues even though it later transpired that the project was performing

Even with the apparent performance variability taken at face value the WtW SIB was nonetheless delivering social prescribing at scale with a larger cohort, higher referrals and a more effective service than delivered previously in other projects, including a local pilot from which this project took learning. Stakeholders were universally positive about the intervention and its effectiveness and proud of the fact that the original vision of helping thousands of people improve their lives was being achieved. This is a phenomenon that we have observed in other CBO projects that we have reviewed – the project can be performing well in the views of stakeholders and when compared to other projects, but still considered by some of those same stakeholders to need action to improve performance which is at variance with what was originally forecast.

"There was a lot of assumption that everything would go well and everyone's interests will be aligned…when the wheels fall off, there are differences in priorities and these differences have come to the fore in a way… Those competing priorities and perspectives are very different in the world…that has been really disruptive and delivery hasn't been as promising as it could have been. It's not as win-win-win as I initially thought." (Stakeholder)

What is much more difficult to determine is whether this process was ultimately beneficial or not, or whether it is even possible to make such a binary judgement. It is clear from our discussions that some stakeholders found the process uncomfortable, and others said that some parties had been 'too tough', and that a more collaborative approach might have been possible. However others argued that all parties were prepared to take tough decisions to make sure that the original vision for the SIB was preserved, and ultimately that people with long term health conditions continued to benefit from the intervention. As one stakeholder commented *"If it all becomes a bit wishy washy and you're all buddies together you don't achieve anything."*

Moreover the collaborative dimension of the project ultimately won out: the key stakeholders worked through the issues and found solutions – although we will never know whether this would have been the case if Outcome B performance had continued to be variable, rather than shown to have been erroneously reported.

The SIB has also highlighted a number of **lessons learnt** in being involved in, and designing, SIBs:

1 There are risks and potential benefits in this kind of Outcomes structure. As explained above, the SIB pays for two outcomes – improved wellbeing (Outcome A) and reduced secondary care usage and costs between treatment and comparison cohorts (Outcome B). Providers can directly influence Outcome A through their work with beneficiaries and the quality of support they bring. However Outcome B carries most of the payment and is important to the commissioner because it is reduced demand and costs that in part justifies the project (along with the social and health benefits to individuals). As noted above Outcome B has considerable merit because it is independently calculated and validated, and success is measured against a strong counterfactual. However it also has risks because it cannot be directly nor necessarily exclusively influenced by either WtW or the service providers. Instead it relies on WtW's logic model bearing itself out, which assumes that improved wellbeing will result in better self-management of LTCs, and ultimately in lower health service demand. We will explore whether this logic model is working in the third review, but the evidence so far is encouraging. However if Outcome B had continued to show variable performance (as it was when this review was conducted) then there would have been some risk in having the bulk of payment tied to an outcome that the delivery bodies do not have exclusive influence over.

2 One must consider carefully the financial risk share between investors and service providers. The initial principle of this and other SIBs (in contrast to a PbR approach) was that financial risk would be transferred from the service providers to the investors. In reality, what we are now seeing in a multitude of SIBs in CBO (such as MHEP and West London Zone) is more of a sharing of risk between providers and investors. Ultimately, in this SIB, that sharing of risk led to some of the providers to withdraw from the contract, and we have seen other examples in SIBs where delivery has been hampered by providers facing financial challenges because they are reliant on payments per patients which are linked to the number of people the project works with – such as in the MHEP SIB[22]. In designing SIBs, stakeholders need to strongly question: If financial risk needs to be transferred from the commissioner, who is in the best position to take on the financial risk? If it is service providers, what are the potential consequences of this if under-performance occurs, and are we comfortable with this? If it is investors, how will this be reflected in the price of outcomes?

It is also worth adding that risk can be shared or placed back with commissioners, especially if they are asked to reprofile outcome payments, pay more for outcomes than originally envisaged, or pay for inputs and activities to lessen the risk of outcomes not being achieved. As noted above, the CCG declined to make such changes in this case and it has subsequently proved that they were not needed.

3 Organisations need to carefully consider what their priorities are within a SIB and, if a project performs differently from original assumptions, whether it is more important to support the delivery and outcomes achievement, or to maintain the exact approach agreed on day one. . The principle built into outcomes-based contracts – that you only pay for success – has ramifications that organisations only realise when projects perform differently than originally expected. If rigidly adhered to, this principle can lead to the halting of cash flow for delivery, which limits the ability to continue improving people's lives and which also limits the evidence-base from the project, and can financially affect small voluntary sector organisations. Commissioners need to consider carefully upfront whether they are truly comfortable with this; What is apparent in this SIB, is that some stakeholders in the CCG were uncomfortable with some of the implications of this, especially for VCSEs.

22 See the second in-doeth review of MHEP for an explanation of its structure and its implications for providers, downloadable at https://www.tnlcommunityfund.org.uk/media/Indepth-Reviews_MHEP_Visit-2_FINAL.pdf?mtime=20190819133237&focal=none

4 Allied to the above, this can mean that there are challenges with using a SIB to fund innovative pilots. One stakeholder within the CCG remarked that the focus on the achievement of outcomes and generation of cashable savings blinkers people's views on the fact that the intervention is intended to be a pilot of the viability of scaling social prescribing: "Nothing else we do as a commissioner uses the rigour in this model. Every other pilot or test, they come in with a bit of paper and everyone goes, 'Woah, fantastic…' We have a different bar for this thing that I think is really hampering people's ability to see the success of it."

5 Transparency and communication is key. There have been mixed interpretations in relation to the expectations and roles of different stakeholders, and how issues should be managed. Stakeholders reported that relationships generally improved when there was stronger communication between the different stakeholders. One stakeholder suggested forming a project steering group that includes all the main stakeholders (commissioner, WtW, service providers and investment fund manager), and we think there is merit in this idea – though it would need to be a space for communication rather than central decision-making, as this would be the role of the WtW Board.

6 The SIB also highlights the difficulty of trying to mitigate against perverse incentives in PbR funding. The Service Continuation Payment is designed to incentivise service providers to support service users over the longer term and, to promote sustained life change rather than dependency. As such it is critical to the success of the intervention and its underlying logic model, since the fundamental ethos of the intervention is to place individuals' strengths at the forefront of the service and enable them to lead their own journey by addressing or overcoming their challenges.

However this payment also incentivised the providers to 'park' beneficiaries to some degree. This creates a difficult dilemma; a payment of this kind is added to avoid the perverse incentive of 'cherry picking', by paying extra for cases that take longer to support. Indeed, practitioners interviewed really valued the fact that they could spend 2+ years supporting beneficiaries if necessary and felt this was key to their achievement of outcomes. And yet, this measure to avoid a perverse incentive in itself created a different perverse incentive (the parking). There does not seem to be an obvious solution to this dilemma, except to select providers on the basis that they share the vision for the service, and will not seek to exploit payments in this way; or continuously monitor how financial payments incentivise service provider behaviour and adapt payments until the 'optimum' balance is reached (if such an optimum even exists).

7 Some service providers are comfortable with an outcomes-based commissioning approach, others are not. Service providers need to have a good understanding of what they are committing to at the outset of the project. The service provider whom we interviewed that remained engaged in the SIB was generally more comfortable with a target-driven and performance-managed approach than the provider we spoke to that chose to withdraw. The service provider that was more comfortable with it also had more experience with the approach. We have found generally across SIBs that different providers (and practitioners within those providers) respond differently to the performance management and outcomes focus of SIB contracts – some embrace this culture and others do not. Equally, there were differences in understanding of the PbR structure at the beginning of the project; as we reported in our first in-depth review, whilst one service provider who had experience of PbR described the PbR aspect of the project as being "fairly straightforward" another who had less experience described it as "incredibly confusing". Service providers should consider before entering a SIB contract whether they are feeling well enough informed to take a view on whether they and their staff will be comfortable with such an approach.

8 In a SIB, it is essential to have strong internal management information systems and data feedback loops. This is not just because services need to evidence achievement against outcomes, but also because the outcomes focus means there is a stronger need to implement data-driven adaptive management processes in real time. Stakeholders felt it was necessary to generate this in-house because it would not be possible to rely on NHS systems to produce this in the speed that is required.

What is clear from a lot of the lessons highlighted above is that stakeholders embarked on this project not fully recognising some of the issues that would materialise; this is perhaps unsurprising given that this was one of the first SIBs to launch in the UK, and claims to be the first to launch within the Health sector. It is difficult to say whether, with the benefit of hindsight, some of these aspects could have been mitigated with more thorough scenario-testing upfront, or whether these were 'unknown unknowns' that were impossible to predict. What is clear now, is that this SIB and others in CBO and beyond, are highlighting some of these lessons learnt, and stakeholders embarking on similar projects are encouraged to learn from these.

The SIB can be viewed against the four CBO objectives as follows:

1. **Improve the skills and confidence of commissioners with regards to the development of SIBs: Partially 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 principle stakeholders to other parts of the commissioning organisation.

2. **Increased early intervention and prevention is undertaken by delivery partners, including VCSE organisations, to address deep rooted social issues and help those most in need: 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.

3. **More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people: Partially achieved.** It is almost certain that the service providers could not have got involved in a PbR-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 change to the payment arrangement does however mean that providers had more financial risk in the later stages of the project. This changes has also, though, meant that the remaining providers have taken on further work, thus generating additional revenue as well as broadening the scope of the services they provide.

4. **Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs: achieved.** As highlighted above, the WtW SIB highlights a number of lessons learnt in relation to the design and delivery of SIBs. Some of the stakeholders involved in the SIB (notable the WtW team and investment fund manager) are proactive in sharing these lessons 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.

The SIB also has some quite interesting features. One such feature is the fact that the outcome payments for Outcome B are attached to an estimate of the counterfactual – so the commissioner only pays for those outcomes above the estimate of what would

have happened anyway. This was of crucial importance in this SIB because the commissioner wanted the savings (or more accurately future avoided costs) from the intervention to cover the cost of their outcome payments. Tying payments to the counterfactual provides the reassurance that demand for services has truly been lower among the cohort receiving the intervention, and thus that quantifiable financial benefits to the CCG have been generated. This is particularly interesting as tying payments to performance against a measure of the counterfactual is seen as the 'textbook' approach to operating a SIB, but is not common in the UK because it has a number of disadvantages (in terms of the additional cost and complexity it can generate, and because it is not always feasible);[23] This SIB suggests that the use of a counterfactual is important when the commissioner wants reassurance that the financial benefits are quantifiable and justify the costs of the outcome payments. It is also likely to strengthen the evidence base for the effectiveness of the intervention – including the case for working at scale, and thus support sustainment of similar projects in the longer term.

One can also interpret the withdrawal of two service providers in a 'glass half empty' or 'glass half full' way. The 'glass half empty' interpretation would be that this withdrawal undermined the extent to which the WtW SIB has enabled smaller and less financially strong VCSE organisations to be involved – a claimed and expected benefit of the SIB at its inception. On this interpretation it is unlikely that there would have been such pressure on providers if they had been conventionally paid. A 'glass half full' assessment would be that the remaining service providers who took over cases from the service providers that withdrew then achieved greater success with these cases, highlighting that the outcomes-based and performance-management elements of the project succeeded in driving up performance. It is also misleading to suggest that financial strength was the primary or only factor affecting providers' decisions. At the start there were two providers with income of around £1m and two much larger providers with turnover of more than £20m – but one each of the former and latter category withdrew, and one in each category stayed and prospered. It is thus clear that at least one relatively 'small' provider was comfortable to continue without a block payment. However it should also be pointed out that none of the providers can be defined as 'small' in terms of accepted VCSE definitions[24] – a provider with income of more than £1m is regarded as 'Large' and one with income of more than £20m is defined as 'Major' – and in 2017/18 there were only 5,464 of the former and 659 of the latter in the UK . So in effect this contract was always limited to relatively strong and 'large' VCSEs from the outset.

Which interpretation (glass half full/empty) you see as the more valid one really depends on your own priorities, and, whether you deem it more important to ensure that all service providers (irrespective of size and financial strength) can securely deliver services without any financial risk, or, whether it is more important to use performance-related payments to maximise outcomes for service users. As one stakeholder put it: *"On one side performance is better; on the other is the tyranny of metrics"* and the conditional payment regime.

As with many SIBs we have analysed, the WtW SIB is a mixed picture of both benefits and challenges, and it is difficult to summarise the overall value for money and benefit of the SIB mechanism. But ultimately one needs to bear in mind that the majority of stakeholders, whilst arguably bruised, continue to be dedicated to the SIB because it is achieving its original purposes: helping thousands of people improve their lives, transferring financial risk (to investors), and linking outcomes payments to realisation of forecast savings for the CCG, which enabled the CCG to launch a socially innovative project at a scale that has not been seen before.

23 Carter et al, 2018. Building the tools for public services to secure better outcomes: Collaboration, Prevention, Innovation. See: https://s3.eu-west-2.amazonaws.com/golab.prod/documents/BSG-GOLab-EvidenceReport-20190730.pdf

24 See the UK Civil Society Almanac 2020 which has standard definitions of VCSEs by size ranging from 'Micro' to 'Super-Major' at https://data.ncvo.org.uk/profile/size-and-scope/

Stakeholders are convinced that the service is proving to be effective, and the data appear to be supporting this view, now that the data validators have corrected the error which led to much of the debate around performance outlined in this report. The CCG is scaling up its use of Link Workers, with one stakeholder believing this is partly due to the success of the WtW service. They also think the project (combined with the funded research studies) will provide an evidence base for social prescribing that will have national consequences. And whilst everyone acknowledges there have been tensions, some see this as leading to positive developments: "If it all becomes a bit wishy washy and you're all buddies together you don't achieve anything." Ultimately, most stakeholders think the positives outweigh the negatives. Therefore, when assessing this SIB it is important to remember the quote from one stakeholder: "It's gone at least well as could have been expected, but boy has it been difficult."

Areas for future investigation in visit 3

- Does the 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 LTC management/lower costs
- 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?
- 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?
- What makes some service providers more disposed towards working on a project funded through an outcomes-based commissioning approach?
- How does the service ultimately perform compared to the other social prescribing services taking place in Newcastle, and to other social prescribing services nationally,
- What role does the capital play in producing any such differences attributed to the SIB mechanism? What are their attitudes to working with Social investment as part of commissioners' relationships with providers in the future?
- What has been the impact of Covid-19 on SIB service user cohort, delivery, outcomes funders and funding in the short and medium term, including anticipated savings and financials?
- What work has been done by project stakeholders to sustain the project delivery beyond 2021 including exploration of changes to service user cohort, geographical coverage, commissioner and funding arrangements?

Appendix A – Summary of data issues relating to Outcome B

A.1 Introduction

This note describes in more detail the data issues relating to Outcome B that are mentioned in the main report, and which led to much of the discussion described in the report about performance variation and how it might be addressed. As this note explains, it transpired in late 2018 that there had been a significant error in the way the data was collected which meant that performance against Outcome B was, in fact, not variable and overall performance was very close to forecast levels.

This note is based on analysis prepared by WtW in November 2018, and therefore it does not provide up to date (2020) analysis of WtW performance against Outcome B

A.2 How Outcome B data is collected

WtW regularly receives aggregated, anonymised secondary care (hospital) cost data from North of England Commissioning Support (NECS). This data is used by WtW, NECS and Newcastle Gateshead CCG to calculate Outcome B payments to WtW. The calculation is based on the difference in total secondary care costs per head between the full eligible Ways to Wellness cohort (in West Newcastle) and a similarly matched comparison cohort in the North and East of Newcastle

A.3 Discovery of data error and immediate effect of correction

WtW's analysis of the data received on the 18th September 2018 highlighted an unexpected change to historic 'fixed' (final) data for the comparison cohort from January 2017. In effect, the NECS historic data for the months from January 2017 to April 2018 differed from the 'final' data that NECS had previously provided, which had been used to calculate historic Outcome B payments over 13 months (April 2017 to April 2018).

Further investigations revealed an error in the formulas in the historic data, in which Accident and Emergency (A&E) costs for the comparison cohort had been excluded from the total cost data from January 2017 to April 2018. The formulas had been corrected in the data which NECS provided in September 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 resulted in a difference (shortfall) of £277,055 (excluding VAT) for those 13 months.

WtW raised the data error with NECS and they confirmed WtW's interpretation (they had not previously been aware of the error and their correction was inadvertent) and agreed with the correction and implications for Outcome B. NECS and the CCG also agreed to payment of the backdated underpayment of Outcome B.

A.4 Effect of correction on Outcome B performance and wider impact

This data correction favourably shifted WtW's financial sustainability and reduced uncertainties. Outcome B projections are much less variable: over the 16 months to date is Outcome B achievement has been 99% of maximum payment.

Furthermore, this data correction has favourably shifted WtW's impact measurement. As explained above, the change to secondary care costs is measured by comparing the full cohort of patients who are eligible for the Ways to Wellness service in the west of Newcastle upon Tyne with a similarly matched cohort in the North and East of Newcastle. The measure calculates the difference between the full eligible WtW cohort and the matched comparison cohort, as matching average characteristics can only be done at cohort level, and the 12-month cost. The measure is then adjusted to account for the proportion of the WtW cohort who had engaged with the service at the onset of the measurement period.

The results show that the Ways to Wellness adjusted cohort averages 38% lower costs per head than the comparison cohort over the past 16 months.

The full Ways to Wellness cohort measurement shows a favourable change in secondary care spend starting in 2017/18, despite an average of only 11% of the full eligible cohort having engaged with the service. The average cost per head for the comparison cohort increased by 11% in 2017/18 over the previous year, while the Ways to Wellness full eligible cohort increased by only 4% in the same period. Secondary care costs for the full eligible Ways to Wellness cohort were, on average, 5% lower than the secondary care costs for the comparison cohort in 2017/18.

Other comparison measures of secondary care costs and activity also show favourable trends. For example, secondary care activity per 100,000 patients was almost equal between the two cohorts in 2016/17. In 2017/18 activity per 100,000 patients increased at twice the rate for the comparison cohort than it did for the full eligible Ways to Wellness cohort. The comparison cohort activity per 100,000 patients was 18% higher than for the full Ways to Wellness cohort in 2017/18.

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